NHSO
National Health Security Office

OPERATION OF NHSO
REGIONAL OFFICES

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1
INTRODUCTION

The operations of the Universal Coverage Scheme (UCS) of the National Health Security Office (NHSO) at the regional level play a crucial role in supporting, connecting, and coordinating between the NHSO and various local agencies. Additionally, the NHSO Regional Office (formerly NHSO branch Office) acts as a mechanism for implementing health insurance policies. The Regional NHSO serves as the main unit of the NHSO in coordinating with local agencies and organizations, as well as monitoring and evaluating service units in the area.

The establishment of the NHSO occurred amidst the wave of decentralization resulting from the 1999 Act on Planning and Procedures for Decentralization to Local Government Organizations, and the health system reform movement in Thailand. Given the importance of decentralization, the concept of creating a "small but beautiful" (i.e., efficient) organization was combined with the primary mission of establishing universal health care (UHC) in the country. As a result, the NHSO needed regional branch offices to decentralize power and responsibilities from the central NHSO to the branch (i.e., regional) offices. This decentralization aimed to ensure that the tasks of coordinating and collaborating with local agencies,

service units, and the public in the area could be carried out quickly, efficiently, and to alleviate the burden on the central NHSO.

In the early days, the NHSO assigned the Provincial Health Offices (PHO) to act as branch offices of the NHSO. Later, the NHSO implemented a policy to establish its own regional branch offices. However, it did not set up an office in every province to maintain the organization's "small but beautiful" structure. Each branch office was responsible for a group of provinces. The NHSO established its first branch office in Khon Kaen Province due to its readiness in various aspects. Over time, additional branch offices, now referred to as NHSO Regional Offices, were established to cover sub-national areas throughout the country.

As of 2023, the NHSO Regions comprised a total of 13 regions. Zones 1-12 encompass groups of provinces, while Region 13 covers Bangkok Metropolitan Region. There are a total of 17,247 registered service units with the NHSO. The service units in the National Health Security System are divided into four categories:

1. Primary service units within the network of regular service unit
2. Regular service units
3. Service units for general referrals
4. Service units for specialized referrals

NHSO Branches work through a Regional Health Security Subcommittee (RHSS) and a Regional Subcommittee for Quality Control and Standards of Public Health Services (RSQS). These bodies are responsible for controlling and supervising the quality and standards of service units and service unit networks within their respective areas. The subcommittee acts as a mechanism for oversight at the regional level and includes representatives from various sectors who are stakeholders in the health security system.

2

BACKGROUND OF THE ESTABLISHMENT OF NHSO REGIONAL OFFICES

2002

Article 25 of the National Health Security Act states: *"The National Health Security Office shall be located in Bangkok or in a nearby province. The Board shall have the authority to establish, merge, or dissolve branch offices in regional areas by announcing in the Government Gazette. The establishment of branch offices must consider the necessity and cost-effectiveness of the operation compared to the expenses. The Board shall also have the authority to delegate state or private agencies to perform the functions of branch offices, with operational expenses reimbursed according to the criteria set by the Board."*

After the establishment of the NHSO under the National Health Security Act of 2002, the National Health Security Board held its first meeting of 2002.[2] During the meeting, the following was resolved: *"Regarding the implementation of universal health coverage and the interim approval of existing regulations and practices until the regulations of the National Health Security Office are established, the relevant regulations and announcements of the Ministry of Public Health related to the creation of universal health coverage shall be used."*

Later, in the third meeting of the National Health Security Board in 2002,[3] the Board resolved to approve that *"Provincial Health Offices serve as interim agencies representing the National Health Security Office in the regions, utilizing the existing fund regulations. This representation does not constitute functioning as branch offices as defined in Article 25 of the National Health Security Act."* This decision was made because, during the early stages of establishing NHSO offices, detailed guidelines for setting up branch offices and preparations for other agencies to operate as branches were not yet established. Therefore, the PHO were tasked to temporarily represent the National Health Security Office.

2003

The National Health Security Board approved to proceed with the announcement in the Royal Gazette, assigning PHO as branch offices of the NHSO in the regions.[4] The key rationale for delegating PHOs to act as branch offices is as follows:

1. In the initial phase, due to the absence of a subnational NHSO structure, it was necessary to assign the PHO as a state agency (that understands the healthcare system well) as a proxy, without the need to invest in establishing a new office.
2. NHSO has the mission to register service units, register beneficiaries for access to UCS rights, and urgently coordinate service units in the area, but there are no branches in the area yet.
3. In the future, if NHSO establishes branches in the area or other suitable agencies, tasks can be reassigned to align with the principle of separating service purchasers from service providers. Assigning tasks to the PHO as NHSO provincial branches would then be possible.[5]

2004

The establishment of the NHSO is based on the principle of "purchaser-provider split." The NHSO functions as the allocator of funds to healthcare providers, both from the public and private sectors. Previously, the Ministry of Public Health (MOPH) acted as both purchaser and provider, which caused significant friction during NHSO's initial establishment. This was due to the loss of control and allocation of healthcare budgeting power to NHSO.[6]

In addition, assigning the PHO as a NHSO branch office found that NHSO policies and operations were not well-received. Therefore, NHSO management conceived the idea of establishing its own regional offices with the aim of smoother operations and maintaining the organization's efficiency and compactness. They chose the approach of setting up regional offices responsible for multiple provinces together, rather than having branches in every province. The first regional office was established in Khon Kaen Province, due to readiness and cooperation received from the area.

In 2004, the National Health Security Board approved the establishment of the first NHSO Regional office in Khon Kaen Province, overseeing 19 provinces. The board approved a staffing framework for the National Health Security Regional Office (Khon Kaen) with 12 positions, in addition to the central NHSO staffing framework. It also planned for an evaluation of the operations to identify strengths and weaknesses for consideration in the establishment of additional regional offices.[7] It was resolved that an evaluation of the Regional Office function would be conducted, with Dr. Olarn Chaipravat serving as the chairperson to coordinate external agencies such as Khon Kaen University. This evaluation was scheduled to occur after completing one year of operations of the Regional Office.[8]

2005

In this year, the NHSO established four additional Regional Offices in Bangkok, Chiang Mai, Nakhon Sawan, and Songkhla.[9] The evaluation of the PHO (as a branch of the NHSO) and the NHSO Regional Office in Khon Kaen was conducted by the Faculty of Public Health, Khon Kaen University. The evaluation results are summarized as follows:

1. The Khon Kaen Regional Office has been able to perform all assigned tasks effectively, except for supporting the development of the service unit registration system.
2. The personnel are capable, with an efficient internal management system and participatory work methods, which have gained recognition from relevant organizations
3. Some aspects of the office's potential have not been fully utilized, such as the IT system
4. Expanding the role of the Regional Office necessitates increasing personnel, which could be achieved through transfers from the Health Security Work Cluster or PHO

In the 3/2005 National Health Security Board meeting, the secretariat formally proposed establishing provincial Regional Offices with the objectives of: 1) Achieving economies of scale in operations, 2) Preventing conflicts of interest, and 3) Expediting local and civil organization participation. The NHSO Policy and Planning Office subsequently reviewed the Regional Office's missions and assessed their operations according to evaluation guidelines. Following this evaluation, the NHSO prepared briefing documents, and received recommendations from the working group to revise the NHSO structure accordingly:

Role and responsibilities of the NHSO Regional Office

1. Support and coordinate with Regional Offices and service units
2. Support the management of the National Health Security Fund, such as managing service compensation
3. Support the development of registration systems and the evaluation of service unit standards and networks
4. Support the development of registration systems to select designated service units for beneficiaries
5. Develop and support the control, promotion, and assurance of quality and standards for service units and networks
6. Protect the rights of beneficiaries in the universal health coverage system
7. Collaborate or support the operations of other relevant departments or assigned tasks[10]

2006

In this year, the NHSO established eight additional Regional Offices, namely Nakorn Ratchasima, Phitsanulok, Rayong, Ratchaburi, Sakon Nakhon, Saraburi, Surat Thani, and Ubon Ratchathani, bringing the total number of Regional Offices to 13.[11]

2012

According to the announcement from the NHSO regarding division of departments, delegation of authority, and internal position definitions in 2012, NHSO divided its Work Clusters into five categories: (1) Strategy and Performance Evaluation, (2) Fund Management, (3) Service Network Support, (4) Support System, and (5) Branch Office and Participation. Regions 1-13 fall under cluster 5 with designated responsibilities as follows:

1. Manage and effectively utilize the National Health Security Fund budget within the assigned responsibilities to achieve efficiency and effectiveness
2. Manage access to healthcare services for eligible individuals under the UCS in the catchment area, ensuring widespread access to quality services
3. Protect rights and promote public understanding within the catchment area regarding their rights and duties under the UCS
4. Support the development of healthcare units within the responsible area to meet specified quality standards
5. Promote local government and civil society participation in the UCS
6. Develop health insurance information systems to effectively and timely fulfill missions, aligned with the Regional Office's master plan
7. Perform other related duties or as assigned

2014

The NHSO cancelled the assignment of the PHO as a branch office of the NHSO, following the National Health Security Act of 2002, which mandated the separation of purchaser and provider roles in the UCS. In addition, the Office of the Inspector General proposed that the National Health Security Board review the assignment of the PHO as a NHSO provincial branch. Additionally, the MOPH also proposed cancelling the NHSO role of the PHO, and discontinuing funding of the PHO through Account 6. NHSO analyzed the situation regarding the assignment of PHOs as Regional Offices and identified the following considerations:

1. There was ambiguity in the chain of command resulting in confusion and dissatisfaction among some PHO chiefs as to their role.
2. Local mechanisms and healthcare units had a better understanding of NHSO's UCS management system, reducing the responsibilities of some provincial Offices.
3. NHSO has Regional Offices coordinating operations between central offices and local agencies.
4. Some roles of NHSO Regional Offices can be adjusted to replace the Provincial Offices.

Due to the aforementioned reasons, the National Health Security Board decided to terminate the designation of the PHO as a provincial branch of the NHSO with the following resolutions:

1. Approving the principle of separating the roles of healthcare providers and public health service providers by terminating the designation of PHOs as provincial branches, and discontinuing Account 6 for provincial branches effective from October 1, 2014

2. Approving the collaboration between MOPH and NHSO with a focus on public health benefits

3. Tasking NHSO to prepare and enhance the capacity of NHSO Regional Offices to accommodate additional tasks, and develop collaborative work models without adversely impacting the service system and local communities

4. Tasking NHSO to coordinate the Strategic Management Committee to study the feasibility of continuous operational models, considering other organizations or agencies to take over operations (e.g., private sector entities, local administrative organizations, etc.) under the condition of budget neutrality, and to propose management plans and progress reports for committee acknowledgement at various intervals.[14]

2015

The roles and responsibilities of NHSO Regional Offices remain unchanged, but there is a restructuring of internal departments within NHSO Regional Offices to align with NHSO's Work Clusters. Each regional office must now have five Work Clusters: 1) Strategic and Performance Evaluation, 2) Fund Management, 3) Service Network Support, 4) Support Systems, and 5) Rights Protection and Participation.[13] The staffing framework for NHSO Regional Offices 1-12 is set at 27-29 positions per Regional Office, while Region 13, Bangkok, has 102 positions.

2021

The internal structure of the NHSO has been adjusted to drive the organization towards being a Category 1 public organization that can work flexibly and agilely, adapting to technological and environmental changes both within and outside the organization. NHSO Regional Offices are now directly accountable to the NHSO Secretary-General, and have redefined roles to emphasize proactive work, driving participation from various sectors in the area. They are responsible for monitoring and evaluating the quality and standards of services, and for decentralizing tasks to local areas, such as audits, monitoring and evaluation (M&E), and implementing health promotion and disease prevention activities.[14]

The restructuring of the NHSO and the adjustment of the roles of NHSO Regional Offices have resulted in a reduced role for the Regional Offices in fund management and administration. Instead, their focus has shifted toward strengthening governance mechanisms for the UCS at the regional level, driving outreach initiatives to increase access to public health services, enhancing the role in auditing service providers' disbursements, and overseeing various evaluations. Meanwhile, the tasks of fostering participation from local administrative organizations (LAO) and the public, resolving access to rights issues, and utilizing information technology (IT) in the management of the UCS remain unchanged.[15]

2023

The roles of the NHSO Regional Offices have been further adjusted to emphasize the importance of auditing and monitoring. NHSO Regional Offices are now the primary mechanism for overseeing, monitoring, and auditing the disbursements of service providers within their respective areas. They are also responsible for supervising and evaluating the efficiency and effectiveness of the services provided.

2024

The National Health Security Board resolved to amend the announcement of the NHSO regarding the establishment of Regional Offices, dated February 15, 2006, due to the following reasons:

1. The names of the provinces did not match the current NHSO Regional Offices, as one office was relocated from "Sakon Nakhon Province" to "Udon Thani Province" and the name was changed from "NHSO Branch Office" to "National Health Security Regional Office"

2. The announcement did not specify the names and number of provinces within the jurisdiction of each NHSO region

3. The provinces designated by the NHSO regions overlap with the health regions of the MOPH (according to the MOPH regulation on establishing health regions for driving health system reform in 2022 and its amendments)

4. The Regional Office names of the NHSO were redefined and sequentially ordered according to the standard geographic regions of Thailand.[16]

Figure 1 shows the current distribution of the NHSO Regions and the provinces in their areas of jurisdiction.

Figure 1: The 13 NHSO Regional Offices by their Respective Areas of Jurisdiction

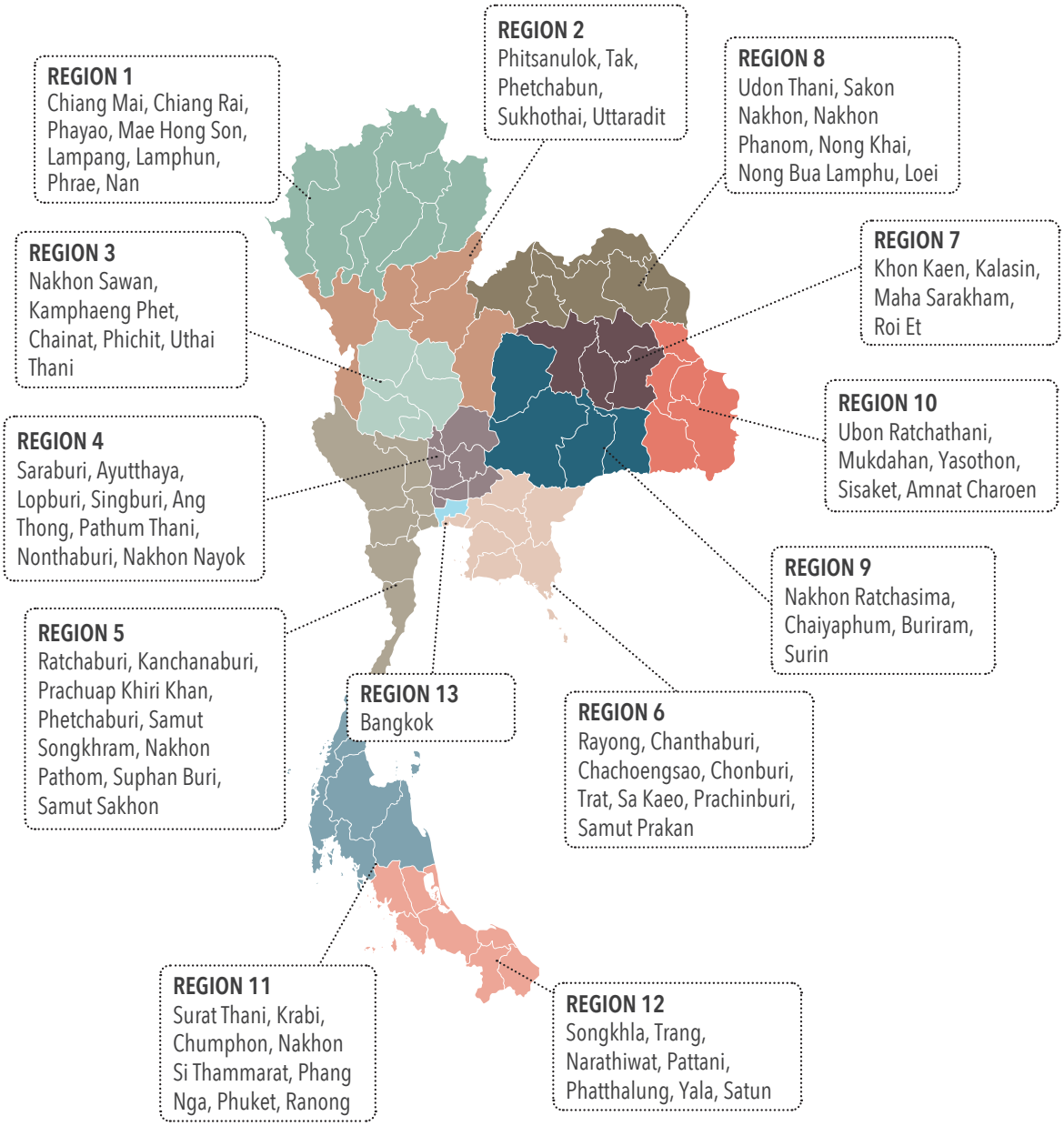
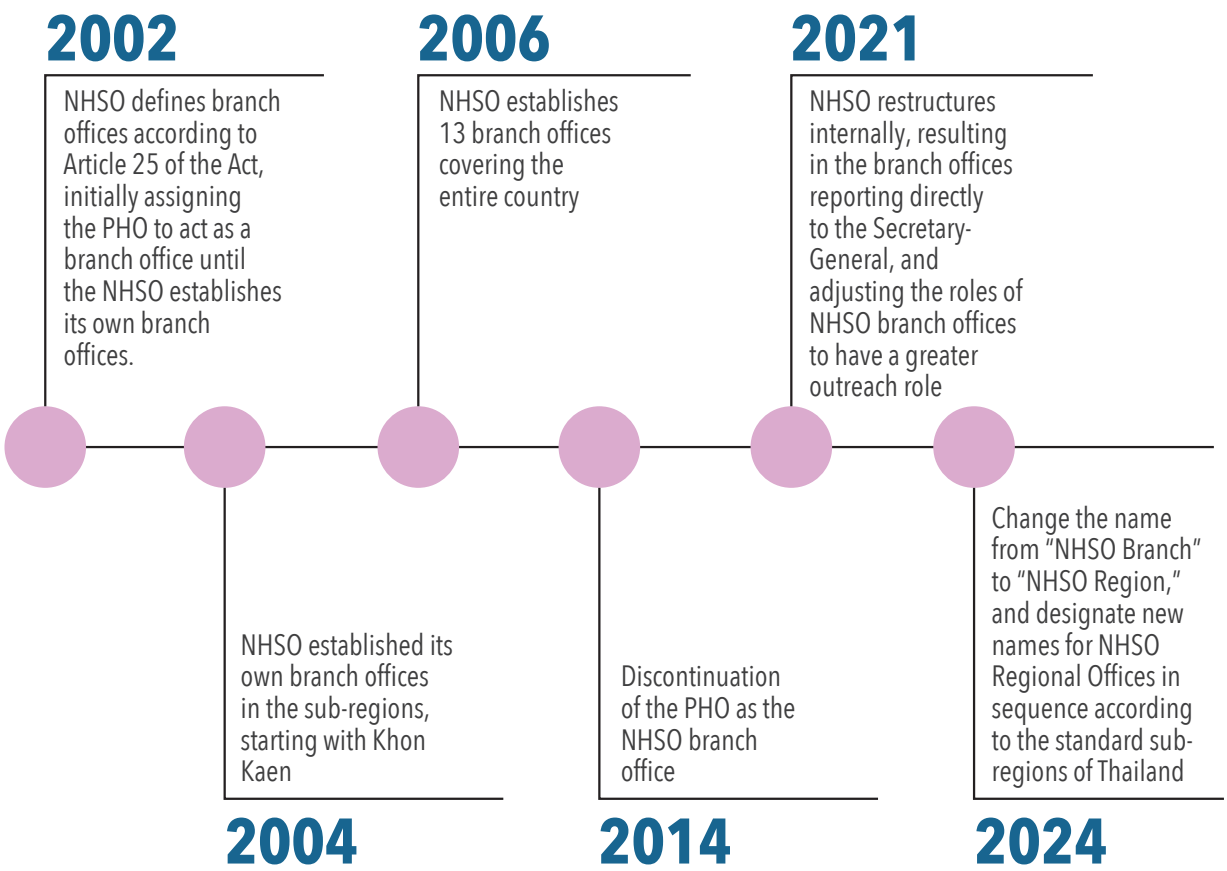


Figure 2: Milestones in the Evolution of the NHSO Regional Offices



3

CONCEPTS AND OPERATIONAL PROCEDURES OF NHSO REGIONAL OFFICES

3.1

CONCEPTS OF IMPLEMENTATION OF THE NHSO REGIONAL OFFICES

3.1.1 ACCESSIBILITY

When NHSO benefits are issued, sometimes services may not be provided in certain areas due to readiness issues or insufficient resources. Therefore, NHSO Regional Offices must coordinate with the MOPH regional health offices to ensure service delivery according to the UCS benefits package specified by the central NHSO Board. The Board defines the entitlements, while NHSO Regional Offices are responsible for actual service delivery.

For example, in chronic kidney disease stage 5, patients often require both peritoneal dialysis (PD) and hemodialysis (HD) treatments. Historically, stage 5 kidney disease patients have a high mortality rate due to the limited benefits of PD and HD treatments covered by health insurance. Traditionally, those patients were required to bear the costs of dialysis themselves, and access to services was not universally available. After the NHSO added end-stage kidney disease treatment to the UCS benefits package, this immediately and significantly increased access of the public to this life-prolonging service and improve quality of life. However, access remained unequal. For example, patients near hospitals offering dialysis services access care sooner than those in remote areas. To address this inequity, NHSO Regional Offices strive to promote access through outreach. Private healthcare units who join the UCS provider network can admit patients from these areas, set pricing, provide equipment to service units, and incentivize services in remote areas so that the public can access benefits and services more readily.

3.1.2 QUALITY

NHSO Regional Offices are also responsible for overseeing the quality of services provided by UCS-participating service units in their respective areas, ensuring that they meet the quality and standards as specified by the NHSO.

3.1.3 EQUITY

The population in each NHSO region should receive equal access to UCS services, regardless of whether they live in an urban or rural area. To that end, NHSO Regional Offices have the responsibility to ensure equality in both access to services and service quality, regardless of where people reside.

3.1.4 EFFICIENCY

NHSO Regional Offices also play a role in assisting the central administration by monitoring and regulating localities, such as overseeing areas with incorrect payment systems, misunderstandings in payment processes, or abnormal payments. NHSO Regional Office personnel work closely with their constituents, understanding service delivery patterns and specific contexts, and their familiarity with local service units allows them to quickly identify irregularities in service operations.

3.1.5 COLLABORATION

Participation is a key factor specified in the National Health Security Act. NHSO Regional Offices have mechanisms, including the Regional Health Security Subcommittee (RHSS) and a Regional Subcommittee for Quality Control and Standards of Public Health Services (RSQS). Both subcommittees are participatory mechanisms outlined in the National Health Security Act.

3.2

STEPS IN IMPLEMENTATION OF THE NHSO REGIONAL OFFICES

3.2.1 SETTING TARGETS

The NHSO headquarters defines performance indicators, and sets targets for achievement by time period, and forwards these to NHSO Regional Offices for operational implementation. Progress toward achieving these targets is aligned with the NHSO national strategy, monitored quarterly, and reported on clearly.

3.2.2 MANAGEMENT

1. Management of the Health Security Fund: NHSO Regional Offices are responsible for designing various budget allocations with clear regulatory mechanisms. The central NHSO specifies policies and develops annual plans. Next, the Regional Offices formulate budgeted projects for submission to the central office for approval. Regional Offices must outline budget management strategies, implement measures, and adhere to guidelines for monitoring budgets in each area efficiently within specified timeframes. Continuous expenditure reporting is conducted at management meetings. Monitoring processes at NHSO Regional Offices include deliverables and Key Performance Indicators (KPIs), with targets re-set annually. For instance, an indicator might be 'Increased access' or 'Improved quality' in specific areas highlighted by the MOPH policy for that year. These indicators are assigned targets, and progress toward these KPI targets, deliverables, and mechanisms are tracked by reports, remote data collection, and managerial visits to NHSO regional areas.

2

Management of the Regional Office: The central NHSO allocates budget to each Regional Office for operations, known as the 'office management budget.' There are criteria for budget allocation. The other part of Office implementation involves field operations. This component is essential for advocating for continuous implementation of strategies from the central office. The activity requires project documentation, budget preparation, and proposals to be submitted to the central NHSO.

3.2.3 MONITORING AND CONTROLLING THE STANDARDS OF SERVICE UNITS IN THE AREA

NHSO Regional Offices conduct audits of service units. If irregularities are found, on-site inspections by specialists are conducted. Upon identifying shortcomings, recommendations are provided for corrective actions, and issues are reported to RSQS as examples for other service units. This process aims to prevent deficiencies and continuously improve quality.

3.3

EXAMPLE OF NHSO REGIONAL OFFICES' OPERATIONS: MANAGEMENT OF AREA-BASED HEALTH PROMOTION AND DISEASE PREVENTION COSTS (PPA) IN 2024

The NHSO frames activities on a region-by-region basis, which then becomes the Regional Office's role in driving local operations. Coordination mechanisms are aligned to manage a capped global budget at the regional level, which is crucial for driving towards objectives.

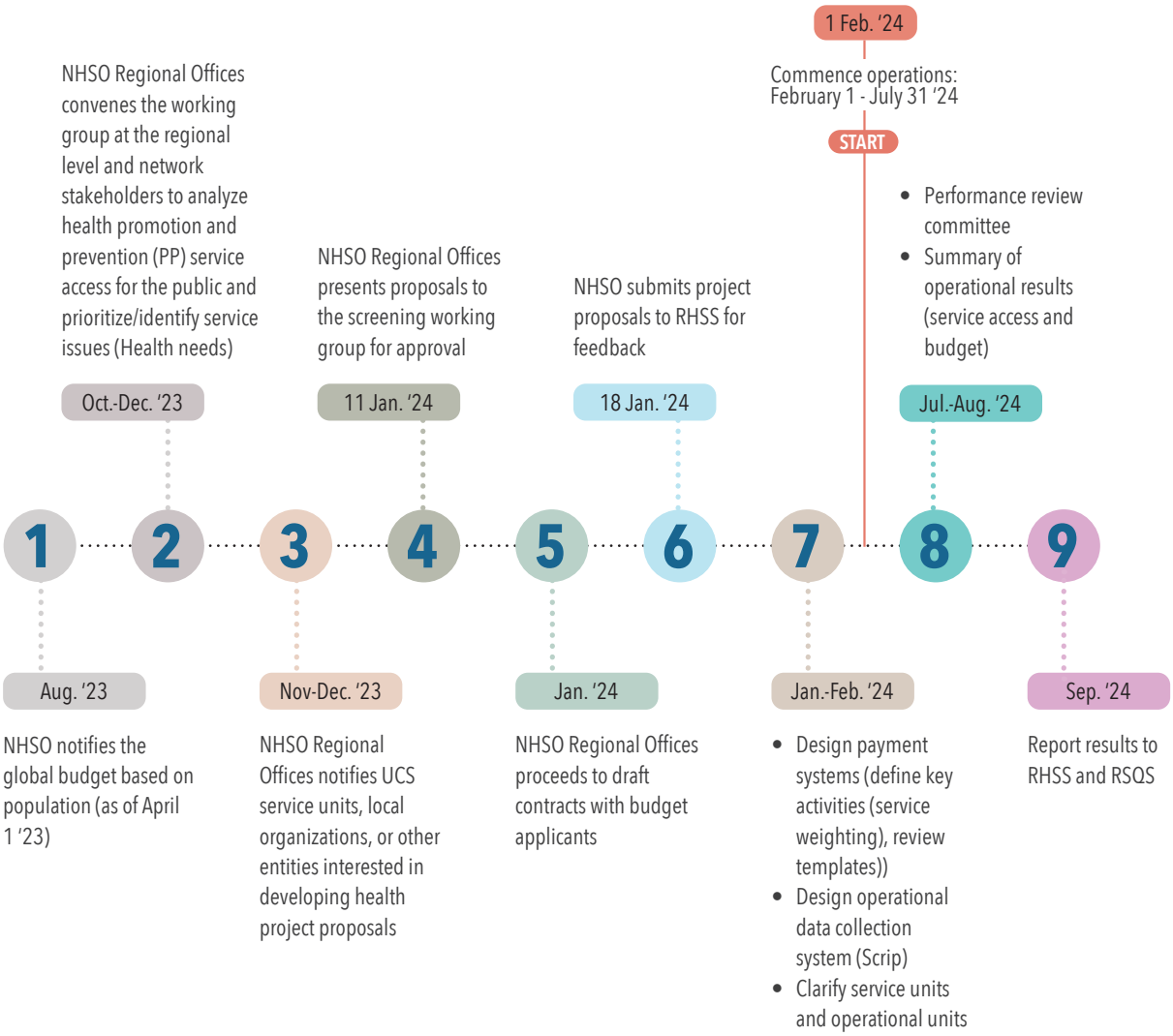
Currently, each Regional Office manages Health Promotion and Disease Prevention Costs (PPA) annually. NHSO notifies each Regional Office of their global budget based on population size. Upon receiving the budget, Regional Offices conduct planning meetings with working groups and network stakeholders to analyze public access to health promotion and disease prevention services. A health needs assessment is conducted to evaluate service requirements in the area. Subsequently, priorities are ranked, and projects are designed to ensure community access to necessary services.

After assessing the health service needs in the area, NHSO Regional Offices notify UCS service units, local organizations, or other entities interested in developing health project proposals. These proposals are then presented to the screening working group for approval. Once a project is approved, the NHSO Regional Office drafts a contract to be entered in with the proposed budget applicants.

NHSO Regional Offices also design payment systems within their areas of jurisdiction, develop operational data collection systems to fit the local context, and clarify financial matters with service and operational units regarding data and information exchange.

Before starting a project, NHSO Regional Offices submit project proposals to RHSS for feedback. Upon completion of project implementation, the results are submitted to relevant committees for performance review and summary, particularly in terms of service accessibility and budget. Subsequently, results are reported to the RHSS and RSQS.

Figure 3: Example of the Operational Steps for PPA in 2024: NHSO Region 9



For example, in 2024, NHSO Region 9 (Nakhon Ratchasima), conducted a health service needs assessment in its area of jurisdiction, and identified four priority issues and main target groups that needed accelerated access to public health services. These include: 1) Mothers and children, 2) Non-communicable diseases (NCD), 3) Pre-retirement and elderly groups, and 4) Other vulnerable groups such as cases of mental illness/drug addiction, prisoners, at-risk and disadvantaged women.

NHSO Region 9 designed payment systems for projects targeting mothers and children, NCD, pre-retirement and elderly groups, and cases of mental illness/drug addiction based on value-based payment (VBP), while other vulnerable groups were to be covered under pre-defined population-based payment schemes within the projects.

Figure 4: Issues and Target Groups that Need Accelerated Access: NHSO Region 9

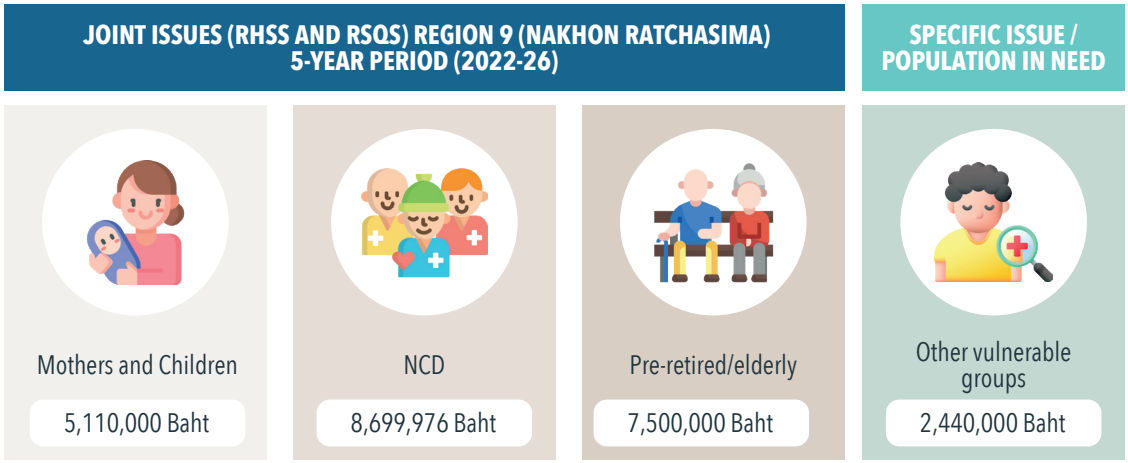


Figure 5: PPA Budget Payment Model for 2024 - NHSO Region 9

#	MODE OF PAYMENT	TARGET BENEFICIARY	COST OF SERVICE/ RATE OF PAYMENT	BAHT AMOUNT	CONTRACTED ENTITY
1	Value Based Payment (VBP) (end of project)	Mothers and children	Pay according to specified service performance	5,000,000	PHO - Chaiyaphum
		NCD	Paid according to specified service performance.	8,539,976	PHO - Buriram
		Pre-retired and elderly	Pay according to specified service performance	6,000,000	PHO - Surin
		Mental illness/drug addiction	Pay according to specified service performance	1,250,000	Psychiatric Hospital
2	Capitation payment specified in the project: 50:30:20	• Vulnerable groups and other issues • Breast cancer screening for at-risk groups (hard-to-reach prisoners) • Behavior modification for stroke and heart disease risk groups • Promote child development with family involvement (Triple P) • Promote health for pre-retirement and elderly groups • Promote health for pregnant women in the community	Capitation payment per population specified in the project	2,960,000	Public / Private sector
Total Budget				**23,749,976**	

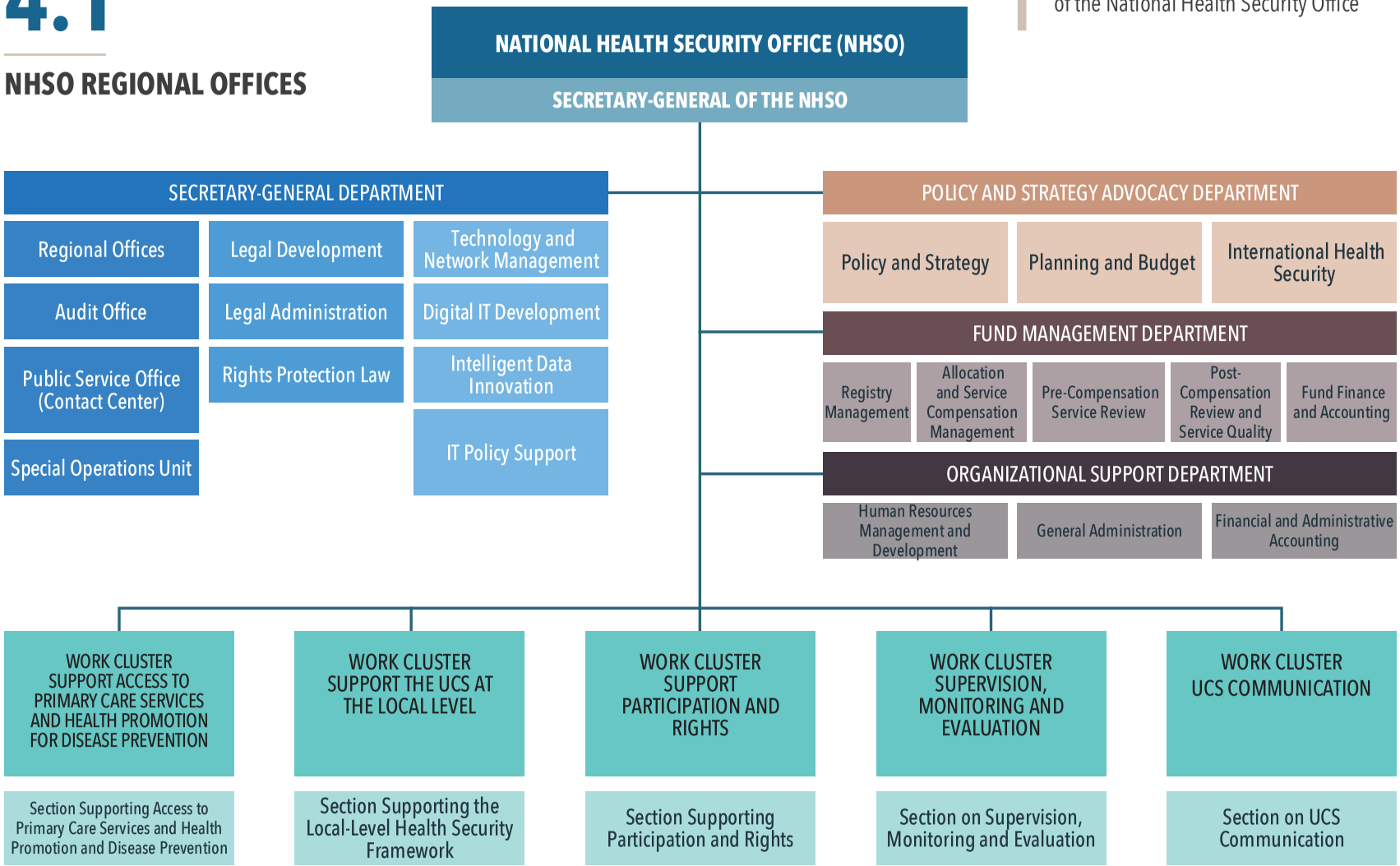
4

STRUCTURE AND RESPONSIBILITIES OF NHSO REGIONAL OFFICES AND RELEVANT SUBCOMMITTEES

4.1

NHSO REGIONAL OFFICES

Figure 6: Organizational Structure Chart of the National Health Security Office



The 2023 announcement regarding the internal division of the NHSO specifies that the NHSO Regional Office is a section directly under the Secretary-General. Additionally, Article 17 of the Office's announcement assigns the Regional Offices the following duties and responsibilities:

1. Strengthen the governance mechanism of the UCS at the regional level.

2. Drive and develop outreach efforts to enhance access to primary care services and health promotion and disease prevention for eligible citizens in the region area.

3. Drive and develop outreach efforts and support the participation and ownership of the UCS by the LAO and all network partners in the region area.

4. Create and develop the participation of eligible citizens in the region area, drive participation mechanisms of various groups to respond to outreach in order to protect rights, analyze and solve access to rights issues, and address complaints under the mechanism of the Regional Subcommittee for Quality Control and Standards of Public Health Services.

5. Serve as the main mechanism for supervising, monitoring, and auditing the disbursement of service units providing services in the region area to ensure accuracy.

6. Procure, drive, and support the presence of service units in the region area comprehensively; supervise, monitor, and evaluate efficiency and effectiveness; manage the fund and access to services and quality standards; respond to the health needs of eligible citizens in the region area, and establish a timely feedback system to service units as follows:

   6.1 Supervise, monitor, and evaluate access to UCS rights (registration) and service unit standards.

   6.2 Supervise, monitor, and evaluate access to services and service quality.

7 Utilize IT systems as tools in managing the UCS at the regional level.

8 Perform other related tasks or those assigned.

NHSO Regional Offices serve as a mechanism to implement policies from the central NHSO into practice within the respective catchment areas. They also coordinate with service units and agencies such as LAO, PHO, and other relevant network partners.

The roles and responsibilities of NHSO Regional Offices have continuously evolved. Currently, the focus of NHSO Regional Offices is on supervision, monitoring, and evaluation, even though this role was also emphasized in the past.[17,18] There was mention of supporting the development of service units to meet quality standards, but there was no clear mention of the role of supervision, monitoring, and evaluation. According to interviews with former NHSO executives, the role of NHSO Regional Offices has shifted from focusing on planning and implementation (plan and do) to emphasizing inspection and correction (check and act). This change occurred because, in the early stages of the NHSO, there was a need to plan the UCS to ensure comprehensive access to services for the public. NHSO Regional Offices were therefore involved in innovating service delivery in their areas, figuring out how to ensure comprehensive access to services for beneficiaries, and determining the appropriate service delivery models. However, now that the foundations and systems for various service delivery models are more established and well-organized, the focus has shifted from planning and implementation, and innovating service delivery methods in the area, to increasing the role of supervision and evaluation to maintain the quality standards of services.

KEY DIFFERENCES BETWEEN THE NHSO REGIONAL OFFICE AND THE PROVINCIAL HEALTH OFFICE (PHO)

The NHSO Regional Office is a division under the NHSO, a state organization established under the National Health Security Act of 2002, supervised by the Minister of Public Health. Its main mission is to manage the National Health Security Fund efficiently and to develop the public health service system to ensure that the public can access quality and standard services. The primary role of the NHSO Regional Office is to implement policies from the central NHSO into practice.

On the other hand, the Provincial Health Office (PHO) is a regional administrative agency under the Office of the Permanent Secretary of the MOPH, as established by the 1974 Royal Decree on the Division of the MOPH's Administrative Units. Its main role includes promoting health and conducting medical and public health activities in the province according to the policies of the MOPH.

The clear difference between the NHSO Regional Office and the PHO is that the NHSO is responsible for fund management and does not function as a service provider. In contrast, the PHO operates in the fields of medical and public health services.

Currently, the NHSO Regional Office and PHO work in a complementary manner. For example, PHO representatives play a role as subcommittee members of the Regional Health Security Subcommittee (RHSS) to provide recommendations and participate in setting the framework for the UCS fund management in the area. Additionally, some PHOs collaborate with the NHSO as service providers. PHOs that provide public health services are considered service units under Article 3. If they meet the standards according to the service unit evaluation criteria and have the qualifications according to the conditions and criteria for service payment, they can apply to become service units. This enables them to receive payments for health promotion and disease prevention services.

In 2024, the NHSO board approved the proposal to advance the government's upgraded 30-baht policy, "One ID Card for Treatment Anywhere in Four Pilot Provinces," with a total budget framework of 366 million baht. Additionally, a budget of 3.65 million baht was allocated to support the PHO and District Health Office (DHO) in monitoring and driving the policy of using a single ID card for treatment everywhere. (Source: National Health Security Office, January 3, 2024. NHSO Board Approves 366 Million Baht Budget Framework to Promote "One ID Card for Treatment Anywhere in Four Provinces.") https://www.nhso.go.th/news/4280.)

Figure 7: Organization Chart of the NHSO Regional Office (NHSO Region 1-12)[19]

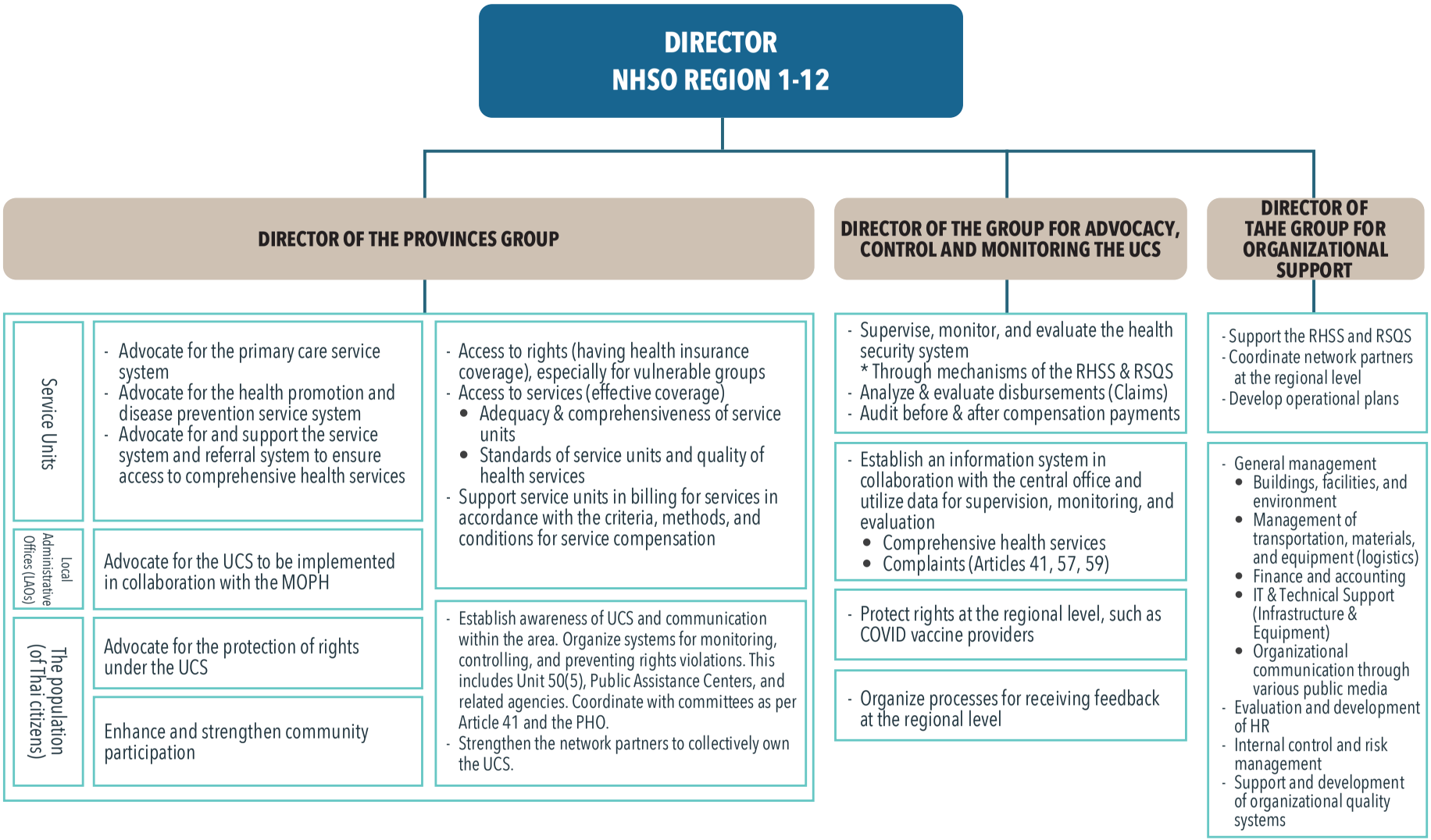


Figure 8: Organization Chart of NHSO Region 13: Bangkok[20]

DIRECTOR OF NHSO REGION 13 : BANGKOK

DIRECTOR OF THE GROUP TO ADVOCATE FOR THE SERVICE SYSTEM						DIRECTOR OF THE GROUP FOR ADVOCACY AND CONTROL AND MONITORING	DIRECTOR OF THE SUPPORT GROUP
PRIMARY SERVICE	**HEALTH PROMOTION AND DISEASE PREVENTION**	**HOSPITAL-BASED SERVICES**	**RIGHTS PROTECTION**	**REGISTRATION**	**MANAGEMENT OF COMPLAINTS**	Establish an information system in collaboration with central units, and utilize the data for monitoring, evaluation, payment oversight, and health outcomes assessment	General management • Document management • Facilities and environment • Supplies and equipment (procurement) • IT support • Vehicles
• Advocate for a primary healthcare system in collaboration with the BMA • Advocate for and support referral systems to ensure comprehensive access to healthcare services • Monitor the quality standards of healthcare units and services • Support healthcare units in fee collection procedures that comply with criteria, methods, and reimbursement conditions • Coordinate with fund management units to monitor medical service reimbursement	• Develop mechanisms to advocate for enhancing access to health promotion and disease prevention services • Advocate for and support service systems to ensure access to health promotion and disease prevention services • Advocate for the National Health Security Fund system to collaborate with the BMA • Manage and support network communities' participation in utilizing the National Health Security Fund budget to care for public health	• Advocate for service systems collaboration with the BMA in developing secondary and tertiary health service systems • Monitor and manage disease-specific fund management services • Supervise the quality of health service units and health services. • Support service units in implementing fee collection in accordance with criteria, methods, and conditions for reimbursement • Coordinate management lines with funds to monitor medical service reimbursement	• Manage access to rights, particularly for vulnerable groups • Coordinate and link complaint management and rights protection jointly with the Work Cluster to support participation and rights protection • Strengthen the network community to jointly own the UCS Develop a system for recording and managing complaints for the office and independent complaint reception units according to Article 50(5) Conduct public relations and organizational communication; Facilitate regional hearing processes	Support the UCS registration of healthcare units to be sufficient and comprehensive Coordinate with service units at all levels (Provider Coordinator) • Procure healthcare units and manage, control, supervise, and standardize service quality • Conduct annual assessments of healthcare units Support registration of eligible Thai citizens to be UCS beneficiaries; manage access to UCS rights with the Registration Management Section	Manage inspection, coordinate management, and disburse initial assistance payments to complainants under Article 41 or Article 18 (4)	Evaluate and develop the HR component Conduct internal Control & Risk Management Support and develop the organization quality system Manage the allocation of medical service expenses disbursed as capital expenditures (depreciation budget) Law and legal affairs • Support the operations of RHSS, RSQS and working groups • Coordinate network partnerships at the regional level • Develop annual office operational plans • Supervise, monitor, and evaluate UCS performance through the RHSS and RSQS mechanisms
						Manage the verification of medical service compensation payments and service quality (pre and post-disbursement	

4.2

DIFFERENCES BETWEEN OPERATIONS OF NHSO REGION 1-12 AND REGION 13 (BANGKOK)

(adapted from the report "Proposal for Development Guidelines for Health System Management in Bangkok Metropolitan Area: Special Health Region" by HSRI and NHSO, BMA 2018)

DIMENSION	NHSO REGION 1-12	REGION 13 (BANGKOK)
Geographic scope	Each region comprises of four to nine provinces in its area of jurisdiction	This is a region with a single province, divided into 6 sub-areas. The population of each sub-area is comparable to that of a province. For example, the Central Bangkok Area has a population of 800,000 equivalent to provinces like Lampang, Nakhon Phanom, Lopburi, and Kanchanaburi. Therefore, the 6 sub-areas are comparable to 6 provinces, and populations in each sub-area may vary in various aspects.
Population	Each region has from 4 to 5 million residents (of all health insurance coverage rights)	The total population with health insurance rights (any entitlement) is about 8 million, which includes registered citizens numbering about 6 million (as of 2017), and the population eligible for UCS coverage in Bangkok is estimated to be about half of all eligible healthcare beneficiaries in Bangkok
Top management	The provincial governor, who is appointed by the Ministry of Interior	The governor, who is elected by the public, and works in collaboration with the BMA council of representatives
Administration	Civil servants of the MOPH, who are under the Civil Service Commission, and apply the Civil Servants Law and MOPH policy	BMA staff are civil servants under the BMA. The BMA uses the BMA Civil Servant Act through the BMA Council. Policies come from the Governor.

DIMENSION	HSO REGION 1-12	REGION 13 (BANGKOK)
Budget	Allocate government budget	Allocated from BMA local taxes, such as sign taxes, house taxes, etc. Most of the budget received from the central government is allocated to the education sector.
Number of UCS providers	The 12 regions have about 900 hospitals and 10,000 primary care facilities in their areas of jurisdiction, most of which are under the authority of the MOPH	Bangkok has various affiliated service units: - University-affiliated hospitals - Hospitals under the MOPH - Hospitals under the Royal Thai Army - Hospitals under the BMA (9 hospitals) - Private hospitals - Private clinics - Public health service centers under the BMA (68 centers)
Primary service	Tambon Health Promotion Hospitals (THPH)	Community health centers; private clinics
Community relations	Service is easier to access due to better community relationships across provinces	Community outreach is not yet widespread, and there are various types of people served by community health centers
Efficiency of hospital-based care	According to development of service plans	Hospitals have high capabilities, mostly treating difficult/complex diseases or health conditions, leading to high patient costs
Cost/expenditure	Costs are cheaper than for the same service in Bangkok	Cost/expenditure per patient is higher than in the other regions

NHSO Region 13 (i.e., Bangkok) differs from NHSO Region 1-12 in many aspects, including geography and a larger catchment population than the other regions. The population is diverse with high in-/out-migration rates. Governance in Bangkok differs from the other regions as the metropolis is a special administrative zone. In terms of public health, Bangkok lacks Tambon (sub-district) Health Promoting Hospital (THPH) but has several affiliated hospitals with high efficiency and various types of healthcare providers such as community health centers and private clinics.

Moreover, Bangkok differs from the other regions as it lacks a PHO; Bangkok operates under a special Local Administrative Organization (LAO) format. Therefore, the NHSO established the "NHSO Bangkok Region" under the announcement on January 8, 2003, outlining the roles of the NHSO Bangkok Region, primarily in UCS management and coordinating participating service units within Bangkok.

One important mission of NHSO Region 13 is managing funds because Bangkok has a variety of service units from both the public and private sectors, and there is minimal transfer of patients outside the region. Therefore, Region 13 is empowered to design fund management according to local needs, under regulations and guidelines set by the National Health Security Board. Funds managed within Region 13 include inpatient funds, outpatient funds, and budgets for health promotion and disease prevention services.[21]

However, the role of Region 13 and Bangkok RHSS underwent a major overhaul in 2021 following corruption cases related to budget allocations in the metabolic disease screening program and fraudulent payments in the dental disease prevention program. There were 288 implicated service facilities, resulting in total damages to the NHSO amounting to 691 million baht. Upon investigation, it was found that Bangkok RHSS executives and subcommittee members had influenced policies that led to these corrupt practices, many of whom were hospital owners themselves. On July 5, 2021, NHSO approved a restructuring of the responsibilities of the Region 13 RHSS to better align with their mission, including the dissolution of the Bangkok RHSS and its entire committee. Interim representatives were appointed to replace them, with their financial management powers revoked and their roles in financial management at the regional level redefined. They still retain authority in oversight, monitoring, and evaluating fund management within the region, and provide guidance to the NHSO Board.[22] Furthermore, the structure and components of the Bangkok RHSS have been streamlined to be more compact, inclusive, and have clear management systems to mitigate potential conflicts of interest.[23]

Not only has Bangkok RHSS been adjusted, but also the internal structure of NHSO's Region 13 has been revamped as a result of corruption investigations. The role of NHSO's Region 13 in payment management and design, as well as registration tasks, has been reduced, with these responsibilities transferred to the central NHSO. This has left Region 13's role primarily focused on advocating for its area of jurisdiction, overseeing evaluation and monitoring, and supporting system functions, marking a significant change for Region 13.

4.3

COMMITTEES AND TASK FORCES AT THE REGIONAL LEVEL

NHSO Regional Offices collaborate with committees and working groups at the regional level, which serve as mechanisms for advocating for the UCS and promoting participation from various sectors. This aims to achieve shared ownership in the UCS. Therefore, the composition of these committees and working groups at the regional level must include diverse representatives from government, private sector, and public representatives who are stakeholders in the UCS.

4.3.1 REGIONAL HEALTH SECURITY SUBCOMMITTEE (RHSS)

According to the 2022 announcement of the National Health Security Board regarding the appointment of the Regional Health Security Subcommittee, the responsibilities of RHSS are specified as follows:

1. Supervise, oversee, and monitor the management of funds, including the registration of service units and networks, to align with the policies, criteria, methods, and conditions set by the committee.

2. In cases where operations are conducted according to the committee's announcements regarding operational criteria and management of the National Health Security Fund as stipulated in Article 18(4), and criteria, methods, and conditions for reimbursing healthcare services as stipulated in Article 46, if urgent circumstances specific to the local context arise which may impact public service delivery or cause other damages, consider adjusting the criteria and conditions in the announcement as necessary, and report to the committee at the earliest opportunity for further action.

3. Develop proposals regarding the criteria for managing the fund as necessary within the context of the region area, to propose amendments or establish criteria for the next fiscal year, subject to committee review.

4. Provide consultation, recommendations, and opinions to the office regarding fund management to comply with regulations or announcements set by the committee.

5. Establish task forces related to health security work in the region area as necessary.

6. Perform other duties as assigned by the committee.

The Regional Health Security Subcommittee (RHSS) of Region 1-12 consists of:

1. Qualified persons, up to 7 individuals, serve as chairpersons or subcommittee members, including:
    1. Subcommittee members within the subcommittee, not exceeding 2 persons.
    2. Qualified individuals within the region area.

2. Regional Health Inspectors of the MOPH in the region area serve as subcommittee members.

3. Healthcare system administrators and service unit managers in the region area, totaling 9-13 individuals, serve as subcommittee members, including:
    1. Provincial Health Office (head of the PHO) within the region area.
    2. Hospital directors of central or general hospitals, one person.
    3. Community hospital directors, one person.
    4. THPH directors, one person.
    5. Directors of non-MOPH-affiliated state service units (if any), one person.
    6. Private hospital administrators (if any), one person.

4. LAO administrators and service recipients or the public sector in the region area, as proportionally designated by the office, totaling 10-18 individuals, serve as committee members, including:
    1. Provincial administrative organization (PAO) chiefs or municipal mayors or Tambon administrative organization (TAO) chiefs.
    2. Representatives of complaint receiving units as per Article 50(5) or civil society coordination centers or representatives of private organizations registered under the National Health Security Act 2002 or civil society organizations in the healthcare sector or consumer organizations within the region area.
    3. Village Health Volunteers (VHV), up to 2 persons.
5. Regional office directors or assigned office managers of the region area office serve as deputy chairpersons of the committee.
6. Deputy regional office directors or assigned office managers of the region area office, who are appointed as committee members and secretaries.

Moreover, university-affiliated hospital directors in the region area (if any) shall act as consultants.

The RHSS for Region 13 (Bangkok) consists of:

1. Up to 8 qualified individuals, including:
    1. Subcommittee members within the subcommittee, not exceeding 4 persons, with 1 chairperson and up to 3 other members
    2. Qualified individuals within the area as subcommittee members
2. The appointed official serving as the MOPH Inspector for Region 13, Bangkok, serves as a subcommittee member.

3. Healthcare system administrators and service unit managers in the area, totaling up to 8 individuals, serve as committee members, including:

   1. Director of BMA Department of Health
   2. Director of the BMA Department of Medical Services
   3. Administrator of a medical school-affiliated hospital with over 1,000 beds, one person
   4. Administrator of a state-affiliated medical unit under the Department of Medical Services of the MOPH, one person
   5. Administrator of a state-affiliated unit under the Ministry of Defense or the National Police Office
   6. Administrator of a non-MOPH-affiliated state unit such as under the BMA or Ministry of Justice, one person.
   7. Administrator of private hospital units, two persons, including one from a hospital and one from a clinic.

4. Up to 8 service recipients or members of the public serve as subcommittee members, such as representatives of consumer organizations, representatives of complaint receiving units as per Article 50(5), civil society coordination centers, or representatives of private organizations registered under the National Health Security Act 2002.

5. The NHSO secretary-general or deputy secretary-general, as appointed, serves as the deputy chairperson of the subcommittee.

6. The director of the Region 13 Office (Bangkok) serves as a subcommittee member and secretary.

4.3.2 REGIONAL SUBCOMMITTEE FOR QUALITY CONTROL AND STANDARDS OF PUBLIC HEALTH SERVICES (RSQS)

According to the 2019 announcement of the NHSO Quality Control and Standards Committee regarding criteria, methods, and conditions for selection and appointment of the Regional Subcommittee for Quality Control and Standards of Public Health Services, the RSQS has the following powers and responsibilities:

1. Compile data on complaints, preliminary payment assistance consideration, and other information within the catchment area to summarize, analyze problems, limitations of the healthcare service system, and develop preventive and corrective proposals. Also, enhance service systems to align with the conditions of service units in the region area.
2. Control and supervise the quality and standards of service units and service network within the catchment area.
3. Establish measures to control and promote the quality and standards of service units and service network within the catchment area.
4. Audit the quality and standards of service units and service network within the responsible region area, and notify service units and parent organizations to improve and monitor the evaluation of quality and standards.
5. Promote public understanding and participation within the catchment area in monitoring and controlling service units and service network.
6. Regularly report operational results to the national Health Service Quality and Standards Control Committee every year.
7. Form task forces as necessary and appropriate.
8. Perform other duties as assigned.

According to the 2019 announcement of the Quality Control and Standards Committee

regarding criteria, methods, and conditions for selection and appointment of the Regional Subcommittee for Quality Control and Standards of Public Health Services, Clause 5 establishes the Regional Subcommittee for Quality Control and Standards of Public Health Services Region 1-12, consisting of representatives from agencies or organizations who hold positions, professions, or reside permanently in that region area as follows:

1. Representative from the Office of the Permanent Secretary, MOPH, 1 person
2. Representative from a regional hospital or general (provincial) hospital, 1 person
3. Representative from a community (district) hospital, 1 person
4. Representative from a private sector service unit, 1 person
5. Legal officer assigned by the Office of the Prosecutor attached to the Office of Public Prosecutions, 1 person
6. Qualified personnel from medical colleges specializing in obstetrics and gynecology, surgery, geriatrics, pediatric medicine, and psychiatry, 1 person each
7. Representatives from the Nursing Council, Dental Council, Pharmacy Council, Physiotherapy Council, Medical Technologist Council, and Occupational Therapist Council, 1 person each
8. Representatives from medical practitioners, 2 persons
9. Representatives from PAO, municipalities, and TAO, 1 person each
10. Representative from private sector organizations in 9 areas related to the National Health Security Act, 6 persons

Clause 6 shall have a Quality Control and Service Standards Committee for Region

13 (Bangkok), consisting of representatives from agencies or organizations holding positions, professions, or domiciles in Bangkok, as follows:

1. Representative from a university-affiliated hospital, 1 person.
2. Representative from an army, navy, air force hospital, or National Police Office, 1 person.
3. Representative from a MOPH Department of Medical Services hospital, 1 person.
4. Representative from a private sector specialized service unit, 1 person.
5. Representative from a registered BMA Ob-un community clinic, 1 person.
6. Representative from the Hospital and Art of Medicine Support Division, Department of Health Service Support, MOPH, 1 person
.
7. Prosecutor attached to the Office of Public Prosecution, assigned, 1 person.
8. Qualified medical specialist from the Royal College of Physicians in Obstetrics and Gynecology, Surgery, Geriatrics, Pediatrics, and Psychiatry, each specialty 1 person.
9. Representative from the Nursing Council, Dental Council, Pharmaceutical Council, Physical Therapy Council, Medical Technology Council, and Professional Council, each 1 person.
10. Representative from medical practitioners, 2 persons.
11. Representative from the BMA Department of Medical Services, 1

person.

12 Representative from the BMA Department of Health, 1 person.

13 Representative from private sector organizations in 9 areas related to the National Health Security Act, 6 persons.

4.3.3 WORKING GROUP ON GUIDELINE ESTABLISHMENT FOR THE USE OF THE NATIONAL HEALTH SECURITY FUND BUDGET BY SERVICE UNITS UNDER THE JURISDICTION OF THE MINISTRY OF PUBLIC HEALTH AT THE REGIONAL LEVEL (5X5 WORKING GROUP).

The composition of the 5x5 working group includes 5 representatives from agencies under the MOPH and 5 representatives from the NHSO at the regional level. This working group serves as a governance mechanism for UCS that can effectively reduce conflict between the MOPH and the NHSO that have occurred in the past.[22]

4.4

GUIDELINES FOR COLLABORATIVE OPERATIONS BETWEEN NHSO REGIONAL OFFICES, COMMITTEES, AND NETWORK PARTNERS AT THE REGIONAL LEVEL

NHSO Regional Offices adopt quality standard guidance at the regional level based on the SAAPDE principles (Shared vision, Agility, Accountability, Participation, Diversity, Equilibrium), established by the Quality Control and Standards Committee of the NHSO.[24] NHSO Regional Offices apply the SAAPDE principles in planning operations and advocating for operational mechanisms in the area, specifying them as operational plans, clear guidelines, and metrics.

4.4.1 SHARED VISION

1. Emphasize that every mechanism participates in setting goals and strategies.
2. Each mechanism establishes operational plans according to its responsibilities to achieve common goals.

4.4.2 AGILITY

1. Propose creating a data set linking all mechanisms
2. Apply technology to communicate information in the area to increase access to services

4.4.3 ACCOUNTABILITY

1. Implement activities according to principles of 'good governance'

4.4.4 PARTICIPATION

1. There should be knowledge support for various mechanisms in the area
2. Link and return information to network partners and service units
3. Strengthen people's ownership of UCS

4.4.5 DIVERSITY

1. Organize a forum to exchange knowledge among various network partners
2. The composition of the subcommittee is diverse from all sectors

4.4.6 EQUILIBRIUM

1. Communicate to create understanding in the context limitations of each area to achieve acceptance and reduce conflict between service providers and service recipients[25]

5

KEY FEATURES OF NHSO REGIONAL OFFICES

5.1 NHSO Regional Offices, familiar with their area of jurisdiction, can address deep-seated issues requiring coordination. NHSO works closely with local service units and local organizations under Article 47, including the Tambon Health Fund, Rehabilitation Fund, and Long-Term Care Fund. Proximity to local organizations allows NHSO to swiftly inspect and resolve area-specific issues, leveraging expertise and familiarity with the local context. NHSO Regional Offices can also design payment and service systems tailored to specific local contexts.

5.2 Working with civil society networks or Gold Card rights protection units involves engaging the public in various NHSO operations, such as communicating about UCS benefits and handling complaints through these networks. The presence of NHSO Regional Offices enhances UCS accessibility. NHSO's civil society network encompasses more than just Village Health Volunteers (VHV), and includes various types of persons with a volunteer mind-set, such as hospital-based volunteers, health-conscious volunteers who care for recovered patients, and non-hospital volunteers. These volunteers guide the public on hospital treatment, particularly for complex diseases like chronic kidney disease, HIV/AIDS, and cancer. They ensure patients remain within the healthcare system, such as PLHIV volunteer groups who collectively encourage hospital medication adherence. This is an additional dimension compared to VHV, especially in difficult-to-reach areas like condominiums and factories.

6

WAYS FORWARD FOR IMPROVING PERFORMANCE OF THE NHSO REGIONAL OFFICES

6.1 The NHSO Regional Offices have undergone structural adjustments according to NHSO central regulations. Currently, work clusters are assigned to collaborate with provincial levels, enabling problem-solving at the provincial level. However, there are limitations at the regional level due to insufficient personnel and skill expertise.

6.2 The emphasis on the role of NHSO Regional Offices strengthens the implementation of policies from central to local levels, addressing gaps in service coverage and enhancing efficiency in monitoring and supervising units that do not yet meet NHSO standards and quality criteria.

6.3 There is an ongoing need to promote collaboration among NHSO Regional Offices, RHSS, RSQS, and network sectors through shared ownership and participation to develop UCS oversight.

6.4 There should be more integration of resources with other health funds such as Social Security, Civil Servants Medical Benefits Scheme, and Foreign Migrant Health Insurance funds, each managed diversely, necessitating service units to transmit data across different management systems of the three main funds, resulting in unequal benefits for the public.

7

SUMMARY

NHSO Regional Offices play a crucial role in supporting, linking, and coordinating between NHSO and various agencies in their areas of jurisdiction. They serve as a mechanism to translate NHSO policies into practical implementation across all parts of the country, through advocacy and outreach efforts. Their main mission is to ensure access to comprehensive healthcare services and promote disease prevention among eligible populations within their respective regions, whether urban or remote rural areas. In addition to their core mission of ensuring equitable access to services, NHSO Regional Offices also contribute to developing standardized and high-quality public health service systems. This is achieved through monitoring and evaluating service units, with oversight conducted through RHSS and RSQS, involving representatives from multiple sectors including government, private, and civil society. NHSO Regional Offices collaborate with entities like LAO, PHO, and the BMA to enhance public health services, UCS oversight, and promote joint system ownership.

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