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Development Strategy for the Local Health Security Fund in National Health Security Office Region 10, UbonRatchathani,Thailand

Arun Boonsang[1]*,Somboon Penpim[2]
[1]College of Medicine and Public Health, UbonRatchathani University, Thailand
[2]National Health Security Office Region 10,UbonRatchathani, Thailand

***Corresponding author:** Arun Boonsang. College of Medicine and Public Health, UbonRatchathani University, Thailand. E- mail: arun.b@ubu.ac.th

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ABSTRACT

Local health security funds or Community Health Fund are an innovation introduced to achieve greater local government involvement in Thailand's Universal Health Coverage and is an outcome of decentralizing power to local administrations and serves as a health fund for people in local communities. The fund's budget is subsidized by the National Health Security Office which the contributes to a fund with a condition that the local government provides matching funding, but it also found that most funds run by fund administrative committee of Local Administrative Organizations had significant weakness such as their lacked strategies for deploying funds, had taken few steps to promote cooperation among local health care providers and lacked systematic mechanisms for assessing available resources and health informatic system. This study aimed to develop a strategy for agreeing and implementing the Local Health Security Fund in a northeastern Thai provinces. It applied mixed research methodology to investigate fund strategies and development models. The quantitative study component involved a questionnaire completed by 720 members serving on funds administrative committees from 270 fund. The results of study identified six strategies employed by existing funds : 1**)** Strengthening and developing the capacity of fund committee. 2**)** Developing the capacity of the fund mentoring team, 3**)** Developing the information system 4**)** Promote and support the process of strengthening collaboration mechanisms between health organizations, 5**)** Promote and develop fund potential and 6**)** Developing strategies for health promotion and disease prevention. And the model of LHSF developmental strategy is consistent with the empirical data (CMIN / df = 1.867 ,p = .000 , GFI = .937 ,AGFI = .907 , CFI = .968 , NFI = .935 , RMSEA = .037

Therefore, the study provides significant finding on best element from existing strategies can be brought together to formulate an improved strategy for local health security fund development. Also, The funds should be promote health and prevent disease as their core objectives, explore how funding can be maximized and used to achieve maximum health gain, and develop a role as center for learning about community health.

Keywords: *Development Strategy, Local Health Security Fund, Thailand*

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INTRODUCTION

Localhealthsecurity funds (LHSFs) (sometimes called community health funds) are an innovation introduced to achieve greater local government involvement in Thailand's Universal Health Coverage(UHC) scheme.1and is an outcome of decentralizing power in favor of local administration and serves as a health fund for people in local communities. LHSFs were established in 2006 by virtue of the National Health Security Act B.E. 2545 (A.D.2002).2With the aim of decentralizing power in favor of local communities to better provide for community health care. A LHSF budget includes a local government contribution as well as funding from Thailand's National Health Security Office (NHSO), the agency that manages and funds the wider UHC scheme. A number of exemplary models of community health carehave been developed across the country, including emergency ambulance services, alcohol-free communities, family relation projects, home services for disabled people, improved elderly care, diabetes and hypertension prevention programmes, and the provision of physical and mental therapies for patients with chronic illnesses. By the end of February 2010, 3,946 rural and urban local government organizations were overseeing LHSFs. The funds are managed at the sub-district level known as the tambon. In rural areas these bodies take the form of tambon administrative organizations (TAOs), while in urban settings they are known as municipalities.This number of LHSFs will increase because information about early best practice has inspired other communities nationwide to develop community health programs.3 Local government involvement in health promotion,has been strengthened by the establishment of sub-district funds for prevention of disease and promotion of health services known as the "TambonHealth Insurance Fund" (THIF) . 4 The THIF was initiated by the NHSO with the aim of increasing awareness and involvement of local governments and communities in health promotion and disease prevention activities, particularly where these benefit hard-to-reach groups within communities. These groups are burdened with a predominance of chronic noncommunicable diseases.5 which are difficult to address without inter-sectoral cooperation by concerned organizations and ownership by the communities. Starting in 2006 the NHSO allocated monies to THIFs with the aim of improving accessibility to health promotion and disease prevention (P&P) services. Improvement focused inter alia on developing proactive service for key target groups, the closing of gaps in access to health care, and the empowerment of local administrative officers and community groups. Local government bodies were invited to participate in the THIF initiative on a voluntary basis, subject to the condition that they provided matching funds. The NHSO initially earmarked 37.5 baht per eligible local resident to the THIF for disease prevention and health promotion services, while local governments were obliged to match 10%, 20%, or even 50% of the budget according to their financial capability. Since 2009, the per capita budget allocated by the NHSO has increased to 40 baht and the proportion of the contribution from local governments has been raised to 20, 30 and 50 percent. The fund is managed by a committee comprised of representatives from the municipality or TAO, community leaders and health workers. The number of local governments setting up a THIF increased dramatically from 869 in 2006-7 to 2,677 and 3,933 in 2008 and 2009 respectively out of a total of 7,851 tambons. By 2009 fifty percent of local governments had a THIF. Early evaluation of the THIF initiative suggests that it has been successful in raising public awareness and engagement in tackling health problems.6

Currently more than 10 billion baht per annum is allocated to the population covered by LHSFs and 99.67% of all local government organizations are participating, but the overall effectiveness of the funds remains unclear. It is worth noting that Japan, the first Asian nation to achieve universal health coverage with a 70-year long history, achieved this by employing a 20% co-payment policy, and that even today some problems still exist. There is no redistribution or equalization among funds and it particularly burdened Japan's National Health Insurance system.7 The experience of setting up similar funds in developing countries shows promise.

For example, the community health fund in Tanzania was initially a pilot program subsidized by matching funds from the government, the World Bank's International Development Association, and other donors. The aim is that members' contributions will increase gradually until they can cover most of the costs. Tanzania's community health fund provides a financing mechanism for health care in rural areas based on secure access to health care at a time of critical need through prepaid health services. 8

In the literature review of official documents and research reports on the situation in Thailand, we found that most localhealth security funds run by municipalities and TAOs had significant administrative weaknesses. They lacked strategies for deploying funds, had taken few steps to promote cooperation among local health care providers, and lacked systematic mechanisms for assessing available resources and workload distribution. We found that there was a dearth of research on how LHSF might develop in future, with debate on this largely confined to the guidance provided by the official NHSO strategy document. A LHSF committee thus had little information on how best to develop its fund, create a framework for cooperation between local partners, and create projects for service improvement that might be achieved through wider public participation. Therefore, this gap in knowledge captured the research team's interest and highlighted the need to survey existing practices so as to develop improved strategies for managing LHSFs. It was decided to develop a structural model that built on the best lessons emerging from existing strategies, which would begin to map out an improved consolidated strategy and encourage LHSF committees to move towards a more standardized approach.This study aims to develop a strategy for agreeing and implementing the Local Health Security Fund (LHSF) in a northeastern Thai province.

MATERIALS AND METHODS

Study design and Data sources

This research and development study employed the mixed method convergent design.9 This study aimed to develop a strategy for agreeing and implementing the Local Health Security Fund in a northeastern Thai provinces. It applied mixed research methodology to investigate fund strategies and development models. The population consisted of 720 LHSFs administrative committees who were not in the interview samples, from 270 funds in 5 provinces across NHSO region 10UbonRatchathani, Thailand. The samples were selected by multi–stage random sampling and the sample size was determined with a ratio a of 20 respondents per parameter which was considered most appropriate.10The proposed model was relatively complex with an estimation of approximately 36 parameters, and the study required 720 respondents.Five research steps were involved.11: (1)Strategy creation, (2)Strategy examination,(3) Data collection and analysis, (4) Strategy model validation and (5) developmental Strategy guidelines(Figure 1).

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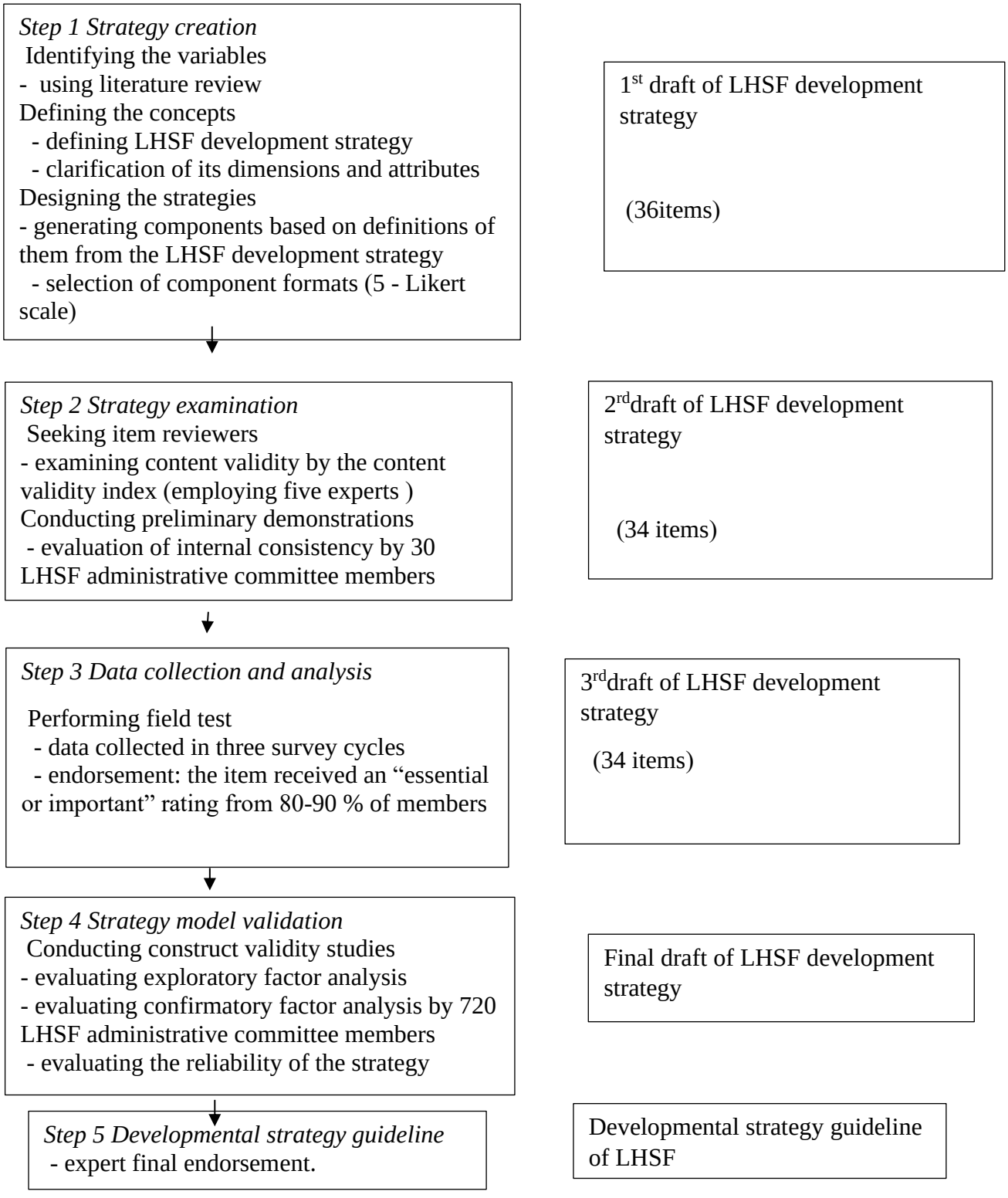

FIGURE 1. Steps of Strategy Development

Data Collection

The components of the strategy were constructed based on concepts and theories resulting from reviewing and synthesizing the components of the strategy. This involved focus groups among representatives of the LHSF at the sub-district level, community health alliances, and local health fund stakeholders. Five focus groups were conducted involving 60 subjects (including representatives from LHSF administrative committees). In-depth interviews were arranged including experts on LHSF such as policy makers, researchers and representatives from LHSF administrative committees comprised of eight experts. Finally, the study sought to find consensus in a workshop seminar comprised of all of the groups before the examination and development of LHSF strategy was synthesized and a hypothetical model for research was determined. The objective was clarification of the dimensions and characteristics of designing a funding strategy.

The Delphi process is an expert consensus method that can be used to develop best practice guidelines. This includes policy makers, academicians, LHSF administrative committee members, health providers and civil society organizations. The advantage of the Delphi method over other methods used in projects described above, such as expert working groups and focus groups, is that expert opinions are gathered anonymously through the use of an online (or postal) survey, allowing for all participants on the panel to equally influence the results.12 This study used a Delphi technique comprised of three rounds. A list of respondents was selected purposively to represent the various groups mentioned above. 71 experts drawn from this group completed the Delphi survey instruments. The first-round instrument summarized opinions about possible strategies for the LHSF and invited experts to refine the ideas. The second round effectively repeated this exercise, but added information about what was stated in the first round. This gave respondents an opportunity to change their minds or to confirm their views given that they had learned what other respondents thought. The questionnaire was tested by five experts for its content validity and content component coverage, and then an index of Item/Objective Congruence (IOC) was analyzed, before strategies with an IOC index of 0.5 and above were selected. This indicated that a particular strategy was in congruence with the objectives and content to be determine.13The results were that IOC indexes ranged from 0.71 to 1.00. Construct validity and suitability were also tested by pilot testing the questionnaire with 36 subjects in order to determine the reliability of the entire questionnaire.

The result was that the reliability ranged from .756 - .906. The questionnaire was improved and then used to collect data from a group of 720 subjects. The construct validity and suitability of the strategies were tested and the results ranged from .539 - .976. The questionnaire was improved and then used to collect data from a group of samples comprised of 720 LHSF administrative committee members who were not in the interview samples, from 270 funds under 5 provinces across NHSO region area 10, UbonRatchathani, Thailand. The samples were selected by multi–stage random sampling and the sample size was determined with a ratio of 20 respondents per parameter which was considered most appropriate.10As the proposed model was relatively complex (an estimated 36 parameters), the study required 720 respondents.

Statistical Analysis

After the data analysis of the components and strategies of the LHSF from the first stage was obtained, the quality and appropriateness of the strategies had to be confirmed. Therefore, the second order confirmatory factor analysis (second CFA) technique was used to analyze the data collected from nationwide survey questionnaires which were sent back from LHSF administrative committees through the AMOS program14.This technique was used to confirm whether or not the factors and developmental strategies of the LHSF based on the initial interviews were consistent with empirical data. In this research, the second CFA of LHSF strategies used latent variable analysis to check model validity or the developed models consistent with particular levels of empirical data.

Ethical Consideration

The ethics committee of the provincial UbonRatchathani public health office approved this study (registration no. SSJ.UB 2561 – 018) on May 8, 2018.

RESULTS

Socio-demographic characteristic

The questionnaire was improved and then used to collect data from a group of 720 subjects. The results of the study found that the LHSF administrative committee included a majority of 438 males (60.83 %) and the average age was 48 years (S.D. = 9.31). The majority of the respondents in the group were married (78.33 %). Most had a careers as a government workers (72.50%). The majority were at an education level of a Master's degree or higher (49.4%). The average income of the majority exceeded 20,000 baht (80.83%). The majority of positions in the LHSF were committee positions (83.33 %) and the average work experience was 5 years (S.D. 2.59).

The results of this study have been offered within Three prospectuses such as problem and obstacles of management process of LHSFs, empirical and confirmative strategies. The findings are presented below.

The number of participants in-depth interviewed was eight and focus group discussion was 60. The data of informants are shown in table 1.

TABLE 1. The Example of Coding process for subcategories to category and Theme

Topic	Subcategory	category	Theme
What are obstacles to manage fund.	The chairman of fund lacks vision and Leadership in managing the fund Committee lacks of knowledge and skill in for fund management Lack of fund development strategic The fund lacks the participation of various network partner in the community. Lacks of mentoring system and monitoring and evaluation from higher agencies. Lacks of confidence in the use of fund budget Fear of inspection from audit agencies.	Leadership Lack of knowledge and skill Development strategy Participation Lack of mentoring system Lack of confidences	Portrait to obstacles and develop fund strategic.
What are the fund development strategy	Strengthen and develop the capacity of LHSF committees Develop the capacity of the fund mentoring team; Develop the information system, communication-related technology and research support R2R; Promote and support the process of strengthening collaboration mechanisms among health organizations Promote and develop fund capability Develop strategies for health promotion, disease prevention, consumer protection and health hazards warnings	Strengthen and development capacity of committees Development competency of the fund mentoring team. Developing a information system. Enhance cooperation of health network. Promoting and developing fund potential. Health promotion and disease prevention.	

The theme of portrait to obstacles and develop fund strategicinNHSO region 10 reflected that the fund administration committee already has budget in place but having many obstacles to manage fund from leadership, fund committee, management system, confidences and participation. A summary of twelves categories consisting of six classes of obstacles and six development strategy were revealed (Table 1).

The new finding of the research are from group discussion and in-depth interviews with representatives from relevant health network partner. The six categories of the main problem and obstacles of LHSFs administration found that 1)The chairman of fund lacks of vision and Leadership in managing the fund ,

2) The fund committee lacks of knowledge and skill for fund management 3) Lack of fund development strategy. 4)The fund lacks the participation of various network partner in the community. 5) Lacks of mentoring system and monitoring and evaluation from higher agencies. And 6) Lacks of confidence in the use of fund budget because fear of inspection from audit agencies.. While the six categories of development strategy for the fund consisted (1) Strengthen and development capacity of committees,(2) Development competency of the fund mentoring team, (3) Developing a information system, (4) Enhance co-operation of health network, (5) Promoting and developing fund potential, and (6)Health promotion and disease prevention.

The results indicate that there are a number of problem and obstacles to manage fund and the results also indicate that development strategy for the fund in NHSO region 10 has considered every level of community health network partners, fund administrative committees and regulations of local government and attempts to tackle existing obstacles in practice.

Empirical Strategies

The first stage revealed that the literature was relevant to the issues of LHSF including that 1) most local funders had appointed a subcommittee delegation following the NHSO criteria for administrative work, finance and a project assistant secretary, etc. 2) The secretaries of the LHSF were usually the municipal and the Tambon Administration Organization (TAO) workers. 3) Most of the board's committees had management processes and community health planning experience. The majority of the board knew the committee's role in relation to local health security fund management from training courses, conferences, seminars, etc. the effective bases for community needs. Moreover, the findings demonstrated that the development of creative strategies obtained 6 strategies with 36 questions for which each quote is classified by an identifier in a consensus at the end of the quote. The identifiers are: strategy 1: strengthen and develop the capacity of the LHSF committee(Board_delv); strategy 2: develop the capacity of the fund mentoring team (Coach_delv); strategy 3: develop an information system, communication-related technology and research support R2R(Data_res); strategy 4: promote and support the process of strengthening collaboration mechanisms among health organizations(Network_str); strategy 5: promote and develop fund capability(Learning_cen); strategy 6: develop strategies for health promotion, disease prevention, consumer protection and health hazard warnings(Promotion_pre).

Furthermore, the second stage of strategy examination resulted in using the Delphi technique in the final round and revealed that the Delphi questionnaire contained 36 questions that included a rationale for the LHSF 6 strategies and 34 sub-strategies (as mention above. This was comprised of a 1) Board_delv strategy comprised of 6 sub-strategies (such as the committee came to the fund to set the vision, mission and goals of the LHSF through the participation of all sectors etc.); 2) the Coach_delv strategy is comprised of 5 sub-strategies; 3) the Data_res strategy is comprised of 6 sub-strategies; 4) the Network_str strategy is comprised of 5 sub-strategies; 5) the Learning_cen strategy is comprised of 6 sub-strategies; and the 6) Promotion_pre strategy is comprised of 6 sub-strategies.

Confirmative Strategies

The results of data analysis of the inter–correlation matrix of 6 strategies of LHSF showed a value from 0.482 to 0.964. All strategies of correlation were significant at 0.001 level (2-tailed).

The results of the fourth stage found that the first–order CFA (First Model) revealed that the chi-square ($\chi 2$) value was 606.311 at a degree of freedom, df = 410.00 with a probability of 1 (P–value =.000). This means that the Chi-square value deviated significantly from null. The GFI and AGFI value were .937 and.907respectively, and the RMSEA =.037

Additionally, there were results of a second order CFA with a statistical program for developing strategies for the LHSF. This study found that: (1) the Fund Development Strategy consisted of 6 strategies as follows: strategy

1: strengthen and develop the capacity of LHSF committees; strategy 2: develop the capacity of the fund mentoring team; strategy 3: develop the information system, communication-related technology and research support R2R; strategy 4: promote and support the process of strengthening collaboration mechanisms among health organizations; strategy 5: promote and develop fund capability; strategy 6: develop strategies for health promotion, disease prevention, consumer protection and health hazards warnings and (2) the strategies developed for the LHSF were congruent with empirical data including Chi-square($\chi 2$) = 606.311 and the degree of freedom (df) = 325.00 , $\chi 2$ /df = 1.867 , p – value = .000, the goodness of fit (GFI) = 0.937, adjusted goodness of fit index (AGFI) =.907 and root mean square error of approximation (RMSEA) = .037

TABLE 2 . The results of the second – order CFA with a statistical program for development strategies for the LHSF

Strategies	**Estimate**	**SE**	**C.R.**	**Regression Weight standard**	**R^2**
Board_delv	0.835	0.084	9.933***	0.794	0.631
Coach_delv	0.214	0.046	4.659***	0.480	0.230
Data_res	1.000	…	…	0.797	0.635
Network_str	0.814	0.101	7.669***	0.837	0.700
Learning_cen	1.125	0.102	11.066***	0.957	0.916
Promotion_pre	1.404	0.116	12.060***	0.887	0.787

*** means statistical significance at the 0.000 level

From Table 2, The regression weight standardized factor is considered for all elements greater than 0.30 with values ranging from 0.480to 0.957. The most influential element is Learning_cen (promote and develop fund capability) at 0.957, followed by promotion_pre, Network_str, Data_res, Board_Delv and Coach_delv, respectively. Considering the standard error (SE) and t-statistic, the difference was statistically significant at the 0.001level and the C.R. (critical ratio) >3.291 in All pairs of variables. It was found to be statistically significant at the 0.000 level. Thus each sub-element in the overall model is related. This relationship is derived from the relationship between the variance and covariance of the normalized subcomponents. It was concluded that the overall factor measurement model was appropriate and harmonized with the individual data obtained from the sample.

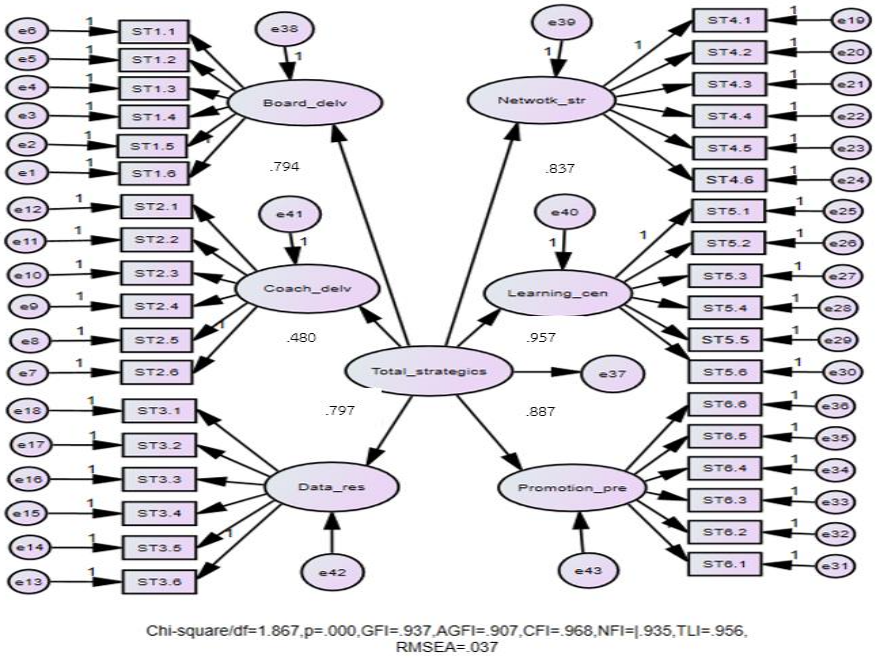

FIGURE 2.The results of the model analysis of developmental strategies of LHSF obtained from the first order and second-order CFA

From figure 2, the results of the analysis. The second corroborative component of the overall development strategy with the AMOS program yielded the following model conformance index: Chi -square / df =1.867 ,p = .000 , GFI = .937 ,AGFI = .907 , CFI = .968 , NFI = .935 , RMR = .030 , RMSEA = .037

The conformity index met the criteria: the relative chi-square was less than 2, the RMSEA index, the RMR was less than 0.05, and the GFI, AGFI, CFI, and NFI indexes were greater than.90. The overall development strategy (Total- Strategics) consists of 6 strategies, namely..Learning_cen, Promotion_pre, Network_str, Data_res, Board_delv and Coach_delv. When considering the weighting of the six latent variables from the standard weighting coefficient (R2), it turned out that Learning_cen was the most important. followed by Promotion_pre, Network_str, Data_res, Board_delv and Coach_delv, (R2 = .916, .787, .700, .635, .631 and .230 respectively).

The results of the final step are the guidelines document comprising the developmental strategies of the LHSF. The guideline document is comprised of 6 strategies containing 34 items. These guidelines demonstrate ways to improve the LHSF and these developmental strategies also reveal benefits for potential utility policymakers and LHSF committee members.

DISCUSSION

The main problem and obstacles of LHSFs administration found that 1)The chairman of fund lacks vision and Leadership in managing the fund , 2) Committee lacks of knowledge and skill for fund management, 3) Lack of fund development strategy, 4)The fund lacks the participation of various network partner in the community, 5) Lacks of mentoring system and monitoring and evaluation from higher agencies. And 6) Lacks of confidence in the use of fund budget because fear of inspection from audit agencies. Similarly,15 .The study revealed two urgent problems of LHSFC among lacking of knowledge and understanding for conducting Strategic Route Map (SRM) and lacking of knowledge and understanding for operating action plan to promote health care in each area. Moreover, nine key factors of success in LHSF's management in Muang district, Phrae province were revealed.

They were the factor of partnership and networks participation from all sectors; the factor of monitoring and evaluation with continuously; the factor of community participation in conducting action plan; the factor of strategic route map conducting; the factor of understanding in role of LHSFC and managerial process; the factor of communication channel which rapid and accessible; the factor of learning exchange and field trip study from the best practice of LHSF's management; the factor of the visionary leaders and the factor of LHSFC's potential development annually. The results of LHSFC's potential development found that LHSFC had knowledge and understanding increased after training. The difference was statistically significant at 0.000 confidence level of 99% ($p<0.01$) both of the strategic route map training and the action plan training.Andthis study shown that the six fund development strategies 34 items can be promote and develop the fund management committee's capacity to plan strategies for operation on their own as well as promote community participation. The results of the research findings illustrate that for the strategy of promote and develop fund capability had the greatest impact on overall development strategy. which the most important factor is the people have health self-reliance activities that are included in the community plans and can be put into practice. These result in people being able to take care of themselves in health, such as exercise activities., etc.Similarly,16.The results revealed that: Fund operations most of them have not been evaluated. Especially in the provision of services according to the benefit package for pregnant women and the provision of services according to the benefit package for adults. This is because the fund committee still lacks knowledge, understanding and lack of mentors to supervise, follow, help. The model consisted of 5 elements: the first element was the goal. The second element was the input. The third element was element was the 5 steps of process 1) establishment of provincial mentors, 2) creating knowledge 3) creating guidelines for job, 4) creating a guideline for fund committees, 5) improving. The fourth element was products. The fifth element was condition for success. The evaluation of the model's suitability and feasibility was at a high level. The results of the trial using the model the fund committee has knowledge there is a way to operate there was a statistically significant increase in participation. The results of the assessment of all five sets of benefits passed.

The new finding are the six categories of development strategy for the fund which the most influential element is promote and develop fund capability strategymay be because the goal promoting local health security funds to be in accordance with the objectives of the Fund with efficiency and effectiveness what is important and necessary to do first is that the fund must have guidelines or strategies to promote and develop the potential or capability of the fund to have high potential. Until being able to be a model in fund management.And followed by develop strategies for health promotion, disease prevention may be due to the fund must have a clear strategy for health promotion and disease prevention. To be used as a guideline for planning projects and activities of the Fund. In addition, the LHSF administration to be effective, there must be evidence of a strategy to promote and support the process of strengthening collaborative mechanisms and developing the capacity of the fund mentoring team.Similarly,17 found that a community-based budget for community health funds allowing participation of local government in public health requires thorough monitoring and oversight. There were questions about the appropriateness of using those funds for certain activities and the limitations of local government for understanding public health. It needs a balanced and solid relationship between the health sector and community to cooperate in using this fund effectively with a mechanism to monitor checks and balances as well as for building capacity. Strategic development is needed for health promotion and disease prevention. Similarly,18 according to an evaluate study of Wungsang Local Fund Health security (WLFHS) found that the role of the local fund health security committees in local government should change and develop knowledge, skill, and training local fund health security management. The interactive of the various components gives rise to a particular strategy, each of which could be shaped and made to function in a variety of ways. Some useful tips are given when shaping up the above-mentioned components, viz. (1)

The target committees; emphasis is on the refinement into sub-committees using social criteria. This group is the starting point in the definition of roles and interplay of the other components. (2) The service provider and facilitator; there will be role changes subservient to the new role and responsibility of the people in community(3) The individual as a society or community member; they should be prepared to take more active role and responsibility in items of health promotion and disease prevention and (4) The local governmentorganizations should have develop their capabilities continuously and regularly. Similarly,19 found health financing reform in Vietnam where is undertaking health financing reform with a view to achieve universal coverage of health insurance within the coming years. To date, around half of the population is covered with some type of a health insurance or a prepayment. This review applies a conceptual framework of health financing to provide a coherent assessment of the reforms to date with respect to a set of key policy objectives of health financing, including financial sustainability, efficiency in service provision, and equity in health financing. Based on the assessment, the review discusses the main implications of the reforms focusing on achievements and remaining challenges, the nature of the Vietnamese reforms in an international perspective, and the role of the government. The main lessons from the Vietnamese experiences, from which other reforming countries may draw, are the need for sustained resource mobilization, comprehensive reform involving all functions of the health reform. Future analysis should include continued evaluation of the reforms in terms of impacts on key outcomes and the political dimensions of health reform.And strategy ofdevelop an information system, communication-related technology and research support R2Ris also an important strategy for the development of local health insurance funds. If the fund has information that is up-to-date and true. will be able to take advantage of planning to solve problems on the spot There is communication through modern and timely channels. Including support for research from routine work and innovation. So futurepolicy need tobe informed by research evidence regarding the organizational framework required to deliver Universal health coverage at the local level.Similarly,20The impact of decentralization on the UCs. Decentralization had limited impact on the implementation of the UCS. The Plan and Process for Decentralization to Local Administrative organization Act of 1999 mandated ministries, including the MOPH, to develop action plans for the decentralization of functions, resources and staff to the elected Local Administrative Organizations (LAOs) by 2010. The Act also set a target for increasing the share of government budget that should be transfer to LAOs from 9% to 35% by 2006. In 2006, the law was amended to remove the 2006 deadline and reduce the minimum share of the nation budget to be transferred to 25%, with a target of 35%. Devolution of health care centers to Tambon Administrative Organizations (TAOs) and municipalities was initiated in the second plan for decentralization, prepared in 2006. Under the guidelines for devolution developed by the MOPH, devolution of a health care center can only occur when two criteria are met. First, the TAO/ municipality must meet “readiness” criteria to manage the manage the health center: the LAO must have received a good governance award and demonstrated capacity for and commitment to health by establishing a public health section in the TAO and contributing resources to a community health fund. The latter is an NHSO initiative to encourage local governments to lead and commit resources to disease prevention and health promotion activities; the NHSO contributes to a community health fund with a condition that the local government provides matching funding. Second, at least 50% of health centers staff must support devolution of their health center and be willing to transfer to LAO employment, including the health center head. With these exacting criteria, by 2009 only 28 of 8,000 health centers owned by the MOPH had devolved to TAOs. Regarding decentralization of hospital management, only one of more than 600 district hospitals has become autonomous under the provisions of the 1999 Public Organization Act., but a problem which has persisted since the UCS was launched has been the tension between different organization, interest groups and stakeholders.

Many of policy adjustments made as the UCs was implemented have involved power swing between the MOPH and NHSO,or between organizations at different levels such as the PHOs and CUPs, and central intervention has sometimes been needed to control the behaviour of particular actors. However, by 2010 there were signs of positive developments in this area, with some local government organizations beginning to play a bigger role, and more scope for community involvement in local health fund and local government health promotion projects.

As for evidence- based health finance and policy reform in Thailand, it was found thatThailand is an emerging democratic polity. The 2001 election reflected the strong demand of people for change because people were suffering from the recession. The Thai Rak Thai (TRT) party won the election because of its many popular policies tackling the economic crisis. Immediately after the TRT party, s landslide victory, with about 40.6 percent of the popular vote 21and the formation of the new government, the plan for implementing the universal health insurance policy was reformulated, based on evidence and experience. After detailed study and discussion, the scheme was modified from the voluntary, publicly subsidized health insurance systems, proposed during the election campaign, to a social welfare, totally tax-based system, with minimal copayment of 30 Baht per visit. Two months after setting up the new government, the policy was implemented in six provinces that had experience testing the new system under the Medical Welfare Scheme financial reform, supported by the world bank. The Universal Coverage (UC) policies created a big change in term of timing – a rapid increase of coverage (extending coverage to the 18.5 million people were previously uninsured) – and radical shift funding away from major city hospitals to rural provinces and district hospitals in order to build up primary care. This also involved changes in budgeting, regulation, and management rules and systems, resulting from the adoption of the contract model. Other aspects of new system were developed incrementally from the existing system. These included the benefit package, the use of primary care services, the patient-referral system, the quality assurance system, and private provider collaboration. The most challenge aspects of UC system design were the shift toward a tax-based financing system, attempt to standardize the benefit package and payment method between several schemes , splitting purchasers from providers, and decentralization of fund management. And The coverage and the benefit scheme. The Universal Health Care Coverage Scheme aims at providing universal access to essential health care and reducing catastrophic illness from out- of pocket payments by establishing a tax-based financing system and paying providers on a capitation basis.All Thai citizens are entitled to access to quality health care and a single standard benefit package. The benefit package includes a set of health interventions stipulated in a contact between purchaser and provider at every level of health services. It has been classified into three component: The curative package, the high-cost care package, and the promotive and the preventive package. The curative package cover ambulatory and hospitalization services with some exclusions, such as cosmetic surgery, infertility treatments, organ transplants, and the provision of private room and board. Initially ARV treatment for HIV/ AIDS and renal replacement therapy were excluded 22but were included in October 2003 and January 2008, respectively, because of strong social movement.

CONCLUSION

The study revealed thatthe main problem and obstacles of LHSFs administration found that the chairman of fund lacks vision and Leadership in managing the fund , the committee lacks of knowledge and skill for fund management ,lack of fund development strategy, the fund lacks the participation of various network partner in the community, lacks of mentoring system and monitoring and evaluation from higher agencies, lacks of confidence in the use of fund budget because fear of inspection from audit agencies. And the new finding are the six categories of development strategy for the fund which the most influential element is promote and develop fund capability strategy, followed by develop strategies for health promotion, disease prevention , promote and

support the process of strengthening collaboration mechanisms among health organizations , develop an information system, communication-related technology and research support R2R, strengthen and develop the capacity of LHSF committees and develop the capacity of the fund mentoring team , respectively.

In summary, it is necessary to strategy development building of local health security fund and capability development of LHSFs administrative committee to support a good public health management system at the local level.This study suggested that the developmental strategies can be used to create associated guidelines for planning according to these six strategies along with health promotion and disease prevention activities which are the basis and objective of the fund. This will be aid LHSF administrative committees and stakeholders and empower local governments to develop appropriate health plans and manage funds locally and autonomously. This will enhance the participation of various sectors and would collectively and constructively enable the LHSF to implement more social equity and sustainable health care systems to promote sustainability, adequacy, fairness and efficiency.

CONFFLICT OF INTEREST

The authors have no conflicts of interest to declare.

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