Urban Health Systems: Participatory development of health service systems

1. Definition

An urban area, as defined by the Royal Institute, refers to a municipal area with a population of 10,000 and above. According to Mahidol University's Glossary of Terms in Population and Social Research (2015), it refers to an area with a significant urban character, i.e. densely populated or having large population compared to the area size, with most people working in occupations other than agriculture.

A health system refers to a system of all relationships connected to health (Section 3, National Health Act BE 2550 (2007), covering such significant aspects as access, coverage, quality and safety, leading to a higher level of good health and health equity, having efficiency, protection of social and financial risks and meeting public expectations. The health system consists of at least six basic components: 1) health service delivery, 2) health workforce, 3) health information, 4) medical products, vaccination, and technology, 5) health financing, and 6) leadership and governance (for more details, see Document NHA 8/Main 3/Annex 1).

Health care systems/health service systems means the form of health service management as one of many components of a health system. The term is often used to refer to health service provision systems or programmes made available for the general public through investments by the government and/or the private sector. A health care (or health service) system consists of various activities of health promotion, disease prevention, treatment and rehabilitation. In a wider sense of the word, its components may cover the following aspects: 1) individual healthcare for persons and families, available at hospitals, clinics, community health centers, physicians' offices , and in the comfort of the home of service recipients, 2) public health services necessary to keep the environment conducive to health, such as controlling of water, food and drugs, and safety rules and regulations intended to protect particular groups of the population, 3) training, educational and research activities/programmes concerning disease prevention, patient identification, and treatment, and 4) collection of service fees from external bodies, e.g. health insurance systems.

2. Introduction

Urbanization is among the top priority factors in the consideration of the 21st century world's health system owing to its significant health impact. By 2050 more than 70% of the world's population is expected to live in an urban community. For Thailand, according to the estimation made by the Institute for Population and Social Research, Mahidol University, in 2013 the urban population accounted for 45.90% of the total population, compared to 36.12% in 2011. This indicates an upward trend of the Thai population to be urban dwellers living an urban life. Important factors that carry health impacts in an urban area include urban governance, population characteristics, natural and man-made environments, social and economic development, management of health service and emergency, and food security.

While urbanization brings with it a host of opportunities, it can pose a big challenge to achieving better health for the urban population. All the cities in the world at present and other upcoming cities are facing triple threats , for examples, HIV/AIDS, tuberculosis, pneumonia, acute diarrhea, such chronic non-communicable diseases as

asthma, heart diseases, cancer and diabetes, injuries, violence, and traffic-related hazards and injuries.

The challenges that Thailand faces with regard to urban health include ischemic heart diseases, stroke, laryngeal and lung cancers, HIV/AIDS infection, and liver cancer. The urbanization process is accompanied by rapid changes in various contextual aspects of economic, social, cultural or environmental. Such things as economic fluctuation, living in crowded society, and quick pace of life, are affecting the health of urban dwellers. Other glaring problems include inequity, unequal access to health resources, economic discrepancy (one of the factors that prevent lower-income and disadvantaged groups from getting access to quality service), social violence, narcotic problems, consumer protection regarding food, drug and medical products, housing deficit, environmental degradation, inadequate coverage of public services, and influx of migrant workers. All these problems come with "urbanization". It is found that an urban way of life with its diverse complexities is very much different from the rural counterpart.

Urbanization in Thailand has seen a fast change. People migrate from different parts of the country and abroad. They all come from different and unequal economic status, with different attitudes, personal beliefs and patterns of social interaction, making health problems of urban people more severe, especially with regard to public health management which might result in less opportunity for lower-income or disadvantaged groups to get access to quality service or to receive continuous health care for chronic diseases on a regular basis. To ensure better health for the urban dwellers, there is a need to develop the health system as fast as possible, especially in one important element, i.e. the health service system, so that it could respond effectively to these challenges.

3. Urban health service system

An effective urban health service system should cater for the needs of the public as demanded by the context in three basic ways: 1) improving the health of the people under its jurisdiction, 2) responding to public expectations, and 3) providing financial protection against the burden of illnesses. In this matter, the international community suggests that to enable a health service system to effectively tackle urban health problems, it is very important to develop the primary care system as fast as possible, well-equipped with professionals capable of providing quality services.

As a result of rapid expansion of urban communities, primary care system is charged with greater significance. A study of the forms of urban primary care systems in 14 countries has yielded several insights applicable to Thailand. These countries are: Brazil, Canada, Spain, Cuba, South Korea, Japan, Taiwan, Hong Kong, Denmark, Sweden, Belgium, UK, USA, and Australia. Basing the study on WHO Regional Office for Europe Framework for assessing primary care system, the study reveals that countries in which frontline service units are staffed with general medical practitioners or practitioners of family medicine usually see continuous health care with good cooperation among care-givers, leading to effective treatment results and better control of health spending. Most countries where the government is paying for health spending usually have in place the primary care services staffed with general practitioners or family physicians as frontline units for patient screening. On the other hand, in countries where the general public is responsible for their health spending in the form of compulsory health insurance systems, there are no systems for front office services to

screen patients; instead, there are systems in which co-payment is introduced to control unnecessary usage of services.

At present Thailand plans to put in place an urban health service system which is focused on strengthening primary care system. However, it is found that there are diverse agencies involved in health service provision from the government and private sectors, including local government organizations. Most health services provided by the government sector are under the Ministry of Public Health. On 1 October 2013 the ministry issued a policy on "health zones" to be implemented urgently. The idea is to decentralize the management power from the central level to regional levels through formation of health service zones. There are 12 zones, each covering 4-8 provinces (with a population of 3-6 million). The objectives of the policy are to provide greater public access to quality service, create equity in the allocation of health resources, and enhance management efficiency. Yet, in practice, the health zones as envisaged by the Ministry of Public Health are not quite extended enough to cover such sectors as local government organizations, university hospitals, hospitals affiliated with other government units than the Ministry of Public Health, and private hospitals. In 2015, the Ministry of Public Health came up with an idea to implement the MOPH urban health services in various forms as follows:

1. Community clinics: This is to set up more clinics for better public access. This may be delivered by the MOPH itself or contracted out for easy access to users. Services available only include basic curative ones.

2. Urban community health centers: Medical doctors are on duty on convenient time for the people, usually outside normal government working hours, 5-7 days a week, offering services in well-defined areas under their jurisdiction (catchment areas). Services include medical care (treatment) and public health (community) and offer through a team led by family medicine doctors**.**

4. Urban hospitals: Efforts are being made to construct new or expand existing hospital buildings for care of out-patients and in-patients in urban areas where regional or general hospitals are overcrowded (with a high bed occupancy rate). The idea is to provide adequate service to both out-patients and in-patients, using only needful specialists of major medical specialty, without having all sub-specialties in place. Referral systems with health facilities of other levels both at a lower level and with host hospitals need to be in place.

Moreover, the Ministry of Public Health has four models of primary care management, according to the primary care service structure. Some are self-operated within the MOPH, others are performed in collaboration with local government organizations and the private sector as follows;

1) Social medicine groups or family and community medicine groups which exist in regional or provincial hospitals, e.g. Khon Kaen Hospital and Hat Yai Hospital.

2) Service units in certain hospitals which are authorized to use the total capitation budgets after deduction of health personnel salary to cover all cost of out-patient care, health promotion and disease prevention, and facility depreciation costs, e.g. at Phra Nakhon Si Ayutthaya Hospital and Maharat Nakhon Ratchasima Hospital.

3) Hospitals which work in collaboration with local government organizations. There is a pooling of funds for out-patient care and support of health personnel, while the in-patient funds are exclusively managed by hospitals concerned, e.g. Phitsanulok Municipality working with Phraphutthachinnarat Hospital and Naresuan University Hospital.

4) Hospitals which authorize local government organizations or the private sector to do the work on their behalf. A host hospital will buy services from either local government units or private entity as municipality, private clinics, or the so-called "warm community" clinics.

In addition to services offered by the MOPH, a number of laws have authorized local government organizations of various levels to manage public service systems for the good of the local communities on several items. These items include, "public health, family health, and curative treatment" and "development of the capability of the people regarding behavior and awareness on health". In this connection, the existing two special local government organizations in Thailand are operating within the contexts of health service systems in their areas of jurisdiction as follows:

1. Bangkok Metropolitan Administration (BMA): In Bangkok there are a total of 142 public and private hospitals (only 28% are government-owned) and 4,558 private clinics of all types (excluding drug stores), i.e. general practice, dentistry, Thai traditional medicine or alternative medicine, nursing and midwifery, medical technology, and physiotherapy. Of this number, there are 270 primary care units participating in the national health security scheme: 94 belonging to the public sector, and 176 to the private sector. The BMA offers primary care both proactively and reactively to the people, through their 153 health facilities: 144 under the Health Department (68 health service centers and 76 health service sub-centers) and 9 hospitals under the Medical Service Department.

2. Pattaya City: In Pattaya area there are a total of 5 public and private hospitals (two public and three private hospitals), two Tambon health-promoting hospitals, one Pattaya City health service center, 249 private clinics of all types (excluding drug stores), and 484 drug stores.

4. Problem, constraints, and opportunity for development

Urban health service systems are beset with many problems and need to be tackled urgently by all sectors, organizations, and professionals concerned. The list of important issues below serves as illustrative examples only:

Issue 1: Health service delivery

1. The organization of urban health service systems shows much duplication of work done by the public and private sectors as well as local government organizations. In addition, there are a number of constraints regarding the integration of health service planning and networking, especially in patient referral and return systems. There are rooms for the improvement of efficiency.
2. Health service units are not adequately distributed in urban areas to provide good coverage. People living and working in certain parts of urban areas cannot get access to health services, resulting in health inequality and inequity.
3. Health services in some areas where there are health facilities still do not reach certain groups of the urban population, especially those in health promotion and disease prevention. For instances, in the 0-5 year-old children group the vaccination rate is still low, while health service delivery does not adequately cover latent population groups and foreign migrant workers.
4. A number of people lack confidence in the quality of primary care service and tend to seek health services from hospitals, often unnecessarily, resulting in congestion at hospitals while impeding development and efficiency of secondary and tertiary care services.
5. Urban health service facilities tend to focus on curative care and adopt a reactive approach rather than health promotion and disease prevention.

6. Preliminary findings of a study on the participatory development of primary care service systems in urban areas: a case study in Bangkok in the third quarter of 2015, showed that more than 40% of the people entitled to the Civil Servant Medical Benefit Scheme and social security scheme opted to pay out-of-pocket for their treatment and healthcare for the sake of convenience. Also interestingly, more than 50% of the people preferred to go to state and private hospitals for various medical services rather than to health service centers, clinics or drug stores. In addition, it is found that some major factors affecting their decision to choose a particular health service are the availability of medical supplies, modern medical technology which are of good quality and accepted standard, perceived image of the hospitals and the presence of specialized doctors.

7. Urban population tends to be individualistic. Despite being knowledgeable and highly educated averagely, some do not have adequate awareness of self-healthcare, health promotion and disease prevention, and active participation in solving health problems at population level.

Issue 2: Health financing

1. The health service procurement system of the public sector funds does not allow local government organizations to efficiently participate in the management and provision of health service to the local people. The way the money is allocated does not match well with their capability and contexts. For instance, the participating local government organizations are required to provide comprehensive health services as set in the framework of the Ministry of Public Health's standard services. As a result, some local authorities with the capability to do health promotion and disease prevention but without the capability for treatment are left out. Their role and proximity to the local people are, therefore, not made use of. The situation also affects the participating private sector, causing inequity in the reimbursement process and difficulties in the referral of patients to other service facilities which are better equipped, especially when it comes to referral from private to publichospitals. The current situation also does not motivate the private sector to participate fully.

2. Participating local government organizations cannot use the money allocated by the National Health Security Office to hire health workers to provide health services because the government budget auditing authority holds a different view that the money cannot be spent for that purpose.

3. The Tambon health fund faces a similar problem. Although there is a regulation on reimbursement payment by the National Health Security Office, the government budget auditing agency argues against it. Those administrators of local government organizations who already had authorized the payment had to bear the burden themselves, thus causing much uncertainty among other local government organizations whether or not to participate in the health scheme. In addition, there exist a variety of funds, each with its own regulation on payment; so, there is much discrepancy and little efficiency in practice.

4. Urban health service management is beset with lack of budget for the purpose, as service is consumed not only by the city's legitimate residents but also by foreigners and latent population who migrate or come to work in urban areas without proper documentation and registration.

5. Health financing measures are not in line with health seeking behaviors of the urban population who tends to use private services. As a result, some people find themselves in financial straits, unable to pay for the treatment by themselves. Others

resort to health services outside the normal health insurance schemes, e.g. by going to drugstores, and cannot be reimbursed, thus causing unnecessary financial household burdens.

Issue 3: Participatory management of health service system (leadership and governance)

1. There is little participation by service-providing agencies, whether public or private, or local government organizations. They all operate under different laws, rules and regulations with no common strategic plans for health service development, making it difficult to provide good health service to the public in a comprehensive manner. Besides, in specific areas where special administrative organizations exist, there is no lead organization serving as a coordinating center for a truly integrated service system..

2. There is little co-planning and resource sharing on health personnel, information systems, and expensive medical equipment, leading to duplication of investment and little cost-effectiveness.

The above-mentioned examples of things happening in urban areas nationwide, including areas of BMA and Pattaya City, clearly show that those problems cannot be solved by any single agency. Urban health services are provided by a number of agencies which are diverse with little work integration among them, with lack of connecting mechanisms and unclear patient referral and return systems. All this accounts for limitations in the management for participatory development of urban health service systems, in terms of policy formulation and work direction, infrastructural settings which encompass the number and quality of health personnel, strength of information systems, sufficiency of resources including medical and other material supplies, medical technology, organization of the medical and health service systems, including cycle of management, payment, and reimbursement of health budgets. In addition, there are often few mechanisms conducive for the serious and continuous coordination of the work within and between sectors. All this indicates the lack of common ownership in the urban health service systems, despite the fact that division of geographical areas according to certain administrative power and boundary has been in place. Thus, the whole health system seems to be functioning and developed without clear direction. Inevitably, urban residents find themselves at a greater health risk.

It is natural, therefore, that every sector concerned with urban health service systems should come together to set a strategic plan, determine guidelines for development, and set up mechanisms to drive forward good urban health service systems. This will ensure that provision of health services could accommodate all the health needs of the urban population effectively, adequately and in line with the real contexts.

5. Issue for consideration by the National Health Assembly

Requesting the National Health Assembly to consider Document NHA 8/ Draft Resolution 3: Urban health systems: Participatory development of health service systems.

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