Chapter One: Introduction

1.1 Introduction

This chapter introduces the background of the research conducted for this thesis. The first part of the chapter discusses the concept of primary health care (PHC), the reforms to PHC in the Thai healthcare system, the details of the Sub-district Health Promoting Hospital (SHPH) Policy, who frontline managers are and the challenges they face, the importance of leadership and management development for frontline managers, and the research literature relevant to this thesis topic. The second part of the chapter presents the aims and the significance of the thesis. The final part of the chapter discusses the research methodology, the researcher's perspective, the limitations of the research and the thesis structure.

1.2 Background of the thesis

PHC is one of the crucial components in a healthcare system. It is a first point of contact for a patient in the healthcare system and provides an integrated and continued health service by a multidisciplinary team. PHC, therefore, needs to be accessible, acceptable and affordable to the entire population (Pritchard, 1978, p. 11; Saltman et al., 2006, pp. 5-17; Starfield, 1998, p. 26; WHO, 1978, 2008). PHC, based on the holistic comprehensive approach, has been implemented worldwide, including in Thailand, with the ultimate goal of reducing health problems, improving the effectiveness of the health service system (Jirojwong & Liamputtong, 2009, p. 27; Walley et al., 2008), building community capacity (Green, 1999, p. 55; Walley et al., 2008), increasing social justice (Braveman & Tarimo, 2002; Gillam, 2008; Green, 1999, p. 51) and achieving the sustainable development of health and wellbeing (McMurray, 2007; Walley et al., 2008).

In accordance with the 1978 Alma-Ata Declaration (WHO, 1978), there was a major policy shift to the PHC philosophy in the 4th – 5th Five-Year National Health Development Plan (1977-1986) of Thailand in order to achieve the long-term goal of ―Health for All by the Year 2000" (Bureau of Policy and Strategy, 2009, p. 15; Office of Primary Health Care,

1985, p. 32). The Thai government attempted to expand the health infrastructure to cover all rural communities and to decentralize health sector management to provincial, district, sub-district and village levels (Bureau of Policy and Strategy, 2009, p. 11). In 1980, the Tambon (sub-district) health centre[1] was created as the place for interaction between the government and villages (Ingavata, 1990).

Over the past three decades, the Thai government has attempted to develop the PHC system by implementing various reforms and innovations (Wibulpolprasert, 2011; Wibulpolprasert, Tangcharoensathien, & Kanchanachitra, 2008), including implementing the Healthy Public Policy strategy in line with the Ottawa Charter Promotion in 1986 (Bureau of Policy and Strategy, 2009, p. 15), the decade of healthcare development in 1992 (Ramasoota, 1997), the Health Decentralization Policy in 1999 (Krueathep, 2004; Srisalux et al., 2009; Tima, Srisasalux, & Taearak, 2009; WHO, 2002), the Universal Health Coverage Policy in 2001 (Bureau of Policy and Strategy, 2009, p. 16; Ramesh, 2009), the Healthy Thailand Policy in 2004 (Bureau of Policy and Strategy, 2009, p. 55) and, recently, the SHPH Policy in 2009.

The SHPH policy was announced on 29 December 2008 and implemented by the MoPH in 2009 in order to reorient PHC services to focus more on proactive health promotion in the community. The policy aimed to improve the efficiency, quality and equity of the healthcare system by upgrading 9,769 Primary Care Units (PCUs) to SHPHs (MoPH, 2010a; Ministry of Public Health, Ministry of Social Development and Human Security, & Ministry of Labour, 2011; The Government Public Relations Department, 2009; Tima & Sealim, 2012; Wibulpolprasert, 2011, pp. 262, 280, 336). The SHPHs are public health agencies with 33,225 health personnel at the primary level of the administrative structure of the MoPH (Wibulpolprasert, 2011, pp. 336-337). Therefore, the SHPHs are the first point of contact for people in the catchment community to access PHC services (Bureau of Policy and Strategy, 2009).

SHPHs are administrated by PHC managers who are either public health officers or registered nurses, endorsed to hold the position of manager (Bureau of Policy and Strategy, 2009; MoPH, 2011). There were 9,769 PHC managers in 2009. These frontline managers are

[1] This name was changed to ‗Primary Care Unit‘ in line with the Universal Health Coverage Policy of 2001 and later to ‗Sub-district Health Promoting Hospital‘ in line with the Sub-district Health Promoting Policy of 2009.

the largest management group in the administrative structure of the MoPH (Bureau of Policy and Strategy, 2009; Wibulpolprasert, 2011, p. 337). They have a managerial role within the SHPHs, among stakeholders' organizations and in the catchment community, and the role is changing as the SHPH policy develops (Bureau of Policy and Strategy, 2009; Office of the Civil Service Commission, 2009).

Health services organizations operate in complex and dynamic circumstances (Clinton, 2004, p. 99; Shortell & Kaluzny, 2006, p. 64). Frontline managers in health services organizations are faced with challenges, such as the variety of community needs beyond the sphere of influence of the managers (Clinton, 2004, pp. 104-105; Egger et al., 2005), the lack of functional support systems and inadequate working environment to support good management (WHO: SEARO, 2007), the low confidence and abilities in health services management (Burns, 2007; WHO, 2007), and the pressure of high expectations of both clients and top-down managers (Burns, 2007). Other challenges are changes in demographics with the ageing of the population shifting the incidence of disease from acute to chronic, and continuing technological development (Grant, 2010; Harris, 2006; Shortell & Kaluzny, 1997, p. 44). Changing healthcare policies and the restructuring of health services organizations can add additional complexity by affecting the clarity of roles of frontline managers (Clinton, 2004, p. 106; Egger et al., 2005).

These challenges have influenced the performance of frontline managers and have contributed to high turnover and failure rates (Burns, 2007; Egger et al., 2005). As a consequence, healthcare systems are losing valuable human resources and incurring significant costs to repeatedly fill vacant positions (Burns, 2007; Egger et al., 2005).

Given the challenges facing frontline managers and the attention placed on improving healthcare systems to achieve the Millennium Development Goals (MDGs), the search for ―managers who can lead and leaders who can manage" has become an important focus for health services policy (WHO, 2007, p. 1). Human resource development in leadership and management to increase the competencies of frontline managers to manage and lead complex healthcare organizations must be given a much higher priority in today‗s health services system (Burns, 2007; Egger et al., 2005; Filerman, 2003; Isouard, 2010; John & Sue, 2007). In Thailand, the Phitsanulok Declaration of the First International Conference on Health

Services Delivery Management affirms that leadership and effective health management are vital to the delivery of quality PHC in local rural district health services (Briggs at al., 2010).

Since the 2009 SHPH reforms were introduced, studies have attempted to evaluate the successes and challenges of implementing the SPHP from various perspectives, such as from the perspective of health providers, clients and stakeholders (Kaewkim et al., 2012; Neelasri, 2011; Petcharatana et al., 2010; Suwanthong et al., 2012; Tima & Sealim, 2012). The studies, utilizing differing methodologies and study contexts, demonstrate that the implementation of the SHPH policy could enhance health services at the PHC level.

Other studies have identified the competencies and characteristics of health professionals working at the SHPHs, such as nurses, public health officers and PHC managers (Arunperm & Sriruecha, 2011; Arunsang & Boortanarat, 2011; Bouphan, 2012; Iemrod et al., 2011; Iemrod & Jenausorn, 2012; Malai & Bouphan, 2010; Nontapet, Isaramalai et al., 2008; Puncha & Bouphan, 2011; Puphanpun & Bouphan, 2011; Yompuk et al., & Imame, 2012). Most of these studies were conducted based on the quantitative approach.

Although PHC managers are directly affected by the SHPH policy and are considered as key to the success of the policy, there are no studies that have examined their perceptions of the leadership roles and management functions they need to employ to effectively implement the SHPH policy.

1.3 Aims of the thesis

This thesis employs a hermeneutical phenomenological approach to deliberately narrate the lived experiences of PHC managers regarding their leadership roles, management functions and challenges in implementing the 2009 SHPH policy in Phitsanulok Province, Thailand. The thesis has the following three aims to address the research gap emerging from the literature review.

1. Explore the perceived knowledge, attitudes and practices regarding leadership roles and management functions of PHC managers working at SHPHs and implementing the 2009 SHPH policy in Phitsanulok Province, Thailand.

2. Explore the challenges regarding leadership roles and management functions of PHC managers working at SHPHs and implementing the 2009 SHPH policy in Phitsanulok Province, Thailand.
3. Identify the training needs regarding leadership roles and management functions of PHC managers working at SHPHs and implementing the 2009 SHPH policy in Phitsanulok Province, Thailand.

1.4 Significance of the thesis

The findings of this thesis will contribute significantly to the understanding of the Thai PHC managers' leadership roles and management functions during a process of policy change. First, because this thesis employs a hermeneutical phenomenological approach, the findings will fill the gap in the literature by providing empirical evidence based on qualitative research regarding leadership roles and management functions of the PHC managers working in complex and dynamic healthcare organizations at the sub-district level in Thailand.

Second, because this research uses an eclectic theoretical framework to better understand the leadership roles and management functions that are important for PHC managers as they implement the transition to healthcare reform with respect to the SHPH policy, it will contribute to the literature on utilizing complex adaptive systems theory (Anderson & McDaniel, 2000; McDaniel, 2007; McDaniel & Driebe, 2001; Plesk & Greenhalgh, 2001; Plesk & Wilson, 2001), neo-institutional theory and typology of archetypes (Greenwood & Hinings, 1993; 1996), and diffusion of innovations theory (Greenhalgh et al., 2004; Greenhalgh et al., 2005; Rogers, 1983).

Third, this thesis focuses on PHC managers working at SHPHs who are considered as the first contact points of the PHC facilities in the health system in Thailand. The PHC managers are the group of health professionals affected directly by the SHPH policy. They are considered as the change agents because, in order to implement this policy, they have to diffuse and transfer the information and knowledge regarding this policy to their sub-ordinates and stakeholders in the community. They also have other important roles in the

healthcare system because they manage and provide health services provisions directly to people in the community. The results of this thesis will reflect the experiences and perceptions of the PHC managers in relation to the SHPH policy. The thesis will also describe the challenges in implementing this policy. Hence, the findings regarding the PHC managers' perspectives are considered as one of the important keys that can provide strategies for successfully implementing the SHPH reform policy in Thailand.

Fourth, it is important for all frontline managers to continually improve their leadership and management competencies and skills. Developing the skills of leaders with the right training will provide them with confidence and improve their effectiveness at work (Burns, 2007). This thesis will contribute to the information available for the educational and professional development of PHC managers in Thailand as well as other countries with a similar context to Thailand's healthcare system.

1.5 Methodology

The main purpose of the research is to deliberately narrate the actual lived experiences of PHC managers regarding their leadership roles, management functions and challenges in implementing the 2009 SHPH policy in Phitsanulok Province, Thailand. The interpretivist paradigm, based on a hermeneutic phenomenological research design, is utilized to understand the meanings of the lived experiences of several PHC managers interviewed for this research (Creswell, 2013, p. 79; Denzin & Lincoln, 2000, p. 191; Liamputtong & Ezzy, 2005, pp. 18-20).

Phitsanulok Province was purposively selected out of the 76 Thailand provinces as a case study because of convenience and representativeness: I work in Phitsanulok Province and have contacts and networks within the Phitsanulok Provincial Health Office and District Health Offices, enabling conduct of the research within financial and candidature time constraints; and Phitsanulok Province is considered as the central province and the medical hub in the lower northern region of Thailand (including primary, secondary and tertiary contracting units) and has a variety of geographic areas (including urban, rural and remote

areas); thus, it is representative of the various types of health services provision and the complexity of the healthcare system in Thailand.

I collected data by using semi-structured interviews with a diverse group of seventeen PHC managers. This method allowed investigation of information through direct interchange with the managers in order to gain information about their lived experience and to understand the meaning they make of that experience (DePoy & Gilson, 2003, p. 114; Seidman, 2006, p. 9; Stufflebeam & Shinkfield, 2007, p. 318).

Thematic analysis was employed to analyze the content of the text by categorizing the recurrent issues into common themes (Green & Thorogood, 2004, p. 177; Minichiello et al., 2004, p. 633; Ritchie & Lewis, 2003, p. 214). More details about the methodology and research design for this thesis are presented in Chapter Three.

1.6 Researcher's perspective

Phenomenological research is a strategy of inquiry used to understand people's experiences about a phenomenon and the meaning they give to these experiences (Creswell, 2009; Minichiello et al., 2004, p. 63). There are two main schools of phenomenological thought: descriptive phenomenology described by Edmund Husserl and interpretive or hermeneutic phenomenology described by Martin Heidegger (Carpenter, 2010, p. 125; Minichiello et al., 2004, pp. 632-633). In the Husserlian approach, the researchers are required to "bracket", suspend and disengage their judgements, preconceptions and prior knowledge regarding a participant's experience being examined in research (Crotty, 1998, p. 83; Carpenter, 2010, p. 125; Minichiello et al., 2004, pp. 632-633; Padgett, 2012, p. 35). The Heideggerian approach believes that the researcher's experience and knowledge are important and should be used to guide the interpretation in understanding the phenomena (Barnacle, 2001, p. 18; Carpenter, 2010, p. 126; Minichiello et al., 2004, pp. 632-633). Since this research employs the hermeneutic phenomenology, the latter approach was employed. The researcher's experiences and perspective regarding this study are presented in this section.

From June 2001 to May 2005, I studied for a Bachelor of Public Health degree from a public university in Thailand. After receiving this degree, I worked as public health officer at a SHPH for approximately one year. While working in this position, I was responsible for community health promotion, community health education, school health promotion, primary care services, food sanitation, environmental health and communicable and non-communicable disease control. I then became a lecturer in the Faculty of Public Health at a public university in Thailand.

I then took study leave from June 2006 to May 2007 and completed a Master of Public Health degree in Health Systems Development from a public university in Thailand. From May 2007, I continued working as a lecturer in the Bachelor of Public Health programme at the university, primarily responsible for unit-coordination in the subjects Foundations of Public Health, Health Research, Community Empowerment Techniques and Community Health Education. I was also responsible for conducting research in the field of public health, particularly at PHC level, such as health services evaluation, patients‘ satisfaction and needs, development of village health volunteers and community participation. In addition, I held the position of Assistant Dean for Student Affairs from 2007, providing advice to students on their study and living arrangements, facilitating and assisting them in the administration of their special projects, and liaising between students and other lecturers in the Faculty.

In February 2010, I was admitted to the Doctor of Health Services Management (DHSM) doctoral programme at the University of New England in Australia.

I have, therefore, had experience in the health sector in Thailand as a practitioner when working at a SHPH, as an academic when working as a lecturer, as a researcher when conducting research and as an administrator when working as the Assistant Dean of Student Affairs. I bring the following perspectives to this thesis, reflecting both my experience and findings from the literature review.

- PHC has an important role in improving the entire healthcare system and ultimately population health, especially for those in the rural and remote areas. However, the PHC services need to be improved to enable them to deal with constant changes occurring in the healthcare system and in society.

- Renovating PHC facilities and providing them with a budget are not enough to effectively improve the PHC services. Political, technical, socio-cultural perspectives, such as human resources development, public policy and rules and laws, need to be holistically considered in order to sustain the changes at the PHC level. Although it takes time to put them into practice, sustainable change and development need to be based on the participation and engagement of stakeholders at all levels, from policy to practice.
- Health professionals at PHC facilities in Thailand provide four aspects of health services: health promotion, disease prevention, curative care and rehabilitation. Health promotion and disease prevention are the main responsibilities of the health professionals. These services should be given more attention and should attract more investment, keeping in mind that it takes time to notice their outcomes and impacts.
- Health professionals charged with health promotion and disease prevention are often perceived as less important in a healthcare system because the results of their work are difficult to measure. Thus, there is less attention and investment in such professionals by the central government, leading to problems such as the significant turnover of health professionals.
- Health professionals at PHC facilities, particularly PHC managers, are considered as the change agents at the primary level in the healthcare system; the success of change in the healthcare system at PHC level largely depends on the effectiveness of PHC managers to influence the change. Thus, the effective functioning of the PHC system requires that team leaders are capable of leadership and management.

My pre-understanding and perspective are reflected from experience and from a literature review and may differ from the diverse realities that may be obtained from the participants in this thesis.

1.7 Limitations of the thesis

The limitations of the thesis are mainly related to the generalization of its findings. Phitsanulok Province was purposively selected out of the 76 provinces of Thailand as a case study. The sample size in this study was purposive rather than randomized because the

objective of the purposive sampling technique in qualitative research is not to be able to generalize the results of the study, but rather to obtain the rich experience from a diversity of participants (Liamputtong & Ezzy, 2005, p. 44). Only seventeen PHC managers were interviewed out of a possible 143 PHC managers in Phitsanulok Province. Therefore, the case study research design, diverse purposive sample strategy, and small sample size of participants limit the generalizability of results.

However, it is important to note that a case study research design was selected in this study because this qualitative research does not aim to predict or make inferences from the study results to the wider population but the findings can be used to provide an in-depth understanding of the issue under investigation.

1.8 Thesis organization

This section provides a brief overview of the content of the next five chapters in this thesis. Chapter Two is a literature review consisting of three main sections: a discussion of the literature on the concepts of leadership and management; an outline of the evolution of primary health care from the international level to the national level in Thailand, and details of the Thai healthcare system and the SHPH policy; and finally a discussion of the eclectic theoretical framework applied in this thesis, including complex adaptive systems theory, neo-institutional theory and typology of archetypes, and diffusion of innovations theory.

Chapter Three begins with a justification for the thesis methodology and design before describing the study setting and population profile, sample size and sample framework, and recruitment of participants. Methods for data collection procedure and data analysis are also explained in this chapter, as are the rigour and trustworthiness, methodological issues and limitations and ethical considerations.

The results of this thesis are identified in four themes presented in Chapters Four and Five. Chapter Four comprises three main sections. First, the justification of the data analysis techniques is described in order to clarify the data analysis techniques and procedures used in this study. Second, the informants' profiles are outlined in order to highlight important

factors in the background of study participants. Third, the Themes 1 and 2 that emerge from the data analysis are presented. Theme 1 describes the changes regarding the SHPH policy affecting the three levels of the PHC system, including the individual level, the organizational level and the community level. These changes give rise to many challenges for the participants. Theme 2 discusses important attributes of PHC managers in Thailand, which consist of passion for holding a PHC manager‘s position, altruism for other people‘s happiness and benefits, intention to achieve a life goal, and progression in the career path.

Chapter Five presents Themes 3 and 4. Theme 3 describes the importance of teamwork in the organization and its related issues, such as trustworthiness and understanding in the team and teamwork strategies. Theme 4 explains the essential skills of networking and doing teamwork with clients and stakeholders in the community.

Chapter Six presents a discussion of the major findings and presents the conclusions reached within the context of the theoretical framework and previous research related to this topic. Finally, the implications for policy and practice are discussed along with recommendations for further research in this field of study.

1.9 Conclusion

This chapter principally provides the basic foundation for the study, identifies the research gap the study will help to fill, and presents the purpose of this thesis. As PHC is crucial to the overall functioning of the healthcare system, Thailand has adopted PHC principles in its national health policy. PHC managers are the largest management group in Thailand‘s healthcare system. They have leadership roles and management functions within the SHPHs, among stakeholder organizations and in the catchment community. Their roles and functions are currently changing because of the 2009 SHPH policy which aims to upgrade 9,769 PCUs at the sub-district level to SHPHs with an emphasis on health promotion. Therefore, this thesis employs a hermeneutical phenomenological approach which principally aims to deliberately narrate the actual lived experiences of PHC managers regarding their leadership roles, management functions and challenges in implementing the 2009 SHPH policy in Phitsanulok Province, Thailand.

Chapter Two: Literature Review and Theoretical Frameworks

2.1 Introduction

This chapter addresses and critically analyzes literature relevant to the research aims of understanding the perceptions of PHC managers regarding leadership roles and management functions, the challenges they face in implementing the SHPH policy and the training needs required to address their leadership roles and management functions. To do this, this chapter discusses the literature used to inform this research in three sections. The first section deals with concepts of leadership and management. The second section discusses the devolution of PHC from the international level to the national level in Thailand together with details of the Thai healthcare system and the SHPH policy. The third section discusses the eclectic theoretical framework applied in this study, which is based on complex adaptive systems theory, neo-institutional theory and typology of archetypes, and diffusion of innovations theory.

2.2 Leadership and Management

The aims of this study focus on leadership roles and management functions of PHC managers that are necessary for them to implement the SHPH policy. Therefore, this section begins by discussing the concepts of ―leadership” and ―management”, and goes on to explain the norms of management in the Thai culture. The section then outlines the roles, responsibilities and competencies required of managers in health services, especially those of frontline managers. The section concludes with a discussion of possible ways that health services managers might meet the challenges they face.

Concept of Leadership versus Management

Scholars contend that there are qualitative differences between the concepts of ―leadership” and ―management” and refer to skills that cannot occur in the same person. Other scholars hold the view that leading and managing are distinct processes or roles but that they can be

combined in the same person (Marquis & Huston, 2003, p. 4; Yukl, 2010, pp. 24-25). Differences between the concepts are summarised in Table 2.1.

Table 2.1: The comparison between leadership and management

	Leadership	**Management**
Creating an agenda	Establishes direction: Develops a vision of the future and strategies for achieving that vision.	Plans and budgets: Establishes detailed steps and timetables for achieving set results and allocates the necessary resources.
Developing a network for achieving the agenda	Aligns people: Communicates direction and duties to all whose cooperation is needed so as to create teams and coalitions that understand the vision and strategies and accept their validity.	Organises and allocates responsibilities: Establishes structure for achieving the plans, assigns staff and delegates, develops policies to guide subordinates, and designs control systems.
Executing the agenda	Motivates and inspires: By satisfying basic human needs, energizes people to overcome barriers to change.	Controls and solves problems: Monitors results against plans, identifies deviations, and then organizes to close gaps.
Outcome	Produces change, often to a dramatic degree. Has the potential to produce extremely useful change (e.g. new products).	Produces a degree of predictability and order. Has the potential to produce key results expected by stakeholders.

Sources: Bratton et al. (2005); Kotter (1990); Kotter (1996).

Leadership has been defined in many different ways, but most definitions share an assumption that “it involves and influences the processes concerned with facilitating the performance of a collective task” (Yukl, 2010, p. 41). The core processes of leadership are establishing direction, aligning people, and motivating and inspiring them (Kotter, 1990, pp. 4-5). Leadership is associated with the words “vision”, “change”, “creativity”, “dynamism” and “risk-taking” (Hughes et al., 1996, p. 14; The Canadian Coalition for Global Health Research, 2006). Leadership processes attempt to produce significant change or movement in human organizational systems (Bratton et al., 2005, p. 8; Kotter, 1990; The Canadian Coalition for Global Health Research, 2006). Sometimes, the person who is nominated as “leader” may not be part of the formal organization or may not have a delegated position and authority but who nevertheless has power to influence others to follow (Marquis & Huston,

2003, p. 4). Leaders value flexibility, innovation, adaptation and long-term perspective and pay attention to personal relations in an organization (Rowitz, 2009, p. 42; Yukl, 2010, p. 25; Zaleznik, 1977). They are concerned with what things mean to people and they try to get people to agree about the most important things to be done (Yukl, 2010, p. 25).

Management, on the other hand, is a distinct function that cuts across all organizational functions and subsystems (Shortell & Kaluzny, 2006, p. 22). Daft (2012) provides a list of four managerial functions: 1) planning, 2) organizing, 3) leading and 4) controlling. That is, ―leading” is only one of the functions a manager must perform; the extent of that function depends on the manager‘s position within the organization. Managers usually have an assigned position and authority within the formal organization and they are expected to carry out specific functions, duties and responsibilities. They need to manipulate people, money, time and other resources to achieve organizational goals (Marquis & Huston, 2003, p. 4). Management is associated with the words ―planning”, ―procedures”, ―paper work”, ―regulations”, ―control”, ―consistency” and ―efficiency” (Hughes et al., 1996, p. 13). Managerial processes produce a degree of order and consistency in human organizational systems (Bratton et al., 2005, p. 8; Kotter, 1990) and are linked to the roles of those who have to set plans and objectives, to make decisions, to communicate with and motivate workers and to assess product quality (Guo, 2007; Guo & Anderson, 2005; Harris, 2006). The WHO (2007b, p. 1) notes ―while leaders set the strategic vision and mobilize the efforts towards its realization, good managers ensure effective organization and utilization of resources to achieve results and meet the aims”. They value stability, order, impersonal concern and have a short-term perspective, being concerned with how things get done and how to do things better (Rowitz, 2009, p. 42; Yukl, 2010, p. 25; Zaleznik, 1977).

Both leadership and management are vital to organizational success and individuals will vary in their capacity to act in these roles (Gopee & Galloway, 2009; Hughes et al., 1996; McGurk, 2009; Bratton et al., 2005, p. 10). Yukl (2010, pp. 25-26) agrees that both leadership and management roles are necessary, but states that they need to be balanced to meet the situation.

Health services managers must take on a combination of executive leadership, and organizational and strategic management roles to meet the clinical and business services components of their organizations (Shortell & Kaluzny, 2006, p. 44; Rowitz, 2009, p. 46). When health services managers implement good management practices, including leadership, they strengthen the organization‘s capacity, develop better health services and help improve people‘s health (Galer et al., 2005, pp. 7-8).

Management in the Thai Culture

Culture, leadership and management are conceptually intertwined. Cultural norms define how a given organization will define leadership. Leadership creates and changes culture, while management acts within a culture (Isouard, 2010a; Schein, 2004, p. 11). Schein (2004, p. 225) notes: ―culture is created by shared experience, but it is the leader who initiates this process by imposing his or her beliefs, values, and assumptions at the outset”. Thus, it is ultimately the function of leaders at all levels of the organization to incorporate cultural values into their organizations (Isouard, 2010a; Komin, 1990, p. 681) and to find ways to change the organizational culture if it becomes maladapted and threatens organizational survival (Schein, 2004, p. 11).

According to Hofstede (1997), the Thai management style is influenced by four attributes. First is the high ―power distance” in Thai organizations, leading to the considerable dependence of subordinates on superiors. The focus on hierarchies is normal in Thai society (Browell, 2000, p. 116; Thanasankit, 2002, p. 132; Thanasankit & Corbitt, 2000). Thanasankit (2002, p. 132) states that ―a *Pu Yai* (superior or authority-power figure) will normally have the authority to make decisions”. Subordinates, therefore, tend not to get involved in decision-making processes in order to avoid confrontation with their superiors (Thanasankit, 2002, p. 132; Thanasankit & Corbitt, 2000).

Thais are taught respect for and belief in the *Pu Yai* or elders, teachers and experts (Browell, 2000, p. 110; Thanasankit, 2002, p. 132; Thanasankit & Corbitt, 2000). Thais need to *Kreng Jai* or show consideration merged with respect to those higher in rank and seniority. Thais also believe in *Bun Khun* or patronage relationship, doing favours for one another,

particularly for those who render assistance to you. Criticism and being controversial are inappropriate and impolite in Thai society, particularly regarding *Pu Yai*, elders, teachers and experts. Thais attempt to avoid making others “lose face” by using the softer approaches to those making a mistake (Thanasankit, 2002, p. 132).

Second, Thais have a collective culture (Hofstede, 1997, p. 55). That is, the interest of the group prevails over the interest of the individual (Hofstede, 1997, p. 50) and there is a strong sense of loyalty to increase the level of harmony and reduce the level of conflict in society (Browell, 2000, p. 110). Thanasankit and Corbitt (2000) explain that the basis of Thai culture resembles family links and places an emphasis on trust and relationships with others. Collectivism and power distance tend to be negatively correlated. As Hofstede (1997, p. 54) explains “large power distance countries are also likely to be more collectivist, and small power distance countries to be more individualist”.

Third, Thais tend to display higher levels of feminine than masculine attributes (Hofstede, 1997, p. 84). This characteristic, linked to religious beliefs in Buddhism, encourages good working relationships and co-operative behaviour that aims to create peacefulness and harmony (Browell, 2000, p. 111; Komin, 1990, p. 693; Lewis, 2005). In addition, Thai men and women enjoy equal status, as demonstrated by the high number of female managers (Browell, 2000, p. 111).

Fourth, Thais have strong uncertainty avoidance. They design structures in their organizations to foster interpretability and predictability (Hofstede, 1997, p. 116). Lifelong employment is important to ensure a degree of certainty (Browell, 2000, p. 110).

Komin (1990) further identifies nine value orientations in the Thai socio-cultural system: 1) high ego and sense of independence; 2) *Bun khun* relationship or the psychological bond between two persons, such as leader and subordinate; 3) smooth, kind, pleasant and conflict-free interpersonal relationships are valued; 4) flexibility, shifting their decisions depending upon situational factors; 5) belief in religion and supernatural or magical power; 6) education as “a means to climb up the social ladder, rather than as an end-value in itself”; 7) interdependence in society; 8) *Sanuk* – a fun orientation – functions as the means to enable

smooth social relationships; 9) a task orientation, especially among farmers and skilled workers, involving the belief that hard work is necessary.

Levels of health services managers and their roles, responsibilities and competencies

Health services managers are principally concerned with ensuring that their organizations are appropriately structured, and ensuring that their organizations are safe, effective, and efficient and provide quality services (Shortell & Kaluzny, 2006, p. 44). The general skills and knowledge required for health services managers include: 1) development of organizational vision and related strategies, 2) empowerment of individuals, teams, and communities, and 3) leadership and change management abilities (Harris, 2006, p. 11). Passion and emotional intelligence are also important for the leader. Marques (2007, p. 645) also emphasizes the importance of passion: ―if a leader is not passionate about what he or she does, there might not be a reason for him or her to be leading in the first place".

Moss and Barbuto (2010) further identify that altruism – self-sacrifical behaviour – is another vital characteristic of successful servant leaders. Altruism has a direct impact on leadership effectiveness and can strengthen the relationship between social astuteness and effectiveness. Moss and Barbuto (2010, p. 169) state that ―organizations that promote the value of serving others would be able to bring forth altruistic tendencies in their works. Organizations that articulate socially responsible values and ethical practices would likely attract and retain altruistic employees". A study conducted by Barclay (2004) found that altruistic leaders tend to gain a good reputation and trust. This finding is supported by Avolio and Locke (2002) who note that leaders who are altruistic have a positive impact on their teams and their organizations. Barbuto & Wheeler (2006, p. 318) pointed out that leaders with a high ―altruistic calling" wish to serve and are willing to sacrifice self-interest for the benefit and needs of followers and others.

Health services managers tend to work in hierarchical structures, having various roles, responsibilities and the need for different knowledge and skills depending upon their positions in the organization (Clinton, 2004, pp. 104-106; Galer et al., 2005, p. 83; Harris, 2006, p. 26; Kraut et al., 2005; Yukl, 2010, p. 90).

Guo (2003) studied the roles and skills of senior healthcare managers in the context of the needs of the current healthcare environment. He identified three significant roles and related skills: an interpersonal role, which requires leadership and liaison skills; an informational role, which requires the skill of gathering information for problem identification; and decision-making, which involves a number of skills such as communication, conflict-resolution, information systems management, coordination and change-management. These findings are consistent with Mintzberg's (1973, 1979, 1989) ten core managerial roles.

Frontline managers are the first rung of the management hierarchy and affect the engagement and retention of employees (Heaslip, 2010). Burns (2007, p. 73) notes that ―[e]xcellent patient care requires excellent leaders at all levels, particularly at the frontline". Their primary responsibilities are to structure, coordinate and facilitate work activities with a short-term perspective (a few weeks to two years) (Clinton, 2004, p. 105; Yukl, 2010, p. 90). They should have the skills and competencies to formulate and implement policy and strategy, ethically managing self, people and resources in the organization, developing health programmes and services to reduce inequalities, working with and for communities and conducting research to improve the health and well-being of the community (Orme et al., 2007, pp. 86-87). In particular, frontline managers need to learn and be comfortable with four critical skills: planning and organizing work in a team, delegating appropriate tasks to individual team members, recruiting staff to match newly created tasks or positions, and networking with others to gain their support. They need to be available and accessible to subordinates, listen to their needs and supervise them on their performance. They also need to build and maintain a network of relationships with people inside and outside the organization (Galer et al., 2005).

The challenges faced by health services managers and overcoming them

Health services managers work in a complex and dynamic environment (Clinton, 2004, p. 99; Shortell & Kaluzny, 2006, p. 64; Taytiwat et al., 2010). They often lack clarity in their roles and responsibilities, particularly when organizational reforms are under way (Egger et al., 2005; Taytiwat et al., 2010). Roles and relationships between the centre and other levels of health services managers are shifting, especially in countries engaged in some form of

decentralization (Egger, 2005), requiring health services managers to continuously adapt to new situations (Clinton, 2004, p. 99). In addition, healthcare organizations employ a diversity of health professionals, and are challenged by rapidly changing demographics, including an ageing population, shifts in emphasis from treating only acute diseases to also treating chronic diseases, and by continuing technological development (Grant, 2010; Harris, 2006; Isouard, 2010b; Shortell & Kaluzny, 1997, p. 44).

Briggs et al., (2012) examined the Australian health managers' perceptions regarding the health system. The findings indicated that health managers perceived *‗the health system as one of constant change, mostly non-adaptive, and a system of parts controlled by bureaucrats and political interests'* (Briggs et al., 2012, p.641). Despite these managers enjoying their managerial roles, they felt that *‗they lacked influence and control and had a lack of power in that role, being participants in change that is imposed, rather than being in active control of the change process*'(Briggs et al., 2012, p.649).

Tejativaddhana, (2012) identified the major challenges and barriers to the delivery of PHC at the district level in Thailand from community hospital directors (CHDs) and health services stakeholders. According to the CHD respondents, they pointed out that they were dissatisfied with the lack of transparency within Thai bureaucracy and the with the patronage healthcare system in Thailand. They felt uncomfortable working in their managerial role because of the overcentralised regulations, too much hierarchy and lack of coordination between the different agencies and levels.

At the operational level, the Regional Strategic Plan for Strengthening Health Services Management in the South-East Asia Region highlighted that most countries in the South-East Asia Region, including Thailand, are challenged by a shortage of appropriately trained managers, lack of functional support systems and inadequate working environment to support good management (WHO: SEARO, 2007): ―At present, a lack of leadership and management capacity is a constraint, especially at operational levels of both private and public health sectors" (WHO, 2007b, p. 1). Another challenge for frontline managers in the healthcare system is that they are required to meet a variety of community needs beyond the control of the managers, and respond to those needs within a fixed budget and with a staff comprising a

variable mix of health professionals. Changing healthcare policy and restructuring of health services organization effects the clarity of roles for frontline health managers in management (Clinton, 2004, p. 106; Egger et al., 2005). This challenge is compounded when there is lack of transparency, and insufficient monitoring and support systems (Egger et al., 2005).

Lipksy (1980) describes that frontline managers, the so-called ‗street level bureaucrats', have ‗the discretion and relative autonomy of professionals in re-construing and applying policy at the local level' (Braithwaite et al. 2002: p. 191). However, they are faced with the various challenges because of the position they occupy between policy-makers at a higher level and citizens who are their clients at a lower level and because of their work conditions in this situation (Ellis, 2011; Evans, 2011; Hupe & Hill, 2007). Those challenges are, for instance, an overburdened workload (demand for services overtakes the supply), lack of resources and complexity in measuring performance (Raone, 2013, p. 5).

Burns (2007) notes that frontline managers in the healthcare system often lack confidence and abilities in health services management. They feel under pressure because of high expectations from both clients and managers higher up in the healthcare organization. They struggle with some very basic problems, such as limited skills in basic accounting and managing drug stocks (Egger et al., 2005). Such challenges influence the performance of the frontline managers and contribute to high turnover and high failure rates of the frontline managers. Therefore, healthcare systems are losing valuable human resources and are ineffective in spending time, money and energy in order to repeatedly fill the vacant positions (Burns, 2007; Egger et al., 2005).

Given the challenges facing the frontline managers, coupled with the attention that is being placed on improving healthcare systems to achieve the Millennium Development Goals (MDGs), the search for ―managers who can lead and leaders who can manage" has become one of the important keys to better scale up health services (WHO, 2007b, p. 1). In Thailand, the Phitsanulok Declaration of the First International Conference on Health Services Delivery Management recognized that leadership and effective health management are important to the delivery of quality PHC in local rural district health services (Briggs et al., 2010; Briggs et al., 2010). The Declaration affirms the findings of John and Sue (2007) that

the frontline managers must have leadership skills in order to motivate and empower employees.

Human resources development in leadership and management for the frontline managers must be given much higher priority for advocacy and investment by senior leaders (Filerman, 2003; Hanson & Isouard, 2000). Frontline managers have to be continually improved and trained in the professional leadership knowledge, skills and competencies they need to better manage their work in complex healthcare organizations (Burns, 2007; Egger et al., 2005; Hanson & Isouard, 2000; Isouard, 2010a).

The WHO has identified four inter-related dimensions necessary for building leadership and management capacity at the operational level: 1) adequate number and distribution of managers, 2) appropriate competencies of managers, 3) functional support systems of the national health system (e.g. budget, information, human resources, drugs, equipment, buildings, vehicles and other commodities) and 4) an enabling working environment (e.g. the nature of the health management team in the organization, the variety of stakeholders in the catchment area and the broad culture, the political and economic context in society) (WHO, 2007b).

Summary

This section emphasized that having a combination of leadership and management skills is necessary for health services manager at all levels, including for a PHC manager working at the frontline in the Thai healthcare system, but these two components need to be balanced in regard to the organizational norms, culture, context and environment. In order to successfully achieve the MDGs, PHC managers need to develop their leadership and management skills in order to meet the challenges they face from the complex health services system that operates in a dynamic context.

To provide a foundation for programmes aimed at developing the leadership and management skills of PHC managers, this study aims to discover what PHC managers actually do in managing and leading SHPHs and in implementing the SHPH policy at the

PHC level in Thailand. Thus, the details of Thailand‘s PHC system and the SHPH policy are discussed in the following section.

2.3 Primary Health Care

Any research into managers is context-dependent. The importance of context is a predictor of management and leadership style (Briggs, 2008; Kimberly & Evanisko, 1981). The context of this study is the management of PHC. Therefore, this section describes the features of the PHC context, the complex and dynamic changing contexts in which PHC managers exercise their leadership, and how that context might impact on the PHC manager roles as exemplified in the empirical studies.

There are four sub-sections of the PHC philosophy and its context that are central to this study: 1) the evolution of primary health care, 2) the evolution of primary health care in Thailand, 3) sub-district health promoting hospitals and 4) empirical studies of sub-district health promoting hospitals.

2.3.1 Evolution of primary health care

This sub-section provides information on the origin of PHC and the issues regarding PHC: the Declaration of Alma-Ata, comprehensive PHC, selective PHC, primary care and Health for All by the Year 2000. Then, the emphasis on health promotion through ―the Ottawa Charter for Health Promotion", the concept of health promoting hospital and the MDGs are presented. After that, the affirmation of PHC and the consideration of PHC implementation are described. Some examples of countries that have been implementing PHC in their healthcare system are illustrated at the end of this sub-section.

Before the mid-1970s, there was an emphasis on providing a hospital-based healthcare system. Such a system did not cater for health promotion education and left a large number of people, particularly in less-developed countries, with no access to healthcare at all (Nyilas & Véges, 1977). In 1975, ―the basic needs approach" to poverty was emphasized by organizations such as the World Bank. The approach focused on providing the minimum

requirements, such as clothing, food, shelter, safe drinking water, education and health, essential for families to survive within communities. The International Labour Organization (ILO, 1976) and Streeten & Burki (1978) noted that three principles are essential for the basic needs approach to succeed: participation, self-reliance and social justice. PHC developed from the roots a basic needs approach, aiming to solve the problem of social inequity, particularly for the poor, hungry, sick and people without permanent shelter in Africa and Asia (Cueto, 2004; Nyilas & Véges, 1977).

In 1978, a PHC declaration was proposed by the WHO (1978) at the International Conference at Alma-Ata in view of addressing the social and health inequities in all countries. This conference expressed the need for urgent action by all governments, all health and development workers and the world community to protect and promote the health of all people of the world. The conference strongly reaffirmed that “health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right” (WHO, 1978). In order to achieve the highest possible level of this definition of health, it was proposed that PHC should be accepted and implemented worldwide (Phillips, 1990; Walley et al., 2008; WHO, 1978).

PHC is a practical approach to making essential healthcare universally accessible to individuals and families in the community in an acceptable and affordable way, and with their full participation (Francis et al., 2008; Gillam, 2008; WHO, 1978, 1978). The ultimate goals of PHC are to increase social justice (Braveman & Tarimo, 2002; Gillam, 2008; Green, 1999, p. 51), to build community capacity (Green, 1999, p. 55; Walley et al., 2008), and to achieve sustainable development of health and wellbeing (McMurray, 2007; Walley et al., 2008). Even though newer definitions of PHC draw upon interdisciplinary perspectives, there appears to be some consensus that PHC is the first level of contact of individuals and families with the national health system, providing essential healthcare close to where people live and work, and as part of the continuing healthcare process (Hogg et al., 2008; Schaay & Sanders, 2008).

As a philosophy, PHC is about social justice and equity in healthcare, health promotion and disease prevention, holistic understanding and recognition of the multiple determinants of

health, and community development within a holistic framework, with the aim of providing essential community-focused healthcare (Talbot & Verrinder, 2010, p. 4; Whitehead, 1992; WHO, 1978, 1978). As a set of five principles, PHC is meant to provide accessible and acceptable healthcare through health promotion, appropriate technology and cost-effectiveness in relation to the available resources, multisectoral collaboration, and community participation and empowerment (Calnan & Rodger, 2002; Pritchard, 1978, pp. 11-13; Tarlier et al., 2003; WHO, 1978, 1978). As a set of eight elements, PHC focuses on public health education, proper nutrition, clean water and sanitation, maternal and child healthcare, immunization, local disease control, accessible treatment and essential drug provision (Pan American Health Organizations, 1997; Talbot & Verrinder, 2010, p. 6; WHO, 1978, 1978).

PHC has unique components when compared with secondary and tertiary health care (Starfield, 1998). Starfield (1998) clarifies that PHC is considered as the first point of contact in the healthcare system, having the longitudinal responsibility for the patient, involving the comprehensiveness of care from all types of healthcare services and the coordination or integration of physical, psychological and social aspects of health. McMurray (2007, p. 41) emphasizes that PHC requires the principle of intersectoral collaboration among sectors in the community. Community participation is considered as the key concept of sustainable PHC delivery (Bindari-Hammad & Smith, 1992, p. 41; Brown et al., 2005; Francis et al., 2008; McMurray, 2007).

Comprehensive Primary Health Care and Selective Primary Health Care

―Comprehensive Primary Health Care" (CPHC), or the horizontal approach, was a fundamental human right affirmed by the Declaration of Alma-Ata in 1978, and was a holistic approach in providing health services (De Maeseneer et al., 2008; Lawn et al., 2008; Maciocco & Stefanini, 2007; Rohde et al., 2008; WHO, 1978). CPHC emphasizes that peoples' health and wellbeing at individual, community and population levels are affected by the complex interrelationships among physical environment, politics, culture, economics and society (De Maeseneer et al., 2008; Maciocco & Stefanini, 2007; Rifkin & Walt, 1986). CPHC has been emphasized worldwide to reduce health problem issues (Maciocco &

Stefanini, 2007; Rohde et al., 2008). However, this concept of care was too broad (Crooks & Andrews, 2008, p. 5; Cueto, 2004) and it was hard to apply in an inadequate resources situation, particularly during the world economic crisis (Cueto, 2004; Maciocco & Stefanini, 2007; Magnussen et al., 2004). Many people in low and middle income countries still faced disparity and inequity in basic health services (Braveman & Tarimo, 2002; Hall & Taylor, 2003). Walsh and Warren (1979) proposed that there was a need in developing countries for a change of health services delivery which should emphasize equity and access at affordable cost. Consequently, ―Selective Primary Health Care" (SPHC), or the vertical approach, was presented as an ―interim" strategy to fight disease based on cost-effective medical intervention (Crooks & Andrews, 2008; De Maeseneer et al., 2008; Lawn et al., 2008; Maciocco & Stefanini, 2007; Rohde et al., 2008; Walsh & Warren, 1979).

SPHC is relevant to the medical paradigm which focuses on medical intervention from health professionals (Phillips, 1990, p. 63; Rohde et al., 2008; Willis et al., 2009). SPHC emphasizes the specific causes of death, such as growth monitoring, oral rehydration solution, breastfeeding and immunisation, or the so-called (GOBI) (Crooks & Andrews, 2008, p. 5; Wisner, 1988). Family planning, female education, and food supplementation were added later, known as ―GOBI-FFF" (De Maeseneer et al., 2008; Walsh & Warren, 1980; Wisner, 1988). However, SPHC‘s emphasis could attain only short-term goals and did not sufficiently increase population health, suggesting that the SPHC should be either abandoned or integrated into the CPHC. Consequently, CPHC has been re-emphasized because of its potential to tackle the current world-wide challenges caused by complex environmental, economic, political, and social factors (Cueto, 2004; De Maeseneer et al., 2008; Maciocco & Stefanini, 2007; Magnussen et al., 2004 Rifkin et al., 1988; Wisner, 1988).

Primary Health Care and Primary Care

Governments and healthcare decision-makers understand PHC in different ways, which leads to differences in national healthcare systems (Haines et al., 2007). In principle, PHC refers to healthcare that is comprehensive, universal, affordable and delivered equitably (Hall & Taylor, 2003). A focus on ―first-contact care" is often the focus of PHC, particularly in

developed countries, in order to ensure equitable and affordable primary medical care or primary care (PC) (Hall & Taylor, 2003; Talbot & Verrinder, 2010, pp. 6-7).

The term PC is often used interchangeably with PHC or sometimes PC is viewed as synonymous with PHC (Talbot & Verrinder, 2010, p. 7). Contemporary notions of PC are derived from the biomedical model of diagnosis, treatment and care and equate with SPHC. The focus of PC is at the level of the individual (Talbot & Verrinder, 2010, p. 7; Willis et al., 2009, pp. 35-37). The health services of PC are disease prevention, consumer surcharges and health education, while the focal point of SPHC is at the level of population. Screening and surveillance, immunization and primary prevention are relevant to SPHC (Willis et al., 2009, pp. 35-37).

The explicit focus of CPHC is on health equity and social justice. Comprehensive services are based on both social needs and health needs and the health services provided should be of little or no cost to consumers, such as provision of housing and shelter, social support, food and nutrition and a safe environment (Willis et al., 2009, pp. 35-37).

PC, SPHC and CPHC are community-based services at the entry point to the formal healthcare system that are delivered by a range of practitioners such as family doctors or general practitioners, nurses and allied health professionals (Crooks & Andrews, 2008, p. 7; Willis et al., 2009, p. 37). PC and SPHC cannot fully achieve the PHC Alma-Ata declaration envisioned by the WHO in 1978 because they delivered to principal VI of the declaration missing out the important concept of community participation, necessary for ensuring equity (Crooks & Andrews, 2008, pp. 7-8).

Health for All by the Year 2000

After the Declaration of Alma-Ata in 1978, the WHO initiated a number of policy directions aligned with the PHC philosophy. In 1982, the WHO and the United Nations Children's Fund (UNICEF) stated that PHC is the key to attaining a socially and economically productive life by the year 2002, popularly known as ―Health for All by the Year 2000" (Baum et al., 1992; Francis et al., 2008; Pan American Health Organizations, 1997; Schaay

& Sanders, 2008; WHO, 1981). This strategy emphasized the need to reorient health systems and services, intersectoral collaboration, public participation and health equity (WHO, 1981).

Health Promotion

In 1986, ―The Ottawa Charter for Health Promotion" emphasized five actions: building healthy public policy, creating environments which support healthy living, strengthening community action, developing personal skills, and reorienting healthcare (Chambers & Walker, 2012; Talbot & Verrinder, 2010, pp. 8-9; WHO, 1986). The Ottawa Charter for Health Promotion is regarded as the formal beginning of the New Public Health movement, overcoming the reductionist shortcomings of SPHC (Talbot & Verrinder, 2010, p. 7) and requiring a new orientation to the analysis, management and prevention of priority health issues, the need to work for change to the environment rather than focusing on change at the individual level, and the need for a partnership relationship with communities and other sectors of government and private institutions (Baum, 2008, p. 311; Chambers & Walker, 2012; Fleming & Parker, 2007, pp. 31-36; Talbot & Verrinder, 2010, pp. 9-10).

The term ―Health Promotion" was coined in 1945 by the medical historian, Henry E. Sigerist, who defined the four major tasks of medicine as promotion of health, prevention of illness, restoration of the sick and rehabilitation. He noted that health was promoted by providing a decent standard of living, good labour conditions, education, physical culture, means of rest and recreation; and promotion required the co-ordinated efforts of statesmen, labour, industry, educators and physicians (cited in Kumar & Preetha, 2012).

The term ―Health Promotion" was also relevant to the 1974 ―Canadian Lalonde Report" that proposed four determinates of health: biology, lifestyle, health services and environment (Hancock, 1986). The Report suggested that, while most attention had been paid to medical treatment provided by the health services, improving environment and lifestyle would offer the greatest opportunities for promoting public health in the future. The Lalonde Report and the Ottawa Charter for Health Promotion focused on the social determinants of health (SDH) (Earle et al., 2007, pp. 69-70).

SDH are understood as the social conditions in which people live and work (Willis et al., 2009, p. 37). SDH was recognized by the WHO in the Declaration of Alma-Ata (1978) to achieve the vision of Health for All by the Year 2000 (WHO, 1981). SDH include income, employment, the social gradient, early childhood, access to healthcare, education, secure and affordable food sources, social support, gender, culture and social exclusion, and are aligned to PHC through the concepts of reducing health inequalities, increasing human rights and distributing power to people (Willis et al., 2009, pp. 38-39).

Health promotion pays attention to the biomedical model, and the roles of all sectors in society to control the determinants of health, including environmental, economic, political and social factors (WHO, 2012). It encourages a sustainable health status in the community and motivates people to improve their living conditions; the aim is to encourage people to take responsibility for the health conditions for themselves, their families and communities (Buasai et al., 2007).

Health Promoting Hospitals

As a result of the Ottawa Charter for Health Promotion, there was a reorientation of health services towards ―Health Promoting Hospitals" (HPH) in 1988 (Mchugh et al., 2010; Pelikan et al., 2001; Whitehead, 2004, p. 259). The HPH is one of five key health promotion areas designated within a settings-based health promotion strategy. The other four are health promotion at home, school, workplace and community (Whitehead, 2004, p. 259).

The aim of the HPH is to shift the focus of health services from curative care to a more holistic approach that encompasses the principles of health promotion (Mchugh et al., 2010, p. 230). This means that health services resources and priorities should be reoriented from tertiary care and secondary care to PHC (Whitehead, 2004, p. 259). The health promotion practices should be encouraged in tertiary and secondary hospitals and in PHC settings (Mahmud et al., 2010).

The first project ―Health and Hospital" was initiated by the international network of WHO-Europe in 1989 in Vienna, Austria, and was implemented successfully in 1996. The HPH

concept was then implemented in 20 hospitals in 11 European countries in ―The European Pilot Hospital Project of Health Promoting Hospital” (1993-1996). Since 1995, the national and regional network of HPH has been further developed with the aim of implementing the HPH concept into as many other hospitals and healthcare institutions as possible (Pelikan et al., 2001, p. 239).

The development of the HPH concept was enabled by several initiatives including 1) the Budapest Declaration on Health Promoting Hospitals in 1991, 2) the Vienna Recommendations on Health Promoting Hospitals in 1997, and 3) the setting of five core WHO HPH standards in 2004 (management policy, patient assessment, patient information and intervention, promoting a healthy workplace, and continuity and cooperation) (Mchugh et al., 2010, p. 230).

Following the successful implementation of the HPH concept in Europe, it has been expanded and implemented in other parts of the world such as Canada, Australia, Mongolia, and Thailand (Pelikan et al., 2001, p. 239). However, the interpretation of the HPH concept varied, affecting the activities and the sustainability of implementation (Johnson & Baum, 2001).

Millennium Development Goals

In 2000, the United Nations outlined a set of development targets related to the reduction of poverty and hunger, ill-health, gender inequality, a lack of access to education and clean water and environmental degradation, along with the proposed development of cooperative global partnerships, known as the Millennium Development Goals (MDGs) (United Nations, 2000).

Like the Alma-Ata Declaration, the MDGs clearly acknowledge that social and economic development are entwined to simultaneously produce health gains (Negin et al., 2010). The set of MDG targets will expire in 2015, and while many targets have been achieved, others might not be able to be met (Melamed & Scott, 2011), leading to a renewed interest in the PHC approach.

After more than 30 years of the Alma Ata Declaration and the target of Health For All, along with pressure from WHO Member States and regions, there is a return to adopting the values and principles of the PHC approach, and particularly its approach to the social determinants of health and inequality (De Maeseneer et al., 2008; Melamed & Scott, 2011; Montegut, 2007; WHO, 2008b). There is also the campaign ―15 by 2015” calling for all major global health donors, such as the World Bank, the Global Fund, the WHO, and the Bill and Melinda Gates Foundation, to allocate at least 15 per cent of their vertical grants to be invested in strengthening CPHC that is affordable and accessible for all, particularly for people in Africa, Asia and Latin America (De Maeseneer et al., 2008; Heath, 2008; Montegut, 2007).

Reaffirmation of Primary Health Care and Health Promotion

In 2003, the international report on PHC on the 25th anniversary of the Alma-Ata Declaration was published. It was a call for countries around the world to ensure the development of PHC by strengthening human resources capability, supporting community participation, and evaluating and researching the improvement of PHC and the overall healthcare system (WHO, 2003).

WHO also initiated the Commission of Social Determinants of Health in 2005 and its final report was released in 2008 and made three principal recommendations: improve daily living conditions; tackle the inequitable distribution of power, money and resources; and measure and understand the problem, and assess the impact of action (WHO, 2008a).

In 2008, the WHO also published the ―World Health Report: Primary Health Care (Now More Than Ever)” in order to reemphasize that health systems need to better solve the health challenges in a changing world by implementing PHC (WHO, 2008b). This report emphasized four necessary conditions to revitalize PHC: universal coverage reform to improve health equity, services delivery reform to make health systems people-centred, public policy reform to promote and protect the health of communities, and leadership reform to make health authorities more reliable (WHO, 2008b).

In 2010, recognising that health and wellbeing are influenced by political, social and economic factors, ―The Adelaide Statement on Health in All Policies” moved towards shared

governance for health and wellbeing, noting that it was the responsibility of all sectors and governments to improve the healthcare system (Krech & Buckett, 2010; WHO, 2010).

Considerations in the implementation of primary health care

Various aspects need to be considered in order to successfully implement the PHC philosophy. The WHO states that “all governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors” (WHO, 1978, 1978). Governments need to determine social goals – such as improvement in the quality of life and delivering maximum health benefits to the population – and set health activities that will be acceptable to the community and to individuals to ensure their active participation in attaining the goals.

PHC and community efforts towards social and economic development in general are most likely to succeed when they are mutually supportive (Taytiwat et al., 2010; WHO, 2008b). Hence, good relations between the health sector functions and the other social and economic sectors, and a need for harmony within the health sector, through to support for PHC by all other levels, are required (Tejativaddhana et al., 2012; WHO, 2008b).

Because PHC is delivered by family medical practitioners and multidisciplinary teams, the skills these health professionals require and their training will vary widely throughout the world depending upon the particular form of PHC being provided (Hixon & Maskarinec, 2008; Lawn et al., 2008). Whatever their level of skill, it is important that they understand the real health needs of the communities they serve (Tejativaddhana et al., 2012), and that they gain the confidence of the people (Lawn et al., 2008; WHO, 1978, 1978). The understanding of the needs of people in their community integrated with the components of the PHC is necessary to set proper activities (Lawn et al., 2008; Tejativaddhana et al., 2012).

Hixon and Maskarinec (2008) add that family medicine and multidisciplinary teams need to control the cost of providing healthcare services by using resources judiciously in order to enable the health system to be inclusive, particularly including vulnerable groups such as the homeless and uninsured.

Primary health care worldwide

PHC has now been implemented worldwide to reduce health problem issues and to improve effectiveness in the health services system (Jirojwong & Liamputtong, 2009, p. 27; Walley et al., 2008). A comparison of twelve western industrialized nations indicates that countries with a stronger orientation to PHC are more likely to have better health levels at lower costs (Starfield, 1998, p. 12). Russell et al. (2010) and Thomas (2006, p. 137) suggest that the management of a PHC organization should emphasize CPHC, integrating CPHC into the healthcare system. PHC organizations, particularly in remote areas, have the tendency to be an integrating PHC organization because of the advantages of cost-effective health-care intervention (Ekman et al., 2008; O'Donohue et al., 2005; Thomas, 2006, p. 138; WHO, 1997).

In Australia, New Zealand and the United Kingdom, PHC organizations have provided health services based on the integrated care model and reap significant benefits such as increased physician participation and satisfaction and reduction in diagnosing and prescribing costs (Rowan et al., 2007; Russell et al., 2010). From the point of view of the health services users, it is often claimed that integrated programmes are better than the vertical programmes because the care provided is fitted to the patient‗s needs and leads to more adequate service delivery, resulting in increased patient and provider satisfaction and decreased long-term costs (O'Donohue et al., 2005).

PHC interventions have also been used in developing countries. Menandhar et al. (2004) describes how participatory intervention with women‗s group meetings has had a positive impact on birth outcomes in Makwanpur district, Nepal, with reductions in neonatal mortality to around 30 per cent (Manandhar et al., 2004). The Mitanin programme of Chhattisgarh state in India is a significant example of a large-scale community health worker programme established in 2000. It aims to provide outreach services to the 18 million rural inhabitants of Chhattisgarh state through the creation of a network of 54,000 women community volunteers to deliver family-level rights-based outreach activities at a community-level. Although it is difficult to attribute the precise contribution the programme has made, it is considered to have lent valuable support to improving child survival, as evidenced by the decrease in infant

mortality from 85 deaths per 1,000 live births in 2002 to 65 deaths per 1,000 live births in 2005 (Registrar General India, 2006). In 2000 the Ghana Health Service launched a national programme of scaling up the transformation of clinic-based PHC and reproductive health services to community-based health services, a model of community health services innovation that was developed and tested by the Navrongo Health Research Centre. Essentially, the Navrongo experiment illustrated that the relocation of nurses to communities and reorientating management systems was more supportive of accessible, community-based nursing care, and it was possible to reduce childhood mortality by a third in seven years and reduce fertility rates by one birth in a decade (Debpuur et al., 2002).

More recently, the WHO noted the success of PHC in Thailand. Thailand began implementing PHC in 1977, using village health volunteers and village health communicators, trained by public health officers, to extend coverage of priority interventions and PHC activities at community and household level. In 2001, Thailand launched the universal coverage scheme, where universal access to health services was ensured through the introduction of a nominal prepayment of 30 baht per citizen for health services (Pannarunothai et al., 2004). Thailand‘s PHC programme has now expanded to include HIV and AIDS services and a focus on achieving the MDGs (United Nations, 2000).

2.3.2 Evolution of primary health care in Thailand

This sub-section describes the development of the Thai healthcare system from the pre-western medicine era until the implementation of the SHPH policy. During this evolution, there were a number of significant reforms and innovations such as the implementation of the Alma-Ata Declaration in 1978, the establishment of the Tambon (sub-district) health centre in 1980, the implementation of Healthy Public Policy regarding the Ottawa Charter Promotion in 1986, the implementation of a health decentralization policy in 1999, the implementation of the Universal Health Coverage Policy in 2001, the adoption of the MDGs in 2004 and, in 2009, the implementation of the SHPH policy.

Before 1828, or the pre-western medicine era, there was no formal healthcare system in Thailand. People took care of themselves. Thai traditional herbal medicine, Indian Ayurveda

(a Hindu system of traditional medicine native to India), and Chinese traditional medicine principles were employed. From 1828 to 1889, the Thai Royal Family took an interest in western medicine and began to modernize Thailand‘s indigenous medical practices. The first hospital and medical school, Siriraj, was established in 1888 (Bureau of Policy and Strategy, 2009, pp. 7-8; Lyttleton, 1996).

Curative care was emphasized in the government‘s health policy enunciated in the 1st Five-Year National Health Development Plan in the early 1960s, because of epidemic diseases such as smallpox and cholera (Lyttleton, 1996; Yongkittikul et al., 1988). In the 1st to 3rd Five-Year National Health Development Plans (1961-1976), the Thai government launched several healthcare programmes, such as the vertical diseases control programme for tuberculosis and hookworm. A mobile health centre was established to provide health services for people in rural areas, along with a programme to use health volunteers to help in the control of malaria. In 1974, the MoPH received assistance from the WHO to plan and establish a more robust healthcare system (Bureau of Policy and Strategy, 2009, p. 10).

In accordance with the 1978 Alma-Ata Declaration, the Thai government agreed to adopt the PHC system and the MoPH experimented with PHC programmes in Chiangmai and Korat Provinces with the aim of establishing such programmes countrywide (Bureau of Policy and Strategy, 2009, p. 52). The 4th and 5th Five-Year National Health Development Plan (1977-1986), therefore, contained a major policy shift to the PHC philosophy (Bureau of Policy and Strategy, 2009, p. 15; Office of Primary Health Care, 1985, p. 32). In order to achieve the long-term goal ―Health for All by the Year 2000", PHC approaches in Thailand are based on the four principles of appropriate technology, people‘s involvement, intersectoral coordination, and self-reliance (Nittayarumphong, 1990), leading to an emphasis on comprehensive health programmes (Bureau of Policy and Strategy, 2009, p. 15; Ramasoota, 1997). These programmes encouraged people‘s participation in the health scheme in order to widen the use of government health services and increase the efficiency and scope of health promotion (Lyttleton, 1996; Ramasoota, 1997).

In 1980, the ―Basic Minimum Needs" or ―Quality of Life" programme was developed to determine and guide multi-sectoral village-level programmes because the Thai government

needed to establish concrete criteria for achievement of PHC goals (Bureau of Policy and Strategy, 2009, p. 15; Lyttleton, 1996). With the support of the Ministries of Public Health, Interior, Agriculture and Education, community leaders were trained in assessing the community needs (basic minimum needs) of their villagers. The –grassroots” information was then utilized to plan healthcare services appropriate to the needs of communities (Bureau of Policy and Strategy, 2007).

The government attempted to expand the health infrastructure to cover all rural communities and to decentralize management in the health sector to provincial, district, sub-district, and village levels (Bureau of Policy and Strategy, 2009, p. 11). In 1980, the Tambon (sub-district) health centre was created as the place for interaction between the central government and village communities (Ingavata, 1990). One health centre was established for every ten villages in Thailand. These health centres were usually staffed by at least two paraprofessionals who were graduates of a Public Health College (Lyttleton, 1996). During this period, many community health innovations were created, such as village drug funds and community funds for health development in other forms, resulting in the transfer of technology to communities and the development of management skills as well as community participation in self-healthcare and community health development (Ramasoota, 1997; Siwaraksa, 2001; Wibulpolprasert, 2011). The government selected village health workers, village health volunteers (VHVs) and village health communicators (VHCs), to work closely with the health staff at the sub-district health centre (Office of Primary Health Care, 1985, p. 33; WHO, 2011, p. 21).

VHVs were expected to be responsible for simple health services, such as treatment of minor illnesses, health promotion and disease prevention, while the main role of VHCs was to disseminate health information to villagers, such as information about healthy living and communicable diseases (Bureau of Policy and Strategy, 2007, p. 48; Office of Primary Health Care, 1985, p. 33). The objective of the project was to increase the capability and responsibility of the sub-district and district level health personnel, and focused on community participation (Lyttleton, 1996; Nittayarumphong, 1990; Wibulpolprasert, 2011).

In 1982, the Office of Primary Health Care was established as a division of the Office of the

Permanent Secretary, MoPH (Office of Primary Health Care, 1985). Regional centres for PHC were also established in four regions. These centres were used to train and supervise the provincial, district and village health workers. The government attempted to develop and train village health workers in every village. As a result, about 800,000 village health workers throughout Thailand were trained, marking a degree of success in the introduction of a major component of the PHC principles of people‘s involvement and community participation (Nittayarumphong, 1990). However, in 1993, the MoPH later decided to enhance the capacity of village health workers by upgrading all VHCs to VHVs and a ―National Association of Village Health Volunteers" was established to support the VHVs‘ activities (Bureau of Policy and Strategy, 2007, p. 48).

In 1986, the MoPH emphasized the development of a healthy public policy under the Ottawa Charter for Health Promotion and increased resources for health promotion through the promotion of healthy behaviour and lifestyles (Bureau of Policy and Strategy, 2009, p. 15). Many projects, such as healthy cities, health-promoting schools, health-promoting workplaces, and health-promoting hospitals were implemented. Rural health development policies and projects included an expansion of community participation in self-healthcare and creating supportive environments for health (Wibulpolprasert, 2011).

In 1989, the government developed the PHC programme by initiating the PHC model in Ayuthaya Province, the so-called ―Ayuthaya Project". This project utilized action research to test the family medicine model and the three concepts of integrated healthcare: continuity of care, integrated care and holistic care. The results showed that strong health centres were necessary to take care of people‘s health and reduce referrals to district hospitals (Wibulpolprasert, 2011). As a result, the government launched several projects to enhance PHC. In 1992, the project known as ―The Decade of Health Centre Development (1992-2001)" was implemented to upgrade infrastructure and facilities of health centres, and to increase the capacity of nursing care in health centres. In 1997, the project ―Good Health at Low Cost" was introduced to improve accessibility and efficiency of PHC services (Ramasoota, 1997).

In 1998, ―The Health Promoting Hospital Plan for Thailand" was officially developed by the

MoPH in order to shift the hospital‘s services to a more integrated proactive approach of health promotion and prevention, as well as to empower hospital staff to take control of their health in a supportive physical and social environment (Auamkul et al., 1999; HPH Committee, 1999). The operational plan was divided into two phases. Phase I (1999-2000) was implemented with the aim of developing 24 learning HPH models. Phase II (2001 onwards) was intended to expand the HPH concept into all hospitals under the MoPH on the voluntary basis (Auamkul et al., 1999; HPH Committee, 1999).

In 1999, as health decentralization had been an item on the national agenda in compliance with the 1997 Constitution of Thailand and the Decentralization Plan and Process Act of 1999, the MoPH attempted to decentralize and transfer most of the health centres at the sub-district level to local government organizations (Krueathep, 2004; Srisalux et al., 2009; Tima et al., 2009; WHO, 2011, p. 19). The local government organizations working under the Ministry of Interior had to increase their capacities and responsibilities in order to administer the health centres which used to be managed by the MoPH (Krueathep, 2004; WHO, 2007a). The MoPH, in response to this vital transition, has also had to develop action plans for the decentralization of functions, resources and staff to the local administrative organization (Hawkins et al., 2009; Srisalux et al., 2009). The ten-year plan from 2001 to 2010 of health decentralization was launched by the decentralization committee in 2000 (Tima et al., 2009). However, local government organizations play a very limited role in health services today because the action plan regarding the Act was never finalized or implemented (Intaranongpai et al., 2011; WHO, 2011, p. 19). Most public health centres currently remain with the MoPH (Tima et al., 2009). Therefore, the decentralization process in the health sector has been delayed in the devolution of health service facilities from the central to local government levels (Intaranongpai et al., 2011; Srisalux & Kovinta, 2008; Taearak et al., 2008).

In 2001, the Thaksin-led Government of Thailand launched ―The Universal Health Coverage Policy" (UHC) in order to implement universal health insurance cover for Thailand‘s population (Bureau of Policy and Strategy, 2009, p. 16; Hughes et al., 2010; Ramesh, 2009; Tejativaddhana et al., 2012). People are required to register with one PHC contractor network, which consists of health centres and a district hospital serving about 50,000 people

(Ramesh, 2009, p. 354). The clients under this policy need to pay 30 baht[2] per visit on admission to public healthcare facilities, including health centres, community hospitals and general hospitals. Children aged below 12 years, the elderly, the disabled and low-income groups do not need to pay this charge (Ramesh, 2009; Somkotra & Detsomboonrat, 2009; Towse et al., 2004).

Before the implementation of the UHC Policy, most people were covered by the Health Welfare Scheme. Another scheme was the Voluntary Health Card Scheme. The Scheme operated from 1986 to 2001 and required people to buy a prepaid health insurance card in order to get free healthcare services of hospitalization for up to six times per year per family. The card initially cost 300 baht but this was increased to 500 baht. From the 1970s to 2001, free medical care was made available to low-income groups subsidized by the government. Social Security Health Insurance was established in 1990, under the Social Security Act, to provide medical benefits to employees in the private sector. All employees as well as the self-employed were covered in December 2005 (Prakongsai et al., 2007; Ramesh, 2009; Wibulpolprasert, 2011).

After the implementation of the UHC policy, the health insurance scheme consisted of six parts (Ramesh, 2009; WHO, 2011, p. 22; Wibulpolprasert, 2011):

1. The Social Security Scheme is the joint payment by both the employees and their employers and will give aid to the employee when the employee is sick.

2. The Workmen‘s Compensation Scheme aims to protect the employee from work-related injuries, illnesses and funeral costs and employers must contribute to this scheme.

The first and second schemes for private employees provide cover for 15% of the population.

3. The Civil Servant Medical Benefits Scheme (covering 7% of the population) is the scheme providing benefits to government employees and compensating them for the low salary they receive as a government employee.

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[2] 42 Baht approximated to US$1 in 2001.

4. The Universal Coverage Scheme (UCS) (covering 76% of the population) provides all Thai people with insurance and guarantees that they can receive a standard level of healthcare. Clients are divided into two groups: the first group needs to pay 30 Baht per health visit, while the second group (children aged below 12 years, the elderly over 60 years of age, the disabled, veterans, mongs and the low-income groups) does not need to pay. UCS has a ceiling to its benefit package.

5. Traffic Accident Insurance for vehicle owners, which requires compulsory vehicle insurance to cover accidents or sickness caused by traffic accidents.

6. The Private Health Insurance scheme, which is a voluntary insurance scheme.

A migrant health insurance scheme is also available for purchase among registered non-Thai migrants who have a work permit. Unfortunately, the majority of the 2-4 million non-Thai migrants in the country are not covered by health insurance and have difficulty in accessing health services (WHO, 2011, p. 22).

From 2002, under the UHC policy, health centres have been upgraded to Primary Care Units (PCUs) to provide for the basic health needs and PHC services of the whole population. The UHC policy also established the network system of PCU management, the so-called ―Contracting Unit of Primary Care" (CUP). In each district, community hospitals or large PCUs, which met certain standards, were designated as centres of networks or the CUP for satellites of small PCUs (Chaivoraporn et al., 2003; Hughes & Leethongdee, 2007; Hughes et al., 2010; Jongudomsuk, 2005; Tejativaddhana et al., 2012).

Under the 2002 Health Security Act, the systems of capitation-based funding and ―purchaser-provider split" were introduced in order to make the UCS sustainable and strengthen the PHC system (Hughes & Leethongdee, 2007; Hughes et al., 2010; WHO, 2011, p. 22). Traditionally, funding was allocated to each health facility based on funding history (WHO, 2011, p. 22). This meant that large hospitals in central regions usually had a significant proportion of healthcare funds because of the large number of patients they treated and, therefore, healthcare funding was predominantly spent on secondary care (Hughes & Leethongdee, 2007). In order to solve this problem, the new system of capitation-based

funding was implemented to allocate funds based on the demand-side of the registered population living in the catchment area of each health facility (WHO, 2011, p. 22). This meant that hospitals or CUPs in rural areas received more funds in line with the registered number of the local population and had more power in providing health services (Hughes & Leethongdee, 2007). A per capita payment is pre-paid each year to cover the minimum benefit package, with an initial payment of 1,202 baht per capita in 2002 (Bureau of Policy and Strategy, 2009, p. 34; Hughes & Leethongdee, 2007). Even though the funding was increased to 1,308.50, 1396.30, 1,659.20, 1899.69 baht per capita in 2004, 2005, 2006, 2007 respectively, the UCS still was under-funded (Bureau of Policy and Strategy, 2007). In terms of ―purchaser-provider split", the National Health Security Office (NHSO) was established as an autonomous purchasing agency under the supervision of the MoPH (Hughes & Leethongdee, 2007; Hughes et al., 2010). The NHSO has the important roles to purchase health services for people on behalf of the UCS and to collaborate with the providers (hospitals and CUPs) (WHO, 2011, p. 24). The NHSO as the purchaser in the healthcare system can increase service standards because the providers (hospitals and CUPs) need to meet certain service standards before they can participate in the UCS (Ramesh, 2009, p. 359).

The implementation of the UHC policy by the MoPH has had an effect on the entire Thai healthcare system, particularly at the PHC level (Taytiwat et al., 2010; Tejativaddhana et al., 2012; WHO, 2002, 2007a). The focus of this policy is to increase health facilities, health resources and quality of medical resources at the district level. This policy, which has the same ideals as the Declaration of Alma-Ata, focused on ensuring that everyone is able to access healthcare (Kuakul, 2009; Prakongsai et al., 2007; Taytiwat et al., 2010; Tejativaddhana et al., 2012). The UHC policy has increased health insurance coverage from 75 per cent of the population before 2001 to 90 per cent in 2002. The share of public finance for healthcare has increased from 56 per cent in 2001 to 63 per cent in 2002, and reached 64 per cent in 2005 (Prakongsai et al., 2007). The coverage of all health security systems had increased to ninety-nine per cent of the Thai population in 2009 (WHO, 2011, p. 22).

Despite the UHC policy contributing benefits and development to the Thai healthcare system, there were problems with the implementation of the policy (Boonyapaisarncharoen et al., 2008; Hughes & Leethongdee, 2007; Hughes et al., 2010; Prakongsai et al., 2007;

Tejativaddhana et al., 2012). For example, there was disparity between the authorities for PHC services provision at the district health team level (Tejativaddhana et al., 2012). Hospital directors have the power to control resources allocation. They tend to put more emphasis on curative services in the hospital than on health promotion and health prevention activities at community health centres and this leads to the failure to fund the latter adequately (Hughes & Leethongdee, 2007; Hughes et al., 2010). In addition, the number of clients accessing health services also significantly increased because most people were covered by health insurance and were able to access health services at the public PHC facilities. Clients became dissatisfied because of the long waiting times and believed the public PHC facilities were of low quality because of poor quality medicines and supplies and the lack of medical skills of the public healthcare providers. The result was that secondary and tertiary facilities were full of clients (Prakongsai et al., 2007).

To respond to the clients' needs, public healthcare providers were under pressure to improve their performance and efficiency but were faced with financial and human resources limitations (Boonyapaisarncharoen et al., 2008; Ditton & Lehane, 2009). The government and the MoPH sought to solve the problem by reforming the PHC system by turning the focus on to health promotion and using it to improve the health of the entire population (Prakongsai et al., 2007; Wibulpolprasert, 2011).

In 2004, the MoPH initiated the ―Healthy Thailand" policy as a strategic approach to reducing behavioural health risks (Bureau of Policy and Strategy, 2009, p. 55). This strategy emphasized health promotion in a bid to achieve the eight global MDG targets by 2015 (Travis et al., 2004). As Thailand has achieved some of these goals, particularly the decline in infant and maternal mortality, the government further set higher standards of the MDGs, the so-called ―MDG-Plus targets" (Bureau of Policy and Strategy, 2009, p. 55; Wibulpolprasert, 2011, p. 30). In August 2005, WHO chose Thailand to host the 6th Global Health Promotion Conference to share its progress in health promotion towards the MDGs (Bureau of Policy and Strategy, 2009, p. 51).

In its assessment of Thailand's progress on the MDGs, the WHO (2011) acknowledged the significant achievements of health services based on PHC in Thailand, such as the antenatal

care coverage, the comprehensive nutrition programme, and good water and sanitation facilities. However, the WHO also noted that there are gaps in Thailand‘s health services, especially for the poorest and the migrants in Thai society. Wibulpolprasert (2011, p. 387) notes that there are still many challenges with regard to caring for the health of the Thai people, such as how to care for an ageing society and the increasing prevalence of chronic diseases, dealing with emerging diseases (SARS, avian flu) and re-emerging diseases (tuberculosis, malaria, and dengue haemorrhagic fever).

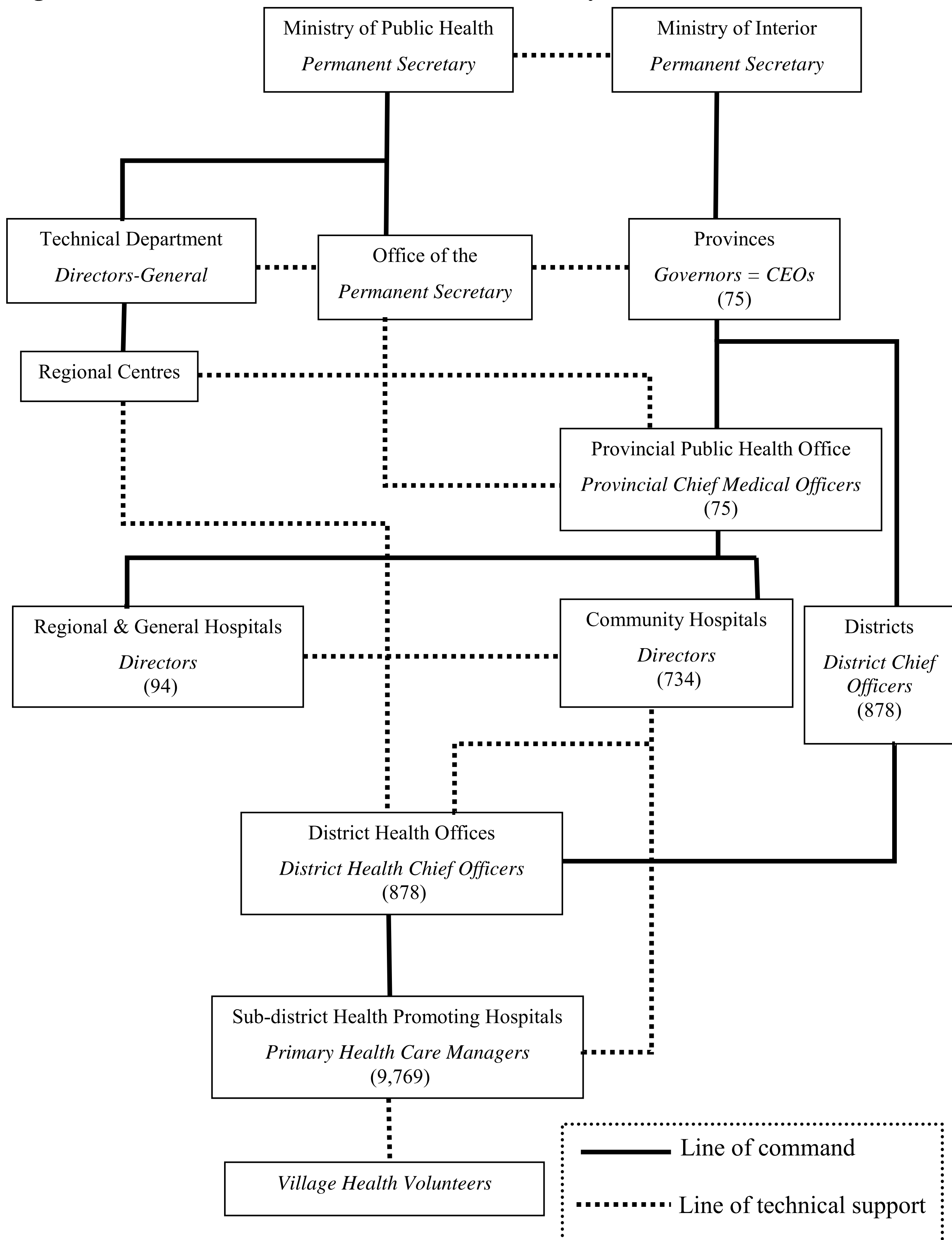
Against this background, the Thai government introduced the SHPH policy in 2008 and the policy was implemented in 2009. As a result of the policy, PCUs at the Tambon (sub-district) level were upgraded to ―Sub-District Health Promoting Hospitals (SHPHs)" (Bureau of Policy and Strategy, 2009, p. 17; MoPH, 2010a; MoPH, 2010b; Wibulpolprasert, 2011).

2.3.3 Sub-district health promoting hospitals

This sub-section discusses the current Thai healthcare system, the position of SHPHs in the system and details about the SHPH policy.

Health services in Thailand are provided by both the private and public sectors (Ramesh, 2009, p. 346; Wibulpolprasert, 2011). In the public sector, the MoPH is responsible for two-thirds of all health facilities across the country. Other public health facilities are medical school hospitals, under the Ministry of Education, and general hospitals under other ministries (such as the Ministries of Interior and Defence) (WHO, 2011, p. 19). In each province, there is a provincial governor or chief executive officer (CEO) who administers all activities of the organizations in his/her jurisdiction. Thus, as described in Figure 2.1, the Provincial Public Health Officer in each province, with the technical support from the MoPH, has to directly report his or her activities to the CEO in the Ministry of Interior (Wibulpolprasert, 2011, p. 336). However, the MoPH, working together with other ministries, is the main government agency responsible for management, support, monitoring, controlling and evaluating the health facilities of both private and public sectors (Bureau of Policy and Strategy, 2009; Ramesh, 2009; Wibulpolprasert, 2011, pp. 363-366).

Figure 2.1: The administrative structure of the Ministry of Public Health



Source: Adapted from Wibulpolprasert (2011, p. 337)

The private sector consists of the private hospitals, clinics and drug stores. These health facilities are mostly located in the major provinces and urban areas, especially in wealthier urban areas. The public sector plays the most important role in Thailand's healthcare system, particularly in rural areas. The public healthcare system consists of regional hospitals (501-1,000 beds) for tertiary care, general or provincial hospitals (120-500 beds) for secondary care, community or district hospitals (10-120 beds) for secondary and primary care, and SHPHs (no in-patients) for PHC (WHO, 2011, p. 19; Wibulpolprasert, 2011, pp. 269-277). The types and number of public and private health facilities under the MoPH are presented in Table 2.2.

The SHPHs are the public health agencies at the lowest level in the administrative structure of the MoPH. They are considered as the first point of contact for healthcare for people in the catchment community (Bureau of Policy and Strategy, 2009). The SHPHs have specific geographical boundaries and a target population and provide a comprehensive PHC service, including primary medical care and public health services focusing on health promotion and disease prevention. As shown in Figure 2.1, SHPHs work under the management of District Health Offices, and receive support from the community hospitals in the form of medical supplies and health personnel (doctors, dentists, pharmacies, and nurses) (Wibulpolprasert, 2011, pp. 336-337).

Table 2.2: Number of public and private health facilities under the management of the Ministry of Public Health in 2009

Type of Facility	Administrative Level			
	Bangkok Metropolis	Province	District	Sub-district
Public Sector				
- Regional hospitals	-	25	-	-
- General hospitals	26	69	-	-
- Community hospitals	-	-	734	-
- SHPHs	-	-	-	9,769
Private Sector				
- Private hospitals	96	226	-	-
- Private clinics	3,878	13,793	n/a	n/a
- Drug stores	4,590	12,597	n/a	n/a

Source: Adapted from Wibulpolprasert (2011, pp. 269-272)

Table 2.3: Distribution of SHPHs by region in 1979, 1987, 1996-2003, 2006, and 2009

Region	Number of SHPHs and (SHPH to population ratio)											
	1979	1987	1996	1997	1998	1999	2000	2001	2002	2003	2006	2009
Central	1,219 (1:7,781)	1,635 (1:4,729)	2,377 (1:3,654)	2,471 (1:3,554)	2,508 (1:4,298)	2,523 (1:4,219)	2,524 (1:3,681)	2,559 (1:4,628)	2,559 (1:4,611)	2,549 (1:4,629)	2,564 (1:5,179)	2,558 (1:5,476)
North	914 (1:10,748)	1,616 (1:4,775)	1,965 (1:4,412)	2,151 (1:4,103)	2,203 (1:4,393)	2,225 (1:4,345)	2,231 (1:4,093)	2,210 (1:4,667)	2,216 (1:4,670)	2,220 (1:4,662)	2,227 (1:4,739)	2,231 (1:4,862)
South	688 (1:8,230)	1,252 (1:3,821)	1,400 (1:3,839)	1,488 (1:3,653)	1,505 (1:3,864)	1,513 (1:3,922)	1,516 (1:3,872)	1,507 (1:4,427)	1,526 (1:4,418)	1,521 (1:4,433)	1,510 (1:4,753)	1,512 (1:4,993)
Northeast	1,277 (1:12,747)	2,489 (1:5,818)	3,100 (1:5,248)	3,367 (1:4,900)	3,398 (1:5,063)	3,428 (1:5,102)	3,433 (1:4,972)	3,462 (1:5,427)	3,509 (1:5,387)	3,475 (1:5,440)	3,461 (1:5,442)	3,468 (1:5,356)
Total	**4,088 (1:10,064)**	**6,992 (1:4,964)**	**8,842 (1:4,411)**	**9,477 (1:4,173)**	**9,614 (1:4,522)**	**9,689 (1:4,514)**	**9,704 (1:4,262)**	**9,738 (1:4,890)**	**9,810 (1:4,872)**	**9,765 (1:4,895)**	**9,762 (1:5,106)**	**9,769 (1:5,218)**

Sources: Wibulpolprasert (2011, p. 280)
Note: The figure in ( ) is the ratio of one SHPH to population outside municipal areas and sanitary districts.

As shown in Table 2.3, the distribution of health facilities between urban and rural areas is not consistent with the aim of equity because the urban areas have more health facilities than rural areas. In 2008, the ratio of population per hospital bed in Bangkok was 312:1 while the ratio in the Northeastern region was 779:1 (Wibulpolprasert, 2011, p. 269-278). This maldistribution leads to problems in the Thai healthcare system, including inequities in resources allocation, accessing healthcare and health status, health expenditure compared to income, and inefficacy in providing quality health services (Wibulpolprasert, 2011, pp. 302-324). In the last three decades (1979-2009), the government and the MoPH have attempted to resolve these problems by building more SHPHs to cover all sub-districts across the country. The SHPH to population ratio thus had a rising trend in all regions of the country, from 1:10,064 in 1979 to 1:5,218 in 2009, as shown in Table 2.3. Following this development, the Prime Minister, Abhisit Vejjajiva, announced the current SHPH policy on 29 December 2008, for implementation by the MoPH in 2009, to improve the efficiency, quality and equity of the healthcare system by upgrading 9,769 PCUs to be SHPHs, with 33,225 health personnel (MoPH, 2010a; Ministry of Public Health, Ministry of Social Development and Human Security, & Ministry of Labour, 2011; The Government Public Relations Department, 2009; Tima & Sealim, 2012; Wibulpolprasert, 2011, pp. 262, 280, 336).

The SHPH policy is the strategy being used to reorient PHC services to focus more on proactive health promotion in the community (MoPH., 2011). Ideally, people across the country would now have an equal right to receive standard quality health services. The development of SHPHs would also reduce the transportation costs for local people in travelling from their communities to a hospital at the district and provincial levels (Petcharatana et al., 2010; The Government Public Relations Department, 2009).

There are three phases in the implementation of the SHPH policy. The first phase was the pilot project, which involved upgrading 1,001 PCUs in 2009. The second phase (2010-2012) aimed to upgrade the rest, some 8,768 PCUs. The last phase will focus on the quality development of all SHPHs by the year 2019 (Tima & Sealim, 2012, p. 607).

There are three sizes of the SHPHs based on the population in the catchment area. A small SHPH serves a population of less than 3,000. A medium SHPH serves 3,000 to 7,000 people. A large SHPH serves more than 7,000 people (MoPH, 2010a). As well, SHPHs fit two models: single and grouped. Those SHPHs responsible for more than 3,000 people are single-model SHPHs and employ at least four permanent health personnel. Small SHPHs are grouped till the total number of people they are responsible for makes up at least 3,000. The total number of employed permanent health personnel in these grouped model SHPHs should be at least seven (Bureau of Policy and Strategy, 2009; MoPH, 2010b).

The SHPH policy states that, in the 2010 to 2012 fiscal years, the MoPH, the Local Administrative Organization, the National Health Security Office and the Thai Health Promotion Foundation would support this PHC development project with funding to the tune of 30.9 billion baht and another 15 billion baht would come from the ―Thailand: Investing from Strength to Strength Project”, or ―Patibatkan Thai KhemKhaeng” (MoPH, 2010b; The Government Public Relations Department, 2009). The MoPH also provided guidelines for the PCU on how to improve the three important components of health services management: infrastructure of the health facility, health services provision and management system (Bureau of Policy and Strategy, 2009; MoPH, 2010a). Small SHPHs, medium SHPHs and the large SHPHs received a special budget of 500,000 baht, 700,000 baht, and 900,000 baht respectively, enabling them to upgrade and renovate infrastructure. Almost 1,000 ambulances

were purchased, together with more medical equipment (MoPH, 2010a). A medical online system (Telemedicine), such as Skype facilities and Web cams, was also set up to enable health personnel at SHPHs to link with physicians working in community hospitals at the district level (MoPH, 2010b; The Government Public Relations Department, 2009; Tima & Sealim, 2012; World Press, 2012).

SHPHs implement the HPH concept, emphasizing integrated health services, promoting health, and providing disease prevention and rehabilitation services for the individual, families and the community in their catchment area (HPH Committee, 1999; Yompuk et al., 2012). The SHPH policy states that SHPHs must provide proactive, flexible and appropriate health-promoting and disease prevention services, appropriate curative and rehabilitation care in consultation with the district hospital, must set up an effective referral system, network with stakeholders in the community, strengthen VHVs and improve the skills mix for health personnel and encourage teamwork (HPH Committee, 1999; Yompuk et al., 2012). Part of the services to be provided by SHPHs is home-care or ―home ward". That is, sick people can opt, where appropriate, to be cared for in the home rather than in a hospital, without the patient incurring further expenditure. The SHPH team must take care of the home-care patients, keeping in mind the necessity for holistic service – serving body, mind, society and spirit (Petcharatana et al., 2010).

SHPHs operate within the context of local participation and social acceptance. The three groups of stakeholders within the SHPH network are the SHPH itself, local government and people in the community. All members in the network participate in setting the SHPH health service agenda to ensure that local needs are taken into account and the competencies and experience of network members are utilized (Intaranongpai et al., 2011; Jitramontree et al., 2012; Petcharatana et al., 2010; Phothacharean & Nichapa, 2012; Rodjanatham et al., 2012; Sakornkhan & Nualnetr, 2011). VHVs, especially, have an important role in assisting the SHPH team to provide health promotion and disease prevention information to the villages for which they are responsible (Jopang et al., 2012; Settheetham & Chantra, 2012; The Government Public Relations Department, 2009). Local authorities can help the SHPH team to control dengue haemorrhagic fever (Pudthasa et al., 2010). School administrators, teachers, school cooks and students' parents can assist the SHPH team to control obesity

among elementary school students (Pongpitak, 2011). Religious leaders, particularly the most senior of them, can support the SHPH team to solve the problem of drug addiction. The religious leaders participate in the drug addiction treatment programmes and help addicts by providing them with counselling and spiritual support (Manowachirasan et al., 2012).

Health personnel at the SHPHs are mainly civil servants, but the proportion of civil servants has been steadily declining, as more and more temporary employees are placed on contract in order to create flexibility in accordance with current central management procedures (Wibulpolprasert, 2011, p. 340). In 2009, there were a total of 33,225 health personnel working at the SHPHs and the overall one health staff member to population ratio was 1:1,534 (Wibulpolprasert, 2011, p. 262). Trends in the health workforce in SHPHs are given in Table 2.4.

Table 2.4: Health personnel at SHPHs by region, 1987-2003 and 2006-2009

Region	Number of health personnel and (one health staff to population ratio)												
	1987	1996	1997	1998	1999	2000	2001	2002	2003	2006	2007	2008	2009
Central	4,217	7,724	7,917	8,928	9,017	8,769	8,150	8,027	7,604	8,174	8,166	8,804	9,002
	(1:1,833)	(1:1,125)	(1:1,109)	(1:1,207)	(1:1,180)	(1:1,059)	(1:1,453)	(1:1,470)	(1:1,552)	(1:1,625)	(1:1,634)	(1:1,523)	(1:1,556)
North	3,233	5,734	6,826	6,970	7,167	7,068	6,558	6,456	6,043	6,349	6,337	7,159	7,484
	(1:2,387)	(1:1,512)	(1:1,293)	(1:1,389)	(1:1,349)	(1:1,292)	(1:1,572)	(1:1,603)	(1:1,713)	(1:1,662)	(1:1,674)	(1:1,489)	(1:1,449)
South	2,318	4,628	5,038	5,152	5,264	5,146	4,843	4,761	4,463	4,609	4,588	5,415	5,688
	(1:2,064)	(1:1,161)	(1:1,079)	(1:1,129)	(1:1,127)	(1:1,141)	(1:1,378)	(1:1,416)	(1:1,511)	(1:1,557)	(1:1,572)	(1:1,339)	(1:1,327)
Northeast	4,573	9,114	10,430	10,236	10,569	10,248	9,693	9,591	9,015	9,632	9,619	11,050	11,051
	(1:3,167)	(1:1,785)	(1:1,582)	(1:1,681)	(1:1,655)	(1:1,666)	(1:1,938)	(1:1,971)	(1:2,097)	(1:1,956)	(1:1,968)	(1:1,722)	(1:1,681)
Total	**14,341**	**27,200**	**30,211**	**31,286**	**32,017**	**31,231**	**29,244**	**28,835**	**27,125**	**28,764**	**28,710**	**32,428**	**33,225**
	(1:2,421)	**(1:1,434)**	**(1:1,309)**	**(1:1,390)**	**(1:1,366)**	**(1:1,324)**	**(1:1,628)**	**(1:1,657)**	**(1:1,762)**	**(1:1,733)**	**(1:1,745)**	**(1:1,552)**	**(1:1,534)**

Sources: Wibulpolprasert (2011, p. 262)
Note: The figure in ( ) is the ratio of one health staff to population outside municipal areas and sanitary districts.

Health personnel at the SHPHs consist of 4-10 staff depending on the size of the SHPH and they have various health professional backgrounds such as public health officer (4-years study), community health worker (2-years study), registered nurse (4-years study), technical nurse (2-years study), assistant pharmacist (2-years study), assistant dentist (2-years study), Thai traditional medicine practitioner (4-years study or certificate) and other administrative

staff. Some SHPHs, particularly large and medium sized ones, also have a visiting doctor from a community hospital to provide primary medical care every week or fortnight (MoPH, 2010c; WHO, 2011, p. 19).

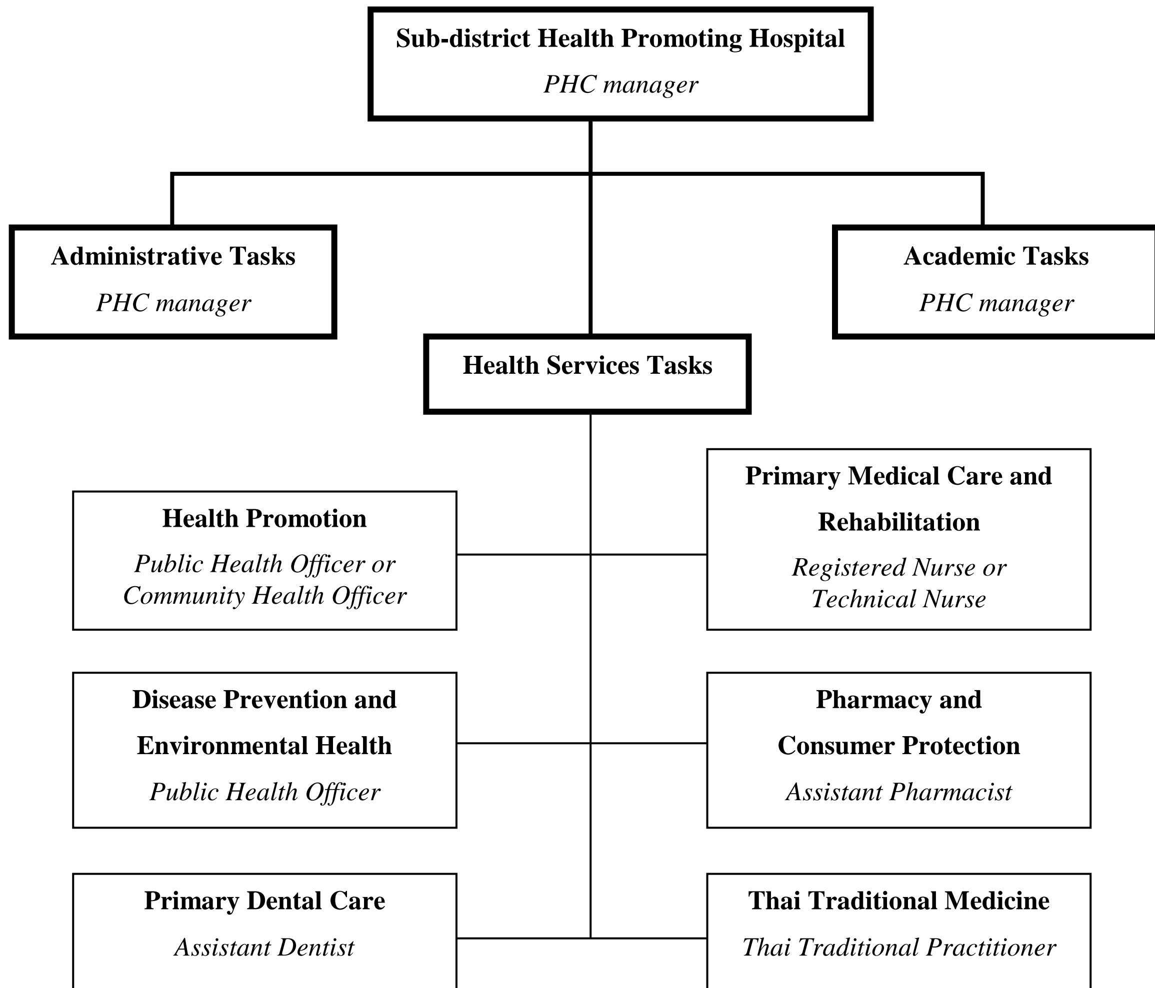
There are three main tasks in a SHPH: administrative, academic and providing health services. Administrative tasks involve planning and evaluating strategies, coordinating projects and activities with other government organizations and non-government organizations, managing the budget, and supporting the health team. Academic tasks have to do with conducting research in order to find a solution for community health problems. The health services tasks consist of various services such as health promotion, disease control and prevention, environmental health, primary medical care, primary dental care and rehabilitation, pharmacy and consumer protection and Thai traditional medicine. Normally, the administrative duties are the PHC manager‘s primary responsibility (MoPH, 2010c). In general, the administrative structure of a SHPH is shown in Figure 2.2.

A SHPH is administrated by a PHC manager, who is either a public health officer or a registered nurse, endorsed to hold the position of manager (Bureau of Policy and Strategy, 2009; MoPH, 2011). There were 9,769 PHC managers in 2009. These frontline managers were the largest management group in the administrative structure of the MoPH (Bureau of Policy and Strategy, 2009; Wibulpolprasert, 2011, p. 337). They have managerial responsibility within the SHPH organization, for stakeholders' organizations and for the catchment community. Their role is changing as the new policy of developing SHPHs is being implemented (Bureau of Policy and Strategy, 2009; Office of the Civil Service Commission, 2009).

2.3.4 Empirical studies of sub-district health promoting hospitals

The findings of studies into the SHPH policy are discussed in this sub-section. The studies fall into four groups: the assessment of the SHPH policy from various perspectives; the assessment of the SHPH policy from the clients‘ perspectives; the competencies of health personnel working at SHPHs; and the competencies of PHC managers working at SHPHs.

Figure 2.2: The administrative structure of a SHPH



Source: Adapted from Ministry of Public Health (2010c, pp. 5-6)

1. The assessment of the SHPH policy from various perspectives

There are three studies in this group. The first two studies, by Tima and Sealim (2012) and Petrachatana et al (2010) aimed to evaluate the progress of the implementation of the SHPH policy and the improvement of the health service system at SHPHs. A third study, by Suwanthong, Rudtanasudjatum, and Jaidee (2012), identified the important factors influencing the success of health services management in the SHPHs.

Tima and Sealim (2012) evaluated the progress of the implementation of the SHPH policy during its pilot phase in the fiscal year 2009. The study utilized questionnaires, in-depth interviews and focus groups. Questionnaires were sent to 1,001 PHC managers working in

small (6.9%), medium (55.4%) and large (37.7%) SHPHs that had been upgraded in 2009. The in-depth interviews and focus group discussions were conducted with the PHC managers, health personnel, supporting staff and local people in 12 selected SHPHs. The results from the health providers' perspective indicated that the SHPH policy could stimulate and encourage the development of health services, but their understanding of the policy was unclear as there was a lack of communication. There were also problems and needs for additional support with regard to the workforce, equipment, infrastructure and financing. The results from the local people's perspective showed that local people went to SHPHs for medical health services and had an expectation for services equivalent to those provided at the district hospital. The study recommended that there should be improved communication and public relations to correct this misperception. The study also recommended public hearings on the SHPH policy and the formulation of a long-term SHPH development policy with clear criteria and standards for evaluation, legislation for the development process, specific organizational structures and mechanisms, and development of targets in a realistic and gradual manner. The study recommended further emphasis should be placed on resolving workforce problems, developing service networks, deploying a proactive (rather than passive) service approach, transferring missions to local agencies, and conducting evaluative research to determine suitable scale and level of development.

Petcharatana et al. (2010) conducted a case study to evaluate the health services system management of Dong Kan Yai Health Promoting Hospital, one of the four selected SHPHs in Kam Khuan Kaeo District, Yasothorn Province, that had been upgraded in 2009. They employed a theoretical framework described as the context, input, process and product (CIPP) model. The PHC manager, the president of the sub-district administration organization and the director of Kam Khuan Kaeo Hospital were interviewed. Clients of the SHPH were given questionnaires to evaluate their satisfaction. The SHPH's documents, such as the annual report and E-data base, were reviewed. Petcharatana et al. found that the health services systems of the SHPH were managed with the participation in a tripartite structure of people, health personnel and local government. The SHPH established sub-district health promoting board committees to work as the people's representatives for planning public health solutions in the community and for setting up the health services system. The committees also got involved in managing the budget the SHPH received from the local

government and from donations by the people in the community. There were a reasonable number of health personnel and good medical equipment and supplies in the SHPH because of an adequate budget. The case study found that implementation of the SHPH policy appeared to increase clients‘ satisfaction because they could get access to continuity of care and holistic care, lending weight to the benefits of community participation and empowerment in the provision of health services.

Suwanthong et al. (2012) conducted a cross-sectional predictive study aimed at uncovering which supportive factors affected successful total quality management (TQM) based on the perceptions of health personnel in the SHPHs in Samut Prakan Province. Data collected from 240 questionnaires completed by health personnel showed that efficient teamwork was the important factor influencing the success of TQM in SHPHs.

2. The assessment of the SHPH policy from the clients' perspective

After the SHPH policy was implemented, two studies were conducted to evaluate clients‘ understanding, expectations, opinions and evaluation of the quality of SHPH services. Both studies employed questionnaires as the main instrument for collecting data from clients.

Neelasri (2011) surveyed 400 people about the Nong-Ngu-Leum Sub-district Health Promoting Hospital located in Muang District, Nakhon Pathom Province. Analysis of the results showed that people generally thought that the focus of the SHPH was on health promotion and disease prevention programmes. Most people did not understand that an SHPH does not have the same capability to treat complex diseases as a district or provincial hospital has. This study also measured the opinions of people about the SHPH. The results showed that people gave the facilities a high score (on a scale of 1 to 5, with five being ―very good" and 1 being ―very bad") (mean = 4.14, S.D. 0.78) but a lower score for services accessibility (mean = 3.91, S.D. 0.85).

Kaewkim et al. (2012) evaluated the expectations and perceptions of clients of the quality of health services of the SHPHs in Nakhon Si Thammarat Province by analyzing responses to 354 questionnaires completed by the SHPHs‘ clients. Their research findings revealed that most of the participants were female with average age 41.12 years, were married, had

attained a primary education or less, were occupied in agriculture, and had an average income of between 5,001 and 10,000 baht per month. The reasons for using health services delivery were proximity to home and convenience to attend the SHPHs. The clients gave high ratings for quality of services of the SHPHs. Clients suggested that the SHPHs should provide a 24-hour emergency care service, extend the area of the car-park and health services, add adequate medical equipment, increase the number of health officers, develop the potential of health officers and add conveniences such as electric fans and drinking water to increase the quality of their services.

3. The competencies of health personnel working at SHPHs

The competencies of nurses and public health officers working at SHPH were investigated in three studies. Data were collected by mixed methods in order to validate the information and to develop the concept of competencies.

Nontapet et al. (2008) explored the concept and structure of primary care competency of nurses working at SHPHs in Thailand. Data were collected in a two-step approach: an integrated systematic review of national and international publications and interviews of nursing experts, primary care authorities, nurses working at SHPHs and public health officers. The results indicated that there were four main primary care competencies. First, interpersonal relationships, consisting of communication, coordination, team-work, social involvement, collaboration and facilitation. Second, care management, including service systems management, resource management, quality management, information management, and environmental health management. Third, integrated healthcare services, consisting of health promotion, disease prevention, treatment/prescription, rehabilitation, continuous care and holistic care. Fourth, professional accountability, consisting of moral sensitivity, respect for patients‘ rights, code of ethics, patient advocacy, professional development and self-development.

Iemrod et al. (2011) considered the competency indicators of public health officers at SHPHs. The study consisted of two phases: first, constructing the competency indicators of public health officers by examining documents, and conducting in-depth interviews, focus group discussion and an operational seminar; second, verifying the indicator qualities by

utilizing the Delphi technique through experts' inquiries and examining the validity of the model using the LISREL 8.72 programme. The finding was that there were eight main competency indicators: 1) healthcare system analysis and community health assessment, 2) community diagnosis and community health problem solving, 3) teamwork and networking, 4) integrated health services for individual and families in the local community, 5) budget management, 6) leadership and systematic thinking, 7) routine for research and 8) morals and ethics in a health professional career.

Following this study, Iemrod and Jenausorn (2012) conducted another study with the aim of assessing those eight main competency indicators with 85 public health officers in SHPHs in Tak Province. Self-evaluated rating scale questionnaires were employed and data were analyzed using descriptive statistics. The findings indicated that 52.9 per cent of participants were male, 41.2 per cent were aged 41-50 years, 65.9 per cent were married, 83.3 per cent had a bachelor degree, and 49.5 per cent had work experience of 16-25 years. The scores from the self-evaluated rating scale questionnaires were graded into three levels: those scoring below 178 were regarded as having overall low competency levels; those with moderate levels of overall competency scored between 178-205; and those with high levels of competency scored more than 205. The results indicated that 24 (28.2%) participants were at low level, 39 (45.9%) participants were at moderate level and 22 (25.9%) participants were at high level. The researchers suggested there was a need for competency development of public health officers, particularly of those who scored low on overall competency.

4. The competencies of PHC managers working at SHPHs

Eight studies investigated the competencies of PHC managers working at the SHPHs. The first two studies identified the competencies and characteristics of PHC managers. The next six studies investigated the factors supporting and influencing the management competency of PHC managers. The studies in this group were mostly based on the quantitative approach.

Yompuk et al. (2012) studied the roles of PHC managers in SHPHs. This study employed two phases, with the first one being a qualitative study reviewing related literature on competency and interviewing six high-level experts at the policy level. The second phase was

a quantitative study to confirm the competency elements identified in the first phase, using data from 650 questionnaires completed by PHC managers of SHPHs. The results indicated that the roles of PHC managers of SHPHs consisted of ten components: coordination, communication, strategy planning, analytical thinking, leadership, teamwork, community working, services mind, community participation and technology and information.

The Thai government announced the policy known as ―Yoo Dee Mee Sook" (National Well-being Policy) in 2008, to improve the quality of life of people in the country. Under the Ministry of Interior, the Provincial Governor or CEO of each province had to formulate and implement programmes at the provincial level aimed at achieving the national policy. The Healthy Tambon (sub-district) Project was one of the Trang Province Strategies initiated by the CEO of Trang Province with the aim to improve people's health at sub-district level. The PHC managers working at SHPHs in Trang Province had to adopt the Healthy Tambon (sub-district) Project and were considered as the key to successful implementation of the project. Arunsang and Boortanarat (2011) explored the characteristics of 125 PHC managers in Trang Province and studied the relationship between management capability of PHC managers and the success of the Healthy Tambon (sub-district) Project. The results from questionnaires showed that 53.6 per cent of participants were female and the average age was 47 years. 58 per cent of participants had a higher level of education than a bachelor degree and had worked for about 14 years. Each SHPH, on average, had 3.58 health personnel covering a population of 4,112. This study indicated that there were seven competencies of PHC managers that had a positive relationship with the success of implementing the Healthy Tambon (sub-district) Project. The seven competencies consisted of organizational planning, organizational managing, human resources managing, directing and controlling, coordinating, reporting and budgeting. This study also pointed out that most of the problems that PHC managers encountered related to delays and inadequacy of budget allocation, the large number and complexity of reports and a shortage of numbers of health personnel working at SHPHs.

Malai and Bouphan (2010) conducted a cross-sectional descriptive research study in order to investigate the effects of support from the upper level organizations, such as District

Hospital, District Health Office and Provincial Health Office, on health programme management of the PHC managers in Chaiyaphum Province. Questionnaires were administered to 100 PHC managers and the results were analyzed using Multiple Regression Analysis. The overall support from the upper level organizations, such as human resources support, budget support and supplies and equipment support, had positive effects on health programme management at a moderate level with statistical significance of 0.05 (r=0.687, p-value < 0.001). The main problem found in the health programme management was insufficient personnel support from the upper organizations.

Bouphan (2012) explored the factors affecting conflict management by PHC managers in Khon Kaen Province. 197 participants were recruited, using a systematic sampling technique, to complete a given questionnaire. Data from the questionnaires were analyzed using Pearson Product Moment and Multiple Linear Regression. The results showed that the level of conflict management of the heads of SHPHs was moderate ($x = 3.36 \pm 0.39$). The regression analysis identified three factors affecting a PHC manager's competency in dealing with conflict: experience of conflict, beliefs and values, and channels of communication. Together these factors predicted 53 per cent of conflict management competency at a statistically significant level (p-value < 0.05).

Arunperm and Sriruecha (2011) researched the factors affecting the competencies of PHC managers in Kalasin Province. Questionnaires were distributed to 131 PHC managers. Pearson Product Moment and Stepwise Multiple Regression were utilized for data analysis. The findings showed that manpower (r = 0.683, p-value < 0.001), budget (r = 0.425, p-value < 0.001) and equipment (r = 0.408, p-value < 0.001), had a high correlation with high PHC manager competencies. Punyakaew and Bouphan (2011) conducted a similar study, administering 78 questionnaires to PHC managers working in the northern zone of Khon Kaen Province. The results of the study were consistent with the Arunperm and Sriruecha (2011) study; manpower (r = 0.289, p-value = 0.010), budget (r = 0.512, p-value < 0.001) and equipment (r = 0.581, p-value < 0.001), had appeared to have positive influence on the competencies of PHC managers. In addition, the Punyakaew and Bouphan study found

another factor influencing the competencies of PHC managers was the training in ability development of PHC managers (r = 0.353, p-value = 0.002).

Puncha and Bouphan (2011) investigated the relationship between motivation factors and organizational support, and change management of 141 PHC managers working in Khon Kaen Province. Data from questionnaires were analyzed using Pearson Product Moment and Stepwise Multiple Regression. Results showed that motivational factors and organizational support were significantly correlated with change management of PHC managers (r = 0.607, p-value < 0.001 and r = 0.559, p-value < 0.001, respectively). There were significant variables that predicted the change management ability of PHC managers, such as achievement motivation factor, policy and administration factor and organizational support in management factor (manpower, budget and equipment). These three factors could predict the change management of the PHC managers at 51.3% of accuracy.

Puphanpun and Bouphan (2011) also examined the effect of various motivation factors on the administrative performance of 198 PHC managers in Nakhonratchasima Province. Questionnaires were administered and the statistics employed for data analysis were Pearson Product Moment and Stepwise Multiple Regression. The results showed that the motivational factors that could predict the PHC managers‘ administrative performance were relationships among staff, work characteristics and success and advancement in work. Jointly, these three factors predicted PHC managers‘ administrative performance with 47.6 per cent of accuracy. The main obstacles to the PHC managers‘ administrative performance were shortage of human resources in the SHPH and inappropriate salary and revenue of PHC managers.

Summary

There have been studies conducted in an attempt to evaluate the success and challenges of implementing the SPHP from various perspectives, such as those of health providers, clients and stakeholders (Kaewkim et al., 2012; Neelasri, 2011; Petcharatana et al., 2010; Suwanthong et al., 2012; Tima & Sealim, 2012). These various studies, utilizing differing methods and study contexts, demonstrated that the implementation of the SHPH policy could develop the health services at the PHC level. There were also studies conducted to identify

the competencies and characteristics of health professionals working at the SHPHs, such as nurses, public health officers and PHC managers (Arunperm & Sriruecha, 2011; Arunsang & Boortanarat, 2011; Bouphan, 2012; Iemrod et al., 2011; Iemrod & Jenausorn, 2012; Malai & Bouphan, 2010; Nontapet et al., 2008; Puncha & Bouphan, 2011; Puphanpun & Bouphan, 2011; Yompuk et al., 2012). Most of these studies were conducted based on the quantitative approach. However, missing from the studies surveyed is one that examines the perceptions of PHC managers.

Since PHC managers are directly affected by the SHPH policy and they are considered key people in the successful implementation of the policy, understanding their perceptions and how they manage and show leadership within their roles, especially in the transition period, could prove valuable for further policy decisions. This thesis therefore employed a hermeneutical phenomenological approach to deliberately narrate the actual lived experiences of PHC managers with regard to how they lead and manage the SHPHs as they transition from the previous health system to the new one.

Because PHC managers currently work in systems that can be characterized as complex and adaptive – changing as reforms and innovations are implemented – the study utilizes theories that help to predict behaviours within such systems. The theories used are complex adaptive systems theory and neo-institutional theory. Since the innovation of SHPH policy also plays an important part in the transition process, diffusion of innovations theory is also used in the study to help analysis of how PHC managers adopt, disseminate and implement the SHPH policy. Consequently, these three theories are utilized in this thesis as the eclectic theoretical framework presented in the following section.

2.4 The development of an eclectic theoretical framework and the application of organizational theories

It is important to take a broad perspective from different points of view, such as economic, technical structuralism, social, organizational and institutional studies in order to better understand healthcare reform (Blaauw et al., 2003). This approach is supported by Mickan & Boyce (2006, p. 63), who assert that understanding complex change in healthcare

organizations should be considered and appreciated from more than one theoretical paradigm. Greenwood and Hinings (1993, p. 1052) and Brock (2006, pp. 158-159) also emphasize that organizational structures and management should be considered and analyzed by using a holistic perspective rather than simply by studying a set of organizational properties. Taking this advice, this study uses an eclectic theoretical framework to better understand the important leadership roles and management functions for the PHC managers who are working in the transition period of healthcare reform in Thailand. The eclectic theoretical framework involves the utilization of several theories to help understand results from interviews with PHC managers. The theories used are: complex adaptive systems theory (Anderson & McDaniel, 2000; McDaniel, 2007; McDaniel & Driebe, 2001; Plesk & Greenhalgh, 2001; Plesk & Wilson, 2001), neo-institutional theory and typology of archetypes (Greenwood & Hinings, 1993, 1996), and diffusion of innovations theory (Greenhalgh et al., 2004; Greenhalgh et al., 2005; Rogers, 1983).

2.4.1 Complex adaptive systems theory

Healthcare organizations are complex systems, need to be adaptive and can be only partially understood from the reductionist, traditional scientific paradigm (Kernick, 2006; McDaniel, 2007; McDaniel & Driebe, 2001; Plesk & Greenhalgh, 2001; Plesk & Wilson, 2001; Zimmerman et al., 2009). Complex adaptive systems (CASs) theory enables a broader understanding of healthcare organizations, helping to provide the framework from which to study how PHC managers lead and manage the SHPHs.

This part begins by explaining the development and characteristics of CASs theory. Then, the CASs theory for health services managers in health services organizations is explained. Finally, the application of CASs in empirical studies is outlined.

2.4.1.1 The Development and characteristics of CASs

Systems theory offers a range of insights into the ways in which organizations function (Dooley, 1997; Harris, 2006, p. 62). The systems approach places emphasis on all elements of the organization from inputs, to process, output, and finally outcome (Robbins &

Barnwell, 2006, p. 82) and recognizes the importance of the interaction between organizations and environments (Amagoh, 2008; Dooley, 1997). Harris (2006, p. 62) and Shortell and Kaluzny (2006, p. 21) explain that there are two perspectives to understanding management in organizations: organizations as closed systems and organizations as open systems. Organizational adaptability and innovation are factors that show that organizations interact with their environment and are, therefore, open systems (Harris, 2006, p. 67; Shortell & Kaluzny, 2006, p. 21). In this study, the SHPHs are recognized as open systems.

Complexity theory has developed from systems theory recognizing the concept of synergy and evolution; this focuses on understanding that "the whole universe is greater than the sum of the parts and how all its components come together to produce overarching patterns as the system learns, evolves and adapts" (Dann & Barclay, 2006, p. 21). Complexity theory recognizes that "a system is an integrated whole" (Dann & Barclay, 2006, p. 22). To understand a system, it should not be broken down into its component parts. Instead, it should be studied using a holistic management process (Dann & Barclay, 2006). From such a perspective, managers function to minimize specification and increase the relationship between parts in order to yield more creativity (Dooley, 1997; Plesk & Wilson, 2001).

The complexity view is different to a reductionist or Newtonian perspective which lends itself to viewing organizations as equivalent to machines (Dooley, 1997; Plesk & Wilson, 2001). Managers with this reductionist perspective of organizations resist change, demand detailed specification of changes, and reduce variation in an organization (Dooley, 1997; Kernick, 2006; Plesk & Wilson, 2001). Such managers believe that they can control, predict and manage problems with certainty because the organization or system has simple relationships (small inputs have small effects, large inputs have large effects) (Kernick, 2006, p. 386). Clearly, this is not the situation in which PHC managers find themselves. PHC managers need to carry out their managerial roles in a constantly changing situation involving a wide range of people within the organization, among stakeholders' organizations and in the catchment community (Bureau of Policy and Strategy, 2009; Office of the Civil Service Commission, 2009).

The literature of complex systems theory has been growing extensively and there are major forms of complexity theory: Complex Adaptive Systems (CASs), Complex Evolving Systems (CESs) and Dynamic Open Complex Adaptive Systems (DOCASs) (Dann & Barclay, 2006). The theories have been applied to studying real-world systems including evolutionary biology, social insects (such as ant colonies), weather and business in the process of adaptation and survival (Dann & Barclay, 2006). However, a CAS is one of the most important ideas in all of complexity theory and involves the interaction of people and activities that are highly interdependent in an unpredictable situation (Amagoh, 2008; Holbrook, 2003; Shortell & Kaluzny, 2006, p. 30).

A CAS is ―a system that adapts through a process of ‗self-organisation‘ and selection into coherent new behaviours, structures and patterns" (Dann & Barclay, 2006, p. 22). Plesk and Greenhalgh (2001) point out that a system consists of a collection of individual agents who have freedom to act in ways that cannot be totally predicted, and such actions are related to each other. In other words, ―one agent‘s action changes the context for other agents" (Plesk & Greenhalgh, 2001, p. 625).

In the CASs, chaos is avoided by the application of simple rules that guide people‘s behaviour and through the development of self-managed groups and teams (Innes et al., 2005, p. 234; Shortell & Kaluzny, 2006, p. 30). Order and rules evolve through synergistic patterns of social connection and relationships, without the need for hierarchical systems of control (Harris, 2006, p. 67). Plesk and Greenhalgh (2001, p. 625) illustrate the idea by noting that ―in a biochemical system, the rules are a series of chemical reactions. At the human level, the rules can be expressed as instincts, constructs, and mental models". They go on to explain that agents in CASs respond to the environment by employing internalized rule sets that force action; for example, a doctor might act in response to the patients‘ ideas, concerns and expectations (Plesk & Greenhalgh, 2001).

Characteristics of CASs

CASs are characterized by a number of elements interacting locally in a fluid, flexible and non-linear manner (Mickan & Boyce, 2006, p. 67). McDaniel (2007, pp. 22-23) clarifies that ―complex adaptive systems are characterized by 1) diverse agents that learn, 2) that interact

with each other in nonlinear way, and therefore, 3) self-organize, 4) have emergent properties, and 5) co-evolve with the environment”.

First, CASs consist of diverse agents and this diversity is considered as the source of creativity needed for agents‘ growth and survival (Innes et al., 2005; Kernick, 2006, p. 386; McDaniel, 2007). These agents, or the so-called ―information processors”, have the capacity to adapt their behaviours based on information they receive (McDaniel, 2007, p. 15). Agents have the capacity to learn and act in ways that are not predictable and linear and agents can be individuals, functional groups, social institutions, or organizational processes (Stroebel et al., 2005, p. 439). McDaniel and Driebe (2001) explain that agents in a healthcare system are not only referred to as individual people, such as administrators, clinicians and patients, but agents might also include processes and functional units, such as nursing processes, as well as entire organizations such as insurance companies. They go on to point out the main concept of agents: ―the one characteristic that these agents all share is that they can process information and react to changes in that information” (McDaniel & Driebe, 2001, p. 15).

Second, the relationship among diverse agents is another important component of CASs (Anderson & McDaniel, 2000, p. 86). McDaniel & Driebe (2001, p. 17) note that ―[s]mall changes can lead to big effects and big changes can lead to small effects”. This means that there is interaction from the feedback loops in CASs. An agent‘s actions can feed back, either positively or negatively, on itself and it can also influence other agents (Amagoh, 2008; Kernick, 2006; McDaniel, 2007; McDaniel & Driebe, 2001). For instance, the management of many illnesses in family medicine requires attention not only to the illness but to the relationship between a physician and a patient and his/her family. These relationships determine the degree of cooperation of the patient and family, and the physician‘s understanding of the causes and treatment of the illness. Another example is that, in healthcare organization, the relationship among team members is vital to overall performance of the organization (McDaniel & Driebe, 2001).

Third, self-organization is the spontaneous emergence of new structures and new forms of behaviour in an open system that result from interactions among agents of such a system (Amagoh, 2008; Anderson & McDaniel, 2000, p. 87; Innes et al., 2005; Kernick, 2006;

McDaniel, 2007; Paina & Peters, 2012). ―A special case of self-organization is known as self-organized criticality" or is ―sometimes termed edge of chaos" (Kernick, 2006, pp. 387-388). The edge of chaos is the area between disorder and predictable stability that fits with others. Network connections in this area are neither too tight nor too loose, which means that they can optimally innovate and adapt (Kernick, 2006, p. 388). An instance of self-organization in healthcare systems is that ―when diagnostic related groups (drgs) became the standard for prospective payment in healthcare, then healthcare organizations began to develop entire work units devoted to redefining a physician‘s diagnosis of illnesses in such a way as to maximize payments to the organization. This was not the intent of those who implemented drgs but it was an organizational form that emerged from changing patterns of relationships" (McDaniel & Driebe, 2001, p. 18).

Fourth, emergence is unpredictable or unknowable and it is fundamental to CASs (Anderson & McDaniel, 2000, p. 87; Kernick, 2006; McDaniel, 2007). McDaniel (2007, p. 24) explains that ―emergence is the development of novel and coherent patterns and properties during the process of self-organization in a CAS". When agents are interacting and self-organizing in a non-linear nature, particularly when there is a crisis in the CASs, new strategies and behaviours will be developed (Amagoh, 2008; Kernick, 2006; Paina & Peters, 2012). The emergence thus gives systems the flexibility to adapt and self-organize in response to external challenges (Kernick, 2006, p. 387). For instance, ―the medical unit in a hospital is more than the sum of the talents of individual workers but is an emergent property of the whole unit". This means that ―the managerial task goes beyond getting the best employees but to facilitating the emergence of the unit itself" (McDaniel & Driebe, 2001, pp. 19-20).

Fifth, McDaniel and Driebe (2001, p. 20) exemplify co-evolution as ―when a major hospital system develops and implements a new pharmaceutical control system, this will change the hospital‘s relationship with pharmaceutical suppliers including, possibly, changing their source of competitive advantage. Agents do not simply adapt to the environment and each other. They co-evolve with each other and with the environment in a constant pace of change. A physician changes her practice pattern and nurses, therapists and clerks are affected. A new process for managing pharmacy supplies is put in place and the relative competitive advantage of pharmacy suppliers is changed".

2.4.1.2 CASs for health services managers in health services organizations

Today‘s organizations operate in rapidly changing contexts and in compounding complexity and uncertainty at all levels of society (Avery, 2004, p. 6), Shortell and Kaluzny (2006, p. 30) state that all organizations, including health services organizations, have features of CASs. ―Treating organizations as CASs allows a new and more productive management style to emerge in health care" (Plesk & Wilson, 2001, p. 746). Plesk and Wilson (2001, p. 749) also point out that ―the science of complex adaptive systems brings new concepts that can provide fresh understandings of troubling issues in the organization and management of delivery of health care". Thus, CASs theory is gaining in popularity as the context of healthcare becomes more specialized and complex (Harris, 2006, p. 67; Paina & Peters, 2012).

Harris (2006, p. 62) notes that a healthcare system is both unpredictable and self-organizing. Shortell and Kaluzny (2006, p. 16) and Harris (2006, p. 67) explain that health services organizations, as human organizations, are unique because of the diverse range of practitioners, the complexity of the work and the difficulty of measuring success. Health services organizations have been transformed and have evolved towards something new all the time (Amagoh, 2008). When the five characteristics of CASs (diverse agents, non-linear interaction, self-organization, emergence and coevolving system) are considered, it helps to explain that no individual has the capacity to be able to predict the future of a healthcare system, but it is necessary to continuously probe for the simple solution for each circumstance (McDaniel & Driebe, 2001, p. 22).

CASs and healthcare managers

In the traditional view, a health services manager was considered as an external controller of the entire system. However, complexity views reveal that ―the manager must first and foremost recognize him/herself as an agent of the system whose patterns of interaction with other agents is the art of the overall set of factors that is leading to the dynamic behaviour of the system" (McDaniel & Driebe, 2001, p. 24). The manager‘s behaviours and actions will affect the system‘s organization but the outcome from those behaviours and actions will not be predictable (McDaniel & Driebe, 2001, p. 24).

Burnes (2005, p.82 cited in Senior & Swailes, 2010, p. 50) states that ―managers need to promote self-organizing processes and learn how to use small changes to create large effects" because the planned change from top-down may not always result in the expected effect in a complex organization. Plesk and Wilson (2001, p. 749) also emphasize that effective healthcare organization does not need a specified and detailed plan. Instead, leaders ―who seek to change an organization should harness the natural creativity and organizing ability of its staff and stakeholders through such principles as generative relationships, minimum specification, and the positive use of attractors for change". Leaders should promote a shared vision and supportive organizational environment among staff members and other stakeholders, including clients, instead of using the coercive or financial incentive approaches (Sturmberg et al., 2012, p. 205). Plesk and Wilson (2001, p. 748) also emphasize that ―the leaders‘ role is to create systems that disseminate rich information about better practices, allowing others to adapt those practices in ways that are most meaningful to them" in order to innovate a variety of creation and to spread good practice within the healthcare system.

By comparing with the bureaucratic approaches, Anderson and McDaniel (2000, p. 88) propose eight leadership tasks for managers to effectively work in professional CASs of healthcare organizations. First, managers should pay more attention to ―relationship building" and less to ―role defining". Second, in order to gain coordination, crafting ―loose coupling" among members of staff to enable self-organizing in the organization is better than relying on ―tight structuring". Third, as ―simplification" might cover the critical clues in organization, the managers should generate ―complicated sets of information-driven networks" that can facilitate the creation of order. Fourth, ―diversity" of staff members is the resource of the process of emergence for new ideas in the organization, while ―oversocialization" can reduce creativity of staff members. Fifth, ―sense-making" for members of staff to create meaning is more essential than ―decision-making" when the managers do not know the trajectory of a system. Sixth, the task of the managers is to create a ―learning" organization rather than to ―know" and tell others in the organization to do everything. Seventh, in an uncertain circumstance, searching for ―improvisational" behaviour of members of staff is more important than attempting ―to control" them through a variety of structural strategies. Eighth, the managers should not set up a ―formal planning process based

on forecasting events”; instead, they should ―think about the future” in new ways, such as scenario planning and they should develop ―the ability to create what is needed at the moment out of whatever materials are at hand” (Anderson & McDaniel, 2000, pp. 87-90).

2.4.1.3 The application of CASs in empirical studies

According to the Lars and Keith 2012 research review, CASs could be applied by managers to promote and improve the integration of health and social care for many of those suffering chronic conditions. As the work of integrated care becomes more sophisticated and involves more agents, the mindset of managers in management has to alter from a mechanistic system to CASs (Lars & Keith, 2012, p. 40). The ―innovative managers” have a crucial role in promoting integration by creating working relationships built on trust between managers and providers and providers and users (Lars & Keith, 2012, pp. 44-45, 48). The user is considered as a co-producer of care. Therefore, the benefits of CASs to integrated care are productive relationships, better care outcomes and user‘s satisfaction (Lars & Keith, 2012, p. 39).

Burns (2001) conducted a study with the aim of determining if complexity principles intuitively made sense to front-line healthcare leaders. Fifty-nine leaders, including supervisors, managers, directors and administrators at three hospitals of a healthcare system in San Diego, California completed a survey which used Likert scale questions based on Edgeware‘s Nine Emerging and Connected Organizational and Leadership Principles. The findings were that organizations have an advantage when there is diversity of thought among the members, and leaders are most successful when they develop relationships among people (principle 4); the way to achieve success in a complex organization is to let action emerge from the bottom up and to learn from small things that work and link the successful pieces into a more complex system (principle 8); and a complexity lens is more useful for understanding healthcare organization than the machine metaphor (principle 1). One-third of study participants agreed that successful leadership needed strong direction and control (Burns, 2001, p. 481). Burns (2001, p. 482) argued that his study showed that ―the emerging field of complexity science offers healthcare leaders an opportunity to view leadership in a new way. Just like farmers, leaders can acknowledge that they cannot control many of the variables needed to achieve success. They must instead learn to promote organizational

strategies, action, learning and adapting". Burns further emphasized (2001, p. 474) that "leadership that uses complexity principles offers opportunities in the chaotic health care environment to focus less on prediction and control and more on fostering relationships and creating conditions in which complex adaptive systems can evolve to produce a creative outcome". A limitation of the Burns study was its small sample size and focus on only the broad principles of leadership. He noted that a qualitative approach, such as using interviews, would make a contribution towards a better understanding of leadership attitudes and behaviours and to complexity science (Burns, 2001, p. 482).

The Multimethod Assessment Process (MAP)/Reflective Adaptive Process (RAP) is "a change process that uses complexity science to guide and inform its methods and to understand the impact of changes" (Stroebel et al., 2005, p. 440). The MAP/RAP approach was applied in the ULTRA (Using Learning Teams for Reflective Adaptation) study to improve the quality of care delivery for multiple chronic conditions in independent primary care practices (30 intervention and 30 control) in New Jersey and Pennsylvania. Stroebel et al. (2005, p. 443) employed a case study example from the ULTRA study to illustrate the application and impact of the MAP/RAP process. The results show that the MAP/RAP process consists of the main guiding principles that "an understanding of practices, vision and mission is useful in guiding change, learning and reflection helps organizations adapt to and plan change, tension and discomfort are essential and normal during change, and diverse perspectives foster adaptability and new insights for positive change" (Stroebel et al., 2005, p. 438).

Miller et al. (1998) studied the implementation of change in delivery of healthcare services in primary care practices. They investigated three primary care practices using the CASs model. The results from these case studies showed that primary care practices consisted of various agents: physicians, officers and patients. When change occurred, these agents interacted with each other in order to respond to the change based on the attractors, internal motivators and value system of the practice. Three strategies (joining, transforming and learning) were utilized to promote change in practice and practitioner behaviour. A limitation of the Miller et al. study was its cross-sectional design and lack of consideration of external factors. In-

depth case studies, including both qualitative and quantitative measures over time, should be conducted to improve overall understanding of the complexity of the change process in primary care practices.

In 2001, Miller et al. published the results of another study that used complexity science to help understand and improve family practices. They used three complexity science properties: self-organization, emergence and co-evolution. Two family practices that had high quality of care, as measured by delivery of preventive health services and patient satisfaction, were selected as case studies. The research illustrated that family practices were local professional CASs and they varied greatly. –Successful practices are those that minimize errors, make good sense of what is happening, and effectively improvise to make good practice. Seeking to eliminate error by dampening all variation through the imposition of excessive standardization and external controls is unlikely to be sustainably effective and is likely to have long-term negative consequences" (Miller et al., 2001, p. 876).

Focusing on the reorganization (merger) of an intensive care unit (ICU) between two Swedish county hospitals in September 1997, Lindberg et al. (2003) interviewed six people involved in leading the ICU about their understanding of their work and leadership roles. The study participants indicated that –their ICU organisation and their practical daily work clashed with how the organisation was structured and how work was performed in practical daily care work" (Lindberg et al., 2003, p. 360). Such a situation could lead to dissatisfaction with their present work because of the hectic pace, interruption, disintegration and unsettled structures of their reorganization (Lindberg et al., 2003, p. 357). Lindberg et al. (2003, p. 359) suggested that when organizational change was imposed, it should be consistent or co-evolving with the works of health-care workers, becoming a natural part of daily work in order to reduce resistance to change. When healthcare workers agree to and support the change, it could increase the creative power of the organization.

The CASs model was applied by Innes et al. (2005) to understanding the consultation process between doctors and their patients in clinical practice. This study attempted to explore the nature of consultation in terms of the characteristics of CASs and to identify the important skills utilized. The study authors did not describe their methodology but argued that there is a

diversity of agents that may affect consultation processes, including doctors, nurses, patients and relatives. These agents interact with and relate to each other and each agent changes in response to the changing context, illustrating the self-organization and co-evolution process of CASs. For instance, ―feedback loops in the consultation change the practice of the doctor and the behaviour of the patient during the consultation and in the future consultation" (Innes et al., 2005, pp. 48-49). Consultation work illustrates nonlinearity and uncertainty because the doctor cannot completely predict, for example, whether the intervention given to the patient will achieve the outcome or not (Innes et al., 2005, p. 49). Through a CAS lens, doctors need to work with uncertainty in ways that are both creative and relatively safe (Innes et al., 2005, p. 51). Innes et al. (2005, p. 52) point out that ―the framework provided by complexity theory helps us understand the role of the doctor, not as an objective external observer, as suggested by traditional medical models of the doctor-patient interaction, but as an enquiring participant, who seeks to influence change in a patient's condition".

Summary

CASs theory offers a method to study organizations as open systems operating in complex and changing environments and functioning as learning, evolving and adapting systems. Five main characteristics of CASs are diverse agents, non-linear interaction, self-organization, emergence and co-evolution. As health services organizations have the characteristics of CASs, health services managers, including the PHC managers in this study, thus should understand and utilize the theory of CASs to discover new ways of leading and managing their organizations.

2.4.2 Neo-institutional theory and typology of archetypes

The primary healthcare system in Thailand has experienced constant change through reforms and innovations, as discussed in section 2.3.2 of this chapter on the evolution of primary healthcare in Thailand. The changes have significant effects on the leadership roles and management functions of PHC managers. Neo-institutional theory and typology of archetypes are change theories that can provide useful insights into the effects of change and are, therefore, included in the research for this thesis.

This section begins by outlining the development of neo-institutional theory. Then, the institutional changes through the processes of deinstitutionalization and isomorphism are respectively described. Following this, the typology of archetypes, as ideas, beliefs and values of institutional members towards the institutional changes, is presented.

2.4.2.1 The development of neo-institutional theory

Institutional theory is complicated to explain because of the large number of meanings given to the word ―institution" (Robbins & Barnwell, 2006, pp. 279-281) and because ―it taps taken-for-granted assumptions at the core of social action" (Zucker, 1987, p. 443). Robbins and Barnwell (2006, p. 279) define institutional theory as ―an approach which integrates an organisation‘s past actions and the social and environmental pressures on it to explain organisational practices". Shortell and Kaluzny (2006, p. 533) define institutionalization as ―the state of the change process in which change is integrated into the ongoing activities of the organization". That is, organizations attempt to adapt, not only to the values of their internal groups but also to the values of external society (Hatch, 1997, pp. 83-84). Zucker (1987, p. 443) affirms that an organization is influenced by normative pressures from both within the organization itself and from external forces, such as the state. Therefore, the pattern of organizational behaviours is influenced by ideas, values, and beliefs that initiate in the institutional environment (Greenwood & Hinings, 1996, p. 1025).

Hatch (1997, p. 84) notes that recognizing the social and cultural basis of external influences on organizations, however, is only one contribution of institutional theory. Neo-institutionalists attempt to move beyond mere recognition of the social and cultural foundations of institutions to describe the process by which practices and organizations become institutions. In the traditional conceptualisation of institutionalism, the central emphasis is on the competing values, coalitions, issues of influence as well as informal structures and power. This is in contrast to the view of neo-institutionalism with its emphasis on ―legitimacy, the embeddedness of organizational fields, and the centrality of classification, routines, scripts, and schemas" (Greenwood & Hinings, 1996, pp. 1022-1023). Greenwood and Hinings (1996, p. 1026) also explain that the focal point of view of neo-institutional theory is upon the network of organizations, and not upon the individual

organization. Therefore, neo-institutional theorists “treat organizations as a population within an organizational field” (Greenwood & Hinings, 1996, p. 1026).

As the PHC subsystem is not only networked within that subsystem, such as the networks among the SHPHs, but is also influenced by and connected to other subsystems within the organizational field, such as the networks with community hospitals and district health offices, neo-institutional theory is thus relevant to this study because we are examining a subsystem of PHC within the wider health system or organizational field.

Dacin et al. (2002) argue that, when new norms and practices diffuse throughout an organization or among organizations in a given field, this process can increase the degree of legitimacy and finally become institutionalized. Relating this to the PHC managers working at the SHPHs, they are responsible for adopting and implementing the changes of the SHPH policy in order to receive support and legitimacy, and ultimately improve health services outcomes.

2.4.2.2 Institutional changes through the processes of deinstitutionalization and homogenization (isomorphism)

Greenwood and Hinings (1996, p. 1026) explain that change occurring in an institution can be classified into two patterns. First, “convergent change occurs within the parameters of an existing archetypal template”. Second, “radical change, in contrast, occurs when an organization moves from one template-in-use to another”. These two types of change patterns are relevant to revolutionary and evolutionary change, that is, “whereas evolutionary change occurs slowly and gradually, revolutionary change happens swiftly and affects virtually all parts of the organization simultaneously” (Greenwood & Hinings, 1996, p. 1024). Hence, convergent (evolutionary) change of an institution is quite hard to be aware of and observe, while radical (revolutionary) change of an institution can explicitly present in large discontinuities with former patterns (Dacin et al., 2002). As presented in section 2.3.3 of this study, Sub-district Health Promoting Hospitals, the SHPH policy was announced on 29 December 2008 and implemented by the MoPH in 2009 with the aim of improving the efficiency, quality and equity of the healthcare system by upgrading 9,769 PCUs to be

SHPHs. As a result of these policy decisions, PHC managers have been affected by radical (revolutionary) change.

Greenwood and Hinings (1996) explain that radical change requires both precipitating and enabling dynamics. Precipitating dynamics are the internal pressures for change. This pressure arises when powerful stakeholders become dissatisfied with a prevailing template and they have a commitment to values that differ from current values. However, precipitating dynamics are not enough to guarantee that change will occur. Thus, an enabling dynamic is needed. This pressure originates from powerful groups who have the leadership capacity to take action in initiating change (Samia et al., 2012, p. 217). Dacin et al. (2002) add that agency or institutional entrepreneurship has an important role in initiating and responding to institutional change and in producing successful diffusion and institutionalization of practices. PHC managers, as agencies or institutional entrepreneurs, are important actors in precipitating and enabling implementation of the changes required by the SHPH policy.

Institutional changes through the process of deinstitutionalization

Deinstitutionalization is ―the process by which institutions weaken and disappear" (Scott, 2001: 182 cited in Dacin et al., 2002). Deinstitutionalization is influenced by three main sources: functional, political and social pressures. Functional pressures for deinstitutionalization stem from perceived problems in performance levels (Dacin et al., 2002). Realization that operating structures are performing poorly is an instance of an indication of internal triggers for change (Senior & Swailes, 2010, p. 22).

Political pressures are about the changes of power distribution that have supported and legitimated the existing institutional arrangements (Dacin et al., 2002). These changes might be the result of environmental changes, performance crises and other factors that affect the legitimacy of an organization (Dacin et al., 2002). Senior and Swailes (2010, p. 16) argue that healthcare systems might be influenced and controlled by governments through the countries' policies.

Deinstitutionalization may also be influenced by social pressures. This type of pressure is involved with the heterogeneous divergence of religions, cultures, beliefs, attitudes and practices of the different workforces in organizations (Dacin et al., 2002; Senior & Swailes, 2010). For instance, the rationing decisions of healthcare providers might change in response to external factors such as changing population demographics and new treatments or technologies (Senior & Swailes, 2010, pp. 18-19). Consequently, Senior and Swailes (2010, p. 18) state that ―all the socio-cultural factors influence the way organizations are set up, run and managed".

Institutional changes through the process of homogenization (isomorphism)

Greenwood and Hinings (1996, p. 1023) clarify that ―institutional theory is not usually regarded as a theory of organizational change, but usually as an explanation of the similarity (isomorphism) and stability of organizational arrangements in a given population or field of organizations". Isomorphism, the process of homogenization, is ―a constraining process that forces one unit in a population to resemble other units that face the same set of environmental conditions" (DiMaggio & Powell, 1983, p. 149). That is, institutional isomorphism forcefully increases the similarity in structures, procedures and practices among organizational networks (Currie & Suhomlinova, 2006; Greenwood & Hinings, 1996, p. 1023). Zucker (1987, p. 443) emphasizes that isomorphism within the institutional environment increases the probability of organizational survival. DiMaggio and Powell (1983, pp. 150-154) identify three mechanisms of institutional isomorphism, including 1) coercive isomorphism, 2) mimetic isomorphism and 3) normative isomorphism.

Coercive isomorphism mainly results from political pressure affecting the legitimacy of an organization; for example, the organization might be forced to change because of a mandate or legislation from the government (DiMaggio & Powell, 1983, p. 150).

Mimetic isomorphism occurs when there is uncertainty in the organization. This means that the standard response to uncertainty is a powerful pressure of imitation (DiMaggio & Powell, 1983, p. 151).

Normative isomorphism relates to professionalization. There are two particularly interesting aspects influencing normative isomorphism: 1) ―the resting of formal education and of legitimating in a cognitive base produced by university specialists"; and 2) ―the growth and elaboration of professional networks that span organizations and across which new models diffuse rapidly" (DiMaggio & Powell, 1983, p. 152).

Institutional theory has provided a powerful theoretical perspective for describing and explaining the process of healthcare reform (Lockett et al., 2012). The following studies, for instance, demonstrate how institutional isomorphism is useful for understanding organizational influence in healthcare systems. Campion and Gadd (2009) utilized institutional isomorphism theory to examine the pressure forced on organizations by peers, regulators and professionals in implementing intensive insulin therapy (IIT) as the standard of care approved by the trial single-site Leuven study in 2001. Although there were later studies indicating that IIT was not effective and increased the risk of hypoglycemia, IIT was still widely adopted in order to maintain legitimacy from other peer organizations, regulatory agencies and professional societies. This study showed that organizational pressures, through the mechanisms of mimetic isomorphism, coercive isomorphism and normative isomorphism, had an important role in the adoption of IIT. Campion and Gadd (2010) conducted a similar documentary review by employing institutional isomorphism theory to explore the adoption of three types of healthcare information technology (HIT) in U.S. healthcare organizations. Even though the effects of the changes in implementing HIT did not improve efficiency, those organizations still had to implement HIT because there were pressures from peers, regulators and professional societies to do so. In summary, these two studies demonstrate that the mechanisms of institutional isomorphism are a useful framework for researchers, decision-makers and practitioners to examine the nature of change in healthcare organizations and it is important for healthcare researchers, practitioners and managers to consider organizational influence when implementing organizational change (Campion, & Gadd, 2009).

Lockett et al. (2012) studied the role of institutional entrepreneurs (genetics doctor, genetics nurse and primary cares nurses) in implementing new pathways for cancer genetic services within the English National Health Services. Semi-structured interviews and comparative

case analysis were employed to examine the relationship between the subject position of an institutional entrepreneur (IE) and their ability to enact institutional change. The results indicated that ―those who have limited structural legitimacy under prevailing conditions are most willing to engender change, but also least able; whereas those who have strong structural legitimacy are most able, but often least willing". However, ―those who are able rhetorically to combine a balance of structural and normative legitimacy are most able to produce change" (Locked et al., 2012 p. 356). The results of this study demonstrate that institutional entrepreneurs as agents of change are among the key persons who need to be considered in order to successfully reform healthcare.

With regard to institutional changes emerging through the processes of deinstitutionalization and homogenization (isomorphism), functional pressure, social pressure, and political pressure and coercive isomorphism may be utilized to explain the PHC reform in Thailand as the means of implementing the SHPH policy.

2.4.2.3 The typology of archetypes

According to neo-institutional theory, institutional changes (either convergent change or radical change) occur in response to institutional pressures through the processes of deinstitutionalization and homogenization (isomorphism). These institutional pressures can lead one organization to adopt another organizational archetype or, in other words, ―the institutional context provides templates for organizing" (Greenwood & Hinings, 1996, p. 1025). Archetypes are ―ideal types, in that they represent configurations which are useful for the analysis of actual organizations" (Cooper et al., 1996, p. 635). Greenwood and Hinings (1993, p. 1052) define an archetype as ―a set of structures and systems that reflects a single interpretive scheme". Greenwood and Hinings (1993, pp. 1071-1072) further emphasize that the set of structures and systems is congruent with ideas, beliefs and values of organizational members. Consistent with the neo-institutionalist emphasis upon values, they suggest that ―the configuration or pattern of an organization‗s structures and systems is provided by underpinning ideas and values, that is, an interpretive scheme" (Greenwood & Hinings, 1996, p. 1025). Cooper et al. (1996, p. 644) point out that ―a manager needs to understand the differing interpretive schemes in order to intervene effectively in the organization". This

suggests that the interpretive schemes of PHC managers and of other members in their teams need to be changed in order to successfully implement changes regarding the SHPH policy.

The archetypal professional organization has been constantly experiencing change in responding to the environmental forces through the process of delegitimization and de-institutionalization. Brock (2006, pp. 161-163) suggests that the main forces of change in professional organizations might be deregulation and competition, technological development and globalization of services, leading to the emergence of a new archetype of the professional organization over time. Brock (2006, pp. 168-169) further contends that there are three competing archetypes: the Professionalism and Partnership (P^2) model, the Managed Professional Business (MPB) model, and the Global Professional Network (GPN) model.

The P^2 model is the strategic management model found in professional organizations and differs from those in other general organizations (Brock, 2006, p. 159; Greenwood, Hinings, & Brown, 1990 p. 730). The owners of the professional organization are the professional partners. This means that the professional partners both manage their organization and provide services directly to their clients. The main archetype of the healthcare organization, such as in the traditional family doctor, is of “professional dominance” (Brock, 2006, pp. 159, 167). That is, the health professionals, particularly the physicians or doctors, have considerable autonomy in controlling and making a decision from the macro-level (organizational policy) to the micro-level (patient care decision) (Brock, 2006, p. 159). A traditional SHPH, as a health centre, could be considered as a P^2 organization because there is only either a community health officer or a technical nurse working at the SHPH.

Since the traditional archetype (P^2) has changed “to accommodate changing cultural values, such as the importance of being businesslike” (Cooper et al., 1996, p. 643), the archetype of MPB has been developed in professional organizations (Brock, 2006, p. 164; Cooper et al., 1996, p. 643). Brock (2006, p. 163) adds that there is a shift from the autonomous model of professional organizations to the heteronomous, where professionals are subject to bureaucratic control. The present SHPHs can be categorised as the archetype of MBP because there are various health professionals working in each SHPH, such as a visiting

doctor from a community hospital, a public health officer, a community health officer, a registered nurse, a technical nurse, an assistant pharmacist, an assistant dentist and a Thai traditional medicine practitioner.

Due to the increasing pressures from deregulation, competition, globalization, new technology and client demands, the archetype of a GPN model has emerged, particularly in the large global professional firms such as the burgeoning hospitals across international boundaries (Brock, 2006, pp. 166-169). There are six important characteristics of the GPN: 1) managerialism and becoming more “businesslike”, 2) more reliance on formal networks, 3) more individualized reward systems, 4) increasing corporate governance, 5) increasing global reach, and 6) moving towards multidisciplinary practice in a “one-stop-shop” (Brock, 2006, pp. 164-166).

When there is a change from one archetype to another, such as from P^2 to MPB, the organizational change is not entirely shifted or transformed from one archetype to another. Instead, the new archetype layers on the old one, so-called sedimentation (Brock, 2006, p. 168; Cooper et al., 1996, p. 624). In other words, as Brock (2006, p. 169) explains, “in this sense, it reflects the emergence of a conjoint or hybrid archetype … combining new business values and structures with central elements of the older professional interpretive scheme”.

The typology of archetypes is an approach that has been used to explain and analyze the development of change in professional organizations, (“an organization primarily sustaining professionalized occupations” (Brock, 2006, p. 157)), particularly the dynamics of change in private legal and accountancy firms. However, the typology of archetypes is increasingly useful for analyzing change and uncertainty in other general professional organizations, such as universities, hospitals, medical practices and the like (Brock, 2006, p. 157; Kirkpatrick & Ackroyd, 2003, p. 732). For instance, Samia et al. (2012) conducted a longitudinal (four-year) qualitative case study to investigate the content, mechanisms and process of radical change of health services in the community in Canada. In order to remove duplication of care and provide a continuum of care for patients, an integrated services delivery project between the family physician clinic and the regional healthcare providers was implemented to move away from a provider-driven, fragmented delivery to a patient-centred, integrated delivery.

Based on multiple sources of data, including semi-structured interviews, observation of meetings and documentary review, the findings indicated that transforming from one template of healthcare delivery to another affected the change in structures/systems and underlying values. The finding from the case study was that ―successful change occurred when there was convergence of a variety of precipitating and enabling mechanisms" (Samia et al., 2012, p. 231), such as dissatisfaction with the prevailing template, the commitment of powerful groups/stakeholders to new values, the capacity to change through proper leadership, the social interaction among members of different groups, and the incentive system.

Summary

Neo-institutional theory describes the change processes by which practices and organizations within the organizational field become institutions in order to receive support and legitimacy. The institutional changes, such as healthcare reform, can occur either gradually or swiftly at the interpersonal, sub-organizational, societal, or even global levels through the processes of deinstitutionalization and isomorphism. In order to successfully change the archetypes affecting the institutional changes, the interpretive schemes (ideas, beliefs, and values) of organizational members need to be changed too. Therefore, neo-institutional theory and typology of archetypes model provide useful insights for agencies or institutional entrepreneurs, including the PHC managers in this study, to understand how to effectively lead and manage an organization or institution that is changing.

2.4.3 Diffusion of innovations theory

As the SHPH policy is considered as an innovation in the healthcare system of Thailand, this section defines and describes diffusion of innovations theory which can be utilized to understand how the SHPH policy was transferred and diffused, and how PHC managers within the SHPHs have received and adopted this innovative policy.

This section begins by providing information regarding the development of diffusion of innovations theory. Then, the main elements of diffusion of innovations theory proposed by

Everett Rogers are elucidated. At the end of this section, the application of diffusion of innovations theory in empirical studies is presented.

2.4.3.1 The development of diffusion of innovations theory

Diffusion of innovations theory emerged and developed from various research traditions and multiple fields (Greenhalgh et al., 2004; Greenhalgh et al., 2005; Oldenburg & Glanz, 2008, p. 315; Rogers, 1983, pp. 52-53). In the early sociological diffusion tradition, Gabriel Tarde, one of the European grandfathers of sociology and social psychology, proposed the most fundamental ―law of imitation" that is today known as the ―adoption" of an innovation (Rogers, 1983, pp. 40-41). Soon after Tarde‗s proposition, the anthropologists, named the ―British diffusionists" and the ―German-Austrian diffusionists", explained that change in one given society results from the introduction of innovations from another society (Rogers, 1983, pp. 41-42). The rural sociology tradition, a subfield of sociology, went on to formulate the paradigm for diffusion research which became the dominant view (Greenhalgh et al., 2004; Greenhalgh et al., 2005; Rogers, 1983, p. 51). Consequently, much of the significant research in this tradition was on agricultural production (Greenhalgh et al., 2004; Greenhalgh et al., 2005; Greer, 1977, p. 508; Rogers, 1983, p. 54). Ryan and Gross‗s 1943 analysis of the diffusion of hybrid-seed corn among farmers in two Iowa communities is one of the classic diffusion studies in the rural sociology tradition. In time, diffusion of innovations studies were expanded and applied in other research traditions, for example in communications, marketing, education, geography, anthropology, and public health and medical sociology (Greenhalgh et al., 2004; Greenhalgh et al., 2005; Rogers, 1983, pp. 52-53).

In the 1950s, diffusion of innovations model began to be recognized in the field of public health and medical sociology (Rogers, 1983, p. 65). In 1966, James Coleman, Elihu Katz, and Herbert Menzel investigated the diffusion of a new antibiotic drug named ―gammanym" tetracycline that had begun to be used in late 1953 among physicians in four communities (Friedkin, 2010; Rogers, 1983, p. 66). The findings indicated that physicians, who were early adopters of the new drug, conveyed information about the drug to their networks and influenced other physicians to consider adopting it (Friedkin, 2010; Rogers, 1983, p. 67). In other words, ―the physicians‗ contact networks contributed to the diffusion of the drug"

(Friedkin, 2010, p. 147). Rogers (1983, pp. 65-66) pointed out that ―the drug study helped illuminate the nature of diffusion networks, suggesting the role that opinion leaders played in the ‗take off' of the s-shaped diffusion curve". Since the study of drug diffusion, a number of other diffusion studies have been completed in the public health and medical sociology fields, with an emphasis on family planning issues, particularly in developing countries (Rogers, 1983, pp. 68-69).

In a recent systematic review conducted by Greenhalgh et al. (2004), diffusion of innovations theory has been applied in studies of health service organizations in thirteen research traditions: 1) rural sociology, 2) medical sociology, 3) communication studies, 4) marketing, 5) development studies, 6) health promotion, 7) evidence-based medicine, 8) structural determinants of organization ―innovativeness", 9) studies of organizational process, context, and culture, 10) inter-organizational studies (networks and influence), 11) knowledge utilization, 12) narrative studies and 13) complexity studies. The first four of these research traditions comprised ―early diffusion research" which ―produced some robust empirical findings on the attributes of innovations, the characteristics and behaviour of the adopter, and the nature and extent of interpersonal and mass media influence on adoption decisions" (Greenhalgh et al., 2004, p. 589; Oldenburg & Glanz, 2008, p. 315). The other research areas have subsequently emerged and been developed using methods found in early diffusion research studies (Greenhalgh et al., 2004, p. 590). The organizational and management literature is one of the prominent research areas where the diffusion of innovations approach has been applied (Greenhalgh et al., 2004, pp. 591-593). Therefore, this study applies diffusion of innovations theory in the field of health services organization at the PHC level in Thailand.

2.4.3.2 Everett Rogers's diffusion of innovations theory

Diffusion of innovations is commonly referred to as ―the spread and adoption of new ideas, techniques, behaviours or products throughout a population" (Dobbins et al., 2002, p. 3). This classical model of diffusion of innovations attempts to understand the inquiry of ―how do responsive individuals within an organization receive and adopt innovative ideas?" (Greer, 1977, p. 508).

Rogers (1983, p. 5) defines diffusion as ―the process by which an innovation is communicated through certain channels over time among the members of a social system". According to this definition, the main elements of diffusion are 1) innovation, 2) communication channel, 3) time, and 4) social system (Rogers, 1983, p. 35).

1. Innovation

An innovation is ―an idea, practice, or object that is perceived as new by an individual or other unit of adoption' (Rogers, 1983, p. 11). Rogers (1983, p. 12) makes the point that technology is the foundation of innovation and it means ―a design for instrumental action that reduces the uncertainty in the cause-effect relationships involved in achieving a desired outcome". There are five attributes of innovation that determine its rate of adoption: 1) relative advantage, 2) compatibility, 3) complexity, 4) trialability and 5) observability. The attribute of re-invention also influences and sustains the success of adoption (Greenhalgh et al., 2004; Rogers, 1983, p. 16). SHPH policy, as one of the innovations in the healthcare system of Thailand, should have these attributes of innovation in order to be successfully implemented. This policy should be perceived by adopters, the PHC managers and others stakeholders, as better or having more advantages than the previous policy. It should be consistent or compatible with the values, past experiences and needs of adopters. The content of the policy should not be perceived as difficult or as being too complex to understand and implement. The policy should be proven (trialability) and have positive results (observability) for the adopters. Also, the policy should not have too many details or specific processes of implementation, but rather be modifiable and capable of re-invention by adopters to suit the context of each SHPH in the process of its implementation.

2. Communication channel

The communication channel is ―the means by which messages get from one individual to another" (Rogers, 1983, p. 17). The communication channel is the essence of the diffusion process in connecting and exchanging information about the new innovation between an individual or unit who has had experience of adopting the innovation and another individual or unit who has not had experience of adopting the innovation (Rogers, 1983, p. 17). Mass

media channels, such as newspapers, radio, television, have a huge impact in transmitting the information about the innovation to many audiences (Rogers, 1983, p. 18). However, Rogers (1983, p. 18) and Robinson (2009) believe that interpersonal channels of “near-peers” have more effective power to motivate an audience to adopt an innovation, because people tend to trust and follow peers who have successfully adopted an innovation. Face-to-face communication is an essential component of spreading innovation from early adopters to the rest of the population (Robinson, 2009; Rogers, 1983, p. 18). Within the social system, Rogers (1983, pp. 18-19) and Greenhalgh et al. (2004, p. 602) propose that communication will be more effective between two individuals having a high degree of homophily or similar attributes, such as social status, education and interest. Effective communication will also occur if those individuals have high empathy, “the ability of an individual to project him- or herself into the role of another” (Rogers, 1983, p. 19). Hence, communication channels make up an important component to help understand the transference processes of the SHPH policy from the Thai government at the policy level to PHC managers at the operational level.

3. Time

Another important element of the diffusion process is time, involving three dimensions: the innovation-decision process, innovativeness and rate of adoption (Rogers, 1983, pp. 20-23). The innovation-decision process can cause either adoption or rejection of an innovation by an individual, and it can also lead to the discontinuation in the adoption of an innovation when an individual feels dissatisfied with an innovation (Dobbins et al., 2002; Rogers, 1983, p. 21).

Innovativeness is “the degree to which an individual or other unit of adoption is relatively earlier in adopting new ideas than other members of a social system” (Rogers, 1983, p. 22). Rogers (1983, p. 22) suggests five categories of adopters: 1) innovators, 2) early adopters, 3) early majority, 4) late majority and 5) laggards. Innovators have a tendency to have high innovativeness because they are the first group to adopt an innovation in their system. Robinson (2009) emphasizes that understanding the personalities and needs of these five groups is vital in selecting and utilizing an appropriate technique to diffuse an innovation to each group.

The time element in the diffusion process indicates that the policymakers of the SHPH policy in Thailand should understand the nature of the adopters, that is, the PHC managers. Some of the PHC managers might be innovators, but others may not be and this can affect the rate of implementing this policy. In addition, PHC managers who are implementing the SHPH policy need to consider the nature of their subordinates and other stakeholders in the community in order to use appropriate strategies in transferring this policy.

4. Social system

A social system ―is a set of interrelated units that are engaged in joint problem solving to accomplish a common goal" (Rogers, 1983, p. 24). Denis et al., (2002, p. 72) state that ―those interested in promoting wisdom in the adoption of innovations must become deeply aware of the specific ways in which they are likely to interact with their social contexts". Hutchison et al. (2001, p. 129) also point out that ―fundamental change may be difficult to achieve when it fails to advance important social values". The social system consists of both structures and norms that regulate, stabilize and standardize an individual‘s behaviours in adopting an innovation. These two constituents can either facilitate or impede diffusion of innovations in the social system (Rogers, 1983, p. 24-27). In the social system of SHPHs, PHC managers are considered as the opinion leaders and they have an important role in diffusing and implementing the SHPH policy.

Changes from adopting an innovation can have an effect from the individual level to the social system level, the so-called consequences of innovations (Rogers, 1983, p. 31). In general, change agents, who attempt to diffuse an innovation into a system, expect positive consequences (desirable, direct, and anticipated). However, the consequences of innovations might radically change the system, and not all changes may be positive (Rogers, 1983, p. 32). Dobbins et al. (2002) explain that the consequences of innovations in health services organizations might be on patient outcomes (i.e., patient satisfaction, increased quality of life, and decreased mortality/morbidity), organizational performance indicators (i.e., improved efficiency, decreased costs) and health-system outcomes (i.e., expenditures, resource allocation). As outlined in sub-section 2.2.4, empirical studies of SHPHs, the consequences of implementing the SHPH policy have had both positive and negative aspects (Kaewkim et al., 2012; Neelasri, 2011; Petcharatana et al., 2010; Tima & Sealim, 2012).

2.4.3.3 The application of diffusion of innovations theory in empirical studies

Over several decades, the theory of diffusion of innovations has been applied to understand the processes and steps of transferring and disseminating public health innovations (Greer, 1977, p. 513; Oldenburg & Glanz, 2008, p. 314). The innovations in healthcare may be ―preventive, curative, rehabilitative or palliative and encompass all of the instruments, equipment, drugs and procedures used in the delivery of health care" (Dobbins et al., 2002, p. 3). Oldenburg and Glanz (2008, p. 321) further emphasize that ―most innovations in public health consist of more complex, multicomponent programmes, guidelines, policies, and legislation, where the unit of adoption is a group of implementers or a whole organization or system". The following are some of the studies applying diffusion of innovations theory to understand the processes of and factors influencing the adoption of innovations in a healthcare system.

Greenhalgh et al. (2004, pp. 610-612) conducted a meta-narrative review of diffusion of innovations in health services delivery and organization. One section of this study‗s results indicated that the implementation of an innovation depends on many factors such as organizational structures, human resources issues, funding, intraorganizational communication, interorganizational networks, feedback, adaptation reinvention and leadership and management. Greenhalgh et al. found that if an innovation is consistent with an objective of the management of healthcare organizations, and if a leader or manager of a healthcare organization has an opportunity to be actively involved in, and is frequently consulted regarding, the adoption of an innovation, the innovation is more likely to be implemented and routinized into the organization.

Bodenheimer et al. (2003) studied changes that occurred among United States primary care physicians who were facing difficult issues such as overwork, and inability to deliver services in response to the patient‗s needs and expectations. The physicians introduced innovations in primary care practices, including functioning primary care teams, open access scheduling, the chronic care model, collaborative physician interaction, group medical visits and the paperless electronic office (Bodenheimer et al., 2003, p. 796). The researchers explained that all of these innovations rely on the formation of primary care teams: ―Without

teams, most of these innovations would be unsustainable because they add to the huge workload of primary care physicians. With teams, physicians can spend more time training and supervising team members and less time seeing patients with uncomplicated problems singly. The creation of teams is the key element in primary care redesign that allows other innovations to succeed" (Bodenheimer et al., 2003, p. 798).

In order to identify the internal change drivers and change process in implementing managerial innovations, such as budget or funding-holding systems, performance-based incentive mechanism, structured clinical governance tool, etc., between a local health authority (LHA) and general practice (GP) in the CASs of primary care, Longo (2007) conducted interviews with key actors from three LHAs located in the same region of Emilia-Romagna in central Italy. There were at least six people from each LHA including one top-level manager, one manager from the primary care unit (Primary Care Department), one GP union leader, and three to five GPs not leading the union (Longo, 2007, pp. 217-218). The results indicated that ―the most important drivers recognized are: the commitment, competence, and leadership of key professional and managerial players; the agreements and the consequent quality of relationships arising among the key actors; and the resources dedicated to enable change management in primary care. This is coherent with the suggestions coming from the CAS approach" (Longo, 2007, p. 224). The researchers identified a limitation of this study as being lack of consideration of the external change drivers, such as changes in the contracts of national GPs and the regional policy in primary care, even though these drivers certainly influenced the implementation of change in the primary care system (Longo, 2007, p. 317). Longo also noted as a limitation to this study the fact that it focused on only one region of the Italian context (Longo, 2007, p. 224).

There is an increasing trend for implementing new guidelines, methods and tools in PHC, but there are few studies conducted to understand the factors influencing adoption of those innovations (Carlfjord et al., 2010). In order to bridge the knowledge-to-practice gap in healthcare, Carlfjord et al. (2010) applied the Everett Roger‘s diffusion of innovations theory in a study aimed at identifying the key factors influencing the adoption of computer-based lifestyle tests being introduced in PHC in Sweden. Sixteen focus group interviews and two

individual interviews were conducted with groups of GPs, nurses and other staff members. In total, there were 67 study participants from six PHC units (Carlfjord et al., 2010). This study indicated that factors to be taken into account when implementing innovation in PHC were positive expectation and perception of staff toward the innovation, innovation characteristics (the advantage of innovation and its compatibility with existing routines), opinion leader, context of organization (workforce and their workload) and staff characteristics (Carlfjord et al., 2010, pp. 9-10). The limitation of this study was relevant to the generalizability of its results because it did not consider the context and networks which might also influence the adoption of innovation (Carlfjord et al., 2010).

As the innovativeness of nurse leaders plays an important role in the implementation of an innovation in acute care hospitals such as evidence-based practices, Clement-O‘Brien et al. (2011) investigated the factors influencing innovativeness among 106 chief nursing officers (CNOs) in acute care hospitals of New York State by using information obtained in a mailed survey. The main results indicated –graduate level education, years of CNO experience and leadership course completion were identified as significantly influencing innovativeness of CNOs” (Clement-O‘Brien et al., 2011, p. 431). In other words, both educational experience and work experience influenced the willingness of those managers to initiate and implement the innovative projects. Because this study was conducted in only one U.S. state, the generalizability of its findings may be limited. In addition, the mailed survey instrument has accuracy limitations because participants may provide answers they believe to be desirable ones rather than providing answers that reflect their situation (Clement-O‘Brien et al., 2011).

As the implementation of complex innovation reform of PHC was centred on family medicine in Bosnia and Herzegovina in 2001 involving organizational, financial, clinical and relational changes, Atun et al. (2007) conducted a study in 2004-05 to examine the introduction and diffusion of such reform. In-depth interviews based on four themes: 1) the nature of the innovation, 2) the characteristics of the innovation that facilitated the diffusion process, 3) the communication process between the innovator and adopter and 4) contextual, individual and organizational factors which hindered or enabled the uptake and diffusion of the innovation, were employed. The purposive sample consisted of 58 key stakeholder informants involved with the PHC reform, including policy-makers, managers, clinicians,

family medicine doctors, family medicine nurses and patients. The findings indicated that the innovations of this PHC reform policy ―are not simply disseminated but rather assimilated into the health system" (Atun et al., 2007, p. 29). The important factors influencing the diffusion of this complex innovation reform were the benefits of the innovation perceived by stakeholders, the level of consensus of a diverse group of adopters and the wider context of society, such as wars (conflict issues in Bosnia and Herzegovina), culture, tradition, country's history, governance system and political system. This study demonstrates that it is important for policymakers to understand the nature of the innovation, the perceived benefits of the innovation, adopter characteristics and contextual society. The limitation of this study is associated with the use of purposive rather than random sampling, but this can be overcome by ensuring rigour at every stage of the study (Atun et al., 2007, p. 37).

Ferlie et al. (2005) conducted a qualitative study to investigate whether the boundaries between professional groups in the U.K. healthcare sector (both acute care and primary care settings) have any effects on the spread of innovations. The researcher conducted 232 interviews (119 from acute care settings and 113 from primary care settings) consisting of the opinion leaders in three key professional groups (physician, nurse and allied health), and then produced eight comparative case studies. The results demonstrated that ―social and cognitive boundaries between different professions retard spread, as individual professionals operate within unidisciplinary communities of practice" (Ferlie et al., 2005, p. 117). The limitation of this study might be that one deviant case study cannot be easily explained and the researchers have not considered ―issues of differing access to power", such as the differences between senior nurses and junior physicians (Ferlie et al., 2005, p. 132).

Summary

Diffusion of innovations theory provides a framework for this thesis to understand the processes and steps of adopting and disseminating public health innovations, including the SHPH policy. The four main elements (innovation, communication channel, time and social system) need to be taken into account in order to successfully implement any innovations. The PHC managers, as the opinion leaders in the social system of the SHPHs, have an important role in diffusing and implementing the SHPH policy.

2.5 Conclusion

The literature shows that the PHC managers in Thailand, the frontline managers working at the PHC level, are faced with many challenges occurring in a complex health services organization under dynamic changing circumstances such as those resulting from the SHPH policy. The literature also emphasizes that human resources development in leadership and management should be one of the solutions for this group of health services managers to be able to effectively manage those challenges in order to improve health services to achieve the MDGs.

The eclectic theoretical framework adopted for the study reported in this thesis includes 1) complex adaptive systems theory, identifying that a healthcare organization operates in a highly uncertain environment, consisting of diverse agents, involving a large number of non-linear interactions, continuing self-organization, having emergent properties, and co-evolving with the environment; 2) neo-institutional theory and typology of archetypes, which explains that a healthcare organization adapts and changes the archetype, an interpretive scheme, in response to institutional pressures in order to survive and to receive support and legitimacy; and 3) diffusion of innovations theory, which describes innovation as constantly occurring in the healthcare system and which is communicated amongst agents in a social system through certain channels over time. Together, these theories assist in an understanding of how a healthcare organization is continually being changed and adapted to meet the challenges posed by its environment and how the changes occurring in a healthcare organization can affect the leadership roles and management functions of the PHC managers working in a complex adaptive healthcare organization.

In the next chapter, the research methodology and design of this study are presented and justified. The explanation of the method for data collection and analysis is also discussed, as are the ethical considerations and the criteria used to judge the quality of this study.

Chapter Three: Methodology

3.1 Introduction

This chapter begins by justifying the theoretical perspective and the methodology for this research, then goes on to discuss the study setting and population profile, sample size and sample framework, recruitment of participants, and participant profile. The chapter also explains the data collection procedure and data analysis as well as the rigour and trustworthiness of the study, methodological issues and limitations and ethical considerations.

3.2 Justification for the theoretical perspective and research methodology

The philosophical viewpoint – or paradigm – for this study is that the nature of existence (ontology) is multiple and has dynamic realities (Crotty, 1998, p. 10; Klenke, 2008, p. 16; Lincoln & Guba, 1985, p. 37). The nature of human knowledge (epistemology) is ―socially constructed by individuals from within their own contextual interpretation" (Klenke, 2008, p. 16). This means that there is no objective truth waiting for discovery. Instead, truth, knowledge and meaning are constructed by engaging with the realities in the world (Crotty, 1998, pp. 8-9; Denzin & Lincoln, 2008, p. 32). Consequently, to uncover information, the researcher needs to interact with what is being researched and get as close as possible to the participants being researched (Creswell, 2013, p. 20; Klenke, 2008, p. 17; Lincoln & Guba, 1985, p. 37).

Both ontology and epistemology are related and translated to theoretical perspective, methodology and methods of research (Crotty, 1998, p. 4; Denzin & Lincoln, 2008, p. 31; Holloway & Wheeler, 2010, p. 21; Klenke, 2008, p. 18). In this study, the theoretical perspective was based on interpretivism and the research methodology used was a hermeneutical phenomenological approach. The method employed to gather data was a semi-structured interview, and data was analyzed using thematic analysis. This section of Chapter Three justifies the theoretical perspective and research methodology while the details of research methods are presented in the following sections.

Theoretical perspectives of social research have been influenced by the two paradigms of positivism and interpretivism (Borbasi & Jackson, 2007, p. 158; Holloway & Wheeler, 2010, p. 22; Lincoln & Guba, 1985, p. 37). Positivists believe that social research can be conducted in the same way as studies of the natural sciences, such as in physics or chemistry. Positivists usually employ quantitative methods that are standardized and repeatable to test hypotheses or theories (Holloway & Wheeler, 2010, p. 22; Rice & Ezzy, 1999, p. 12; Walsham, 1995) because ―they believe that such methods will lead to true and objective results" (Rice & Ezzy, 1999, p. 12).

From an interpretivist point of view, however, such objectivity is neither possible nor desirable. Interpretivists believe that what distinguishes human social actions from physical objects is that the former are inherently meaningful (Denzin & Lincoln, 2000, p. 191; Holloway & Wheeler, 2010, p. 25). Rice and Ezzy (1999, p. 12) explain that ―people are fundamentally different to things because of the centrality of meanings and interpretations to human social life". The intepretivist ―looks for culturally derived and historically situated interpretations of the social life-world" (Crotty, 1998, p. 67) and ―seeks to produce descriptive analyzes that emphasize deep, interpretive understanding of social phenomena such as leadership" (Klenke, 2008, p. 23). Hence, in order to understand particular human social actions and phenomena, the researcher must grasp the meaning and interpret the actions that constitute a phenomenon (Denzin & Lincoln, 2000, p. 191; Rice & Ezzy, 1999, p. 12).

Interpretivists assume that ―the researcher and reality are inseparable and knowledge is based on abstract descriptions of meaning and constituted through a person‘s lived experience" (Klenke, 2008, p. 20). Because the subjective meanings of the individual are developed from experiences, and these meanings are varied and multiple, research from an interpretivist‘s viewpoint attempts ―to look for the complexity of views rather than narrow the meaning into a few categories or ideas" (Creswell, 2013, p. 24). Interpretivist researchers intend to make sense of, or interpret the meaning of, others and inductively develop a theory or pattern of meaning (Avis, 2005, p. 6; Creswell, 2013, p. 25). They recognize that ―their own background shapes their interpretation, and they position themselves in the research to acknowledge how their interpretation flows from their own personal, cultural, and historical

experiences" (Creswell, 2013, p. 25). The researcher attempts to interact with the human subjects of the enquiry and use their preconceptions in order to guide the process of enquiry and interpretation (Avis, 2005, p. 5; Walsham, 1995). Interpretivism is, thus, integral to studies utilizing the phenomenological approach, in which individuals describe their experiences (Creswell, 2013, p. 25; Denzin & Lincoln, 2000, p. 192).

Phenomenology is broadly defined as ―the study of phenomena: appearances of things, as they appear in our experience, or the way we experience things, and thus the meaning things have in our experiences" (Klenke, 2008, p. 222). The objective of phenomenological study is to understand people‘s views of their experiences and the meanings they give to these experiences in terms of their thoughts, feelings, understandings, or interpretations (Denzin & Lincoln, 2000, p. 192; Liamputtong, 2013, p. 8; Minichiello et al., 2004, p. 63; Moustakas, 1994). A phenomenological study identifies the essence of lived experiences of several individuals about a phenomenon as described by participants (Borbasi & Jackson, 2007, p. 158; Creswell, 2009, p. 13; Creswell, 2013, p. 76). Phenomenologists ―focus on the social construction of the life-world, emphasizing that people‘s actions can only be understood when they are situated in the taken-for-granted meaning and routines that constitute their everyday world" (Rice & Ezzy, 1999, p. 16). They have the question ―how does a person experience a phenomenon". They are interested in the lived experience rather than ―second-hand experience" (Liamputtong, 2013, p. 8). In other words, a phenomenon should be researched from the perspective of the subject who has an experience of the phenomenon, not from descriptions of those who have not experienced the phenomenon.

There are two main schools of phenomenological thought: descriptive phenomenology, and interpretive or hermeneutic phenomenology (Crotty, 1996; Carpenter, 2010, p. 125; Rapport, 2005, p. 126). Edmond Husserl (1859–1938) studied and developed descriptive phenomenology to establish a rigorous and unbiased method for understanding of human experience (Barnacle, 2001, p. 17; Klenke, 2008, p. 223; Carpenter, 2010, p. 125; Palmer, 1969). Concerned with the experiential underpinnings of knowledge, Husserl argued that ―the relation between perception and its objects is not passive. Rather, human consciousness actively constitutes objects of experience" (Denzin & Lincoln, 2000, p. 488). In the Husserlian approach, researchers are required to ―bracket", suspend and disengage their

judgements, preconceptions and prior knowledge regarding the experiences of participants being examined in the research (Crotty, 1998, p. 83; Carpenter, 2010, p. 125; Minichiello et al., 2004, pp. 632-633; Padgett, 2012, p. 35); this is known as the Epoche process (Moustakas, 1994, p. 22; Rapport, 2005, p. 126).

Martin Heidegger contended that researchers could not –bracket” their experiences of phenomena (Barnacle, 2001, p. 18; Minichiello et al., 2004, pp. 632-633). Heidegger proposed and developed interpretive or hermeneutic phenomenology for the study of –being” or ways of –being-in-the-world” – referring to how people make sense of the world (Dreyfus, 1991, p. 6; Klenke, 2008, p. 224; Carpenter, 2010, p. 126; Packer, 1985; Rapport, 2005, p. 127; Walker, 2011). In his famous 1927 book *Being and Time*, Heidegger emphasized the concept of –Dasein”, which, in translation, means –being-there” (Crotty, 1996, p. 78; Palmer, 1969, p. 126; Rapport, 2005, p. 131). This means that –we exist in a world where there is reciprocal interdependence between the self, others, and objects which slowly come to our awareness as the need arises” (Klenke, 2008, p. 225).

Interpretive or hermeneutic phenomenology has been widely utilized in healthcare research (Chan et al., 2010; Rapport, 2005) and it –focuses on describing the meanings attributed by individuals to being in the world and how these meanings influence the choices that they make” (Lopez & Willis, 2004, p. 729 cited in Carpenter, 2010, p. 126). The Heideggerian approach –requires researchers to reflect not only on their situation within the research, but also on notions of neutrality and knowing” (Minichiello et al., 2004, pp. 632-633). The researcher‘s experience and knowledge are important to guide the interpretation and understanding of the phenomenon (Carpenter, 2010, p. 126; Rapport, 2005, p. 133) because it is the researcher‘s experience and knowledge that enables engagement between researcher and participant (Barnacle, 2001, p. 17).

My background and perspective for this thesis, outlined in Chapter One, is moulded by working and teaching in the field of health services management at primary health care level in Thailand. This knowledge and these experiences are relevant to understanding the experiences of the research participants and interpreting the data gained from interviews with them. Bracketing in the context of this research would be difficult, if not impossible, as I

interviewed fellow health professionals working in healthcare organization at primary health care level. This implies that the interpretive paradigm of hermeneutic phenomenology is the most appropriate methodology for this research, which aims to obtain and reflect on the experiences of individual PHC managers with respect to their leadership roles and management functions. Therefore, hermeneutic phenomenology was applied in this study to examine the lived experiences of PHC managers working at SHPHs in implementing the SHPH policy in Phitsanulok Province, Thailand.

3.3 Study setting and population profile

A case study is a process of inquiry about a contemporary case, particular situation, event or phenomenon (Denzin & Lincoln, 2000, p. 436; Green & Thorogood, 2004, p. 37; Wan, 1995, p. 169). A case study approach is generally employed in situations in which ―how and why questions are being asked about a contemporary set of events, over which the investigator has little or no control" (Yin, 2003, p. 9). The aim of a case study is to conduct an in-depth study of one or more individuals, programmes, events, activities, or processes within a bounded system such as a setting or a context (Creswell, 2009, p. 13; Liamputtong, 2013, p. 202; Øvretveit, 1998, p. 127; Stufflebeam & Shinkfield, 2007, p. 319). Yin (2003, p. 14) notes that case study research can use either single or multiple cases. A reason to study only one case is to capture the circumstances and conditions of an everyday or commonplace situation, the so-called representative or typical case (Yin, 2003, p. 41). The logic for using multiple cases is either to predict similar results across cases (a literal replication) or to predict contrasting results across cases but for predicable reasons (a theoretical replication) (Yin, 2003, p. 47).

In this study, Phitsanulok Province was purposively selected out of the 76 provinces of Thailand in which to gather data for a single case study. There were two reasons for selecting Phitsanulok Province: convenience and representativeness. The selection was convenient because I works in Phitsanulok Province and therefore has contacts who work in the Phitsanulok Provincial Health Office and District Health Offices; this enabled me to conduct the research within the financial and candidature time constraints. Phitsanulok Province is representative because its SHPH policy, implemented in October 2009, has features also found in other Provinces that have implemented the SHPH policy, including:

1) Provision of various health services. Phitsanulok Province is considered as the central province and the medical hub in the lower northern region of Thailand. The SHPH has primary, secondary and tertiary contracting units.

2) Variety of geographic regions, including urban, rural and remote.

Together, these features reflect the various types of health services provision and the complexity of the healthcare system in Thailand. Figure 3.1 is a map of Thailand showing the location of Phitsanulok Province.

Figure 3.1: Map of Thailand showing the location of Phitsanulok Province

Source: http://www.welt-atlas.de/map_of_thailand_political_6-934

Phitsanulok Province consists of nine districts. The Central District is considered an urban area and the other eight districts are classified as rural areas. In Thailand, the Central District is akin to a capital city. There are many important government organizations in the Central District, such as the Provincial Health Office, the Provincial Court, and the Provincial Hospital. The numbers of people and the population density of Central District are higher than those of other, rural districts. Figure 3.2 is a map of the districts of Phitsanulok Province.

Figure 3.2: Map of Phitsanulok Province and its districts with names and locations of surrounding provinces in Thailand and the country of Laos

Source: http://www.thaihotelslinks.com/Phitsanulok/map.php

According to the SHPH Policy, there are two models, single and group models (Bureau of Policy and Strategy, 2009). Single model SHPHs are large and responsible for more than three thousand people. The group model comprises small SHPHs, each responsible for less than three thousand people that are integrated so that, together, they are responsible for at least three thousand people (Bureau of Policy and Strategy, 2009). In Phitsanulok Province, there are a total of 143 SHPHs: 19 single model SHPHs and 126 group model SHPHs. The

details of number and types of SHPH of each district in Phitsanulok Province are presented in Table 3.1 (Phitsanulok Provincial Health Office, 2011).

Table 3.1: The number and types of SHPHs in Phitsanulok Province

No	Districts	Types of SHPHs		
		Single Model	Group Model	
		Number of SHPHs	Number of groups	Number of SHPHs
1	Bangkatum	2	5	11
2	Bangrakum	0	6	20
3	Chatitrakan	1	4	9
4	Nakhonthai	0	7	20
5	Nernmaprang	1	5	10
6	Phitsanulok (Central District)	9	6	15
7	Promphiram	3	7	16
8	Wangtong	3	7	16
9	Watbost	0	4	9
Total		19	51	126

Source: http://www.plkhealth.go.th/map/dat/detail_total.php

3.4 Sample size and sample framework

In phenomenological research, “it is essential that all participants have experience of the phenomenon being studied” (Creswell, 2013, p. 155). Liamputtong (2013, p. 8) also explains that the participants in a phenomenological study should have lived experience rather than “second-hand experience” of the phenomenon. This is consistent with purposive sampling because its prime rationale is to recruit participants who have an in-depth understanding of the issue under investigation or can relate “information-rich” experiences (DePoy & Gilson, 2003, p. 115; Liamputtong, 2013, p. 14; Minichiello et al., 2004, p. 213). Klenke (2008, p. 226) points out that “the phenomenologist uses purposive or theoretical sampling in an effort

to identify informants who can illuminate the phenomenon of interest and can communicate their experiences”.

In this study, purposive sampling, also known as theoretical, non-probability, or judgment sampling (Liamputtong, 2013, p. 14), was employed to recruit PHC managers as study participants because of their direct experience of implementing the SHPH policy. While exploring other perceptions regarding the implementation of the SHPH policy would have enhanced the richness of the case study data, it was beyond the scope of available research time to extend the study to other stakeholders.

Maximum variation sampling is a kind of purposive sampling strategy and –involves finding heterogeneous samples across wider sample groups” (Liamputtong, 2013, p. 16). Creswell (2013, p. 156) explains that the –maximum variation” of sampling strategy can provide multiple perspectives. Using this strategy, a researcher determines, in advance, some criteria that differentiate sites or participants, and then selects sites or participants that span the difference (Creswell, 2013, p. 157). The criteria will depend on the theoretical framework and research findings of what is already known on the topic, and might be age, gender, ethnicity, social class, geographic location, health status and nationality (Liamputtong, 2013, p. 16). Creswell (2013, p. 155) explains that using criteria to recruit participants works well in phenomenological study because recruited participants are people who have experienced the phenomenon being studied.

In this study, participants were initially recruited based on the selection criteria. Before collecting the data, three criteria of educational background, type of SHPH and location of SHPH were determined based on the literature review. However, after conducting the first few interviews, I found that age, gender and management work experience of participants could also influence leadership roles and management functions. Six criteria, therefore, were used to recruit the participants, as presented in Table 3.2.

Table 3.2: Selection criteria used to recruit the participants

Selection Criteria	
Gender	Male Female
Age	< 35 35 - 44 45 - 55 > 55
Management work experience	< 10 10 - 20 > 20
Educational background	Diploma Bachelor Master
Type of SHPH	Single model Group model
Location of SHPH	Urban Rural

In this study, an iterative approach of coding and discussion between myself and my supervisors occurred until consensus was reached that saturation had occurred (more detail of the iterative process is presented in sections 3.7 and 3.8). The data reached the point of data saturation after interviewing the seventeenth participant; in other words, there was no new information or themes emerging after seventeen participants had been interviewed.

3.5 Recruitment of participants

To recruit study participants, I sent a letter requesting permission to conduct the research to the authority at the Phitsanulok Provincial Health Office (Appendix 1). From there, the letter granting permission (Appendix 2) was distributed to nine District Health Offices in the Province. I then made initial phone contact with the chief of each District Health Office to request further permission and to obtain a monthly meeting date of administrative committees. The administrative committees of each District Health Office consist of the chief and staff of the District Health Office and the PHC managers from each SHPH. Thus, I could

meet all PHC managers in the one location and invite them to volunteer to participate in the study.

I gave a five to ten-minute oral presentation at a monthly meeting of each District Health Office. After the presentation, I gave each PHC manager a PHC manager's demographic questionnaire (Appendix 3) and study invitation leaflets containing information about the research and my contact details (Appendix 4). PHC managers were invited to contact me if they were interested in volunteering to participate in the research and to complete the demographic questionnaire.

I and my supervisors used the data from submitted demographic questionnaires to select a group of PHC managers, using the criteria of age, gender, work experience, educational background, type of SHPH (single and group models) and location of SHPH (rural and urban). I then contacted the potential participants and organized suitable interview times.

3.6 Participants profile

As explained above, study participants were purposively selected based on six criteria in the recruitment process to maximize variation of responses and perceptions of experiences, and increase the diversity and richness of the data. Table 3.3 represents the characteristics of the seventeen participants. To safeguard the anonymity of participants, their real names were replaced by a fictitious name. These fictitious names are also used in this thesis, particularly in Chapters Four and Five, when the words or perceptions of participants are presented.

3.7 Data collection procedure

The interview technique is appropriate in the tradition of hermeneutic enquiry for obtaining the lived experience of participants (Walker, 2011). The interview is a method to investigate information through direct interchange with an individual or group in order to appreciate the lived experience of people and to understand the meaning people make of that experience (DePoy & Gilson, 2003, p. 114; Kvale, 1996; Seidman, 2006, p. 9; Stufflebeam & Shinkfield, 2007, p. 318). The interview method gives the researcher the opportunity to

Table 3.3: PHC manager characteristics for study participants

Fictitious Name	**Age** (years old)	**Total working experience** (years)	**Management working experience** (years)	**Gender**		**SHPH's Location**		**SHPH's Model**		**Educational background**						
										Diploma		**Bachelor**			**Master**	
				Male	Female	Urban	Rural	Group	Single	Diploma of Public Health (community health)	Diploma of Nursing and Midwifery	Bachelor of Public Health	Bachelor of Nursing	Other bachelor degree	Master of Public Health	Other master degree
Prang	45	21	13		/		/	/			/	/			/	
Chai	34	13	5	/			/	/		/				Health Education		
Win	37	16	5	/			/	/		/				Health Education	/	
Chanon	48	27	27	/			/	/		/				Health Education	/	
Prera	49	28	19	/			/	/		/		/				
Thunva	41	19	4	/			/		/	/						
Rasa	49	25	18		/		/	/			/		/			
Kaew	57	36	22		/		/		/		/			Education		
Khwan	45	20	11		/		/		/	/			/			
Praw	48	29	10		/		/		/		/	/				
Yada	53	33	14		/	/		/			/	/				
Ken	46	25	25	/		/			/	/		/				
Pim	48	27	10		/	/		/			/		/			Public administration
Nawat	47	26	26	/		/			/					Science		Public administration
Por	46	27	18		/	/		/			/	/				
Sarun	49	27	27	/		/			/	/		/			/	
Ake	46	27	25	/		/			/					Education		
Total (Max-Min) [Mean]	(57-34) [46.35]	(36–13) [25.05]	(27–4) [16.41]	**9**	**8**	**7**	**10**	**9**	**8**	**8**	**7**	**7**	**3**	**6**	**4**	**2**

discuss and explore past events, including sensitive experiences or topics that might not be accessible by using structured questionnaire methods (Taylor, 2005, p. 41).

There are various methods of investigation in the interview process (DePoy & Gilson, 2003, p. 114; Minichiello et al., 2004, p. 62). A semi-structured interview uses features from both unstructured and structured methods (May, 2001, p. 123; Minichiello et al., 2004, p. 62; Richards & Morse, 2007, p. 114; Seidman, 2006, p. 15). Taylor (2005, p. 39) notes, “no research interview can be entirely devoid of structure, even if that structure is the use of a single open question to prompt thought and discussion”. Thus, qualitative research interviews may be “semi/lightly structured, loosely structured or in-depth in format and aim” (Taylor, 2005, p. 39).

The phenomenological interview “is often described as in-depth in structure, and will be the nearest to an unstructured interview” (Taylor, 2005, p. 47). Pollio et al. (1997, p. 29) state that “the goal of the any phenomenology interview is to attain a first-person description of some specified domain of experience, with the course of dialogue largely set by the respondent, and the interview begins with a few prespecified questions concerning the topic”. The researcher usually has a set of opening questions and will probe and reflect back with participants in order to allow for both “a description of the phenomenon and an exploration of its meaning to emerge” (Taylor, 2005, p. 47). May (2001, p. 123) and Yin (2003, p. 90) explain that the semi-structured interview allows participants in the study to answer more on their own terms than the structured interview, while it still provides a greater structure for comparability over the focused interview.

In this study, data collection was conducted between August 2011 and April 2012 using semi-structured interviews as the main source of data collection. The interview schedule (Appendix 5) was developed from two main sources. The first source was my own knowledge of the phenomenon and the second source was the literature review as presented in Chapter Two.

The hermeneutic researcher uses interviews to uncover meaning by “conducting face-to-face interaction that captures mantic and semantic levels of understanding” (Rapport, 2005, p.

136). The face-to-face approach helps the researcher to be able to access the non-verbal communication of the participants (Taylor, 2005, p. 46).

Every interview session in this study took place in a face-to-face setting. Before conducting each interview, I telephoned each participant to arrange an interview date, time and place that was most convenient to the participant. The interview sessions were mainly held at the participant‘s SHPH. However, five participants preferred to be interviewed after they finished the monthly meeting at the District Health Offices. Interviews lasted between 40 and 90 minutes.

Before commencing the interview session, Rapport (2005, p. 133) and Taylor (2005, p. 42) describe that it is very important to establish rapport and relationship with the participant in order to ensure an atmosphere of trust, confidence and acceptance. This will further facilitate the interview process through more open and free conversation. Taylor (2005, p. 45) suggests that ―it is often better to begin the interview with background information questions, which the participant should find easy to answer and then to progress to the more complex or sensitive questions as the interview relationship develops". Rapport (2005, p. 134) advises that trust is further encouraged through the employment of ―active listening" techniques. Besides, the role and status of the interviewer is another issue that needs to be considered because the power distance between the participant and researcher may affect and influence the participant‘s response and information (Taylor, 2005, p. 42).

At the start of each interview session in this study, I introduced myself and thanked the participant for taking part in the study. I then explained the aims of the research, the procedure for data collection and how the data would be used. To reduce possible feelings of power distance, especially because a study participant might be aware that I am a colleague, I emphasized that I would like to take the role of a ―learner" not a ―researcher" in the interview. I stressed that all of the participant‘s perceptions of his or her work experiences were of value in my learning process. After this introduction, I gave the participant a copy of the study information sheet (Appendix 7) and the consent form (Appendix 8). Participants were made aware that they had the right to participate or withdraw at any time without having to give a reason and without penalty or prejudice. I emphasized that all information or

personal details gathered in the course of the study would remain confidential. No individual would be identified by name in any publication of the results. I also asked the participant if he or she had any enquiries regarding the study. A few participants asked about some issues, such as my reasons and expectations in conducting this study. At the conclusion of this introductory conversation, the interview continued as per the interview schedule.

During the interview session, Rapport (2005, p. 134) and Taylor (2005, p. 44) explain, the researcher may use various strategies such as making encouraging noises, reflecting on remarks made by the participant and probing an idea expressed by the participant. Creswell (2009, p. 183) and Seidman (2006, p. 114) also recommend that the researcher should record information from interviews by making hand-written notes, by audiotaping, and by videotaping because this can assist the researcher in the process of data analysis (Kvale, 1996, p. 160).

During each interview session in this study, I informally talked to the participants and carefully listened to them telling their stories. I used prompting questions when the participants did not elaborate on a point or became side-tracked. Besides this, after receiving permission from the participants, note-taking and a digital voice-recorder were used in this study while conducting in-depth interviews. Participants were made aware at the start of the interview that they could ask for the digital voice-recorder to be stopped, and anything could be edited or erased at any time during the interview.

After each interview session in this study, I asked the participants if there was anything else that they would like to add or discuss regarding the research study. One participant suggested that the findings from this study should be shared with and presented to others, such as the administrative committee in each District Health Office, who may receive the benefits from it. I then told participants they would be sent a transcript of the interview with a request to read the transcript to ensure its accuracy. Participants were asked to let me know if there were parts of the transcript the participant would like to change. Each participant was also asked if I might contact them again by either telephone or email if there was an issue that needed to be clarified. All of the participants understood and agreed that I could have further

contact. At the end of the interview session, I thanked the participant again for giving up their time and for providing me with valuable information in the interview.

3.8 Data analysis technique

Data analysis in a hermeneutic phenomenological study “enables the researcher to objectify and interpret accounts in order to understand more clearly the world of the research participant” (Rapport, 2005, p. 134). Normally, the qualitative data gained from interviews are transcribed into text prior to the analysis (Denzin & Lincoln, 2000, p. 829; Liamputtong, 2010). Denzin and Lincoln (2000, p. 825) define text as “a heuristic device to identify data consisting of words and images that have become recorded without the interventions of a researcher (e.g. through an interview)”. Thematic analysis is an analysis of the content of the text or data by categorizing the recurrent issues into common themes (Green & Thorogood, 2004, p. 177). Minichiello et al. (2004, p. 633) explain that the objective of thematic analysis is “to identify themes in the data”. Green and Thorogood (2004, p. 180) also explain that thematic analysis is appropriate for descriptive research that has the aim of describing the key issue of concern to a particular group of people. Therefore, thematic analysis was utilized in this study and I did it manually.

Ritchie and Lewis (2003, pp. 217-262) describe stages involved in qualitative analysis that consist of data management, descriptive accounts, and explanatory accounts. Data management involves identifying and sorting themes from raw data. Descriptive accounts are the process of identifying key dimensions, refining categories and establishing typologies. Explanatory accounts refer to the process of developing explanations about the associations that occur in the text and the links between sets of phenomena (Ritchie & Lewis, 2003, p. 214).

Colaizzi (1978) explains stages of data analysis that consist of: reading and rereading the transcripts; extracting the significant statements with meaning established and noted for each statement; establishing and clustering themes with references back to the original description to ensure validation; describing the phenomenon from the established and clustered themes; and validating the results with the participants.

Miles and Huberman (1994, p. 10) define data analysis as –consisting of three concurrent flows of activity: data reduction, data display, and conclusion drawing/verification". Data reduction is the process of –selecting, focusing, simplifying, abstracting, and transforming the data that appear in written-up field notes or transcriptions" (Miles & Huberman, 1994, p. 11). Data display refers to –an organized, compressed assembly of information that permits conclusion drawing and action". Conclusion drawing and verification –may be as brief as a fleeting second thought crossing the analyst's mind during writing, with a short excursion back to the field notes, or it may be thorough and elaborate, with lengthy argumentation and review among colleagues to develop intersubjective consensus, or with extensive efforts to replicate a finding in another data set" (Miles & Huberman, 1994, p. 11).

In this study, data analysis was conducted during the data collection stage, and analysis of the data informed subsequent interviews. This iterative process was guided by the thematic analysis approach of Ritchie and Lewis (2003), Colaizzi (1978) and Miles and Huberman (1994). I was mindful of the diversity of approaches and adapted them where appropriate into six main stages of thematic analysis.

First, the data from a digital voice recorder was downloaded to my computer and also to an external hard-drive in order to secure the data. The data files in the computer and external hard-drive were password protected to ensure security of the data.

Second, I recorded ideas and issues arising at different stages of the interview in writing as well as into –Memo Software" on the computer. Keeping such a reflexive research journal can help me to reflect on the research process, learning from each interview, improving subsequent interviews and, thereby, assisting data gathering and analysis (Davidson, Halcomb & Ghdizadeh 2010, p. 70; Rice & Ezzy, 1999, p. 201). Taylor (2005, p. 44) points out that –the reflexive journal also provides the researcher with the opportunity to explore emergent themes from the data and to compare these themes with previous ones". Rapport (2005, p. 134) advises that the reflexive research journal should be recorded immediately after the interview is finished because –the experience is still uppermost in the interviewer's mind".

Third, as suggested by Liamputtong (2010, p. 58) and Padgett (2012, p. 158), all interviews were transcribed by myself in order to further master the information, and to gain further social and emotional content from the interview situation. As already noted, all transcripts were forwarded to relevant participants for verification and amendment if requested.

Fourth, to enhance validation of the themes, the first seven interviews were independently interpreted, coded and analyzed by myself and my two supervisors. Since all participants in this study were Thai nationals, and I am a native-speaking Thai national and all interviews were conducted in the Thai language, the first two translated transcripts were sent to an independent translator, who is an academic in a public university in Thailand and who obtained a doctoral degree in public health from a university in an English-speaking country. Then, the first seven transcripts were translated verbatim into English to enable analysis by the supervisors. Results of the preliminary coding conducted by myself and my two supervisors were compared in order to identify the common categories and themes (Padgett, 2012, p. 141).

The first seven interviews were predominantly a pilot study. When my two supervisors read the verbatim translated transcripts, they did not only validate and confirm the coding and emerging themes with me, but they also provided suggestions regarding the interview schedule and process. For instance, I and my supervisors had the agreement that the interview schedule would cover the aims of this study. My supervisors highlighted the important issues in the transcripts that should be addressed with the later participants to see if they also raised these issues. My supervisors asked me to collect some additional information in some interviews when there was an area, word or statement which needed further exploration. My supervisors also advised me against using leading questions and, instead, to encourage participants to elaborate on their stories by using prompts such as ―Can you explain that further?” or ―That‘s interesting; can you expand on that idea?”

Fifth, after I had developed skills in interpreting, coding and analyzing the data, the last ten participants‘ transcripts were analyzed in the Thai language by myself alone. I independently interpreted, coded, and analyzed the transcripts by reading and re-reading the transcripts several times while listening to the actual voices of the participants on the sound files in

order to become immersed in the data and to conceptualise the text of each passage. The aim of the re-reading in the process of analysis is to fully understand and acquire the sense of the data as a whole (Colaizzi, 1978; Carpenter, 2010, p. 133). I then extracted the significant statements from each transcript and then inductively identified the important issues as codes, classified codes into common categories, identified the common categories into nine sub-themes and four main themes and described them in the synthesised data (see Chapters Four and Five) (Colaizzi, 1978; Lincoln & Guba, 1985, p. 203; Richards & Morse, 2007, p. 143; Ritchie & Lewis, 2003). This process is called ―data reduction", as explained by Miles and Huberman (1994, p. 10). The extracted statements, codes, sub-themes and main themes were organised into tables in Microsoft Excel Programme because this helped me in organizing, clarifying and detecting the relevance and consistency of the data. This process is consistent with what Miles and Huberman (1994, p. 11) define as ―data display". Verbatim quotations were presented in the description of synthesized data in order to ensure validation and increase the trustworthiness of the data (Colaizzi, 1978; Carpenter, 2010, p. 134; Lincoln & Guba, 1985).

Sixth, as noted, data from the interviews were collected and analyzed in the Thai language and I then translated the final themes and the supportive quotes from participants into the English language. I then shared the final translated themes and supportive quotes with my supervisors to allow for critical comments. After gaining feedback and verification from my supervisors, I finally developed an overall explanation of the final themes framed by the phenomena of the results of the study (Miles & Huberman, 1994, p. 11). Throughout the data collection and data analysis processes, I consulted, triangulated and verified the synthesized data with my supervisors in order to establish agreement with the research process and to seek suggestions from them (Miles & Huberman, 1994, pp. 266-267). My supervisors could be considered as ―peer reviewers"; they were asked ―to review the data (transcripts and field notes) or emerging findings at different stages of the analytical process in order to validate or question the analytic linkages being made between the data, categories and emerging themes" and thus enhance the rigour of the study (Carpenter, 2010, pp. 134-135).

3.9 Rigour and trustworthiness of the study

Both qualitative and quantitative approaches have criteria that can be used to evaluate the rigour of the research (Liamputtong, 2010, p. 16; Lincoln & Guba, 1985, pp. 290, 301). In quantitative research, the positivist paradigm, the concepts of internal validity, external validity, reliability and objectivity are used to determine the rigour of the research findings (Avis, 2005, p. 13; Lincoln & Guba, 1985, p. 290). It is not possible to test qualitative data against the same criteria because the reality in qualitative research is socially constructed by the individual and cannot be measured (Avis, 2005, p. 13; Liamputtong, 2010, p. 17). Therefore, traditional positivist criteria are replaced by such terms as trustworthiness and authenticity (Denzin & Lincoln, 2000, p. 158). Lincoln and Guba (1985, p. 301) have developed a set of trustworthiness criteria associated with quantitative research. The criteria consist of 1) credibility which equates to internal validity, 2) transferability which equates to external validity, 3) dependability which equates to reliability, and 4) confirmability which relates to objectivity (Denzin & Lincoln, 2008, p. 33; Liamputtong, 2010, p. 18; Lincoln & Guba, 1985, p. 301).

Credibility relates to the question, ―Can these findings be regarded as truthful?" or ―How believable are the findings?" (Liamputtong, 2010, p. 18). A variety of strategies can be applied in order to produce the credibility of interpretation and findings, such as persistent observation (Lincoln & Guba, 1985, p. 301), peer debriefing (Lincoln & Guba, 1985, p. 301), prolonged engagement (Padgett, 2012, p. 35) and triangulation (Liamputtong, 2010, p. 18; Liamputtong & Ezzy, 2005, p. 41; Lincoln & Guba, 1985, p. 301). In this study, credibility was addressed by prolonged engagement during the data collection process. As mentioned in the process of participants‘ recruitment, the advertisement for the research project was carried out among the administrative committees in a monthly meeting of every District Health Office in Phitsanulok Province. Thus, I had an opportunity to introduce myself to the PHC managers. After the interested participants volunteered to participate in the study, I contacted each participant to build a rapport and discuss any concerns regarding the study. During the interview session, I introduced myself again, provided more information about the study and talked informally to the participant. All of these activities were aimed to develop trust with the participants. Another activity performed to increase the credibility of this study

was through the triangulation activities conducted following an interview session. The transcripts were sent back to the participants in order to verify the accuracy of the gained information with the participants. Independent analyses by myself and my two supervisors were conducted to compare the data in the thematic analysis.

Transferability attempts to establish the generalizability of inquiry (Liamputtong, 2010, p. 18; Lincoln & Guba, 1985, p. 297). As described in the sample framework section, a purposive sampling strategy was utilized to select Phitsanulok Province as a case study and the participants for this qualitative study. From the positivist point of view, this technique limits the generalizability of its findings (Liamputtong, 2010, p. 19). However, since qualitative research is concerned with in-depth understanding of participants‘ experiences, it relies heavily on individuals who are able to provide information-rich accounts of their experiences (Liamputtong, 2010, p. 20). Thus, transferability of this study would be addressed by utilizing the diverse purposive sampling technique to ensure a wide range of participants from different sites. Phitsanulok Province has been selected due to the ability to sample a diverse range of settings relevant to the PHC sites (urban, rural and remote areas), thus increasing the study‘s capacity for generalizing its findings to other PHC sites in Thailand. Nevertheless, subsequent studies should be carried out to validate the generalizability of findings.

Dependability is gained through an auditing process to ensure that ―the process of research is logical, traceable and clearly documented" (Liamputtong, 2010, p. 18). As the phenomenologist analyzes and interprets the meaning from quotes and statements in the transcripts (Padgett, 2012, p. 35), the direct quotes from participants in this study were presented in the results chapters (Chapters Four and Five) for other readers and researchers. Thus, this activity will allow other readers and researchers to assess and inspect the adequacy of results interpreted by the student researcher (Liamputtong & Ezzy, 2005, p. 39).

3.10 Methodological issues and limitations

Four methodological issues and limitations of this study are considered and presented in this section. These include 1) the issue of generalization, 2) the representation of stakeholders, 3) the language barrier and 4) the role of the researcher.

First, in terms of generalizability, although the case study research approach was the most appropriate design for this research, several limitations exist. Phitsanulok Province is only one out of 76 provinces in Thailand. Thus, the results of this study, which was conducted in the lower northern region of Thailand, may not in fact represent the perceptions and experiences of PHC managers in implementing the SHPH policy in other regions of Thailand. Also, the sample size in this study was purposive rather than randomized. The objective of the purposive sampling technique in qualitative research is not to be able to generalize the results of the study, but rather to obtain rich experiences from a diversity of participants (Liamputtong & Ezzy, 2005, p. 44). Nevertheless, every possible effort was made to ensure variety in the sample to increase the potential diversity and richness of the data collected. In summary, the limitations of generalizability of this study were caused by the case study research design, the diverse purposive sampling strategy and the small sample size of participants. However, it is important to note that this research was not designed to predict or make inferences from the study results.

The second issue was the narrow range of perceptions captured in this study. The main purpose of this study was to deliberately narrate the actual lived experiences of PHC managers regarding their leadership roles, management functions and challenges in implementing the 2009 SHPH policy in Phitsanulok Province, Thailand. The participants were the PHC managers working at SHPHs in Phitsanulok Province, Thailand. Other stakeholders, who were involved in implementing the policy, were not part of this study, including people such as the Community Hospital Director, the Chief of the District Health Office, the Chief of the Local Government Organization, the Chief of the Municipality, other health professionals working at a SHPH, village headmen, VHVs and clients. Thus, the results of this study represent only the perceptions and experiences of the PHC managers in leading and managing during the implementation of the SHPH policy.

A third methodological issue was the language issue in the data collection and analysis process. Data collection was conducted in the Thai language. Thus, the translation process might affect the content or meaning of data obtained from participants. With regard to language issues, the first two translated transcripts were sent to an independent translator, who is an academic in a public university in Thailand and who obtained a doctoral degree in public health from a university in an English-speaking country. As noted, the first seven interviews were translated verbatim into English to enable supervisors to independently code data to check for the trustworthiness and rigour of my analysis. I used this iterative process to triangulate themes and sub-themes with my supervisors. The next ten interviews were analyzed in the Thai language by myself in order to gain as much meaning and sense from the data conveyed from the participants‘ experiences. However, I translated independently and presented phrases which showed new meanings that might indicate the emergence of a new theme or sub-theme to my supervisors. Then, the final results of the data analysis of the seventeen interviews were translated from Thai into English by myself.

The final methodological issue and limitation of the research was that, as I has worked in the Faculty of Public Health in a public university in Thailand and has had experiences in working as a public health officer at the SHPH, my background might lead to bias in interpreting and analyzing the data. However, my experiences and pre-understanding with regard to this study were disclosed at the outset in order to reduce the likelihood of distortion. Also, it should be noted that this study employs a hermeneutical phenomenological approach, and my experience and knowledge, therefore, are important to guide the interpretation in understanding the phenomenon. I could thus gain insights into the discourse and feelings of the participants. (Barnacle, 2001, p. 18; Carpenter, 2010, p. 126; Minichiello et al., 2004, pp. 632-633).

3.11 Ethical considerations

The concept of informed consent is important to the informants‘ participation in the research (Kvale, 1996, pp. 153-154; Liamputtong, 2013, p. 39; Minichiello et al., 2004, p. 205; Padgett, 2012, p. 83). This research study was conducted according to the Guidelines for Human Research at the University of New England. I received approval for all components

of the research study from the UNE Human Research Ethics Committee (Appendix 6). All the participants were given an information sheet (Appendix 7) outlining the objectives and process of this study, and telling them they could withdraw from the study without penalty at any time during the process. All participants signed a consent form (Appendix 8) to indicate their willingness to participate in this study. Additionally, although the interview questions of this study were not considered as a significant risk to the participants, participants were advised of the availability and contact details of counselling services at local health facilities in case they felt distressed.

All participants were assured of the confidentiality of the information they provided (Kvale, 1996, p. 154). As suggested by Udinsky et al. (1981, p. 14), the protection (bodily, personal, intellectual, moral, spiritual) of human subjects involved in the research process should be the principal consideration. The interviews were conducted privately and a digital voice-recorder was used with permission from participants. The content gained from participants was transcribed by myself only.

The electronic transcript files and voice files were kept on my personal computer with secure password access. The transcripts were stored securely in cupboards at my office. In addition, the electronic voice files and transcripts files were securely stored separately in order to ensure that the participants' records were not accessed and the participants identified. Only I had access to the data. The transcriptions and other data will be kept in the same manner for five (5) years following thesis submission and then destroyed. I will send all the data collected to my principal supervisor for eventual data disposal once the thesis has been completely submitted.

Madaus et al. (1983, p. 158) point out that participants should not be identified because this can affect the social standing and careers of participants. The names of subjects should be kept confidential at all times (Udinsky et al., 1981, p. 14). The professional code for conducting the analysis process should be utilized to create and maintain anonymity and confidentiality of participants (Kumar, 2005, p. 302; Minichiello et al., 2004, p. 208). Therefore, each participant's fictitious name was used to de-identify the participant in the

transcripts. Further, the names of organizations (SHPHs) were blinded in the transcription process in order to protect against invasion of the privacy of the participants.

3.12 Conclusion

The justification for the theoretical perspective and the research methodology were initially presented in this chapter in order to demonstrate how the research design is appropriate to the aims of the study. This chapter then addressed the research methods, including the study setting and population profile, sample size and sample framework, recruitment of participants, participants profile, data collection procedure and data analysis technique. The rigour and trustworthiness of the study and methodological issues and limitations were also identified and, finally, ethical considerations were discussed. The following chapters present the results of the study. The first two main themes are presented in Chapter Four and the last two main themes are presented in Chapter Five.

Chapter Four: Results – Constant Change and Addressing Challenges from Policy Implementation

4.1 Introduction

The results of this study are divided into four main themes presented in Chapters Four and Five. Chapter Four comprises of the Theme 1 and 2 while Themes 3 and 4 are presented in Chapter Five. The results of each theme are described with supportive data to illustrate the shared experiences and perceptions of the participants.

In summary, the themes and sub-themes, emerging from the data analysis are:

Theme 1: Constant change from the policy implementation and its consequences
- Effects of change at the individual level
- Effects of change at the organizational level
- Effects of change at the community level

Theme 2: Passion and altruism, and being self-directed
- Passion and altruism
- Being self-directed

Theme 3: Teamwork in the organization
- Trustworthiness and understanding in the team
- Teamwork strategies

Theme 4: Networking in the community
- Building trustworthiness and understanding with stakeholders
- Networking and teamwork with stakeholders

Theme 1 discusses the challenges faced by participants resulting from the constant changes caused by the implementation of SHPH policy. Change affects PHC managers at three levels: the individual level, the organizational level, and the community level. Theme 2 identifies the values of the PHC managers in Thailand, including: passion for holding the PHC manager‘s position, altruism with respect to other people‘s happiness and benefits, intention to be the

leader, and desire to progress along their career path. This chapter concludes with a discussion of the major findings.

4.2 Theme 1: Constant change from the policy implementation and its consequences

Theme 1 discusses the perceptions of participants about the implementation of the SHPH policy. The participants explained that the implementation of this policy involved constant change, which affected them at three levels: influencing their perceptions, competencies and roles; challenging the organization's human resources and financial management; and impacting on the expectations and understanding of the clients living in the communities for which the participants were responsible. Each effect makes up a sub-theme in this study. Thus, this collective perception of the participants is recognized in these sub-themes:

Effects of change at the individual level
Effects of change at the organizational level
Effects of change at the community level

4.2.1 Effects of change at the individual level

This sub-theme describes three issues raised by the participants regarding the individual level consequences of implementing the SHPH policy. First, the participants had various perceptions towards the change constantly occurring in the healthcare system and organization. Second, they emphasized the need for lifelong learning to improve their competencies in order to successfully work in the PHC manager's position. Third, it was necessary for the participants to perform multiple-roles in SHPHs.

4.2.1.1 Consequences of change

In the healthcare system, change is constant, as described by one participant: *"change happens all the time"* (Win). Prang corroborated this view:

> *It's quite difficult to tell you. It depends on the situation because a thing changes and is changed every day. Everything is changing, such as politics,*

> *society, life-style of people. All of these issues are related to each other. Thus, I have to manage myself and to accept everything. Then, I can be a good manager* (Prang).

This participant further explained that change could affect the way that she worked in the SHPH:

> *Sometimes we have already set a plan but we need to change or adjust that plan to suit the circumstances* (Prang).

The view of Prang regarding constant change was consistent with that of another participant, Chanon:

> *However, my routine work might be changed because some days I probably get a phone call from the District Health Office. Then, I might need to work outside. It is not certain* (Chanon).
>
> *Although it is routine work, it is not fixed with a schedule and it cannot be planned with 1 2 3 steps* (Chanon).

When there is a change, it usually accompanied by new criteria or responsibilities. Thus, the PHC managers have to adjust to this new change, as Prera explained:

> *In terms of management, it changes all the time. For example, the law is changed and that affects changes in rules and regulations used in our organization. In addition, we need to do a lot of reports and documents regarding our work. Therefore, we need to adjust ourselves to the new changes in our work system* (Prera).

Regarding this study, Chai stated that the change included the implementation of the SHPH policy: ―*However, the health policy was changed several times…err…since the thirty-baht scheme policy…until…this policy [SHPH policy]"* (Chai).

Politics seems to be the most powerful factor influencing changes in health policy, as stated by Chanon and Sarun:

> *This is only based on my opinion. When I know the objectives of this policy, I think that there is no difference from the past. I also think that this policy has*

been launched in order to discontinue the Health Decentralization Policy (Chanon).

It's a must that we needed to accept the SHPH policy because, I think, this policy was the result of politics. I think this policy was politically forced from the higher level and this policy pushed us to do such and such (Sarun).

In the following comments, the political issue was also emphasized by Chai and Prera respectively:

I thought that this change was related to politics. If the former government did not do anything, it seemed like they had done no work (Chai)

Political issues and a new government can also affect the reform of the healthcare system (Prera).

Even though the health policy in Thailand was reformed several times, Rasa noted that there is nothing new regarding the SHPH policy:

I think it is the same. The name only was changed. I think no matter how many times it changes, it will still be the same (Rasa).

Chanon and Rasa explained that the criteria or KPIs are still the same as the previous policy:

Everything is still the same. We still need to use the 48 criteria/KPIs of a Primary Care Unit. Therefore, it is not different from the previous context (Chanon).

The standard criteria are not different from the PCU criteria. However, we still need to pass such criteria (Rasa).

Infrastructure and human resources were also still the same, as explained by Por and Ake:

However, the infrastructure and the number of staff are still the same. Thus, I wondered whether it is possible to implement the policy or not (Por).

I feel nothing about the SHPH because we still have to do the same thing. Just the name was altered while the number of staff is still the same (Ake).

Chai had a different perception regarding the SHPH policy. He preferred the status quo and resisted the change:

> *When I had no information regarding this policy, I thought that PCU was already good enough. Why do we need to change the name? Why do we need to do the new name sign?* (Chai).

Initially, Praw was pessimistic about the SHPH policy, but she changed her opinion of the SHPH policy:

> *When I first heard about the SHPH policy, I had quite a negative feeling because I thought it was difficult to implement this policy. Firstly, I had the question 'how can we find more staff?' As determined in the policy there should be four to seven staff in the single model of the SHPH. Thus, I was just wondering how we could find new staff. That's why I had a negative feeling towards this policy. I thought it was quite impossible to implement this policy. However, at present, I think that the SHPH policy is OK because there is one new staff in my SHPH. We can provide the dental care to people because this new staff member is the assistant dentist. The SHPH policy also enhances us to actively working in the community because one of the criteria in the SHPH policy mentions about home visiting* (Praw).

The above perception was consistent with that of Yada:

> *Oh! Yes. When I first heard about the SHPH policy, I thought why it needed to be changed because everything was still the same. This was my first glance at this policy. The detail of this policy was not clear. I thought about what were the benefits of this policy and what aspects needed to be changed? However, after this policy had been implemented, I saw the positive side of this policy because it could contribute benefits to people, particularly in terms of health promotion. I mean the implementation of this policy was clearer* (Yada).

The SHPH policy was perceived by Prera as an opportunity to develop his SHPH:

> *Um...I was delighted when I heard about this policy. I thought that if I got this opportunity, my health centre could be upgraded to be an SHPH and I would get support from the centre. I consulted with my superior and discussed the possibility of getting this opportunity. Um...I discussed with him that my health centre already had staff as determined in the criteria of the SHPH policy. I asked for this opportunity to upgrade my health centre* (Prera).

Thunva also expressed optimism about the opportunities regarding the SHPH policy:

> *The objectives of the SHPH policy are to emphasize the public sector and to upgrade PCUs. I think if we can implement this policy, the benefits will be contributed to the people* (Thunva).

The opportunity to improve the health informatics system was one example of a development resulting from the SHPH policy, as Por explained:

> *I think the change also involves the documentation and reporting. According to the development of technology, the clients' information has to be correctly recorded in the computer and sent to the central level via the internet system. After the central level receives the clients' information and checks that everything is correct, the budget will be sent back to the SHPH* (Por).

Even though Thunva and Por believed that the SHPH policy provided good opportunities for development of health services, they nevertheless noted concerns with the implementation of the SHPH policy:

> *The SHPH policy is good, but the implementation of such policy is another matter that we need to be concerned with. Thailand always has a problem in implementing a policy because that policy is not continuously evaluated by the results of the implementation. After the policy was launched, it was finished, because there was no further process. This time, it was the transition period of the current government because the current government was going to be changed. Hence, no one mentioned this policy* (Thunva).
>
> *According to the development of technology, I think it contributed to the good side because the quality of the clients' database was improved. However, there are insufficient staff in my SHPH to record all the details of the clients' information. I thus have to employ new staff to be responsible for the client database* (Por).

4.2.1.2 Lifelong learning

Becoming the PHC manager, Win pointed out that he needed to have the competencies to perform every function in the SHPH as compared with when he worked as the subordinate:

> *The PHC manager needs to manage everything. If the organization fails, the PHC manager will be evaluated as a failure too. Thus, I need to know everything. Comparing with when I was the community health officer*

> *(subordinate), I could only know my responsibility's jobs. But when I became the PHC manager, it was necessary for me to broaden my work perspective. For example, some responsibilities of the nurse are NCD (Non-Communicable Diseases) and MC (Maternal and Childcare). If you ask me can I work on these nurse's tasks, I would say that I can. But, my expertise/skill/knowledge might not be equal to the nurse's. Instead, I need to know the entire structure, target criteria, and process 1 2 3* (Win).

Another participant, Chai, agreed: *―I attempt to know everything. I need to know not only the positive information but also the negative information"* (Chai). This view was consistent with the view of Por. She explained that she had to know more about the entire range of tasks and responsibilities in the healthcare organization:

> *I think the PHC managers have to broadly know everything and every task in the SHPH. The PHC managers have to be able to analyze the plan and have to know how to achieve the organizational objectives. However, it is not necessary for the PHC managers to conduct everything and every task by themselves* (Por).

Rasa, therefore, emphasized that she had to continually develop herself in order to broaden her knowledge and skills:

> *I needed to know everything when I became the PHC manager. I need to know about the policy, its standard criteria. I need to know the process and method of policy evaluation. How can I pass those standard criteria? Information technology is also necessary for me. Besides, I need to know where the budget resource is. Thus, I need to broaden my knowledge all the time* (Rasa).

The perceived need to have such broad knowledge, skills and information is brought about by the evaluation criteria imposed by the SHPH policy:

> *Um…According to the SHPH policy, I need to adjust myself to the new roles of the SHPH. Also, I need to study in more detail about the criteria and standards of the SHPH in order to control the quality of services. From 'health centre' to 'primary care unit' and to SHPH, the criteria were changed and more details were added. We need to evaluate our SHPH by ourselves (self-evaluation). Thus, we need to know the details of each criterion in order to achieve the standard of the SHPH* (Prera).

Chanon stated that ―*we need to know and understand the objectives of the policy. We even need to deeply know about how we can formulate policy. If we all know that detail, it will be easy for planning”* (Chanon). As well, Khwan pointed out that rules and regulations were another important issue for her to be able to work effectively as a PHC manager:

> *There are many things I need to know, such as academic knowledge and rules and regulations. I think rules and regulations are important for the PHC managers. The PHC manager needs to know about rules and regulations more than their subordinates do* (Khwan).

In order to spend the budget of the SHPH, Chanon argued that the PHC managers needed to know its rules and regulations:

> *The budget comes from various resources, such as the National Health Security Office. It is quite hard to understand the rules and regulations in expending such a budget. You need to study the rules and regulations when you need to purchase any inventories or when you need to employ a worker. If you do not understand all of this information, you might have a problem* (Chanon).

The managers had to make the effort to find out the relevant information in the view of another participant, Thunva: ―*No one can know all of the rules and regulations. However, we can learn and search for such information by ourselves”* (Thunva). This was consistent with the view of Prera: *“I need to search for more information regarding the rules and regulations”* (Prera).

As information technology has an important role in SHPHs, Chanon stated that:

> *All of the information in the organization is kept in the database of the computer. In my opinion, another imperative skill is about information technology involved with both software and hardware. Or we even need to know how to fix the computers. Some SHPHs do not have the staff who know about these techniques or skills* (Chanon).

This view was reinforced by Prera:

> *Organizational development is my desire. I mean that I would like to adjust myself regarding the changes happening all the time, such as technology. As*

all of the reports are mostly processed by technology, I think it is necessary to know such knowledge (Prera).

Ken emphasized that it was necessary to improve the information technology in his SHPH:

The internet system in my SHPH has to be constantly improved because we have to use the internet every day. As I had a chance to see the internet system at the contracting hospital which is very good, do you know I just installed and reset all of the internet system in my SHPH? After the internet system was improved, I then used the password with all the computers in order to increase the security. As I said, I got the idea of the internet system from others (Ken).

This participant also revealed that paper-based reports were being less utilized in the SHPH. It was, therefore, necessary for PHC managers to improve their overall knowledge and skills regarding information technology, Ken believed:

At the present time, our work is based on technology. The reports of our work are rarely made in paper form. We currently send all our reports via the internet, while, in the past, we did it in paper form. However, we still need to print out the reports in a paper form in case the computer has broken down. Besides, we can work everywhere. We can work at home and send the report from our home. As the technology has been developed, everyone should be able to use the programs on a computer. However, as I'm getting old, I have less skill with technology (Ken).

Chanon noted that PHC managers also needed to have skills in conducting research:

Research is also important. Even though I have already graduated with a Master's degree, I still feel worried about conducting research. The Provincial Health Office tries to encourage us to conduct research in the community. Besides, I think that evaluation and research are related to each other. We can evaluate our work by conducting research. Then, in my opinion, our work will be better developed and progress to a higher step (Chanon).

Pim explained that she had developed her communication skills since she became a PHC manager:

I was very reticent and shy in the past, but I needed to be talkative when I became the PHC manager. My colleague told me that I had to practise speaking. Then, my knowledge and skill could be improved (Pim).

As a final comment, Chanon emphasized that he had to be responsible for financial management tasks even though he had not studied them previously:

> *Financial management is also important because we did not learn about financial management. However, we need to use it a lot. Hence, we need to do it correctly and completely. We cannot avoid it* (Chanon).

4.2.1.3 Multiple-roles

It is important for the PHC managers to be able to perform a subordinate‘s role. This view was raised by Rasa in the following words:

> *The challenge of being the PHC manager here is that I need to simultaneously perform both subordinate and manager roles. I feel so tested by hard work, but I think if I can do it I will feel so proud* (Rasa).

The view of Rasa was supported by another participant, Chai, who believed that PHC managers should assist their subordinates in order to get better results in organizational performance:

> *I think that if I do it and it gets the best result, I better do it. Actually, a head should have more responsibility than a subordinate. I think my subordinates are all so tired. Thus, if I can help them, I will do so* (Chai).

Win pointed out that the presence of new young staff in the healthcare organization was one of the factors motivating him to perform the subordinates‘ roles:

> *These two staff members just came to work here. Thus, my challenge is that I need to take the responsibilities of both the manager's position and the subordinate's position* (Win).

The role of curative care provider was another function that PHC managers needed to be familiar with. This view was presented by Chanon:

> *When we mention about skills, there are many issues that the PHC manager needs to know about. As I told you, the responsibilities in the organization are not clearly divided. The PHC managers not only have the responsibility for*

> *management tasks, but I also need to provide clients health services with quality* (Chanon).

Even though there was a registered nurse working in the SHPH, Kaew still had to perform the role of curative care provider:

> *Um ... (Laughing) the main responsibility of the PHC managers is that we have to attend a meeting. There are two meetings, the first and last weeks in each month. I also have other responsibilities at the SHPH. For instance, I have to provide clients with curative care twice a week. In my SHPH, everyone needs to help the nurse providing curative care. However, the nurse still has to be the main person having the responsibility for curative care. The nurse has the main curative work such as client treatment, ANC, and pap smears* (Kaew).

However, the above view of Kaew was different from that of Ken:

> *There are currently four nurses working at my SHPH because I just got a new nurse. Thus, I do not have the responsibility for curative care anymore. As the SHPHs have three main functions including management, health services and academic tasks, I think that I should be responsible only for management tasks such as human resources and financial management* (Ken).

Rasa emphasized that it was necessary for her to provide the curative care as she had a nursing qualification:

> *There are health services regarding curative care. Thus, it's important to have someone who can treat the clients with chronic diseases, such as diabetes mellitus or hypertension. As I have a nursing background, I have to play a nursing role while I also have the responsibility for management. Sometimes, I think that it's quite difficult to let my subordinates who have less nursing skill treat the clients. Therefore, when there is a meeting with other stakeholder organizations, I usually assign my senior subordinate to attend that meeting instead of me* (Rasa).

Prang noted that there are, at present, insufficient staff in the SHPHs and, therefore, agreed that management roles need to be linked to the curative provider role:

> *[Yes I do.] Curative care, health promotion, and health prevention are all important. But our main responsibility is management and policy formulation.*

> *However, as there are not enough staff, I need to help others on the clinic day* (Prang).

The increasing number of clients was one of the factors that led PHC managers to help their subordinates to provide curative care, as Praw and Pim indicated:

> *Um…I'm not only focused on my management responsibilities, but I also need to help my subordinates. For example, when there are numerous clients at the SHPH, I need to help my subordinate (nurse) in providing curative care for those clients. I do not leave my subordinate (nurse) to work alone. She might feel stressed as she has a lot of work. I think we need to help each other* (Praw).

> *I need to observe my subordinates. Also, when I am available, I usually help my subordinates. For example, as I am also the nurse, I help my subordinates to provide curative care. Particularly, if there is an urgent case, I will suddenly stop my own work and help my subordinates. However, if I am not available, my subordinates have to do it by themselves* (Pim).

Ken explained that receiving more wages is a reason that encourages him to perform the curative role:

> *In order to get the overtime payment, I had to be able to provide the curative care for clients in the evening or at weekends* (Ken).

Chanon pointed out that there are negative consequences if PHC managers do not help their subordinates:

> *As I did not provide the curative care to the clients, it seems to them like I did not work. It seemed like I was taking advantage of my colleagues who had to work within the SHPH in order to provide curative care services to clients. Therefore, there was a conflict in my organization. When the clients came to utilize health services at the SHPH, they always met only my colleagues. They did not see me because I was working outside the health centre. It was difficult to tell everyone that I had the responsibility for administrative tasks and needed to work outside the health centre. Thus, the clients claimed that I did not work* (Chanon).

Summary

The analysis for this sub-theme indicates that the implementation of the SHPH policy has significant consequences for PHC managers at a personal level. Study participants perceived

the healthcare system in terms of constant change and one of the main reasons for change was pressure from the context of Thai politics. They had various perspectives regarding the implementation of the SHPH policy. One group of participants believed that the differences between previous policies and the SHPH policy were superficial. A second group of participants resisted changes. A third group believed that the change brought about by the SHPH policy afforded them a positive opportunity to develop their healthcare organization.

Findings in this sub-theme further showed that study participants were directly affected by the SHPH policy because they were responsible for implementing it. As a consequence, they needed to broaden their knowledge base and their competencies to enable them to work effectively in the complex healthcare organization.

Finally, this sub-theme revealed that study participants needed to take on multiple-roles, including that of manager, subordinate and curative care provider roles, because of the shortage of staff and the increasing number of clients, and to secure extra payment for certain aspects of their work.

4.2.2 Effects of change at the organizational level

This sub-theme identifies the two challenges occurring at the organizational level in study participants' SHPHs. Human resources shortage was raised by the participants as the first vital issue that needed to be managed by PHC managers. The second issue was the challenge they faced in effectively managing the budgets of their SHPHs.

4.2.2.1 Challenge of human resources management

Resources management was raised as an important issue by one participant, Thunva, who commented: *"In Thailand, resources are a significant problem. Resources refer to both people and the budget. Therefore, these resources need to be accurately managed. Otherwise, a problem might occur"* (Thunva).

According to Prera, a human resources shortage was a critical issue that needed to be managed by the PHC managers:

> *My responsibility is mainly management tasks. Also, I need to get involved with the services improvement. If there is a problem, such as if there are not enough health providers, or the services system is quite slow, I need to solve such problems* (Prera).

Prera also commented on the human resources shortage: *―I think human resources are the weak point of this policy"* (Prera). Another participant, Prang, argued that *―[e]ven though our organization has become an SHPH, the number of staff is still the same. I have no new staff. Actually, there should be eight staff, but there are only four staff currently"* (Prang). The opinion of Prang was similar to that of Win: *―Our staff are still the same. We haven't changed. It was not as I expected because our staff are still the same"* (Win).

Both Rasa and Khwan argued that the tasks and responsibilities in their SHPHs had increased but the number of staff in their SHPHs remained the same:

> *According to the SHPH policy, our work increased in relation to the standard criteria. However, the number of staff is still the same. Therefore, I think that human resources are the drawback of this policy. As determined in the policy, we need to actively work in the community, the number of staff should be appropriate, and such staff member must be qualified* (Rasa).
>
> *The number of staff is the same. There is no new staff, but there are new tasks. It seems like we have more responsibilities. The evaluation criteria are also quite the same, but there is support regarding medical instruments* (Khwan).

In the following comments, Win and Rasa explain the ideal ratio between health professionals and clients:

> *It would be better if the ratio between the staff positions and the population they are responsible for was appropriate and possible. For example, the ratio between the community practitioner nurse and the responsible population must be 1:5,000. Besides, it is 1:10,000 for a doctor and the responsible population. However, we have no doctor working at the SHPH in the real situation* (Win).

> *The ratio between nurse and clients must be 1 per 5,000. In my SHPH, there are around 7,000 clients in my responsible area, but there is only one nurse. Actually, there should be two nurses according to the standard criteria* (Rasa).

Rasa identified a probable cause of the human resources shortage:

> *From my point of view, I think that the central authority does not know about this problem of human resources. They do not even know that nurses still have to perform management roles. I think that this policy was suddenly announced without consideration for the human resources issue. The number of staff should be relevant to the increasing tasks* (Rasa).

The view of Rasa was supported by Nawat:

> *When I attended the conference arranged by the authorities in the Ministry, they were only talking about the issues of work and responsibility. However, they did not emphasize the human resources issue. They told me that if the number of staff in my SHPH had still not reached the criterion, which was seven staff, I should employ new staff. That was all they suggested to me* (Nawat).

Win proposed that the reason for the human resources shortage might be the location of an SHPH, particularly in rural areas:

> *In this district, there are new junior staff coming to work here, but this district is considered as a rural area. Thus, the new staff always come to work here for a while and then move on to work in another SHPH in urban area* (Win).

In order to resolve the human resources shortage, Nawat suggested that the budget allocation should be increased so that new staff can be employed:

> *The work increased but the staff was the same. Actually, there should have been more money. Then, we can employ the new staff. I think the higher level should only determine the number of staff, such as 10 staff or seven staff, and they only provide us with the budget. Then, we can manage that budget by ourselves. For example, we can use that budget for employing new staff* (Nawat).

Prera argued that there was another possible solution to dealing with the shortage of staff; that is, staff from the district hospital could be rotated to work at his SHPH for a few days each week. However, he considered that this solution might cause a problem for health services provided at the district hospital because there are not enough doctors working there:

> *If we talk about the weakness of this policy, I think we still have the same human resources. Also, we have more responsibilities. Even though we have a network with the district hospital and some staff from the district hospital can come to help us work at the SHPH, it is still not enough and has a problem. For example, if the doctor from the district hospital is sent to work with us in order to take care of the clients with chronic diseases, there are not enough doctors providing the health services at the district hospital. You see what I mean?* (Prera).

When the doctors from the district hospitals could not come to work at the SHPH, Prang had to find another solution, as she explained in the following words:

> *They expect that there should be a doctor working at the SHPH every day. Actually, there is a doctor working at my SHPH only one day a week. However, I tell people that even though there is no doctor, people can come to utilize the curative services at the SHPH because there are registered nurses working at the SHPH* (Prang).

The solution of Prang was consistent with that of Yada: ―*All the nurses in my team were sent to attend the community nurse practitioner course. Then these nurses could be able to support the rotated doctor from the hospital"* (Yada).

Thunva recommended employing residents living in his responsible community to overcome the human resources shortage:

> *The workers employed in my SHPH are the villagers living in this community. I trained them because I would like them to stay working with me as long as possible. I used to train the workers living in other communities and, when these workers were able to work, they usually left to work in other organizations. Then I needed to find other workers again and again. In addition, I tried to employ the villagers as workers, because I thought they would have the ownership of their community and the community could be developed sustainably from the grassroots level* (Thunva).

Chanon suggested that employing a new staff member who had no educational background in the health field, such as financial staff or information technology staff, was important for the SHPHs. Employing these personnel would mean that the health professionals could spend more time on health-related activities such as health promotion in the community:

> *If it is possible, I think we need to increase human resources. There should be a staff member who has the specific responsibility for financial management. Besides, information technology (IT) is also essential. It is hard for me to train all staff regarding information technology. Therefore, if there is an expert in the SHPH, we will have more time to actively work in the community. We will have more time for health promotion work. We will not lose our time doing the financial and IT jobs* (Chanon).

This opinion of Chanon was consistent with that of Ken:

> *I even have the thought that there should be an IT (information technology) specialist. This specialist can look after the internet system and can also maintain the computers of every SHPH in this district. As the staff working at the SHPHs have little IT knowledge and skills, when there is a virus infecting a computer, we cannot fix it. I have only basic knowledge and skills in IT such as Facebook. However, if we have an IT specialist, it would be good* (Ken).

The opinions of Chanon and Ken had been implemented by Ake:

> *I think financial management is a huge task and I think health professionals, such as a nurse or public health officer, should not be assigned this task. I decided to employ a new accountant by using the SHPH's budget. Thus, the health professionals will not lose their time by being responsible for the financial management task. I also employed a health information person to manage the health information system of our SHPH. This staff member isn't responsible for the health information system only, but he/she can also be the assistant of our registered nurses* (Ake).

In order to attract and retain new staff, Win recommended that registering new staff as civil servants might be the appropriate strategy for the government:

> *Besides, they (the authority working at the government level) did not even produce new staff for us. They told us that the health professionals are insufficient, but did not increase the number of students, did not produce more. Actually, when there is a new staff member, such as a community health*

> *officer or public health officer, you should register these new staff as civil servants. When the staff have stability in their work, the students prefer and choose to study for the professional health degrees* (Win).

Where there are limited numbers of health professionals, Prang emphasized that support was essential for the staff having a lot of responsibilities:

> *I would like to adjust the number of staff because the staff have a lot of work. I think we should provide more support to staff because there is not enough staff in each SHPH* (Prang).

Promoting staff satisfaction was considered a compelling issue for Ken:

> *I think human resources is another important issue that the PHC managers need to manage. I know that we have to pay attention to people in the community first. However, for me, I think that I have to pay more attention to my subordinates than those people in the community. I think that if my subordinates are unsatisfied with their work, or they have less money for themselves and their family, they cannot work for others or for people in the community. Thus, I need to look after my subordinates first* (Ken).

This participant provided an example of how he attempted to support and satisfy his staff. Providing his staff with welfare was his first strategy:

> *My subordinates also receive other benefits. For instance, when my subordinates stayed at the welfare houses located in the area of the SHPH in order to look after the SHPH, they would be supported with their tap water and electricity bills. However, there was the subordinate using a lot of electricity because she/her had many air-conditioners. In order to save on the welfare budget, I therefore had to change it so that they would only get the welfare budget on their tap water bill* (Ken).

He emphasized that salary and financial support were also essential issues for him in managing his staff:

> *The next issue is about human resources. Every month, the subordinates' OT (extra overtime payment) has to be paid punctually. There are some SHPHs that have not enough budgets for spending on the subordinates' OT for three to four months. For me, I think that my subordinates' OT is important. I have to make sure for my subordinates that they all will get OT on time every month. In addition, there is some budget for developing the staff in my SHPH.*

> *If my subordinates wish to attend training or a conference, they will be partially supported for their registration fees* (Ken).

The following comment indicates another strategy utilized by this participant, Ken, in order to facilitate the efficiency of his staff:

> *In addition, every staff member in my SHPH has received their own computer. There are both the personal computer and a laptop computer. They do not need to buy it by themselves. I do not want my subordinates giving the excuse that they cannot work on their responsibilities because there are not enough computers or other kinds of support. Thus, I need to facilitate their work. You know what I mean. In my SHPH, the number of computers is larger than the number of staff. Currently, there are eight staff members while there are five personal computers and seven laptop computers in my SHPH. Hopefully, my subordinates can finish their work and send their reports via the internet on time. I try to support my subordinates to work smoothly on their responsibilities* (Ken).

4.2.2.2 Challenge of financial management

The following comments were study participants' perspectives and experiences regarding the financial circumstances of their SHPHs:

> *Yes, there is a problem. However, I still need to manage and produce my work within the given budget. Nevertheless, I think this is not a serious problem* (Prang).
>
> *The biggest challenge is about the budget because we need to manage under limited resources. Our budget is small. Although money is not the most important issue, we cannot ignore that we cannot do anything without money* (Thunva).

Under the circumstance of budget shortage, Win had to help his team to survive by finding other budget resources:

> *If our organization has a reduced amount of budget, we need to work out a budget from other resources* (Win).

Chai provided an example of the method he employed to increase the budget of the SHPH:

> *I don't think that because of more money you get more power. However, I think I still have enough budget because I can get money from other sources. For example, I will get money if I do a screening project for cervical cancer (Pap smear) for the women in the community* (Chai).

Ken increased the budget of his SHPH by opening Thai traditional medicine services in his SHPH:

> *As there are three resources of the budget, the budget in my SHPH principally comes from the first one, the clients' service charges. We annually gain about three to four million baht from the Thai traditional medicine services. This is not the net benefit. We have to deduct the other expenditures, such as the Thai practitioners' salary, tap water and electricity bills, Thai herbal medicines and other things. We will finally gain around 360,000-480,000 baht per year or around 30,000-40,000 baht a month* (Ken).

Philanthropic sources were also used to increase financial resources. The detail of this practice was presented in the following words:

> *I asked my subordinates and networks whether they would like to contribute some of their money for our SHPH or not. For me, I began with donating five-thousand baht ($170) of my own money. However, if some of my team and networks have less income, they could donate less than I did. I also attempted to ask for some donations from the clubs formed by people in the community. All of the donations were from the faithfulness and determination of people in this community. As you can see, I could build a fence around this SHPH by using money from such donations* (Praw).

Reducing the expenditure by saving on use of electrical energy was a strategy used by Thunva and Ken:

> *Um...another method is to save money by saving electrical energy. We need to turn off the lights and fans when we are not using them* (Thunva).
>
> *Even in the SHPH, I still attempt to reduce using the electricity. For example, we turn off the air-conditioning when there is no one in the air-conditioned room. We need to help each other to reduce using the electricity in the SHPH* (Ken).

After the SHPH policy had been implemented, Chai noted that financial support had been provided to his SHPH:

> *My SHPH also gets funding according to the implementation of the SHPH policy. As my SHPH has a very small budget, I can use this amount of money to renovate the building and to buy medical supplies and instruments* (Chai).

Chanon and Rasa described the benefits derived from extra financial support they received as a result of the policy implementation:

> *But if you ask me is this policy good? I think that it is good because we get a lot of support from this policy. For instance, we get a budget which can be used to develop the SHPH. We also have new medical instruments. All of this support will further contribute benefits to people in the community* (Chanon).

> *In general, I think the SHPH policy is good because we gain various advantages from this policy. Firstly, there is the budget. In the past, there were some changes, but there was no supporting budget. Thus, it's much easier when there is a budget because we can use it to renovate the infrastructure or spend it on something else. I think that this budget is important for the PHC manager and subordinates to work effectively in the community* (Rasa).

Pim pointed to the new office items she had in her SHPH:

> *My SHPH received not only the budget of around 340,000 baht. As there was not much budget at my SHPH, we could not buy a new computer. If it was broken, we had to fix it again and again. However, according to the SHPH policy, I think it's good because there was the financial support for us to buy four computers* (Pim).

Prera bought the inventory items, such as a dental unit, Doppler equipment and an air-conditioner, when the SHPH policy was implemented:

> *Yes. I received the dental unit. With the intermesh of maternal and child care, I got the echo sounder (Hand-held Foetal Doppler). Besides, there is the air-conditioner for clients in the service rooms* (Prera).

Thunva gave other examples of inventory items that he spent his budget on:

> *For instance, I bought two refrigerators, a motorcycle and an oxygen tank. I selected this stuff from the listed items because it would certainly contribute benefits to my SHPH* (Thunva).

After receiving the increased financial support, Kaew and Yada spent their SHPH budgets on improving infrastructure:

> *Um…the budget of about 200,000 baht ($7,000) was only allowed to be spent on buying medical instruments or renovating the SHPH infrastructure. Thus, I spent this amount of money to renovate the SHPH's infrastructure. I built more service rooms* (Kaew).
>
> *The budget regarding the SHPH policy was increased. There is a budget to support this policy. We can utilize this budget to renovate the SHPH and increase the competency of our health services* (Yada).

Participants Win and Khwan believed that building renovation was the obvious benefit from the SHPH policy:

> *First, I think the clients can clearly see improvement regarding the building renovation* (Win).
>
> *The infrastructure was renovated and we can also see the change. In the past, it was very old. When there was a budget regarding the SHPH policy, I spent it on the renovation of this building* (Khwan).

Painting the SHPH a new colour was an example of building renovation, as Rasa indicated:

> *In my opinion, the most significant change is the budget which could be used to develop the SHPHs. For example, I spent that budget to renovate this building by painting it a new colour. At that time, I did not know which colour was appropriate. However, my subordinates brainstormed their ideas and finally we voted for this colour* (Rasa).

Thunva commented on the importance of renovating his SHPH in the following words:

> *In these initial three years, I think the SHPH's structure should be renovated in order to increase the area used for work activities, such as a meeting room* (Thunva).

The opinion of Thunva was consistent with that of another participant, Pim:

> *Due to the increasing number of clients, we had to increase the service area. Thus, we made the plan to renovate our building. We tried to make it more*

> *beautiful. When the clients saw it, they then would like to come to our SHPH* (Pim).

Prera believed that one of the benefits of infrastructure renovation was increased staff satisfaction:

> *Um … .if we talk about how the appearance of buildings changed regarding the SHPH policy, I think it's good* (Prera).

Building renovation not only increased the satisfaction of staff working at the SHPH, it increased client satisfaction, according to Kaew and Pim:

> *When clients came to utilize the health services at the SHPH, they said that it looked more beautiful and had more space. I think that it is good for the clients too* (Kaew).
>
> *Regarding the building renovation, the clients said that it looked better. I think that they are quite satisfied with this change* (Pim).

However, Pim said that problems arose because finances promised for renovations were delayed:

> *The first problem was that the budget was not sent to us on time. For example, we had already done the task since December last year, but we just received the budget this February (*Pim).

Another significant challenge posed by the budget allocation was that it was tied to certain types of spending:

> *But my SHPH just implemented this policy in 2011. I found that there is a problem in terms of budget. It is not really a problem but it is quite difficult to manage. The budget had already been determined so that you have to utilize it in 1 2 3 4 steps. I'm not quite happy with the budget framework. It's like this amount of budget has already been marked out for spending* (Win).
>
> *The obvious support regarding the SHPH policy was the budget. Each SHPH received a budget of about $5,700 (170,000 Baht). We could spend this amount of money to buy the medical instruments or inventories by selecting from 34 listed items. Actually, I did not like to buy the new medical instruments listed from the central level because we already had those*

> *medical instruments in our SHPH. However, it was compulsory that we had to buy only the items on the list* (Sarun).

The tied budgets also caused problems for Prera who could not spend his budget on what his SHPH needed:

> *Actually, there was a budget of about one million and three hundred thousand baht [1,300,000 baht~ 43,333AU$] and you could spend this budget for renovation and inventories. However, I cannot exactly remember how much I spent on renovation and inventories. I think I spent about eight hundred and fifty thousand baht [850,000 baht ~28,333AU$] on inventories. I actually planned to buy a referral car, but it was cancelled* (Prera).

Prera's problem was similar to that of Chai, who explained that there were some inventory items, such as a bedsore prevention bed, that he wanted to buy for his patients, but for which he could not get funding:

> *Besides, there are not enough medical instruments. If there is a patient with bedsores and this patient needs to use the bedsore prevention bed, so, how can we help this patient? When we make a request to the district hospital, there is no bedsore prevention bed as well* (Chai).

Pim pointed out that the medical instruments on the item-list were of poor quality:

> *Some of the inventories or medical instruments were of inferior quality. I mean that we needed to send it for fixing after we got it and used it for a while* (Pim).

Summary

This sub-theme provides evidence that there were consequences of the implementation of the SHPH policy that had significant effects at the organizational level. Study participants believed that the SHPH policy was launched under circumstances of shortages in human resources. They identified that they believed that the problem may have arisen because of inadequate consideration by the central bureaucracy about the human resourcing issues of, particularly, the rural areas. Study participants managed this challenge by using various strategies, for instance, rotating health professionals from the healthcare network, employing a resident living in the community as a staff member of the SHPH, or employing more

support staff to work on financial and information technology tasks. Additionally, study participants attracted and retained staff in their SHPHs by providing support for them to increase their job satisfaction.

Managing a budget was another challenge for the study participants in implementing the SHPH policy. The participants needed to ensure the survival of their team and organization within an allocated budget and used a variety of strategies, such as finding other income sources and savings. They noted that the challenges existed even though additional financial support had been provided to improve the capacity to provide health services at each SHPH with the implementation of the SHPH policy. For example, participants described the delayed process of budget transfer and the difficulty in independently spending the budget regarding the needs of each SHPH.

4.2.3 Effects of change at the community level

This sub-theme discusses the consequences of SHPH policy implementation at the community level. Firstly, study participants pointed to the issue of heightened expectations of health services from clients living in their responsible community. Second, they questioned whether the emphasis of health services at the SHPHs should be on health promotion, curative care or both.

4.2.3.1 Expectations from clients

Yada pointed out that the change of name signs as part of the implementation of the SHPH policy was an issue:

> *In general, the physical appearance of the SHPHs was changed, particularly the name sign. The name sign was changed from Primary Care Unit (PCU) to Sub-district Health Promoting Hospital (SHPH)* (Yada).

Another participant, Pim, also raised this matter: *―I think the first change was the name sign”* (Pim). The signage change was noted by Sarun as well: *―As the name was changed, we needed to change the name sign”* (Sarun).

From the health professionals‘ perspective, changing the name of the healthcare organization was only change for the sake of change. This view was represented Sarun:

> *I am quite familiar with the method of changing the name. As you can see, the name of the health centre was changed several times. It was changed from Community Health Centre to Primary Care Unit and Sub-district Health Promoting Hospital. So, the name was changed but the content of the work was not really different* (Sarun).

Sarun‘s perspective was consistent with that of another participant, Chanon: ―*I think that it changed only in name*” (Chanon).

A number of participants believed that changing the name of the healthcare organization had the effect of making the healthcare organization appear more ―luxurious”, raising expectations regarding the level of care available:

> *The name ‘sub-district health promoting hospital’ sounds more luxurious* (Win).
>
> *It sounds more luxurious since its name was changed to be the Sub-district Health Promoting Hospital* (Por).
>
> *Its name was more luxurious because it was changed from the Primary Care Unit to the Sub-district Health Promoting Hospital. Thus, according to the new name, it seemed that our healthcare organization had more potential* (Sarun).

However, one participant, Prang, said that the consequence was a new problem, namely ―*the high expectations of people”* (Prang). Win identified the causes of raised patient expectations in the following comment:

> *When there is the word “hospital” in the name, the people in the community have a high expectations. They assume that there should be a physician at the SHPH and all of the equipment should be better* (Win).

The wording ―Sub-district Health Promoting Hospital” as the new name of the healthcare centre could shape the clients‘ expectations regarding health services provided at the SHPHs. As there was the word ―hospital” in the new name, clients might expect that they could

utilize health services directly from a medical practitioner equipped with advanced medical instruments:

> *I think we have to consider whether it can be the Sub-district Health Promoting Hospital or not. I am really concerned about the word 'hospital' because people might have more expectations. They might wonder whether there is a physician or not. Can they be admitted at the SHPHs? Can every disease be treated at the SHPHs? All of these were my first feelings when I heard about the SHPH policy. I had more pressure when I needed to answer people regarding those enquiries* (Nawat).
>
> *It might cause high expectations in people. As there is the word 'hospital' in the name, I think people might expect that we need to be able to do more. However, most people in this community quite understood about this change. There were only a few people asking me whether there was a physician working in this SHPH or not. They also asked me whether there is a physician working here every day* (Sarun).

Some of the clients clearly expected that the SHPH would have the same competencies and services as the community hospital (district hospital):

> *When people understood that the SHPH was the district hospital, they had the expectations that we had the same competencies as the district hospital and they did not need to go to the district hospital* (Yada).
>
> *Clients think that the SHPHs have the same potential as the community hospitals. For instance, in the past, clients usually went to the emergency room at the community hospital in case of emergency. Whereas they currently thought that they could come to utilize such health services at my SHPH because they thought we had the same potential as the community hospital. In reality, our staff are still the same* (Rasa).
>
> *People in this community had a high expectation of our SHPH. They thought that the SHPH was the community hospital. Do you know that there were some people from another district coming to utilize health services at our SHPH? They told us that they thought our SHPH was the community hospital because our SHPH was quite huge and looked like the community hospital* (Pim).

When clients had high expectations, they tended to request more services, as described in the following comment of Win:

> *Certainly! When the PCU (Primary Care Unit) was upgraded to be the SHPH, the expectations of people in the community increased because the name had been changed from PCU to SHPH. They thought that we should provide them with more services* (Win).

Prang was also pressured by the clients‘ requests according to their needs:

> *Another important challenge is that people request more services because they have more information about their rights from the mass media. For example, if there is a Dengue Haemorrhagic Fever case in the community, the people will suddenly ask me to spray chemicals to kill the mosquitoes for them. There are many requests from people and it can put pressure on our work* (Prang).

When the clients did not receive health services in line with their expectations, they attempted to find out more information about the services provided at the SPHPs:

> *The clients asked me questions about why they could not receive medicine at the SHPH and why we needed to refer them to the district hospital. Besides, as there is the word 'hospital' in the new name, they asked me why there was no in-patient ward. They thought that we could treat them for every disease and they did not need to go to the district hospital. Actually, it was not as they [clients] thought it should be* (Yada).

Some clients even complained about the problems regarding the health services provided:

> *Um…..Sometimes, I talk to the clients in the community and they raised and reflected on some problems regarding the health services at my SHPH. They mentioned about how my subordinates provide the health services for them. They tried to inform me about the problems and they complained about the delay in providing health services* (Prera).

Win had the same experience as Prera:

> *As we know, challenges can happen all the time when we work at a SHPH. There are always problems or complaints from clients* (Win).

In order to resolve the challenge of clients‘ increased expectations, Yada proposed that she needed to build understanding with her clients:

Initially, people expected that there must be patients' beds and doctors at the SHPH. However, we later had to make them understand that there was no in-patient ward at the SHPH and the emphasis of the SHPH was on health promotion. We would visit them at their home (Yada).

Pim had to provide information regarding her SHPH for her clients as well:

As people wondered whether there are in-patient beds and physicians at the SHPH or not, I thus had to inform them after I gained the information from attending the meeting at Bangkok. I informed them that our staff was still the same and there might be a physician coming to our SHPH every month (Pim).

Nawat pointed out that community leaders could assist him by distributing information about his SHPH to people in the community:

I studied the detail of the SHPH policy. Then, I informed people that the emphasis of this policy was on health promotion. We tried to prevent them from getting diseases and so reduce the number of patients. Let's say that there was around 20-30 per cent of curative care. I attempted to explain that to the community leaders such as the VHVs and village headmen. Hopefully, these community leaders would be able to distribute my messages to everyone later (Nawat).

When the clients made enquiries about the SHPHs, this same participant suggested that:

We need to find out the best way to answer the enquiries regarding their expectations. For example, with the question about 'Is there a physician at the SHPH?' I explained to them that we were in the preparation process. According to our limitations, we were trying to negotiate with the higher level. It might take a while in order to develop our SHPH and to have a physician working in our SHPH. This is one example of people's needs. They would like to have a physician who could provide them with curative care (Nawat).

As one participant, Win, argued, –*[t]he client might expect that every staff member at the SHPH should have equal competency to the community practitioner nurs*e" (Win). Therefore, another strategy to deal with the clients' higher expectations following the new designation as a SHPH was to increase staff competencies:

As the name was changed from Primary Care Unit (PCU) to Sub-district Health Promoting Hospital (SHPH), I feel that everything should be better.

When there is the word 'hospital', it affects the way we work. We need to improve ourselves in every aspect of health services. Also, the health professionals' competencies have to be increased because there are more clients, particularly clients with chronic diseases. Therefore, we need to develop ourselves (Khwan).

However, Prera pointed out another interesting issue about balancing the happiness and satisfaction of subordinates and clients:

The clients always have the expectations 1 2 3, when they come to utilize the services. If they do not get 1 2 3 as they have expected, they will feel dissatisfied. We need to develop the quality of our health services, such as that they are not dangerous and have no side effects. We need to explain to the clients our reasons and make them understand. We also need to develop my subordinates in order to have equal competency. However, those subordinates need to be developed with happiness. I need to balance the happiness and satisfaction between my subordinates and clients (Prera).

4.2.3.2 Health promotion versus curative care

The word —hospital" in the name change also affected the perception and interpretation of health professionals regarding health promotion and curative care, according to Prang:

Because….. SHPH is a new word. I thought about how this policy could be implemented. I feel that it was impossible because, when we mention the word 'hospital' there should be a doctor there. There was no doctor at my SHPH. Thus, how could my SHPH become a hospital? However, this word was clarified later so that the core concept of SHPH emphasized health promotion. Then I'm OK and had a better understanding about this policy (Prang).

The perception of Prang was similar to that of Ken who, when he first heard about the new designation of the healthcare organization, thought that the focus of the SHPH policy was on curative care. However, he rather altered his perception after he learned that this policy emphasized health promotion:

Initially, I thought would it be possible to implement the SHPH policy because people in the community understood that the SHPH should have a physician. There should also be in-patient beds at the SHPH. However, after I gained more information that the emphasis of this policy was on health promotion and diseases prevention, I knew that the SHPH was different from the general hospital. Then, I had some direction about what I should do regarding this

> *policy. Thus, we have to put emphasis on health promotion services. We have to find the method to prevent people from getting diseases. For instance, how can we prevent the children from having a lack of nutrition? How can we control the high birth-rate of teenagers? How can we increase the quality of ANC (Antenatal Care)? How can we promote the health of elderly people living in the community? All of these are our health promotion services* (Ken).

Pim emphasized the importance of health promotion:

> *As I used to work as a nurse at the general hospital, I think that the curative service provided at the general hospital is not the root cause of the population's health. Instead, the emphasis of healthcare should be on health promotion* (Pim).

Win also expressed the view that health promotion should be the main activity of the SHPH rather than curative care. He explained that the health promotion tasks were the principal focus in his responsible community:

> *As there is the word 'promoting' in the name SHPH, I thought that the emphasis of SHPH should focus on health promotion. The work should not focus on curative care. On the other hand, if the name has only the word 'hospital', the clients can walk in and get treatment. However, when there is the word 'promoting', I thought we need to work more in the community. Actually, I have already worked at promotion tasks in the community. There are the criteria that we need to visit every mother after she has already delivered a baby. Also, we need to visit every director of organizations located in the community we are responsible for* (Win).

The concept of actively working in the community explained by Win was consistent with the approach taken by Prang and that of Prera, as the following comments show:

> *First, my emphasis is on actively working in the community. I provide people with more public relations. I talk to people and provide them with the information about the SHPH policy and health needs. Overall, I increase more services in terms of actively working in the community* (Prang).

> *The emphasis of the work system currently is on actively working in the community. Actually, we have already done it. However, according to this policy, there are the explicit criteria about actively working in the community. For example, you need to have a project to change the risk behaviours of people in the community* (Prera).

Prera provided more examples of working in the community, such as providing services for clients with chronic diseases and physical therapy for clients with disabilities:

> *You work in the community. You provide services in the community such as the services for the clients with disability or chronic diseases. I provided health services which are mainly related to rehabilitation* (Prera).
>
> *Oh.....For example, physical therapy is important for this client group (clients with disability). Besides, bedsores are another problem that needs to be taken care of* (Prera).

The benefit of active engagement with the community was exemplified by the explanation of Rasa:

> *In the last two years, I went to visit a client with chronic disease. Unintentionally, I found out that the client's child was chained up because of having a mental disorder. I talked with my subordinates having the responsibility for psychiatric issues and I also tried to coordinate with the psychiatrist at the community hospital. Then, the psychiatrist went to visit the client with a mental disorder in order to provide treatment and medicines, while I and my subordinate went to that client's home in order to talk to his/her mother. After a while, my subordinate went to the fresh food market in the community and found that the client with a mental disorder had already been released from being chained up. Do you know how I felt when I knew that news? I felt so glad and proud. Therefore, I think that this work is one of the biggest challenges in my working life. I have more confidence that if I have to face another challenge, I will be able to resolve it* (Rasa).

The experience of Rasa was consistent with the opinion of Nawat in terms of actively working in the community and integrating healthcare with other networks:

> *Actually, the scope of working of the SHPHs is about active working. Active working means that we, as the healthcare providers, need to closely provide health services for people in the community. We need to visit the clients at their homes. We also need to integrate our work with the higher healthcare organizations* (Nawat).

A referral system is a key factor in the SHPH policy for integrating healthcare services, in Yada's view:

> *I think the referral system was developed regarding the implementation of the SHPH policy because the information of the referral system is clearer* (Yada).

Khwan reinforced the view of Yada in her comment that "*The referral system between the SHPHs and the community hospital needs to be improved. The clients have to be effectively referred forward to the community hospital and backward to the SHPHs"* (Khwan).

In the urban area, the local government organization has an important role in the referral system operating between the SHPH and the community hospital. This view was presented by Nawat:

> *I think it's impossible to establish the referral system in the remote area but it's possible in the urban area. In my SHPH, when we need to refer a client to the hospital, we will call the hospital in order to connect with the fast track or express channel for such a client. In addition, we can call 1669 to request the ambulance car from the local government organization for the client. Therefore, the referral system of the SHPHs has to be managed effectively in order to increase the quality and standard of care. Otherwise, a bypass problem will occur because the clients don't recognize the importance of our referral system. The clients will go directly to the higher healthcare level* (Nawat).

Yada further emphasized that information technology would be able to support the referral system in her SHPH:

> *If there is an emergency case, we can call for an emergency vehicle from the municipality any time. Or we can call number 1669 in order to use the emergency services of the district hospital. We can presently refer the clients via the internet system. For instance, we can directly report a pregnancy case from our SHPH to the district hospital. The pregnant clients only come to meet us and we can send their information via the internet system to the district hospital. In the past, such clients had to go to the district hospital for checking up their health by themselves. But now, they can come to check their blood at this SHPH and the blood sample will be picked up by the district hospital staff at our SHPH. After the blood sample has been investigated in the laboratory of the district hospital, the staff at the district hospital will send us the result via the internet system. Thus, the pregnant clients will not waste their time travelling to the district hospital. In addition, we have already installed the Skype programme in the computers of our SHPH. However, the system is still not good. We need to improve the Skype system* (Yada).

However, there are many barriers to be overcome when a PHC manager needs to actively work in the community. Chai pointed out that the constant changes brought about by the new policy could affect the time he is able to work in the community as he needs to spend time formulating a new plan because of a policy change. Instead, this valuable time could be spent on working in the community with other networks:

> *As I just mentioned, the more the government changes the policy, the less time we have for actively working in the community. We need to request support from VHVs, the head of the community, and the head of the local government organization, in order to help us work in the community. However, I still feel ashamed because I always have less time to work in the community than those people (the VHVs, the head of community, and the head of the local government organization)* (Chai

An increasing number of clients with chronic illnesses receiving treatment at the SHPH also poses a barrier to finding time to actively work in the community, according to Praw:

> *In the past, we also had to treat the clients with chronic diseases. However, according to the SHPH policy, there is an increasing number of clients with chronic diseases who used to utilize health services at the community hospital. When we need to spend much time on this group of clients, we have less time for home visiting. However, there are criteria regarding the SHPH policy that we have to visit the clients' home. Thus, as there are more responsibilities, we need to work hard in order to meet such criteria* (Praw).

Another barrier mentioned by Chai was the issue of the shortage in the number of health professionals in the SHPH:

> *I think the staff working at the SHPH has a lot of responsibility, particularly the responsibility within the organization. Thus, we have less time to actively work in the community. We have more patients, while the SHPH policy encourages us to work in the community. Can you see that it is not sensible?* (Chai).

Praw reinforced the belief that increasing numbers of clients with chronic illnesses and a shortage of health professionals were barriers to actively working in her community:

> *We need to visit the clients at their homes as determined in the SHPH policy. But I think it is difficult because we have not enough staff. We have few staff*

but a lot of responsibility. Besides, the number of clients with chronic diseases has increased because they have to get treatment at the SHPH instead of the community hospital. I think this is good for the clients because they can receive prompt treatment at our SHPH and they do not need to go a long way to the community hospital. However, we need to take more responsibility to care for these clients (Praw).

Even though the emphasis of the SHPH policy is on health promotion activities in the community, curative care is still essential for patients and it needs to be arranged and provided for at the SHPHs, in Chai's view:

Most of the plan, about 70 per cent, involves curative care. Normally, a half-day in the morning is services provided for non-communicable diseases (diabetes-mellitus and hypertension), or prenatal care. After that, a half-a-day in the afternoon is a job involved with the other organizations, such as meetings at schools and with the local government organization. Sometimes, our staff have to attend a training programme outside the SHPH. Thus, I need to plan who should work at the SHPH and who should attend such a training programme. Every day, I will set one staff member to stand by at the SHPH in order to provide the curative care for clients. I would rather say that our services are mainly focused on the reactive work [curative care responding to sick clients] at the SHPH because we have less time to work in the community (Chai).

Thunva agreed with this view and further explained that he could build trust with clients by providing them with curative care. He believed that, when clients trusted him, he could then provide them with health promotion information also:

There are four main tasks in our SHPH including health promotion, disease prevention, curative care and rehabilitation. According to the SHPH policy, health promotion and disease prevention should be emphasized. However, in actual practice, we need to primarily focus on curative care because the clients would not trust us if we could not provide them with curative care. Then, we could not educate them with further information if they did not trust us. Actually, based on the theory, health promotion and disease prevention are important, but curative care must come first in the real situation (Thunva).

Knowledge and skills regarding curative care were necessary for every staff member working at the SHPH because everyone needs to help one another in providing treatment for patients, Chai believed:

> *Yes. Miss A and Miss B have the responsibility for curative care. If it is the clinic days and there is a huge number of clients, I will help both of them to check and treat those clients. Everyone working at the SHPH has to do the curative care. Otherwise, the clients will have to wait for a long time and they might feel upset. They might complain about our services and it will have a bad result later* (Chai).

Praw commented on her need for curative care skills:

> *I would like to increase the body of knowledge regarding curative care. As every staff member needs to work overtime such as on weekends, I have to provide curative care. However, I think I still have less skill and knowledge regarding curative care when compared to my subordinates (two nurses and one public health officer). So, I would like to develop nursing skills in order to increase my competencies, such as how to insert a nasogastric tube (Nasogastric Intubation). Actually, I do not expect that I have to have nursing skills equal to my subordinates. I only would like to be able to treat clients when I need to work overtime alone. If I cannot help them, they need to go to the community hospital. Thus, I would like to improve my nursing skills* (Praw).

Summary

This sub-theme indicates that the consequences of implementing the SHPH policy have had a marked effect at the community level. Study participants explained that, as a result of the policy, clients had the expectation that they could obtain the same health services at the SHPH as provided by the community hospital (district hospital) because the name of the healthcare organization was changed from Primary Care Unit (PCU) to Sub-district Health Promoting Hospital (SHPH). Therefore, study participants needed to build understanding with those clients by providing them with information about the SHPH policy and the health services provided at the SHPHs. Additionally, all staff at SHPHs needed to increase their competencies in order to respond to clients' expectations.

This sub-theme also revealed that there was a tension between the need for the SHPH to promote healthy living and the need to provide curative care services. Study participants explained that the SHPH policy encouraged them to work in the community to spread the message of health promotion and disease prevention. Study participants indicated that there were many barriers to actively promoting healthy living and disease prevention in the

community, including changes in systems resulting from introducing new policies, the increasing number of chronic disease clients at SHPHs, the referral system which needs to be improved to enable an integrated healthcare system to work effectively, and the shortages in the number of health professionals. Some of the participants emphasized that, although the emphasis of the SHPH policy was on health promotion and disease prevention in the community, knowledge and skills regarding curative care were still essential for them to work effectively at the SHPHs. This was particularly the case for those working in rural areas, because everyone in the SHPHs needed to help each other in providing treatment for clients.

4.3 Theme 2: Passion and altruism and being self-directed

The values held by PHC managers are described in this Theme 2 section. Study participants indicated that they had a passion for the work they were doing as PHC managers. They believed that PHC managers should dedicate themselves selflessly to helping and supporting others. Additionally, they intended to be good leaders and progress in their careers. These values are developed in two sub-themes:

Passion and altruism

Being self-directed

4.3.1 Passion and altruism

This sub-theme discusses two issues raised by the study participants concerning the values motivating them as PHC managers. First is a passion for their work. They desired to become a PHC manager because they wanted to be leaders. Second is the importance of altruism in their work.

4.3.1.1 Passion

When the participants were asked why they decided to become a PHC manager, two participants, Prang and Praw, stated:

It is my passion. I like to be a leader (Prang).

Actually, I decided to become the PHC manager because I like it. I like to be in this position (Praw).

Another participant, Chanon, commented that: ―*You have to love your position"* (Chanon).

Being happy and proud when something is done with passion and love were the feelings experienced by some of the managers. This was the view of Chanon:

We need to do things that we love to do. Then, we will be happy to do it. For example, if someone likes to write, he or she should be assigned the job related to writing skills. I think that if we do anything with passion, we will finally feel proud with the success of our piece of work (Chanon).

Thunva emphasized the importance of the PHC manager's position saying:

In Thai society, I think that the development of the organization is dependent on leadership. I mean if the organization has a good leader, that organization has already achieved at least 90% of its total achievement (Thunva).

Awards might be one indicator of success in the organization, as Prang realized:

Last year, I got the Health Promotion award at the provincial level from the Provincial Health Office. Then I got the Mental Health Care award at the regional level. This award involved working with the VHVs in the community. This year, I got the Medical Room award (medical supplies management) at the provincial level (Prang).

In the following comment, Pim explained how her passion for working at the SHPH increased:

As I grew up in a rural community, working at the SHPH is much easier than working at the general hospital. When I worked at the general hospital, I needed to spend a lot of time on the patients. It was hard. However, I used to have a chance to work at the SHPH and I found that I loved to work at the SHPH located at the community level. During that time, I was taught by one staff member at the SHPH to do several tasks, such as financial and management tasks (Pim).

There were other factors influencing the decision to become a PHC manager. These factors are illustrated in the following statement by Khwan:

At the start of being the PHC manager, I was very lacking in confidence. As I used to only work as the subordinate, it was difficult for me and I had to study a lot about management. Besides, as I am a woman, I do not like the management tasks. I would be happier doing paperwork. I do not like to manage others. However, my superior manager told me that I was quite fortunate because my subordinate was OK and I also would like to advance in my working career. Thus, I had more confidence and I thought I would be able to work in the PHC manager's position with my subordinate (Khwan).

However, passion for the PHC manager's position can be reduced when there is no prospect of promotion along the career path. This perspective was raised by Rasa:

According to the government's reform in 2005, it seemed that there was no attention to the management track. I thought that if I still worked on the management track, I would not achieve any progress in my working life. Thus, I changed my working path again. I took an examination to study nursing. After that, I became a registered nurse (Rasa).

When the study participant's qualifications are not related to the work, it can also affect the passion for becoming a PHC manager, as noted by Khwan:

As I'm currently holding the position of acting-PHC manager and I'm the registered nurse, I attempt to motivate and support my subordinate to be the PHC manager instead of me. He/she is a public health officer. I think that the manager's position is not quite appropriate for me as I'm currently the registered nurse. Thus, I should leave the management role and encourage this guy to work as the PHC manager instead of me (Khwan).

In addition, the pressure of having too much responsibility can affect the PHC manager's passion, Ake noted:

As I used to work as a subordinate for 7 years, I think working as a subordinate is fine because I did not feel stressed. I did not have to formulate the plan. I only focused on my responsibility. However, when I became the PHC manager, I think I have more responsibility than the subordinates (Ake).

4.3.1.2 Altruism

Win used the idea of —having a public mind" to refer to the generosity of the PHC managers and community orientation:

> *Actually, we should have a 'public mind' when we are working in a public health organization* (Win).

Another participant, Thunva, stated: *―The PHC managers need to do things for other people in the community. Um ... I think finally the benefits have to be contributed to those people"* (Thunva). This view was consistent with that of Nawat who believed that *―[i]n order to change or develop our SHPH, we need to sacrifice ourselves for others"* (Nawat). This participant further stated that *"as I work in this position, I actually don't expect to gain anything for myself. Instead, I attempt to do things for people in the community. When people are happy, I will feel happy as well"* (Nawat).

Becoming a PHC manager, therefore, was demanding work, as highlighted by Chai:

> *First, I think you have to have the willingness and the sacrifice to work for others and I think that it is imperative to make the sacrifice and give a lot of time to working in this position* (Chai).

When compared to the subordinate's position, the PHC manager's position involved more competencies and so more opportunity to help others:

> *I thought that if I came off the subordinate's position and had the PHC manager's position instead, I would be able to help others* (Win).

Nawat emphasized that particular assistance should be provided to the disabled group:

> *As we have to work in the community, the ultimate goal of my career should be focused on the people, particularly the disabled group. We need to do something for them otherwise they will get worse* (Nawat).

Rasa illustrated her altruism with an example of how she helped the migrant people in the community:

> *Another challenge is that some of the clients have no identification card because, in the past, they were not formally registered at the district office when they were born. Or some of them are migrants. Thus, they have no identification card. However, I attempted to help these people by coordinating with community leaders and the community hospital in order to find some*

> *document to use as evidence for formal registration as Thai citizens. Currently, this is in the process of being coordinated with the community hospital* (Rasa).

Chanon believed that managers should also attempt to build an altruistic attitude among their subordinates:

> *I still needed to talk with my subordinates in order to encourage them. I told them that, in our working life, if we have the competency and opportunity, we should do something for others* (Chanon).

Summary:

This sub-theme identified the values that PHC managers considered necessary for their work as a PHC manager. Some study participants said that the passion to be a leader motivated their decision to take on the PHC manager‘s position. They believed that their passion and love for the PHC manager‘s position were linked to the happiness and pride they experienced in their working lives. However, study participants also argued that this passion could be reduced if they did not receive recognition in their chosen careers and if the pressure of responsibility was too high.

This sub-theme also highlighted the importance of altruism for the PHC manager. Study participants explained that PHC managers should generously and selflessly dedicate themselves to helping others, particularly the vulnerable people in their responsible community. They made the point that, when compared to the subordinate‘s position, the PHC manager‘s position was demanding work, but this position also provided more opportunities for helping others.

4.3.2 Being self-directed

This sub-theme describes the three values considered necessary to enable PHC managers to be self-directed. First, the participants explained that they had the intention to become a PHC manager. Second, they pointed out that the PHC manager‘s position gave them autonomy to make certain decisions. Third, the opportunity to advance in their careers motivated them to become a PHC manager.

4.3.2.1 Intention

In the following comment, Chai raised the issue of being self-directed where positive intention was the compelling reason for his becoming a PHC manager:

> *I have the intention that I would like to be in the PHC manager's position and I try to do it to the best of my ability* (Chai).

Prang added that commitment was another significant attribute of the PHC manager:

> *Commitment is important for us. Initially, we need to have commitment. Then, others would like to follow us. This is my opinion in regard to leadership by the PHC manager* (Prang).

Praw was motivated to try to improve the worst SHPHs she encountered and this led to her decision to become a PHC manager:

> *As I used to work at the district health office for ten years, I knew the information about every SHPH in this district because every SHPH had to send the information to me. I knew which SHPH was the best and which SHPH was the worst. I thought that the work of each SHPH was really not as good as I expected. Some SHPHs worked so slowly. I then thought that if I had a chance to work at the worst SHPH, it must be better and it must be a challenging task. As I used to work at the district health office for a long time, I thought that I would like to change myself. Thus, I decided to move from the district health office and work here and I felt happy to do what I wished* (Praw).

After the negative experiences Chai had had with his manager when he was a subordinate, he decided to become a PHC manager to develop his organization in the way he wanted to:

> *When I was a subordinate, I actually thought that the work of my manager was not quite relevant or in line with my expectations. I would like to develop the work. Thus, I volunteered myself to work for my manager. My manager only signed the work done by me. I did everything for my manager* (Chai).

This experience was similar to that of another participant, Win. When he had to move out to work in another SHPH, he gave a speech at his farewell party declaring that he would become a manager:

> *Besides, there was a farewell party and I told everyone that ‘Today, I’m a subordinate working here, but I will come back to work here as the manager’. I would not be a subordinate anymore because I was quite unimpressed with my manager* (Win).

4.3.2.2 Autonomy

Prera stated that *“[o]ne part of my feeling is that I’m proud to be the PHC manager*” (Prera). His feelings were consistent with those of another participant, Sarun, explaining the cause for his feeling of pride in the following words:

> *I think ‘position’ is just a ‘hat’ that you wear because it does not permanently stay with you. However, I was proud to become the PHC manager even though I had more responsibility than other staff. I have to have contact with everyone, particularly when I worked in the rural area. I have to attend the training. I have to know all the stakeholder organizations in the community. Thus, when I go into the community, I know everyone. I feel that I have social standing. This is kind of my motivation for becoming a PHC manager* (Sarun).

Some study participants reported that becoming PHC managers gave them more power and freedom to make decisions. This perspective was exemplified in a statement of Prang: ―*We have more power in making our own decisions”* (Prang). Thunva also thought that ―*it is about freedom because I can do anything I wish*” (Thunva).

Prang explained that she had more power and autonomy:

> *Before becoming a PHC manager, firstly, it’s quite hard for me to do the job or create an idea as I think or wish. On the other hand, since I became a PHC manager, I have more power and freedom than previously to formulate a policy by myself. I can set my goals and create the strategies to achieve those goals* (Prang).

Consistent with the above view, both Chai and Rasa liked the way that they could independently create a plan after they became a PHC manager:

> *A good thing about coming to this position is that I can create a plan and do it by myself. When I was a subordinate, I could not work as I wished even though I had a good plan, because my manager did not like it. Thus, I currently can develop my work as I wish* (Chai).

I felt easier when I became a PHC manager. In the past, when I was a subordinate, I felt upset with my PHC manager. My PHC manager always assigned his/her tasks to me and I had to carry out that work. My PHC manager did not do anything. He/she only signed the reports regarding his/her tasks and I had to finish his/her tasks. Do you know what I mean? He/she did not help me much. Consequently, when I became a PHC manager, I could carry out and sign work done by myself. I felt much better and more comfortable. I could do anything regarding my ideas (Rasa).

Prang pointed out that she could not only create a plan for herself, but she could also plan for the tasks of others:

I like to create an idea and enlarge on it to others (Prang).

Win further explained that he could influence higher levels of administration:

I thought that if I was still a subordinate throughout my entire life, I would have less opportunity to propose and translate my ideas to a higher level (Win).

The same participant said that the district level meetings provide him with the opportunity to put forward his ideas to the higher level of administration:

I think the person who has more chance to participate in a meeting at district level is a PHC manager. Therefore, I would like to be a PHC manager because I will have more chance to push my ideas and thinking. I thought that if I come off the subordinate position and have the PHC manager's position instead, I would be able to help others. Besides, I would be able to propose my ideas in the meeting at the District Health Office (Win).

The PHC manager could also have the power to deal with other stakeholder organizations. This view was illustrated by the comment of Rasa:

Another factor is that I would like to do what I wish to do or develop. I thought that if I became the PHC manager, a community development plan could be rapidly set up as I desired. Besides, compared with subordinates, I thought that it's much easier when I need to negotiate or coordinate with other stakeholder organizations. I thought that the PHC manager can participate in pushing forward the approved plans or any other activities. Accordingly, I thought that PHC managers can contribute more benefit than subordinates do (Rasa).

The influence of a PHC manager could extend to obtaining resources from the municipality, Rasa explained:

> *In my opinion, if we are the PHC managers, we can easily solve a problem because we have more power. On the other hand, if we are the subordinates, it's quite hard to coordinate with other stakeholder organizations because they do not pay attention to the work of subordinates. When I became the PHC manager and I had to borrow some instruments from the municipality, I just called to talk with the head of the municipality and I then easily got such instruments. Therefore, this is one factor why I planned to become a PHC manager* (Rasa).

4.3.2.3 Career Progression

Prera believed that being in a PHC manager's role would afford them more opportunity to progress in their careers:

> *At first, I thought that a leader usually had more advancement in the course of his career* (Prera).

Even though participant Khwan did not think she was good at management tasks, she still decided to become a PHC manager to advance her career:

> *If you ask me whether I would like to be a PHC manager or not, I would say not really. I think I'm not good at management. However, I would like to progress in my career. So, I decided to become a PHC manager. According to the civil system, if I would like to upgrade my level of working position in order to get more salary, I needed to move to work as the PHC manager in this SHPH* (Khwan).

A person's position in the health system is a significant indicator for determining the progression of the careers of health professionals in Thailand:

> *In the past, I used to work at the district health office. My working position was progressively upgraded until I got to level 4. However, if I would like to be upgraded to the higher level, I needed to hold a PHC manager's position at a SHPH. Thus, I decided to work at a SHPH in order to upgrade my work position. Since 1997, I have been working in the management pathway* (Kaew).

In fact, there were many steps and criteria for participants to progress to the PHC manager‘s position, such as work experience and examinations. Chanon described the career path he followed:

> *Actually, it is about the advancement in my career. My first motivation is about the progress in my working career. Second, it involves honour in working. In the past, level 5 was the highest working level and the PHC manager is the only one in the organization who can get the level 5. For me, I could automatically get the level 4 if I had worked for about three years. Work experience is the criterion for upgrading from level 1 to level 2, level 3 and then to level 4. However, you need to pass the examination in order to be upgraded from level 4 to level 5. After that, I passed the examination for an administrative position and I got the level 5. As I told you, it is about the advancement in my career. I had a plan that I would like to retire with the level 5. It was my ultimate goal in my career path* (Chanon).

Work experience seems to be one of the important factors in advancing to the PHC manager‘s position:

> *As I had worked for several years and I had already passed the examination in the management pathway, I thought I was ready to be the PHC manager because I was the senior and had more experience* (Khwan).

However, work experience was not enough for a subordinate to shift into the management track because the examination process was another step in progressing to the PHC manager‘s position:

> *It seems like I have made progress in my working life. As I used to be a subordinate, when I gained more work experience, I thought I had better change myself to a management track. Then, I took the management examination* (Rasa).

The experience of Rasa was similar to career decisions of Sarun:

> *In the past, although my position was not that of a PHC manager, I had the responsibility for management tasks. Therefore, I decided to take the examination in order to change my career track to be completely responsible for management work* (Sarun).

The examination process was an important step to upgrade from the operative position to the administrative position:

> *I passed the examination and got the PHC manager position. Then, my administrative level was upgraded from level 4 to level 5* (Prera).
>
> *After that, there was the announcement about the examination for an administrative position with level 5. I applied for that examination and I passed the examination. Since then, I have formally been the PHC manager* (Chanon).

Prera explained that the examination was administered by the Provincial Health Office:

> *I made the decision to apply to do the examination for the administrative position. In the examination process, the evaluation was carried out by the Provincial Health Office. My examination score was compared with other candidates to fill the vacant positions of PHC manager in this province* (PHCM5).

Summary

This sub-theme explained the three controlling values that motivated study participants to become PHC managers. First was positive intention and commitment to advance from their subordinate position to the PHC manager‘s position. Some of the participants explained that they had had negative experiences with their previous managers, which motivated them to become a PHC manager in order to develop the organization in the way they thought it should be developed.

Second, study participants explained that they felt proud because they had more power and freedom as managers to make decisions. They explained that they could formulate plans for their own organizations, influence those in higher levels of administration and deal positively with other stakeholder organizations.

Third, study participants emphasized that PHC managers usually had more opportunity to advance their careers, which motivated them to take on the position of PHC manager. However, they pointed out that becoming a PHC manager involved many steps, including gaining relevant work experience and taking examinations.

4.4 Conclusion

This chapter has presented the first two themes to emerge from analysis of discussion with study participants. The first theme described that PHC managers experienced constant change and this change was compounded by the implementation of the SHPH policy.The implementation of the SHPH policy affected the PHC managers and their work at three levels: at the individual, organizational and community levels. The constant change was also linked to various challenges such as human resources management, financial management and expectations from clients.

The second theme described the values that were important for the participants in becoming and in working as a PHC manager. Those important values were their passion for the PHC manager‘s position, their altruism for promoting other people‘s happiness and wellbeing, and their intention to be a leader and progression in their careers.

The next chapter presents the last two themes: Theme 3, Teamwork in the Organization, and Theme 4, Networking in the Community.

Chapter Five: Results – Teamwork and Networking for PHC Managers

5.1 Introduction

This study identified four main themes from the analysis of discussions with study participants. Themes 1 and 2 were described in Chapter Four and comprised:

Theme 1: Constant change from the policy implementation and its consequences
- Effects of change at the individual level
- Effects of change at the organizational level
- Effects of change at the community level

Theme 2: Passion and altruism and being self-directed
- Passion and altruism
- Being self-directed

This chapter presents Themes 3 and 4. In Theme 3, the participants shared their experiences of how they work with their subordinates in the organization as a team and in Theme 4, study participants described how they network with the stakeholders in the community. The sub-themes of Themes 3 and 4 are:

Theme 3: Teamwork in the organization
- Trustworthiness and understanding in the team
- Teamwork strategies

Theme 4: Networking in the community
- Building trustworthiness and understanding with stakeholders
- Networking and teamwork with stakeholders

This chapter concludes with a discussion of the major findings in Themes 3 and 4.

5.2 Theme 3: Teamwork in the organization

Theme 3 discusses the study participants‘ experiences in managing and leading their subordinates in their organizations as a team. The participants explained that trustworthiness and understanding in the team were necessary for them to work with their subordinates (first sub-theme). They described a number of strategies that they used in their organizations to work as a team (second sub-theme). Thus, Theme 3 consists of two sub-themes:

Trustworthiness and understanding in the team

Teamwork strategies

5.2.1 Trustworthiness and understanding in the team

Study participants stressed that they needed to build trust and understanding among subordinates to gain commitment and dedication and enable the team to work effectively together.

5.2.1.1 Building trustworthiness and understanding in the team

Study participants believed that teamwork was crucial to enable them to work cooperatively with subordinates in the SHPHs. This view was raised by two participants, Prang and Chanon:

> *First, the skill of working as a team is essential* (Prang).
>
> *As I told you, we need to form all of the staff as a team. We need to work as a team. Teamwork is the most important thing* (Chanon).

In order to work as a team, another participant, Rasa, emphasized that ―*It is important that the PHC managers need to build trust with others"* (Rasa).

For one participant, there was a need to ―*Tie your heart to the subordinates' hearts*" (Prera). These metaphorical words were offered to describe how to build trust with the staff members in the team. The same participant reinforced the importance of trust by stating that *"I'm quite concerned about if I make mistakes. As a result, I might lose my trustworthiness"* (PHCM5).

This participant further pointed out that there were benefits for PHC managers if they gained the trust of their subordinates:

> *I think if we can build trust with subordinates, the commitment and dedication of subordinates will be substantially raised in the organization* (Prera).

In order to build trust among team members, Khwan commented: *"From my experience, I think good managers need to create happiness in the organization. Everyone has to work together with happiness"* (KhwanThis view was supported by Nawat: *―We need to work with happiness. I think that if the subordinates feel happy, I will then feel happy as well. I cannot feel happy if others still feel unpleasant or upset. If I feel happy but another feels bad, it is not real happiness. Thus, I try to make everyone feel happy"* (Nawat). Another participant, Win, focused on the well-being of the team, reinforced this view: *―I attempt to increase the happiness and reduce the stress of my subordinates"* (Win).

PHC managers felt they needed to find solutions for subordinates who faced dilemmas or difficult situations. This view was proposed by Thunva and Chanon:

> *When there was a problem with my subordinates, I attempted to talk with them in order to help them solve that problem. At least, my subordinates could release their stress. One subordinate told me that he did not like to provide the health services regarding curative care. I thus needed to assign other appropriate responsibilities to this subordinate* (Thunva).
>
> *Do they have any difficulty if we assign them the job? If they have a problem, how can we help them? It is about helping each other* (Chanon).

Chanon also suggested that it was the responsibility of PHC managers to facilitate the teamwork among subordinates in the SHPH:

> *Um…..first, definitely you have to have the knowledge of management skills. I have a deep understanding about theories used for reconciliation in the team. It is important to make your subordinates work together and release their feelings about being tired. Second, you need to provide your subordinates with support when they have problems* (Chanon).

The following comment is an example of how Yada supported her subordinate:

> *In my organization, I think I have enough staff, but most of my staff are quite old. Therefore, they are very responsible in their work, but they still have a problem regarding the technology issue. For example, there is one staff member who will retire next year. This guy likes to work on health promotion and disease prevention in the community. However, he usually has a problem with technology. He does not know how to use a computer. He could not use any software. Thus, I need to support and help him. I have to print out all of the work for him to read or I sometimes turn on the computer for him to read on the computer screen. I attempt to support him to work in the team* (Yada).

This approach was similar to the method employed by Win:

> *I need to help my subordinates. Sometimes, I even helped my subordinate with her responsibility because this subordinate was quite old. It was difficult for her to use the computer. Thus, I told her that she could write her work on paper and I could help her with tasks that need to be done on the computer. For example, I did the reports and PowerPoint for her* (Win).

The view that PHC managers should work with their subordinates in order to increase good relationships in the team was presented by Pim:

> *I sometimes have to work with my subordinates. While I am working with them, it seems like I can simultaneously motivate them. My subordinates always ask me to go with them into the community. I think that this is good because I will have an opportunity to meet people in the community and do activities with them. Besides, I think that my subordinates would feel good because I as their manager do not let them carry out their responsibilities alone. I think we need to work as a team* (Pim).

Win emphasized that, although staff members were allocated specific aspects of the policy to meet objectives, it was still necessary for everyone to help one another:

> *I think you have to carry out your responsibilities and I also need to carry out my responsibilities. However, if you cannot do them, I will help you. As I told you, sometimes everyone helps each other until 1 pm to 2 pm because there is a lot of work* (Win).

In addition, in order to build good relationships and trust in the team, Prera pointed out that *“I don't only focus on the work”* (PHCM5). This participant further explained his practice: *“I try to observe the behaviour of my subordinates. If their behaviour changes, they might have*

a problem. The problem might be in regard to a problem in their family. Then, I try to talk to them and take care of them" (Prera).

Praw supported the above view that PHC managers should not only put emphasis on the work of the SHPH but also needed to pay attention to their subordinates' general well-being:

> *Because of my personal characteristics, I take care of my subordinates. I can even sense the feelings of my subordinates. I attempt to observe whether my subordinates are tired or disappointed or not. Every morning, I always walk into the subordinates' room in order to greet them. I would like to see my subordinates and talk to them. In the subordinates' room, I usually write a motto or short message and hang it on the wall for my subordinates, such as 'wishing everyone working with happiness today'* (Praw).

On special occasions, such as a staff member's birthday or on New Year's Day, Yada brought gifts for her subordinates:

> *I can also remember the birthday of every subordinate. I jot down their birthday on my desk calendar. On their birthday, I make a birthday card for them. I cut a piece of paper into a heart shape and put it on my subordinate's table. Do you understand? On New Year's Day, I also have a gift for every subordinate* (Yada).

This strategy was also employed by Prera and Khwan:

> *Um… Suppose it is New Year's Day or a birthday, I will give my subordinates a gift* (Prera).
>
> *On my subordinates' birthday, I also bring them a birthday gift. I think the PHC managers should have sympathy with their subordinates* (Khwan).

Eating food together in the team was another strategy used by Praw and Nawat:

> *Um ... in my team we mostly have ....um….a kind of tradition that we all have lunch together. Everyone brings some food for eating together. If someone does not have food, he/she can buy some food. Then, we can eat together in the room on the second floor* (Praw).
>
> *We always eat together. We will bring food to eat in the kitchen. We sometimes eat out together* (Nawat).

Prera pointed out the advantage of this strategy of providing opportunities for everyone to talk to one another:

> *When there is an opportunity, we try to have something to eat together. While eating, we can chit-chat about an issue which might or might not relate to our work* (Prera).

Another participant, Yada, noted: *―I attempt to create a family atmosphere in my organization. For the lunch time, we also have lunch together. As I said, I try to make this organization like a family"* (Yada). Khwan agreed with Yada‘s view that *―eating together with the team is another strategy I use to increase a good atmosphere in our organization. We cook food in this SHPH together or we bring food from our home"* (Khwan).

Another strategy employed to increase the level of familiarity in the work team was to take fieldwork trips with all staff. This strategy was proposed by Nawat:

> *I annually arrange a trip for all the staff to travel together. Actually, our trip is like a fieldwork trip because we also visit other organizations, such as the local government organization, in order to see good practice. I think this activity can create familiarity in my team* (Nawat).

Understanding the needs of subordinates was another important aspect for developing teamwork, as pointed out by Khwan: *―Um……. good managers have to understand their subordinates. As I am the PHC manager, I think this is important"* (Khwan). Rasa supported this view: *"I attempt to understand my subordinates' thinking. If I would like my subordinates to do anything, I need to primarily think about their feelings"* (Rasa).

Another participant, Prera, added this comment: *"I think that every staff member in my organization needs to know and understand the problems or situations occurring in our organization"* (Prera). This view was consistent with that of Praw: *―I will try to inform them (subordinates) about the work as much as I can. I attempt to let everyone know about any new information or work. I think everyone has to know about such information or work"* (Praw). This participant reinforced the perspective: *―The benefit of sharing information is that, when my subordinates know about the new information or work, everyone will not be*

ignorant. When others ask my subordinates about such information or work, they should be able to say that they have already been informed about such information or work by me" (Praw).

Study participants believed that building understanding within the organization should be carried out using various techniques. A popular technique was to use an informal approach to foster two-way communication:

> *There are many good sides to using the informal approach. For instance, we do not hesitate to talk to each other. If I talk formally to my subordinates, they might feel afraid and worry about consulting me. I think it's too serious to use the formal approach. When I talk informally with them, they comfortably come to ask me what they should do in their work. This is the way I work with my subordinates. I don't know whether it is right or wrong* (Sarun).

Sarun's technique was consistent with the method of another participant in terms of informal approach:

> *I normally come to work in the early morning. Every morning, I try to greet every staff member. Even though I'm the PHC manager, I still need to show respect to my subordinates, particularly the subordinates who are older than me. I try to talk informally with everyone. I ask them whether they have any problem or difficulty in their work or not. Have they finished their assigned tasks yet? What do they plan to do? I mostly use the informal approach with my subordinates. We talk to each other like we are relatives* (Ken).

Pim described that there were many benefits from talking informally with the subordinates:

> *In my team, I attempt to talk with my subordinates by using both formal and informal methods. Actually, I mainly use the informal method to talk with them. We usually have chit-chat in our team in order to listen to each other. I think we gain many benefits from talking together and discussing things in our team* (Pim).

Thunva argued that, while talking with his subordinates, he could assess whether his subordinates had problems:

Each day from 8.00 to 10.00 a.m., I start work by walking around to talk with subordinates at each station in order to evaluate whether there is a problem or not. I will gain important information by talking with them (Thunva).

This perspective was similar to that of Prera:

I, as the leader, need to take care of my subordinates. I need to talk with them in order to know their problems. Actually, it seems like we are trying to take care of our staff (Prera).

When a subordinate has a problem, Chai explained that he also used the method of informal talking to work out a solution to the problem:

Nonetheless, if they (subordinates) have an obstacle, they can come to talk with me. We will brainstorm and express our opinions regarding a possible solution (Chai).

Nawat added that ―*while we are talking, I attempt to motivate them and point out to them a suggestion and I also try to make a joke in order to increase the familiarity in the team"* (Nawat).

Another benefit from informally talking with the subordinates was related to organizational development. This view was expressed by Chanon in this way: ―*It's kind of routine work. When I come to work, I start by greeting and talking to my colleagues. This is how we build up the relationships in the organization. We normally talk about the activities and responsibilities we plan to do for each day"* (Chanon). Prera further reinforced this view: ―*I try to talk with the subordinates in the organization in order to improve on the weakness of our services"* (Prera).

Holding meetings was another technique used to increase the level of understanding among team members. Sarun pointed out that he might arrange a formal meeting with his team members:

I sometimes have a formal meeting, normally every month. However, there are some months when the meetings are cancelled. After I attend a meeting at the district health office or at other organizations, I usually set up a formal

> *meeting in order to inform my subordinates about the policy and the assigned tasks* (Sarun).

However, informal meetings were primarily employed to distribute and communicate information to the team. This view was put forward by Chai:

> *I talk with my subordinates nearly every day. I normally use the informal method by talking with my subordinates for about ten to fifteen minutes. After that, I will let everyone continue to work on their functions and duties* (Chai).

Informal meetings were also popular with a number of other participants:

> *I will also attempt to set up an informal meeting while we are working in our organization. For example, when I go to attend a meeting, I will come back and try to find the time to talk with my subordinates. But it is not formal* (Win).
>
> *It seems that we have an informal discussion in our team. Nevertheless, we sometimes have a formal meeting. But we mostly coordinate in our team by using the informal way* (Chanon).
>
> *I have to talk with everyone in my organization because there are only three staff. I usually use the informal approach to talk with everyone. After I attend an outside meeting, I will come back to talk informally with everyone* (Por).

Pim believed in the value of using an informal meeting:

> *I frequently arrange an informal meeting because my subordinates don't really talk to each other. This might be a problem because they only focus on their work. Thus, I need to encourage them to talk to each other. I usually try to invite everyone to have lunch together and I will use this time to talk with everyone. We talk while we eat* (Pim).

Rasa used meetings as the channel to assign responsibilities to her subordinates:

> *A meeting in my organization will be arranged every time after I attend a meeting outside. We draw out opinions and agreement and we also delegate responsibilities at such meetings. I ask my subordinates whether the assigned responsibilities are too difficult for them or not. If someone thinks that it's quite difficult for him/her, he/she can ask for assistance from other team members* (Rasa).

Nawat commented that, when one of his subordinates had a problem, he arranged an informal meeting in order to work out a solution:

> *It's very important that we need to talk frequently to each other. If we have any problem, such as stress, we should not let it linger on. For instance, if I see that my subordinates feel stressed, I will arrange an informal discussion with my team. I talk to them and ask them whether they have any difficulty in their work or not. Do they need any assistance? After I know their problem, I will try to figure out the solution to their problem. We will help each other in the team* (Nawat).

Summary

This sub-theme shows that study participants believed that it was important to build trust and understanding among team members. Participants explained that they could increase the level of trust by facilitating and helping their subordinates, particularly when the subordinates faced dilemmas or difficult situations. They stressed that they placed emphasis on the work of the SHPH but also paid attention to their subordinates' general wellbeing. They attempted to share some activities with their team members in order to increase levels of familiarity. Study participants further described that a two-way communication method based on an informal approach, such as informal discussion and informal meetings, was the technique mainly used by them as the interactive mechanism for effectively building understanding in the team.

5.2.2 Teamwork strategies

This sub-theme describes the teamwork strategies employed by study participants. The participants firstly commented on their experience of giving their team directions and delegating responsibility in the team. Second, they discussed the importance of participation. Third, they pointed to the issue of Thai culture in relation to teamwork. Finally, they explained how they managed conflict in their organizations.

5.2.2.1 Directing and delegating responsibility

PHC managers had to be able to direct the subordinates in their team, as exemplified in the following quotations:

> *The manager has to manage all staff so they work in the same direction* (Chai).
>
> *I need to be able to determine the direction of everyone regarding the policy of the Ministry of Health* (Win).

Nawat suggested that the direction of the team should be decided by everyone in the team:

> *In order to improve our organization for the benefit of people in the community, I think brainstorming in the team is initially necessary. The team means our staff in the SHPH. We have to talk and plan together. We need to understand our determined concepts we have worked out. Also, we need to have the same direction* (PHCM14).

In the following comments, two participants had a similarity in technique in how they determined the direction of the team with their subordinates:

> *We need to find out our direction or aim. Suppose there is an evaluation of the district health organization to rank the SHPHs in this district, we will make a decision on what ranking number/position we will achieve. We might not wish to be ranked in the first or top three. Instead, we all might prefer to be ranked in the top eight. If everyone (subordinates) in the organization is in agreement, we will try to do as we plan. Somehow, if there is a problem and we think we might not achieve the ranking as we planned, we will talk to each other once more in order to determine our direction and aim again. I use this technique in the hope that everyone (subordinates) will know the direction and aim of the organization* (Chai).
>
> *We should be able to manage our team to reach the same goals we have. In the team, I need to adjust our team to work in the same direction. We need to know what our goals are. For example, if there is a competition among SHPHs in our district, we need to discuss in our team whether we can do it or not. Then, if we agree to join such a competition, what kind of method should we use? We need to consider our competencies and budget. We also need to think about how we can encourage our people in the community to help us. I think if we can draw our direction towards the same ultimate goals, our work will be better, improved* (Chanon).

When everyone in the team knew the organization's direction, the PHC managers needed to delegate the responsibilities to their subordinates. This view was pointed out by Yada:

> *It is not necessary for us to do every task. Instead, we should delegate the tasks and we only control and look after my [our] own team. We motivate them in order to achieve our goals* (Yada).

Ken suggested that PHC managers needed to believe in their subordinates' competencies:

> *Distribution of responsibility is not difficult for me. We need to let our subordinates know what we know. We should not conceal any piece of information from our team. We need to trust our subordinates. No matter if they might make some mistakes. We should not pay much attention to their small mistakes. We can compare a subordinate to a child practising to use a spoon for eating food. In the beginning, some food might fall or be spilled out from the child's dish. Soon, later on, the child will be able to eat the food. In the same way, a PHC manager can be compared to the child's parent who needs to look after their child learning a new thing* (PHCM12).

Subordinates who have been delegated responsibility, Thunva suggested, should be given the power to make independent decisions:

> *As there are three workers employed to work in my SHPH, and I assigned these workers to be managed by my subordinates, I let my subordinates independently manage such workers. I delegated the authority to my subordinates. Therefore, my subordinates have the right to assess those workers and make a decision on whether those workers should be employed again in the next year or not. It seems like my subordinates are my managers because they tell me to do such and such* (Thunva).

This view was consistent with that of Prang:

> *I attempt to distribute power and responsibility to the subordinates. I will divide them as a team based on their expertise and background, such as a team for maternal and child care, a team for mental healthcare, a team for chronic care, and a team for disease control. Each team will set their own plans to visit people and actively work in the community* (Prang).

However, Yada pointed out that PHC managers should also consider their subordinates' competencies when they delegate responsibility:

We need to assign the responsibilities [to them] that mostly suit the competencies of our subordinates. We should not think that we have the power in delegating responsibility and we can assign any task to our subordinates as we want. If we think like this, our subordinates might not be happy in their work. For me, my subordinates have to work with happiness. They should be able to find an agreement that suits everyone. They can talk to me when they are not happy with their assignment (Yada).

The PHC managers should also consider the differences in the competencies of each person. This view was presented by two managers, Chai and Chanon:

In fact, understanding refers to the fact that you need to know the context of your organization because the subordinates have different backgrounds and characteristics (Chai).

Um…..It involves both art and science. I think that the PHC manager needs to understand the difference of each person. The competency of each person is different (Chanon).

Their perspective was reinforced by Prang: ―*A good leader should be able to know the competency of others and be able to assign a suitable task to them"* (PHCM1). In order to know the competency of subordinates, she used the concept of ‗mind-reading' to refer to the skillfulness required of the PHC managers in assessing the thoughts and feelings of their subordinates:

Um…another skill is mind-reading skill. I mean we need to know the abilities of our staff (Prang).

Ken agreed with this view of the need for sensitivity to their team members:

The PHC managers should be able to understand their subordinates. For me, I need to know the characteristics of my subordinates. If one of my subordinates speaks loudly, this means that he/she might be angry (Ken).

The participants believed that, when PHC managers know and understand the competencies of their subordinates, they can delegate the right task to the right person:

We have to know the competency of each staff member. We need to assign the right jobs to the staff (Prera).

> *The manager has to give the right job to the right person* (Chai).

> *Assigning a job to the right person is very important. As I told you, everyone has a good side, such as being generous, kind, and being keen to learn something new* (Chanon).

Prang used the metaphor of a Thai Buddhist principle known as *"Dern-Thang-Sai-Klang" (walking in the middle way),* when referring to the appropriateness of doing anything. In this situation, it means that the PHC manager should assign subordinates the responsibilities that are suited to their competencies:

> *I mean I apply the principle of 'Dern-Thang-Sai-Klang'. I understand other people. I understand the competency of subordinates and the way that they behave and act* (Prang).

This view was supported by Kaew:

> *Um…..I need to delegate the responsibilities. I need to appropriately assign the responsibility to my subordinates. Actually, my subordinates can perform any responsibilities, but everyone cannot perform well in every responsibility* (Ken).

Chanon also noted that responsibilities should be appropriately assigned or delegated according to the subordinates' competencies or aspiration, otherwise dissatisfaction might occur in the SHPH and team output might be reduced:

> *Um….actually, I do not absolutely apply or follow the management theories. As I told you, I need to know the information about my subordinates. I need to know which skill do they have and what they are happy to do. As I told you, if we work without passion or we are ordered to do a job that we do not like, the result of the work will not be sustainable. Or we might even get resistance from subordinates. We will get only a short-term output or only the number regarding KPI, but there is no long-term outcome. Therefore, we need to know the staff's competencies* (Chanon).

The following comments were examples of how study participants delegated responsibility based on their understanding of the competency of a subordinate:

> *For instance, if there is a staff member who is good at academic work, I will assign him such academic work. When we delegate the responsibility to the subordinates, we need to know their skills and their weaknesses. We need to ask them about their needs. Which skill would they like to develop?* (Prera).

> *For instance, there was a nurse who just came to work with me and there was the responsibility for financial management. Instead of assigning that nurse with that responsibility, I thought I had better assign it to the public health officer because it might be difficult for the nurse to understand financial management. I assigned the responsibility regarding curative care only to that nurse* (Kaew).

Prang also explained that she delegated responsibility based on both the background of the subordinate and the function in the SHPH:

> *Um……there are many functions. But the main functions are disease control for the public health officer, curative care for the nurse, and health promotion for the nurse. Therefore, if there is a job, I will assign it to a staff member with regard to their function. For instance, if there are disease control and food safety jobs, the public health officer will be assigned these jobs. If the job is about disease control, I will also assign this job to a public health officer. If the job is related to curative care, a nurse will be given this job* (Prang).

Thunva raised the concept of participation when he delegated responsibilities to his subordinates:

> *I manage my team based on the concept of participation. I consult with my subordinates when I assign the responsibilities to them* (Thunva).

Pim reinforced the need for participation in these words:

> *When I became the PHC manager at this SHPH and I had to assign the responsibilities to my subordinates, I had to consult everyone. There were only three staff when I started working here. I asked them whether they were satisfied with their current responsibilities or not. Would they like to change their responsibilities? We talked to each other* (Pim).

A formal method of delegating responsibility was mentioned by Prang:

> *Um ...how should I tell you……….?? I make it clear by writing down the assignment, job, or activity for each staff member* (Prang).

Pim also used a formal approach for delegating responsibilities in her organization:

> *After everyone was already assigned their new responsibilities, we then wrote down each staff member's responsibilities in the document as our evidence. As you can see, I need to assess the needs of my subordinates and try to make everyone feel happy with their work* (Pim).

This method was similar to the technique used by Ken:

> *In my team, I have to use the formal method for delegating responsibility. For instance, if I have to attend an outside meeting and there is a new task, I will talk with my subordinates in order to find the person to be responsible. I will assign this task to my subordinate by formally writing a document as evidence indicating that that task already has the person responsible for it. Then, my subordinate has to sign his/her name on the document as evidence. In addition, I also do the same with the routine work in my SHPH. Every staff member will be clearly assigned their responsibilities. Everyone has to know the responsibilities of the other staff members in the team* (Ken).

Even though subordinates are given responsibilities, Kaew noted that there was a need to work with cooperation and flexibility in relation to meeting responsibility for the whole:

> *Um…. we need to help each other. It does not mean that, when everyone has already been assigned their responsibilities, we only focus on our own responsibilities. Instead, if someone cannot come to work, we should be able to work on that person's responsibilities* (Kaew).

Por supported this view:

> *Actually, everyone in my team has already been given our own responsibilities. However, we still need to help each other because there are few staff in my SHPH. We need to help each other* (Por).

Staff needed to work as a coordinated team and help one another in order to effectively increase the quality of health services provided at the SHPHs. This view was emphasized by Chai:

> *Although everyone has already been assigned their responsibilities, everyone still needs to help each other. However, if there are some tasks which require special knowledge and skill, such as urethral catheterization or nasogastric*

intubation, the registered nurse must be responsible for such tasks. If there are general tasks such as an injection, a wet dressing, or a dry dressing, we need to help the registered nurse. Thus, the patients do not need to wait for the registered nurse (Chai).

If some tasks were too difficult for the subordinates, the PHC managers believed that they should not be delegated such tasks. Instead, the PHC managers should take responsibility for those tasks:

Some tasks are difficult and have negative consequences if these tasks are conducted by the staff. Hence, I, the manager, have to do it by myself such as work regarding the policy and strategic formulation in organization and work regarding the financial and inventory management (Chai).

A further need for caution about delegating responsibility was pointed out by Chanon. He argued that responsibilities should also be delegated equitably:

Manager from my point of view refers to managing. I mean … according to management theory … tasks or responsibilities have to be equally divided to every staff member. Both staff members working in the centre and staff working at the periphery need to have equal responsibilities. Everyone needs to be equally tried (Chanon).

5.2.2.2 Participation in the team

Participation was essential for working as a team in the SHPH because everyone in the team would feel that support was steadily provided for each other. This view was registered by Chanon:

Participation in the team is imperative. The subordinates should not have the feeling that they are assigned to work alone. This is quite important (Chanon).

Chai believed that when subordinates had a chance to participate in making a decision, they would feel more valued and everyone in the team would happily work together to achieve the goals of the organization:

I think that when we all make a decision together and we can achieve a direction or aim, we all will see the value of ourselves. Finally, we can achieve our aim with happiness (Chai).

This participant also pointed out his reason for employing a participative approach:

> *I did not like to use power to order or assign my subordinates and colleagues, and I had the feeling and belief that I should not use power and rule with them because we were not policemen or soldiers. I did not need to act like 'a policeman catches a robber'. On the contrary, most of my work is involved with coordinating activities with others. Therefore, I need to build relationships among them. If I use power to order or assign them, I might get unsupportive results* (Chai).

As noted by Win, another reason for using a participative approach was that it showed respect for the different characteristics and opinions of subordinates: *"I found that subordinates' ideas are different from mine. Thus, I provide them with an opportunity to think"* (Win). Respecting subordinates' opinions by openly sharing an idea in the team was also emphasized by Win:

> *Then, I will enable my subordinates to think too. After that, we will all share and compare whether our thoughts are the same or different. If we differ, I will ask about and share the underpinning reasons for everyone's thinking* (Win).

This participant further explained that, when he was a subordinate, he did not have an opportunity to participate in making a decision in the team. Therefore, when he became the PHC manager he attempted to encourage his subordinates to participate:

> *I will ask everyone and share our ideas and decisions. I will not make a decision alone because I had no chance to express my idea and opinion when I was a subordinate. Right now, I'm the PHC manager. I will give my subordinates the right* (Win).

This experience was consistent with that of Prera:

> *However, there are some issues where I could not independently make a decision without [my] subordinates' opinions because, when I was a subordinate, my former PHC manager did not ask me to express my opinions. He/she immediately made a decision regarding his/her wish and informed me about his/her own decision later. Thus, when I became the PHC manager and I looked back, I found that my former PHC manager had this weak point* (Prera).

Win encouraged team members to express their opinions:

> *The subordinates in the SHPH need to ask me about the decisions related to their work and responsibilities. However, I will not inform them directly. I will let them think. It is like when the teacher gives the students homework* (Win).

The same approach was utilized by Chai to motivate his subordinates to plan their work:

> *I preferred to encourage my colleagues and clients to express and argue over their opinions. After my subordinates know their responsibilities, I attempt to encourage them to plan their work* (Chai).

Praw exemplified this view regarding team encouragement in the following words:

> *There was a new staff member moving from another SHPH to work here with me. This subordinate really kept quiet and, I thought, he/she might not have a chance to demonstrate his/her competency. For example, he/she did not speak when there were meetings. Actually, I thought that he/she was a talkative person. Thus, when this subordinate began to work with me, I attempted to motivate this subordinate by assigning him/her a responsibility. For instance, I assigned him/her to be the master of ceremonies or moderator in meetings. I always told this subordinate that he/she had to challenge himself/herself. Thus, he/she received opportunities to show his/her competencies* (Praw).

This participant reinforced the view that PHC managers should not assist in every subordinate‘s tasks. Instead, PHC managers should encourage subordinates to carry out their work by themselves. However, if a task is too difficult for a subordinate, the PHC manager should help him/her:

> *I think um…......I sometimes provide my subordinates with too much assistance and they might not be strong. I tried to think what I should do to develop them. So I attempted to let my subordinates do their jobs by themselves. Let them think, learn by themselves. However, if they cannot finish their jobs on time, or if it is an urgent project, I will then help them* (Praw).

Brainstorming with everyone in the team was a strategy used by this participant to encourage her subordinates to get involved in decision-making and planning processes:

> *Whatever we would like to do, we need to think together. I will let my subordinates think about what we would like to develop and we will then write out the plan* (Praw).

Praw further argued that ―*I ask my subordinates to express their opinions. I think we sometimes need to use a democratic system in our organization. Everyone needs to help me think about what we would like to do or develop"* (Praw).

Chai suggested that voting was a constructive method for drawing out an agreement and achieving ownership on the part of everyone in the team:

> *When we need to buy some equipment or medical supplies for our SHPH, I will let everyone vote and make a decision on what kind of equipment or medical supplies are important for us. I think that everyone will have a feeling of ownership due to their involvement* (Chai).

Informal discussion in the team was another technique used by Thunva to arrive at decisions:

> *We have a morning talk. Also, we chit-chat while we eat together. Thus, we gain benefits from our discussion because we can ask questions and share ideas and opinions (*Thunva).

Win also had discussions with his subordinates when he needed to make a decision:

> *Within the organization, we need to talk to subordinates in order to work out an agreement and optimal achievement. For example, I need to talk to subordinates if there is a competition regarding the performance of the SHPH. I ask them whether they agree to join such a competition or not. If everyone says yes, we can brainstorm about our planning. How much energy and time will we give to such a competition? How can we develop our work? Are there any problems if we adopt our planning?* (Win).

The following comment is another decision-making technique utilized by Thunva:

> *After I attended the monthly meeting at the district health office, I then distributed the tasks to my subordinates. For example, when we need to make a decision on the budgetary plan, I will let my subordinates make a decision. I provided them with the form. They could fill in that form regarding the budget that they need to use for their responsibilities. Finally, the annual budget of my SHPH would be planned by everyone* (Thunva).

5.2.2.3 Thai culture in the team

Because of the Thai culture of respect for older people, Chai pointed out that he found it difficult to work with senior subordinates:

> *As I can remember, I used to have a problem with my subordinate who is older than me. I pay her/him respect and honour. Unfortunately, I feel uncomfortable when she/he took the wrong direction and I needed to correct her/him. It seems like I try to teach or order him/her around* (Chai).

This view was consistent with that of Win. He used the expression that *"the child is trying to teach the adult"* as a way of characterizing disrespectful behaviour:

> *I didn't want to tell this subordinate directly because it seems like 'the child is trying to teach the adult'. This is involved with the work process in that I don't like to use a command or authority* (Win).

The same study participant, who was young and had less experience, pointed out that a novice PHC manager was required to pay respect to a senior subordinate:

> *As I am younger than the subordinate, I could not do anything without paying respect to the senior subordinate. Although I'm the PHC manager, I still need to work like we are younger brother and older sister. I need to show my respect to this senior subordinate because she has more experience than me* (Win).

Win also suggested that *"[i]n my opinion, the leader needs to be able to work with subordinates as a relative. I will not consider my subordinates as subordinates. Instead, I think that everyone is on an equal level"* (Win).

When there was no hierarchy in a team, familiarity between PHC managers and subordinates would increase. The Thai experience of extended family relations could be employed in the workplace by the managers, with co-workers treated as ―relatives." This view was proposed by Sarun:

> *In my organization, we do not work like we are the manager and the subordinate. Instead, I work with my subordinates like we are relatives. We*

work like we live in a family. In order to work together, if I can help my subordinates, I'm glad to do something for them. In order to develop the organization, we should not be selfish. We as a team have to go together. There is no hierarchy in my team. I do not wish my subordinates to call me their 'manager'. Instead, I let them call me their 'older brother'. I told them that it was not necessary to call me 'the manager' because I would like to be familiar with my subordinates. I have been doing it like this since I worked in the rural community (Sarun).

Kaew supported this view*: "I try to build familiarity with my subordinates. When we are working, I do not think that I have more authority than them. Instead, I think we are relatives and I am their older sister. I honour my subordinates"* (Kaew). This participant also stated that *"[f]or me, as I said, I do not think that I'm the manager and my subordinates have to be aware of my position. Instead, when there is a meeting, I always tell my younger brothers/sisters (subordinates) that we work like we are relatives. If they have any problem, they can consult with me"* (Kaew). Another participant, Por, reinforced this view: *"As there are few staff in my team, I have no problem working with everyone. Everyone relates to each other like we are relatives. When we have a problem, we will share and help each other"* (Por).

The concept of working as ―relatives or family members" was also employed by Chai as a strategy to establish closer relationships with colleagues and people in the community:

When I first came to work here, I always told my subordinates that we are working like we are a brother and sister in a family. We work like we are a member of the family. I treated everyone like a member of my family or my relative. I told everyone that they should not think that I'm their leader or the PHC manager. They do not need to show me respect. We can share with and talk to each other. They can talk directly to me about their concerns. If I could not solve their problems, I then consulted my higher supervisors working at district level. Hence, I have had a close relationship with my colleagues and people in the community (Chai).

In the following comment, in line with the family approach in the team, Rasa gave examples of some activities she had undertaken with her subordinates:

Everyone comfortably works together. We typically work like we are relatives. Fortunately, I'm older than every subordinate. It seems that I can be their

aunt or their mom. As I told you, I use the principle of kind-heartedness with every subordinate. I donate some of my salary to the staff budget for purchasing things we can use together, such as coffee, sugar, or sweets. Sometimes, we might use that budget to buy some foodstuffs and we can then cook and eat together. I think that I should support my subordinates as much as I can because I think that my subordinates are my children or grandchildren. In addition, if my subordinates get sick and could not carry out their responsibilities, I will volunteer myself to work on his/her responsibilities. It seems like mom taking care of her children. On some holidays, if I do not need to go outside, I usually go to work with my subordinates. It looks like our SHPH is our home (Rasa).

Another approach used by PHC managers to work well with their subordinates was by being a good colleague. This approach was elucidated by Chanon:

I feel that there is actually no boundary between manager and subordinate because we do not obviously separate positions in the SHPH. We are colleagues. I think that if you are the PHC manager, it does not mean that you can only give orders to your subordinates. Sometimes we need to be given orders by our subordinates. Therefore, I would rather define the management function as being a good colleague (Chanon).

Ake emphasized that *"[i]n my organization, there is no manager and subordinates. We are colleagues. We are friends. We can talk frankly to each other"* (Ake). Another participant, Rasa, also explained: *"In terms of management, I think I better say that we are all colleagues because I'm only the acting PHC manager"* (Rasa).

Prera commented that, when there is a friendly atmosphere in the organization, everyone helps each other and this increases the strength of the team:

I work informally with my subordinates. I do not think that I'm the manager. Instead, I think we are colleagues and we need to help each other in order for our organization to survive. Then, we will have more potential when compared with other SHPHs (Prera).

Kaew also employed the approach of working collegially with her subordinates, but she emphasized that it was necessary for her subordinates to carry out their responsibilities:

> *I think that my subordinates love me as I love them because we do not insult and slander each other. We talk familiarly to each other. I do not think that I'm their manager and every subordinate needs to listen and believe me because I am not the person providing their salary. Instead, I always say to my subordinates that everyone is equally working as a government servant under his Majesty the King. However, I still have the right to evaluate subordinates' work in accordance with the working criteria. Thus, they need to carry out their responsibilities fully and they will get a good evaluation score* (Kaew).

The PHC managers believed that they should not work as the leader all the time. Sometimes they needed to be a good follower. This perspective was pointed out by Chanon:

> *The leadership role is that you can be a follower. If you cannot be a follower, you cannot be the leader. Or you might be a leader, but you will be the leader for a short period. Therefore, we need to be a good follower too. This means that we need to give everyone the freedom of thinking. As I told you, I will give freedom to the VHVs. I try to let them think by themselves. Therefore, you might be the leader in some situation or you might be the follower in another situation* (Chanon).

Thunva supported this view:

> *I use the principle that I not only manage subordinates but the subordinates also have to manage me. The subordinates can give me direction. They can tell me what I should do. We talk to each other* (Thunva).

Khwan concurred. She believed that she had to listen to her younger subordinates because her subordinates had more experience than she did:

> *There were three subordinates when I began to work as the PHC manager. One of my subordinates used to work at the district health office. He was younger than me by four years. Thus, this guy had more experience than me and he could teach me about management tasks. It was always suggested I do this and that and I agreed with his opinions. I received a lot of support from this guy. He mainly told me about management* (Khwan).

5.2.2.4 Conflict management in the team

Conflict management as a significant challenge for managers was raised by Prang. She explained that managing conflict among staff members was her primary concern:

> *As I told you, about the conflicts among staff, I think that conflict management is more important than other things. Although we have a huge amount of money, it is still difficult if we cannot control and manage conflict. Therefore, I, as the manager, have to be able to control and manage conflict* (Prang).

This study participant argued that the contradictory opinions and differing characters of her subordinates were the main causes of conflict in her SHPH:

> *First, a conflict is caused by paradoxical thoughts among the staff. Second, the characteristics of each staff member can also be a cause of conflict. Some staff are generous, but some are selfish* (Prang).

This view was supported by another participant, Chai, who explained: ―*The problem of human resources is the first example. There are various opinions occurring in the organization. Thus, I have to find solutions to manage the conflicts"* (Chai).

Chanon believed that conflict could be resolved and reduced by encouraging team members to discuss issues and help one another:

> *As I told you, we should not clearly divide the responsibilities in the SHPH. We should not formally assign the tasks to particular staff members. Instead, we need to help each other. Sometimes, we need to be able to carry out another staff member's responsibilities in our team. Moreover, we need to have the sincere willingness to help each other. Consequently, there will be no conflict* (Chanon).

Information needs to be shared among the team members in order to build the level of understanding in the organization, Chai explained:

> *Sometimes, my subordinate could not come to work. She needs to tell me and I will further inform another subordinate. As well, suppose if I need to go away for a while, I need to let everyone know. Besides, if someone will come to work late, he/she needs to inform the others. All of us know each other. I think that if we know each other, we will understand each other. Then, conflict will be reduced* (Chai).

Some study participants believed that misunderstanding and conflict could be reduced if everyone considered each other's feelings. Chai explained this view:

> *However, if it is necessary for someone to take a short period of leave for his/her private issues, he/she needs to consider the rest of the team. He/she has to check whether the rest of the team is available and will be able to work on performing his/her responsibilities. If everyone is OK, he/she will be allowed his/her short break. I use this strategy because I would like everyone to consider each other's feelings* (Chai).

PHC managers have an important role to play in managing the conflict in their organizations, as noted by Chanon:

> *There is disagreement, but it is not exactly a problem or conflict. Um … It's quite hard to say. I attempt to balance and reduce such disagreement and make them keep working together* (Chanon).

Chai said that when there is a conflict, he has to stop the conflict by separating the parties involved:

> *For example, when there is a problem. I will stop the conflict of the opponents. I try to separate a pair who gets into trouble, and I will then try to find a compromise in the crisis in order to reduce the disagreement and work out a solution. I will separate both of them and talk to each side in order to help both of them to better understand each other. I try to reduce the argument between both of them and manage the conflict situation* (Chai).

When PHC managers have to resolve conflicts in their organizations, Nawat pointed out that they needed to be impartial and fair:

> *As there are many people working together, conflict can normally occur from various factors, such as the differences of thinking and each staff member's feeling of being tired. Thus, the PHC managers have to scrutinize and observe their subordinates to see whether they have a problem or not. If there is conflict in the organization, the PHC managers should be impartial. The PHC managers need to listen fairly to everyone. However, the PHC managers should not get involved in every subordinate's problem if they can resolve their problem by themselves* (Nawat).

Rasa and Nawat also both emphasized that it was necessary for PHC managers to be able to exercise impartiality and fairness:

> *I mainly emphasize the fairness issue. My subordinates need to be treated fairly* (Rasa).

> *I think impartiality is one of the important characteristics of the PHC managers. The PHC managers should not have any bias. The PHC managers have to be fair and reasonable with every subordinate* (Nawat).

Even when conflict occurs between a subordinate and a SHPH client, Ken believed a PHC manager should act impartially:

> *If my subordinates have a conflict or any problem, I will talk to them directly. For instance, if the clients complain that my subordinates are not polite, I have to use both knowledge and skill to find a compromise in the conflict between my subordinates and the clients. However, I should not believe every issue raised by the clients [is true] or I should not believe my subordinates only. I have to be impartial and listen to the reasons of both subordinates and clients* (Ken).

Solutions to managing conflicts between subordinates and clients might be proposed by subordinates. PHC managers should be open to suggested solutions to conflict:

> *I did not want to blame my subordinates when there was a conflict. Instead, I would like to talk with them. I discussed with them the causes of the conflict and its solutions. We tried to evaluate the risks which might happen from such conflict. In order to benefit people in the community, I encouraged them to propose a strategy. I asked them about the weakness and strength of our SHPH. Do they think the clients are satisfied with us or not? What are the problems in our SHPH? Are there enough inventories and medical instruments? I tried to listen to everyone in my team. I think we need to think together* (Pim).

Summary

This sub-theme discussed some strategies that study participants used to manage and lead the subordinates in their organizations. First, participants stated that they had to be able to direct their team to achieve organizational goals by delegating responsibilities and power to their subordinates. In doing this, they needed to consider their subordinates' feelings and competencies in order to match the right task to the right person.

Second, participants stressed that active participation in the running of the SHPH was essential to building teams where every team member feels they can openly share ideas and make decisions. PHC managers attempted to encourage their subordinates to express their opinions by using various decision-making techniques such as informal discussion and voting.

Third, study participants noted that the Thai culture of respect for elders posed a challenge for managers who were younger than their subordinates. Participants suggested that, in such cases, it was important for them to disregard the organizational hierarchical system and employ a family relationship and collegial approach instead. In some circumstances, participants even decided to take the lead from experienced subordinates.

Fourth, study participants described that they needed to be fair and impartial when managing conflicts among subordinates and between subordinates and clients.

5.3 Theme 4: Networking in the community

Theme 4 discusses the participants‘ experiences in networking with stakeholders in their responsible communities. Participants stressed that building trustworthiness and understanding with stakeholders was essential to enable them to work effectively in their responsible communities (first sub-theme). Study participants also identified the strategies they utilized to build networks and teams with stakeholders (second sub-theme). Theme 4, therefore, comprises two sub-themes:

Building trustworthiness and understanding with stakeholders
Networking and teamwork with stakeholders

5.3.1 Building trustworthiness and understanding with stakeholders

This sub-theme described how study participants built trustworthiness and understanding with stakeholders through the processes of 1) developing rapport with stakeholders, 2) community diagnosis and 3) involving the community.

5.3.1.1 Developing rapport with stakeholders

One participant, Chai, emphasized the fundamental need to build rapport with clients: ―*Our organization has to build rapport with our clients*" (Chai). As well, Prera believed it was important that people in the community and the leaders of stakeholder organizations trusted PHC managers.

> *Um… In order to lead people in community and leaders of stakeholder organizations, I think the biggest challenge is how I can get inside their minds. Do they talk about me in positive or negative ways? It is quite a challenge for me to build positive images. It's enough for me if I can be inside their minds about 70 percent. I hope that those people and leaders will talk about or mention me in a positive way. I think this is good enough for me* (Prera).

Good relationships with stakeholders in the community have to be built up by PHC managers in order to build trustworthiness and understanding. This view was presented by Thunva:

> *From my point of view, when I need to negotiate with other stakeholder organizations, I do not like to make a problem with them. In order to work smoothly with them, I need to build good relationships with them* (Thunva).

Another participant, Kaew, agreed that ―*[w]e need to have good human relationships with other people because we sometimes have to work with teachers at schools or staff at the local government organization. We need to talk familiarly with them. I think that they are all my friends"* (Kaew).

In the following comment, Chai explained how he built rapport with people in the community:

> *I introduced myself to the people when I first came to work here. I then tried to develop understanding with them. When clients come to utilize the services at the SHPH, I will let them express their feelings. Then, I will give them some medicine. However, I think that most of the clients would like to find someone to talk to about their problems in order to release their stress. When we give the clients attention, they feel that I am one of their best friends. They will give us back their friendship and trust. Therefore, I can ask them when I need their assistance* (Chai).

Kaew explained how she also tried to build rapport with clients when they came to utilize health services at the SHPH:

> *I do not know about other PHC managers' opinions. But for me, I think I should also have the responsibility for curative care, because I have the opportunity to talk with clients and understand their problems. I also get familiar with them. When the clients come to utilize health services at my SHPH, I usually talk to them while providing them with the treatment. As I just moved to work at this SHPH only two years ago, I get to know the people in the community by undertaking this responsibility* (Kaew).

Another participant, Nawat, reinforced this view of the need to be interested in all clients:

> *We need to have the mentality of service. Whoever comes to utilize health services at our SHPH, we need to have the willingness to provide health services for them. There are two important issues that I would like to emphasize. First, we need to fully exercise our potential in providing health services to the clients. However, if there is a severe case that we cannot treat or manage, we can refer such a client to meet a physician or other health professionals at the higher lever. Second, we need to be impressed by those clients who come to utilize health services with us. I mean we should not only have quality of care, but we also need to behave or treat the clients with good manners. As a result, I think we need to consider both the quality of our care and the satisfaction of our clients* (Nawat).

Rasa further suggested that PHC managers should pay special attention to those clients who work in the stakeholder organizations and come to the SHPH for assistance:

> *When the clients working at other stakeholder organizations get sick, I attempt to give attention to these clients who come to utilize health services at my SHPH. I enthusiastically talk to them and treat them and try to make them feel comfortable. In the same way, when we have to coordinate with them, we can easily talk to them* (Rasa).

This was also the approach taken by both Khwan and Ken:

> *Actually, I pay attention to every client. However, when the stakeholders, such as VHVs or staff of the local government organization, come to utilize health services at the SHPH, I have to pay more attention to these clients. Sometimes, if the stakeholder clients have some urgent work, I might need to ask other clients to let those stakeholder clients jump the queue* (Khwan).

> *We have to pay more attention to the community's leaders. When they come to utilize health services at the SHPH, we have to have a special track for them. Someone might criticize me about equality and human rights issues, but I do not mind. As I have been working as a PHC manager for almost 25 years, it is important to do it like this* (Ken).

In order to develop rapport with people in the community, Sarun proposed:

> *Um … I need to show respect to people in the community, particularly to a person who is older than me. I have to initially greet the community leaders even though they are younger than me. Also, I have to say "hello" to everyone in the community. When they come to utilize the health services at the SHPH, I will welcome them and informally talk to them. I try to show them respect* (Sarun).

Prang pointed out that simply having a discussion seemed to be an effective way to build understanding and rapport with people in the community:

> *We help people understand more about our SHPH by talking with them. Then, the relationship between us and people is increased* (Prang).

Pim believed that, when discussing things with people in the community, she could obtain important information:

> *When I began to work at this SHPH, I went into the community and talked to the elderly in order to get to know them. I also asked them what they thought about the way services and activities were previously conducted, before I came to work here. Then, the elderly told me such and such. I would like to obtain information from various views* (Pim).

This perception was consistent with the view of Prera that tapping into people's knowledge and understanding their concerns were the key ways of working in the community:

> *We should not directly command them. Instead, we primarily need to know and understand their problems. What concerns them? How about their health? Do they have any problems about their career? Do they have stress or headache? How can we help them? We need to talk to them and help them. After their problems have been solved, we then talk to them about our plan. It is not appropriate if we only ask assistance from them* (Prera).

Chai added that PHC managers should be active listeners too. He argued that, when he listened carefully to stakeholders, he could gain important information about their opinions and needs and would then be able to give them relevant assistance:

> *When I work in the community with them, I attempt to be a good listener. I do not like to order them. I try to listen to their opinions. I attempted to listen to their needs. Then, I helped them write the project for using the funding. Finally, they got the funding of about ten to twenty thousand baht* (Chai).

Since Thailand has a mutually supportive culture, PHC managers cannot work alone in the community. Win pointed out that everyone needs to help one another:

> *I think that the civil/government system in Thailand is the so-called supportive society. Thus, management does not involve only myself alone. We need to look around ourselves. We need to help other organizations* (Win).

Thunva commented that assistance to others needed to be given with sincerity:

> *We live in the same community. We need to help each other. We live in a small community. We need to show people our sincerity. I think we will work successfully in the community if we provide the people with assistance and do not only seek advantages from them. Then, I believe that people will know whether we are sincere towards them or not* (Thunva).

This view was consistent with that of Yada:

> *When I needed to do a charity event with my networks in order to get assistance from them, I told my networks that everything I did was for everyone in this community. I would not take all I did with me. After I retire from my position, their children and grandchildren could still utilize all I did. I also told them that if they were older they could also come to utilize health services at this Thai medical centre. This is the way I communicate with my networks. I attempt to show them that everything I do I do it for their community* (Yada).

Thunva gave an example of how he provided assistance to stakeholders:

> *I attempt to provide support to networks if I can. If they would like to borrow equipment from me, I will gladly let them borrow it. For example, the teacher came to borrow a table and chairs from me* (Thunva).

Another participant, Chai, explained that, when he provided teachers with assistance to help them in their work, he would, in turn, receive assistance from them:

> *For example, in the school, I offer the teachers a hand. I mean I try to help the teacher with the work related to health issues. The school has to be evaluated for quality based on the criteria of the basic education commission, Ministry of Education. There are the criteria related to health issues such oral hygiene/health of students, the ratio between weight and height of students. I train the teachers how to check the oral hygiene and calculate the ratio between weight and height. I will provide the instruments. Besides, when the teachers need to teach the students health education, I will provide the teachers with posters and leaflets. The teachers can use all of these things for their quality evaluation. In the past, I have to do all of this work by myself, but now the teachers have the capacity to do it all. From my point of view, when I began to actively work with other stakeholders and provide them with assistance, I then gained assistance back from them* (Chai).

5.3.1.2 Community diagnosis

Chai believed that spending time in the community enabled him to become familiar with and sympathetic to his clients‛ circumstances. His clients would trust him and tell him truthfully about the weakness of the SHPH and he could thus improve the organization using their suggestions:

> *I need to spend plenty of time to study the community because if I do not have enough information about the community I am responsible for, there will be many problems. Besides, if you go into the community, you will get to know and be familiar with the people in the community. When the people come to utilize the services at the SHPH and they are faced with a problem, they will call to inform me about the issue that needs to be resolved. After I have obtained such information from the clients, I will set a plan to solve it. On the other hand, if I'm not familiar with such clients, they will not let me know. Instead, they might gossip with other people about the problems of the SHPH. This will finally damage the image of the SHPH* (Chai).

Pim also pointed out that information about the characteristics of the community was crucial to enable her to develop a realistic plan to solve a health problem in her community:

> *If we would like to know what a community's problem is, we need to study and analyze the community. After we gain the community information, we will use this information to set up a plan for the community* (Pim).

Prera shared this view: *"And ... um ... we need to know how to solve a problem in the community. We need to know the characteristics of the community"* (Prera).

Inappropriate working with people in the community might be caused by a lack of information from and about the community. This view was proposed by Pim:

> *Sometimes, we need to learn from the community too. Something that we desire to tell people to do might not suit them. What should I say? Um ... it might not suit the life-style of those people* (Pim).

With appropriate information, Ken could design the health services to suit the life-style of his clients in the community:

> *We also need to know information about the community. Even though I do not know about my community 100 percent, I try to know as much as I can. For example, we need to know the geographical information of the community and the main careers of people. Do you know I used all of this information to plan the health services in my SHPH? As the people in my community mainly work in the government organization, I thus decided to open a Thai traditional health centre. I think that they are quite wealthy and wish to use the Thai traditional services* (Ken).

Chanon agreed with the above view and gave this illustration:

> *For example, Miss ABC (the previous PHC manager) used to provide health services that are consistent with the life-style of the clients. The clients are mainly agriculturists and they need to work in the early morning. Thus, Miss ABC would open the SHPH in the early morning too. This is one example of the method of how to build relationships* (Chanon).

In the following comments, two participants, Ken and Pim, gave examples of the essential aspects of the community that PHC managers should know:

> *We need to investigate information about the community. If someone asks you about your community, you should be able to answer him/her. For instance, how many villages are there in your community? What are the names of the community leaders? How are the people in your community? What are the major health problems? What is the emphasis in the policy at the provincial level? This is the important information that the PHC managers need to know* (Ken).

For example, we have to know when people will go to make merit at the temple. We need to study information about the community. It seems like we have to work and live in the community (Pim).

Chanon added that:

First, I need to have information about the community. I needed to go into the community in order to study the context of the community. Fortunately, there were the Buddhist ceremonies, such as Thod-Kathin ceremony, which were arranged in the temple when I came to work at this SHPH. I found that the people in this community are generous. They have the willingness to help each other. Also, there was cooperation and assistance from the temple and school. Besides, I also knew that the people in this community used to donate their money for charity in order to renovate the health centre. This shows that people have a public spirit and are generous. They have the kind of Thai characteristic which is a willingness to help each other (Chanon).

5.3.1.3 Community involvement

Good relationships could be built up by being involved in community activities. This perspective was pointed out by Prera:

Besides, relationship-building is another important skill. We can build relationships by getting involved with the activities or events of people in the community. For instance, if there is a cremation event or religious ceremony, we should participate in such events (Prera).

Praw emphasized that:

As I'm the PHC manager, when the clients in this community invite me to participate in their ceremonies, such as a cremation or a wedding, I need to participate almost every time. I think this can promote my work because I can then easily get assistance from them when I request those clients' assistance. I attempt to participate in every event in the community. However, if I am not available, I will tell my subordinate to participate in the events instead of me. As I said, this helps me a lot when I need assistance (Praw).

For Kaew, attending community activities seemed to be one of the essential responsibilities of PHC managers:

> *Recently, I was invited without warning to deliver the speech at a subordinates' ceremony. Um ... I am always invited to be a chairperson in many events such as cremation or wedding ceremonies. I did not need to have this responsibility when I was the subordinate but, when I became the PHC manager, I have to have this responsibility. I have to do blessings at birthday and wedding parties* (Kaew).

Chai explained that he also attempted to build good relationships with stakeholders by attending their activities:

> *The teachers have a plan to teach or train the people in the community. Therefore, I always ask the teacher to let me know if they have a training session in the community. I am really keen to participate in such training with those teachers. Also, the teachers like to have someone to help them in training people* (Chai).

Rasa pointed out that participating in community stakeholders' activities was not the only strategy used by PHC managers to build rapport with the community. PHC managers could also create an activity at the SHPH and invite stakeholders to participate:

> *I also build interpersonal relationships. For example, we arranged a party and invited other stakeholders to participate in the party. Besides, we organized a sport competition in the community with those stakeholders. I attempted to encourage everyone to participate in the competition. In my SHPH, we have already bought sports equipment, such as table tennis. Thus, everyone can come to play every evening. After that, we sometimes cook food and have dinner together. I attempt to build relationships with everyone in as many ways as I can* (Rasa).

Home visiting was another strategy employed by Khwan for becoming involved with people in community and building rapport with them:

> *Um ... I mostly go into the community in order to build familiarity with people. I and my three subordinates visit the clients' homes. Um ... sometimes, we went to eat food with those people. For example, when we had the disease prevention activities with the VHVs, they always made food and invited us to eat food with them. I think it is good because those people in the community feel familiar with me and my subordinates. Thus, I can easily work and comfortably cooperate with them* (Khwan).

Another participant, Ake, emphasized that *"[i]n order to work in the community, we have the team visit the clients at their home"* (Ake). For Prera, stakeholders needed to be a special focus of the manager's work: *"[w]e need to visit stakeholders if they get sick. If we do not know them or are not familiar with them, it will be difficult for us to ask for assistance from them"* (Prera).

These views were consistent with those of Kaew:

> *I think I need to use a psychological technique. Actually, I'm not sure whether it is a psychological technique or not. I usually go to visit clients and stakeholders at their homes. Sometimes, I even eat with them. I go to visit the VHVs and village headmen. They sometimes cook food for me when I have to work with them in the community. Thus, I think I need to visit them* (Kaew).

A home-visiting team for clients with chronic diseases or disabilities living in the community was formed by Por:

> *There is a team for visiting the clients at their homes. The team members consist of the staff from both the SHPH and the Naresuan University Hospital. We have home-visiting for the clients with chronic diseases or disabilities. There are currently around thirty-seven clients that need to be followed up at their home. There are around ten handicapped clients who cannot help themselves. Thus, our home-visiting team has to pay more attention to the ten handicapped group* (Por).

Another strategy used by Prang to build rapport with community stakeholders was to attend the meetings of stakeholders:

> *Other organizations did not know me. Initially, I needed to meet them in order to become familiar with them. It took almost a year. I tried to attend their meetings. Although they did not invite me to the meeting, I asked them to invite me* (Prang).

Involvement in community meetings could not only contribute to greater rapport, understanding and trust between the PHC manager and people in the community, but the PHC manager could also use these events to notify people, especially stakeholders, about

work of the SHPH that might be relevant to those people. This perspective was explained by Pim:

> *As I had already explored the community and found that there was a community meeting, I tried to attend this meeting. The community meeting is arranged at the local government organization and there are both the community leaders and the representatives from various organizations. In the meeting, each participant will get the chance to present their own work. Sometimes, when I presented my work, there were some participants asking me about health issues. I thus had to provide them with the information. I think participating in the community meeting is good because I could get to know many important leaders in this community* (Pim).

Support for this view came from Prang: *"I also need to inform the staff of both municipalities about the concept of the SHPH. Besides, when I need assistance or support from them, I will raise those issues in the meeting. I attempt to make them understand about the SHPH"* (Prang).

There were many important issues that Prera could convey in the meeting:

> *We need to inform them about the situation of our organization. What are we doing right now? What is our weakness? How can we develop our organization? What is the situation of our human and budget resources?* (Prera).

Chai noted that he used these meetings to update clients with information about the SHPH staff's qualifications and the health services provided at the SHPH:

> *I will inform people about our services provided at the SHPH and the competencies of our staff. I try to build up the people's trust in our staff. I told them that we have registered nurses working at the SHPH. These nurses were born in this community and are currently working at the SHPH* (Chai).

As well, Pim used community meetings as an opportunity to distribute information about the SHPH's activities or projects:

> *From the community meeting at the local government organization, I could gain essential information from both the community's leaders and the representatives of other organizations. At the same time, other participants*

could also gain the SHPH's information from me. Besides, if I wanted to conduct a health promotion project in the community and I would like to invite people in the community to join in this project, I could announce it in the meeting. I can tell the village headmen to further inform the people living in their responsible villages (Pim).

When he gave information to stakeholders, Chai explained that he could also ask for their assistance. For instance, he received help from the VHVs and staff working at the local government organization:

Err… I ask for help from the VHV). I will inform VHVs about health issues. Then, VHVs will further inform the people in their responsible households (ten to twenty households). I know that VHVs have also many responsibilities involved with the local government organization, the non-formal educational centre, and currently with the bank for agricultural cooperation. Thus, if some VHVs have no time or it is difficult for them to do something, I will do it by myself. Besides, I have no problem to work with the local government organization. When there is a case (DHF case), I will immediately inform the local government organization to manage this problem. The staff from the local government organization will spray the chemicals to kill mosquitoes. So, I do not need to be concerned about this problem. However, I will also go into the community in order to work with the staff of the local government organization. I think this is the strength of our team (Chai).

Summary

The processes of building trustworthiness and understanding with stakeholders in the community were presented in this sub-theme. First, study participants indicated that rapport with stakeholders had to be developed in order to build trustworthiness and understanding with them. They stated that they could build rapport by showing stakeholders respect and providing them with assistance and support.

Second, study participants indicated that they could familiarize themselves with stakeholders' circumstances when they took time to investigate details about the community. They said that such information could be used to set up plans in solving community health problems. They also emphasized that they could better tailor the SHPH's services when they understood the lifestyle of stakeholders.

Third, study participants explained that they could build good relationships with stakeholders by becoming involved with their community activities, visiting them at their homes and attending their meetings.

5.3.2 Networking and teamwork with stakeholders

Sub-theme 4.2 discussed the strategies utilized by study participants for working in the community. First, the participants explained that they needed to build networks with both the formal and informal stakeholders in the community. Second, they explained that they needed to coordinate activities in the networks they built. Third, they believed that community participation was an effective approach to working with stakeholders in the networks. Fourth, they explained that they needed to delegate their power in making a decision to the stakeholders. Fifth, they explained that they needed to motivate those stakeholders, to whom they had delegated their power, to work. Sixth, they pointed out that they needed to manage conflict which occurred among the various stakeholders in the networks.

5.3.2.1 Building networks

One participant, Prera, noted some basic tasks for managers: *"Um ... Yes. I attempt to build the network and the team"* (Prera). Prang expressed a similar view, noting that building partnerships was one of the main responsibilities of the PHC managers:

> *I need to build partnerships. I have the responsibility to build partnerships, with stakeholders and representatives in the community, to work for the benefit of people in the community* (Prang).

Another participant, Por, believed that *"[i]t's necessary to work with others because doing anything alone makes it difficult to achieve success"* (Por). This view was consistent with the view of Chanon, who noted that, due to the human resources shortage in the SHPH, assistance from networks in the community was crucial for him to successfully manage the SHPH:

> *In our organization, only two or three staff could not do everything. In order to be successful, we need to have assistance from outside. We could not work*

> *with only our staff in the organization in order to pass all 105 KPIs determined by the Ministry of Health* (Chanon).

This participant illustrated his point regarding the assistance he received from people in the community in this way:

> *Yes. We need to get a hand from everyone. For example, the people can help us in building the infrastructure of the health centre* (Chanon).

Prera argued that both formal and informal leaders in the community were important to include in the network of those that PHC managers needed to build trust and understanding with:

> *It is essential for us to know both the formal and informal leaders in our community when we need to manage and work in the community. Also, we need to know the stakeholders in the community* (Prera).

Ken emphasized that knowing how to contact community leaders was important for networking:

> *Importantly, we need to have a network with the community leaders. I always tell everyone that we need to know the community leaders. For me, I have the phone number of every community leader, such as the village headmen and staff working at the local government organization. It is a fault for a PHC manager if he/she does not have all of this information. Sometimes, you even have to know the favourite spots of the community leaders* (Ken).

Kaew agreed with this view, commenting *–I think it is important for me to work in the community. I think the PHC managers should not only provide health services at the SHPHs, but we also need to know the key persons in the community, such as the village headmen and staff of the local government organization”* (Kaew).

In the following observations, Khwan and Pim identified the significant networks that the PHC managers had to work cooperatively with:

> *Our network is obviously the VHVs. Besides, we have to work with the village headmen, teachers and staff members at the local government organization.*

Currently, developers are another network that we have to work with (Khwan).

The first network is the community leaders such as village headmen. The second network is the VHVs. The third network is the staff working at the local government organization. The fourth network is both the teachers at schools and also the students' parents. The fifth network is the community developers who try to create careers for people in the community. I got to know them at the community meeting. The sixth network is the agricultural officers. They are working at the Bank for Agriculture and Agricultural Co-operatives (Pim).

The VHVs, representatives of people in the community, constituted one of the important groups to include in the PHC manager's network. This perspective was taken by Ken and Por:

The VHVs are one of the important mechanisms for us to work with people in the community. They work instead of us. I mean they help us in every aspect. Besides, there is the VHVs day. This shows that they have an important role in Thai society (Ken).

In my opinion, I think these VHVs are so kind because they are public-minded. They wish to help me. They wish to help others (Por).

One participant, Thunva, noted that *"I think if the MoPH has no VHVs, all of the tasks cannot be done easily"* (Thunva). Prera believed the cooperation of the community was necessary because *"[a]*s *you know, it's hard to work alone, it is necessary to build a team, particularly the team of VHVs"* (Prera). Yada agreed: *"Um ... We need to accept that we could not visit or meet every person in the community. However, I attempt to build a team with the VHVs"* (Yada).

To demonstrate the value of the assistance provided by the VHVs in this way, Pim gave this illustration:

As the VHVs are our network, they can help us to explore the community information. I asked them to survey the information of their responsible households. Each VHV usually has around 15 households as his/her responsibility. Besides, the VHVs can help us to distribute our information to people living in their responsible households. I usually print out the information and ask the VHVs to distribute it (Pim).

Chanon expressed the view that it was fortunate for him that some of the VHVs filled other important roles in the community. For example, some of them were village headmen or staff working at the Tambon (sub-district) Government Organization:

> *From the community leader, the village headmen is another group that we need to work with. There are two village headmen. Fortunately, there is one village headman working with us as a VHV. Thus, I have more chance to meet and discuss things with this village headman. Besides, the staff at the Tambon (sub-district) Government Organization are also working with us as VHVs. We get more advantage from VHVs who come from various stakeholder organizations* (Chanon).

This view was consistent with that of Yada:

> *Fortunately, our VHVs also have another important role in the community. Some of them hold the village headman's position. Some of them also are political leaders. Therefore, these VHVs can help us with working in the community. I began to work in the community by building a few networks and those few networks are getting bigger now* (Yada).

Because of the advantages of having the support of those being VHVs in the community, Nawat attempted to encourage key leaders in the community to become VHVs:

> *I needed to find a way to encourage the community leaders to get involved with me. I invited every village headman and their assistants to become the VHVs. Also, I invited the representatives from the local government organization to become the VHVs. I told these village headmen and their assistants and the representatives from the local government organization that they actually did not need to do anything. They only help me to disseminate my messages to people in their responsible area. When there was a meeting, they only came to attend the meeting. I attempted to build familiarity with these community leaders* (Nawat).

One participant, Por, expressed the view that senior VHVs could assist her to recruit a qualified person in the community as a new VHV:

> *In fact, the new VHVs were recruited by the old VHVs. I mean the old VHVs tried to invite other villagers to become VHVs. They tried to invite the villagers who were public-minded and who were good leaders of each village. Some of them might be the assistants of the village headman. Some of them might work at the local government organization. Some of them might even be*

the relatives of the old VHVs. These villagers were invited to become the VHVs by the old VHVs (Por).

This participant argued that there were increasing numbers of the VHVs in the community she was responsible for:

> *When talking about how I recruited the VHVs, I have to begin by telling you that there were not many VHVs when I came to work in this SHPH. Currently, there are around seventy VHVs working with me* (Por).

However, Por pointed out the drawback of the VHVs: *"I found that we lacked young VHVs. Most of the VHVs are middle-aged to elderly and the majority of them have a low education. Thus, they had difficulty doing the documentation work"* (Por).

Prera suggested that PHC managers needed to train the VHVs in order to increase their competencies:

> *If the VHVs have more knowledge and skill, they will help us better. Thus, we need to train them and practise them in order to increase the competency of our team* (Prera).

Networks among the healthcare organizations located in the same district, also called –zone", could provide assistance to each other when the District Health Office allocated a special task or when there was a problem occurring in a SHPH. This view was represented by Praw and supported by Prera:

> *We also need to work with other SHPHs located in this zone* (PHCM10).
>
> *In this district, SHPHs located in the same area are grouped as the so-called zone. Thus, there is the team of health staff who are working at SHPHs located in this zone. When SHPHs are assigned the jobs from the District Health Office, the health staff team of my zone will discuss and share our opinions regarding such jobs. Or when there is a problem, the health staff team will help each other* (Prera).

This perspective about networking with other SHPHs was shared by Win:

> *This is a kind of job where we need to work as a team with other SHPHs* (Win).

This participant emphasized that this mutual assistance among SHPHs would not occur if PHC managers did not help each other:

> *There was a formal invitation letter. I was a member of a team in this district. If I did not help the SHPHs of other sub-districts, the staff from other SHPHs would not wish to help me when I need their assistance* (Win).

Chanon explained that he received assistance from the staff working at the District Health Office:

> *There is one staff member working at the District Health Office. This guy has already got a Master's degree in Public Health, the same as me. He is an expert in terms of academic tasks. So, he can help us in conducting research and writing articles* (Chanon).

Another group that it was important to include in the PHC manager's network was the Tambon (sub-district) Government Organization, Praw explained:

> *The Tambon (sub-district) Government Organization is one of the important organizations we need to work with* (Praw).

Chanon reinforced the view that the Tambon Government Organization was a key stakeholder organization:

> *The Tambon (sub-district) Government Organization located in this sub-district has the power and staff at TGO have already given attention to health issues. As I have just begun to work with them, I currently try to inform them about the information regarding health problems. However, the TGO has already supported some health projects. This is the first stakeholder in this community* (Chanon).

Por explained the important reasons for networking with the Tambon Government Organization:

> *There are two main reasons why we have to work with the local government organization. First, I have to contact the local government organization because the budget is transferred from the National Health Security Office to the local government organization and I can utilize that budget by writing a project for the local government organization. Second, I have to participate in*

> *the activity arranged by the local government organization when there is an invitation letter from the local government organization. Or I sometimes have to formulate the community plan with the local government organization. I attempt to participate with the local government organization. Thus, when we have an activity or need assistance, the local government organization will participate in our activity or will be keen to help us. For instance, when we have a meeting with the VHVs, the director of the local government organization sometimes comes to attend that meeting with us* (Por).

Another participant, Chanon, further indicated that much support was provided by the Tambon (sub-district) Government Organization because he has had a good relationship with this organization:

> *I just came to work here. But I think that the Tambon (sub-district) Government Organization has quite an important role because we can request support, such as the budget of the SHPH and community funding, from this organization. If we have a good relationship with them, we will get many advantages. Working in this SHPH is quite fortunate because the previous staff have already built connections with the Tambon Government Organization. I need to show gratitude to those staff who have already created a good relationship* (Chanon).

This participant also indicated that he could obtain benefits from the Community Development Organization in his SHPH network:

> *There is the Community Development Organization. We also have a good relationship with this organization and it is easy for us to ask for assistance from this organization* (Chanon).

Clubs formed by the PHC managers are important mechanisms for networking in the community. This view was pointed out by Praw:

> *Besides, there are still many clubs. When I came to work here, I attempted to form clubs with people in the community, such as an elderly club, physical activity club and bicycle club. The members of the bicycle club are mainly vendors and shop-keepers in the fresh food market. Thus, they are all quite wealthy people* (Praw).

Pim explained her view: *"I try to frequently talk to, or set up a meeting with, key leaders in the community. I began to work in the community by finding the key leaders. Then I encouraged these key leaders to form a club or group"* (Pim).

Praw suggested that PHC managers should not only form local clubs but they also needed to participate in the clubs' activities and attempt to continuously provide such clubs with support:

> *I have to join in the activities of each club. If I do not participate with them, they will not do so with me. Though I feel tired, I still need to do it. I need to be the main actor at the initial or formation stage. Since I became the PHC manager here, I have attempted to form the elderly club without any financial support. Until 2003, there was some budget from the municipality which could be spent for supporting the activities of the elderly club. I had to learn aerobic exercise with the staff working at the district health office. I then had to teach the leaders of the elderly club about aerobic exercise. As there was some budget from the municipality of four-thousand baht ($130) per month, I used it as payment for the leaders of the aerobic exercise activities. The leaders of aerobic exercise activities were mainly the VHVs and they were trained by me in order to be the leaders of aerobic exercise activities* (Praw).

This participant believed that the clubs would provide the SHPH with assistance when it was needed:

> *Building networks means that we need to participate with them. If we would like to know someone and would like to obtain assistance from them, we need to contact them and participate in their activities. Then, if we ask for any assistance, they will help us in every activity. However, I do not want to bother them too much* (Praw).

PHC managers also need to work in schools located in the community. Thus, Chanon proposed that teachers were key people locally and they should be recruited as one of the groups in the community networks the managers work with:

> *The second stakeholder in this community is the school. According to the SHPH policy, we need to have a committee from various stakeholders. We need to have a committee and we already invited teachers to be on one of our committees. When we set up a meeting, the teachers are keen to attend every meeting. Also, when there was an activity or project, the teachers would*

> *recruit the students to participate in our activity/project. This is a good culture/tradition of other stakeholders in this sub-district. Therefore, working in this area is quite easy. Besides, when they give us assistance, we also need to give them our help in return* (Chanon).

Yada noted the importance of contact with the local Buddhist temple in networking: *"Another network is the temple. There is an abbot. It's quite easy to work with him because I usually go to make merit at the temple. Thus, I've become familiar with this venerable monk. I talk to him about his health condition. How does he feel about his health? If he has any pain or ache, I will provide him with medicine"* (Yada).

5.3.2.2 Coordination

Because PHC managers have to deal with various stakeholders in their networks, Praw raised the important issue of coordination:

> *I have the responsibility for coordination. My subordinates seldom carry out this responsibility. Instead, I coordinate with networks for my subordinates in most activities. Sometimes, I think: did I help them too much? If I did, my subordinates might not get to know other networks. However, my subordinates told me that I, as the PHC manager, am the most appropriate person for coordinating others. Thus, the coordination responsibility is still one of my main responsibilities* (Praw).

This view was supported by Win: *"The main task of community work is related to coordination"* (Win).

Win and Yada believed that PHC managers had an important role in contacting, informing and working with several stakeholders in the community:

> *The coordination task is the first activity of the PHC managers because my subordinates have less chance to make contact with others. The PHC managers have to coordinate with all of those organizations in order to inform them about a project's details* (Win).
>
> *We need to talk to and inform our networks. We need to make them understand our work or plan. Importantly, we need to be able to carry out the plan we talk to them about* (Yada).

In order to coordinate and communicate with stakeholders in the networks, various techniques were used by Kaew:

> *I will go to meet networks by myself. Sometimes, if I become familiar with them, I can just write a letter and ask the VHVs to send it for me. Besides, as we all have a telephone, um … I can call to coordinate with the stakeholder organizations* (Kaew).

Another participant, Pim, added that: *"I communicate with my networks by using both an official letter and a loudspeaker in the village [public address system in the community]"* (Pim).

The PHC manager had to know who to work with in his or her network, particularly when a problem emerged in the organization. This view was expressed by Rasa:

> *I think that the PHC managers should know where and with whom they should co-ordinate when there is a problem occurring. It is necessary for the PHC managers to be able to solve the problem* (Rasa).

Chanon gave this example of a circumstance when a PHC manager might have to request assistance from his or her network:

> *Some SHPHs do not have the staff who know about these (IT) techniques or skills. However, the PHC manager needs to know and coordinate with a person who can solve a problem regarding information technology* (Chanon).

The method of coordinating tasks in this way was illustrated by Rasa:

> *Coordination with stakeholder organizations is important for us because these organizations can help me and my subordinates to work better in the community. We need to know where we can ask for assistance when there is a problem. For instance, as there was flooding occurring in another community, there were some clients from that community who came to utilize our health services. Unfortunately, some of those clients had lost their identification card. Consequently, they could not utilize our health services. However, I attempted to help them by coordinating with the district officer in order to find a solution. Finally, those clients could be issued with a new identification card at the district office and they could utilize the health services as it should be* (Rasa).

In addition, Chai pointed out that a PHC manager might even have to coordinate different groups in the network:

> *I need to manage and coordinate with the heads or representatives of each community. I will inform them about the details of an activity or project that will be held. I will talk with them in order to draw up an agreement. If they do not agree with such activity or project, I will ask them what they need. Or do they want any assistance from other organizations in the community such as assistance from the local government organization. Then, I will coordinate and work it out for them. I need to follow a plan and I need to be the coordinator in the community* (Chai).

5.3.2.3 Community participation

The concept of community participation was emphasized by Prera: *"We need to enhance all of these stakeholders to participate with us"* (Prera). Another participant, Pim, pointed out that *"[s]ometimes, the people in the community reflect their opinions to us. Thus, we have to accept what they need and do not need"* (Pim). Ake also suggested that:

> *In order to utilize the community fund, the stakeholders in the community have to set up a plan together. The stakeholders refer to the community leaders such as village headmen, representatives from the local government organization, and VHVs. Each stakeholder can propose the projects and its objectives and we can discuss and prioritize each project together* (Ake).

According to the SHPH policy, an important task for PHC managers is to gain people's participation and cooperation. It is up to PHC managers to work out strategies for gaining participation. This issue was pointed out by Chanon:

> *I told them (stakeholders) that the cooperation and participation of people are one of the important criteria. I attempted to brainstorm with the community leaders about the methods or strategies that could be used to encourage people's participation* (Chanon).

A meeting was commonly arranged in order to brainstorm for ideas to gain public participation in resolving community health issues. This strategy was employed by Prang and Win:

> *I conduct a meeting in order to brainstorm the opinion of people in the community. We can finally gain a solution to a problem in the community* (Prang).

> *We arranged a meeting with the village headman and people in the community in order to find a solution* (Win).

Thunva normally arranged a meeting every month with those is his network and his subordinates:

> *In each month, there are two formal meetings in my SHPH. The first meeting is arranged for every representative of the networks and my subordinates, while the second meeting is set only for the heads of representatives. We discuss and find solutions in these meetings* (Thunva).

As well, Por stated that:

> *As there are the village headmen in every village, I set up a meeting with VHVs every month. I attempt to translate my knowledge and information to them. I also have to work together with these community leaders. As I just said, I arrange a meeting with both the village headmen and the VHVs on the 5th of every month* (Por).

In organizing community participation, at first, the PHC manager needed to initiate the meetings with community representatives. When there was an urgent issue, the PHC manager needed to set up a meeting for timely discussion of that issue involving only the main representatives of the network in order to find a preliminary solution. A final decision would then be made in consultation with all representatives in the network. This strategy was used by Prera who explained:

> *Actually, I will set up the meeting of the VHVs every month. However, if there is an urgent issue where I need to draw an idea from all of the VHVs, I need to set up a meeting with the chairman and vice-chairman only of each village. After we have already discussed it and shared our opinions about it and set up a plan regarding this urgent issue, we will bring the plan to further discuss it in the monthly meeting with all the VHVs. Therefore, we can save time and every VHV will have a chance to participate in making a decision regarding this plan again* (Prera).

The above method for arranging meetings was also used by Chanon. He thought that the PHC managers should set up a meeting but should allow people in the meeting to create their own plan:

> *In the monthly meeting of VHVs, I will not conduct such a meeting for them. I mean, I will let the VHVs run the meeting by themselves. They need to plan for their budget. They need to manage everything. They need to create their own plan. We only support them or consult with them. For example, we help them type the plan (because they have no skill in using a computer). Hence, the chairman in the meeting must be the representative of the VHVs. Today, there was a meeting. Mr. ABC (VHV) who used to be the village headman proposed in the meeting that VHVs should work as a team. As you can see, we only support them and let them think. Or we might need to make an appointment for them. In the meeting, we might be the moderator* (Chanon).

Chanon also described the strategy he used to encourage the involvement of people as follows:

> *Consequently, a charity event (Thod-Pa-Pah) was arranged again. The people donated their money in order to help us improve this SHPH. Finally, we were successful in terms of community participation* (Chanon).

Other brainstorming strategies were mentioned by Prera, such as ―strategic road map”, ―public policy” and ―the health constitution”. Actually, these strategies have similar concepts in that people have an important role in solving their own concerns. These methods were utilized in order to motivate and encourage every stakeholder level to analyze their own problems. Then, when they knew their circumstances, they could properly formulate their own solutions:

> *Um ... there is another planning strategy called 'public policy'. It is about community analysis by people living in that community. When the people know their own problems, they can then formulate the policy. The people create their own activities 1 2 3 regarding their policy. It is kind of participatory strategy. The people think up policy by themselves. Thus, this process is called 'public policy'. I think that this planning strategy is similar to the SRM. And 'the health constitution' is another planning strategy. Actually, it's similar to the 'strategic road map' (SRM). It is another choice for you. In terms of the health constitution, it was conducted by the municipality located in this sub-district. Um ... the people have participation*

and they know their own problems. Again, it actually looks like the SRM. It is the process of enhancing the participation of people and other networks in the community. We need to talk with every level of stakeholders in order to figure out the same goals. We need to clarify our responsibilities. The networks might be the Tambon (sub-district) Government Organization, community health clubs, education sector (a teacher from the school), and the religion sector (a monk from the temple). We need to elucidate the roles of each network. The representatives from each network will discuss with each other in order to identify their own responsibilities (Prera).

5.3.2.4 Power delegation

Managers believed that, although the Thai government is a hierarchical management system, PHC managers, as government servants, should not abuse their power and autonomy in their communities. Instead, they should add value to the people in their communities. Then respect and assistance will be given to the PHC managers. This perspective was emphasized by Prera in the following comment:

We should not think that we are a government servant with high rank of nobility. Actually, we have the same status as people in the community have. We should not stick firmly to the hierarchy in the government system. We have to see the value of each person. If we only think that we are a government servant and we have a higher rank, we will not get any assistance or cooperation from people in the community (Prera).

When PHC managers acknowledge the value and potential of others, PHC managers will be more confident in trusting community members and in delegating power to them to make decisions. Prang noted:

I would like to strengthen the teamwork in our organization and community. Thus, I attempt to find a representative who has potential to do the work instead of me. I attempt to empower them. For instance, I will let the head of the group make the decision instead of me (Prang).

This participant believed in the potential of her subordinates and VHVs and assigned them to be her representatives in the meeting when she was not available:

Suppose there are four meetings on the same day, I could not attend every meeting. Thus, I will assign my staff or a VHV as my representative at such meetings (Prang).

Another participant, Ken, pointed out the drawbacks if PHC managers did not believe in the potential of others and did not delegate responsibilities to others:

> *As my wife also works as a PHC manager in another district, she is always very busy and looks so tired. She will do everything by herself. For instance, if she plans to bring the VHVs to have a field trip, she will arrange everything. As she does not believe in others, she will manage all of the money, find and book the buses, and so on. On the other hand, for me, I will assign the task to others. I try to distribute the work. I think delegation of responsibility is imperative. The PHC managers should be able to do this* (Ken).

However, when the PHC managers need to delegate responsibility or a task to someone, it should be in accordance with the potential of those chosen for the task. This stipulation was proposed by Chanon:

> *Yes. It seems that we will have a chance to talk and consult with them (VHVs). We need to use a number of strategies. As there are not many VHVs, if we need to mobilize people to participate in an activity with us, we need to find someone who has public relations skills. For instance, Miss ABC is a VHV and she has such skills. Then, I will let her distribute the messages or news to other people in the community. Therefore, we need to assign the right job to the right person* (Chanon).

Forming a committee comprising representatives of the community was a popular management strategy used by PHC managers. This strategy was mentioned by Kaew:

> *Um ... in terms of delegation of responsibility, I appointed the committees for every task. For example, there is a consumer protection committee, physical activity committee, VHV committee and SHPH development committee. We will set up a meeting every two months* (Kaew).

Thunva explained how he formed the VHV committees:

> *My community work began at the small points. I mean I would set up the representatives of each village. In my responsible district, there are 11 villages. I attempted to select VHVs as the representatives of each village. Those representatives would further manage themselves by setting up their chairman and vice-chairman* (Thunva).

Kaew also argued for the criteria and techniques she used to form the members of each committee in this way:

> *The members of each committee could be selected from various groups of people in the community. For instance, I selected VHVs as the consumer protection committee because there are VHVs in every village. I selected the community leaders, such as village headmen and staff of the local government organization, to be members of the SHPH development committees because they have power and some of them could provide us with financial support* (Kaew).

The importance of establishing a SHPH development committee was also mentioned by Rasa. She noted that:

> *According to the SHPH policy, we need to form a committee. The committee has the main responsibility for developing their community. Actually, this committee has already been formed before implementing the SHPH policy. However, we just changed the committee's name to 'the SHPH development committee'. In the past, we had only the committee but no formal name* (Rasa).

The members of the SHPH development committees consisted of various representatives of people and stakeholders in the community, as explained by Pim:

> *The committees consist of three stakeholders including the representatives of people in the community, the staff at the local government organization, and staff at the SHPH* (Pim).

Praw added that:

> *Most of the committees are the VHVs and some of the VHVs are also working at the local government organization* (Praw).

An example of the position of each member of the SHPH development committees was given by Pim:

> *According to the SHPH development committees, the chief executive of the local government organization acted as the chairman of these committees. The village headman was the vice-chairman. The representatives of people in*

> *the community were the administrative members. And I acted as the secretary of the committees* (Pim).

After community representatives had already been recruited and formed as the SHPH development committees, the committees could help and work together with the PHC managers. This method was explained by Praw and Prera:

> *As we are currently forming the SHPH development committees, I think this is OK because these people can help us* (Praw).
>
> *As we have selected the representatives from the community and formed them as the SHPH development committee, we need to talk with this community health committee. They all know about the projects of the SHPH and the situation of the SHPH. Also, they know about the weakness of our staff and health services. If there is a problem, the stakeholders can help us in solving such a problem* (Prera).

5.3.2.5 Motivation

Skill in motivating people was essential for the PHC managers to work successfully with stakeholders in the community. This view was pointed out by Prang:

> *I need to motivate other stakeholders to work together. I have this skill of encouraging and persuading others to work with me. Thus, it seems that my work is quite successful* (Prang).

Another participant, Por, agreed: *"For me, when I work with people in the community, I have to talk to them and I have to encourage them in order to increase their participation and ownership"* (Por).

Both encouragement and assistance were important for the PHC managers, according to Chanon:

> *Thus, one thing that we need to do is to encourage them [people in the community] as part of our team. When they do not know something, we need to provide them with support or guide them* (Chanon).

This view was consistent with the approach of Chai who noted that the PHC manager needed to act like a supporter in order to motivate stakeholders to efficiently conduct a project or an activity that they are interested in:

> *As I told you, I do not like to directly order or tell the people to do things according to my thinking. Instead, I like to be a supporter. I talk to the people and try to assess their thinking. What do they really need to do? If some villagers need a project or an activity regarding some aspect of health, I will try to help them because I have the ability to support them. For example, I let them borrow the weighing machines from my SHPH. I also teach them how to use them. I think if I only order or assign them according to my decision, they do not like to do it. Thus, I attempt to encourage them in doing a project or an activity that they are interested in* (Chai).

When the VHVs feel discouraged about work, Ken responds in this way:

> *I attempt to motivate the VHVs when they feel discouraged. For example, when the VHVs felt that their 600 baht salary (or 20 baht per day) is too little, I would talk to them in order to make them feel better. I attempted to point out to them that their work was not too difficult and complicated for them to do. Each of them has to look after only 15 households. When there was the task for them to survey the health status of pregnant women in their responsible households, some of them might need to survey only 3 households from the total 15 households. Or some of them did not need to do anything because there is no pregnant woman in their responsible households. I attempt to motivate them by showing them that their work is easy* (Ken).

This participant stressed that he attempted to motivate the VHVs to work by making the assigned tasks easy for them:

> *When I work with the VHVs, I will clearly divide the responsibilities among them. I attempt to clearly scope the work of VHVs. Each month, I will assign them only the important tasks. I will not make them feel confused with a lot of information. I have to prepare the tasks and make it easy for them. For example, when there was the chronic disease screening project, I needed to explain this project to the VHVs with simple words. I told them that we could classify people in the community into three groups including normal, at risk and ill groups. This project would focus only on the at-risk group. Thus, we would check this group for hypertension and fasting blood-sugar. Another example is the health security insurance project for people in the community. According to the universal health coverage policy, every person has to have their health security insurance. I then had to conduct this project in order to*

> *survey who still has no health security insurance. I briefly explained the health security insurance system to the VHVs. Then I asked for assistance from the VHVs to survey those uninsured people in the community. From these two examples, I have to support the VHVs and find a way to make their work look easy* (Ken).

Prang indicated that when the VHVs were assigned an important position, they would feel proud of their vital role because they felt valued in doing something for themselves and others:

> *For me, I will put the VHVs in a position such as secretary, public relations, and so on. Then they all will feel so proud with their position. Further, when I go to work with other organizations, such as the district hospital, I will sometimes invite them to go with me. I will introduce them to the staff at the district hospital. Then, they will feel proud that they work with me because they have an important role in my organization. In addition, suppose they get sick and have to go to the district hospital, they will become familiar with the staff at the district hospital. Therefore, VHVs would like to have a position as my representative* (Prang).

Chai commented that he increased the motivation of community leaders through sharing knowledge. He explained that the good health practices of one village could influence the practices of other villages if stakeholders discussed and shared health knowledge and experiences with one another. However, PHC managers might need to organize such knowledge sharing events:

> *Each village has different projects based on their needs and each village has various stages of development. There are six villages. Also, the village headmen and VHVs of each village have diverse levels of attention and interest. For example, Moo 12 (village 12) has an achievement in development. Moo 12 (village 12) got many awards and I think that I can use this village as an example of good practice for the rest of the five villages. I then set up a meeting among villages and let them learn and share from each other. They have the chance to directly talk to the leader of Moo 12 (village 12) about the successful strategies used to develop the village. They knew/learned about the roles of each person in being involved to develop the village, such as the role of village headmen and the role of VHVs. This is a concept that I have just initiated. Hopefully, I can conduct this concept as a project by the end of this month or the beginning of next month. Actually, this project should have been done since the beginning of this year* (Chai).

Another participant, Chanon, explained that he motivated people in the community through their community leaders. He indicated that he raised the awareness of VHVs and community leaders regarding the weaknesses in the SHPH. These elite groups then alerted other people in the community about the issues:

> *The SHPH policy was launched during that time. I then attempted to inform the people in the community about the details of this policy. Simultaneously, I tried to induce their concern about the weak situation of the health centre. I told them if we ranked the performance of eleven health centres located in this district, do you know that our health centre was ranked as the last one. However, I did not visibly announce this message in a public meeting. Instead, I informed only the community leaders or VHVs who had the important roles and power to do something. Then these groups of people could further inspire the people in the community. With regard to the SHPH policy, I informed them of the details 1 2 3 of this policy. For example, if there is a project that VHVs need to do and they do not realize that they need to do it, then I need to inform the representatives of the VHVs that this issue needs to be discussed in the meeting. Therefore, that project will be conducted further by the VHVs* (Chanon).

This strategy was consistent with the approach of Nawat, who explained that:

> *These community leaders are our mouthpieces because they have the power in the community meeting. If I would like to develop the SHPH, such as with building renovation, I would initially inform these community leaders. I would talk to the village headmen and VHVs about what aspect of the SHPH I would like to develop. Then, as these community leaders had an important role in the community, they could later vote and support my plans or projects in a community meeting. Therefore, we received the money which could be spent for our plans or projects to develop our SHPH* (Nawat).

Another community motivation strategy was used by Thunva, who suggested that PHC managers should attempt to express their gratitude to the stakeholders and honour them:

> *We should acknowledge other stakeholder organizations when a community work is successfully implemented. According to Maslow's theory, everyone needs honour and esteem* (Thunva

Expressing admiration in the meeting could be one method to show honour to the stakeholders whose contributions benefit the community, as Prang indicated:

> *But I mostly express admiration for them in the meeting. I will mention the activity that they have done (*Prang).

On important occasions, providing the stakeholders with a gift could be another method for expressing gratitude to stakeholders. This method was employed by Khwan:

> *On special occasions, such as during New Year period, I generally buy a gift for the VHVs and village headmen. The gift might be a bath towel or cookies. We also have a party with the VHVs almost every year. There are only four villages in this community. Thus, I only use a little money to buy a gift for all of them in order to make them feel happy. Then, we can easily coordinate with them* (Khwan).

As well, Yada indicated that she

> *gave a prestige certificate to the people who contribute benefits to the SHPH. For instance, if there is a charity activity and they donate their money, I will honour them by providing them with a prestige certificate. However, this kind of donation activity should not be conducted frequently. For me, I might arrange such an activity every four or five years* (Yada).

Even though providing the stakeholders with a reward was not a sustainable technique over time, Pim explained, she still needed to use this technique to increase their motivation:

> *When I ask for assistance from the VHV, I may need to provide them with a reward. I would like to show my gratitude to them because they helped me a lot. For example, when I needed to invite the people to participate in my project, I asked the VHV to further inform the people in the community. The VHV had to waste both their time and their money for their vehicles. Therefore, even though I know a reward strategy might not be sustainable, I think I have to give something to those VHV in order to increase their motivation in working for us* (Pim).

5.3.2.6 Conflict management

PHC managers needed to work with a wide range of stakeholders, as explained by one participant, Prera: *"There are many organizations located within the community, such as school, police station, and forestry organization. Also, there are a number of community leaders and VHVs"* (Prera). The opinions and needs of those stakeholder organizations might

be different and this could lead to conflict among them. This problem was pointed out by Prang and Chai:

> *Besides, there are about one hundred and fifteen VHV that I have to work with. Among them, there are diverse groups which have conflicts with each other. Thus, this is my challenge* (Prang).
>
> *Working in this area is quite difficult because there is a wide range of opinions and needs from different groups. Each group does not like to work together. I would say that there is about 70 per cent feeling of unity among the groups of people in this area* (Chai).

As Win explained, conflict could occur between the SHPH and the District Organization because of misunderstandings regarding how to carry out a task:

> *However, our district sheriff (Chief of the District Organization) did not agree with this concept of working* (Win).

Conflict might also occur between the sanitation organization and local government organization regarding financial and human resources issues, as highlighted by Prang:

> *In the past, there were the sanitation organization and local government organization. Later, these two organizations were upgraded and became municipalities. Therefore, there are two municipalities and I have to be responsible for the population of those two municipalities. This affects the financial support between these two municipalities because each municipality tries to attract the budget for their own organization. However, the VHVs are united and they need to take care of both municipalities. Then, I attempt to manage these two organizations as one organization. Hence, this is another example of the challenge I face* (Prang).

Chai noted that conflict might arise because of local politics:

> *Nowadays, I am quite concerned about the problem of local politics between the village headman and the head of the local government organization because these two sections are separate* (Chai).

This comment was consistent with the opinion expressed by Yada:

> *I think that the challenge of my work is about the political issue. There is a problem from the national level to the community level. There has even been political conflict among the VHVs. So, what should I do to make them work together? I had to talk to them about it, that it does not matter who you are. You might be a village headman or any other position regarding politics. When you enter this SHPH, all of you have the same position as VHVs. However, if you go out from this SHPH, you can then have other positions as you have. Although these VHVs can contribute many benefits to the SHPH, there are also many concerns according to their various political roles. In terms of politics at the local level, some politicians put more emphasis on concrete issues as in the campaign of their party because they can gain more advantage for getting elected. For instance, they usually see building a road as more important than health issues because it is quite difficult to see the outcome of our work* (Yada).

The PHC managers needed to find solutions to conflict, according to Prang:

> *I have to find methods to let them work together. Then they can demonstrate their potential in working as a team* (Prang).

Rasa supported this view:

> *I think that the PHC managers should know where and with whom they should co-ordinate when there is a conflict occurring. It is necessary for the PHC managers to be able to solve the problem* (Rasa).

Another participant, Thunva, explained that *"[a] few days ago, there was an argument about the community budget. I tried to listen to them. However, if such an argument turned serious, I would then try to stop it"* (Thunva).

"Being a bumper-bar" was the metaphor employed by Chai to illustrate the work of the PHC managers when they needed to reduce the conflict of various stakeholders in the community:

> *I need to join both sections to work together otherwise the work or project cannot be done simply. I need to act like a bumper-bar between both groups* (Chai).

Chanon sometimes solved conflicts by creating understanding among stakeholders about the issues involved:

> *There is currently a problem with issues regarding the referral system. The nurses working at the district hospital always complain about the fact that we refer many clients to the district hospital. Why don't we treat such clients? I think that we might rotate the staff between the district hospital and the SHPH. I mean the nurses working at the district hospital should come to work at the SHPH and staff at the SHPH should go to work at the district hospital. I think we will better understand each other then* (Chanon).

Another technique of conflict resolution was expressed in this way by Rasa:

> *Conflict in the community also challenges us. If we ignore and do not solve such conflict, it might cause the failure of our work later. Thus, we need to help them find a solution. For example, I set up a community meeting for those groups having conflict. I then let them talk and figure out their problems. While they are discussing their solution, I, as an outsider, also observe their meeting. Sometimes, I had to guide them when they did not know what the cause of their problems was. Or I might offer them some ideas. However, I attempted to encourage them to talk in order to solve their conflict by themselves. I think I'm the outsider and I think the insiders are much better at understanding their problem. After the conflict had been solved, we could easily work in the community* (Rasa).

Having a good relationship with stakeholders within a network could also reduce a situation of conflict. The advantage of this was illustrated by Kaew:

> *My subordinate had some conflict with a staff member at the local government organization. Fortunately, the staff member at the local government organization is my friend because we used to study at the same university. I could talk directly with this guy regarding that conflict. It's easier for me to solve such a problem because we are familiar with each other. Besides, when I need to conduct a project and need financial assistance, I can coordinate with this guy and I get support* (Kaew).

Summary

This sub-theme described the strategies that study participants employed to work with stakeholders in the community. First, the participants pointed out that they needed to establish networks that included community stakeholders, such as VHVs, other SHPHs, the Tambon (sub-district) Government Organization, Community Development Organization, clubs in the community, schools and temples.

Second, study participants said that they had the important role of coordinating the groups in the networks, and they did this by employing various communication techniques.

Third, the participants proposed that enabling the community to participate in decision-making regarding health issues was an effective way of discovering worthwhile ideas from stakeholders in the networks. They emphasized that using meetings was a popular strategy for sharing information and making decisions with network members. They also used other strategies to brainstorm ideas with the aim of encouraging every network participant to analyze and solve their own problems.

Fourth, study participants suggested that PHC managers should acknowledge the potential of stakeholders and representatives of people in the community and delegate the tasks and power in making a decision to them. The participants also pointed out that forming committees was a useful method of working with the representatives of people in the community.

Fifth, study participants explained that they needed to use various strategies to motivate stakeholders to work, particularly when those stakeholders felt discouraged or when they faced dilemmas. The participants indicated that expressing gratitude to stakeholders and showing them respect and honour were among the important strategies they employed to motivate stakeholders.

Sixth, study participants noted that one of the challenges in working as PHC managers was to manage any conflict that occurred among the various groups within the community. They reduced conflict by building understanding and good relationships within the networks.

5.4 Conclusion

The last two themes emerging from the data analysis of the discourse of the participants in the study were presented in this chapter. Theme 3 presented the participants‘ experiences in managing and leading the subordinates in their organizations as a team. A number of teamwork strategies used by the participants in their organizations was also presented in this

theme. Theme 4 described the participants‘ experiences in managing and leading the stakeholders as a network through various strategies and techniques in order to effectively work in their responsible communities. The next chapter provides a discussion and gives the conclusions of the findings of this study.

Chapter Six: Discussion and Conclusions

6.1 Introduction

The previous two chapters presented the four major themes and nine sub-themes that emerged from the interviews with PHC managers working at the Sub-district Health Promoting Hospitals located in Phitsanulok Province, Thailand. In this study, a hermeneutical phenomenological approach was utilized to narrate the participants�never actual lived experiences with the aims to:

1. Explore the perceived knowledge, attitudes and practices regarding leadership roles and management functions of PHC managers working at SHPHs and implementing the 2009 SHPH policy in Phitsanulok Province, Thailand.

2. Explore the challenges regarding leadership roles and management functions of PHC managers working at SHPHs and implementing the 2009 SHPH policy in Phitsanulok Province, Thailand.

3. Identify the training needs regarding leadership roles and management functions of PHC managers working at SHPHs and implementing the 2009 SHPH policy in Phitsanulok Province, Thailand.

Study participants described their perceived experiences about the changes to the PHC system imposed by the SHPH policy. They also described their experiences about the necessary competencies required for the PHC manager‘s position and the challenges that they face in that position.

This chapter first presents the major findings and conclusions relating to the research aims of the study. Then, these major findings and conclusions are discussed based on the eclectic theoretical framework and previous research findings described in Chapter Two. This discussion is followed with a consideration of the implications of the study findings for

policy and practice. The final part of this chapter concludes with recommendations for further research arising from the findings and implications of this study.

6.2 Overview of major findings and conclusions

There were four major findings and two main conclusions emerging from analysis of the data gathered in the interviews with PHC managers.

The first finding is that the constant change experienced from the implementation of the SHPH policy affected the PHC managers and their work at three levels: at the individual, organizational and community levels. This constant change was also linked to various challenges: human resources shortages, financial constraints, and high expectations from clients. These findings address the second aim of this study.

The second finding is that certain values were important for the participants in becoming and in working as PHC managers. The important values were their passion for the PHC manager‘s position, their altruism for promoting other people‘s happiness and welfare, their intention to be a leader and the opportunity for advancement in their career path. These findings are relevant to the first and third aims of this study.

The third finding presents the participants‘ experiences in managing and leading the subordinates in their organizations as a team. To do so, the participants needed to use a number of teamwork strategies with subordinates in their organizations in order to direct them to work as a team to achieve the organizational goals. Strategies included allocating responsibilities and delegating power, fostering participation by all members of the team, showing respect for team members, using family and colleague approaches, and practising impartiality and fairness in management of the team. These findings related to the first and third aims of this study.

The fourth finding describes study participants‘ experiences in managing and leading stakeholders who are part of the SHPH network. Strategies and techniques utilized by PHC managers to ensure effective interactions with stakeholders in their responsible communities

were building the network, working on communicating effectively with stakeholders, participating in the community, forming committees and delegating power to them, and increasing the stakeholders' motivation to act in line with SHPH goals by expressing gratitude and respect and showing honour to stakeholders. These findings reflect the first and third aims of this study.

Two major conclusions can be drawn from the four major findings of this study. The first conclusion is that the PHC managers have to demonstrate self-management, team-management and network-management leadership. Self-management leadership highlights that the PHC managers need to have a passion for and intention to be a leader and a desire to advance in their career path. PHC managers also need to have the values of generosity and altruism to help other people. In addition, PHC managers need to be prepared to engage in lifelong learning to broaden their contextual knowledge – such as knowledge of healthcare systems, finance, information technology, rule-regulation-law-policy, and evaluation and research methods – in order to perform the multiple roles of manager, leader, subordinate and curative care provider.

Team-management leadership emphasizes that PHC managers need to form an effective team by building trustworthiness and understanding with subordinates for effective operation of the SHPH. PHC managers need to direct their teams to achieve the organizational goals created and decided upon together by the team members. Delegation of responsibility and team participation are considered as the imperative strategies to be employed by PHC managers in working with their team members. PHC managers also need to manage conflicts occurring in the organization. Another issue highlighted by PHC managers is the need for them to operate within the Thai cultural system to effectively manage and lead team members.

The focus by the participants on network-management leadership suggests that PHC managers need to build networks by gaining the trustworthiness and understanding of stakeholders in the community. PHC managers emphasized that community participation is an effective way of discovering worthwhile ideas from network members and sharing power for decision-making with those network members. After delegating power to network

members, PHC managers need to work in a coordination and motivational capacity in order to facilitate the networks to work effectively. In addition, PHC managers need to manage any conflict occurring among network members in the community.

The second conclusion is that PHC managers face four challenges: constant change in the district health system, financial constraints and human resources shortages, rising clients' expectations, and the need to develop integrated comprehensive PHC services. First, constant change in the district health system seems to be the most significant issue raised by PHC managers. Such changes affect the PHC managers, their teams in the organization, and their stakeholders and networks in the community.

Second, financial constraints and human resources shortages cause PHC managers problems in implementing the SHPH policy. PHC managers need to ensure the survival of their team and organization under conditions of tight budget constraints and human resources shortages and do so by using a variety of strategies.

Third, clients expect to be able to obtain the same health services, particularly curative care, at the SHPH as are provided at the community hospital (district hospital) because the new name of the healthcare organization was changed from Primary Care Unit (PCU) to Sub-district Health Promoting Hospital (SHPH).

Fourth, health services provided at the SHPHs have to be developed as integrated services of primary care and comprehensive PHC. Health promotion, disease prevention, curative care and rehabilitation have a growing importance at the SHPHs because the numbers of chronic disease patients and elderly patients have increased in this past decade. To successfully provide high standards of integrated services at the SHPHs requires the active working in community with networks and an effective referral system with secondary care (district hospital).

6.3 The discussion of major findings and conclusions within the context of the theoretical framework and previous research

In this section, the major findings and conclusions of the study are discussed within the context of the eclectic theoretical framework (described in Chapter Two), which combines complex adaptive systems theory, neo-institutional theory and typology of archetypes, and diffusion of innovations theory to better understand the leadership roles and management functions of the PHC managers during the transition period of the SHPH policy implementation. This study finds that the PHC managers demonstrate examples of leadership roles and management functions highlighted in these theories.

As the healthcare organization in Thailand operates in a highly uncertain environment, understanding PHC practices from the perspective of complex adaptive systems can enhance the PHC managers' abilities to adapt to and manage an unknowable future, and it can help in designing the change process. Neo-institutional theory and typology of archetypes is an approach that integrates an organization's past actions and the social and environmental pressures on the organization to explain the organizational changes and practices. This theory provides a powerful theoretical perspective for describing and explaining the process of healthcare reform. Diffusion of innovations theory assists PHC managers to understand how to effectively adopt and implement the SHPH policy innovation. The literature on previous relevant research studies (described in Chapter Two) is also utilized to compare and validate the findings and conclusions of this study.

6.3.1 Leadership roles and management functions of the PHC managers

This section describes the leadership roles and management functions of PHC managers and is in three parts: self-management leadership, team-management leadership and network-management leadership. Self-management leadership involves the internal values that the participants believe are necessary for them to work effectively in the PHC manager's position. Team-management leadership is another crucial component for the participants to effectively lead and manage the subordinates in their organization. Study participants further

emphasized the component of network-management leadership because they have to coordinate and work with other stakeholders in the community.

6.3.1.1 Self-management leadership

Study participants highlighted three important attributes that they perceived as desirable for them to become a PHC manager and to work in the PHC manager�घs position.

1) The passion and intention to be a leader and to advance in a career path

Passion to be a leader motivated participants‘ decisions to become PHC managers. Study participants described that being happy and proud was the feeling they experienced when anything was done with passion and love. This finding confirms previous research findings that leadership, passion and emotional intelligence are interconnected. It is difficult to effectively accomplish organizational goals, and to smoothly handle relationships and conflict without the incorporation of these components. As Marques (2007, p. 645) notes ―if a leader is not passionate about what he or she does, there might not be a reason for him or her to be leading in the first place".

However, the participants pointed out that passion for the PHC manager‘s position could be reduced when there was no support for progression along the career path and when their qualifications were not associated with their professional work. For instance, PHCM9 thought that she was not an appropriate person for being in a managerial position because she was a registered nurse. In addition, study participants explained that they felt under intense pressure because they had a lot of responsibility and this could hamper their passion for being a PHC manager.

Positive intention and commitment were the compelling reasons for participants to advance from a subordinate‘s position into the PHC manager‘s position. PHCM10 had the intention to improve the position of the SHPH that was rated as the worst SHPH, while other participants (PHCM2, PHCM3) had negative experiences with their managers when they were

subordinates, and wanted to become a PHC manager to be able to manage the organization according to their wishes and expectations.

Study participants stated that the PHC manager‘s position usually offered more opportunity for career advancement and this was a motivator for wanting this position. However, the participants explained that there were many necessary steps and criteria involved in progressing toward a PHC manager‘s position, such as work experience and examinations. These findings are consistent with another study (Puphanpun & Bouphan, 2011) that examined the effect of motivation factors on the administrative performance of 198 PHC managers in Nakhonratchasima Province, Thailand and found that advancement in career was one of the important factors influencing the PHC managers‘ administrative performance.

Study participants also commented that they felt proud because they had more power and freedom in making decisions and formulating policies and projects than when they were subordinates. They explained that they could create ideas for their organization and for the higher level of administration in the healthcare system. They also indicated that the PHC manager‘s position had the ability to deal with other stakeholder organizations.

2) The value of generosity and altruism to be able to help other people

One participant, Win, pointed out that having a ―public mind" (a metaphor used to refer to generosity and altruism) was an important characteristic for the PHC manager. He argued that, compared to a subordinate‘s position, the PHC manager‘s position was demanding work. However, this position had more capacity and opportunity for helping others. Study participants suggested that PHC managers should dedicate their time and effort to helping others, particularly the vulnerable groups in their responsible communities. These findings support the data gathered from 217 leaders from four separate organizations located in the Midwestern U.S. that found that altruism was a vital characteristic of successful servant leaders and had a direct impact on leadership effectiveness (Moss & Barbuto, 2010). Altruism, or self-sacrificial behaviour, also strengthened the relationship between social astuteness and effectiveness (Moss & Barbuto, 2010).

Moss and Barbuto (2010, p. 169) further found that “organizations that promote the value of serving others would be able to bring forth altruistic tendencies in their works. Organizations that articulate socially responsible values and ethical practices would likely attract and retain altruistic employees”. An experimental study also emphasized that altruistic leaders tend to gain the benefit of having a good reputation among others and are perceived as trustworthy (Barclay, 2004). Avolio and Locke (2002) agreed that altruism of leaders had the greatest impact on their team members and organizations. In a literature review, Barbuto & Wheeler (2006, p. 318) pointed out that “altruistic calling was one of the fundamental characteristics of servant leadership. Therefore, leaders high in altruistic calling desire to serve and have a willingness to sacrifice self-interest for the benefit and needs of followers and others”.

3) Lifelong learning to broaden knowledge for working in the multiple-roles of the PHC manager’s position

Study participants emphasized the multiple-roles of the PHC manager‘s position. They described that they not only had to know and understand their subordinates‘ tasks, but they also had to sometimes be able to perform the subordinates‘ work in order to get better results in organizational performance. Study participants further explained that they needed to perform the role of mentor in order to assist and train new subordinates. Additionally, study participants pointed out that, even though there may be a registered nurse in their SHPHs, they still needed to provide curative care services to cope with increasing numbers of clients.

This study indicated that, due to the multiple-roles and greater responsibilities of the PHC manager‘s position, PHC managers had to develop their competencies across a broad range of diverse fields. When compared with subordinates‘ positions, study participants noted that they needed to have broader knowledge and skills. They needed to know more than when they were subordinates. Study participants described that they have to understand all the work involved in the organization including their own managerial work and their subordinates‘ tasks. They also needed to know the important information related to the healthcare system such as the details of the SHPH policy, health information technology, budgetary rules and regulations. The recommendations made by Orme et al. (2007, pp. 86-87) in their report on public health in the 21st Century, align with the study participants‘

experience; frontline managers should have the skills and competencies in formulating and implementing policy and strategy, ethically managing self, people and resources in the organization, developing health programmes and services to reduce inequalities, working with and for communities and conducting research to improve the health and well-being of the community.

However, frontline managers often struggle with some very basic problems, such as limited skills in basic accounting and in managing drug stocks (Egger et al., 2005). Therefore, the way to achieve success in complex organizations is to learn from small tasks and link this learning to more complex tasks (Burns, 2007, p. 480). Stroebel et al. (2005) affirm that learning and reflection can help organizations adapt to change. The managers of professional complex adaptive systems understand that the most imperative learning is learning in real time as a result of action. The role of managers in creating a learning organization is especially critical (Anderson & McDaniel, 2000, p. 89).

6.3.1.2 Team-management leadership

Study participants identified seven key considerations for developing an effective team with their subordinates in their SHPHs.

1) Building an effective team

Study participants stressed that cooperative teamwork with subordinates was important to achieve effectiveness in the SHPHs. This is consistent with previous research findings that the formation of primary care teams is the key element that assists primary care physicians to cope with many difficult issues, such as increased workload and not being able to respond to all of the patients‘ needs (Bodenheimer et al., 2003, p. 796). Teamwork also sustains innovations in primary care practices (Bodenheimer et al., 2003, p. 798). Suwanthong et al. (2012) conducted a cross-sectional predictive research study aimed at investigating supportive factors affecting successful TQM based on the perceptions of health personnel in SHPHs in Samut Prakan Province, Thailand. They collected data through questionnaires

delivered to 240 subjects and found that health personnel perceived that efficient teamwork was the important factor influencing the success of TQM in SHPHs.

2) Building trustworthiness and understanding

The participants indicated that they needed to build trustworthiness and understanding with their team members in order to raise the commitment and dedication of subordinates. Lars and Keith (2012) support the study participants' view that innovative managers have a crucial role in promoting integration by creating working relationships built on trust between managers and providers, and providers and users. Anderson and McDaniel (2000, p. 87) emphasize that managers in professional complex adaptive systems should pay attention to the management of relationships because the set of interdependencies is important in complex adaptive systems. That is, from the complexity perspective, managers should attempt to minimize the specification and increase the relationship between parts in order to yield more creativity (Dooley, 1997; Plesk & Wilson, 2001). Burns (2007, p. 480) also indicates that leaders are most successful when they develop relationships amongst people, and the way to achieve success in complex organizations is to let action emerge from the bottom up. Therefore, the relationship among team members is an important component for leaders to be able to work effectively in complex adaptive systems of a healthcare organization (Anderson & McDaniel, 2000, p. 86; McDaniel & Driebe, 2001; Rogers et al., 2005, p. 14; Rowitz, 2009, p. 42; Yukl, 2010, p. 25; Zaleznik, 1977).

Frontline managers are the first line of the management hierarchy and are the first point of contact with employees. They thus have an important impact on engagement with and retention of employees (Heaslip, 2010). Frontline managers need to build and maintain a network of relationships with people inside and outside the organization. They also need to create new relationships with their subordinates that are both supportive and collegial if their subordinates were formerly their peers (Galer et al., 2005). The study of Puphanpun and Bouphan (2011) also found that relationships among staff in the SHPH have a significant impact on the administrative performance of the PHC managers.

Study participants explained that they could gain the trust of their team by creating a friendly atmosphere in the organization and reducing stress on the subordinates. The key component of ―happiness" was described by participants as needing to facilitate and assist their subordinates, particularly when subordinates were faced with a dilemma or a difficult situation. Study participants explained that they needed to demonstrate empathy by understanding their subordinates‘ feelings, thoughts and passions. Study participants suggested that PHC managers should not only emphasize their formal managerial work, but they also needed to pay attention to their subordinates‘ general wellbeing. These views are supported by the literature indicating that frontline managers need to shift their priorities to subordinates. This means that frontline managers have to be available and accessible to subordinates, listen to their needs and supervise them in their performance (Galer et al., 2005). Study participants further explained that they attempted to make everyone in the organization feel like they are part of a family. They did this through various activities such as cooking and eating food together, giving a special gift on a significant occasion, and sometimes travelling together.

In terms of building understanding, study participants argued that a two-way communication method based on an informal approach, such as informal discussion and informal meetings, was the most useful technique to effectively build understanding in the team. These findings demonstrate that the communication channel is the essence of the diffusion process in connecting with and exchanging information about a new innovation between individuals in a unit (Rogers, 1983). Rogers (1983, p. 18), Robinson (2009) and Friedkin (2010, pp. 146-147) believe that interpersonal channels of ―near-peers" through face-to-face communication have more effective power to motivate an audience to adopt an innovation because people tend to trust and follow their friends who have successfully adopted an innovation.

In addition, study participants explained that when everyone in the organization interacted and shared information, they understood each other‘s perspectives and wishes better, and maintained a positive relationship. Study participants described that, if there was a problem occurring in the organization, everyone knew the circumstances of the organization because they shared the information, and this enabled them to work out a solution together. These

results confirm the findings from the literature review discussed in Chapter Two that when agents interact and self-organize in a nonlinear way, emergent properties occur from the crisis in complex adaptive systems (Amagoh, 2008; McDaniel & Driebe, 2001) and new strategies and behaviours will be developed in regard to the crisis (Kernick, 2006, p. 387).

3) Directing their teams

Study participants argued that they had to be able to direct their team to achieve the organizational goals which had been decided upon in team brainstorming sessions. This finding is consistent with the literature indicating that establishing direction and aligning people are the core processes of leadership (Kotter, 1990, pp. 4-5). In healthcare organizations, ―good leadership and management are about providing direction to, and gaining commitment from partners and staff, facilitating change and achieving better health services through efficient, creative and responsible deployment of people and other resources" (WHO, 2007, p. 1). The frontline managers need to learn and be comfortable with the critical skill of delegating appropriate tasks to individual team members (Galer et al., 2005). The study of Stroebel et al. (2005) also suggests that it will be useful in guiding change when the team understands the practices, vision and mission of the organization.

4) Knowing their team for delegation of responsibility

Study participants highlighted that they had to believe in their subordinates‘ competencies and delegate responsibilities and power to their subordinates. Study participants pointed out that they needed to consider their subordinates‘ backgrounds, competencies and passions in order to appropriately delegate responsibility.

Study participants approached delegation of responsibility with caution. They indicated that after they delegated responsibility they still needed to formally document that delegation as evidence indicating that a particular task had been delegated to a specific individual. Study participants stressed that everyone still needed to help each other even if responsibilities had been delegated to a particular person. Study participants also suggested that responsibilities should be delegated equitably to subordinates. Additionally, they felt that they themselves

should carry out a task if the task was too difficult for subordinates. For instance, PHCM2 stated (see Chapter Five section 5.2.2) that ―[s]ome tasks are difficult and have negative consequences if these tasks are conducted by the staff. Hence, I, the manager, have to do it by myself, such as work regarding the policy and strategic formulation in the organization and work regarding financial and inventory management*"*.

5) Team participation

The concept of participation emerged as another important issue proposed by study participants. They argued that participation was essential for working as a team because every team member could then openly share personal ideas and help make decisions in order to achieve organizational goals. Study participants described that when subordinates had the opportunity to participate in expressing an idea and making a decision, they would understand each other‗s views in the team and respect each other‗s opinions. These participants‗ views are consistent with the literature indicating that complex adaptive systems consist of diverse agents and this diversity is considered as the source of creativity needed for agents‗ growth and survival (Innes et al., 2005; Kernick, 2006, p. 386; McDaniel, 2007). When managers are faced with the complexity of a problem, they need all of the different points of view from the interaction amongst team members in the system (Anderson & McDaniel, 2000, p. 88). The findings from the study by Burns (2007, p. 480) indicate that organizations have an advantage when there is diversity of thought amongst the members. Stroebel et al. (2005) also illustrate that diverse perspectives foster adaptability and new insights for positive change.

Study participants emphasized that they needed to encourage their subordinates to express their opinions by using various brainstorming techniques such as informal discussion and voting. This finding is relevant to a previous study showing that organizational leadership should promote and build a supportive organizational environment that enables all team members to speak out and to cross personal boundaries in order to share with others and to reflect on practices and achievements (Sturmberg et al., 2012, p. 205). In complex adaptive systems, it is important to look to diversity of agents‗ thoughts and opinions for gaining ideas through the emergence process (Innes et al., 2005; Kernick, 2006, p. 386; McDaniel, 2007).

Yukl (2010, p. 25) suggests that leaders should be concerned with what things mean to people, and try to get people to agree about the most important things to be done.

Study participants proposed that brainstorming techniques could be one strategy employed to gain ideas from the team members at the SHPH. O'Sullivan and Leggat (2009) stress that discarding the participation of administrative staff who perform important roles linking health services to clients and community is at the risk of loss of motivation and enjoyment in their work, particularly during the organizational change process.

6) Managing conflict

Study participants emphasized that they had to be able to manage conflict arising among their subordinates in the organization, and conflict between subordinates and clients of the SHPH. This result confirms findings from the literature which states that tension and discomfort are essential and normal during the change process (Stroebel et al., 2005). Study participants argued that conflict was mainly caused by the divergent thinking and varying characters of subordinates. Because of feedback loops in complex adaptive systems (Amagoh, 2008; Kernick, 2006; Paina & Peters, 2012), an agent‘s activity can cause either positive or negative effects on itself as well as influence other agents (Kernick, 2006; McDaniel, 2007; McDaniel & Driebe, 2001).

Various solutions to managing such conflicts were pointed out by the participants. For example, they needed to build understanding in the team and motivate everyone to sincerely help each other. They needed to find a compromise solution to reduce the disagreement. Most importantly, they needed to manage conflict situations with impartiality and fairness. In the literature on the complex adaptive systems paradigm, Innes et al. (2005, p. 234) and Shortell and Kaluzny (2006, p. 30) suggest that chaos is avoided by the application of simple rules that guide people‘s behaviour and through the development of self-managed groups and teams. Order and rules evolve through synergistic patterns of social connection and relationships, without the need for hierarchical systems of control (Harris, 2006, p. 67). Another study suggests that successful family practices are those that minimize errors, make good sense of what is happening, and effectively improvise to make good practice (Miller et

al., 2001, p. 876). Seeking to eliminate error by dampening all variation through the imposition of excessive standardization and external controls is unlikely to be sustainably effective and is likely to have long-term negative consequences (Miller et al., 2001, p. 876).

7) Thai culture in the team

In this study, novice PHC manager participants described difficulty working with their senior subordinates. They found they had less experience than those subordinates and needed to respect them according to their social seniority in Thai society. Study participants thus expressed their view that it was quite hard to use a command and control approach. These findings might be explained by the fact that Thais are taught respect for and belief in *Pu Yai*, elders, teachers and experts within society in general (Browell, 2000, p. 110; Thanasankit, 2002, p. 132; Thanasankit & Corbitt, 2000). In line with the high power distance in Thai society (Hofstede, 1980, 1997), Thais need to *Kreng Jai* or show consideration merged with respect to those of higher rank and seniority (Thanasankit, 2002, p. 132). Thais also believe in *Bun Khun* or doing favours for each other, particularly for those who have provided assistance in the past (Thanasankit, 2002, p. 132). Criticism and being controversial is inappropriate and impolite in Thai society, particularly with regard to *Pu Yai*, elders, teachers and experts (Browell, 2000, p. 110; Thanasankit, 2002, p. 132).

Komin (1990, p. 681) suggests that it is ultimately the function of leaders at all levels of the organization to incorporate socio-cultural values into their management of the organization and to find a way to change the culture of the organization if its culture has become maladapted and cannot survive in the organization (Schein, 2004, p. 11). The participants in this study therefore explained that they attempted to find innovative strategies to manage those senior subordinates in the context of the Thai socio-cultural system. Study participants explained that they increased the level of informality in their team in order to resolve the difficulty of working with senior subordinates. They described that it was important for them to disregard the hierarchical system in the organization by using the ―relatives and colleagues" approach based on the Thai cultural value of harmonious interaction among family members. They pointed out that, because of their need to pay respect to their senior subordinates, they used the technique of being a good colleague and follower even though

they held the position of manager. They emphasized that, when there was a co-operative ―relatives” approach and a friendly atmosphere in the organization, everyone helped each other and this was seen as increasing the strength of the team.

Given strategies used by the participants are consistent with the study of Komin (1990). Komin (1990) identifies the values orientations for Thai management and explains that Thais value a flexible, smooth, kind, pleasant, conflict-free interpersonal relationship. Thanasankit and Corbitt (2000) support the view that Thai culture resembles family links and puts an emphasis on trust and relationships with others. Besides, Thais tend to have a higher level in femininity than masculinity (Hofstede, 1997, p. 84) and have a strong belief in the religion of Buddhism (Browell, 2000; Komin, 1990; Lewis, 2005). All these Thai attributes thus lead to the values of a good working relationship and a co-operative orientation aimed at creating peacefulness and harmony (Browell, 2000, p. 111).

6.3.1.3 Network-management leadership

Study participants described seven aspects that they perceived as important for developing an effective network of stakeholders in the community.

1) Building networks

Study participants emphasized that they needed to build networks with both the formal and informal leaders in the community in order to successfully manage the organization. They explained that, due to the human resources shortage in the SHPH, assistance from stakeholders in the organization‘s community network was crucial to successfully managing the SHPH. Study participants described that they primarily worked with VHVs. Others in their networks in the Ministry of Health were the District Health Office and other SHPHs located in the same district, the so-called zone. The participants also needed to deal with the Tambon (sub-district) Government Organization, Community Development Organization, and schools and members of the local temple. Study participants noted that they needed to form and support clubs in the community and include them in the network. Wibulpolprasert (2011, pp. 336-337) states that the SHPHs work under the management of the District Health

Offices, while they receive support from the community hospitals in the form of medical supplies and health personnel such as doctors, dentists, pharmacies and nurses. The findings regarding the necessity of building networks are consistent with CASs theory; networks are an essential feature of a complex adaptive system because networks allow the system to solve problems using the large numbers of individual nodes that have local interactions with other nodes (Rogers et al., 2005).

New Public Health Management also emphasizes the need for a partnership relationship with communities and other sectors of government and private institutions (Baum, 2008, p. 311; Chambers & Walker, 2012; Fleming & Parker, 2007, pp. 31-36; Talbot & Verrinder, 2010, pp. 9-10). PHC requires the principle of inter-sectoral collaboration (Intaranongpai et al., 2011; McMurray, 2007, p. 41). Alliance and networking strategies lead to both leadership effectiveness and sustainability for PHC services (Briggs et al., 2010; Moss & Barbuto, 2010). Orme et al. (2007, pp. 86-87) agree that frontline managers should have skills in working with and for communities. Frontline managers need to learn and be comfortable with the critical skill of networking with others to gain their support (Galer et al., 2005). Thus, managers who want to develop their leadership effectiveness should focus on developing interpersonal influence and on their networking ability (Moss & Barbuto, 2010).

2) Building trustworthiness and understanding with stakeholders

Rapport with clients and stakeholders had to be developed by study participants in order to foster their trust and understanding. Study participants said that they could build rapport with clients, particularly those clients working in the stakeholder organizations, when they came to utilize health services at the SHPHs. Study participants explained that they had to behave respectfully towards clients and stakeholders when they worked in the community. They also expressed the view that they had to sincerely and positively provide assistance and support to stakeholder organizations. These findings illustrate that innovative managers have a crucial role in promoting engagement with stakeholders by creating productive relationships built on trust between providers and users (Lars & Keith, 2012). This result is consistent with another study (Longo, 2007) indicating that agreement and the consequent quality of relationships

arising among key actors of stakeholder organizations are the important drivers influencing the implementation of change or innovation in a healthcare system.

The participants explained that they could build good relationships with clients and stakeholders by being involved with their activities in the community, such as a cremation event, a wedding ceremony, and a religious ceremony. This finding is consistent with the literature that Buddhism has a pivotal role in Thai culture and primarily serves ―a psychological function” for the people (Komin, 1990, p. 693). Browell (2000, p. 110) also emphasizes that ―[i]n Thailand, the relationship between Buddhism and the national identity and culture has always been important and continues to be so”. Therefore, the PHC managers attempt to follow Thai customs in order to engage effectively with the stakeholders in community.

Visiting clients at their home and attending stakeholders‘ meetings were other strategies employed by study participants for fostering trust and understanding with clients and stakeholders. Study participants also stated that they had to create opportunities to informally visit clients, particularly clients with disability and chronic disease, clients working in the stakeholder organizations, and VHVs. Study participants explained that when they attended meetings of stakeholders, they had an opportunity to receive and share information and get to know the important leaders in the community.

Familiarity with clients living in the community could be increased by examining information from and about the community. Study participants described that they could utilize such information, as well as an understanding about the lifestyles of clients, to set up plans to solve health problems in the community. Using such information could also identify if the SHPH was providing any inappropriate work or services at the SHPHs. Lawn et al. (2008) support study participants‘ views that understanding the needs of people in their communities and integrating these needs with the components of the PHC is necessary to establish appropriate activities. Lawn et al. (2008) and WHO (1978) note that it is important that family medicine and multidisciplinary teams understand the real health needs of the communities they serve, and that they gain the confidence of the people they work with.

3) Community participation

Study participants pointed out that community participation was an effective way of discovering worthwhile ideas about other networks. A strategy of forming groups and inviting them to meetings was employed by study participants to share information and make decisions with stakeholders. The participants explained that they needed to assist the stakeholders to set up and run a meeting initially and encourage those stakeholders to take control of the meeting, with the PHC managers taking on the role of supporter and moderator at the meeting. Study participants also used other brainstorming strategies such as ‗strategic road map‘, ‗public policy‘, and ‗the health constitution‘ to gain community participation. However, they explained that the main concept of these strategies was to encourage each member in the network to analyze and solve their own problems. These findings concur with the literature indicating that community participation is considered as a key to sustainable PHC (Bindari-Hammad & Smith, 1992, p. 41; Brown et al., 2005; Francis et al., 2008; McMurray, 2007).

PHC is a practical approach to making essential healthcare universally accessible to individuals and families in the community in an acceptable and affordable way, and with their full participation (Francis et al., 2008; Gillam, 2008; WHO, 1978, 1978). In order to achieve the long-term goal ‗Health for All by the Year 2000‘, the PHC approach in Thailand is based on the four principles of appropriate technology, people‘s involvement, intersectoral coordination, and self-reliance (Nittayarumphong, 1990). This has led to more emphasis on comprehensive health programmes based on the PHC approach (Bureau of Policy and Strategy, 2009, p. 15; Intaranongpai et al., 2011; Ramasoota, 1997). These programmes encourage people‘s participation in the health scheme in order to widen the use of government health services and increase the efficiency and scope of health promotion (Lyttleton, 1996; Ramasoota, 1997).

The results of this study regarding community participation are also consistent with the literature explaining that the health services provided at the SHPH are based on local participation and social acceptance from three main stakeholders: the SHPH, the local political sector and people in the community (Intaranongpai et al., 2011; Jitramontree et al.,

2012; Petcharatana et al., 2010; Phothacharean & Nichapa, 2012; Rodjanatham et al., 2012; Sakornkhan & Nualnetr, 2011). This means that these stakeholders participate in setting up the health services system according to their local needs. Stakeholders contribute to planning and solving health problems within their communities by using their competencies and experience (Jitramontree et al., 2012; Petcharatana et al., 2010; Phothacharean & Nichapa, 2012; Rodjanatham et al., 2012; Sakornkhan & Nualnetr, 2011). For instance, VHVs have an important role in assisting the SHPH team in providing health promotion and disease prevention in their responsible village (Jopang et al., 2012; Settheetham & Chantra, 2012; The Government Public Relations Department, 2009). Local authorities can help the SHPH team in controlling dengue haemorrhagic fever (Pudthasa et al., 2010). School administrators, teachers, school cooks and students‘ parents can assist the SHPH team in controlling obesity among elementary school students (Pongpitak, 2011). Religious leaders, particularly the most senior of them, can support the SHPH team in solving the problem of drug addiction. The religious leaders participate in the drug addiction treatment programmes and help addicts by providing them with counselling and spiritual support (Manowachirasan at al., 2012).

The results of previous empirical study have also emphasized the concept of community participation and empowerment (Petcharatana et al., 2010). Petcharatana et al. (2010) conducted a case study to evaluate the health services system management of Dong Kan Yai Health Promoting Hospital, one of the four selected SHPHs in Kam Khuan Keao District, Yasothorn Province, that had been upgraded in 2009. They employed a theoretical framework described as the context, input, process and product (CIPP) model. The PHC manager, the president of the sub-district administration organization and the director of Kam Khuan Kaeo Hospital were interviewed. Clients of the SHPH were given questionnaires to evaluate their satisfaction. The documents of the SHPH, such as the annual report and E-data base, were reviewed. The results showed that the health services systems of the SHPH were managed under the participation of the tripartite structure of people, health personnel and the local political sector. The development of the SHPH under community participation and empowerment could increase clients‘ satisfaction because they could get access to continuity of care and holistic care.

4) Power delegation

Study participants explained that, because they were civil servants in the hierarchical system in the Thai government, they were not inclined to strongly exercise their power and autonomy over subordinates and network stakeholders in the community, such as VHVs. Instead, study participants indicated that they attempted to acknowledge the potential of these people and delegated their power as managers to them for making a decision. This strategy would, in turn, help foster respect and assistance from subordinates and stakeholders. These findings demonstrate methods – softer approaches with subordinates and stakeholders – employed by PHC managers to reduce the power distance prevalent in Thai society (Hofstede, 1980, 1997). Study participants also did not want to be seen as being autocratic, being controversial or as criticising experts. They thus need to show respect for and belief in *Pu Yai*, elders, teachers and experts (Browell, 2000, p. 110; Thanasankit, 2002, p. 132; Theerasak et al., 2000).

Forming a committee was a management strategy used by study participants to work with the representatives of the people in the community. Study participants stated that, in accordance with the SHPH policy, they formed particular SHPH committees to help develop the SHPH. The findings from the study previously mentioned (Petcharatana et al., 2010) also indicated that the SHPHs established the SHPH board committees to work as the people‘s representatives for planning public health solutions in the community and setting up the health services system. The committees were involved in managing the budget of the SHPH received from the central government and donations made by the people in the community, thus helping to bolster numbers of health personnel and medical equipment and supplies in the SHPH (Petcharatana et al., 2010).

5) Coordination

Study participants explained that they had an important role in coordinating several community groups within their SHPH network. These findings are consistent with the literature indicating that the primary responsibilities of frontline managers are to structure, coordinate and facilitate work activities with a short-term perspective (a few weeks to two

years) with their subordinates and stakeholders (Clinton, 2004, p. 105; Yukl, 2010, p. 90). The classical management theories, such as those of Taylor (1911), Fayol (1949), Drucker (1954) and Mintzberg (1989), also identified that coordinating is one of the five basic functions of management: 1) planning, 2) organizing, 3) commanding, 4) coordinating and 5) controlling the work of an organization to achieve the determined goals (Bratton et al., 2005, p. 7; Harris, 2006, p. 4; Kotter, 1990, pp. 4-5).

The participants proposed that they achieved coordination of network participants by employing various communication techniques, such as writing official letters, making telephone calls and using community loudspeakers. These findings are consistent with the finding in the literature that leaders have the important role of creating systems that disseminate rich information to others and allow others to adapt such information in ways that are most meaningful and suitable for them (Plesk & Wilson, 2001, p. 748). Leaders have to find strong strategies that enable the agents in the system to share and to work collaboratively with others (Sturmberg et al., 2012, p. 205).

6) Motivation

Study participants pointed out that skill in motivating people was essential for them to successfully work with stakeholders in the community, such as the VHVs and community leaders, in order to increase the stakeholders' participation and ownership. Study participants emphasized that they needed to be active supporters of the stakeholders and motivate them to work harmoniously, particularly when those stakeholders are faced with problems and feel discouraged. This finding supports the conclusion of Kotter (1990, pp. 4-5) that motivating and inspiring are core processes of leadership. Marquis and Huston (2003, p. 4) also stress that a leader is one who has power to influence the willingness of others to follow.

The participants provided illustrations of some of their motivational strategies. First, because the community leaders have an important role and considerable power in the community, study participants attempted to encourage this elite group to motivate other people in the community about an issue that needed to be dealt with or developed. Second, study participants pointed out that expressing gratitude and respect to stakeholders – such as

expressing admiration for them in a meeting, providing them with an occasional gift, presenting them with a prestige certificate, or granting them a reward of some kind – were the important methods they employed to increase the stakeholders' motivation. This second strategy is consistent with the Thai cultural practice of *Bun Khun* or doing favours for each other, particularly for those who have provided assistance to oneself (Thanasankit, 2002, p. 132).

7) Conflict management among the networks

Study participants proposed that one of the challenges in working as PHC managers was to manage the conflict occurring among various stakeholders in the community. The causes of conflict might be differing opinions and needs, misunderstandings between the stakeholder organizations, or local political issues. Therefore, study participants needed to reduce the conflict by building understanding and good relationships among community groups and members. These findings are consistent with the literature on Thai culture indicating that Thais have an intensely collective culture (Hofstede, 1997, p. 55). That is, the interest of the group prevails over the interest of the individual in a collectivist society (Browell, 2000, p. 110; Hofstede, 1997, p. 50) and there is a strong sense of loyalty to increase the level of harmony and reduce the level of conflict in society (Browell, 2000, p. 110).

Summary: leadership roles and management functions of the PHC managers

The results of this qualitative study show that PHC managers need to perform self-management leadership, team-management leadership and network-management leadership. PHC managers also need to have the knowledge, attitude and practice (KAP) about the leadership roles and management functions adapted to a Thai cultural setting. Table 6.1 compares the results regarding the leadership roles and management functions of the PHC managers found in this study and the responsibilities and roles of PHC managers identified in the literature (MoPH, 2010c) and from previous studies (Arunsang & Boortanarat, 2011; Yompuk et al., 2012).

From the literature, there are three main tasks in the SHPH: administrative tasks, academic tasks and providing health services. Normally, the administrative and academic tasks are the main responsibilities of a PHC manager (MoPH, 2010c). However, the results of this study and of two previous studies (Arunsang & Boortanarat, 2011; Yompuk et al., 2012) indicate that the PHC managers have to take on more roles and deploy more skills and competencies than those determined in the literature.

Arunsang and Boortanarat (2011) explored the characteristics of 125 PHC managers in Trang Province and studied the relationship between management capability of PHC managers and the success of the Healthy Tambon (sub-district) Project. The results from questionnaires showed that there were seven competencies of PHC managers that had a positive relationship with success in implementing the Healthy Tambon (sub-district) Project. The seven competencies consisted of organizational planning, organizational managing, human resources managing, directing and controlling, coordinating, reporting and budgeting.

Yompuk et al. (2012) studied the roles of PHC managers in SHPHs. The first phase was a qualitative study carried out by reviewing the related literature on competency and interviewing six high-level experts at the policy level. The second phase was a quantitative study to confirm the competency elements received from the first phase by using questionnaires with 650 PHC managers of SHPHs. The results indicated that the roles of PHC managers of SHPHs consisted of ten components: coordination, communication, strategy planning, analytical thinking, leadership, teamwork, community working, services mind, community participation and technology and information.

The results of this qualitative study add to the findings of the Arunsang & Boortanarat (2011) and Yompuk et al., (2012), studies of the PHC manager‘s roles regarding leadership roles and management functions. Overall, the results of this study indicate that PHC managers should develop themselves through lifelong learning in order to broaden their knowledge for working effectively in the multiple-roles of the PHC manager‘s position. PHC managers should have a values-based approach that enables them to successfully work in their position. Trust-building is important for the PHC managers to effectively work with team members in their organizations and the networks in their responsible communities. Additionally,

Table 6.1: KAP regarding the leadership roles and management functions of the PHC managers

Three main tasks in a SHPH [1]	The roles of PHC managers in SHPHs from previous empirical studies[2,3]	Leadership roles and management functions of PHC managers from the findings of this study
Administrative tasks - planning and evaluating strategies - coordinating projects and activities with other government organizations and non-government organizations - managing the budget - supporting the health team **Academic tasks** - conducting research in order to find a solution to community health problems **Health service tasks** - health promotion - disease control and prevention - environmental health - primary medical care and rehabilitation - primary dental care - pharmacy and consumer protection - Thai traditional medicine	[2]Coordination, Communication, Strategy planning, Analytical thinking, Leadership, Teamwork, Community working, Services mentality, Community participation and Technology and information [3]Planning, Organizational managing, Human resources managing, Directing and controlling, Coordinating, Reporting and Budgeting	**Knowledge (K):** - lifelong learning to broaden knowledge for working in the multiple-roles of PHC manager's position **Attitude and values based-approach (A):** - passion, altruism, self-directed and career progression **Practice (P):** - Trust-building in team and with networks - Teamwork Team direction Responsibility delegation Team participation Thai culture Conflict management - Networking Build networks Coordination Community participation Power delegation Motivation Conflict management

[1]Adapted from Ministry of Public Health. (2010c). *Structure of the regional administration under the Office of Permanent Secretary (in Thai)*. (No 0201/032/ว.364).
[2]Adapted from Yompuk, S., Keiwkarnka, B., Nimitarnun, N., & Imame, N. (2012). The Competency for Administrators in Subdistrict Health Promotion Hospitals in the Permanent Secretary for Ministry of Public Health. *Journal of Public Health and Development, 10*(2).
[3]Adapted from Arunsang, R., & Boortanarat, C. (2011). Relationships between Personal Characteristics, Workload, and the Management Capability of Health Center Chiefs Toward Key Success Indicators of the Healthy Tambon Project in Trang Province. *Princess of Naradhiwas University Journal, 3*(1), 33-4

Thai culture has a pivotal role and influences the way that the PHC managers lead and manage their organizations and communities. PHC managers need to understand and adapt to the strategies that suit Thai attributes and values with aims to create good working relationships, co-operative orientation, peacefulness and harmony with and among their team members and networks.

6.3.2 Challenges of the existing organizational structure and the district health system

This section discusses the challenges of the existing organizational structure and district health system resulting from the implementation of the SHPH policy. The findings (described in Chapter Four) showed that the reform of this policy had an effect at three levels: the individual, organizational, and community levels. At the individual level, the participants perceived that change was constantly occurring in the organization. They had different perceptions regarding the reform of SHPH policy. At the organizational level, study participants perceived that change regarding the SHPH policy leads to two major challenges, namely human resources shortage and financial constraints. At the community level, study participants perceived that people in the community tended to have high expectations from the SHPH policy, particularly in terms of curative care. The managers thus needed to develop the health services provided at the SHPHs to focus more on integrated comprehensive PHC services in order to respond to the needs and expectations of those people. The constant change from the SHPH policy implementation and its consequences at the three levels are discussed in more detail in this section.

6.3.2.1 Constant change in the district health system

The participants interviewed in this study perceived that changes were constantly occurring in their organizations. This perception confirms the finding in the literature indicating that health services managers in complex adaptive systems are being transformed and are evolving towards something new all the time (Amagoh, 2008; Senior & Swailes, 2010, p. 50). Therefore, health services managers at all levels are faced with various challenges (Shortell & Kaluzny, 1997, p. 44) because they have a complex role and are working in a complicated and dynamic changing situation in health services organizations (Clinton, 2004, p. 99; Shortell & Kaluzny, 2006, p. 64).

Study participants expressed their view that the changes involved in the new SHPH policy affected and interacted with their work because new criteria and responsibilities were always emerging. These findings are in line with the literature that changing healthcare policy and restructuring health services organizations can affect the clearly understood roles of these frontline health personnel in management (Clinton, 2004, p. 106; Egger et al., 2005). Hence, frontline managers should have skills and competencies in formulating and implementing policy and strategy (Orme et al., 2007, pp. 86-87).

Study participants emphasized that, due to the constant change, they had to be able to adjust and transform themselves, a process of self-organizing, to meet the changes. These descriptions are consistent with the five characteristics of CASs proposed by McDaniel (2007, pp. 22-23), namely that “complex adaptive systems are characterized by 1) diverse agents that learn, 2) that interact with each other in a nonlinear way, and therefore, 3) self-organize, 4) have emergent properties, and 5) co-evolve with the environment”. Adaptation and self-organization are important to ensure the survival of organizations in a turbulent and unpredictable situation in a healthcare system (Harris, 2006, p. 67). This means that if the organizations are changing and becoming different, then it is the role of the health services managers to adapt to the situation (Clinton, 2004, p. 99).

Study participants raised different perceptions regarding the reform of SHPH policy. First, some of the participants recognized the benefits and opportunities afforded by this policy for developing their healthcare organization. This group of participants can be categorized as the innovators or early adopters who are eager to try an innovation and are able to cope with the high degree of uncertainty about the innovation (Rogers, 1983, pp. 248-249). Another study undertaken in Sweden indicated that the positive expectation and perception of staff toward the innovation is one of the key factors influencing the adoption of innovation in PHC (Hutchison et al., 2001).

Second, some of the participants explained that they initially had a negative perception because, as the policy was somewhat radical, the detail of the policy was not clear and it seemed impossible to implement. However, these participants stated that their perspective altered in a positive way after they gained more information about the SHPH policy. This group of study participants behaved as the “early majority” who deliberate for some time before completely adopting an innovation (Rogers, 1983, p. 249).

Third, some of participants shared their perception that there was nothing new in the policy. For example, they believed that the criteria, KPIs, infrastructure and human resources were still the same as in the previous policy. This group of participants might be considered the ―late majority” who do not adopt an innovation until most others in their social system have done so (Rogers, 1983, pp. 249-250).

Lastly, some of the participants even resisted the reform of the SHPH policy because they perceived it as only little changed, for example involving changing only the name and having a new name sign. This group of participants would be classified as the ―laggard group” which tends to be suspicious of an innovation and is fixed on the current situation or status quo (Rogers, 1983, p. 250).

The results regarding the different perceptions of various participants confirm the finding in the literature that understanding the personalities and needs of the types of adapters is vital to selecting and utilizing an appropriate technique to diffuse an innovation to each group (Robinson, 2009). Greenhalgh et al. (2004) explain that the difference in rate of adoption could depend on many factors such as organizational structures, leadership and management, the human resources issue, funding, intraorganizational communication, interorganizational networks, feedback and adaptation reinvention. Isouard (2010a) and Isouard (2010b) also suggest that successful national health reform needs to account for various aspects of change: political, cultural, behavioural and professional factors. Therefore, the findings of this study show that the types of adopters and those other related factors influencing the rate of adoption have to be considered in order to successfully implement an innovation, such as the SHPH policy. The findings also suggest that the PHC managers, as they are the early adopters, have to consider their peers, especially their subordinates in the organization and stakeholders in the community, and they have to select and utilize the appropriate strategies that suit the characteristics of their peers.

Study participants mostly emphasized that political pressure seemed to be the most powerful factor influencing the change regarding the SHPH policy. They explained that political pressure radically affects the reform of the healthcare system in Thailand and directly forces PHC managers to adopt and implement the SHPH policy. These descriptions raised a number of issues relevant to neo-institutional theory and typology of

archetypes which maintain that an organization is influenced by pressures from both within the organization itself and from external forces, such as the state (Zucker, 1987, p. 443). The organization thus needs to change or conform to the environment characterized by external norms and rules in order to survive and to receive support and legitimacy (Shortell & Kaluzny, 2006, p. 28).

The change resulting from the mandate or legislation from the government is called political pressure (Dacin et al., 2002) or coercive isomorphism (DiMaggio & Powell, 1983, p. 150). Senior and Swailes (2010, p. 16) explain that healthcare systems might be influenced and controlled by governments through the country‘s policies. Political pressure can lead to revolutionary change that happens swiftly and affects virtually all parts of the organization simultaneously (Cooper et al., 1996, p. 1024). However, from complex adaptive systems perspective, Sturmberg et al. (2012, p. 205) point out that the important issue is that effective change should not result from coercive pressure. Instead, the change should emerge from a shared vision and it should co-evolve with the individual healthcare worker‘s attractor patterns. ―In operational terms, this would translate to a person‘s particular needs shaping all relevant interactions within the health system. This ideal requires all system levels to respond adaptively (rather than prescriptively) to a challenge" (Sturmberg et al., 2012, p. 204). This assists in developing best solutions for individuals and communities (Sturmberg et al., 2012).

The results of the Miller et al. (1998) study also indicate that primary care practices, consisting of various agents, such as physicians, officers and patients, interact with each other in order to respond to the change based on the attractor, internal motivators and value system of the practice. Carlfjord et al. (2010, p. 359) agree and explain that change should be consistent with a natural part of daily work and it should support and develop the prevailing tasks in order to reduce the resistance to change and at the same time to create the power of the organization. In addition, the managers who demonstrate that they are institutional entrepreneurs have the leadership capacity to take action in enabling the change to occur (Lockett et al., 2012; Samia et al., 2012, p. 217). They need to produce significant change or movement in human organizational systems (Bratton et al., 2005, p. 8; Kotter, 1990; The Canadian Coalition for Global Health Research, 2006) because they have an important role in initiating and responding to institutional change and in producing successful diffusion and institutionalization of practices (Dacin et al., 2002;

Lockett et al., 2012). Thus, these findings suggest that PHC managers as institutional entrepreneurs should have competencies in managing and leading under conditions of constant change and because of the complexity of PHC organization.

6.3.2.2 Financial constraints and human resources shortages

Study participants indicated that, before the implementation of the SHPH policy, they were concerned with the challenge of budget constraints, particularly for those working in the rural areas. They needed to ensure the survival of their staff and organizations by employing a variety of strategies. For example, they and their teams could receive the special payment from the Provincial Health Office when they conducted a screening project for cervical cancer (Pap Smear) in the community. Study participants opened Thai traditional medicine services in the SHPH in order to receive the service charge from clients. Study participants also explained that if they had a good relationship with networks and people in the community, they might be able to receive donations from charity fundraising events from those people. Study participants also suggested that they had to find strategies to reduce the expenditure in the SHPH, such as saving electrical energy. These findings agree with those of Hixon and Maskarinec (2008) that family medicine and multidisciplinary teams need to control the cost by using resources judiciously in order to make the health system more inclusive for people, particularly for vulnerable groups such as the homeless and the uninsured that exist outside the system.

Study participants explained that, after the implementation the SHPH policy, financial support was provided which could be used to buy new medical instruments and office items and to renovate the infrastructure of SHPHs. The SHPH policy provided that the small, medium and large SHPH received a special budget of 500,000 baht, 700,000 baht, and 900,000 baht respectively (MoPH, 2010a). The MoPH additionally provided guidelines for improving SHPHs‘ three important components of health services management, namely infrastructure of the health facility, health services provision and the management system (Bureau of Policy and Strategy, 2009; MoPH, 2010a). As a result, infrastructure of the SHPHs was renovated and reconstructed, and almost 1,000 ambulances were purchased, together with more medical equipment (MoPH, 2010a).

Study participants optimistically described that the financial support could contribute to the benefit and satisfaction of both the staff working in the SHPHs and clients utilizing the health services at the SHPHs. This finding agrees with another study (Longo, 2007, p. 224) indicating that the resources dedicated to enabling change management in primary care are one of the most effective drivers in implementing managerial innovations in primary care systems. Greenhalgh et al. (2004, p. 611) supported the contention that the innovation is more likely to be implemented and reutilized if there is dedicated and ongoing funding for implementation of knowledge. Previous empirical study indicated that there were more health personnel and medical equipment and supplies in the SHPH when there was an adequate budget. These developments could increase clients' satisfaction because they could get access to continuity of care and to holistic care (Petcharatana et al., 2010).

However, study participants noted that challenges remained to achieving good financial management even though every SHPH received the additional financial support. Some stated that the financial support given was not enough. Others raised the issue of delayed transfers of funds from the central office. As well, some study participants pointed out that they had difficulty in independently spending their budget allocation according to the needs of their SHPH because budget spending was fixed to be spent according to the budget framework determined by the central government. These results support the fact that study participants, as PHC managers, have the role of utilizing resources effectively under circumstances of budget shortages.

Study participants also noted that shortages in human resources at SHPHs were a management challenge. They explained that most of the SHPHs still did not have the extra staff to meet the criteria set by the SHPH policy, which states that there should be at least seven staff in the group model of the collective SHPHs and they should have at least four staff in the single model of SHPH (Bureau of Policy and Strategy, 2009; MoPH, 2010b). Recent studies conducted in north-eastern provinces of Thailand (Intaranongpai, Hughes, & Leethongdee, 2012; Intaranongpai et al., 2011) also affirm that the SHPHs are not developing as fast as planned because there is still a major problem regarding recruitment of professional staff for primary care and severe staff shortages persist.

Study participants pointed out that shortages of human resources could lead to inappropriate ratios between the health professionals and clients. Study participants identified that the main cause of human resources shortages might be that this centrally determined policy was implemented without adequate consideration of the human resources requirements. They noted that it took time to source new staff, while the policy itself could be swiftly announced and mandated. Study participants also explained that new staff who came to work for a while at the SHPHs, particularly in the rural area, often moved on to work in urban SHPHs, thus creating ongoing staff shortages. These results demonstrate that those responsible for health system change at the systemic structure level may not have adequately engaged an important group, the health managers within the system, in the reform process.

Participants pointed out that the ability to manage the challenge of human resources shortages was an important task of PHC managers. Study participants explained that various strategies could be used to meet this challenge. For instance, rotating health professionals from the healthcare networks, such as the district hospital or another SHPH, to work in the SHPH might be a short-term solution. However, study participants cautioned that this solution might cause a problem to the healthcare networks because there might also be shortages of health professionals at the district hospitals. Study participants provided another solution of employing residents living in the SHPH area as staff of the SHPH. Study participants also proposed employing support staff, such as financial staff or information technology staff, to alleviate the workload of health professionals. Additionally, study participants proposed that attracting and retaining existing staff was another solution; thus, they needed to help and support their subordinates in order to increase work satisfaction and stability. They suggested that all staff at the SHPH should be registered as civil servants and the staff should be provided with the usual civil servant benefits such as welfare housing, laptop computers and payment of overtime. A recent study by Intaranongpai et al. (2012) also found that Sri-isaan, one of the provinces in north-eastern Thailand faced with severe staff shortages, has chosen to provide scholarships to students, a strategy aimed at boosting future doctor and nurse recruitment to work in the province.

6.3.2.3 Rising clients' expectations

The participants explained that, when the SHPH policy was implemented in 2009, the name of the healthcare organization was changed from Primary Care Unit (PCU) to Sub-district Health Promoting Hospital (SHPH), some participants believed that changing the name of the healthcare organization was only change for the sake of change. This finding might be explained through the mimetic isomorphism of neo-institutional theory and typology of archetypes where the government has the tendency to mimic or model a previous government policy that they perceived as successful or legitimate by implementing the health reform policy and creating a new name for the healthcare organization (DiMaggio & Powell, 1983, p. 152).

Study participants pointed out that changing the name could make the healthcare organization appear more ‗luxurious'. However, study participants explained that the name change might lead to clients' higher expectations of the level of care available. In other words, the participants indicated that, when there was the word ―hospital" in the name, the people in the community had an expectation that they should be able to obtain the same health services as were provided at a community hospital at the district level. The clients might expect that there were health services provided by a medical practitioner (physician, MD) equipped with advanced medical instruments and they tended to request more services. These findings are consistent with the literature indicating that frontline managers are required to meet a variety of community needs beyond their control. Frontline managers need to respond to those needs within a fixed budget and with a staff comprising a variable mix of health professionals (Clinton, 2004, pp. 104-105; Egger et al., 2005). Burns (2007) points out that the challenges faced by frontline managers consist of low confidence and abilities in health services management and the pressure of high expectations from both clients and top-down managers.

Previous empirical studies also show that local people went to SHPHs for medical health services and expected services identical with those provided at the district hospitals (Tima & Sealim, 2012). Clients understood that the focus of the SHPH was on health promotion and disease prevention programmes, but they also expected the SHPH to have the same capability to treat complex diseases as district or province hospitals have (Neelasri, 2011).

Tima and Sealim (2012) believed that the reason for misunderstanding the SHPH policy might be because the policy was unclear as there was a lack of communication.

Study participants explained that, when clients had high expectations, they tended to request more services. They also pointed out that, when the clients did not receive health services in line with their expectations, some clients complained about the limited health services provided at the SHPHs. These findings are consistent with the proposition of ―consequences of innovation" in diffusion of innovations theory that when there is a change occurring from adopting the innovation, there may be changes from the individual level to the social system level with either desirable or undesirable consequences (Rogers, 1983, pp. 31-32). In general, change agents, who attempt to diffuse an innovation into the system, usually expect positive consequences such as patient satisfaction, increased quality of life, decreased costs, and decreased mortality/morbidity (Dobbins et al., 2002). However, the consequences of innovation might turn the system upside down (Rogers, 1983, p. 32). The results of the study of Sturmberg et al. (2012) also illustrate that primary care providers work in a highly complex environment, compared to the more structured, and less complex, secondary and tertiary health care level. They have to ―juggle" multiple diverse and time-competing demands and they have to consider a range of possible explanations for their patients' complaints (Sturmberg et al., 2012).

Study participants stressed that they needed to resolve the challenge of clients' expectations. They suggested that they had to build understanding with those clients by providing them with information about the change regarding the SHPH policy. Study participants added that they received assistance from community leaders to distribute information to people in the community. These findings demonstrate that the PHC managers have to help others in the organization and system to make sense of the system (Thomas, 2006, p. 8). This is consistent with propositions within complex adaptive systems theory; that is, sense-making is one of the important tasks of effective management because sense-making is a strategy for organizations and their agents to create meaning and understanding in complex adaptive systems (Anderson & McDaniel, 2000, p. 89). Rogers et al. (2005, p. 11) also propose that the PHC managers, as change agents, need to make an effort when clients or other agents in systems are opposed to an innovation or have differing attitudes and orientations towards the innovation. The change agents have to communicate information about the innovation by conveying background

information about the innovation so that potential adopters can make sense of the innovation. Failure to transmit all such information can result in diffusion failure (Rogers et al., 2005, p. 11).

Study participants pointed out that another solution to dealing with clients' expectations is to increase staff competencies because there are more clients, particularly clients with chronic diseases. Knowledge and skills regarding curative care was also emphasized by the study participants because clients did not need to go to the community hospital. However, while attempting to increase the competencies of the subordinates, another interesting issue is about balancing the happiness of their subordinates and satisfaction of clients

6.3.2.4 Development of integrated comprehensive PHC services

Study participants believed that the new name of the healthcare organization incorporating the word "hospital" also affected the perception and interpretation of health professionals regarding health promotion and curative care. Initially, some study participants thought that the focus of the SHPH policy was more on curative care than health promotion because of the word "hospital". Study participants argued that, even though actively working in the community was indicated in the SHPH policy, curative care was still essential for clients and it needed to be arranged for and provided at the SHPHs. Study participants emphasized that knowledge and skills regarding curative care were necessary for both PHC managers and subordinates, particularly for those working in the rural areas, because everyone needed to help each other in providing treatment for clients. These findings are consistent with the notions of PC derived from the biomedical model of diagnosis, treatment and care and equate with SPHC (Talbot & Verrinder, 2010, p. 7; Willis et al., 2009). The focus of PC is at the level of the individual (Willis et al., 2009, pp. 35-37).

Study participants held the view that, based on theory, health promotion and disease prevention are important, but curative care must come first in the real situation. This finding shows that there are competing institutional archetypes in the SHPHs. According to the ideology of the health promoting hospital, the archetype of the SHPH should focus on health promotion. However, in reality, study participants perceived that curative care

still had a pivotal role in providing health services at the SHPH. This is consistent with the literature indicating that the archetypal professional organization has been constantly experiencing change in response to environmental forces through the process of delegitimization and deinstitutionalization and this leads to the emergence of a new archetype of the professional organization (Brock, 2006). The values and beliefs of the interpretive scheme need to be changed in order to successfully change the archetype (Brock, 2006, p. 160). The results of this study also confirm the results of the study of Samia et al. (2012) which investigated the content, mechanisms and process of radical change of health services in the community in Canada, finding that transforming from one template of healthcare delivery to another affected the change in structures, systems and underlying values, the so-called archetype. Samia et al. (2012, p. 231) note that “successful change occurred when there was convergence of a variety of precipitating and enabling mechanisms” such as dissatisfaction with the prevailing template, the commitment of powerful groups/stakeholders to new values, the capacity to change through proper leadership, the social interaction among members of different groups, and the incentive system.

However, study participants explained that they rather altered their perception regarding the competing institutional archetypes in the SHPHs after they obtained the information that the policy actually emphasized health promotion. They stressed that, because there was the word “promoting” in the new name of the healthcare organization, health promotion should be the main activity of the SHPH rather than curative care. These findings suggest that, while most attention had been paid to medical treatment provided by the health services, environment and lifestyle would offer the greatest opportunities for promoting public health in the future. The WHO (2012) notes that health promotion does not pay attention to a biomedical model only, but also to the roles of all sectors in society in health promotion, taking into account a more active role for the community to take control over the determinants of health. Health promotion plays an important role in improving health behaviour for sustainable health status and in motivating people to improve their living conditions. Its aim is to develop people‘s sense of responsibility for health conditions for themselves as individuals, as members of families, and as communities (Buasai et al., 2007). It also emphasizes the importance of environmental, economic, political and social factors affecting health (WHO, 2012). Therefore, the focus

of health services should be shifted from curative care to a more holistic approach that encompasses the principles of health promotion (Mchugh et al., 2010, p. 230).

Study participants explained that health promotion was relevant to the concept of actively working in the community. These findings support the literature that the SHPH policy in Thailand is the strategy being used to reorient PHC services to focus more on proactive health promotion in the community (Ministry of Public Health, Ministry of Social Development and Human Security, & Ministry of Labour, 2011; The Government Public Relations Department, 2009). The participants indicated that actively working in the community mainly involved working with various clients such as those with chronic diseases, disability and mental illness. This finding is in line with the literature that the challenges regarding the turbulence and uncertainty in healthcare organization are the diversity of the health professionals in the healthcare system, continuing technological development, changes in demographics due to the ageing of the population and shifting from acute to chronic disease (Grant, 2010; Harris, 2006; Shortell & Kaluzny, 1997, p. 44). Wibulpolprasert (2011, p. 387) also states that there are still many challenges regarding Thai people‘s health, such as those of an ageing society and chronic diseases, emerging diseases (SARS, avian flu) and re-emerging diseases (tuberculosis, malaria, and dengue haemorrhagic fever).

Study participants pointed out that health promotion was also relevant to the principle of integrating healthcare with other networks through the referral system. They believed that the local government organization had an important role in the referral system between the SHPH and the district hospital. Nawat emphasized that the referral system of the SHPHs had to be effectively managed in order to increase the quality and standard of care. These findings illustrate the importance of integrating healthcare at the PHC level. This is consistent with Russell et al. (2010) and Thomas (2006, p. 137) who suggest that the management of a PHC organization should place more emphasis on CPHC, integrating CPHC into the greater healthcare system. The PHC organization, particularly in remote areas, has the tendency to be an integrating PHC organization because of the advantages of its implementation, such as cost-effective health-care intervention (Ekman et al., 2008; O'Donohue et al., 2005; Thomas, 2006, p. 138; WHO, 1997). In Australia, New Zealand and the United Kingdom, PHC organizations have provided health services based on the integrated care model and get significant outcomes such as increasing

physician participation and satisfaction and reduction in diagnosing and prescribing costs (Rowan et al., 2007; Russell et al., 2010). From the point of view of the health services users, it is often claimed that integrated programmes are better than the vertical programmes because the care provided is fitted to the patient‘s needs and leads to more adequate services delivery. As a result, this can increase patient and provider satisfaction and reduce the long-term costs (O'Donohue et al., 2005).

Study participants further explained that the development of technology assisted and supported the referral system in the SHPHs. Study participants pointed out that clients‘ information could be reported between SHPHs and the district hospital via the Internet. Health professionals of the SHPH and district hospital could consult and discuss clients via Skype, for example. These findings are consistent with the literature that the medical online system, or so-called Telemedicine, such as Skype and Web cam, can be set up to link with the community hospital at the district level in order to facilitate consultation by health personnel at SHPHs with physicians (MoPH, 2010b; The Government Public Relations Department, 2009; Tima & Sealim, 2012).

However, the participants identified the barriers to proactively working in the community. For instance, Chai described that the constant change occurring in the organization, such as the change of health policy, could affect actively working in the community because he needed to spend time formulating a new plan to implement the new policy. Praw emphasized that the shortage of health professionals and increasing numbers of chronically ill clients getting treatment at the SHPH were other barriers that could impede actively working in the community because staff had to spend time with these clients and there were not enough staff for home visits in the community.

6.4 Implications of the findings for policy and practice

This section addresses the implications of the findings of this study for policy and practice regarding the leadership roles and management functions and challenges of PHC managers at SHPHs implementing the PHC reform policy during 2011 in Phitsanulok province, Thailand. The recommendations are: 1) policy reform should be based on public participation; 2) there is a need for effective policy translation and policy evaluation; 3) policy, planning and strategy are required for human resources

development; 4) there should be professional development opportunities for PHC managers; and 5) there should be a network for integrated healthcare at district health system level. The first and second recommendations are relevant to policy decisions. The third recommendation is relevant to both policy and practice, while the last two recommendations are relevant to practice.

6.4.1 Policy reform based on public participation

Study participants mostly emphasized that political pressure seemed to be the most powerful factor influencing change regarding the SHPH policy. They explained that political pressure radically affects the reform of the healthcare system in Thailand and it directly forces PHC managers to adopt and implement the SHPH policy. The change resulting from the mandate or legislation from the government is called political pressure (Dacin et al., 2002) or coercive isomorphism (DiMaggio & Powell, 1983, p. 150). Senior and Swailes (2010, p. 16) explain that healthcare systems might be influenced and controlled by governments through the country‘s policies. Political pressure can lead to revolutionary change that happens swiftly and affects virtually all parts of the organization simultaneously (Cooper et al., 1996, p. 1024). However, from the complex adaptive systems perspective, Sturmberg et al. (2012, p. 205) point out that the important issue is that effective change should not result from coercive pressure. Study participants‘ views are consistent with those of Sturmberg et al. (2012, p. 204) in that they had a pessimistic perception about the SHPH policy because this policy was somewhat radical, the details were not clear, and it seemed impossible to implement. Isouard (2010b, p. 23) suggests that ―professional practice and its membership are key factors that need to be accounted for when planning and implementing health reform measures”.

These findings imply that policy reform should be based on a bottom-up approach. Public debate, public hearings, public engagement and public participation should be emphasized in order to ensure that the needs of communities and populations are considered and to reduce the resistance to change of policy reform from those stakeholders implementing the policy and affected by such policy (Tima & Sealim, 2012). The policy makers should arrange civil society and public forum meetings when they are formulating a new policy in order to construct a long-term SHPH development policy with clear criteria and standards for evaluation in a realistic and gradual manner (Tima &

Sealim, 2012). This approach will make health managers and other stakeholders feel that they are central to the reform process. They will feel that they have an important role to play and will become active participants in the change process of policy reform, rather than feeling that they are not in control of its implementation.

The participants also described that as managers they had a feeling of personal pride because they had more power and freedom in making a decision and formulating a policy or designing a project than when they were subordinates. They explained that they could create ideas for their organization and for their higher levels of administration and they had the ability to deal with other stakeholder organizations. However, some of the participants pointed to the challenges regarding the financial support that they received from the SHPH policy. They explained that they had difficulty in independently spending their budget allocations according to the needs of their SHPHs because the budget was already fixed and had to be spent within the budget framework, which was determined by the central authority.

These findings infer that public policy should provide guidance, principles or frameworks instead of giving detailed prescriptions and controls to health providers in the delivery of health services, because of the diversity in the geographic location, differences in the health needs of particular populations and the diversity in context, structure and system of the healthcare organization. Greenhalgh et al. (2004) and Rogers (1983) explain that re-invention is one attribute of innovation that influences and sustains the success of adoption. In other words, the policy should not have too many details or specific processes of implementation. In the case of the SHPHs, policy should be modified and re-invented by adopters to suit the context of each SHPH in the process of its implementation. This approach will further enable effective localized management and authority in the delivery of health services.

6.4.2 Effective policy diffusion

The results of this study reveal that the reform of the SHPH policy affects the understanding and expectations of both the staff at SHPHs and their clients. In terms of staff understanding and expectations, the participants had different perceptions regarding reform of the SHPH policy. Some study participants recognized the benefits and

opportunities afforded by the policy for developing their healthcare organization. Some participants indicated that they initially had a pessimistic perception because, as the policy was somewhat radical, the detail of this policy was not clear and it seemed impossible to implement. However, study participants stated that their perspective altered in an optimistic way after they gained more information about this SHPH policy. In terms of clients‘ understanding and expectations, study participants pointed to the challenge of rising clients‘ expectations, explaining that the people in the community had a high expectation that they should obtain the same health services as were provided at the community hospital at the district level. The participants explained that they needed to resolve this challenge by building understanding with those clients and providing them with clear information about the changes regarding the SHPH policy.

These findings suggest that policy diffusion, communication channels and public relations have to be improved. Information regarding the SHPH policy should be effectively transferred to health professionals, stakeholders and people in society generally (Tima & Sealim, 2012). From diffusion of innovations theory, the communication channel is the essence of the diffusion process in connecting and exchanging information about the innovation between an individual or unit with experience in adopting the innovation, and another individual or unit with no experience in adopting the innovation (Rogers, 1983, p. 17). Mass media channels, such as newspapers, radio and television, have a huge impact in transmitting information about the innovation to many audiences (Rogers, 1983, p. 18). However, Rogers (1983, p. 18) and Robinson (2009) also point out that interpersonal channels of –near-peers” have more effective power to motivate an audience to adopt the innovation because people tend to trust and follow their friends who have successfully adopted an innovation. Face-to-face communication is an essential component of spreading an innovation from early adopters to the rest of the population (Robinson, 2009; Rogers, 1983, p. 18). Additionally, Greenhalgh et al. (2004) and Rogers (1983, pp. 15-16) suggest that the content of the innovation, which in this study refers to the SHPH policy, should not be perceived as difficult or as having high –complexity” to understand and implement. Therefore, there should be a wide variety of ways to diffuse information regarding the policy available to stakeholders involved in the reform of the SHPH policy.

6.4.3 Policy, planning and strategy for human resources development

Study participants emphasized the issue of human resources shortages, particularly in rural areas. They described that most SHPHs, in reality, still did not have the new staff to meet the criteria of the SHPH policy at the time of interview. The participants explained that the workforce shortage could lead to inappropriate ratios between health professionals and clients. They identified that the main cause of the challenge of human resources shortage might be that this centrally determined policy was implemented without adequate consideration of the human resources requirements and it took time to source the new staff, while the policy itself was swiftly announced and promoted.

These findings suggest that the Government and MoPH should invest in and pay more attention to the issue of human resources. The healthcare workforce at SHPHs needs to be quantitatively and qualitatively increased and developed in order to respond to the clients' needs (Tima & Sealim, 2012). The WHO (2007) also emphasized that adequate numbers and distribution of managers is one necessary factor for building leadership and management capacity at the operational level.

Study participants further pointed out that they decided to become PHC managers because of their passion for the possibilities of the position. The participants also explained that the PHC manager's position usually offered more opportunity for their career advancement and this could motivate them to work towards this position. However, they expressed the view that their passion for the PHC manager's position could be reduced when there was no support to advance in their career and when their qualifications were not associated with their professional work.

These findings imply that producing increased numbers in the healthcare workforce is not enough to sustain the development of human resources. The Government and MoPH should also build an appropriate work environment and have a plan and strategy to attract and retain new and existing staff using financial rewards or other incentives to promote better performance. According to the literature, some health personnel at the SHPHs are civil servants, but the proportion of civil servants in Thailand has steadily declined, as there are more and more temporary employees working on contract in order to create flexibility in accordance with modern state management procedures (Wibulpolprasert,

2011, p. 340). The participants in this study thus suggested that all the staff at the SHPH should be registered as civil servants and the staff should be provided with the usual benefits for civil servants such as welfare housing, laptop computers and overtime payment. Study participants‘ suggestions are consistent with Thai culture which has strong uncertainty avoidance (Hofstede, 1997, p. 116). Therefore, lifelong employment is important to ensure a degree of certainty (Browell, 2000, p. 110).

In addition, study participants suggested that employing a new staff member who had no educational background in the health field, such as financial staff or information technology staff, was important for the improved functioning of SHPHs. Employing such support staff would mean that the PHC manager and other staff at SHPHs could spend more time on health-related activities such as health promotion in the community. This recommendation means that the Government and MoPH should determine in their planning or policy development that there should be support staff competent in finance and information technology, especially in the SHPHs.

6.4.4 Professional development for PHC managers

The results of this study reveal that PHC managers need to be more knowledgeable about a wider range of issues than when they were subordinates because they have multiple roles in managing and leading themselves, their team in the organization and their networks in the community. This means that the professional leadership skills of health services managers need to be developed in order to increase their competencies for managing and leading complex healthcare organizations (Burns, 2007; Isouard, 2010a, 2010b; Taytiwat et al., 2010). The WHO (2007) proposes that appropriate competencies of managers lead to the development of improved health services at the operational level. Human resources development in leadership and management for the frontline managers must be given much higher priority for advocacy and investment by senior leaders (Filerman, 2003; Hanson & Isouard, 2000). Thus, the abilities of frontline managers have to be continually improved and they must be trained in the knowledge, skills and competencies they need to better manage their work (Burns, 2007; Egger et al., 2005; Hanson & Isouard, 2000; Isouard, 2010a, 2010b).

Study participants explained that they needed to develop their competencies across a broad range of diverse fields in order to manage the challenges occurring in the complex health services organization under the dynamic changing circumstances they face, with the aim of improving health services to achieve the MDGs. Hixon and Maskarinec (2008) and Lawn et al. (2008) agree and indicate that health professionals at the PHC level require training that varies widely throughout the world depending upon the particular form of PHC being provided. According to the findings of this study, PHC managers require greater contextual understanding of the Thai healthcare system and policy. They also need to be developed in the areas of change management, soft skills for building trust and working with people who are their team members and stakeholders, implementing teamwork with Thai cultural characteristics, community engagement and networking, primary health care, health promotion, curative care, human and financial management under challenging circumstances, and information technology skills. These findings suggest that there should be a strong policy for the local health managers' development to gain their capacities for the SHPHs arrangement in the transitional period.

Forms of continuing education and training for the PHC managers should be available or more accessible. Universities and other educational institutions should construct forms of continuing education and training that are suitable and flexible for the PHC managers because the PHC managers usually have their workload coupled with human resources constraints in the SHPHs. It is difficult for PHC managers to leave their work to study for a formal degree from a university. Maintaining their learning, both from experience and formal education, is very important to and for PHC managers. Thus, an experiential training programme at workplace level with mentors might be the solution for them. However, this kind of training requires greater engagement between professional colleges, health organizations and education and training institutions than is the case at present.

Constructing the required forms of continuing education and training alone is almost certain to be inadequate to ensure that PHC managers will attend such training for improving their competencies. The WHO (2007) suggests that there should be functional support systems at the national level to strengthen health management development at the operational level. The Government and MoPH should have the policy, regulations and

procedures to oblige PHC managers to pass some forms of continuing education and training, such as at least one course per year.

In addition, study participants explained that there were many steps and criteria to follow in progressing to the PHC manager's position, such as gaining work experience and going through the examination process. A study by Taytiwat et al. (2010, p. e62) also proposes that the roles of health managers in Thailand, such as the director of a community hospital, are usually "gained by seniority of clinical experience, rather than through management training or having management qualifications". However, the participants profile in Chapter Three section 3.6 shows that most of the study participants have no qualification in health management. This suggests that the existing PHC managers should complete some form of continuing education and training in health management and the next generation of PHC managers should be professionally qualified through a specific qualification in health management. The Government and MoPH should further develop health management professionalism for the PHC managers.

6.4.5 Networking development for integrated healthcare at district health system level

The findings of this study reveal that the PHC managers have an important role to play in developing integrated comprehensive PHC services. The participants explained that health services provided at the SHPHs should be integrated, providing both proactive health promotion and disease prevention in the community and curative care for clients at the SHPHs. Study participants also emphasized that the referral system and information system of the SHPHs had to be effectively managed in order to increase the quality and standard of health services. Study participants had the view that integrated healthcare should respond to the challenges of an ageing society and chronic diseases. Study participants further pointed out that, due to shortages of human resources in the SHPHs, assistance from the networks was crucial to successfully manage the SHPH. Thomas (2006, p. 21) proposes that individual heroic leaders are not enough to develop integrated PHC. Shared leadership through a form of advanced team-work, where the team as a whole has a leadership role, is needed at all levels of society for integrated PHC to become a reality (Thomas, 2006, p. 21). Therefore, these findings imply that there should

be a network for integrated healthcare at the district health system level. This network might be named the ―district network for developing integrated healthcare".

The district network for developing integrated healthcare should be considered as the cooperating point among stakeholders and have the main responsibility for managing and developing the overall district health system in areas such as financial management, human resources management, referral system and information technology system. This network would also provide necessary support and would be the knowledge management centre for SHPHs at the sub-district level, and be involved in areas such as conducting research for solving the health problems in the district or arranging in-service training regarding the needs of staff working at the SHPHs. Consequently, the PHC managers and staff working at the SHPHs will have more time and improved competencies to better manage their SHPHs and communities at the sub-district level.

The district network for developing integrated healthcare might be managed by a general manager and some staff qualified in health services management. This network might form committees as a single management team including 1) the director of the community hospital, 2) the chief of the district health office, 3) representatives from the community hospital, 4) representatives from SHPHs, usually PHC managers, 5) representatives from the district health office (usually public health officers), 6) representatives from other organizations in the district, such as the municipality, hospitals under other ministries, private hospital/s, and 7) representatives from the population sector. However, the study by Tejativaddhana et al., (2012, p. 16) noted that ―although PHC needs to be acknowledged and implemented by all stakeholders within the health industry and government, the roles and responsibilities of the stakeholders in health services management at the district level need to be clarified".

6.5 Future research

This section provides five recommendations for further research based on the findings of this study. First, future research should replicate the research questions of this study but in other areas, such as in another province or in other regions of Thailand, or with a larger study of PHC managers across Thailand, to enable greater generalisation of findings.

Second, the results of this study represent the perceptions and experiences of the PHC managers only in leading and managing during the implementation of the SHPH policy. A future study should be conducted to explore and understand the perceptions and experiences of other stakeholder groups regarding the leadership roles and management functions of the PHC manager. Stakeholder groups might include subordinates of PHC managers, VHVs, village headmen, chief executives of the local government organization, chiefs of district health offices and directors of community hospitals, because these stakeholder groups have to work with and are influential with regard to PHC managers. Thus, the leadership roles and management functions of the PHC manager will be more clearly understood and identified based on the points of view of those stakeholders groups.

The third important area for future investigation emerging from this study is to develop the curriculum content or training programmes in continuing professional education that would be most suitable for PHC managers. This study revealed the leadership roles and management functions of PHC managers. Thus, it will be useful to develop the content, learning design and evaluation of such training programmes based on the findings of this study. This attention to delivering suitable training programmes will better prepare and develop PHC managers to become professional health services managers.

The next potential area of future research is to build on the recommendations represented in section 6.4.5 of this chapter and would involve exploring the structure, roles and responsibilities of the proposed district network for developing integrated healthcare. As there are many stakeholders from various government ministries at the district level, such as MoPH, Ministry of Interior and Ministry of Education, it is important to identify the structure, roles and responsibilities of this network in order to help them work more cooperatively and to reduce the overlapping functions among the stakeholder organizations.

Lastly, future research is required to study how to effectively diffuse the health policy into practice for the community, for health professionals and for stakeholders. The findings of this study point to the challenges of misunderstandings and expectations of both health professionals and clients regarding the SHPH policy. This implies that the process of policy diffusion of the SHPH policy was not completely effective and needs to

be improved. Accordingly, further research should investigate how best to diffuse information about the policy and determine what kind of strategy is appropriate for effectively implementing the policy in the Thai cultural context.

6.6 Conclusions

This chapter identified and discussed the two major conclusions of this study drawn from the four major findings of the research. The first conclusion was that PHC managers have to demonstrate the three components of self-management, team-management and network-management leadership adapted to a Thai cultural setting. The second conclusion was that PHC managers experience the four challenges: 1) constant change in the district health system, 2) financial constraints and human resources shortages, 3) rising clients' expectations and 4) development of integrated comprehensive PHC services.

Following a discussion of the two major conclusions, five implications for policy and practice were identified. First, policy reform should be based on public participation. Second, there is a need for effective policy translation. Third, policy, planning and strategy are required for human resources development. Fourth, there should be professional development opportunities for PHC managers. Fifth, there should be a network for integrated healthcare at the district health system level.

Finally, this chapter concluded with recommendations for further research arising from the findings and implications of this study in order to enable greater generalisation of findings, to understand the perceptions of other stakeholder groups regarding the leadership roles and management functions of the PHC manager, to develop the curriculum content or training programmes most suitable for professional development of the PHC managers, to explore the structure, roles and responsibilities of the district network for developing integrated healthcare, and to study the most effective strategy for diffusing the health policy into practice.

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Appendices

Appendix 1 Introduction Letter for the Thai Health Authority at Phitsanulok Provincial Health Office

School of Rural Medicine
University of New England Armidale NSW 2351 Australia
ruralmed@une.edu.au www.une.edu.au/ruralmed/
Phone 61 2 6773 3322 **Fax** 61 2 6773 2388

May 19th, 2011

Dear Dr BoontermTansurat,

My name is Wutthichai Jariya and I am studying Doctor of Health Services Management at the University of New England, Armidale, NSW, Australia. Currently, I am conducting a research project entitled *"From 'Primary Care Units' to 'Sub-district Health Promoting Hospital': what are the leadership roles and management functions of primary health care managers in Phitsanulok Province, Thailand? A Phenomenology Approach"*. This research is in the process of ethics approval from the Human Research Ethics Committee. Thus, this letter is written in order to inform you regarding the research and to request your permission to conduct this research in Phitsanulok Province.

With regard to the sub-district health promoting policy, the objective of this study is to explore the leadership roles, management functions and challenges of primary health care managers as of 2011, at sub-district health promoting hospitals implementing the 2009 primary health care reform policy in Phitsanulok Province, Thailand. The total sample of this study will consist of about sixteen primary health care managers from different sub-district health promoting hospitals. They will be interviewed for about an hour to two hours regarding their work experience as managers at sub-district health promoting hospitals.

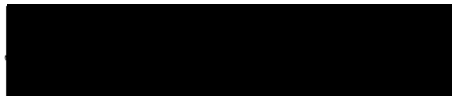
I have enclosed copies of my participant invitation, information sheet for participants, and consent form for participants in this research. Should you have any questions or desire further information regarding this letter or research, please contact me at (+612) 6773 3889 or by e-mail at wjariya@une.edu.au. You may also wish to contact Professor John Fraser, my principal research supervisor, at jfrase22@une.edu.au.

In conclusion, the student research, Mr.WutthichaiJariya, would like to ask your permission to interview some of the primary health care managers working at sub-district health promoting hospitals in Phitsanulok Province. Could you please indicate whether or not you will permit this study to be conducted by signing your name on the permission form and sending it back to me at wjariya@une.edu.au.

Sincerely Yours,

....

Mr.WutthichaiJariya
Candidate in Doctor of Health Services Management
School of Rural Medicine, Faculty of The Professions,
University of New England, Australia



....

Professor John Fraser
Principal Supervisor, School of Rural Medicine,
Faculty of The Professions, University of New England, Australia

School of Rural Medicine
University of New England Armidale NSW 2351 Australia
ruralmed@une.edu.au www.une.edu.au/ruralmed/
Phone 61 2 6773 3322 **Fax** 61 2 6773 2388

Permission Form

I, ..., Provincial Chief Medical Officer of Phitsanulok Province, have read the letter of introduction from Mr.WutthichaiJariya for in regard to his research project "*From 'Primary Care Units' to 'Sub-district Health Promoting Hospital': what are the leadership roles and management functions of primary health care managers in Phitsanulok Province, Thailand?: A Phenomenology Approach*". I would like to inform you that your request for permission to conduct research has been /has not been (circle one) granted.

....

Provincial Chief Medical Officer

Phitsanulok Province

Please **sign and keepthis copy for your records.*

School of Rural Medicine
University of New England Armidale NSW 2351 Australia
ruralmed@une.edu.au www.une.edu.au/ruralmed/
Phone 61 2 6773 3322 **Fax** 61 2 6773 2388

Permission Form

I, ..., Provincial Chief Medical Officer of Phitsanulok Province, have read the letter of introduction from Mr.WutthichaiJariya for in regard to his research project ~~–F~~*From 'Primary Care Units' to 'Sub-district Health Promoting Hospital': what are the leadership roles and management functions of primary health care managers in Phitsanulok Province, Thailand?: A Phenomenology Approach"*. I would like to inform you that your request for permission to conduct research has been /has not been (circle one) granted.

....
Provincial Chief Medical Officer
Phitsanulok Province

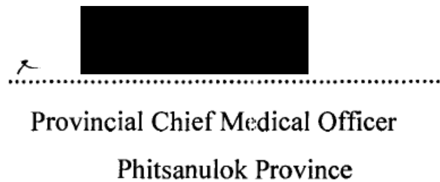
*Please **sign and send**thiscopyback to Mr.WutthichaiJariya at wjariya@une.edu.au.*

Appendix 2 Approval from the Thai Health Authority at Phitsanulok Provincial Health Office

School of Rural Medicine
University of New England Armidale NSW 2351 Australia
ruralmed@une.edu.au www.une.edu.au/ruralmed/
Phone 61 2 6773 3322 **Fax** 61 2 6773 2388

Permission Form

I, ...Boonterm Tansurat...., Provincial Chief Medical Officer of Phitsanulok Province, have read the letter of introduction from Mr.Wutthichai Jariya for in regard to his research project "*From 'Primary Care Units' to 'Sub-district Health Promotion Hospital': what are the leadership roles and management functions of primary health care managers in Phitsanulok Province, Thailand?: A Phenomenology Approach*". I would like to inform you that your request for permission to conduct research has been / has not been (circle one) granted.



....
Provincial Chief Medical Officer
Phitsanulok Province

Please **sign and send this copy back to Mr.Wutthichai Jariya at wjariya@une.edu.au.*

Appendix 3 PHC Manager's Demographic Questionnaire

Informant code………….

PHC Manager's Demographic Questionnaire

Research Project: From ‗Primary Care Units' to ‗Sub-district Health Promoting Hospital': what are the leadership roles and management functions of primary health care managers in Phitsanulok Province, Thailand?: A Phenomenology Approach

1. Gender □ Male □ Female

2. Marital status □ Single □ Married □ Divorced

3. Age …………Year(s) ………..Month(s)

4. Educational background

No.	Qualification	Institution	Year of graduation

5. How long have you been working in the health field since you graduated with your first degree (exclude the periods of leave from work)?

…………….Year(s)…………..Month(s)

6. How long have you been working in health services management?

…………….Year(s)…………..Month(s)

7. How long have you been in the position of primary health care manager in this sub-district health promoting hospital?

…………….Year(s)…………..Month(s)

8. Could you please tell me about the previous positions/experiences you have had before you became the PHC manager at this SHPH?

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9. How many health professionals are there in your SHPH and what are their positions and qualifications?

No.	Position	Qualification

10. Regarding the sub-district health promoting hospital (SHPH) policy, when was this policy adopted in this SHPH?

In which month?......................................which year?.......................................

Thank you very much for your information

Informant code………….

แบบสอบถามข้อมูลทั่วไปของผู้เข้าร่วมงานวิจัยเรื่อง

จาก “ศูนย์สุขภาพชุมชน” สู่ “โรงพยาบาลส่งเสริมสุขภาพตำบล” อะไรคือบทบาทภาวะผู้นำ และหน้าที่การบริหารของผู้อำนวยการโรงพยาบาลส่งเสริมสุขภาพตำบลในจังหวัดพิษณุโลก ?

การวิจัยเชิงคุณภาพแนวปรากฏการณ์วิทยา

1. เพศ ☐ ชาย ☐ หญิง

2. สถานภาพสมรส ☐ โสด ☐ สมรส / อยู่ด้วยกัน ☐ หม้าย / หย่าร้าง / แยกกันอยู่

3. อายุ ....ปี…………เดือน

4. ประวัติทางการศึกษา

ลำดับ	คุณวุฒิ	สถาบันการศึกษา	ปีที่สำเร็จการศึกษา

5.กรุณาเขียนอธิบายประสบการณ์การทำงานของท่านก่อนที่จะได้มาดำรงตำแหน่งเป็นผู้อำนวยการโรงพยาบาลส่งเสริมสุขภาพตำบล

ลำดับ	ตำแหน่ง	สถานที่ทำงาน	ช่วงระยะเวลาของการทำงาน เช่น พ.ศ. 2525-2530

6. ระยะเวลาในการทำงานด้านสาธารณสุขของท่านตั้งแต่จบคุณวุฒิทางการศึกษาแรก

……………..ปี…………..เดือน

7. ระยะเวลาที่ท่านรับผิดชอบงานด้านการบริหารระบบบริการสุขภาพ

เจ้าหน้าที่ปฏิบัติงาน ณ สำนักงานสาธารณสุขอำเภอ ……………..
ปี…………..เดือน

หัวหน้างานฝ่ายส่งเสริมสุขภาพที่โรงพยาบาล ……………..
ปี…………..เดือน

หัวหน้าสถานีอนามัย/ศูนย์สุขภาพชุมชน ……………..
ปี…………..เดือน

ผู้อำนวยการโรงพยาบาลส่งเสริมสุขภาพตำบล ……………..
ปี…………..เดือน

อื่น ๆ โปรดระบุ... ……………..
ปี…………..เดือน

8.ตำแหน่งและคุณวุฒิการศึกษาสูงสุดของเจ้าหน้าที่และลูกจ้างในโรงพยาบาลส่งเสริมสุขภาพตำบลของท่าน

ลำดับ	ตำแหน่ง	คุณวุฒิการศึกษาสูงสุด

9.โรงพยาบาลส่งเสริมสุขภาพตำบลของท่านได้ดำเนินตามนโยบายโรงพยาบาลส่งเสริมสุขภาพตำบลตั้งแต่ เดือน...................................ปี.....................................

ชื่อ-สกุล...เบอร์โทร..................................

โรงพยาบาลส่งเสริมสุขภาพตำบล.....................…........................

รูปแบบของโรงพยาบาลสุ่งเสริมสุขภาพตำบล ☐ กลุ่ม ☐ เดี่ยว

***** ขอขอบพระคุณท่านเป็นอย่างสูงที่ได้กรุณาให้ความร่วมมือในการตอบแบบสอบถามนี้*****

Appendix 4 Invitation Leaflet

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UNE **VOLUNTEER !** UNE

UNE **FOR SHARING** UNE

UNE **YOUR EXPERIENCE** UNE

UNE **OF** UNE

UNE **PRIMARY HEALTH CARE** UNE

UNE **MANAGER** UNE

UNE **Phone:** +61-2-6773-3889 (office), +61-41-2202725 (mobile)
Email: wjariya@une.edu.au UNE

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School of Rural Medicine

University of New England Armidale NSW 2351 Australia

ruralmed@une.edu.au www.une.edu.au/ruralmed/

Phone 61 2 6773 3322 **Fax** 61 2 6773 2388

Are you a primary health care manager?

Are you working at a sub-district health promotion hospital?

YES !

VOLUNTEERS ARE INVITED TO TAKE PART IN A DOCTORAL RESEARCH STUDY.

THIS STUDY IS LOOKING AT EXPERIENCES OF PRIMARY HEALTH CARE MANAGERS WORKING AT SUB-DISTRICT HEALTH PROMOTION HOSPITALS IN PHITSANULOK PROVINCE.

I wish to invite you to participate in my research project.

From 'Primary Care Units' to 'Sub-district Health Promotion Hospital': what are the leadership roles and management functions of primary health care managers in Phitsanulok Province, Thailand? A Phenomenology Approach

The aim of this study is to explore the leadership roles, management functions and challenges of primary health care (PHC) managers as of 2011, at sub-district health promotion hospitals (SHPHs) implementing the 2009 PHC reform policy in Phitsanulok Province, Thailand.

Please be advised that participation is completely voluntary. If you decide to participate, you are free to withdraw your consent from the project and discontinue at any time without having to give a reason and without consequence.

Should you agree to participate, you will be asked to participate in an in-depth interview of about one to two hours at a time convenient to you.

If you are interested and wish to participate in this research study, Please contact Mr.Wutthichai [Wut] Jariya.

Telephone or text: +61-41-2202725
Email: wjariya@une.edu.au

Thank you very much for your kind attention !

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Phone 61 2 6773 3322 **Fax** 61 2 6773 2388

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อาสาสมัคร

เข้าร่วมการศึกษาวิจัย

เพื่อร่วมถ่ายถอดประสบการณ์

การทำงานของผู้อำนวยการ รพสต.

โทรศัพท์: +61-2-6773-3889 (office), +61-41-2202725 (mobile)

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ท่านคือ ผู้อำนวยการ รพสต ใช่หรือไม่ ?

ท่านกำลังทำงานอยู่ที่ รพสต ในจังหวัดพิษณุโลก ใช่หรือไม่ ?

หากใช่ !

ขอเรียนเชิญ ท่าน ผอ.รพสต.
ในจังหวัดพิษณุโลกเข้าร่วมเป็นส่วนหนึ่งของการ
ศึกษาวิจัยเพื่อร่วมถ่ายถอดประสบการณ์การทำงาน
ในฐานะผู้อำนวยการโรงพยาบาลส่งเสริมสุขภาพตำบล

กระผมใคร่ขอเรียนเชิญท่านให้เกียรติเข้าร่วมในการศึกษาวิจัย

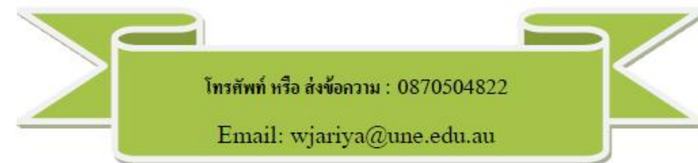
"จากศูนย์สุขภาพชุมชนสู่โรงพยาบาลส่งเสริมสุขภาพตำบล"
อะไรคือบทบาทภาวะผู้นำและหน้าที่การบริหารของผู้อำนวยการโรงพยาบาลส่งเสริมสุขภาพตำบลในจังหวัดพิษณุโลก? การวิจัยเชิงคุณภาพแนวปรากฏการณ์วิทยา

การศึกษาวิจัยนี้มีวัตถุประสงค์เพื่อสำรวจและทำความเข้าใจในบทบาทภาวะผู้นำหน้าที่การบริหารและปัญหาอุปสรรคของผู้อำนวยการโรงพยาบาลส่งเสริมสุขภาพตำบลในจังหวัดพิษณุโลกอันเนื่องมากจากดำเนินงานตามนโยบายการพัฒนาโรงพยาบาลส่งเสริมสุขภาพตำบลในปีพุทธศักราช **2552**

การเข้าร่วมในการศึกษาวิจัยนี้มิได้ถือว่าเป็นการบังคับ หากแต่ถือว่าเป็นความสมัครใจ ดังนั้นหากท่านได้ตัดสินใจเข้าร่วมในการศึกษาวิจัยนี้แล้วท่านสามารถตัดสินใจขอออกจากการเข้าร่วมการศึกษาวิจัยนี้ได้ตลอดเวลาโดยไม่จำเป็นต้องให้เหตุผลและการตัดสินใจขอออกจากการเข้าร่วมการศึกษาวิจัยนี้จะไม่มีผลกระทบอันใดต่อท่าน

หากท่านยินดีที่จะเข้าร่วมในการศึกษาวิจัยนี้ท่านจะถูกขอให้เข้าร่วมในการสัมภาษณ์เชิงลึกแบบตัวต่อตัว ซึ่งจะใช้เวลาโดยประมาณ 1-2 ชั่วโมงในช่วงเวลาที่สะดวกกับท่าน

หากท่านมีความสนใจเข้าร่วมการศึกษาวิจัยนี้ กรุณาติดต่อ นายวุฒิชัย จริยา (วุฒิ)



...ขอขอบคุณทุกท่านที่ให้ความสนใจ...

Appendix 5 Interview Schedule

Interview Schedule

1. Establishing rapport between the student researcher and participants

First of all, I would like to introduce myself. My name is Wutthichai Jariya and you are welcome to call me Wut. I'm studying for the Doctor of Health Services Management degree at the University of New England, Armidale, NSW, Australia. So, this research is considered as one part of my study.

Before I commence the interview session, I would like you to read the information sheet which will provide you with the details of this study. After that, when you understand what is involved and if you are willing to participate in this study, could you please sign your agreement in the consent form?

You may keep the information sheet because it has important contact information in case you have any questions regarding this research.

2. Explaining the process of the interview to a participant

According to the information sheet that you just received, this interview session will take about an hour to two hours.

During the interview, I will use a voice-digital recorder in order to ensure that I will make an accurate record of what you say.

However, you can ask for the voice-digital recorder to be stopped, edited, and erased at any time during the interview.

Importantly, I would like to inform you again that all of your information and responses will be kept secure in a locked filing cabinet at the researcher's office in order to ensure your anonymity and confidentiality.

3. Asking a participant about his or her inquiries about this research

Up to this point, do you have any inquiries regarding anything that you do not understand that you would like to make about this interview session?

4. Interview Questions

Q1. Could you please start by describing why you decided to become the primary health care (PHC) manager in this sub-district health promoting hospital (SHPH)?

Prompts:

- Motivation? Salary?Respect?Power?Commitment?Glory?

- Could you please explain more about what kind of process you followed to become a PHC manager (how do/did you become PHC manager)?

Seniority?Compulsory?Appointment?Application?

- Could you please explain your feelings/how you feel about the position of PHC manager? (Difficult?Proud? Satisfying? Frustrated?)

Q2. In your opinion, what knowledge do you think is necessary for a PHC manager?

Q3. Based on your experience, please tell me about the personal qualities and attitudes that are important for a PHC manager?

Q4. From your point of view, do you think there are any particular skills and competencies that are essential to support a PHC manager?

Q5. How did you learn/gain the knowledge, personal qualities, attitudes, skills, and competencies?

Q6. What do you consider to be the challenges of working as a PHC manager?

Q7. Could you please tell me what you understand by management function?

Q8. Could you please tell me what you understand by leadership role?

Q9. Do you think management function and leadership roles are similar or different? How?

Q10. Could you please tell me about your main responsibilities as PHC manager in this SHPH?

Q11. Could we now talk about the SHPH policy? How did you find out/ know about this policy?

Q12. Could you please tell me what is your understanding of this policy?

Q13. From your experience, what are the differences in your responsibilities before and after implementing the SHPH policy? *(This question is for the PHC managers who have worked as PHC managers before the SHPH policy was launched.)*

Prompt:

How did you prepare and adjust yourself in regard to this policy?

Q14. After implementing the SHPH policy, how would you assess the implementation of this policy?

Prompt:

- *Overall, what do you think about the SHPH policy?*

Q15. From your experience of implementing the SHPH policy, what is going well for this policy?

Q16. From your perspective, could you please tell me the challenges in implementing the SHPH policy?

Prompts:

- *Subordinate? Stakeholder? Clients? Budget? Material? Services? Time?*
- *How do you minimize/solve those problems/challenges/ barriers/difficulties?*
- *Why can't you perform as you think you should? What do you think the causes are? (Your competencies? Management system? Policy? Higher manager? Social factors? such as culture, norms, respect, tradition, or anything else?)*

Q17. If you had the power to formulate this policy, or if you were the person in authority, how would you go about improving the SHPH policy?

Prompt:

- What would you do differently if it was within your power to do so?

- If this policy is still not good, how do you think we can improve the implementation of this policy?

- What would you like to tell the government or policy formulator?

Q18. Based on the present policy/situation, what are the training needs for PHC managers according to the SHPH policy?

Prompt:

- What are the important knowledge/competencies/skills/supports/assistance for PHC managers?

- How can we improve/build up the competencies of PHC managers regarding their needs?

- What kind of appropriate methods/strategies are there/are required to improve/build up the competencies of PHC managers regarding their needs?

Q19. Do you have any other issues regarding the SHPH policy?

Appendix 6 UNE Human Research Ethics Committee Approval

Ethics Office
Research Development & Integrity
Research Division
Armidale NSW 2351
Australia
Phone 02 6773 3449
Fax 02 6773 3543
jo-ann.sozou@une.edu.au
www.une.edu.au/research-services

HUMAN RESEARCH ETHICS COMMITTEE

MEMORANDUM TO:	Prof J Fraser, Dr D Briggs, Adj/Prof J Madison & Mr W Jariya School of Rural Medicine

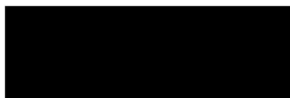
This is to advise you that the Human Research Ethics Committee has approved the following:

PROJECT TITLE:	From 'Primary Care Units' to 'Sub-district Health promotion Hospital': What are the leadership roles and management functions of primary health care managers in Phitsanulok Province, Thailand? A Phenomenology Approach.
APPROVAL No.:	HE11/105
COMMENCEMENT DATE:	24/05/2011
APPROVAL VALID TO:	24/05/2012
COMMENTS:	Nil. Conditions met in full.

The Human Research Ethics Committee may grant approval for up to a maximum of three years.
For approval periods greater than 12 months, researchers are required to submit an application for renewal at each twelve-month period. All researchers are required to submit a Final Report at the completion of their project. The Progress/Final Report Form is available at the following web address: http://www.une.edu.au/research-services/researchdevelopmentintegrity/ethics/human-ethics/hrecforms.php

The *NHMRC National Statement on Ethical Conduct in Research Involving Humans* requires that researchers must report immediately to the Human Research Ethics Committee anything that might affect ethical acceptance of the protocol. This includes adverse reactions of participants, proposed changes in the protocol, and any other unforeseen events that might affect the continued ethical acceptability of the project.

In issuing this approval number, it is required that all data and consent forms are stored in a secure location for a minimum period of five years. These documents may be required for compliance audit processes during that time. If the location at which data and documentation are retained is changed within that five year period, the Research Ethics Officer should be advised of the new location.



Jo-Ann Sozou
Secretary/Research Ethics Officer

24/05/2011

A11/104

Appendix 7 Information Sheet

School of Rural Medicine
University of New England Armidale NSW 2351 Australia
ruralmed@une.edu.au www.une.edu.au/ruralmed/
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The people responsible for this study are:

Professor John Fraser (Supervisor)
Phone: +61-2-6773-2752
Email: jfrase22@une.edu.au

Dr David Briggs (Supervisor)
Phone: +61-2-6765-5398
Email: dbriggs@une.edu.au

Adjunct Professor Jeanne Madison (Supervisor)
Phone: +61-2-6773-3667
Email: jmadison@une.edu.au

Mr Wutthichai Jariya (DHSM Candidate)
Phone: +61-2-6773-3889
Email: wjariya@une.edu.au

Information Sheet for Participants

Research Project:
From ‗Primary Care Units' to ‗Sub-district Health Promoting Hospital': what are the leadership roles and management functions of primary health care managers in Phitsanulok Province, Thailand?: A Phenomenology Approach

I wish to invite you to participate in my research on the above topic. The details of the study follow and I hope you will consider being involved. I am conducting this research project for my Doctor of Health Services Management (DHSM) degree at the University of New England.

The aim of this study is to explore the leadership roles, management functions and challenges of primary health care (PHC) managers as of 2011, at sub-district health promoting hospitals (SHPHs) implementing the 2009 PHC reform policy in Phitsanulok Province, Thailand. Understanding leadership and management is important for developing the ability of PHC managers in effective work practices in a complex, changing health care system.It is hoped that what is learned from this study will provide essential information and strategies for developing the leadership and management competencies and skills of PHC managers in order to successfully implement the current SHPH reform policy in Thailand.

Please be advised that participation is completely voluntary. If you decide to participate, you are free to withdraw your consent from the project and discontinue at any time, without having to give a reason and without consequence if you decide not to participate or withdraw at any time.

Should you agree to participate, you will be asked to participate in an in-depth interview of about one to two hours at a time convenient to you. There will be a series of open-ended questions that allow you to explore your views, experience, and practices related to the implementation of the SHPH policy. With your permission, a digital voice-recorder will be

used to ensure the accuracy of an interview session. Following the interview session, a transcript will be provided to you if you wish to see one. Any information or personal details gathered in the course of the study will remain confidential. No individual will be identified by name in any publication of the results. All names will be replaced by pseudonyms; this will ensure that you are not identifiable.

The electronic transcripts files and voice files will be kept in the personal computer of the student researcher with secure password access. The transcripts will also be stored securely in cupboards of the researcher's office. In addition, the electronic voice files and transcripts files will be securely stored separately in order to ensure that the participants will not be assessed and identified. The transcriptions and other data will be kept in the same manner for five (5) years following thesis submission and then destroyed. Only the investigators will have access to the data.

It is anticipated that this research will be completed by the end of 2012. The results may also be presented at conferences or written up in journals without any identifying information.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No. HE11/105 Valid to 24/05/2012).

Should you have any complaints concerning the manner in which this research is conducted, please contact the Research Ethics Officer at the following address:
Research Services
University of New England
Armidale, NSW 2351.
Telephone: (+612) 6773 3449 Facsimile (+612) 6773 3543
Email: ethics@une.edu.au
Or please contact the local contact person in Phitsanulok Province at the following address:
Dr. Phudit Tejativaddhana
Dean
Faculty of Public Health, Naresuan University
Muang, Phitsanulok 65000 THAILAND
Tel. (055) 966416; Fax. (055) 966418
Email: prawitt@nu.ac.th

Adjunct Associate Professor
School of Health
University of New England
Armidale, NSW 2351 AUSTRALIA
E-mail: ptejativ@une.edu.au

Thank you for considering this request and I look forward to further contact with you.

Regards

Mr. Wutthichai Jariya
Candidate in Doctor of Health Services Management
School of Rural Medicine, University of New England, Australia

School of Rural Medicine

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ผู้รับผิดชอบงานวิจัย :

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เอกสารชี้แจงข้อมูลเบื้องต้นสำหรับผู้ร่วมวิจัย

การศึกษาวิจัยเรื่อง :

“จากศูนย์สุขภาพชุมชนสู่โรงพยาบาลส่งเสริมสุขภาพตำบล” อะไรคือบทบาทภาวะผู้นำและหน้าที่การบริหารของผู้อำนวยการโรงพยาบาลส่งเสริมสุขภาพตำบลในจังหวัดพิษณุโลก ? การวิจัยเชิงคุณภาพแนวปรากฏการณ์วิทยา

กระผมใคร่ขอเรียนเชิญท่านให้เกียรติเข้าร่วมในการศึกษาวิจัยดังกล่าวข้างต้นโดยรายละเอียดของการศึกษาวิจัยจักได้กล่าวต่อไปในเอกสารชี้แจงฉบับนี้กระผมหวังเป็นอย่างยิ่งว่าท่านจะพิจาณาเข้าร่วมในการศึกษาวิจัยนี้ซึ่งถือว่าเป็นส่วนหนึ่งที่สำคัญของวิทยานิพนธ์ระดับปริญญาเอกของกระผม ในสาขาวิชาการบริหารระบบบริการสุขภาพ มหาวิทยาลัยนิวอิงแลนด์

การศึกษาวิจัยนี้มีวัตถุประสงค์เพื่อสำรวจและทำความเข้าใจในบทบาทภาวะผู้นำหน้าที่การบริหารและปัญหาอุปสรรคของผู้อำนวยการโรงพยาบาลส่งเสริมสุขภาพตำบลในจังหวัดพิษณุโลกอันเนื่องมากจากดำเนินงานตามนโยบายการพัฒนาโรงพยาบาลส่งเสริมสุขภาพตำบลในปีพุทธศักราช2552การทำความเข้าใจภาวะผู้นำและการบริหารมีความสำคัญอย่างยิ่งต่อการพัฒนาขีดความสามารถของผู้บริหารระดับปฐมภูมิในการทำงานอย่างมีประสิทธิภาพภายใต้ความซับซ้อนและเปลี่ยนแปลงของระบบสุขภาพ นอกจากนี้ สิ่งที่ได้เรียนรู้จากการศึกษาวิจัยครั้งนี้ ยังถูกคาดหวังว่าจะสามารถนำเสนอข้อมูลและกลยุทธ์ที่สำคัญต่อการพัฒนาศักยภาพด้านภาวะผู้นำและการบริหารของผู้บริหารระดับปฐมภูมิ ซึ่งจะนำไปสู่ความสำเร็จในการดำเนินงานตามนโยบายปฏิรูปโรงพยาบาลส่งเสริมสุขภาพตำบลของประเทศไทยต่อไป

การเข้าร่วมในการศึกษาวิจัยนี้มิได้ถือว่าเป็นการบังคับหากแต่ถือว่าเป็นความสมัครใจดังนั้นหากท่านได้ตัดสินใจเข้าร่วมในการศึกษาวิจัยนี้แล้วท่านสามารถตัดสินใจขอออกจากการเข้าร่วมการศึกษาวิจัยนี้ได้ตลอดเวลาโดยไม่จำเป็นต้องให้เหตุผลและการตัดสินใจขอออกจากการเข้าร่วมการศึกษาวิจัยนี้จะไม่มีผลกระทบอันใดต่อท่าน

หากท่านยินดีที่จะเข้าร่วมในการศึกษาวิจัยนี้ ท่านจะถูกขอให้เข้าร่วมในการสัมภาษณ์เชิงลึกแบบตัวต่อตัว ซึ่งจะใช้เวลาโดยประมาณ 1-2 ชั่วโมงในช่วงเวลาที่สะดวกกับท่านในการสัมภาษณ์จะมีชุดคำถามให้ท่านแสดงความคิดเห็นและถ่ายถอดประสบการณ์การทำงานที่เกี่ยวเนื่องกับนโยบายการพัฒนาโรงพยาบาลส่งเสริมสุขภาพตำบลกระผมจะขออนุญาตท่านในการใช้เครื่องบันทึกเสียงระหว่างการสัมภาษณ์เพื่อที่จะได้สามารถบันทึกสิ่งที่ท่านให้ข้อมูลได้อย่างถูกต้องหลังจากการสัมภาษณ์หากท่านต้องการขอดูข้อมูลเพื่อความถูกต้องอีกครั้งเอกสารการถอดเทปจะถูกสำเนาและส่งให้ท่านข้อมูลส่วนตัวของท่านและข้อมูลที่ได้จากการสัมภาษณ์จะถูกเก็บเป็นความลับรายชื่อทั้งหมดของผู้เข้าร่วมการศึกษาวิจัยนี้จะใช้ชื่อสมมุติแทนชื่อจริงในกระบวนการวิเคราะห์และเผื่อแพร่ข้อมูลที่ได้จากการศึกษาวิจัยซึ่งกระบวนการนี้จะช่วยยืนยันว่าท่านจะไม่ถูกเปิดเผยหรืออ้างอิงถึงได้ไฟล์เอกสารการถอดเทปและไฟล์เสียงจากการสัมภาษณ์ทั้งหมดจะถูกเก็บไว้ที่เครื่องคอมพิวเตอร์ส่วนตัวของผู้วิจัยซึ่งจะต้องมีการให้รหัสลับในการเข้าใช้คอมพิวเตอร์ดังกล่าวเอกสารการถอดเทปจะถูกเก็บไว้อย่างปลอดภัยที่ตู้เก็บเอกสารที่มีกุญแจล็อคในห้องทำงานของผู้วิจัยนอกจากนี้ไฟล์เสียงจากการสัมภาษณ์จะถูกเก็บแยกกันกับเอกสารการถอดเทปเพื่อเป็นการยืนยันว่าผู้เข้าร่วมการ

ศึกษาวิจัยจะไม่ถูกเปิดเผยไฟล์เอกสารและข้อมูลทั้งหมดที่ได้จากการศึกษาวิจัยนี้จะถูกเก็บไว้5ปีและหลังจากที่การศึกษาวิจัยนี้ได้สำเร็จและส่งรูปเล่มวิจัยเป็นที่เรียบร้อยแล้วข้อมูลทั้งหมดจะถูกส่งกลับไปให้อาจารย์ที่ปรึกษาเพื่อเข้ากระบวนการทำลายข้อมูลต่อไปจากกระบวนการทั้งหมดข้างต้น ผู้วิจัยเท่านั้นที่จะสามารถเข้าถึงข้อมูลที่ได้มาจากการสัมภาษณ์จากผู้ร่วมวิจัยทั้งหมด

การศึกษาวิจัยนี้มีกำหนดว่าจะเสร็จสมบูรณ์ในปลายปีพุทธศักราช2555และหลังจากนั้นผลจากการศึกษาวิจัยอาจจะถูกเผยแพร่ในเวทีวิชาการหรืออาจจะถูกตีพิมพ์ในวารสารวิชาการ อย่างไรก็ตาม ข้อมูลส่วนตัวของท่านจะไม่ถูกเปิดเผยต่อสาธารณชนเป็นอันขาด

การศึกษาวิจัยนี้ ได้ผ่านการรับรองโดยคณะกรรมการด้านจริยธรรมส่วนงานวิจัยในมนุษย์ ของมหาวิทยาลัยนิวอิงแลนด์ (หมายเลขอนุมัติ HE11/105 อนุญาตถึง วันที่ 24 เดือนพฤษภาคม พ.ศ. 2555)

หากท่านมีข้อร้องเรียนหรือสงสัย อันเกี่ยวเนื่องกับการศึกษาวิจัยนี้ ท่านสามารถติดต่อเข้าหน้าที่ด้านจริยธรรมของมหาวิทยาลัยนิวอิงแลนด์ตามที่อยู่ด้านล่างนี้

สำนักงานบริการการวิจัย มหาวิทยาลัยนิวอิงแลนด์
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ขอขอบคุณท่านเป็นอย่างสูงสำหรับการพิจารณาเอกสารนี้ และหวังเป็นอย่างยิ่งว่า กระผมจะได้ติดต่อท่าน เพื่อดำเนินการเก็บข้อมูลของการศึกษาวิจัยนี้ต่อไป

ด้วยความเคารพ
นายวุฒิชัย จริยา
นักศึกษาปริญญาเอกสาขาวิชาการบริหารการบริการสุขภาพ
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เมืองอาร์มิเดล รัฐนิวเซาท์เวลส์ ประเทศออสเตรเลีย

Appendix 8 Consent Form

School of Rural Medicine

University of New England Armidale NSW 2351 Australia

ruralmed@une.edu.au www.une.edu.au/ruralmed/

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Consent Form for Participants

Research Project:

From ‗Primary Care Units' to ‗Sub-district Health Promoting Hospital': what are the leadership roles and management functions of primary health care managers in Phitsanulok Province, Thailand?: A Phenomenology Approach

I, ………………………………………, have read the information contained in the Information Sheet for Participants and any questions I have asked have been answered to my satisfaction. **Yes/No**

I agree to participate in this activity, realizing that I may withdraw at any time. **Yes/No**

I agree that research data gathered for the study may be published using a pseudonym. **Yes/No**

I agree to the interview being audiotape recorded and transcribed. **Yes/No**

……………………………..   ……………………………

Participant   Date

……………………………..   ……………………………

Researcher   Date

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ใบแสดงความยินดีในการอนุญาตให้เข้าสัมภาษณ์ของผู้เข้าร่วมการศึกษาวิจัย

การศึกษาวิจัยเรื่อง :

“จากศูนย์สุขภาพชุมชนสู่โรงพยาบาลส่งเสริมสุขภาพตำบล” อะไรคือบทบาทภาวะผู้นำและหน้าที่การบริหารของผู้อำนวยการโรงพยาบาลส่งเสริมสุขภาพตำบลในจังหวัดพิษณุโลก ? การวิจัยเชิงคุณภาพแนวปรากฏการณ์วิทยา

ข้าพเจ้า...ได้อ่านรายละเอียดในเอกสารเอกสารชี้แจงข้อมูลเบื้องต้นสำหรับผู้ร่วมวิจัยและพร้อมกันนี้คำถามและข้อสงสัยอันเนื่องมาจากการศึกษาวิจัยนี้ดังกล่าวได้ชี้แจ้งโดยผู้วิจัยจนเป็นพี่พอใจและเข้าใจแล้ว **ใช่ / ไม่ใช่**

ข้าพเจ้ายินดีที่จะเข้าร่วมการศึกษาวิจัยนี้ และข้าพเจ้าได้ทราบแล้วว่าข้าพเจ้าสามารถถอนตัวออกจากศึกษาวิจัยได้ตลอดเวลา **ใช่ / ไม่ใช่**

ข้าพเจ้าตกลงว่าข้อมูลที่ถูกเก็บจากการศึกษาวิจัยนี้อาจจะถูกเผยแพร่ในวงวิชาการโดยใช้ชื่อสมมุติ **ใช่ / ไม่ใช่**

ข้าพเจ้าอนุญาตให้ผู้วิจัยสามารถใช้เครื่องบันทึกเสียงระหว่างการสัมภาษณ์ **ใช่ / ไม่ใช่**

………………………………..	…………………………..
ผู้เข้าร่วมการศึกษาวิจัย	วัน/เดือน/ปี
………………………………..	…………………………..
ผู้วิจัย	วัน/เดือน/ปี