

CHAPTER ONE

INTRODUCTION

1.1 Introduction to the study

The research presented in this thesis looks at understanding the role of Thai Community Hospital Directors (CHDs) in implementing the Universal Health Coverage (UHC) policy in relation to Primary Health Care (PHC). This chapter provides a background to the role of the Thai CHDs, the UHC policy and PHC. The purpose, aims and significance of the study are described and an overview of the theoretical framework and the methodology used to guide this study is presented.

1.2 Background to the study

The Thai health system is a complex combination of public and private resources with multiple organisations, financing, and management arrangements attempting to deliver health services to 65 million Thais (Bureau of Policy and Strategy 2007). It is based at the secondary and tertiary levels on the Western bio-medical model of health services (Sawanpunyalert 2002), and emphasises top-down, vertical health programmes, producing specialist health professionals to serve the urban community (Bureau of Policy and Strategy 2007; Phoolcharoen 2005). However, Thailand adopted the PHC concept and the WHO goal of 'Health for All by the Year 2000' and incorporated them into the *4th National Social and Economic Development Plan (1977–1981)*, after the declaration of the concept of PHC at Alma Ata in 1978 (Bureau of Policy and Strategy 2007). The Thai for PHC is '*Garn Sa-tha-ra-na Sook Mool Than*' (a foundation of public health) (Health Care Reform Project Office 2001).

The implementation of PHC in Thailand has produced many advantages but it has also faced many challenges and problems. During the past four decades, the health status of Thais has improved dramatically due to medical advances and the expansion of public health facilities, as well as more effective and responsive health programmes (Bureau of Policy and Strategy 2007). Thailand has undergone significant economic development

and has also experienced many of the health challenges facing countries in transition (National Economic and Social Development Board Office 2005). However, the Thai health system faces many complex issues which cause the health services to be inefficient, inequitable, and of a lower quality in comparison to some Western nations (Wibulpolprasert 2005).

In 2001, Thailand adopted the Universal Health Coverage (UHC) policy, which focuses on PHC. The main target was the 18.5 million uninsured Thais, who were mostly underprivileged and living in rural areas (Towse, Mills & Tangcharoensathien 2004:103). The Primary Care Unit (PCU), which is the front-line health facility and close to the community and workplace, is meant to be the most accessible health facility (Health Care Reform Project Office 2001). It aims to provide comprehensive and integrated care, which includes curative care, health promotion, disease prevention and rehabilitation, as well as ensuring the transfer of patients to secondary and tertiary hospitals when required.

All public hospitals are required by the Central Government to participate in this project and to establish PCUs and upgrade Health Centres (HCs) located in their districts to act as outreach centres. People are expected to access these PCUs/HCs, which are located close to their residential or work areas, for receiving health care as their first contact to receive health care (Wibulpolprasert 2005). The agencies of the Ministry of Public Health, which are community hospitals, district health offices and health centres, are the major organisations in implementing this policy in rural areas (Bureau of Policy and Strategy 2007). The MoPH requires all community hospitals to become Contracting Units for Primary Care (CUPs); which these need to provide primary health care and manage and allocate health funding within the districts (Hughes & Leethongdee 2007).

The CH provides primary and secondary health care services for most of the Thai population (Chokevivat 2002; Wibulpolprasert 2005). WHO (1990; 1992) and Mills and Ranson (2005) have identified that this provision of primary health services within the hospital environment is problematic and probably inefficient. Therefore, the MoPH has instructed the CHD to focus on both the hospital and community (Bureau of Policy and Strategy 2005). The community focus is to mobilise the existing health resources closer to the people and, therefore, offer primary health care more efficiently with less cost (Prakongsai et al. 2002). The focus of change is the movement away from an exclusive

bio-medical approach to a more inclusive patient-centred approach with its social and cultural context for health (WHO SEARO 2004).

The change in the focus of the CH means the CHD needs to establish a PCU to provide primary care services for the eligible population in the sub-district in which the CH is located; this PCU can be either within or outside the CH and needs to act as a prototype for other PCUs that will be established (Yanggratoke 2005). Some of these 'new' PCUs will be upgraded HCs. The CHD needs to collaborate with both the HCs and the Chief of District Health Office (CDHO), because the HCs (new PCUs) are managed by the CDHO. These upgrades would provide a network of primary care services to benefit people who live in sub-districts outside the main town. Many of these requirements will be a challenge the CHDs because of the long history of bureaucratic, rather than visionary leadership in the Thai health system.

The UHC policy has been established in many developed and developing countries but there are problems in its full implementation and some countries have failed because of rising cost and limited health dollars (Hughes & Leethongdee 2007; Nitayarumphong & Mills 1998). The implementation of the UHC policy in Thailand has provided benefits for the population, such as health insurance coverage for all, relatively accessible health services, and reduced payments on health care. These are all popular with people, but quality services are still a problem (Jongudomsook 2005; Suraratdecha, Saithanu & Tangcharoensathien 2005).

In implementing the UHC policy in relation to PHC, the CH is in an ever changing environment and is tested in many ways. It faces many challenges, such as new diseases and changing patterns of diseases; inequitable resource allocation in health services; and a policy of universal health coverage for a widely dispersed and largely poor population (Wibulpolprasert 2005).

The CHD, as the middle manager of the provincial health system and the leader of the district health system of Thailand, is a catalyst for communication up and down the organisational structure, and between executives and front-line services for the rural poor in implementing this policy (Yanggratoke 2005). They are responsible for the organisation of health services to the rural poor who collectively number over 38 million

people (Wibulpolprasert 2005), but require effective collaboration with other health services stakeholders in the district to achieve this (Yanggratoke 2005).

The CHDs in this study have to undertake various roles, as clinician, hospital manager and CUP manager. It is assumed that the role of the CHD is influenced by structural interests, professional sub-cultures, the organisational context and the relationship between the community hospital and the communities. The clarification of the role of the key actors, in this case the CHDs, and the identification of barriers to the implementation of the PHC, may ensure more effective strategies to achieve the goal of policy implementation and thus health care reform (Beyer 1998; Kekki 2006; WHO 2003b).

1.3 Purpose and aims of the study

This study seeks to explore the working world of the CHDs in implementing the UHC policy in relation to PHC. The focus is on understanding the CHDs' interpretation of the UHC policy, how their actions or inactions are shaped by their understanding of the policies and political contexts, and both the intended and unintended consequences of their interpretation of the objectives of the Thai health care system. The study seeks to identify contradictions in worldviews between what the CHDs believe, how they interpret health policies and their intended consequences, and how the health care system supports or does not support the successful implementation of the formal policies.

The Health System Research Institute (2002) reports that the implementation of the UHC policy was 'trial and error' and dependent on the capability of the directors of the hospitals. However, there is little research that explores how the CHDs experience their role in the current context of Thai health care in implementing the UHC policy in relation to PHC. There is a need to establish how they view the UHC policy, PHC and their role in implementing such policies (Andrews, Sullivan & Minichiello 2004). This study set out to explore the perceptions of the CHDs, and the health services stakeholders who can influence their decision-making, regarding the implementation of the UHC policy in relation to PHC at district and sub-district levels.

The following three aims were developed to explore these perceptions:

1. To understand the roles of the Thai CHDs in implementing the UHC policy in relation to PHC through the experiences of the informants, including the Thai CHDs and the health services stakeholders who can influence the CHDs' decision-making.
2. To identify the barriers to the implementation of the UHC policy and the delivery of PHC at the district level.
3. To propose possible strategies for CHDs to facilitate sustainable primary health services administered from the community hospital.

1.4 Significance of the study

This applied research project is in the field of health services management in the developing country of Thailand. The findings of this study are significant at three levels. First, as a guide at policy level for the policy makers to understand why the implementation of the UHC policy is incomplete and at this stage has failed, and what strategies can be best implemented to achieve health care reform. Second, as a guide at a practical level for the CHDs to improve their role in implementing health care reform (the UHC policy) and facilitating sustainable primary health services administered from the community hospital. Third, by adding new knowledge to the research literature with respect to Alford's (1975) theory of structural interests as a barrier to health care reform, and the role of CHDs in implementing health care reform.

Moreover, the role of the CHDs and barriers to the role in implementing the UHC policy in relation to PHC are described in this study. Positive and negative factors influencing the effectiveness of their role in implementing the health care reform are explored, with a particular focus on the influence of structural interests, organisational culture, and professional sub-cultures. The findings will make a unique contribution to the Thai and international health services management literature by providing an insight into the shared experiences of the CHDs and the other health services stakeholders working in Nakhorn Rachasima, a North-Eastern province of Thailand. The findings will also

contribute to the utility of the structural interest theory (Alford 1975) as a theoretical framework for understanding the implementation of health care reform in Thailand. Finally, they will contribute to the literature on the development of management skills for CHDs as middle health managers who are the change agents of the health care reform policy.

1.5 Theoretical framework

In trying to understand the complexity of the role of the CHDs in implementing the UHC policy in relation to PHC (rural health care reform), a conceptual framework incorporating contextual influences was developed (Figure 1.1). The theories used in this study to facilitate the insights and explore the experiences of the CHDs in implementing the rural health care reform are: i) PHC as described by WHO (1978); ii) Alford's (1975) theory of structural interests; iii) the organisational context which is the Thai bureaucratic management style; and iv) professional sub-cultures. This study uses the role of the CHDs as the means to examine institutional barriers to achieving a successful implementation of health care reform.

This study used the definition of PHC, as described by WHO (1978) in *the Declaration of Alma-Ata 1978*, which is the comprehensive, equity-oriented approach to people's basic health needs (Werner et al. 1997). WHO (2003b) calls for all countries to revitalise PHC, in order to meet the goal of 'Health for All' in the 21st century. The reports show that some countries interpret PHC differently from that described by WHO (1978) and thus have an inappropriate approach to the implementation of PHC (Kekki 2006; Phillips 1990; WHO 2003b). As a result, those countries fail to provide appropriate PHC services to meet the health needs of their populations and the sustainability of PHC in those countries is problematic (LaFond 1995). This theoretical framework promises to shed light on how the CHDs understand PHC and their approach to the implementation of PHC.

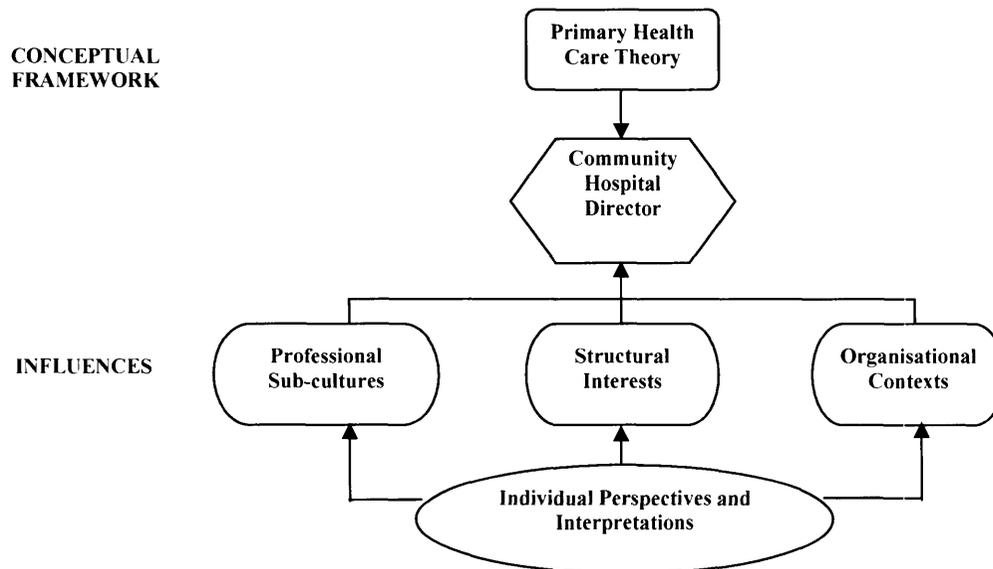


Figure 1.1: Conceptual framework and contextual influences for understanding the role of Thai Community Hospital Directors in implementing the Universal Health Coverage policy in relation to Primary Health Care

The structural interest theory of Alford (1975) is used in this study to understand why the health care reform in Thailand has been so slow to be fully implemented and why in some parts it has failed. This theory broadens the views on the implementation of health care reform by providing the theoretical framework to investigate structural issues that can lead the reform to fail. The leadership of each manager is important, but leadership alone cannot overcome the problems of a fragmented health system and its failure to sustain integrated health care to meet the health needs of the poor (Alford 1975; Evans, Han & Madison 2006). This theoretical framework explores and identifies various powerful interest groups who can influence the effectiveness of the implementation of this rural health care reform policy.

According to Carney (2006), effective implementation of the health policy (the UHC policy of this study) is dependant on the organisational culture. Policy makers and health managers need to understand and identify these factors to succeed in policy implementation. The MoPH's management style, which is rigid and centralised in control, influences the implementation of the UHC policy by inhibiting its effectiveness (Jindawattana & Pipatrojanakamol 2004; Na-Ranong & Na-Ranong 2002). This management style has also made the management of community hospitals more difficult

with health programmes generally planned centrally and implemented locally (Jongudomsook 2005). The national health programmes ordered by the central Ministry are not relevant to the health needs at the local community level (Hasuwankij 2004). This study explores experiences and provides insights of how and why the CHDs' management style impacts on their work regarding the implementation of the UHC policy in relation to PHC.

Bloor and Dawson (1994) report that differences in professional sub-cultures can negatively influence organisational culture and result in a conflict between different professionals and staff in a health team. Thailand has developed its health system along the Western bio-medical model (Wibulpolprasert 2005) and the CHDs also are trained in the bio-medical approach (Chokevivat 2001). In implementing the UHC policy in relation to PHC, the CHDs are required to collaborate with the CDHO and health centre staff to upgrade health centres to PCUs to provide quality primary health services to the population. The medical professions, however, determine how health services are delivered and devalue the health promotion work of other health services staff (Friedson 1970; Willis 1989). There is evidence that there is a conflict between CHDs, CDHOs, and health centre staff in implementing this rural health care reform (Hughes & Leethongdee 2007; Working Group on Quality of Life and Health Development 2004). It is critical that we show how CHDs and the health services stakeholders in the district health team work together in implementing the UHC policy and providing primary health services at district and sub-district levels, and why and how the conflict has arisen.

1.6 Introduction to the methodology

A qualitative paradigm is utilised for this study. This research is primarily descriptive and exploratory, relying on multiple sources. Evidence is gathered through in-depth interviews with the CHDs and health services stakeholders and from a focus group interview with the CHDs. The triangulated data and the interpretive nature of this qualitative study provide a deep understanding of the role of the CHD at a time of change in health services delivery at the primary health care level. The main goal of a qualitative study is to provide an account that fully captures the participants' meanings. Thematic analysis is used to analyse the study data, since this study involves an interpretative and

inductive process and its nature is consistent with qualitative research where theories are guided by the emergent data, rather than preconceived existing theories (Hansen 2006).

1.7 Limitations and key assumptions

This research study investigates the perceptions and experiences of eight CHDs who work in community hospitals in Nakhorn Rachasima Province, in North-Eastern Thailand, and another thirty-five stakeholders involved in the implementation of the UHC policy in rural areas. The CHDs were chosen using a purposive sampling technique. The small non-random sample chosen for this study makes the generalising of the findings of this study to the wider population of the CHDs limited. The perceptions of this sample are limited to the North-Eastern region of Thailand; they may not reflect the perceptions of health professionals or health service recipients from other regions of Thailand. Rather than try to generalise the findings from the case study, the results are rich in description and reflect the perceptions of the participants. Therefore, the findings of this study, if applied in other contexts, require adaptation and should be considered in light of other findings in health services management literature regarding PHC, structural interests, organisational culture, professional sub-cultures, and roles of health managers in implementing health care reform. Only the story of the role of the CHDs in implementing the UHC policy in relation to PHC has been presented in this study. The focus of the CHDs' role is outside their hospitals. It is worth noting that the perceptions of the CHDs regarding their role inside the hospital were not explored, because this was not within the scope of this study.

A key assumption of this study is that appropriate primary health care can be delivered more cost-effectively closer to the client than situated in the hospital setting (Atun 2004; Commission on Macroeconomics and Health 2001; WHO 1990, 1992). Within the present health structure and social customs of Thailand, however, moving primary health care from the hospital to the community represents a major change for both health service providers and patients (Towse, Mills & Tangcharoensathien 2004).

A second assumption is that the CHD is pivotal in this change and has been identified as such by the UHC policy (Yanggratoke 2005). CHDs have been given the responsibility to

improve the efficiency of health reform; this relies on changing the provision of primary health services at community level (Health Care Reform Project Office 2001). Care delivery for rural and poor Thais, who are most vulnerable and disadvantaged with socio-economic and health problems, devolves from the community hospital. The CHD is not only a medical director of a bio-technical secondary care facility but also a leader of community public health services.

A final assumption of this study is that PHC, as described by WHO (1978), and the structural interest theory (Alford 1975) are an appropriate theoretical framework to investigate and explain the effectiveness of the implementation of the health care reform. This assumption is based on findings from previous studies on health services management and other health and non-health sectors where the theory has successfully predicted, to some extent, the effectiveness of health care reform to integrate health systems to sustain PHC and to meet the health needs of the rural poor with equity and efficiency.

1.8 Definition of terms

The following terms have been used throughout this thesis.

1.8.1 Primary Health Care (PHC)

The definition of PHC varies between individuals and even for countries in the same region, such as in Europe (Boerma, Groenewegen & Van der Zee 1998). Each country interprets and adapts the original definition of PHC to match its political, socioeconomic and developmental contexts (Atun 2004; WHO 2003b). In this study, the term 'Primary Health Care' (PHC) is used according to *the Declaration of Alma-Ata 1978* (WHO 1978). The full definition of PHC is presented in Section 2.5.

1.8.2 Primary Care (PC)

Primary care refers to the first contact through which people enter into the health system; it is a core component of primary health care (Alberta Association of Registered Nurses 2003:1). The term 'Primary Care' in this study is not equivalent to 'Primary Health Care';

it is only one component of PHC. Primary care is used to ‘connote conventional primary medical care striving to achieve the goals of primary health care’ (Starfield 1998:11).

1.8.3 Universal Health Coverage (UHC)

The Universal Health Coverage (UHC) policy was launched in 2001 by the Thai Government to reform the Thai health system to provide health services to all regardless of a person’s ability to pay (Jongudomsook 2004). The UHC policy aims to provide health services efficiently, equitably and universally, based on clinical needs (Bureau of Policy and Strategy 2007). Developed countries, such as Australia and the United Kingdom, find these aims a challenge to implement (Duckett 2004; Nitayarumphong & Mills 1998). Thailand is also challenged and is a leading example for developing countries of planned access to quality health services (Jongudomsook 2005). The strategies used in reforming the health sector under this policy are: the adoption of per capita funding, the reorientation of service delivery from hospitals to the primary care units, and promoting consumer rights (Bureau of Policy and Strategy 2007:32).

1.8.4 Primary Care Unit (PCU)

The philosophy of primary health care (PHC) introduced by WHO (1978) and the principles of Family Medicine underpin the operation of the PCU (Health Care Reform Project Office 2001). The UHC policy encourages the use of PCUs, close to communities or workplaces, as front-line facilities (Health Care Reform Project Office 2001). The MoPH requires the community hospitals to establish at least one PCU in the hospital’s area of responsibility and network with other health centres (to be upgraded to PCUs) outside the main town.

1.8.5 Community Hospital (CH)

The community hospital (CH) is a secondary care facility of the MoPH. It is the front line health facility and provides medical and comprehensive health services in rural areas at the district level (Chokevivat 2001). It is the most peripheral health facility which has at least one medical doctor (Supawong & Kadgarnglai 1998; Wibulpolprasert 2005) and

services disadvantaged people beset by the complex arrays of health problems of a transitional country. The CHs are classified by number of beds which vary from 10 to 150; the most common totals are 30 and 60 beds, and by levels of care which are basic, intermediate and high (Wibulpolprasert 2005:288). All CHs are required to change in structure and function to become a CUP in implementing the UHC policy (Bureau of Policy and Strategy 2007).

1.8.6 Contracting Unit for Primary Care (CUP)

The MoPH provides a per capita funding to CUPs which are required to manage and allocate such funding to support primary and secondary care in the local area and to pay for referrals to tertiary-care and other health facilities (Jongudomsook 2004). Each CUP is required to provide comprehensive care, which includes curative, rehabilitative, disease prevention and health promotion care for their eligible community members within a thirty minute travel time from the CUP (Health Care Reform Project Office 2001). Personal health promotion and preventative care for all eligible members of the district are paid on a per capita basis which is adjusted by a performance-related payment (Jongudomsook 2005).

1.8.7 Community Hospital Director (CHD)

The Community Hospital Directors (CHDs) are medical doctors who are appointed to be managers of the hospital. Most are basic doctors or generalists, but some are specialists. They are responsible for both clinical and management work for their hospitals. Their responsibility is also to ensure the quality of care provided by their health facilities. Moreover, they coordinate with other public health services that service the community through prioritising health programmes based on community health needs, developing specific health programmes, and overseeing the implementation and evaluation of programmes (Tarimo 1991). Under the UHC policy, besides working as clinicians and hospital managers, they are required to become CUP managers who must organise comprehensive care for the eligible populations in their districts.

1.9 Organisation of the thesis

In Chapter Two the relevant literature related to working environments of the CHDs in implementing the UHC policy and PHC is introduced. The literature review presents the factors identified in government reports and the published Thai literature on the health care system and its reform. The aim is to identify the issues that may form part of the CHDs' 'public' discourse. First, the literature review describes the context of health care in Thailand and the health care reform through the UHC policy and PHC. Second, the theoretical framework of PHC and its evolution as well as the issues related to its implementation in international and Thai contexts are discussed. Third, the evolution of the Thai community hospital, its management, its role in implementing the UHC policy and PHC are identified. Next, the theoretical issues regarding structural interests, the Thai bureaucratic management style, and professional sub-cultures, are discussed in relation to the problems and barriers to the implementation of the UHC policy and PHC. Last, the proposed strategies for improving the roles of CHDs in achieving the UHC policy are presented.

Chapter Three presents a justification for the paradigm chosen for this study, which provides evidence of the congruency of the methodology of the research topic. A qualitative approach was chosen. This chapter provides a detailed description of the selection and recruitment of participants, as well as the method and procedures of data collection and the development of the interview schedule. The participants' profiles and the researcher's role are described. The latter is presented in order to locate the researcher within this study and describe his background and intentions. Following this is a justification of the thematic data analysis technique. An outline of the steps taken to ensure rigour and trustworthiness is presented, and methodological limitations are identified and discussed. Finally, the ethical considerations relevant to this research study are identified and discussed.

The results of the study are presented in Chapter Four, which contains a detailed account of the data analysis. The results are presented in four main sections as four themes emerged from this study.

Chapter Five provides a discussion of the conclusions and implications of the study. First, the major conclusions are presented in relation to the aims of the study. Next, the implications of the findings for policy and practice are discussed and suggestions are made for changes to policy and practice, at the macro- and micro-levels, which could pave the way to improving the CHDs' role in facilitating the sustainability of the PHC services provision. Finally, recommendations are made for further research into this field of study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The health needs of the rural poor in Thailand are significant from a sociological and health services management point of view and are the context for this research. The historical background of the Thai health services system helps explain the development of the present system of health delivery. The health reforms in the current system see the implementation of health programmes developed under the auspices of international agencies. These programmes are intended to redress the inequities in health services delivery to the rural poor, who are the most vulnerable and disadvantaged members of the community, with severe socio-economic and health problems. The implementation of these reforms has been challenged by the bureaucratic structure and funding issues of the Thai health system and the challenges facing the health workers, particularly Community Hospital Directors (CHDs), trying to implement these reforms without clear guidelines about responsibilities and interpretation of the policies. The community hospital is the lynchpin of care delivery for the rural poor and the CHD is in a pivotal position to address the health needs of this section of the population. The CHD is not only a medical superintendent of a bio-technical secondary care facility but also a leader of community public health services. With current economic constraints, there is renewed interest in improving quality health care in the rural sector so that the Universal Health Coverage Scheme (UHC) policy is achievable for these citizens as well as the more advantaged urban citizens. This research aims to understand the role of the CHD, because of the strategic importance of this position to the delivery of health care, both curative and preventive, for the rural poor. The purpose of this literature review is to identify the factors identified in government reports and the published Thai and international literature on the health care system and its reform. The aim is to identify the issues that may form part of the CHDs' 'public' discourse.

2.2 Overview of Thailand

Thailand is a democratic monarchy situated in South-East Asia, bordered by Myanmar, Laos PDR, Cambodia, Vietnam and Malaysia. In 2007, the population is approximately 65 million people, 31.5% of whom live in the metropolitan areas of Bangkok and other regional capitals (Bureau of Policy and Strategy 2007:19-20). The population is mainly Buddhist (95%) but other religions include Islam, Christianity, Brahmanism, Hinduism and Sikhism (Wibulpolprasert 2005). The area of the country is 513 115 sq km (Bureau of Policy and Strategy 2005:14) compared to Australia's 7 69 2024 sq km (Department of Foreign Affairs and Trade 2007b). Geographically, Thailand has five regions (Central, North, North-Eastern and South) and the Bangkok Metropolitan Area (BMA). The North-Eastern is the poorest among the five regions (Wibulpolprasert 2005). The administrative system is divided into central, provincial, and local levels. There are 75 provinces and Bangkok, the capital city which is treated administratively as equivalent to a province. There are 876 districts, 8233 sub-districts (Tumbons) and 72 831 villages throughout the country.

Thailand operates a capitalist economy. The GDP was \$US176.2 and 206.3 billion in 2005 and 2006 respectively (Department of Foreign Affairs and Trade 2007c) compared to Australia's GDP of \$US 713.1 and 755.6 billion in 2005 and 2006 respectively (Department of Foreign Affairs and Trade 2007a:55). The economic growth rate was about 4.5% and 5.0 % of GDP in 2005 and 2006 respectively (Department of Foreign Affairs and Trade 2007c) compared to Australia's economic growth rate which was 3.0% and 2.4% in 2005 and 2006 respectively (Department of Foreign Affairs and Trade 2007a:55) and that of the US which was 3.2% and 3.3% in 2005 and 2006 (Department of Foreign Affairs and Trade 2007a:70). Thailand's resource base is agriculture and tourism and secondary industries are developing. The per capita income in 2001 was \$US 2707 and \$US 3136 in 2005 and 2006 (Department of Foreign Affairs and Trade 2007c).

Prior to 1997, there was a long period of political instability with fifty changes of government during the preceding thirty years (Wescott 2001:37). In 1997, an economic crisis spread from Thailand and involved several other South-East Asian countries. The major outcomes for Thailand were the bankruptcy of industries and businesses, increased unemployment, high interest rates, and high inflation (Bowornwathana & Poocharoen

2005). International monetary aid assisted recovery. Dr. Thaksin Chinnawatra, the leader of the Thai Rak Thai party, was the Prime Minister under the *Constitution of the Kingdom of Thailand, 1997* from 2001 until 19 September 2006. He was ousted by a military coup. The interim government was appointed to oversee political reform. It is headed by General Surayud Chulanont, a retired general (The World Bank 2006). The first national referendum on a new constitution was conducted on 18 August 2007 with the majority of people accepting it. The *Constitution 2007* is currently in force. The general election occurred in December 2007. The new government is led by Mr. Samak Sundaravej, the leader of the People Power Party (Percy 2008).

2.3 Overview of the Thai health system

2.3.1 Health status

During the past four decades, the health status of Thais has dramatically improved due to medical advances and the expansion of public health facilities, as well as more effective and responsive health programmes (Bureau of Policy and Strategy 2007). Life expectancy has increased from 60 to 70 years for males and 66 to 75 years for females in the period 1980 to 2007 (Bureau of Policy and Strategy 2007:20). In 2004, the life expectancy of newborns was 70.3 years, higher than the average for developing countries (65.2 years) and the world population (67.3 years) (UNDP 2006:284, 286). Infant mortality decreased from 84.3 per 1000 live births in 1964 (Wibulpolprasert 2002:183) to 19.0 in 2004, lower than the world average infant mortality rate of 57.0 (The World Bank 2007).

Some other indicators showing improvement in the Thai population health status are:

- The rate of low-birth-weight newborns (weighing less than 2500 grams) has improved from 10.2% in 1990 (Wibulpolprasert 2002:185) to 9.0% in 2004 (UNDP 2006:306).
- Maternal mortality ratio declined from 374.3 per 100 000 live births in 1962 (Wibulpolprasert 2002:185) to 24.0 per 100 000 live births in 2004 (UNDP 2006:316).

- The mortality rate of children under the age of five (per 1000 children) was 75.0 in 2004 for the world population, but only 21.0 for the Thai population (UNDP 2006:316, 318).
- Fertility rate (births per woman) of Thais was 1.9 in 2005, lower than the world average which was 2.7 (UNDP 2006:298, 300).

According to the Australian Institute of Health and Welfare (2006:401, 403, 406), in Australia in 2004 life expectancy at birth for males and females was 78.1 and 83.0 years respectively. The fertility rate was 1.77 births per woman. The infant mortality rate was 4.7 deaths per 1000 live births. In 2001, the maternal mortality rate was 8.0 deaths per 100 000 confinements (UNDP 2006:315). When compared to developed countries, Thailand must continue its efforts to improve the health status of its people.

Table 2.1 shows the progress of some of the Thai population and health status characteristics from 1960 to 2007. It also shows that there was an increase in the aged population (i.e. over 60 years) from 4.5% in 1960 to 10.5% in 2007.

Table 2.1: Characteristics of the Thai population and health status, 1960–2007

Characteristics	1960	1970	1980	1990	2000	2007
Total population	26 260 000	34 397 000	44 825 000	54 548 000	62 056 000	65 064 000
• male						
• female	13 154 000	17 124 000	22 329 000	27 062 000	30 885 000	31 951 000
	13 104 000	17 274 000	22 496 000	27 487 000	31 171 000	33 113 000
Dependency ratio	92.0	85.0	75.0	57.7	53.3	50.0
Population under 5 (%)	10.2	16.4	12.1	8.2	8.3	7.5
Population aged 15–60 years (%)	52.2	49.8	56.4	63.4	60.0	66.8
Population over 60 years (%)	4.5	5.1	5.3	7.4	9.2	10.5
Population in urban areas (%)	12.5	13.2	17.0	18.7	35.0	31.5
Population per sq km	51	70	87	106	121	127
Life expectancy at birth (years)						
• male						
• female	53.64	57.73	60.25	63.50	70.00	68.4
	58.74	61.57	66.25	68.75	75.00	75.2
Infant mortality rate (per 1000 live births)	84.3	56.3	48.0	35.0	22.0	16.3

Source: Adapted from Bureau of Policy and Strategy (2007:20).

2.3.2 Health challenges

Thailand has undergone significant economic development and has experienced many of the health challenges facing countries in transition (National Economic and Social Development Board Office 2005). Health transition involves the social, cultural, behavioural, environmental and bio-medical aspects of health (Cleland 2001; Kunstader & Kunstader 2001; Palloni 2001; Walle 2001). Countries in transition are confronted with demographic changes and both communicable and non-communicable diseases. Some of the contemporary health challenges are related to the socio-economic and health effects of globalisation; the interconnectedness of countries through cross-border economics, technology; and culture (Beaglehole & Bonita 2003:254; McMichael & Beaglehole 2003; WHO Thailand 2007). Some of these health problems are: chronic diseases, e.g., heart disease and diabetes; cancer; disease related to behaviour and lifestyle, e.g., tobacco smoking, alcohol consumption, food and drug consumption, and disease associated with unhealthy sexual practices (HIV/AIDS and some infections related to these conditions such as Tuberculosis); motor vehicle accidents; aging; mental health disorders and suicide; and work-related conditions in the industrial sector such as Silicosis, Byssinosis and lead poisoning and work injuries (Bureau of Policy and Strategy 2007; Kanchanachitra et al. 2005; Kanchanachitra et al. 2007; WHO Thailand 2007; Wibulpolprasert 2002, 2005).

Wibulpolprasert (2005:177-178) reports that four leading causes of death among Thai people of all ages during 1997–1999 were: 1) circulatory diseases, mainly cerebrovascular disease (18.6%); 2) cancer of the liver and bile ducts, and lung cancer (16.2%); 3) HIV infection in the working age group due to inadequate sexual health programmes (15.5%); and 4) accidental drowning among school-age children and traffic accidents which were associated with motorcycles (12.4%). In addition, the Bureau of Policy and Strategy, MoPH (2007:20), points out that the five major causes of death of all ages in 2005 were: 1) malignant neoplasms; 2) accidents and poisonings; 3) hypertension and cardiovascular disease; 4) diseases of the heart; and 5) diseases of the respiratory system.

2.3.3 Health services system of Thailand

2.3.3.1 Structure of the Thai health services system

The Thai health care system developed under the patronage of the monarchy. It initially was reliant on traditional medicine but in the mid-19th century Western medicine was introduced by Dr. Dan Beach Bradley, an American missionary, and this was subsequently supported by the monarchs (Wibulpolprasert 2005). The American missionary doctors were the key people who brought modern techniques in medical and public health care, such as smallpox inoculation, anaesthetic techniques, control of cholera by using water mixed with tincture which patients took orally, and maternal and child care, to Thailand (Phoolcharoen 2005). This medical reformation was also associated with economic development in Thailand as the country opened up to trade with the West (Wibulpolprasert 2005).

In 1942, the Ministry of Public Health (MoPH) was established and there has been an expansion of health facilities and training of health professionals throughout the country (Bureau of Policy and Strategy 2005). Many health policies have been implemented since 1961 under the *National Economic and Social Development Plan* (Jongudomsook 2005). The 10th *National Economic and Social Development Plan* is currently in place (Bureau of Policy and Strategy 2007). It focuses on a ‘patient-centred approach and the philosophy of sufficiency [in the] economy’ (Bureau of Policy and Strategy 2007:13). The first *National Health Act* was enacted in 2007 (National Health Commission Office 2007).

Thai health care is organised and provided by the public and private sectors as is shown in Figure 2.1. The MoPH is the government agency that promotes, supports, controls and coordinates all health service activities (Bureau of Policy and Strategy 2005, 2006, 2007). It is also the dominant health care provider, particularly for people who live outside Bangkok, especially those in rural areas (Wibulpolprasert 2005). The MoPH has tertiary care hospitals, mostly located in Bangkok, regional and provincial hospitals at provincial level outside Bangkok, and community hospitals and health centres at district and sub-district level mostly in rural areas. The majority of the poor, whose average income in

2005 was about 1230 baht per month (National Statistic Office 2006:35), receive medical and public health services at the MoPH's hospitals and health centres.

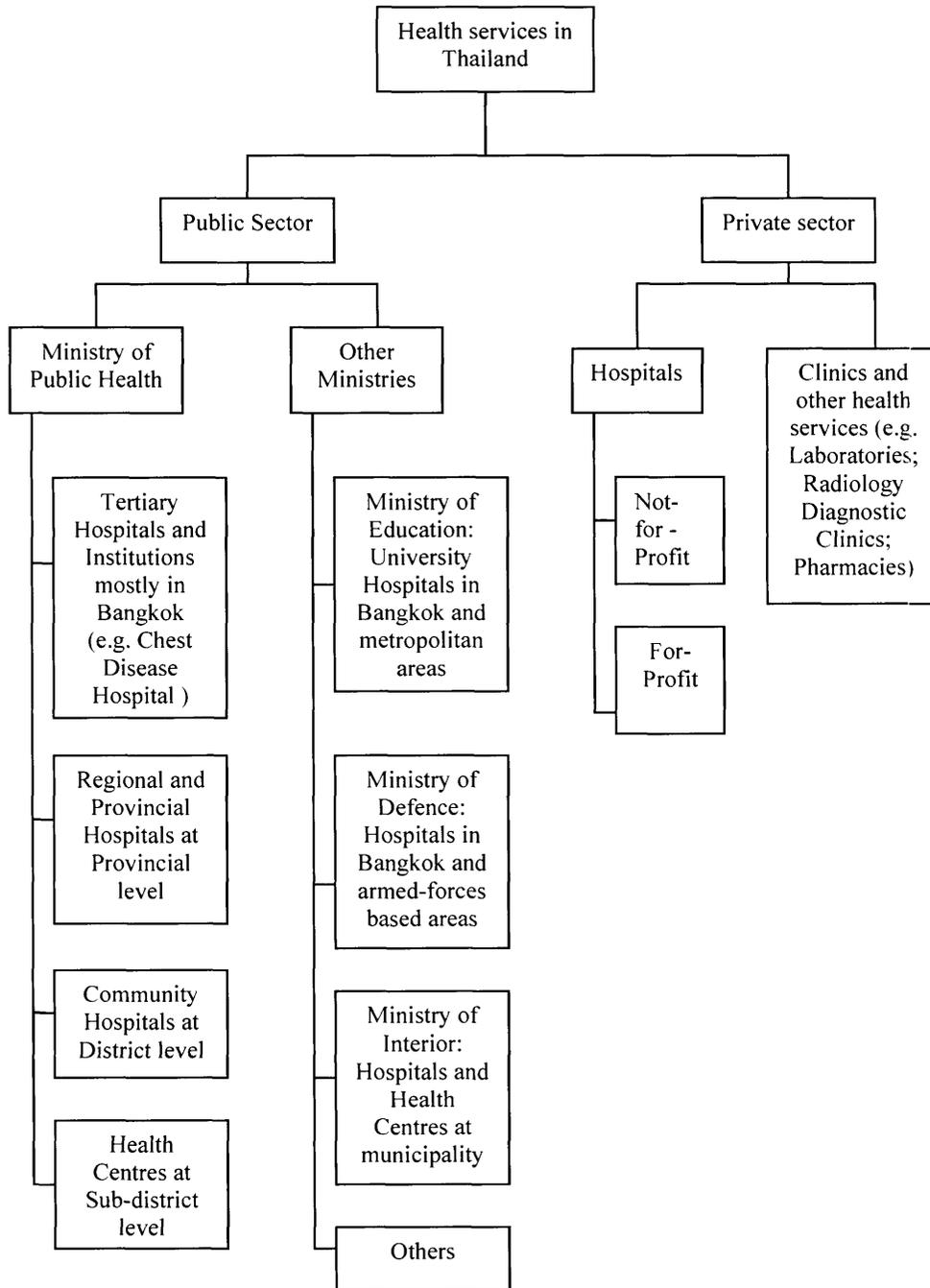


Figure 2.1: Structure of Thailand's health services

Source: Adapted from Wibulpolprasert (2005:317-319).

The other public hospitals are the responsibility of other Ministries, for example, the Ministry of Education; the Ministry of Defence; the Ministry of Interior; and others (e.g.

state enterprises; autonomous government agencies). These hospitals are mainly located in Bangkok and other metropolitan cities, either providing health care for their own personnel or providing specific activities (e.g. teaching and research). However, they all provide medical services, mostly tertiary care, for people. The multiple providers are a major problem for the health services structure (Mills & Ranson 2005).

These various health care systems are not co-ordinated. Interestingly, Thai people who have the right to access the hospitals of the MoPH can also access the facilities of the other Ministries. This duplication of facilities and services is an important and systemic problem for the costs and efficiency of the Thai health service (National Health Commission Office 2006).

The private sector has for-profit and not-for-profit hospitals, clinics and other health services (e.g. laboratories, radiology, and physical therapy). They are all located in Bangkok, metropolitan areas and affluent urban areas. When people access private sector services they usually have to pay, except where some hospitals accept a public health insurance scheme, e.g. social security scheme, or they have a contractual agreement with the Ministry of Labour to take care of its members by means of a per capita budget from the government. The lucrative private health sector is similar to that of Western countries. The MoPH is responsible for controlling these private health services, but does not do so strictly (Sawanpunyalert 2002). There are problems of overcharging so that some people are unable to cover their medical expenses (Nitayarumphong & Pannarunothai 1998).

The cooperation among health services is loosely organised both between public–public and public–private agencies (Health System Research Institute 1997). For example, the medical technology investment plans are fragmented and not well- integrated between the public and private sectors and between various public facilities. Generally, these lead to inefficiencies in the Thai health system (National Health Commission Office 2006).

In 2004, there were 1278 hospitals in both the public and private sectors, with 980 (77%) in the public sector and 298 (23%) in the private sector. The number of hospital beds in the public sector was 106 902 (80%) and in the private sector 26 343 (20%) (Bureau of Policy and Strategy 2004:1). The MoPH is the main health provider, with 875 hospitals and 86 667 hospital beds, as shown in Table 2.2. The report of the Bureau of Policy and

Strategy (2004:3-4) also shows that the majority of the MoPH's health facilities are outside Bangkok (see Tables 2.3 and 2.4).

Table 2.2: Number of hospitals and hospital beds under the management of various Ministries and the private sector, 2004

Agencies	Number of hospitals	Number of beds
Ministry of Public Health	875	86 667
Office of the Prime Minister	2	748
Ministry of Finance	1	82
Ministry of Transportation	1	120
Ministry of Interior	1	80
Ministry of Justice	2	550
Ministry of Education	15	8556
Ministry of Defence	63	6987
State Enterprises	7	737
Municipality	13	2375
Private sector	298	26 343
Total	1278	133 245

Source: Bureau of Policy and Strategy (2004:1).

Table 2.3: Number of hospitals and hospital beds under the management of the Ministry of Public Health by region and Bangkok, 2004

Region	Number of hospitals	Number of hospital beds
Bangkok	12	4838
Central (excluded Bangkok)	224	26 517
North-Eastern	290	24 119
Northern	191	17 622
Southern	158	13 571
Total	875	86 667

Source: Bureau of Policy and Strategy (2004:4).

Table 2.4: Number of regional, general, and community hospitals under the management of the Ministry of Public Health by region, 2004

Region	Ministry of Public Health Hospitals (outside Bangkok)							
	Regional Hospital		General Hospital		Community Hospital		Total	
	Number of hospitals	Number of beds	Number of hospitals	Number of beds	Number of hospitals	Number of beds	Number of hospitals	Number of beds
Central (excluding Bangkok)	9	5723	27	8782	172	7899	208	22 404
North-Eastern	6	4934	14	5430	259	11 728	279	22 092
Northern	5	3676	15	5383	162	7075	182	16 134
Southern	5	3099	14	4152	130	4760	149	12 011
Total	25	17 432	70	23747	723	31 462	818	72 641

Source: Bureau of Policy and Strategy (2004:3).

According to Wibulpolprasert (2005:277-278), in 2004 the following public health facilities were distributed throughout Thailand:

- Bangkok: 5 university hospitals, 29 general hospitals, 19 specialised hospitals, 61 health centres and 82 health centre branches.
- Regional level: 4 university hospitals, 25 regional hospitals and 40 specialised MoPH hospitals. A regional hospital has over 500 beds and medical specialists in all fields.
- Provincial level: 70 MoPH general hospitals and 57 Ministry of Defence hospitals. A general hospital is one that is equipped with 200 to 500 beds and has major medical specialists.
- District level: 725 community hospitals and 214 municipal health centres. Community hospitals vary in size from ten to 150 beds, the hospital covering a population of 10 000 or more. Most are in rural areas and provide primary and secondary medical care to communities. Most newly graduated doctors and nurses are required to work at community hospitals for at least 2 or 3 years.
- Sub-district (Tambon) level: 9765 health centres. Some Tambons have more than one health centre. A health centre is a front-line unit, covering a population of about 1000–5000, the health professionals including at least a health centre officer, and technical nurse. There are registered nurses at some health centres. These centres are open during the day only and have nursing services on-call

during the night. Primary care services, curative care and health promotion, as well as disease prevention advice and skills, are provided at these centres.

- Village level: 66 223 rural primary health care centres operated by villagers (PHCCVs), and 3108 urban PHCCVs. PHCCVs are established in remote areas, covering a population of 500 to 1000 and managed by village health volunteers (VHVs) under the supervision of health officers from sub-district health centres. Services provided at this level include health promotion, disease prevention and simple curative care.

The private sector shares some of the responsibility for providing curative care. In 2004, there were 346 private hospitals of which 100 were in Bangkok and 246 in other provinces, 14 953 surgeries (3100 in Bangkok and 11 853 elsewhere) (Wibulprasert 2005:279). Table 2.5 presents the public and private health facilities in Thailand in 2004.

Table 2.5: Number of public and private health facilities in Thailand in 2004

Type of Facility	Bangkok (urban)	Provinces (urban)	Districts (rural)	Tambons (rural)	Villages (rural)
Public University Hospitals	5	4	-	-	-
Regional Hospitals	-	25	-	-	-
Specialised Hospitals	19	40	-	-	-
General Hospitals					
-Public	29	70	-	-	-
-Private	100	246	-	-	-
Community Hospitals	5	-	725	-	-
Private Clinics	3100	11 853	-	-	-
Health Centres	61	-	214	9765	-
HC Branches	82				
PHCCV	-	3108	-	-	66 223

Source: Adapted from Wibulprasert (2005:277-279). HC = Health Centre; PHCCV = Primary Health Care Centre operated by Villagers.

In brief, there are more health facilities and more health professionals available in the urban areas than in the rural areas in which the most vulnerable and underprivileged people live. This indicates the disparity and inequity between urban and rural areas.

2.3.3.2 Health funding

According to the WHO (2006:184) Report, in 2003 the total health expenditure in Thailand was 3.3% of gross domestic product (GDP); 61.6% by the public sector and 38.4% by the private sector. The government expenditure on health was 13.6% of total government expenditure. The MoPH, which is the central agency of the government, is the largest source for public funding while the household is the major source for private health spending (Wibulpolprasert 2005).

Wibulpolprasert (2005:323, 331) reports that the allocation of government health funding has been closely associated with hospital-based services and that ‘most of the national health expenditure was used for curative [care], 30% or one-third of which was spent on drugs’. Since the launch of the UHC policy, the government has allocated more funding to health promotion and disease prevention programmes as one of the strategies for health system reform (Jongudomsook 2005; National Health Commission Office 2006; Wibulpolprasert 2005).

Since 2001, the government’s health funding has been spent through three main health insurance schemes, which cover the entire population: the Civil Servant Medical Benefit Scheme (CSMBS); the Social Security Scheme (SSS); and the Universal Health Coverage Scheme (UHCS), called the ‘30-Baht Scheme’ (Suraratdecha, Saithanu & Tangcharoensathien 2005). The estimated coverage of these three schemes and payment per capita in 2005 are shown in Table 2.6.

Table 2.6: Estimated coverage of health insurance schemes in 2005

Scheme	Population Coverage (Million)	Payment (Baht per capita)
Civil Servant Medical Benefit	4.15	Fee for service (7078.23)
Social Security	8.74	Capitation (1250.00)
Universal Health Coverage	47.34	Capitation (1396.30)

Source: Adapted from Bureau of Policy and Strategy (2007:37).

Three key points are worth noting. First, The CSMBS provides medical benefits to civil servants, public employees and their dependents (Pachanee & Wibulpolprasert 2006). The scheme is paid wholly from the general tax revenue based on a fee-for-services retrospective reimbursement system. It is managed by the Comptroller General Department of the Ministry of Finance (Pannarunothai, Patmasiriwat & Srithamrongsawat 2004). This scheme covered approximately 4.15 million people in 2005 (Bureau of Policy and Strategy 2007:37), and 5.14 million people at June 2007 (National Health Security Office 2007a:1). The benefits of this scheme include: medical consultations, medical treatment, operations and other therapeutic care, drugs, in-patient care, and obstetric delivery expenses. Beneficiaries can access health care at any public health facility on a fee-for-service basis as out-patients or in-patients (Jongudomsuk 2005). Private health facilities are also allowed to be used under the scheme, but with limitations (Pachanee & Wibulpolprasert 2006). Care provided for the beneficiaries under this scheme is not subject to the referral system. Jongudomsuk (2005) argues that fee-for-services reimbursement and a weak monitoring system on the part of the Ministry of Finance caused the dramatic escalation of expenditure from 2000 baht per capita in 2002 (Bureau of Policy and Strategy 2005:31) to 4000 in 2003 (Jongudomsuk 2005:16) and 7078.23 in 2005 (Bureau of Policy and Strategy 2007:37).

Second, the SSS is financed by compulsory contributions from employers, employees, and the government, on an equal share basis (Suraratdecha, Saithanu & Tangcharoensathien 2005). This scheme is based on the *Social Security Act 1990* and is managed by the Social Security Office under the Ministry of Labour (Pannarunothai, Patmasiriwat & Srithamrongsawat 2004). The SSS covers non-work-related sickness, maternity and those who are invalids, together with a cash benefit which is 50% of the employee's wages and paid in the event of a person's death (Jongudomsuk 2005:15). There were 8.74 million people in this scheme in 2005 (Bureau of Policy and Strategy 2007:37), and 9.36 million at June 2007 (National Health Security Office 2007a:1).

A hospital with more than 100 beds can be a contracting unit. This scheme pays the providers by means of the contract per capita system (Pachanee & Wibulpolprasert 2006). The care provider choices are in-network public or private facilities (Suraratdecha, Saithanu & Tangcharoensathien 2005). The scheme emphasises curative care only, and offers no encouragement for the participating hospitals regarding health promotion and

disease prevention (Waleeittigul 2004). In addition, the Bureau of Policy and Strategy, MoPH (2007:35), reports the only health promotion and disease prevention programmes provided are health education and immunisation. The per capita payment was 1700 baht in 2004 (Bureau of Policy and Strategy 2005:31) and 1250 in 2005 (Bureau of Policy and Strategy 2007:37).

Last, the UHCS or Gold Card Scheme or Universal Coverage Scheme (Suraratdecha, Saithanu & Tangcharoensathien 2005:273) provides medical and health care services with acceptable standards and quality for people who are not in the CSMBS or SSS. There were 47.34 million people in this scheme in 2005 (Bureau of Policy and Strategy 2007:37), and 46.74 million at June 2007 (National Health Security Office 2007a:1). It covers about 75% of the population, mostly poor people in rural areas. In June 2007, there were approximately 1 million people, whose residential information cannot be verified, who were still not registered for their correct health care coverage (National Health Security Office 2007a:1). It is generally known that they were in rural and remote areas.

Funding for this scheme is from general tax and managed by the National Health Security Office (NHSO) under the supervision of the Minister of Public Health. Public hospitals are the main health providers covering about 95% of the beneficiaries (Pachanee & Wibulpolprasert 2006:312). In 2007, the MoPH was the major provider of services to 90% of the beneficiaries through its 875 hospitals (National Health Security Office 2007a:2). The beneficiaries were classified into two groups. i) Those who are exempt from a co-payment of 30 baht¹ per instance of care. Target populations are the poor, the elderly, children 12 years old or under, veterans, community leaders, monks and the disabled. ii) The second group is those who must pay a co-payment of 30 baht each time they access the health services (Suraratdecha, Saithanu & Tangcharoensathien 2005). Since the beginning of 2007, all beneficiaries are exempt from the co-payment (National Health Security Office 2007b).

The benefits of this scheme include: most health services except cosmetic care, obstetric delivery beyond two pregnancies, drug addiction treatment, infertility treatment, and some high-cost interventions (Suraratdecha, Saithanu & Tangcharoensathien 2005). Since

¹ 1 \$AUS approximately equals to 30 baht in 2007

October 2003, access to antiretroviral drugs has been covered (Pachanee & Wibulpolprasert 2006:312). In 2006, the Minister of Health announced a special project in 2007 for 200 beneficiaries who have end-stage chronic renal failure to have access to renal transplantation services (National Health Security Office 2006a). In September 2007, the Minister of Health announced the pilot project for haemodialysis for 400 beneficiaries who have chronic renal failure (The Information and Public Relations Office 2007).

The budget in the 2004 financial year was 1308.50 baht per capita and for 2005 it was 1396.30 baht per capita (National Health Security Office 2007b:79). However, the report shows that this budget should have been 1447 and 1510 baht per person in 2004 and of 2005 respectively (Bureau of Policy and Strategy 2007:36). Even though the funding rate was increased to 1659.20 baht per capita in 2006 and 1899.69 baht per capita in 2007, the required rates have not been obtained (National Health Security Office 2007b:79). This means that the Thai health services under the UHC Policy have been under-funded. More details of the UHC policy are presented in Sections 2.4 and 2.5.

2.3.4 Problems of the Thai health services system

2.3.4.1 Inequities in the health system

a) Inequities in resources allocation

During the past two decades, even though Thailand has its expanded health facilities and health infrastructure has been developed in all districts and sub-districts, there has been an inequitable distribution of health facilities and health professionals, especially doctors, between rural and urban areas. The Bureau of Policy and Strategy, MoPH (2004:3) reports that the ratio of hospital beds per doctor in the North-Eastern region, which has the poorest people, was 10:1, 2.5 times of that of the Bangkok area, which was 4:1 in 2002. Moreover, the ratio of population per hospital bed of the North-Eastern region was 747:1, while that of Bangkok was only 224:1 in 2004, as shown in Table 2.7. This means that people in the North-Eastern region have far less opportunity to have hospital treatment than people in Bangkok.

Table 2.7: Number of hospitals and hospital beds, ratio of beds per doctor and population per bed by region, 2004

Region	Number of hospitals	Number of hospital beds	Ratio of hospital beds per doctor	Ratio of population per hospital bed
Bangkok	111	25 596	4:1	224:1
Middle (excluding Bangkok)	360	38 211	8:1	390:1
North-Eastern	345	28 736	10:1	747:1
Northern	259	23 807	9:1	503:1
Southern	203	16 895	8:1	501:1
Total	1278	133 245	7:1	469:1

Source: Bureau of Policy and Strategy (2004:3).

In 2004, the ratio of population per doctor in the North-Eastern, Northern and Southern Regions was 7466:1, 4534:1 and 3982:1 respectively, while the average ratio for the country was 3305:1 and that of the Central Region 3134:1. The ratio for Bangkok was substantially different; it was 879:1, as shown in Table 2.8 (Bureau of Policy and Strategy 2004:5). This means there are approximately 8.5 times more doctors in Bangkok than there are in the North-Eastern areas and 5 times more than in the Southern and Northern Regions.

There is an argument about the level of training needed for health care workers at the primary level (WHO SEARO 2004). There is evidence that the rural sector is not compensated for the low numbers of highly trained medical professionals by having trained health workers with skills in primary prevention and health promotion, as well as health care infrastructure development (Wibulpolprasert 2005).

Furthermore, since the expansion of private health facilities in Bangkok and in other large cities, there has been a major shift of human resources from the public sector to the private sector, as well as from rural to urban areas (Pachanee & Wibulpolprasert 2006). The urban-rural disparity is increasing greatly.

Table 2.8: Number of doctors and population per doctor ratio by region and by agencies, 2004

Region	MoPH	Other Ministries	State Enterprise	Municipality	Autonomous Government Agencies	Private Sector	Total	Ratio of Population per Doctor
Bangkok	685	3595	2	601	29	1614	6526	879:1
Central (excluding Bangkok)	3078	479	-	4	89	1102	4752	3,134:1
North-Eastern	2351	309	-	6	1	208	2875	7,466:1
Northern	1867	364	10	17	3	378	2639	4,534:1
Southern	1394	454	-	4	1	273	2126	3,982:1
Total	9375	5201	12	632	123	3575	18 918	3,305:1

Source: Bureau of Policy and Strategy (2004:5). MoPH = Ministry of Public Health.

b) Inequity in accessibility to health care

There are more facilities, medical technologies and physicians in urban areas; opportunities to access health services, therefore, are unequal between people in urban and rural areas (see Table 2.2). Wibulpolprasert (2005:340) reports a greater percent use of health facilities staffed with doctors by people in urban communities compared to people in rural communities; 52.5% (in 2003) and 52.9% (2004) in urban communities against 49.8% (2003) and 50.5% (2004) in rural communities. Urban dwellers had more opportunity to access quality health facilities than the rural poor.

c) Inequity in health status

During 1964–1965, the infant mortality rate (IMR) per 1000 births was 85.5 in non-municipal areas and 67.6 in municipal areas. The difference ratio of the IMR in non-municipal areas and that in municipal areas was 1.26. However, during 1995–1996, the IMR in non-municipal areas was 28.23 and that in municipal areas was 15.24. The difference ratio of the IMR in non-municipal areas from that in municipal areas was 1.85, which was greater than before (Wibulpolprasert 2005:341). In addition, Wibulpolprasert (2005:341) reports that in 2002 there were regional disparities in the health index². The

² Health index is a component of human advancement index developed by the United Nations Development Programme (UNDP). It is related to life span, health status, health promotion and health services (population to doctor ratio) (UNDP Thailand 2003).

index for people in the North-Eastern region was 0.6234, while in Bangkok and in the country as a whole the indices were 0.7884 and 0.6889 respectively.

d) Inequity in health expenditure compared to income

The poor have a greater burden of health expenditure in proportion to their income than do the rich; as much as 3.6 times higher in 2000 (Wibulpolprasert 2002:52). In 2002, this margin dropped to 1.6 times (Wibulpolprasert 2005:51). This was due to the benefits the poor received through the UHC policy. Wibulpolprasert (2005:342) argues structural inequity still exists, because the poor only received more benefits in accessing out-patient care at community hospitals and health centres, while they still receive less care at tertiary medical facilities than the rich.

2.3.4.2 Problems of inefficiency in the health services system

There is no clear separation of primary health care provided by medical and health professionals with basic training and specialist care in secondary and tertiary settings, so that the health-seeking behaviour of Thais is related to curative services which are mainly provided by specialists (National Health Commission Office 2006). All of the secondary and tertiary acute-care hospitals provide primary medical care (Sawanpunyalert 2002; Wibulpolprasert 2002, 2005). Consequently, patients usually bypass lower levels of care for the secondary and tertiary facilities, often without the necessity to do so.

The referral system from primary care to secondary and tertiary level health professionals or specialists does not have the primary health care professionals acting as ‘gatekeepers’, as is the case in Western countries such as Australia. This process is inefficient, because primary health care is much cheaper to deliver than care at higher levels. Prakongsai et al. (2002:603-605) show this in their study of the unit cost of ambulatory care in the budgetary year 2001; the unit costs for services at the health centres, community and general hospitals, private clinics, private and university hospitals with primary care conditions were 62, 262, 378, 100, 353, and 679 baht per visit respectively. Over-use of drugs is another cause of inefficiency (Chokevivat & Chuthaputti 2005; Jongudomsook 2005; Phoolcharoen 2005).

The duplication of services and lack of well-organised cooperation between public–public and public–private health agencies are the cause of excessive costs for the health system

(Health System Research Institute 1997). The medical profession is the major stakeholder in the health industry and the health services have developed, as is the case in other capitalistic countries, for example the USA and Australia, with the dominance of the medical profession (Wibulpolprasert 2005; Willis 1989). The priorities of the health policies and the bio-medical or curative approach of health services reflect the values of this elite (Phoolcharoen 2005). The gatekeeper role of the generally trained medical practitioner is not well-developed, because access to specialists and hospital services is not channelled through a referral system (Boonyapaisarncharoen & Pongsupap 2005; William, Prueksaritanond & Aramrattana 2002).

The bulk of the health budget for the UHC programme in 2006 was spent on curative care (approximately 70%) with only 5% on health promotion and disease prevention (National Health Security Office 2007a:27); most of Thai health expenditure is used for curative care, as is the case in Western countries (Lyttleton 1996; National Health Commission Office 2006).

Moreover, the more Thailand develops its health services, the greater is the use of expensive and high-technology medical equipment, mostly for diagnostic and curative care. Some are used inappropriately and duplicated in the system. For example, in 2003, Thailand had 266 CT scanners, 31 Magnetic Resonance Imaging Machines, and 113 Mammogram machines (Wibulpolprasert 2005:337). More than half belong to private hospitals in Bangkok and the metropolitan areas (Wibulpolprasert 2005:337).

Health professionals may use more expensive technology, relying more on diagnostic machines, rather than detailed and thorough history-taking and medical examinations in appropriately timed patient–doctor consultations. Patients also pressure doctors for the latest tests (Health System Research Institute 1997:2-3, 9-10). Chungsathiensup (2004) points out that this problem is related to the prevailing bio-medical paradigm of the Thai health professionals where health and illness has a disease orientation, rather than patient-centred care.

2.3.4.3 Problems of the quality of the services system

A hospital accreditation organisation, HA (Thailand), adapted from the Canadian model, conducts quality assurance audits (Supachutigool & Wongkanarattanagool 2004).

However, in 2006, only 135 of the 961 hospitals participating in the UHC programme reached the required standard; 622 hospitals partially met that standard for HA accreditation (National Health Security Office 2006b:5). Two hundred and four hospitals were not accredited. Most of these were community hospitals in rural areas. As a result the quality of health services in the rural sector is problematic.

2.3.4.4 Problems of accessibility to emergency services

Despite the expansion of health services in both the public and private sectors, problems with medical emergency services continue (Wibulpolprasert 2005). Medical transportation and evacuation procedures from the site of an accident to a hospital are not under a responsible agency and do not have any systematic management. This is important in relation to traffic in urban areas and retrieval services for emergency patients in rural areas.

2.3.4.5 Lack of end-user participation

In the Thai health care system, the end-user normally has little negotiating or bargaining power with either the doctor or other health professionals, because the health professionals possess and control information unilaterally (Wibulpolprasert 2002, 2005).

Medical language is another barrier for ordinary people in health care settings. Doctors and other health professionals usually communicate with each other using specific medical language and, when they communicate with patients and families, they often do not speak plainly. Patients may decide to seek medical assistance from other practitioners, but they often do that for reasons related to how as well as what health care is delivered. Health professionals control the type, quality and quantity of a consumer's demands (Wibulpolprasert 2005).

The Thai health system faces higher costs because of the problems outlined above, and every strategy must be implemented to achieve greater efficiency and effectiveness. Both the tertiary health and primary health sectors are being scrutinised to get better results for

the Thai people at a lower cost. According to the National Health Commission Office (2006), it is crucial for the Thai health services system to be reoriented from a hospital-based to a primary health care-based system that emphasises health promotion and community participation. A health system relying more on PHC than on specialist care has advantages in terms of better population health outcomes, improved equity, access and continuity, and lower cost (Atun 2004).

2.4 The Universal Health Coverage policy

The government in 2001 launched the Universal Health Coverage (UHC) policy with the aim of reforming the Thai health system to provide health services to all regardless of a person's ability to pay (Jongudomsook 2004). The main target was the 18.5 million uninsured Thais, who were mostly underprivileged and living in rural areas (Towse, Mills & Tangcharoensathien 2004:103). The strategies used in reforming the health sector under this policy are: the adoption of per capita funding, the reorientation of service delivery from hospitals to the primary care units and promoting consumer rights (Bureau of Policy and Strategy 2007:32). Hughes and Leethongdee (2007:1002) argue that the financial reallocation strategy includes 'the creation of a purchaser-provider split' and a per capita funding system.

The Thai *Constitution of 1997*³ incorporates the concept of the UHC policy when it states:

A person shall have an equal right to access to quality medical and public health services, and the poor shall have a right to receive free health care from public health facilities as provided by law. The participation by local government organisations and private sector shall be promoted insofar as it is possible in order to enhance public health facilities' efficiency and quality in health care provision. The state shall prevent and eradicate harmful contagious diseases for the public without charge, as provided by law.

(Office of the Council of State 1997)

In November 2002, the *National Health Security Act* was enacted to ensure the sustainability of the UHC policy in terms of policy, financing and institutional support (Bureau of Policy and Strategy 2007:32). The major element in this reform project is to

³ The 1997 Constitution was the first constitution to be drafted by a popularly-elected Constitutional Drafting Assembly and was called the 'People's Constitution' (2005).

expand the coverage of primary health services to enhance accessibility to essential health care for the population (Jongudomsook 2005). The Primary Care Unit (PCU), which is the front-line health facility and close to the community and workplace, is meant to be the most accessible health facility (Health Care Reform Project Office 2001). The PCU must also provide comprehensive and integrated care, which includes curative care, health promotion, disease prevention and rehabilitation, as well as ensuring the transfer of patients to secondary and tertiary hospitals when required. The philosophy of primary health care (PHC) introduced by WHO (1978) and the principles of Family Medicine underpin the operation of the PCU (Health Care Reform Project Office 2001).

The PCU, which meets the necessary standard, can be a Contracting Unit for Primary Care (CUP). This can comprise a stand-alone unit or a network of small PCUs. The policy promotes networking of PCUs in the public to public or public to private sectors (Jongudomsook 2005). The minimum registered target population should be 10 000 per PCU. A per capita payment is pre-paid each year to the CUP to cover the minimum benefit package.

The budget for the UHC policy is allocated to provinces according to the number of people registered as beneficiaries. Resources are re-channelled to the PCU based on the number of registered members. In-patient services at the secondary and tertiary care facilities are paid based on their performance, which is determined by the number and type of patients referred by the PCU.

The government requires all public hospitals to participate in this project and some private hospitals participate in the project as well. The project encourages hospitals and contracting units to either establish PCUs or upgrade the quality of medical services at Health Centres (HCs) located in their areas. These are to act as outreach centres and are expected to be close to residential or work areas so that people can access them easily (Wibulpolprasert 2005).

The programme was started in April 2001 and expanded to cover the country by January 2002 (Bureau of Policy and Strategy 2007:32). The report of the NHSO (2007a:2) shows that there were 1194 contracting units which included 963 hospitals and 231 PCUs (surgeries) in June 2007. The numbers of public and private agencies in 2007 which are

contracting units are presented in Table 2.9. The challenges and barriers in implementing the UHC policy are presented in Section 2.10.

Table 2.9: Numbers of hospitals and primary care units which are Contracting Units for Primary Care under the Universal Health Coverage policy by Agencies, 2007

Agency	Number of hospitals	Number of PCUs	Total
MoPH	830	4	834
Other Ministries	73	80	153
Private sector	60	147	207
Total	963	231	1194

Source: Adapted from National Health Security Office (2007a:2). PCU = Primary Care Unit; MoPH = Ministry of Public Health.

2.5 Primary Health Care

Primary Health Care (PHC) has emerged as the comprehensive, equity-oriented approach to people's basic health needs (Werner et al. 1997). Johnson and Paton (2007:27) argue that the health needs of a community result from the interaction of the 'hierarchy of associated factors with behavioural, social, political and environmental bases'.

According to *the Declaration of Alma-Ata 1978* (WHO 1978:para. 6), PHC is:

... essential health care which is based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that they can afford. This is to occur at every stage of their development according to the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact for individuals, the family and community. This constitutes the first element of a continuing healthcare process.

Primary Health Care has been promoted by WHO as the strategy to achieve 'health for all by the year 2000' (Phillips 1990:151). The definition of health in this context is broad; it is stated as a human right and comprises much more than an absence of disease or infirmity for individuals and communities (Bunton & Burrows 1995). Rather, it is a holistic status of physical, mental, and social well-being (WHO 1978). Such a goal cannot be attained by the health sector alone, but through the collaboration between that sector and many other social and economic sectors (McMurray 2003:43).

The comprehensive approach of PHC aims to overcome the failure of the paternalistic ‘Western bio-medical’ and ‘authoritarian’ models of health services delivery of the past (Cohen & Purcal 1989:2; Werner et al. 1997:15). Keleher and Murphy (2004) and Labonte (1992) describe such models as reductive and narrowly precise in focus. The focus of such models is on ‘the absence of disease, to be brought about by medical interventions based on modern science and technology’ (Asthana 1994:190-191).

There are many factors influencing health, stemming from the complexity of the social and environmental determinants of health. A determinant of health is a ‘factor or characteristic that brings about a change in health, either for the better or for the worse’ (Keleher & Murphy 2004:4). Population health is strongly influenced by the social and environmental determinants of health (Hawkes & Ruel 2006) and include: income, employment, access to food and social capital, and exposure to agents in air, water and soil (Marmot 2005).

Phillips (1990:150) asserts that PHC requires health care reform ‘not only in types of health care and their location but also in [the] attitudes of administrators, providers, educators and “receivers” who would become more actively involved not only in health but also in much wider tasks of [the] economic and physical level’. Primary Health Care involves people, rather than technologies (Bennett 1979). Health professionals require a new view of health and a new approach to solving health problems, such as the ‘social model of health’ in order to meet these complex needs (Johnson & Paton 2007:22). Such a model is underpinned by the concept of community development. It is more an inductive than a reductive process; it is much more holistic, and seeks explanatory relationships and ways of planning to address health problems (Labonte 1992). Johnson and Paton (2007) advocate that an holistic understanding of the determinants of health will enable health professionals to reduce health inequities.

Keleher and Murphy (2004) argue that population health is involved with the health improvement of the whole population, or of a specific population sub-group in order to reduce health inequalities. The population health approach is concerned with health and illness, interventions, and outcomes as they occur in the population and seeks to understand the social systems influencing them (Berkman & Kawachi 2000).

Johnson and Paton (2007:22) propose health services be reoriented to ‘change aspects of the social and environmental determinants of health that are promoting ill health, rather than continuing to focus on illness after it appears, or trying to get individuals to change their lifestyles and behaviours’. This proposal is one of the strategies to improve health outcomes for a population, which are different from those strategies designed to improve individual health problems. Such a strategy is related to the population health approach and can enhance the effectiveness of health promotion programmes (Baum 2002; Labonte 1992).

2.5.1 Principles and values of Primary Health Care

The Declaration of Alma-Ata 1978 (WHO 1978:para. 7) proposes a set of principles of PHC that it should:

- i) Reflect and evolve from the economic conditions and sociocultural and political characteristics of the country and its communities and be based on the application of the relevant results of social, biomedical and health services research and public health experience;
- ii) Address the main health problems in the community, providing promotional, preventative, curative, and rehabilitative services;
- iii) Involve, in addition to the health sector, all related sectors and aspects of national and community development; in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demand the coordinated efforts of all those sectors;
- iv) Require and promote maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develop through appropriate education the ability of communities to participate;
- v) Be sustained by integrated, functional and mutually-supportive referral systems, leading to the progressive improvement of comprehensive health for all, and giving priority to those most in need; and
- vi) Rely, at local and referral levels, on health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed, suitably trained – socially and technically – to work as a health team and to respond to the expressed health needs of the community.

In addition, a set of core activities of PHC is proposed that it should at least include:

- a) education concerning prevailing health problems and the methods of preventing and controlling them
- b) promotion of food supply and proper nutrition

- c) adequate supply of safe water and basic sanitation
- d) maternal and child health care, including family planning
- e) immunisation against the major infectious diseases and injuries
- f) provision of essential drugs.

The WHO's (2003b) global report reveals that there are differences in how PHC has been understood, defined and applied at individual country level. McMurray (2003) shows that most interpretations of PHC at Alma Ata incorporate five main principles:

- a) accessibility; b) appropriate methods; c) health promotion and prevention;
- d) community participation; and e) intersectoral collaboration.

a) Accessibility

Primary Health Care requires equal access to care for all people. The aim is to allow people to have a fair opportunity to attain their full health potential (Whitehead 1995). Health services should be physically, socially, and financially accessible to all, based on health need. People with similar needs should have equal access to similar health services. The distribution of resources and coverage of PHC services should be greatest in those areas with the most need.

b) Appropriate methods

Primary Health Care guides countries to develop and use technology in the most appropriate way for the health needs of the community. The technology used should be cost-effective and affordable for each country (Kekki 2006). Atun (2004) reports that a health system based on PHC gains more advantages than one based on specialist care. The advantages are: i) an improvement of population health; ii) higher patient satisfaction; iii) a reduction in aggregate health care; iv) increased cost-effectiveness; and v) improved access to care.

c) Health promotion and prevention

Primary Health Care suggests a comprehensive approach that is based on promotional, preventative, curative, and rehabilitative care. Promotional care addresses basic causes of ill health at the level of the community and the nation. Preventative care reduces the incidence of disease by addressing the immediate and underlying causes at the individual level. Curative care reduces the prevalence of disease by stopping the progress of disease

among the sick. Rehabilitative care reduces the long-term effects or complications of a health problem. McMurray (2003) argues that the PHC principle is to increase emphasis on health promotion. It is associated with ‘enabling the conditions for healthy choices and ensuring that support systems are available to help people achieve the level of health to which they aspire, prevention of ill health or injury, and successful rehabilitation from illness’ (McMurray 2003:40).

d) Community participation

Families and communities, rather than being only passive beneficiaries of development aid, need to get actively involved in taking care of their own health (Werner et al. 1997). The community should be involved in the definition of problems and the setting of priorities (McMurray 2003). They should have the freedom to be innovative in order to find solutions to their health problems, to have the opportunity of entering into dialogue with skilled health personnel and to be able to constantly review the implementation of PHC to ensure it functions according to its declared goals (Phillips 1990).

Rifkin (1985) views community health in relation to community participation as having three main approaches: i) medical; ii) health planning; and iii) community development. These reflect the attitudes of health practitioners and the community as to who should be doing what regarding health services provision and management and what forms of health services should be provided (Phillips 1990).

The medical approach regards health as the absence of disease which can be obtained through highly technological and scientifically advanced services. The community responds to the actions of, and directions provided by, medical professionals. This approach is based on the Western model of health care and emphasises the individual patient-doctor relationship (Cohen & Purcal 1989). Cohen and Purcal (1989) argue that this approach is problematic in relation to universal coverage, because it benefits only a very small group in the community.

The health planning approach considers health improvements can be obtained from the appropriate delivery of health services. This approach believes that effective planning will ensure access to proper care for the most needy.

The community development approach has its origin in the community development tradition (Rifkin 1985), which sees health in the broader context of improving living conditions and the environment. This approach is recognised as having a ‘bottom-up’ orientation. The philosophy of this approach is that health cannot be achieved only through health services or a well-planned, efficient and functional delivery system, rather, health is achieved through intersectoral collaboration and community participation. In Phillips’ (1990) view, the community development approach is underpinned by the holistic concept of PHC described by WHO (1978). This approach supports the view that the community can understand health as well as controlling health services and being responsible in their use (Rifkin 1985).

McMurray (2003:35) argues that the actual goal of PHC is ‘to build community capacity to achieve sustainable health and wellness’. Johnson and Paton (2007:33) add that one of the key goals of community participation is to reduce the ‘information asymmetry’, where health professionals view health from their own perspective without considering the community’s and patient’s perspectives.

Johnson and Paton (2007:30-33) propose that the ‘democratic approach’, which seeks to redistribute power from dominant structural interests to the repressed community, is central to the community participation component of PHC. This approach involves effecting change through collective and individual action. Atkinson et al. (2005) demonstrate that this approach has an impact on reconstructing the health system through bettering the health of the whole population. Full and more real participation by the community is achieved through true democratic means (Sennun et al. 2006).

Gawston and Barbour (2003) propose the concept of a partnership between patients, families and health care providers. This approach is defined by Johnson and Paton (2007:31) as a ‘partnership’ or ‘patient-centred’ approach and they show it is strongly aligned with PHC. The model aims to encourage sharing of information, responsibility, evaluation, and decision-making (Gawston & Barbour 2003).

Johnson and Parton (2007:31) point out that there are two levels of partnership: ‘individual relationships between practitioners and patients, and ... the involvement of the community and consumers of health services in health service planning, development and

evaluation'. They argue this approach fits in between the ideologies of the 'democratic approach' and the 'consumerist approach'. In addition, they warn that 'if a singular ideological approach dominates the community and consumer participation strategy within a health service, there will be limited benefits for the community, consumers and the health service' (Johnson & Paton 2007:33).

WHO (2000b:18) affirms that 'decentralisation of institutional responsibility and accountability in the health system coupled with capacity development of local services are the most important factors for the implementation of PHC'. There is evidence that in Benin community involvement in PHC helped reduce infant mortality rates, improve immunisation coverage, and increased access to antenatal care (WHO 2000a).

e) Intersectoral collaboration

Health services are seen to have sole responsibility for the public health care system with no links to other sectors and that they are focused on the individuals who present for care (Alberta Association of Registered Nurses 2003). However, PHC requires a co-ordinated effort with other health-related sectors whose activities have a great impact on health of the community, such as agriculture, animal husbandry, water and sanitation, transportation, and education. Intersectoral collaboration is required to achieve social and economic development of a population and improvement in its health. Johnson and Paton (2007:36) argue: 'there is no place in modern health policy for a compartmentalised view'. All health services, including hospitals, should be reoriented to address population health and work together with other sectors and communities in an integrated way to reduce health inequities (Johnson & Paton 2007).

WHO (2005a) emphasises the importance of intersectoral collaboration in regard to an integrated health policy in the *Bangkok Charter for Health Promotion*. During the past twenty years WHO has tried to promote intersectoral co-ordination at community level, but there are many constraints, such as tension between selective PHC and capacity-building approaches, reluctance to decentralise authority to local levels and improve the balance of resources between curative and promotive and preventive care activities, and weak capacities in health services research (WHO 2000b). WHO (2003b) suggests that an increased commitment by all sectors can be seen if the purpose of collaboration and the role of each stakeholder is clarified.

2.5.2 Selective Primary Health Care

The concept of selective PHC is different from that of PHC described in the *Alma Ata Declaration* (Banerji 1984; Phillips 1990; Werner et al. 1997). Walsh and Warren (1979) argue for a 'selective PHC' strategy which focuses on cost-effective medical interventions. They and their supporters contend that the form of comprehensive PHC described in the *Alma Ata Declaration* is too costly and unrealistic, especially for developing countries (Cueto 2004; Magnussen, Ehiri & Jolly 2004; Walsh & Warren 1979). Their perspective has influenced many countries, especially developing countries, to turn away from the original concept of PHC because of the scarcity of resources and the world economic crisis which led to sharply reduced funding donations (Cueto 2004; Magnussen, Ehiri & Jolly 2004).

Selective PHC explores specific causes of death, paying special attention to the most common diseases, such as diarrhoea and diseases produced by a lack of immunisation, of infants in developing countries (Walsh & Warren 1979). It initially focused on four vertical programmes: growth monitoring, oral rehydration therapy, breastfeeding, and immunisation (GOBI). Family planning, female education, and food supplementation (FFF) were added later. These interventions target only women of childbearing age (15–45) and children up to the age of five. Scholars contend that these narrow selection conditions for these population groups abandon the original focus of PHC, because they are only designed to improve health statistics not social equity and health systems development (Magnussen, Ehiri & Jolly 2004; Phillips 1990; Werner et al. 1997).

However, according to Evans, Hall and Warford (1981), selective PHC creates the right balance between scarcity and choice. It attracts the support of some donors, scholars, and agencies, such as UNICEF and the World Bank (Cueto 2004). Some scholars assert that most international agencies are interested in short-term technical programmes with clear budgets, rather than broadly defined health programmes (Rifkin, Muller & Bichmann 1988). In contrast, Unger and Killingsworth (1986) criticise selective PHC on the grounds that it lacks an empirical foundation.

Banerji (1984) asserts that, in practice, the results of selective PHC do not live up to expectations, with many key concepts of PHC stripped away by the selective PHC

approach (Werner et al. 1997). The broader meaning of health in terms of social and economic development, intersectoral collaboration and community participation disappear. Magnussen, Ehiri and Jolly (2004) add that there is little coordination among the vertical programmes in a selective PHC approach, leading to duplication and waste in the health services.

Werner et al. (1997) argue that selective PHC contradicts PHC philosophy, because it ignores the development and sustainability of health systems and infrastructures to improve population health. They argue most interventions are determined by external health experts and not by communities. Selective PHC 'adopts an authoritarian or paternalistic approach in "selecting" for others a number of limited vertical health programmes and leaves the other causes of ill-health untouched' (Banerji 1984:314-315). It is a narrow techno-centric approach that does not address the social causes of disease (Cueto 2004). Phillips (1990:161) argues the selective PHC approach is similar to 'primary medical care' which is disease-oriented. It is the reinvention of the vertical health programmes which depend on highly technological interventions and health professionals (Gish 1982). Sen and Koivusalo (1998) add that it is counterproductive. It fails to overcome the inequities inside poor countries (Werner et al. 1997). WHO (2003b) argues vertical health programmes can be effective only if they address the wider health needs of the community. Developing basic local infrastructure for PHC can diminish inappropriate referrals for diagnosis to higher levels of care (WHO 2003b).

In 1995, LaFond studied the implementation of PHC in less developed countries and found the selective PHC approach led to unsustainable PHC services provision for the health needs of the rural poor. These countries cannot integrate existing vertical health programmes or build the capacity of local health workers to manage current and new challenges to meet the health needs of the rural poor (LaFond 1995). The countries emphasised short-term goals. As a result, the selective PHC approach has an adverse impact on the health development process in these countries (Rifkin & Walt 1986). Newell (1988) adds that it is a counterrevolution and must be rejected. There is a need for an approach to PHC which is integrated and more organised and coordinated (van Oosterbos 2006).

WHO (2003b) affirms that the principles of PHC continue to be valid and calls all Member States to adopt PHC, as described in the *Alma Ata Declaration*, to meet the complex health needs of communities in the twenty-first century. Comprehensive PHC is affordable and deliverable in developing countries (Segal 1987).

2.5.3 Primary Health Care and Primary Care

Primary Health Care means different things to different people (Showstack, Rothman & Hassmiller 2003), and the definition of PHC varies even for countries in the same region, such as Europe (Boerma, Groenewegen & Van der Zee 1998). Each country interprets and adapts some aspects of primary health care to match with its own social, political, and developmental contexts (Atun 2004; WHO 2003b). According to McMurray (2003:34), ‘the terms primary health care and primary care are used interchangeably, and this occasionally causes confusion’. She points out that primary health care comprises both principles and strategies that will make people healthy by preventing illness, protect people from harm, and help people adjust to, or recover from, illness or disability (McMurray 2003). Furthermore, she defines primary care as initial intervention or the first line of care required by people when they need health care because of injury or illness (McMurray 2003).

The Alberta Association of Registered Nurses (2003:1) explains that primary care refers to the first contact through which people enter into the health system and that it is a core component of primary health care. However, McMurray (2003) argues that primary care extends to the primary management of a person’s condition.

Starfield (1998:11), in *Primary Care: Balancing Health Needs, Services, and Technology*, states: ‘the change required to convert conventional primary medical care in industrialized nations to a broader primary health care as defined at Alma-Ata ... [is essential]’. She also explains the terminology of primary care in her book is used to ‘connote conventional primary medical care striving to achieve the goals of primary health care’ (Starfield 1998:11). Starfield (1998) reveals four unique attributes of primary care – first contact care, ongoing care (longitudinality), comprehensive care and co-ordinated care. First contact care refers to care which is accessible at the time of need. Longitudinality is care focused on the long-term health of a person not on the short term

of a disease. Comprehensive care refers to the availability of a range of services at the primary care level for common health problems. Co-ordinated care means care which primary care providers provide by coordinating with other special health and social services providers through a referral system, when the patients need those services.

According to Atun (2004:16), many developing countries and countries in transition interpret PHC only as an essential set of health interventions which ‘... leads to equating primary care with selective vertical programmes’. WHO (2003b) reveals that developed and middle-income countries, which have resolved the problem of accessibility, tend to interpret PHC as a level of care, while countries with low resources perceive PHC as a system-wide strategy for development. Some scholars argue whether primary care is only one component of PHC (Atun 2004; Kekki 2006; McMurray 2003). For some, PHC consists of a broader approach and encompasses all the determinants of health (Keleher 2001; McMurray 2003). Primary Health Care is not just for poor and disadvantaged populations; the principles of PHC are relevant to all populations and communities (WHO 2003b).

2.5.4 Problems in the implementation of Primary Health Care

The WHO (2003b:17, 29-31) global report reveals that many countries cannot implement PHC completely nor achieve the expected results from the implementation of PHC because of the following problems:

1. a lack of political commitment and leadership and, as a result, insufficient continuity of policy
2. unrealistic initial objectives that are not being achieved
3. local PHC services are seen as inappropriate, and are bypassed by the communities they serve
4. a lack of integration between PHC and other parts of the health (and social care) system
5. PHC staff have the wrong skills, and are not motivated
6. an ineffective intersectoral approach has not been developed
7. PHC policies and models are not sustainable
8. community involvement is not working

9. inadequate resources and insufficient emphasis on sustainability
10. unrealistic expectations of PHC
11. insufficient evidence on which to base local policy
12. a lack of practical guidance on PHC implementation
13. failure to address the demands, as well as the needs, of populations.

Abdallah and Burnham (n.d.:8/7) suggest these causes for the failure in the implementation of PHC:

1. improper translation of PHC as a primary level of care (first level health care), which ignores the holistic and integrated nature of PHC
2. lack of supervision and training may result in poor quality services
3. inappropriate payment, such as prolonged delays in health worker salaries, may result in hostile attitudes towards patients
4. drugs may not be available at lower levels of PHC systems, therefore, patients bypass first-line health centres and go directly to hospitals
5. referral system may not be functioning well
6. different sectors may not be used to working together
7. community may not be willing to take responsibility for the health care system.

According to Kekki (2006), some of the problems in the implementation of PHC are: weak managerial capabilities at all levels of care; inappropriate human resources policies and planning leading to inequitable allocation of health professionals; unsatisfactory working conditions for health workers: low salaries, poor living conditions and inadequate career structures; and imprecise roles and responsibilities of stakeholders. For the last problem, there must be agreement on 'who supplies which treatment or gives which care and where, as well as who communicates with whom and who is responsible for the coordination' (van Oosterbos 2006:1).

LaFond (1995) reports that the failure to sustain primary health services for the poor in less developed countries is due to a dependence on international donor countries. The failure is the result of the donor countries' influence, which conflicts with national policy-making bodies in ways that are not useful to the recipient nations. In South-East Asian countries there is a lack of political commitment for the implementation of PHC and community participation is only rhetoric on the part of bureaucrats and politicians who use the community to bolster their positions (Cohen & Purcal 1989).

WHO (2003b) recommends countries that have been unsuccessful in the implementation of PHC need to understand why the implementation failed and plan remedial action to maintain the benefits of PHC for their people. These countries must strengthen PHC at both local and national levels to meet new challenges. Primary Health Care needs to be located in a new paradigm which addresses broader population health and the concerns of social justice, human rights and equity and these countries should prepare to respond to a population health crisis. Effective PHC models need to be adaptable to rapidly changing situations and be responsible for identified local health needs. Furthermore, capacity building approaches and vertical health programmes should be synergised for the overall health of the population. However, there is no 'blueprint' for the effective implementation of PHC (WHO 2003b:15). Each country requires its own specifications that fit with its economic, sociocultural, and political contexts (WHO 1978).

2.6 Primary Health Care in Thailand

2.6.1 Evolution of Primary Health Care in Thailand

Before 1978, development of health programmes in Thailand was based on the Western bio-medical model, which emphasised top-down, vertical health programmes, producing specialist health professionals to serve the urban community (Bureau of Policy and Strategy 2007; Phoolcharoen 2005). As a result, there was a severe lack of health professionals and health resources in rural areas. The government launched a 15-year project to extend sophisticated health facilities to rural areas by establishing district hospitals (community hospitals) in all districts (Bureau of Policy and Strategy 2007)⁴. Despite the extension of such facilities, the health needs of people were still not met and people perceived the quality of health care provided by the public health facilities as being poorer than care at larger centres and even more so than at private facilities. Thailand needed to rethink and reorient its health development policy and strategy to be more comprehensive, as is the nature of PHC (Phoolcharoen 2005).

⁴ The community hospitals had a very important role in developing primary health care in the early 1980s. Then, the health centres took a more active role in implementing primary health care in the 1990s. The academics involved in medical education also supported the primary health care initiative in Thailand by redefining the medical curriculum to encourage medical students to play an active role as facilitators of PHC. More details of the evolution of PHC in relation to the development of community hospitals are presented in Section 2.7.

Thailand adopted the PHC concept and the WHO goal of 'Health for All by the Year 2000' and incorporated them into the *4th National Social and Economic Development Plan (1977–1981)*, after the declaration of the concept of PHC at Alma Ata in 1978 (Bureau of Policy and Strategy 2007). The Thai for PHC is '*Garn Sa-tha-ra-na Sook Mool Than*' (a foundation of public health) (Health Care Reform Project Office 2001). According to the Bureau of Policy and Strategy, MoPH (2007), PHC is used as a main strategy to promote health for all Thais. There are four aspects: community involvement; health system reorientation; intersectoral collaboration; and appropriate technology (Nitayarumphong 1990). Ramasoota (1997) adds that self-reliance is another principle used for the implementation of PHC in Thailand.

Thailand implemented PHC using two different approaches – medical and community development (Bureau of Policy and Strategy 2007:43). Both of these emphasised extending basic health services to the community. They aimed to encourage people to use health services at local health centres and district hospitals, rather than going directly to the provincial or upper-level hospitals.

The first approach involved implementing a set of activities suggested by *the Declaration of Alma Ata*, and delivered by health workers at health centres or rural health facilities (Bureau of Policy and Strategy 2007; Pawabutr 1994). The government made health centres the front-line health services to cover all sub-districts when it launched the *Decade for Health Centre Development Project (1992–2001)* (Wibulpolprasert et al. 1996). The government also provided more health professionals, such as medical doctors and nurses, to provide care to rural people at the district hospitals (Pachanee & Wibulpolprasert 2006), and health workers (or public health officers) to provide care at the health centres (Phoolcharoen 2005).

In 1964, the government launched a pilot project to reorient medical education towards community health at Chiang Mai University, located in the capital city of the Northern region of Thailand (Bureau of Policy and Strategy 2007:44). This project aimed to change the attitudes of medical graduates towards serving rural communities. Also, villagers were able to study midwifery and sanitation on the condition that they returned to work at the health centres and serve their communities. The government reviewed this approach and found that there was a lower rate of acceptance for services provided by these

community graduates (Bureau of Policy and Strategy 2007). It was hypothesised that this was due to a lack of community participation in the planning and people's understanding of available services (Bureau of Policy and Strategy 2007). As a result, a second approach was proposed.

The second approach dealt with community participation; local resources can be mobilised to ensure the accessibility of health care for underserved people and the services can be maintained by the community (Bureau of Policy and Strategy 2007). Health volunteers are critical to achieve 'Health for All' (Jongudomsook 2004). There were two groups of health volunteers: Village Health Volunteers (VHV) and Village Health Communicators (VHC). Initially, the first group was trained to undertake simple health services, including treatment of minor illnesses, health promotion and disease prevention (Bureau of Policy and Strategy 2007). One VHV was expected to be responsible for one village (Jongudomsook 2005:14). In addition, VHVs were senior to the VHCs (Pawabutr 1994), with each VHV responsible for ten VHCs (Bureau of Policy and Strategy 2007:48). The VHCs were responsible for disseminating health information, provided by the government, about health education, epidemics and communicable diseases (Bureau of Policy and Strategy 2007). Each VHC was expected to be responsible for ten to fifteen families (Jongudomsook 2005:14).

One year after the implementation of this initiative, the rate of acceptance of public health services had increased (Bureau of Policy and Strategy 2007). It was found, however, that the expected roles of health volunteers were not achieved and many VHCs were inactive and lost from the system (Hongvivatana et al. 1987). As a result, after 1993, the MoPH decided to upgrade all VHCs to VHVs (Bureau of Policy and Strategy 2007:48) and established the 'National Association of Village Health Volunteers'. The Ministry provided funding to support the VHVs' activities and so enhance the professional capacity of the health volunteers (Jongudomsook 2005:14). In 2002, there were 758 538 VHVs (Bureau of Policy and Strategy 2007:48).

The Ministry funding provided medicines for every village; it was later changed to a multi-purpose fund with a broader health development objective (Jongudomsook 2005), with the aim to enable people to participate in the health of their own communities. However, there were serious problems regarding the sustainability of this fund, especially

when the government withdrew its support. From 1986, the MoPH solved this by allocating annual funding to each village (Jongudomsook 2005:14). This funding was expected to be managed by the community to serve their health needs with the support of health officials, but it was later revealed that most of the funding was used for activities directed by health officials (Leerapun, Siwiroj & Termsirikulchai 2000). Since 2004, this annual health funding has been transferred to VHVs through local governments, rather than through agencies of the MoPH (Supradit 2001:71). The government has increased annual funding since 2005 to 10 000 baht per year per village (Nakhorn Ratchasima Provincial Health Office 2007:26).

Another initiative was the 'Basic Minimum Need' (BMN) approach, developed in 1982 (Pawabutr 1994). It provided objective indicators for quantifiable and tangible health outcomes (Ramasoota 1997). This approach was underpinned by intersectoral collaboration and promoted bottom-up planning from grassroots levels (Bureau of Policy and Strategy 2007). Community leaders were trained in assessing community needs (basic minimum needs) with the support and collaboration of officials from government agencies responsible for rural community development — the Ministry of Public Health, the Ministry of Education, the Ministry of Agriculture and the Ministry of Interior (Bureau of Policy and Strategy 2007). In the Nakhorn Ratchasima Province, this project is implemented as the 'Sustainable Health for All' programme (Nakhorn Ratchasima Provincial Health Office 2006a).

Community Primary Health Care Centres (CPHCCs) or Primary Health Care Centres operated by Villagers (PHCCVs) were established in every village. The VHVs run these centres. In 1998, there were 67 682 CPHCCs established nationwide (Jongudomsook 2005:14). Wibulpolprasert (2005:278) reports that in 2003 there were 66 223 CPHCCs registered in rural areas and 3108 CPHCCs registered in urban areas. However, the report of Leerapun, Siwiroj and Termsirikulchai (2000) shows that the public were reluctant to use these centres.

Thailand also adopted five health promotion areas that were identified by the Charter of Health Promotion in Ottawa 1986 (Jongudomsook 2004). They are: building a healthy public health policy; creating supportive environments; developing personal skills; strengthening community action; and reorienting health services (World Health

Organization-Health and Welfare Canada-CPHA 1986). Thailand emphasised the development of a healthy public health policy, which led to legislative measures against tobacco and alcohol consumption (Bureau of Policy and Strategy 2007). At present, the government has increased resources for health promotion, emphasising the promotion of healthy behaviour and life styles (Bureau of Policy and Strategy 2007). Most scholars support that health promotion should be underpinned by the principles of PHC (Johnson & Paton 2007; McMurray 2003; World Health Organization-Health and Welfare Canada-CPHA 1986).

In 2001, the Thaksin Government launched the UHC policy which focuses on providing an equitable universal health insurance coverage for the whole population (Hughes & Leethongdee 2007:1001). Primary health services have been promoted for eligible populations which receive care through primary care units or health centres. Thai primary care emphasises quality first contact care provided at primary care units or health centres by health professionals, preferably general practitioners (Boonyapaisarncharoen & Pongsupap 2005). The MoPH suggests that the philosophy of PHC, as defined in *the Alma Ata Declaration 1978*, must be incorporated in the provision of such services and health promotion should be encouraged (Health Care Reform Project Office 2001). The key concepts of primary care are: community self-reliance; holistic care; continuity; equality; and community involvement (Health Care Reform Project Office 2001). The contractual relationship and the standards for a contracting unit were laid down in the MoPH's manual — *Primary care: 'Close-to-home, close-to-heart' health services* (Health Care Reform Project Office 2001).

In 2003, the MoPH initiated a major strategy, 'Healthy Thailand', to reduce behavioural health risks and major health problems in Thailand (Bureau of Policy and Strategy 2007:53). This strategy emphasised health promotion. In 2004, the MoPH determined targets for this programme: exercise; diet; emotional development; disease reduction; and environmental health (Bureau of Policy and Strategy 2007:54). This strategy aims to achieve the global targets of the Millennium Development Goals (MDGs) by 2015 (Bureau of Policy and Strategy 2007:55). There are eight goals, of which six are related to health (WHO 2003a):

- Goal 1: Eradicate extreme poverty and hunger
- Goal 2: Achieve universal primary education

- Goal 3: Promote gender equality and empower women
- Goal 4: Reduce child mortality
- Goal 5: Improve maternal health
- Goal 6: Combat HIV/AIDS, Malaria and other diseases
- Goal 7: Ensure environmental sustainability
- Goal 8: Develop a global partnership for development.

According to the Bureau of Policy and Strategy, MoPH (2007:55), Thailand meets some of these targets, such as the decline in infant and maternal mortality. The government is furthering development by setting a higher standard called the MDG+ targets. The current (interim) government aims to improve the quality of life of the poor. Despite the fact that Thailand has achieved remarkable progress, some groups, such as aged people living in remote areas, do not receive benefits from the government's programmes (Bureau of Policy and Strategy 2007).

Kekki (2006) warns that the problems with the implementation of the MDG targets will be similar to those of the vertical programmes, unless local PHC infrastructure is developed and strengthened. He adds that 'ownership of the MDG targets must also be addressed, not only by governments but also by civil society and health care providers. To achieve the MDGs requires integrated approaches to service delivery' (Kekki 2006:15). WHO (2003b) suggests that the expectation of achieving the MDGs is unrealistic if the health system is not driven by PHC principles.

2.6.2 Problems with the implementation of Primary Health Care in Thailand (before the implementation of the Universal Health Coverage policy)

Despite the fact that Thailand has achieved excellent outcomes from implementing PHC, such as a remarkable reduction in maternal and infant mortality rates and communicable diseases and the increase in coverage concerning family planning, sanitation and nutrition, more improvements are needed to meet the social, economic and political changes, emerging health problems and the more complex health needs of the twenty-first

century (Ramasoota 1997). Some problems/challenges of the implementation of PHC in Thailand for the last two decades are:

a) Philosophy of Primary Health Care

Ramasoota (1997:3) argues that the philosophy of PHC, regarding equity of access to care and giving priority to the most needy, was not recognised by Thai health professionals and managers. In addition, health workers did not understand decentralisation in the implementation of the programme and its concept of PHC (Supradit 2001:63).

b) Misinterpretation of Primary Health Care

As discussed earlier, the meaning of PHC has different interpretations in different countries and it is often confused with primary care (Cueto 2004; Health Care Reform Project Office 2001). In Thailand, health officers perceive PHC as the health activities prescribed by the MoPH for communities or VHVs. The implementation of PHC by the MoPH and its agencies has been on prescriptive activities, rather than goals and this may explain the confusion (Health Care Reform Project Office 2001). Health workers and VHVs did not understand the principles of PHC as proposed by WHO (1978).

Thailand interprets primary care as ‘primary medical care’ or first contact care provided by health officers at health centres and out-patient departments of the community hospitals (Health Care Reform Project Office 2001; Taearuck 2000). Cueto (2004:1871) suggests that such an interpretation limits PHC to being ‘an addition to pre-existing medical services, a first medical contact, an extension of health services to rural areas, or a package of selective primary health care interventions’.

The MoPH in Thailand does not have clear practical guidelines for health officers at the ‘primary medical care’ level on how to organise health services by incorporating the principles of PHC (Health Care Reform Project Office 2001). Rather, the MoPH only prescribes that those health officers deliver a set of health activities suggested in the *Declaration of Alma Ata 1978* (Wibulpolprasert et al. 1996). As a result, the principles of PHC are not understood correctly and cannot be implemented in any practical fashion (Health Care Reform Project Office 2001).

Furthermore, Ramasoota (1997) explores people’s belief that care provided at local health centres is of lower quality than that provided at a primary medical level at the community

hospitals, because workers at the health centres are of lesser standing than those working at the hospitals. Frenk (1990) contends that primary health care should not be considered as second-quality care, simplified technology, or poor health care for the poor. The Health Care Reform Project Office, MoPH (2001), recommends that Thailand should reorganise its health services to fit with the principles of PHC.

c) Bureaucratic management style

Ramasoota (1997) reports that the lack of political commitment and lack of continuity of support for PHC by the MoPH has affected the implementation of PHC in a negative manner:

PHC had to be sustained through the personal interest of the incumbent Permanent Secretary of MoPH. If the Permanent Secretary's background was not in preventive medicine, PHC activities showed a tendency to slow down.

(Ramasoota 1997:3)

Leerapun, Siwiroj and Termsirikulchai (2000:71) describe the centralised bureaucratic management style of the MoPH as a barrier to the successful implementation of PHC. They reveal that the way the MoPH implemented PHC activities and designed the structure of PHC for communities were very rigid with only a single, fixed model for all communities. Ramasoota (1997:3-4) argues: 'the MoPH ... manipulated and directed a top-down approach to control the community through PHC'. The opportunity for the community to be able to learn, undertake innovations and initiate the prescribed health programmes is limited. However, Parker, Walsh and Coon (1976) warn that the community and its learning process is usually diverse and complex; it is too idealistic to expect bottom-up community health efforts and those of enlightened experts will expand the political power of the rural community in an easy way (Parker, Walsh & Coon 1976). Supradit (2001:82) argues that the MoPH should establish a broad policy, rather than prescribe the community's activities, so that the community has an opportunity to initiate its own activities which meet its needs.

In addition, the rigidity of Thai bureaucracy inhibits the successful implementation of PHC at the sub-district and village levels. This is evident in the annual health funding for the community, which was limited to only three activities; other health activity needs of the community could not be paid for because of the government's rigid financial regulations (Supradit 2001:64).

Moreover, Ramasoota (1997:4) states: 'VHVs were abused and exploited by the MoPH administrators. They were used as an extension of the community to bargain with politicians for power'. In some situations, this has led to accusations of corruption (Leerapun, Siwiroj & Termsirikulchai 2000). To prevent these problems, Ramasoota (1997) proposes that strong political commitment is needed at all levels but management must be decentralised. Cohen (1989:160) asserts that the emergence of PHC was a challenge to bureaucratic power.

d) Health services and health professionals

Ramasoota (1997) points out that the misinterpretation of PHC principles has led to a lack of an integration of health services provided by VHVS at PHCCVs. The national health system and PHC activities are not aligned with the socioeconomic development of the community (Ramasoota 1997:3).

There is a problem for health services at the primary medical care level, because, even though the government has expanded the primary health care infrastructure to cover all areas, especially those at sub-district and district levels, patients tend to bypass health centres and go directly to the community hospitals or upper-level hospitals. They perceive the latter offers a better quality of care (Jongudomsook 2005; Nitayarumphong 1990; Pongsupap 1999).

Taearak (2000) points out services were duplicated at health centres and the OPDs of the community hospitals. He argues that this may be due to the dual role of community hospitals as primary care providers and as first referral centres. People regard the quality of care at hospitals to be higher than that at health centres, because there are more qualified health professionals who can provide sophisticated high-technology interventions (Pongsupap 1999). Cohen (1989:160) argues the power of the Thai medical profession arises from its 'capitalist expansion' and 'the assumption that "scientific medicine"' is superior.

Even health workers are trained in the bio-medical mode and often encourage people to attend health facilities even when they are only slightly ill (Ramasoota 1997). As a result, there is overcrowding of patients at the community hospitals so that the care provided at hospitals is ineffective and inefficient (Taearak 2000; Wibulpolprasert et al. 1996).

Physicians have to see many patients within a very limited time, as they are obliged to provide care for all patients, including those who do not really need to see a doctor. The danger is that some patients who are the most needy may not receive appropriate care (Taearuck 2000). Another danger is that the specific role of community hospitals as first referral centres is undermined (Pongsupap 1999). The government has implemented the UHC policy in an attempt to strengthen the capacity of the primary care system, by improving the quality of medical services at health centres and upgrading health centres to be primary care units (Wibulpolprasert 2005).

In addition, Boonyapaisarncharoen and Pongsupap (2005) point out there is shortage of qualified primary health professionals, especially family doctors. The existing primary care professionals are trained in the bio-medical model and very few have adequate skills to deal with the social context of health (Jongudomsook 2004).

e) Community participation

Even though the government sends annual health funding (10 000 baht) directly to VHVs, the activities of the VHVs are set up and directed by workers at health centres and not on the initiative of the VHVs or based on community needs (Supradit 2001:63). Those activities are prescribed by the MoPH (Supradit 2001:71). Supradit (2001:64) asserts: ‘the government sector did not allow people to think and make their own decision on solving health problems by themselves freely’.

Cohen and Purcal (1989:11) report that community participation in South-East Asian countries, including Thailand, is operationalised in such a way that it focuses on ‘compliance with government notions and plan of development accompanied by incorporation of villagers as “participants” in state-controlled institutions’. Community participation seems to be only code for health officers to use the community as a means to deliver services in a top-down, vertical structure, because this is seen as more efficient (Asthana 1994; Cohen & Purcal 1989; Leerapun, Siwiroj & Termsirikulchai 2000).

In her report, Supradit (2001:64) found that heads of village and local government (Tambon Administrative Organisations) did not understand PHC principles and activities and there was a lack of support from them. In addition, Ramasoota (1997:4) found that the communities did not understand the purpose of community development due to the

government's unclear approach. Supradit's (2000:4) study shows health administrators have a negative view of the ability of VHVs and local government; they are not strong enough and can not rely on themselves regarding health care. She argues communities lack skills in the assessment of health programmes (Supradit 2001:64). Furthermore, their leadership is not sophisticated enough (Ramasoota 1997:3). Supradit (2000:4-5) asserts that the goal of community self-reliance has not been achieved since the VHVs and communities do not participate in health activities, concerning problem identification, planning and implementation, as well as monitoring and evaluating health programmes, proactively and fully. A part of this failure may be due to a lack of knowledge and skills in community development and community participation on the part of VHVs and a lack of financial incentive for them to do so (Ramasoota 1997:3).

Supradit (2001:82) suggests that health officials should adjust their attitudes and roles to facilitate true community participation, rather than being a controller or a 'headmaster'. The controlling role of health officials prompts communities to be passive and dependent recipients of health services (Gawston & Barbour 2003). Ife (1995) argues that the community is viewed less holistically which results in the maintenance of the existing hierarchy and its structural inequalities. Evans, Han and Madison (2006:186) point out:

Decentralised decision making will have far greater potential within the concept of community where people interact with each other in a variety of roles and as whole people, where people are encouraged to contribute their full range of talents and abilities for the benefit of the entire community.

2.7 The community hospital

The community hospital (CH) is a secondary care facility of the MoPH and provides medical and comprehensive health services in rural areas at the district level (Chokevivat 2001). As the front line health facility for Thailand's rural health service, the CH is responsible for the rejuvenation of health services in rural areas in which half of the Thai population (i.e. approximately 44 million people) reside (Bureau of Policy and Strategy 2007:19-20). It is also the most peripheral health facility, which has at least one medical doctor (Supawong & Kadgarnglai 1998; Wibulpolprasert 2005), servicing disadvantaged people beset by the complex arrays of health problems of a transitional country. The problems are: i) communicable diseases which are typical of developing countries; ii) non-communicable diseases which are typical of developed countries; and iii) global

diseases which are typical of contemporary transitional countries (Bureau of Policy and Strategy 2007; WHO Thailand 2007). World economic expansion has increased the expense of patented drugs and medical technology (Wibulpolprasert 2005).

2.7.1 Evolution of the Thai community hospital

In order to understand the Thai CH a review of its history is provided to set the context. In 1886, King Rama V initiated the development of the first modern hospital in Thailand, which was established in 1888 as the 'Siriraj hospital' in Bangkok (Chokevivat 2002:53). Patients could receive medical services and medication without payment as a contribution proposed by the King to his citizens, but the hospital accepted donations or medical fees from the rich and others who were able to pay (Thai Royal Medical Association under the Patronage of the King 2000:20). Since then, many modern hospitals were established, but all were in Bangkok. In response to the very high infant mortality rate (400 per 1000 live births), the Minister of Interior, Somdej Krompraya Dumrong Rachanupab, who was responsible for national health, established district level medical depots (*O-Sot-Sa-La*) in 1913 (Chokevivat 1980:11). The 'medical depot' comprised a clinic and pharmacy, as well as a residential area for the doctor. There was one chemist's house in each town. Public doctors, namely 'Royal Doctors' (*Mor-Luang*), were appointed to be the managers of the medical depots (Chokevivat 1980:11); these doctors provided free medication and services for underprivileged patients but relied on donations from the community to do so. The Government supplied medicine to the doctors at cost price. They could add a surcharge to the medicine. The doctors' public responsibility was to look after the health of civil servants and prisoners. Private patients could receive free medical services from 9.00 am until 12.00 noon (Chokevivat 1980:11).

Chokevivat (2002) points out that Chaopraya Surasrivisissak, the Governor of Phitsanuloke Province, proposed the appointment of traditional healers as doctors at sub-district (Tambon) level. The sub-district comprised ten villages of ten houses each. The chief of sub-district proposed the best local traditional healer in its community to the government who appointed him as the doctor of the sub-district. Since then, there have been both Royal doctors in towns and local traditional doctors in the sub-districts outside the towns.

The medical depot is the origin of the community hospital (Chokevivat 1980:11). In 1932, the name was changed to 'health house' (Chokevivat 1980:11). There were two types of health houses. A medical doctor worked at the 'first-class health house'. The 'second-class health house' had no medical doctor, but did have a nurse or health officer. They were renamed 'first-class health stations' and 'second-class health stations' in 1952 (Chokevivat 1980:12). In 1972, the first class health station was renamed 'the medical and rural health centre' (Chokevivat 1980:12), and in 1974 'the medical and health centre' (Chokevivat 1980:12). The government in 1975 upgraded this centre to be 'the district hospital' (Chokevivat 1980:12). Finally, in 1982, the district hospital was renamed 'the community hospital' and its structure and human resources were reorganised to accord with its broader responsibilities (Chokevivat 1980:12).

According to Chokevivat (2002:69), provincial hospitals were established in 1934, because the government wanted to expand health infrastructure to large towns outside Bangkok. Politically, this first group of hospitals was established in the provinces near the border of the country to show neighbouring countries, which had been colonised, that Thailand had never been colonised.

According to Supawong and Kadgarnglai (1998:43-44), the CH has been upgraded from being a health centre, because the government planned to expand health services to rural and remote areas as one of its rural development strategies in 1974 (*4th National Economic and Social Development Plan (1977–1981)*). Following the *5th National Economic and Social Development Plan (1982–1986)*, the government adopted a policy of establishing community hospitals in all districts. Then, the government developed its ten-year plan of health centre development (1990 to 2000) to expand health facilities to all sub-district levels (Chokevivat 2002:70). Nurses and other health professionals, but not medical doctors, were to work in these health centres.

After 1977, Thailand adopted the primary health care strategy from the World Health Organisation (WHO) which had the goal of 'Health for All by the Year 2000' (Bureau of Policy and Strategy 2005:5). Consequently, health professionals had two roles: health care provider and community facilitator for health (Supawong & Kadgarnglai 1998). Health officers at health centres facilitate community self-care. However, their lack of competency in this public health role, as well as the number of health professionals at

such centres, makes it difficult to provide health for all (Chokevivat 2002; Supawong & Kadgarnglai 1998).

The CH provides bio-medical curative care for people in the community. The services are entirely in the hospital, including out-patient and in-patient services. The community health services are delivered through health centres under the management of the Chief of District Health Office. However, the CH has to work collaboratively with these organisations to meet the health needs of the people.

The tendency of most patients to bypass health centres for hospital medical care has made out-patient facilities overcrowded. Relatives accompanying patients to hospital consultations are the norm in Thai culture, resulting in higher expenses for both hospital and patients. Before 2001, the poor had a low-income scheme they could use for free medical services and prescriptions (Suraratdecha, Saithanu & Tangcharoensathien 2005), however, the budget was not enough to provide care to the poor (Chokevivat 2001). The CHD had to ask for more resources through donations from the community or rich people. Some hospitals shifted costs from either walk-in paying patients or other higher-paid-scheme patients to subsidise the poor and those patients who are unable to pay (Watcharanugoolgeart 2004).

Before the UHC Policy, the problems facing the CHs were: shortage of health resources, such as medical doctors, nurses and other health professionals; under-funding and out-of-date medical technology and clinical practices; lack of community orientation; a very high turnover of health professionals, particularly doctors; and a severe clinical overload (Chokevivat 2002; Jongudomsook 2005; Phoolcharoen 2005; Wibulpolprasert 2005). Table 2.10 shows that the workload of rural doctors in CHs is much heavier to those who work in other settings.

The Thai district health systems are characterised by a medical orientation, with no or little attempt being made to develop mechanisms that take into account the important contribution other sectors can make to health (Eawsriwong 2002). Health workers were, and still are, being trained in sophisticated, expensive and institutional patient care (Phoolcharoen 2005). In most cases, they have too little orientation towards, and too little interest in, the health issues in their communities. Most health problems are present in

those communities and not in hospitals and clinics. Schwartz and Tumblin (2002:1422) point out that ‘most physician administrators, through a combination of ignorance, inertia, and intransigence, remain rooted in the command-and-control bureaucratic structure’.

Table 2.10: Workloads of doctors in Thailand, 2002

Health facilities	(1)No. of OPs	(2)No. of IPs	(3)IPs adjusted*	Total workload (1) + (3)	No. of doctors	Workloads/doctor	Comparison index
Community hospitals	17 831 867	3 305 860	46 282 040	64 113 907	2732	23 467.8	2.2
Regional/General hospitals	5 823 778	2 605 672	46 902 096	52 725 874	4619	11 415.0	1.1
University hospitals	934 774	303 866	5 469 588	6 404 362	2576	2486.2	0.2
BMA hospitals	430 098	81 267	1 462 806	1 892 904	543	3486.0	0.3
Private hospitals	4 025 727	1 535 831	21 501 634	25 527 361	3572	7146.5	0.7
Total	26 046 244	7 832 496	112 618 164	150 664 408	14 042	10 729.6	1.0

Source: Wibulpolprasert (2005:254). BMA = Bangkok Metropolitan Administration; IPs = In-patients; No. = number; OPs = Out-patients.

Note: * In order to generate the same outputs, in-patients in each hospital category are adjusted as follows:

1) Adjustment of community and private hospitals = In-patient (IP) x 14

2) Adjustment of regional/general hospitals, university hospitals and BMA hospitals = IPx18

According to the new mandate and structure of the MoPH in 2003 (Ministry of Public Health 2003:4, 7), the CH is being transformed into a public organisation under the supervision of the MoPH through the PCMO at the Provincial Health Office (PHO). The CH’s organisational structure, which is determined by the MoPH, is shown in Figure 2.2. It is intended to be a flattened hierarchical structure. Due to the unclear direction of government policy regarding health decentralisation, it is still problematic whether the CHs will belong to local government or be a public autonomous organisation under the supervision of the MoPH (Nakhorn Ratchasima Provincial Health Office 2007).

In Figure 2.2, the non-service and service activities are clearly displayed. The CH offers both individual medical care for patients and community health services. The latter provide primary care services in the hospital and collaborate with health centres in the community in delivering those services.

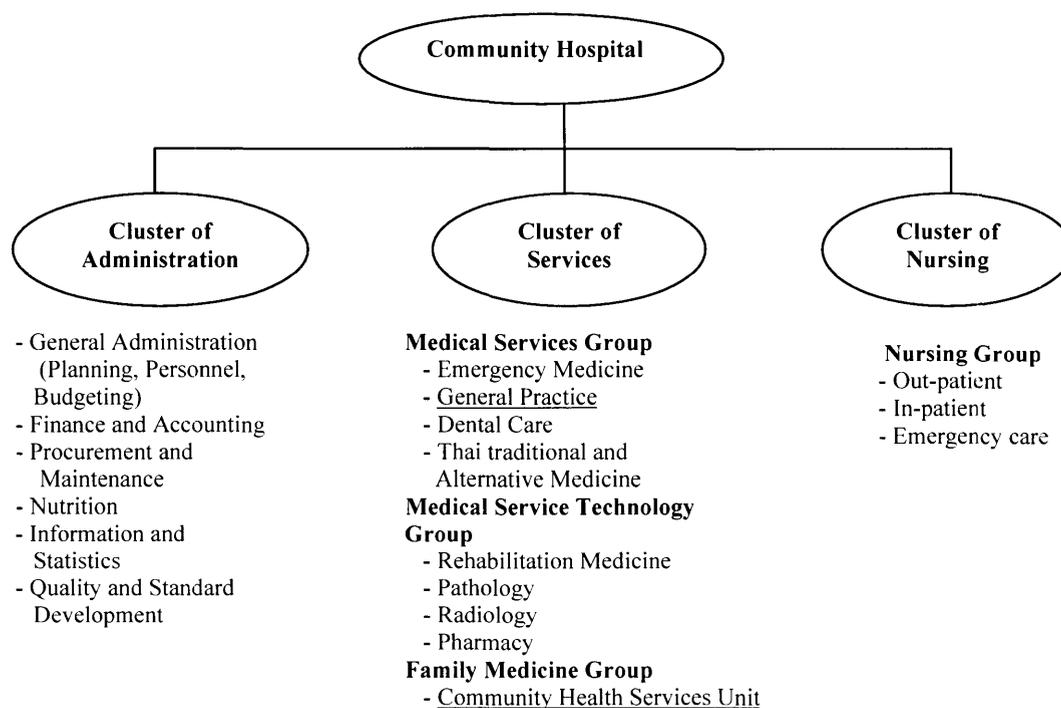


Figure 2.2: The organisational structure of the Thai community hospital, 2003

Source: Ministry of Public Health (2003:7).

The number of beds in CHs varies from 10 to 150; the most common totals are 30 and 60 beds (Wibulpolprasert 2005:288). The report of the Bureau of Policy and Strategy, MoPH (2004:1-4), reveals that in 2004, the number of beds in CHs were 31 462 which were 36% of total hospital beds. The number of CHs comprised 83% of the total of the MoPH's hospitals and 57% of all hospitals in Thailand. The statistics were shown in Tables 2.2, 2.3 and 2.4. Table 2.11 presents the statistics of the number of doctors, beds and community hospitals in 2001 and 2003. These show an increase in the number of beds and doctors at CHs. Pachanee and Wibulpolprasert (2006:314) show that the increase in the number of the doctors at CHs was due to the government's response to increasing demand in the mid-1990s. This was done by increasing the numbers of basic doctors trained by 600 per year during 1993–1995. In spite of this, Pachanee and Wibulpolprasert (2006) argue there is still a doctor shortage in rural and remote areas, because there is a high resignation rate of doctors to continue their studies or work at private hospitals in big cities.

Table 2.11: Number of doctors, beds and community hospitals in 2001–2003

Year	Number of community hospitals							Number of beds	Number of doctors	Doctor/bed ratio	Doctors per CH
	10-bed	30-bed	60-bed	90-bed	120-bed	150-bed	Total				
2001	83	410	148	59	18	2	720	29 780	2725	1:10.9	3.8
2002	83	415	148	59	18	2	725	29 930	3785	1:8.0	5.2
2003	83	415	148	59	18	2	725	29 930	4084	1:7.3	5.6

Source: Adapted from Wibulpolprasert (2005:288). CH = Community Hospital.

For the CH to provide curative and preventive services, there has to be collaboration ‘up the line’ to policy makers, that is the MoPH and the NHSO situated in Bangkok and the Provincial Chief Medical Officer (PCMO) at the provincial health office; and ‘down the line’ to medical and health professionals in the CHs and other community facilities, community leaders, infrastructure developers and end-users. The CHs have to collaborate with other organisations, such as the Office of the Chief of the District, District Health Office (DHO), Health Centres (HCs) and local government at district (Municipality) and sub-district (Tambon Administration Organisation or Department of Local Government) levels. The district health services are loosely organised through the District Health Coordinating Committee (DHCC), mostly chaired by CHDs; the Chiefs of District Health Office (CDHO) are the deputy chairs. The members of this committee include representatives from CHs, DHOs, and HCs. There are also local governments and community representatives included in such committees, but that is very rare. Figure 2.3 shows the complexity of the Thai health system at provincial and district level. It also shows the important stakeholders in the provincial and district health systems.

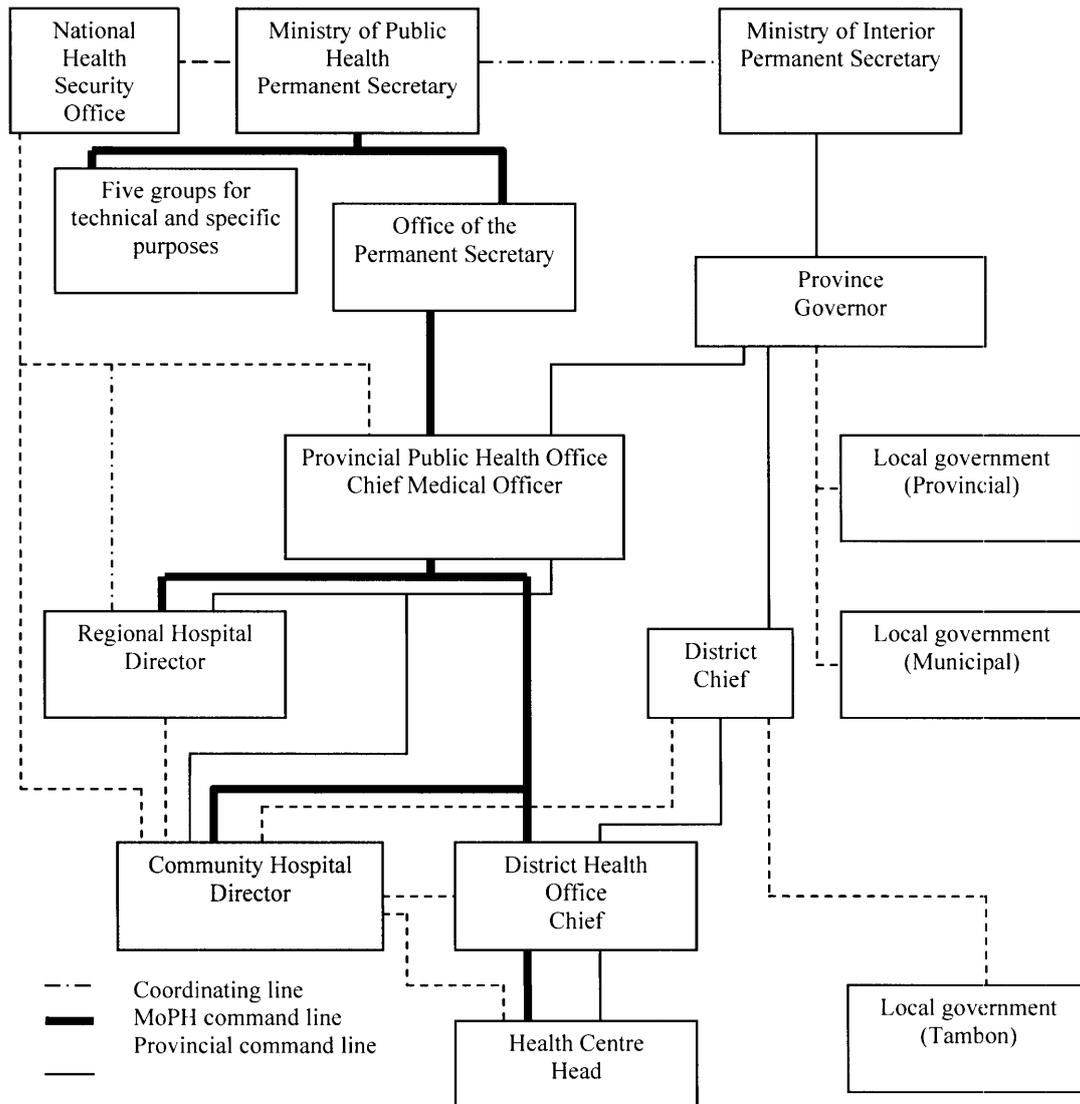


Figure 2.3: Provincial health administration structure, 2007

Source: Adapted from Ministry of Public Health (2003); Nakhorn Ratchasima Provincial Health Office (2007); Wibulpolprasert (2005).

2.7.2 Management of the community hospital

The CHDs in rural areas are appointed on the basis of seniority, rather than on their ability to lead health teams and solve community health problems (Hasuwankij 2004).

There are two tiers of health managers servicing the community: in the community hospital, the director is a medical graduate; the chief of the district health is more often a public health graduate (Supawong & Kadgarnglai 1998). The doctors have greater prestige and patients gravitate towards hospitals. These directors have a limited capacity

concerning public health, health prevention programmes and health infrastructure, so the community suffers (Chokevivat 1980).

Hasuwankij (2004) contends that the directors of rural community hospitals have never been formally trained in management, but learn by trial and error. University and medical school training is about treating individual patients with bio-medical technology in an urban context and this is inadequate for administrative work in rural areas and meeting local health needs which are highly complex. The populations are typically diverse and vulnerable (Phoolcharoen 2005). Some of the skills required are: communication, financial management, and public health and human resource management (Hasuwankij 2004).

The support for a management career path for the CHDs is subordinated to the medical career path. Medical doctors working in a community hospital can be promoted to level 9⁵ as health professionals (Pachanee & Wibulpolprasert 2006). However, there are few positions available at that level across the nation. CHDs can be promoted to be level 8 only. If a CHD wants to move to work at another CH and there is no available CHD position for them, then they may have to drop to level 7 in order to be able to apply for available positions. There may be meetings at the provincial health level to rotate CHDs for each district in the province, but only if the CHDs agree to move.

The management of community hospitals is made more difficult by the centralisation of decision-making within the MoPH. Hasuwankij (2004) points out that the national health programmes ordered by the central Ministry are not relevant to health needs at the local community level. Health programmes normally are planned centrally and implemented locally (Jongudomsook 2005). Planning and managing financial resources are also controlled by the MoPH (Hughes & Leethongdee 2007). There is often an inequality in budget arrangements for rural areas compared to urban areas (Wibulpolprasert 2005). Recruitment of health professionals is arranged centrally with little input from the communities.

⁵ The ranking system for the promotion of public officials has 11 levels, which are related to educational background and the responsibilities of the position. A graduate with a bachelor's degree would start at level 4. Promotion is then by longevity in the respective rank. Those with Masters or Doctoral level qualifications can be promoted to level 5 and 7 respectively. At this level there are two promotion lines: academic and management. The Permanent Secretary is at level 11; the Director General is at level 10.

The bureaucracy of the Thai health services is reflected in the management style of the community hospitals, which is characterised by an authoritative approach, little independence and initiative, the strong influence of Ministry control, the focus on bio-medical services for in-patients, and poor budgetary flexibility (Phoolcharoen 2005). The management of community hospital is much more in line with Fayol's general principles of management, cited in Megginson, Mosley and Pietri (1992:54), which emphasise demand and control; 'a scalar chain of command: organisations should have a chain of authority and communication that runs from the top to the bottom and should be followed by managers and subordinates'; and centralisation of authority and responsibility.

Nowadays the style of management of community hospitals reflects 'Frederick W. Taylor's concept of Scientific Management' (Megginson, Mosley & Pietri 1992:52), in which each worker is encouraged to produce more because of the economic problems in health services (Jonudomsook 2005; Meads 2006). The responsibilities of a manager in this approach are planning, directing, and controlling the activities of subordinates to achieve the highest output in a timely fashion. Subordinates are expected to work to a plan without question and 'accept and obey the authoritative manager' (Megginson, Mosley & Pietri 1992:57). Consequently, creativity and innovation is not valued. Thai culture, which avoids confrontation and respects authority and seniority, adjusts well to Taylorism (Chungsathiensup 2002; Komin 1990).

Weber (1968) discusses the power and limitations of bureaucracy which is characterised by: i) specialised jobs; ii) a rigorous set of rules; iii) clear authority-responsibility relationships; iv) an impersonal approach; v) a merit system of reward and employment; and vi) lifelong employment. Petersen (1994) adds that with the control system of the bureaucracy and its hierarchy the manager is superior and the employee is subordinate.

The drawback of this management approach is that the organisation is rigid, inflexible and sometimes inefficient (Petersen 1994). However, the strength of the health services bureaucracy allows health care delivery to continue throughout politically turbulent times (Jongudomsook 2005). Nevertheless, the rigidity of the health services does not accommodate to the changing health needs of end-users (Megginson, Mosley & Pietri 1992).

2.7.3 Challenges in community hospital services provision in rural

Thailand

As coordinator for public health services for the community, the CHD must prioritise health programmes based on health needs, develop specific health programmes, oversee implementation and evaluate programmes (Tarimo 1991). For example, in dealing with the leading causes of death and important health issues the CHD faces significant challenges.

a) HIV infection in the working age group

The bio-medical approach treats individual sufferers, but the HIV epidemic is not responding to this approach. A more collaborative and social approach needs to be developed to prevent infection and control the spread of the disease (Schmittiel et al. 2006). Some of the factors to consider in rural Thailand are the migration of rural workers to urban areas and neighbouring countries, literacy levels, religions, education for women and poverty (Hasuwankij 2004; Wibulpolprasert 2005).

The functionalism that underpins bio-medical health services is described by Bilton et al. (1996:414) as 'the management and control of the sick'. The sick in this theoretical tradition are exempt from normal social roles; they need professional help, are obliged to get better and are expected to seek professional treatment. The patient in the Parsonian 'sick role' is compliant and passive, while the doctor is the expert, directive and active (Parsons 1951:428-465).

A social constructionist perspective relates health and illness to social, political, cultural, economic and historical contexts (Nettleton 1995). Just as the application of medical knowledge is particularly vulnerable to the 'social and political circumstances in which doctors practice' (Nettleton 1995:18), the interpretation of the health needs of the community is subjected to the same values of the patriarchal and capitalist society. To overcome the modern epidemic of HIV in rural areas, the multiple truths inherent in postmodernism have to be considered, rather than the traditional history of medicine that advocates a single scientific truth. These multiple truths are accessed through a pluralist framework by including the various stakeholders in health needs assessment and service

delivery (Cheek et al. 1996). The people affected by HIV, or vulnerable to it, must be active and empowered in their health care (Beeker, Guenther-Grey & Raj 1998).

b) Malaria and Tuberculosis

WHO Thailand (2007) reports that Thailand faces significant Malaria infection in the Mekhong subregion. Malaria is multi-drug resistant and spreads very rapidly because of high population movement and high forestation. Tuberculosis has a low cure rate for new infectious cases, and even more concerning is that the detection rate of new cases is estimated to be lower than the rate of infection. Both Tuberculosis and Malaria are related to immigrant workers who help spread the diseases in their travels (Wibulpolprasert 2005). Most of these immigrants are poor, live in inadequate housing, have a low standard of living, poor sanitation and have inadequate drinking water. These 'illness-generating conditions of society' (Waitzkin 1983:77) were described by Engels in England, Virchow in Berlin, and Allende in Chile.

Waitzkin (1983) points out that successful health programmes for these problems must transform the living and working environments of these people, because the 'disease[s] originate ... in part from social conditions'. The decline in Malaria and Tuberculosis follows the economic advancement of the population; therefore the CHDs must advance the social well being of the rural poor to attack the major cause of the spread of these contagious diseases.

c) Chronic diseases such as circulatory diseases and cancers

Western culture has influenced Thais since Thailand opened up to trade with European countries and the USA (Phoolcharoen 2005). Multi-nationals and transnationals, such as McDonalds, KFC, and Coca-Cola, have expanded into Thailand. Consequently, Thais have adopted many aspects of Western culture such as the fast-food diet (Wibulpolprasert 2005). The fast foods, which are appealing and easy to find even in the rural provinces, contain low-density cholesterol. Also in rural areas, some people imitate modern fast-food shops. However, the quality of cooking is poor with, for example, fried chicken recooked in oil, which is repeatedly reused, and left overnight without refrigeration. Consequently, both lead poisoning, because of the utensils used, and heart disease occurs (Wibulpolprasert 2005).

Capitalism has influenced the lifestyle of Thais; work is more plentiful in urban areas as the agricultural industry declines (Hasuwankij 2004). The rural poor work in the cities for higher wages and often go home when sick which places a burden on the community hospital (Hasuwankij 2004). The alienation of the worker from the products of his toil with developing capitalism was described by Marx in his *Economic and Philosophic Manuscripts of 1844* (Marx 1964). Not only is this change in the life of rural workers seen in Thailand, but also the relentless pursuit of wealth through capitalism at the cost of traditional rural life is obvious. These changes affect health with the more sedentary ways of working, high consumption of junk food, and moving to become a consumer society. The cultural and social analysis is central (Lupton 1994) to solving these complex problems. Food safety, for example, must consider the proper handling and storage of food for a society that has always eaten casually from street food vendors.

d) Diseases associated with behaviour and lifestyle such as tobacco smoking and drinking alcohol

Wibulpolprasert (2002; 2005) reports an increasing trend in Thailand of diseases caused by smoking, such as emphysema, coronary atherosclerosis, chronic obstructive pulmonary disease (COPD) and lung cancer, while alcohol consumption is related to cirrhosis and accidents. The bio-medical approach only treats these conditions when symptoms occur. The root cause of these health problems is from a capitalist economy in which international and local companies sell tobacco and alcohol products that, until recently, went without any health warnings. Coupled with the underpinning social and psychological problems that people have, people turn to smoking cigarettes and drinking alcohol for relaxation or to forget the poverty at home or the conditions at the workplace. Driving after consuming alcohol has only received publicity since 2004.

Health programmes in rural areas must address these major health problems as well as maternal and child health, immunisation, and mental, occupational and environmental health (Wibulpolprasert 2005). For the health environment there are new challenges that need more flexible management strategies in the community hospitals. The CHDs, who study bio-medical techniques in an urban medical school, need to cope with the new realities in rural areas involving different patterns of diseases and new staffing and community needs. The contemporary challenge is to change the management of these

facilities to ones that are in touch with the needs of the community they serve to ensure accessibility for the needy population.

Moreover, the economic problems for developing countries are now no longer viewed in the light of simply responding to crises. These countries have to find innovative ways to achieve better status for all at low cost. Many countries, both rich and poor, talk of reform because of the huge cost of health services to their economies. *Reform* according to Siklsana, Dlamini and Issakov (1997) (quoted in Mills & Ranson 2005:549) refers to ‘a sustained process of fundamental change in policy and institutional arrangements, guided by government, designed to improve the functioning and performance of the health sector, and ultimately the health status of the population’.

Common problems of health services reform are: i) inadequate resources and funds for a basic level of care for the population; ii) inefficiency and ineffective health systems, for example, many programmes funded by the public sector are not very cost-effective, inadequately cover highly cost-effective interventions, and cause a budget shortfall in hospital care; iii) poor quality of public health services; iv) new bio-medical technology demands on limited funds; v) new problems, such as HIV/AIDS, and the growing importance of chronic diseases; and vi) inaccessibility of health services for poor people (Mills & Ranson 2005:549-550).

Thailand is not alone in attempting to manage its health services in a more effective and efficient manner because of the increasing demands placed on the health budget. In its recent health policy Thailand targets health promotion and individual responsibility to improve health, as well as targeting major health system reform (Bureau of Policy and Strategy 2007). In both these strategies, health promotion and health services reform, the community hospital is at the forefront; it has to change functionally to meet national goals and the communities’ health needs.

Finally, the community hospital is challenged by the social factors bearing on the rural population. The socio-demographic changes in the rural environment, as a result of developing capitalism and border migration, and the recent implementation of the UHC policy, and finally the centering of PHC in the community hospital, all contribute to challenges for rural health services during an unprecedented dynamic period.

2.8 The community hospital and the Universal Health Coverage policy

After 2001, the government launched the UHC policy with an aim of providing equitable quality health care accessible to the Thai population (Jongudomsook 2004). In rural areas the implementation of this policy is mainly under the control of the MoPH (Bureau of Policy and Strategy 2007). The new UHC health policy has required the 723 CHs to change in structure and function (Bureau of Policy and Strategy 2007). Each CH has to become a Contracting Unit for Primary Care (CUP) which controls and allocates MoPH health funding within the district (Hughes & Leethongdee 2007). The MoPH funds are allocated to each CUP on a per capita basis for primary medical care (out-patient care) and on complex formulae, such as a Diagnosis-related Group (DRG), or on a case-based payment system with a global budget for in-patient care. The CUP then uses some of this funding to support primary and secondary care in the local area and to pay for referrals (Jongudomsook 2004). The number of professional staff per CUP is specified (Health Care Reform Project Office 2001). Each CUP is also required to provide personal health promotion and preventative care for all eligible members of the district, for which it is paid on a per capita basis plus performance-related payments (Jongudomsook 2005). For eligible community members within a thirty minute travel time distance from the CUP, each CUP is required provide comprehensive care, which includes hospital and community services (Health Care Reform Project Office 2001). Nitayarumphong (2005) argues this method of funding hospitals or CUPs leads to costs being contained and a more responsive attitude to the local community. Meads (2006) points out that Thailand is entering the managed care era. The concern for managed care is that efficiency of care must not be achieved at the expense of quality of care and the health needs of the population (Smith & Goodwin 2006). The CUP is required to manage demand for its services and to meet the health needs of its eligible population (Smith & Goodwin 2006).

The UHC programme aims to redistribute resources to peripheral end services by reforming funding distribution. Such a measure ‘was a departure intended to reduce the historical geographic inequalities in spending patterns that had bedevilled the Thai health system’ (Hughes & Leethongdee 2007:1004). Previously, both funding and allocation of resources were historically-based; the more resources and the larger the hospitals, the greater the budget allocated. This means tertiary care facilities in Bangkok and in the Central-region provinces received more funding and resources than other facilities

regardless of the health needs and the size of the population they served. Community hospitals in rural areas, which served larger populations but had fewer resources, were disadvantaged. This situation is similar to that in other industrialised countries where the health care systems are ‘primarily individually oriented, disease based, and ... are largely organised around tertiary-level curative settings’ (Cheek et al. 1996:83). This bio-medical approach, however, does not serve the health needs of the majority of the population. The accumulation of resources in the big cities tends to serve rich people, the ‘bourgeois’, who have more opportunities than the rural poor, the ‘proletariat’ (Marx 1964). The implication is the health system is unwilling to devote resources to those who cannot contribute to the economy. The medical system increases this disparity in society, rather than improving the situation of the poor (Lupton 1994).

Under the UHC Policy, the budget is redistributed per capita of registered population. It aims to rechannel the resources to needy areas. However, the CHD as a CUP manager must be proactive in seeking the registered population. If the CHD waits for people to come to register, the health needs of the community will not be met. People may not be compliant, passive and grateful enough to protect their own rights and take responsibility for their own health.

However, the money does not solve all health problems. Even though the UHC Policy provides a budget based on the number registered in the community, it will not solve health problems in the community if the CHD and the health team do not change their perspective from a bio-medical approach to one centred on public health, the patient and the community (WHO 2005b).

The paternalistic system in which doctors are dominant and the patients subservient is inappropriate in solving complex health problems (Bilton et al. 1996). This practice style must be adjusted to meet the health needs of community by listening to patients more and empowering them to be able to care for themselves and their families. Meeting this requirement, the interaction between each part of society will construct and manage health and illness (Bilton et al. 1996).

The UHC policy encourages people to use their PCUs, which are close to their communities or workplaces, as their front-line facilities (Health Care Reform Project

Office 2001). They are encouraged to receive primary care services at the PCU before being referred to hospital if this is needed. The CH needs to be more proactive in providing primary care services by establishing its own PCUs either within the hospital or outside the hospital to provide primary care services for the eligible population in the sub-district in which the CH is located, and to be a prototype for other potential PCUs. The CH also needs to collaborate with HCs, which are under the management of the CDHO, to upgrade HCs to PCUs. These upgrades would provide a network of primary care services to benefit people who live in sub-districts outside the main town.

The government encourages CHs to achieve full accreditation, 'Hospital Accreditation' (HA), and PCUs and HCs to achieve 'Health Care Accreditation' (HCA) (Nakhorn Ratchasima Provincial Health Office 2006a). It is worth noting achieving these accreditations is not reflected in the funding each CUP receives. The hospital and primary health unit accreditation bodies are different and no formal integration of the two bodies has as yet occurred.

However, Johnson and Paton (2007:30) argue the approach of the accreditation system is based on the assessment of individual patient satisfaction and originates in the 'consumerist approach', dominated by the need for improvement in efficiency, economy, and effectiveness of health services (Beresford 2002). Gawston and Barbour (2003) contend this approach focuses on data from individuals, rather than from the wider community, and can increase the unrealistic expectations of consumers, which are beyond the capacity of the health services, and has little impact on improving quality because of difficulties in interpreting findings. This approach does not redistribute power or challenge dominant structural interests, because health professionals and authorities still control decision-making (Beresford 2002).

The CH is expected to be a facilitator of primary care and to work more closely with the community than before. Health promotion and disease prevention are encouraged. Health costs are expected to be lowered by reducing the number of unnecessary cases attending hospital (Atun 2004). The UHC policy has made a big change to not only CHs but also the Thai health services system, through, for example, financial reform, health services reform, public administration reform, and decentralisation of health services as well as more participation by the community (Jongudomsook 2004). The UHC policy introduces

a managed care system to the Thai health system and emphasises reducing demand for health care in order to meet the real health needs of the community effectively and efficiently (Meads 2006; Smith & Goodwin 2006).

The focus of change is the movement away from an exclusive bio-medical approach to a more inclusive patient-centred approach with its social and cultural context for health (WHO SEARO 2004). The change involves the coordination of public health services for the area at the level of the CHs. This activity involves researching the needs and assets of the communities and ensuring that those needs are met through coordination of the local services. Thai health reform has proposed the CH be a focus for community health interaction, with both end-users and service providers working in synergy, rather than being just an end point of service distribution for the MoPH (Health Care Reform Project Office 2001; Jongudomsook 2005).

2.9 The role of the community hospital in Primary Health Care

To get the community hospitals to support primary health care, a clear understanding of what a community hospital should do is needed. The role of the community hospitals needs to be considered within ‘the context of the health needs of the country as well as within the larger health care system, including the capacity of services to provide effective health care’ (International Hospital Federation 2005:27).

Besides being the first referral centre, community hospitals provide services which are typical of first contact facilities (health centres) (WHO 1990). Such services include general out-patient curative care, follow-up of chronic patients, and certain kinds of preventative programmes, such as vaccinations and growth monitoring. When a community hospital tries to be both health centre (i.e. first contact level unit) and hospital (i.e. first level referral unit), there are a number of negative consequences on quality of care provided at the health centres and community hospitals (WHO 1990).

The 1990 WHO report found, first, community hospitals provide inadequate primary care, because the community hospital is not an adequate setting in which to give full attention and time to the human dimension of individual care. Second, the community hospital also

provides an insufficient level of referral care because of the scarcity of physicians, who are already overloaded with primary medical care, much for people with problems that could have been solved at health centres. Last, the community hospital 'creates a vicious circle in which the health centres work below par, because they suffer from the community hospital competition for resources and prestige' (WHO 1990:4).

The role of hospitals in PHC is primarily to help develop the partnership between hospitals, health centres, district health offices and other government and non-government agencies as well as the communities they serve for the support of 'Health for All' (WHO 1992). The role of community hospitals is much more than that of a curative care facility. Rather, their role is in linking with every aspect of district health development. They have an obligation to ensure that the entire population can access effective and affordable care by involving communities in the planning, implementing, and evaluation of health programmes.

Fundamentally, the hospitals act as supporters of the health centres (WHO 1990). The hospitals should devolve their primary care provision role to health centres as far as is practicable but with the hospitals' continuing support (WHO 1992). WHO (1992:55) recommends community hospitals improve the quality care at health centres by:

- 1) providing and supporting continuing technical training and supervision of staff at health centres to maintain their efficiency and motivation
- 2) assisting in procuring, storing and distributing drugs, laboratory supplies and equipment
- 3) providing transportation
- 4) assisting in the maintenance of buildings and equipment
- 5) being involved in planning of health-related activities and health education
- 6) being involved in budgeting and auditing, when practical
- 7) being involved in quality-assurance programmes and safety monitoring
- 8) collecting, analysing, and sharing information, and record keeping
- 9) facilitating and encouraging community-based initiatives.

Moreover, WHO (1992) warns that the community hospital must not act as if superior to the health centre, but instead emphasise the provision of support.

The focus of the activity at the first contact and first referral levels are the people in the community. WHO (1992:18) points out the true challenge to the community hospital is that of 'achieving effectiveness in reaching outwards to strengthen peripheral health services in the district and building up its internal strength'. The two basic characteristics of the community hospital should be its concern with helping patients to be healthy, rather than just curing disease and its integration as a functional part of the district health services system (WHO 1992).

According to a model of integrated district health care, community hospitals should provide the kind of care and technical support that cannot or should not be further decentralised. The community hospital will have to maintain its curative role, but attention to priorities and budgetary limitations should lead to a redistribution of both finance and effort with the usual large expenditure on the hospital giving way to a more balanced financing of all the district health services (WHO 1990).

The integration of the first referral level hospital into the district health care system, overseen by a district health council or board, is recognised as 'the best way of strengthening primary health care' and reorienting health services to promote health (WHO 1992:56). WHO (1990) suggests that an integrated health system requires clarification of the role and responsibilities of all stakeholders in the district health system. Each health service, community hospital, health centre and district health office has to work collaboratively as a single entity with the fully comprehensive range of promotional, preventive, curative, and rehabilitation activities (Johnson & Paton 2007; WHO 1990, 1992).

2.9.1 The community hospital and the management of district health services based on Primary Health Care

In order to implement the UHC policy, the community hospital, as a CUP, is responsible for commissioning primary health services at health centres, but HCs report to the district health office and not to the hospital. The CUP Board structure was introduced to encourage all health providers in the district health system to work together as a team.

However, the management of district health services is through the CUP Board, which has adopted the structure of the DHCC (see Section 2.7.1).

WHO (1990) argues that the central issue of district health services management is the relationship between the CHD and CDHO. There is no single successful model for managing a district health system based on PHC for different countries (WHO 1990), and the appropriate model needs to fit the sociopolitical contexts of each country. The main requirement is a change in people's attitudes and motivation (WHO 1992). One of the main obstacles to such change is the absence of a conceptual model for those who have to implement that change.

A clear conceptual model of the district health care system is required by the district health management team. Constant contact is needed with the realities faced at the first contact care level by including health centre personnel in the district health management team. District management also requires a legal and administrative basis in order to have the necessary authority to manage district health services. They must have the power to facilitate decentralisation and a clear definition of their responsibilities. It requires a well-organised working relationship with other government and non-government agencies. WHO's (1990:29-33) report offers three relationship models: i) authoritarian; ii) technocratic; and iii) participatory.

2.9.1.1 The authoritarian model

In this model management is in the hands of one person, or a small group of individuals, who 'manage and supervise' the health network. The organisational structure may be formal or functional. The formal version of this model has an advantage in that it provides good possibilities for management of a district as an integrated system; the drawback is that in reality it does not work. From a functional viewpoint there is a complete divorce between the lines of authority of the CDHO and CHD. Thailand employs this model of district health management (WHO 1990:30), where the CDHO is not a physician, reports to the Ministry of the Interior and has authority over the whole district and all the health centres, except for the community hospital and the sub-district surrounding it. The hospital is the responsibility of the hospital director, a medical doctor who reports to the

MoPH. The effectiveness of district health services management under this model depends on the relationship between the CHD and CDHO (WHO 1990).

2.9.1.2 The technocratic model

Here, management is the responsibility of a committee representing key health personnel in the district: the physicians, nurses and hospital administrator. The responsibilities of this district management team include organising the health services of the whole district, including the supervision of the peripheral health centre network.

The advantage of this model is that care can be integrated rationally and effectively between the first contact level and first referral level, if the physician, who can identify truly critical incidents, is sensitive to the problems. The weakness is that it only works if the physicians who make up this district management team are committed to the development of this system. The danger is that if the attitude of the group of the district health management team is hospital-centred, then the district will be managed as a function of the hospital. The team requires a thorough understanding of the decentralised model of health care and direct experience of provision of care at the first contact level.

2.9.1.3 The participatory model

The district management team in this model works closely together with an assembly of the people in charge of the health centres. This model includes representatives from community and non-government organisations. The advantage of this model is that it offers the opportunity for intersectoral collaboration and may provide a useful counterweight to physicians who are too self-focused and motivated by the bio-medical framework.

The CHDs need to change their approach on district health services management from the authoritarian model and move beyond the technocratic model to the participation model, in which local government and the community can participate. With the participatory model intersectoral collaboration can occur and the health needs of the poor in the local community can be met effectively.

2.10 Problems in implementing the Universal Health Coverage policy in relation to Primary Health Care

2.10.1 Problems

Even though the implementation of the UHC policy has achieved health insurance coverage for all Thais, increased accessibility to health services, reduced out-of-pocket health care payments and gained popularity among the people (Jongudomsook 2005), there is still an issue about whether people get quality services (Suraratdecha, Saithanu & Tangcharoensathien 2005). Both government reports and published Thai and international literature on the Thai health care system and its reform reveal that there are many problems in implementing the UHC policy.

a) Increased curative services demand

Table 2.12 shows the beneficiary utilisation rate under the UHC policy as described by the Bureau of Policy and Strategy (2007:37). From 2002 to 2005, utilisation rates increased for both out-patients and in-patients. Increasingly greater numbers of beneficiaries are accessing curative services under the UHC policy. Even when out-patient numbers decreased in 2005, the number of visits increased.

Jongudomsook (2005:22) points out that people have a basic right to expect higher quality services under the *Constitution 1997*. However, he argues the public health sector cannot meet that demand, because there are shortages in health personnel and funding is limited (Jongudomsook 2005). The Working Group on Quality of Life and Health Development (2004) showed health providers perceive people lack self-reliance and are over-dependent on the health system. The authors contend, however, people's behaviour in seeking care for simple health problems is similar to their behaviour before the UHC policy was implemented. They point out 'grassroots' people still do not understand their rights and responsibilities fully under the UHC policy (Working Group on Quality of Life and Health Development 2004).

Table 2.12: Beneficiary utilisation rate under the Universal Health Coverage policy, 2002–2005

Item		2002	2003	2004	2005
Utilisation rate	Out-patient (visits/person/year)	2.27	2.52	2.54	2.56
	In-patient (episodes/person/year)	0.090	0.087	0.092	0.096
Numbers of patients, visits and days	Out-patient (million patients) (million visits)	41.396 102.95	32.538 115.01	39.66 119.64	38.21 120.88
	In-patient (million patients) (million days)	3.39 14.93	3.99 14.46	4.329 16.63	4.53 17.89

Source: Adapted from Bureau of Policy and Strategy (2007:37).

b) Under-funded health services

Since the launch of the UHC programme in 2001, the Thai health services have been under-funded (National Health Security Office 2007b:79). The 2004–2005 required per capita funding and the per capita funding provided for the UHC programme were presented in Section 2.3.3.2. Promised funds were never allocated in full (Hughes & Leethongdee 2007:1005). As a result, most of the funding was used for curative care and the community hospitals and health centres were unable to develop health promotion and disease prevention programmes.

During the 2004 budgetary year, many of the approximately 265 CHs in rural areas were in debt to about 1387 million baht and required funding assistance (Bureau of Policy and Strategy 2005:30; 2007:36). These budget blowouts are due to: the community hospital having to serve unregistered poor patients who come from outside its region of responsibility, such as illegal immigrants – these people are very vulnerable and can spread diseases, such as Malaria, Tuberculosis and HIV/AIDS, to the community; increased numbers of patients seeking help from hospitals than was the case prior to the UHC policy; and the staff of the community hospital not being trained to develop and implement health promotion and disease prevention strategies.

The Bureau of Policy and Strategy, MoPH (2007), reports many hospitals need contingency funding from the Central Government to meet with their expenditure because of the high cost of health personnel. The viability of funding for health providers is crucial, especially in rural areas where medical services are inadequate. Closing even one health facility in a rural area may negatively affect the health status of the rural poor (Bureau of Policy and Strategy 2007).

For health promotion and disease prevention programmes, CHs require adequate and appropriate funding (Jongudomsook 2005:26), which the UHC policy should guarantee to contractors (Suraratdecha, Saithanu & Tangcharoensathien 2005).

c) Shortage of primary health care professionals

Health professionals find rural work especially difficult because of the heavy workload, financial burdens, the shortage of other health professionals (especially family practices in rural areas), and their lack of primary health care knowledge (William, Prueksaritanond & Aramrattana 2002:74).

In 2002, there were 3758 doctors working in Thai community hospitals looking after 38 million people, while there were 15 229 doctors working in both public and private hospitals in Bangkok and other metropolitan areas outside Bangkok looking after 25 million people (Wibulpolprasert 2005:249, 252). In addition, in 2002, workloads for doctors working in community hospitals were 23 467.8 patient visits per doctor compared to lower workloads of 11 415.0 in regional hospitals and 2486.1 in university hospitals in metropolitan areas (Wibulpolprasert 2005:254).

In addition, many doctors in rural areas have resigned because of a lack of confidence in the position, for financial reasons, or because of the lack of opportunities to continue their education (Dhammarungsri 2003; Watcharanugoolgeart 2004). Community hospitals in remote areas, which have to look after large populations, cannot manage because of the shortage in both human resources and money.

A part of this situation may arise from the competing demands from the dual track policy of the Thaksin Government (Pachanee & Wibulpolprasert 2006:312). The UHC policy emphasises providing health care for all, especially the rural poor, while the Government

at the same time has promoted a policy on trading in health services, serving the rich and foreigners. These two policies have increased demand for health services (Pachanee & Wibulpolprasert 2006). Another cause for the resignation of doctors may be the internal brain drain from the public sector to the private sector and from rural areas to city areas (Pachanee & Wibulpolprasert 2006).

The shortage of health professionals in the community hospitals, which are an important focus for primary health care in Thailand's health system, may be improved by more appropriate workforce redistribution and effective retention of personnel (Pachanee & Wibulpolprasert 2006). Suraratdecha, Saithanu and Tangcharoensathien (2005:283) argue that, in rural areas, there is a limited choice of health providers, which are mostly community hospitals and networks of health centres. Encouraging a competition policy for providing care to rural areas may be counterproductive. Constructive strategies need to be explored instead.

Jongudomsook (2005:28) points out the weakness of the primary health care system in Thailand is at the health centre level where there is a scarcity of resources and a shortage of qualified health professionals. The Working Group on Quality of Life and Health Development (2004) argues the shortage of health professionals in rural areas is not in terms of numbers, but in terms of qualifications. Health professionals in rural areas are mostly new, less experienced graduates. This is not equitable health services delivery to the rural community. The group points out that there is no strategic plan for the recruitment, training and development of health professionals, or for the subsequent allocation of these health professionals to rural areas to support the implementation of the UHC policy.

According to Hughes and Leethongdee (2007:1006), the shortage in medical doctors not only affects the quality of care at the community hospitals, but also obstructs the UHC policy aim of building the capacity of rural health centres to provide 'close to the client' care. Most qualified medical staff still work in community hospitals while the PCUs are located in the sub-districts of the hospital district. The care provided by staff at the hospital PCUs is similar to that provided by staff at the out-patient departments of the community hospitals and is similarly bio-medically dominated (Hughes & Leethongdee 2007).

The Working Group on Quality of Life and Health Development (2004:iii) points out most community hospitals emphasise providing medical care and making health centres ‘like the hospital or branches of the hospital’ (in providing medical care). Rather, the community hospitals should support health centres to provide holistic care (with an emphasis on health promotion and disease prevention) and encourage the community to be involved in health care. The Working Group on Quality of Life and Health Development (2004:iii) reports some medical doctors at community hospitals do not want to work at primary care units or health centres.

d) Inequity in accessibility to quality health services

The Bureau of Policy and Strategy, MoPH (2007:34), reports the unequal benefits, the varying management of different health schemes, and ‘the rapid implementation of the UC scheme [UHC policy] lead to obstacles in access and provision of services’. The benefits of various health schemes are presented in Section 2.3.3.2. People living in a city or in areas that have more health services have more choices regarding their registered hospitals. In rural and remote areas, people have limited choice and normally are assigned compulsorily to a health centre or community hospital close to their residential area, where they can then access their primary care services.

Inequity in the access to health services is still present and remains unsolved (Hughes & Leethongdee 2007). In addition, rural health facilities have compounded problems: a lack of resources and heavy workloads. It is a challenge to keep the system sustainable and to meet the peoples’ expectation of health services. The study by Suraratdecha, Saithanu and Tangcharoensathien (2005) reveals people perceive the care provided through the UHC scheme to be lower in quality to care provided through other schemes. They also show socioeconomic disparities still persist and accessing care is still difficult because of the lack of appropriate transport and the high cost of travel to the health facilities. There is an urgent need to explore how the community hospitals can overcome or cope with these problems. The Working Group on Quality of Life and Health Development (2004) confirms that some people eligible to access care through the UHC programme do not do so, because they do not trust the quality of the health services provided. They perceive the medicine provided as poorer quality. Even though the survey from the NHSO shows a high number of people are satisfied with the quality of care provided under the UHC programme (National Health Security Office 2007a), the Working Group on Quality of

Life and Health Development (2004:iv) contends indirect assessment shows a low number of people are satisfied with this programme and 45% of the participants would like to change their assigned hospitals.

e) Less-than-expected quality of health services

The Bureau of Policy and Strategy, MoPH (2007:35), reports problems in the provision of quality health services. The quality of services, as a 'close-to-client' concept advised by the Commission on Macroeconomics and Health, WHO (2001), of many community hospitals or contracting units for primary care do not meet the fully accredited standard level due to the shortage of qualified primary health personnel. In 2006, 204 hospitals, mostly CHs in rural areas, were not fully accredited (National Health Security Office 2006b:5). The quality of rural health services remains a problem.

Hughes and Leethongdee (2007:1004) argue that one of the causes for the reported low quality of health services in rural areas may be due to CHs, particularly in the North-Eastern region, delaying the referral of patients to tertiary care so as to retain their per capita funding by reducing the cost of referrals or through delayed-referral payments. They also report the dominance of the CH has affected the quality of primary care services (Hughes & Leethongdee 2007). Some CHDs have retained the funding, which was to be allocated to the health centres and the district health offices in rural areas, for projects within the hospital. Some CHDs 'used their power [as CUP managers and the chairs of the CUP Board] to allocate resources according to their own priorities' (Hughes & Leethongdee 2007:1004). Almost all CUP Boards are chaired by CHDs whose roles are those of physician and manager.

Jongudomsook (2005:27) reports that per capita funding did not encourage CUPs to provide health promotion and disease prevention programmes and CUPs used that funding for 'cross-subsidizing the cost of curative services, which they felt inadequate to finance'. The payment for health promotion and disease prevention programmes has been adapted by using performance-related payments to adjust the appropriate per capita funding (Jongudomsook 2005). However, Jongudomsook points out that, because there is a lack of an effective information system, the implementation may not be effective.

The Health System Research Institute, MoPH (2002), reports a lack of practical guidelines in accrediting health services. The major guidelines used emphasise the principles of hospital accreditation, which focus on curative care. The accreditation guidelines for health promotion and disease prevention programmes are still unclear.

2.10.2 The influence of structural interests on the implementation of the Universal Health Coverage policy

While many authors worldwide have written about health reform, an overview of Alford's (1975) theory of structural interests will first be presented in this section as it has helped situate this study within the Thai context. Alford (1975) studied health care reform in New York City between 1950 and 1971 and his theory on structural interests is presented in his work, *Health Care Politics: Ideological and Interest Group Barriers to Reform* (1975). Alford's (1975) theory is still considered robust and applicable in explaining different structural interest groups within the health care literature. For example, his theory has been used in Australia by Duckett (1984), Gardner (1995), Palmer and Short (2000), Lewis (2002), and Evans, Han and Madison (2006); in the UK by Ham (1981; 1992; 2004), North (1995), Allsop and Mulcahy (1996), Harrison (1999; 2001), Powell (2000), North and Peckham (2001), Lewis (2002), Ferlie and McGiven (2003), Hunter (2004), and Addicott and Ferlie (2007); in the Netherlands by Lewis (2002), in other European countries by Oliver and Mossialos (2005); and in the US by Peterson (2003). Using this theoretical framework could be invaluable in explaining the implementation of the UHC policy in Thailand. His three major interest groups are useful to identify the actors who either support or resist reform in the Thai health care system. Beyer (1998) argues health care reform can progress in a focused and planned way if the various aspects of the policy process – content, context and actors – are understood.

Before Alford's (1975) theory to reform was developed, there were two major approaches to health care reform – 'market' and 'bureaucratic' approaches. The market reformer emphasises increasing choices of health care provided by 'the plurality of health care providers' with the hope to serve the different health care demands of different consumer groups. However, this model is seen as negative, creating duplication, waste and inefficiency. LaFond (1995) and Meads (2006) argue that the market approach to health

care reform may not solve the inequity of health services delivery to rural areas where there is a scarcity of health facilities and health resources and not many incentives for investors to autonomously organise health care for the rural poor. This approach will not achieve effectiveness in health care to reduce inequity and inequality, and to increase health care access for the rural poor (Hunter 2004).

Another model is the bureaucratic approach to health care reform, which emphasises the efficiency of the health system through central planning. This approach, however, is seen by the market reformer as cumbersome, lacking competitiveness and responsiveness to the different health demands of the customer.

Some authors, such as Alford (1975), North and Peckham (2001), Evans, Han and Madison (2006), and Addicott and Ferlie (2007) reject reform that relies solely on either bureaucratic or market interventions. They argue that they will fail, because both models of reform neglect the invisible barriers to the reform, which are the influential powers of various strategically structured interest groups, particularly professional groups. Addicott and Ferlie (2007:396) argue: ‘the key feature of structuralism is that dominant groups may control agendas to promote or protect their dominance, even if not responding to a direct challenge – the powerful remain so without having to act’.

Alford (1975) proposes health care reform, or barriers to reform, should be seen as the outcome of conflict between structural interest groups. In his analysis, there are three major health groups, medical/professional monopolists, corporate rationalists and community interests, strategically structured in the health system. These structural interests can be classified as being respectively ‘dominant, challenging, and repressed’ (Alford 1975:14). According to Alford (1975:14), dominant structural interests are ‘those served by the structure of social, economic, and political institutions as they exist at any given time’. He points out these interest groups do not need to act or organise to defend their interests; rather, the other institutions will act or organise to defend interests for them. The medical professions are the major representatives of these interest groups. They claim that ‘they represent the community’s interests’ (North & Peckham 2001:426). There are various interests represented within the profession sharing a common interest in preserving professional autonomy. According to North and Peckham (2001), the power of these professions is protected by the law and their practices.

The challenging structural interests are those being created by the changing structure of the society. Representatives of these interests are groups, such as hospital administrators, government health planners, public health agencies and researchers. They share a general interest in ‘creating an efficient, effective, integrated and co-ordinated health care system’ (Evans, Han & Madison 2006:175). These interest groups aim to challenge some fundamental interests of the medical/professional monopolists and to extend control over the work of professional monopolisers.

The repressed structural interests are the opposite of dominant ones and are ‘those of the “community population”’ (Alford 1975:15). According to North and Peckham (2001:427-428), these groups are not able to afford health care or are neglected by ‘patterns of provision preferencing more affluent neighbourhoods’. These three structural interest groups are not in isolation from each other. Alliances can be formed where there is the possibility of mutual benefit. However, the alliances do not ‘guarantee power sharing and could result in the exploitation of the weaker’ such as the community groups (North & Peckham 2001:428). Other scholars support Alford’s (1975) argument that the dominant interest group are medical doctors and that the community rarely has a voice. For example, Harrison (1999), North and Peckham (2001), and Addicott and Ferlie (2007) studied health care reform in the UK, while Evans, Han and Madison (2006) studied health care reform in rural Australia. Cohen and Purcal (1989) studied primary health care reform in South-East Asian countries and found medical hegemony dominated the health system, resisting health care reform. According to these authors, bureaucrats use the rhetoric of community participation to get the community to comply with their interests. LaFond (1995) believes that bureaucrats in less developed countries fail to reform the health system and sustain primary health care for the poor, because they serve the requirements of the donor countries/agencies, rather than the real health needs of the population. In a similar vein, Beyer (1998) reports that the failure of the implementation of the new district health system in the Republic of Benin was due to resistance from medical monopolisers. According to this author, there is a lack of analysis of the ‘actors’ and contexts of the implementation of the reform (Beyer 1998).

In their study of health care reform in rural Australia, Evans, Han and Madison (2006) reveal that health managers could not lead the reform, because they have limited capacity to influence the views of the wider community and they are not valued highly by the

community. These authors found that rural GPs, who represent the medical monopolists, provide strong resistance and that a shift of power between structural interests within the health care sector is necessary for health care reform to be successful and the integration of health care to be sustained. Ermacora (2004) argues health services should reflect the needs of the population as experienced by the community, rather than by professionals or bureaucratic agencies and that the community can make rational decisions regarding health services. She calls for capacity building for the community to be able to participate in health services through information sharing between professional, bureaucratic organisations and the community. Ermacora (2004) and Evans, Han and Madison (2006) have similar views that health care reform is best achieved through community development through community participation.

The structural interests who are involved in the implementation of the UHC policy and their impacts on the Thai health care reform are presented as the following issues: a) lack of political commitment; b) conflict between the Ministry of Public Health and the National Health Security Office; c) resistance from medical monopolists; and d) lack of full community participation.

a) Lack of political commitment

Despite the fact that the Thaksin Government had a strong policy in quickly implementing the UHC policy (Pannarunothai, Patmasiriwat & Srithamrongsawat 2004:28), Hughes and Leethongdee (2007:1006) reveal that the lack of political commitment from the Government in the final years of its rule ‘blunted the original objectives of the universal coverage reforms’. This led to under-funding and resulted in low quality services and double standards, which ‘led in turn to loss of public confidence’ (Hughes & Leethongdee 2007:1006). It is doubly difficult that the goal of health care reform requires a radical reform at a time when Thailand has political uncertainty (Hughes & Leethongdee 2007). Na-Ranong and Na-Ranong (2002) report that the Government lacked a clear understanding of the philosophy of the UHC policy. As a result, problems were solved for the short-term and only those readily visible and the Government, by establishing the NHSO, duplicated the administrative structure of the MoPH. The result was confusion and conflict, with a lack of integration between the UHC policy and other health schemes.

b) Conflict between the Ministry of Public Health and the National Health Security Office

The overlap in responsibilities between the MoPH and NHSO has caused tensions in the Thai health system (Hughes & Leethongdee 2007:1007). In implementing the UHC policy, the Government has established the National Health Security Office (NHSO) as an autonomous agency separate from the MoPH (Jongudomsook 2004), with '[responsibility] for the implementation of the UHC policy' (Jongudomsook 2005:22). The system separates the MoPH (as health provider) and the NHSO (as health purchaser) and is called a 'purchaser-provider split' (Hughes & Leethongdee 2007:1002). The concept of this split is seen as radical and innovative, because 'the system did not rely on a local purchasing body to determine patterns of district services but gave this responsibility to a coordinating provider organization' (Hughes & Leethongdee 2007:1002). However, the MoPH slowed the implementation of the concept of a local purchasing body and 'delay[ed] passing the reforms to the NHSO' by requesting that the MoPH oversee the reform in the transitional period until May 2006 (Hughes & Leethongdee 2007:1003). Furthermore, the MoPH requested the per capita funding be transferred to the CUPs through the provincial health offices (the agencies of the MoPH at provincial level), which act as local health insurance offices, bypassing the NHSO. The NHSO quickly appointed the PHOs as its local representatives, but much of the direction still came from the MoPH, which controlled the UHC funding provided to the CUPs (Hughes & Leethongdee 2007:1003).

This makes the roles of the MoPH and the NHSO in the implementation of the UHC policy confusing. The spirit of purchaser-provider split was not implemented at the local level as 'the de facto responsibility for providing comprehensive district health services lay with the CUPs, creating the unusual situation in a purchaser-provider system that coordination depended on a body on the provider side' (Hughes & Leethongdee 2007:1003). Jongudomsook (2005:22) asserts there was 'role confusion and conflict of power' between the MoPH and the NHSO. The NHSO is responsible for managing funding for personal care while the MoPH still plays a dominant role in managing the funding for public health programmes. This lack of effective coordination between those two important agencies has resulted in a deterioration of the effectiveness of the implementation of the UHC policy (Jongudomsook 2005).

c) Resistance from medical monopolists

As with many other capitalistic countries, such as the USA and Australia, the Thai health services have developed with the medical profession as the dominant stakeholder in policy development and implementation (Willis 1989). The priorities of the Thai health policies are biomedical technology and curative approaches to health and these reflect the values of the elite stakeholders. Both patients and the population generally accept the medical practices (Smart 1986). The UHC policy challenges the power of the medical monopolists, especially medical specialists.

Hughes and Leethongdee (2007:1005) report that the new hospital funding formula (UHC funding including hospital funding) irritated many medical doctors who work at the super-tertiary care hospitals in Bangkok and in the Central province. They resisted the health care reform from the 'old-style physician-administrators who control the MoPH and hospitals' and the systems' 'cultural resistance' to the concept of purchasing health care (Hughes & Leethongdee 2007:1006). These medical doctors used their power to mobilise support and influence the decisions of the senior bureaucrats at the MoPH to change the way the NHSO funded health services. Since the second year of the implementation of the UHC policy, rather than favouring the disadvantaged rural health facilities the funding again favoured the more affluent health facilities in big cities and towns (Hughes & Leethongdee 2007:1005).

As a result, the MoPH has adapted the funding system in a way that contradicts the initial aim of the UHC policy, which was to redistribute resources and funding to health facilities with less resources and capital serving greater numbers of poor people from health facilities with greater resources and capital serving fewer poor. The remote community hospitals, which have very few health professionals, have been significantly affected by this change with the MoPH protecting the larger-sized hospitals 'through top-slicing of the budget for salaries and in-patient activity ...' (Hughes & Leethongdee 2007:1005).

Hughes and Leethongdee (2007:1007) argue the MoPH controls 'the disbursement of the central salary budget to favour the status quo'. The impact of per capita funding on the redistribution of resources from affluent areas to rural areas was obstructed. This situation shows the MoPH failed to continue the radical reform of the Thai health system (Working

Group on Quality of Life and Health Development 2004). More pressure has been put on the community hospitals and health centres in rural and remote areas as they have had to face both a shortage of health professionals and a shortage of funding. The Working Group on Quality of Life and Health Development (2004) criticises the MoPH that it did not provide funding according to the principles of equity. This has impacted on the quality of care and further disadvantaged rural people.

Another institution which represents the dominant medical monopolists and can affect policy by advising government is the Medical Council of Thailand (MCoT). Most MCoT Board members are from the medical schools in the large cities. The MCoT is responsible for approving the medical curriculum, registering medical practitioners, controlling professional ethics, and monitoring continuing medical education. There are problems in the regulation of the medical workforce (Junjareon et al. 2004); for example, there is no real logic in the ratio of specialists to GPs for appropriate services and there is a need for GP services in rural areas. The medical school training, however, encourages specialisation with a high density of specialists in urban areas. The medical curricula are dominated by specialty disciplines and patient consultation is taught as disease-centred dialogue, rather than as patient-centred communication.

The biomedical model of medical education has remained dominant. The training of medical students is disease-centred, rather than patient-centred. The social, cultural and economic context of health (that is, the constructionist view of health, advanced originally by Berger and Luckman 1966) has not made much impact on either medical education or the shaping of health services. The overriding perspective is functional Parsonian, and the passive 'sick role' for Thai patients fits in with the patriarchal health system in general (Parsons 1951).

The resistance from the medical monopolists has resulted in a lack of services coordination between services at community hospitals and those at health centres, and inappropriate resources distribution at local level (Hughes & Leethongdee 2007:1006). At the beginning of the implementation of the UHC policy, many staff at health centres complained they received inadequate funding from CUP managers, who are medical doctors, to run their health centres. Jongudomsook (2005:28) points out the problems were due to the inadequate funding of the UHC programme and the attitude of the CHDs

who were less concerned about providing health promotion and disease prevention programmes.

Moreover, Jongudomsook (2005:28) argues a lack of health services coordination at the primary care level was due to the lack of a clear role for the health providers who provide primary care. Community hospitals, health centres, private clinics (surgeries) and drug stores overlap in the delivery of primary care, with the role of some primary care providers duplicated. He suggests research is needed to clarify the roles and responsibilities of primary care providers and how the primary care networks can function effectively (Jongudomsook 2005).

d) Lack of full community participation

The Thai patriarchal health system does not effectively include patients and community members in the policy making process. End-user involvement in health services policy and implementation occurs only in a limited way.

The *Decentralisation Act 1999*, which was launched in the Chuan Government, advocated a greater role for local governments in the decentralised administration of the health system and recommended 35% of government funding be channeled to local governments by the year 2006 (Hughes & Leethongdee 2007:1002). However, Pannaruthai, Patmasiriwat and Srithamrongsawat (2004:25) argue that there are overlapping roles of different levels of the local governments under this Act. There are three levels of local government: the provincial level, 'Provincial Administration Organisation' (PAO); the district level, 'Municipality'; and the sub-district level, 'Tumbon Administration Organisation' (TAO) or 'Department of Local Administration' (DLA). All these levels of government are elected. However, currently, the PAO and the Municipalities are supervised by, and report to, the Ministry of Interior (MoI) through the Provincial Governor, who is a bureaucratic officer appointed by the Cabinet through the MoI. The TAOs report to the Chief of District, who is a bureaucratic officer at district level and reports to the Provincial Governor. Each level of government is autonomous but loosely connected to each other and this loose connection creates an atmosphere which stultifies cooperation.

The *Decentralisation Act 1999* legislates the MoPH to devolve all of its health services to the management of the local governments by 2010 (Yanggratoke 2001:2). In addition the *National Health Act 2002* encourages the purchasing agencies, which include the representatives of health sector and those of the local governments, to be at local level (Jongudomsook 2004). However, according to Hughes and Leethongdee (2007:1002), ‘the details of local purchasing remained unclear ...’ and ‘... further capacity building in local government would be necessary before this aspects of reforms could be implemented’. Moreover, the report of the Working Group on Quality of Life and Health Development shows that there was no mechanism for engaging the community in developing the UHC programme to meet the community’s needs (Working Group on Quality of Life and Health Development 2004:v).

Nevertheless, the role of local governments as the health care purchaser is developed through the pilot project in which local governments, funded by the MoPH, support health promotion and disease prevention. Jongudomsook (2005:26) asserts that involving the local governments and community in financing health promotion and disease prevention programmes can ensure the effectiveness of the programmes.

However, the role of the local governments in purchasing out-patient and in-patient care is not promoted, because some high authorities perceive the local governments lack the ability to manage medical services, which require a higher level of knowledge (Hughes & Leethongdee 2007).

At the services delivery level, Jongudomsook (2005:25) reveals that health personnel still have a ‘conventional approach to health service provision by considering people as clients of health services’, which is inappropriate. He argues such an approach limits the full participation of individuals, families and the community in health activities, especially decision-making about what needs to be done to meet their needs. He calls for the empowerment of health volunteers; their opinions and decisions need to be accepted and respected for them to be more capable and confident in participating in health decisions. Beyer’s (1998) study of the district health care reform in the Republic of Benin in 1997 reports the reform failed from a lack of coordination between the health and administrative (local government) sectors and from resistance from the specialist doctors who were challenged by the new authority of the public health physicians. WHO (2003b)

argues that health is not solely the responsibility of health professionals, that everybody in the society must have a role to play in the health system (WHO 2000b).

Jongudomsook (2005:23) reports that more civil groups are involved in public health policy, but fewer people at the grassroots level participate. He argues the approach of the MoPH to support community participation was inappropriate; the support was ‘centrally organized and implemented nationwide using the top-down approach’ (Jongudomsook 2005:29). It limited the empowerment of the community. ‘[I]t is rather difficult to expect the bureaucracy to support the empowerment of civil society owing to its limitations, unless it is extensively reoriented’ (Jongudomsook 2005:29). He suggests that the links of the civil society movement at national and local levels should be encouraged (Jongudomsook 2005). All levels of the community should be empowered and supported to be able to fully participate in making decisions, managing, and evaluating health services to meet their needs (Working Group on Quality of Life and Health Development 2004).

The patient or community interaction with the community hospital is no different to other aspects of the Thai health service. However, there is an overwhelming need to change the community hospital. It must change its way of functioning, not just to satisfy its constituents, but to meet the new policy directives from the MoPH. The new policy directives seek to ensure UHC is achieved by mobilising more community health initiatives that are cost effective and sponsored by the CHD as leader of these community health programmes.

2.10.3 The influence of the organisational culture (Thai bureaucratic management style) on the implementation of the Universal Health Coverage policy

Carney (2006) points out that organisational cultural dimensions are crucial for the effectiveness of the implementation of the UHC policy and they should be understood and identified. This section focuses on the Thai bureaucratic management style and Thai culture that may impact on the implementation of the rural health care reform.

The UHC policy was one of the tools of the Thaksin Government to reform public administration. Primary care development is designed to achieve the ‘modernisation’ of the national health system (Meads, Iwami & Wild 2005:253). Modernisation is defined by Meads, Iwami and Wild (2005:257), as ‘decentralisation, regulation, governance, partnership, and stewardship’. These form the framework of New Public Management (NPM) (Dunleavy & Hood 1994), although this conceptual structure is not the focus of this study. The framework is intended to promote the transition from working in a bureaucratic culture to a more managerial culture (Painter 2005).

According to Painter (2005:7), the administrative reforms of the Thaksin Government used the ‘model of executive government’, which mimics the NPM’s language. However, Painter contends that NPM was used in a ‘symbolic role’ by the government (Painter 2005:24). Much of the language of the reform programmes is ‘managerialist’ in tone. Painter (2005:3) argues this reform is ‘best understood as a politicisation programme, rather than as a managerial one’. He points out the managerial reform of the Thaksin Government ‘is being deployed in order to redistribute bureaucratic power to the political executive’ (Painter 2005:4).

Bowornwathana and Poocharoen (2005) criticise this reform, because it was not true decentralisation, rather it is a shift of power away from bureaucratic channels to a consolidation and centralisation of power of the political executives, especially that of the Prime Minister (Bowornwathana 2004; Painter 2005). Moreover, Pathmanand’s report (2001:39) shows that despite the Thaksin Government offering a social programme which included ‘cheap’ health care as their election strategy, once in power, they concentrated on economic development with big capital, rather than establishing capacity development and democratisation.

Jindawattana and Pipatrojanakamol (2004) reveal the top-down approach of the Government on the implementation of the health care reform by showing that the Government rushed in the implementation of the UHC policy without true participation from stakeholders and communities. Furthermore, Na-Ranong and Na-Ranong (2002) report the MoPH implemented the initial phase of the UHC policy, so health providers from other ministries had no chance to participate in making decisions. It reflects the authoritarian management style of the MoPH. The MoPH was seen as using its power to

only protect funding for its own health facilities and for solving internal MoPH problems. There was a lack of a clear direction for the decentralisation policy. Staff felt the MoPH did not decentralise authority to them but only pushed responsibility on them.

In addition, the report of the Working Group on Quality of Life and Health Development (2004) shows that there is a problem with coordination between the community hospitals and district health offices resulting in conflict. This was seen as a result of the rushed implementation of the top-down policy. Consequently, the roles and responsibilities of both organisations in implementing the UHC policy are ambiguous. The health centres report to the district health office while the community hospitals hold the funding. When the community hospitals assign funding to the health centres the CDHO needs to approve the activities to be performed by the health centre staff. If the CDHO wants to develop some health promotion and disease prevention activities for the community the CHD has the authority and responsibility to allocate per capita funding for these activities, not the CDHO. Some CHDs have not provided funding to the CDHOs to carry out such activities, and these health activities have not been implemented. Some CDHOs are not satisfied that they have no part in the management of the funding. This conflict and confusion has impacted on health centre staff; they feel as if they have two bosses – the CHD who provides funding to them and the CDHO responsible for their career path.

The autocratic management style is seen, not only at the national level, but also at the local level. The Working Group on Quality of Life and Health Development (2004) report that, in some districts, the health centre staff were not consulted on the decision as to whether health centres should be upgraded to primary care units. The decision for upgrading those health centres rested on two heads – the CHD and CDHO. As a result, there was conflict between the health centre staff and the CHD and CDHO. This conflict impacts on the effectiveness of primary health services delivery and management at the front-line health services and thus on the implementation of the UHC policy.

Chungsathiensup (2002) argues lower-ranked workers in the Thai public health system dare not question or challenge staff in positions senior to them. This fits very well with Thai culture which avoids confrontation (Cooper & Cooper 1992; Holmes & Tangtongtavy 1995). Lower-ranked staff deal with the power differential by deferring, waiting for orders to act (Bloor & Dawson 1994). The management of the Thai public

health system rests on patronage and the attendant power ritual (Chungsathiensup 2002), a system very open to corruption.

Samudavanija (1987) argues the Thai bureaucracy is hierarchically organised, and reflects the differentials in status and power, rather than a rational division of labour or chain of command. This situation is based on personal relations of patronage and dependency, in which deference and loyalty are more important than merit (Samudavanija 1987). The security of the bureaucracy members is the priority, rather than functional rationality (Painter 2005). In addition, Siffin (1966) points out the Thai bureaucracy is typified by corruption, factionalism, departmentalism and low responsibility for, and lack of courage in, decision-making. Bureaucrats aim to preserve the status and autonomy of their cliques and departments or of themselves and their 'clients' (Siffin 1966).

Dixon (2005) reports the failure of performance-based reform in Thailand because of the highly-centralised control of budgeting by the Bureau of Budget in relation to other public agencies. In addition, Gamage and Suksomchitra (2004) report this style of management has led to failure in the Thai education system. Hofstede (1991) suggests the management culture of Thais has a high degree of the following attributes: i) power distance; ii) collectivist culture; iii) uncertainty avoidances; and, iv) femininity.

Thai culture is one with high power distance. Thais accept wide differences in power in their organisations (Komin 1990) and subordinates are unlikely to approach and contradict their bosses directly (Thanasankit & Corbitt 2000). According to Thanasankit (2002), high power distance results in a hierarchical organisational structure for most organisations across Thailand and the leaders of the organisations are viewed as father figures. Due to paternalism and dependence, the flat management structure approach is not effective and does not accelerate decision-making in Thai organisations (Rohitratana 1998), where decision-making commonly does not have a team approach (Thanasankit & Corbitt 2000), but is authoritarian (Holmes & Tangtongtavy 1995). In addition, the leader's role is perceived as that of a controller, rather than a colleague (Thanasankit 2002).

The authoritarian management style creates a 'superior-inferior' concept, which is already dominant in Thai culture (Rohitratana 1998:190). Hallinger and Kantamara (2000)

explain this results in an acceptance that decision-making should be made by leaders who are in positions of authority and discourages subordinates 'to dare to make mistakes, or to take initiative' (Thanasankit & Corbitt 2000). Furthermore, Komin (1990) and Thanasankit (2002) demonstrate that power in Thai society is constructed by position, title and status related with position and rank, rather than by personality or education.

Second, Thais have an intensely collective culture, which constructs and locates the context for change in group or social interests, rather than individual interests. They look primarily to their referent social groups in order to make sense of their role in change (Holmes & Tangtongtavy 1995). Thais are likely to express their view or opinion as a group, rather than as individuals (Thanasankit & Corbitt 2000). Decision-making, management and promotion are based on group performance (Hofstede 1991). Moreover, Thai culture values trust and relationships (Thanasankit & Corbitt 2000). Thanasankit and Corbitt (2000) argue personal relationships are stronger than work relationships and relationships between superiors and subordinates are considered to be equivalent to family relationships.

Third, the high level of avoidance, which results from uncertainty in how to respond to a given situation, can be demonstrated by the way that 'Thais are strongly socialised to conform to group norms, traditions, rules and regulations' (Hallinger & Kantamara 2000:192). Thais base their relationships on trust and emotion. Last, the high level of feminine qualities lead Thais to place a high value on stability and harmony in social relationships and avoid conflict as much as possible (Hallinger & Kantamara 2000; Thanasankit & Corbitt 2000).

Thanasankit (2002) argues the four attributes of Thai values described by Hofstede (1991) are not sufficient to frame all aspects of culture that influence management. He explores four other Thai values: i) *Pu Yai*; ii) *Kreng Jai*; iii) *Face Saving*; and, iv) *Bun Khun* (Thanasankit 2002:32-33). *Pu Yai* is a superior or power figure who normally has the authority to make decisions; this is similar to the concept of 'power distance' described by Hofstede (1991). *Kreng Jai* refers to feelings of being considerate or reluctant to impose upon another person (Klausner 1981) and this value can be observed in the actions of all superiors, equals and inferiors. *Face Saving* leads Thais to avoid conflict and criticism at all times. Thais also try to avoid making others lose face at all costs.

However, this value discourages subordinates from challenging their bosses. Last, *Bun Khun* is described by (Holmes & Tangtongtavy 1995:30) as:

... indebted goodness, [and] is a psychological bond between someone who, out of sheer kindness and sincerity, renders another person the needed help and favour, and the latter's remembering of the goodness done and his ever-readiness to reciprocate the kindness.

Thais believe in *Bun Khun* (Thanasankit 2002). It is a reciprocal relationship between two people to respect and do favours for each other. This can help create a friendly social relationship. However, this connection can be exploited and used to obtain power in Thai society (Rohitratana 1998). The patronage system embraces this value. Samudjavanija (1987) states it is difficult to separate the emotional relationships between superiors and inferiors (a characteristic of Thai culture) and the rational relationships which the bureaucrats need to function efficiently.

Finally, Evans, Han and Madison (2006) point out that there must be an appropriate preparation for organisational and community development in order that health care reform fits with the Thai bureaucratic organisational culture. Bowornwathana (2004:248) argues reform requires 'cultural change' and a long-term, rational strategy.

Rural health care reform will only be effective if the CHDs and their stakeholders understand, in depth, how organisational culture and traditional cultural norms influence their strategic involvement and the implementation of organisational change in the Thai social system (Carney 2006; Hallinger & Kantamara 2000).

2.10.4 The influence of the professional sub-cultures on the implementation of the Universal Health Coverage policy

The Working Group on Quality of Life and Health Development (2004) report on a conflict between a community hospital medical team sent to work at the outlying health centres and the staff at those health centres. The conflict was due to a lack of clarity in the roles and responsibilities of the two groups. The health centre staff felt their role was devalued as all patients were seen by a medical doctor. They felt some of the patients should have been seen by them. The health centre staff felt as if they were second class practitioners and the community lacked trust in them. They were separated from the

medical team and the two groups were not effectively working as a team. Some of the health workers left the health centre when the medical team came; they went to carry out health activities in the community or find something else to do, rather than stay at the health centres.

The Working Group on Quality of Life and Health Development (2004) report reveals some medical doctors had a negative attitude towards the health centre staff. The doctors regarded those staff who went away from the health centres when the medical team came to work at health centres as being unable to provide quality care, because they lacked the medical knowledge and skills. The health centre staff, in contrast, regarded the medical doctors' knowledge as limited to medical care with no understanding of the philosophy of PHC; their presence did not help improve health care (in the broader context) at the health centres. Moreover, the conflict arose, because members of the medical team from the hospital who work in rotas at health centres or primary care units were paid a loading/extra while permanent staff were not. It is not clear how the careers and financial incentives, as well as continuing education, of primary care level workers will be developed.

Bloor and Dawson (1994:284) argue the conflict between medical doctor and health centre staff may be due to differences in professional sub-cultures; medical doctors 'need to maintain high standards of professional practice and, in particular, to make accurate professional assessments and diagnoses of patients' conditions before deciding what services to provide to meet their needs'. Friedson (1970:128) points out that this is because '[the] principle of professional dominance...' has an influence on the bureaucratic organisational structure and culture. Furthermore, Bloor and Dawson (1994:284) assert '[t]he primary cultural system [in Thailand] currently supports a medically dominated operating system which is integrated with general medical services provided at the [community hospitals] ...'.

The interaction of people within an organisation can shape patterns of organisational culture which will be developed over time but can be influenced by the dominant individual or group (Schien 2004). Health professionals enter their organisations and bring their professional cultures and form the professional sub-cultures within their organisations, which can be compatible with, conflict with or contradict the organisational culture. Bloor

and Dawson (1994) state that professional sub-cultures can influence and shape organisational culture. The professional sub-cultures are not static, but develop over time through the interaction of the external environment and internal cultural elements of the organisation.

A case study of a Home-Care Service in Australia by Bloor and Dawson (1994:287) shows five types of professional sub-cultures, which may 'conflict, coincide and interlock' with each other and can influence, shape and redirect the organisational culture. First is the dominant sub-culture, which is that of the medical staff who are influential within their organisations.

Second is the 'orthogonal sub-culture' (Martin & Siehl 1983), which is that of physiotherapists and occupational therapists who accept the primary cultural system regarding the need for high standards of professional practice while having conflict with those of the dominant medical sub-culture. This sub-culture facilitates 'the development of new proposals and the redefinition of common elements without radically questioning the dominance of the medical subculture' (Bloor & Dawson 1994:286).

Third is the dissenting sub-culture which is that of the social workers. Their culture lies somewhere between an orthogonal and counter-culture. Their culture does not oppose, but is different from the dominant culture. They challenge the existing dominant sub-culture and offer alternative values and practices and can become the new dominant and enhancing sub-culture.

Fourth is the deferential sub-culture which is that of paramedics who defer to health professionals, especially the medical professional. This sub-culture is compatible with the organisational culture through deference. Last is the enhancing sub-culture which is that of geriatrician. This sub-culture is compatible with the organisational sub-culture through 'the unquestioning support and advocacy of the "rightness" of the core assumptions, values and beliefs' (Bloor & Dawson 1994:286).

In the conflict between the medical team of the community hospital and health centre staff, the health centre staff tend to be the deferring sub-culture while the medical doctor and medical team are the dominant sub-culture. However, these differences in

professional sub-cultures resulted in an ineffective integration of care and primary health services delivery at the peripheral health centres (Working Group on Quality of Life and Health Development 2004). Anderson and McDaniel (2000) argue that a successful health care organisation depends on the contributions of a multidisciplinary team, rather than that of a single professional. WHO's (2000b) vision of professional cooperation across the health services system requires: '...other health workers [be given] greater responsibility, autonomy, and dignity in a truly collaborative relationship' (Friedson 1970:232). The CHDs and the stakeholders need to understand how the professional sub-cultures interact and shape the organisational culture, so that they can learn from each other and blend their sub-cultures to align with their new organisational culture – working together to deliver primary health care to meet the health needs of the rural poor.

2.10.5 Future Challenges

Thailand may be one of very few countries to have tried to provide universal health insurance coverage for their population, while it underwent an economic crisis and still faces a scarcity of resources (Phoolcharoen 2005). The implementation of this policy was too rapid (Hughes & Leethongdee 2007), while 'the existing health infrastructures, including health professionals and health workers have limited capabilities to perform their new roles and functions' (Bureau of Policy and Strategy 2007:39). Critically, health services are still under-funded and the quality of medical services is less than expected (Bureau of Policy and Strategy 2007). The future challenges of the implementation of the UHC policy are how to: sustain the programme, meet the demand for quality health services by the community, and stabilise financial support for hospitals and other health care providers (Bureau of Policy and Strategy 2007:38; Hughes & Leethongdee 2007:1006). The most challenging is how to 'ensure equitable access to quality health services' (Pachanee & Wibulpolprasert 2006:316).

Tackling these problems requires money. However, money by itself will not be enough in the absence of management and leadership. To meet these challenges, WHO (2003b) recommends the Thai health system be driven by the principles of PHC as described in *the Declaration of Alma Ata 1978*. Furthermore, Rotem (1989) suggests improving access to quality care in rural areas which are under-resourced. Health managers at local levels

require management development within their own contexts, so they can correctly translate the UHC policy into the strategic and operational plans which reflect the priority health concerns in their communities.

The Health System Research Institute (2002) reports that the implementation of the UHC policy was ‘trial and error’ and dependent on the capability of the directors of the hospitals. To overcome those challenges, the CH should change its working style to be more proactive and more community-based as well as more patient-centred (Yanggratoke 2005). In theory, the CHD should take the role of leader of the district health system and be an agent for change in facilitating the move from a disease-centred and individual-based to a patient-centred and community-based health care system. The magnitude of this change cannot be underestimated in a traditional bureaucratic and medically-dominated health service in a developing country whose culture is marked by authoritarian structures and procedures (Chungsathiensup 2002; Eawsriwong 2002; Hughes & Leethongdee 2007).

2.11 Roles of the Community Hospital Director in achieving the Universal Health Coverage policy in relation to Primary Health Care

The community hospital is in the midst of a turbulent period and is tested in many ways. It is facing many challenges: new diseases and changing patterns of diseases; inequitable resource allocation in health services; and a policy of universal health coverage for a widely dispersed and largely poor population. The CHD, as the middle manager of the provincial health system and the leader of the district health system, is the catalyst to facilitate communication between all levels of the system’s structure (Yanggratoke 2005).

The CHDs have a huge responsibility implementing the curative and preventive streams of the UHC Policy. They must: i) be aware of the social origin of illness and develop community infrastructure through their leadership in government and community networks; ii) manage resources prudently to blend bio-medical services and health promotion programmes; iii) recognise and deal with threats to public health; iv) develop sustainable health services that provide quality and appropriate care for rural people; and

v) monitor and evaluate health care to maintain a continuous improvement in service delivery.

In order to achieve these goals, health services must be 'adaptable, flexible, innovative, competitive relationship oriented, communicative, team driven, having flattened hierarchies, able to retain employees, engender loyalty in customers' and promote life-long learning (Schwartz & Tumblin 2002:1420). Transformational change is integral to the cultural change needed; this will give priority to corporate function and relationships, but not to structure (Schwartz & Tumblin 2002:1424).

According to Dubrin and Dalglish (2003:75-82), to effect transformation the leaders must:

- raise people's awareness of the importance and values of certain rewards and how to achieve them
- help people look beyond self-interest by using entrepreneurial skills to encourage people help others in order to achieve team goals
- help people search for self-fulfilment
- help people understand the need for change both emotionally and intellectually. The leaders need listening skills to overcome the emotional crisis of the employee.
- invest managers with a sense of urgency for change. Leaders must be able to show what is necessary and achievable, as well as the available opportunities.
- commit to greatness and build a better future for everyone
- adopt a long-range perspective and, at the same time, observe organisational issues from a broad, rather than a narrow perspective.

The CHDs must have a more organic management style: They must be more flexible, more outgoing to the community, patient-centred, trained in public health administration, and must have the necessary power to carry out their task. The contingency approach of management described by Shortell and Kaluzny (1994:18), in which management styles can be different and 'depend ... on ... specific environments and technologies' with which managers are involved, might be the more appropriate direction for contemporary Thai community hospitals. Furthermore, WHO (2005b) recommends that a public health

perspective, crucial for 21st century health services, should be incorporated in the roles of health professionals and managers.

Yanggratoke (2005) suggests there should also be close collaboration and coordination between community hospitals, district health offices and health centres through the district health collaboration committee or CUP Board. The district health team is the key factor for a successful bridging of secondary and primary care to provide continuous and holistic care for the community. A district health administrative and development committee, which comprises the CHD, CDHO, health officers from health centres, local government and experts, needs to be developed. This committee will have the responsibility to appoint a working group drawn from the PCU at the community hospital, health centres and community representatives, to develop health activities which meet their community's needs. Figure 2.4 shows the proposed collaboration required to strengthen primary care services at district level. In Nakhorn Ratchasima Province, such collaboration has been initiated in the management of the CUP Board, where the CHD and DHO rotate the position of chair of that Board. This policy is known as 'Two Becomes One' (Nakhorn Ratchasima Provincial Health Office 2006a, 2007). However, it is still very rare to have local government and community participation on such a Board.

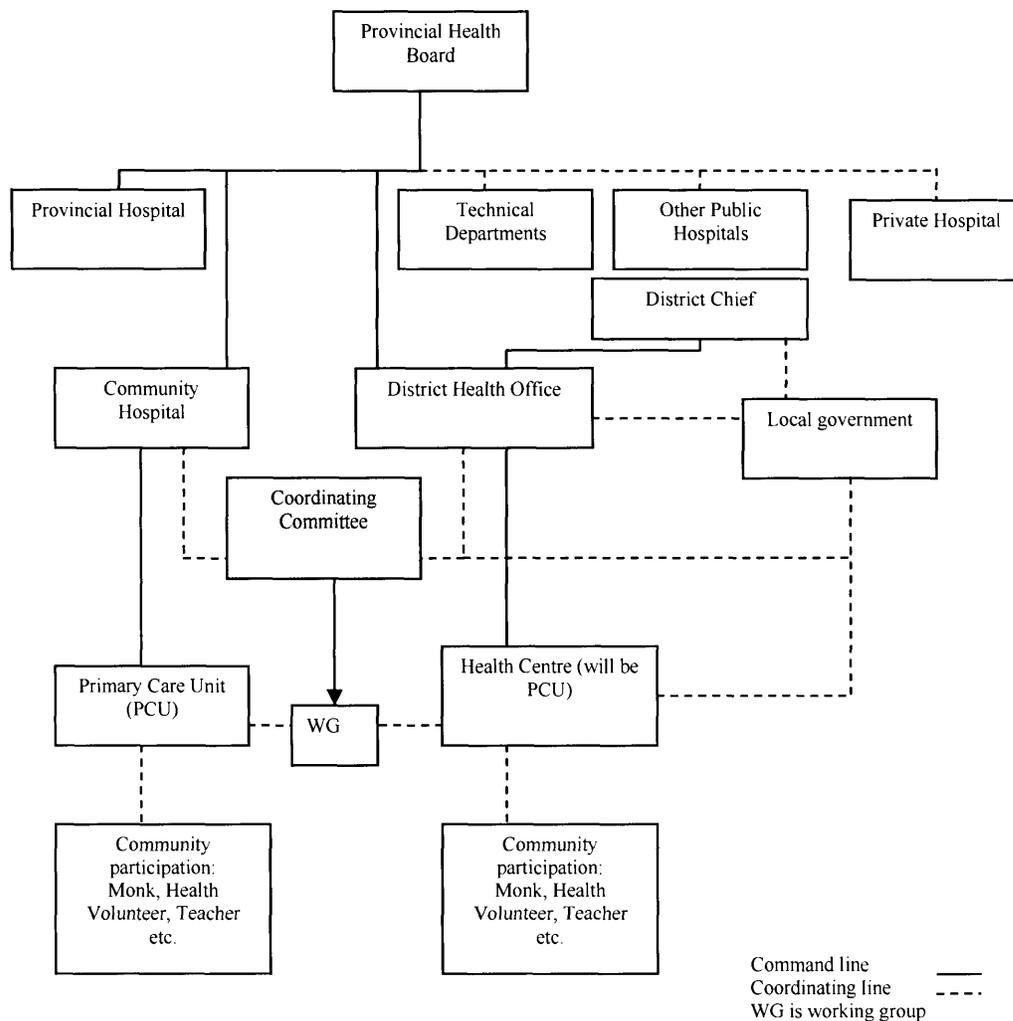


Figure 2.4: Proposed Thai District Health Services System

Source: Adopted from Yangkratoke (2005).

2.11.1 Required knowledge and skills for effective collaboration

In implementing the UHC policy, CHDs require effective collaboration with the stakeholders in the district (Yanggratoke 2005). At the Nam Pong Hospital, a community hospital in Khon Khaen, a province in the north-eastern region of Thailand, primary care services are successfully delivered to the community by the community hospital, because of the support of, and collaboration with, the local government (Leelakraiwan 2002). Austin (2000) argues that effective collaboration requires people who are skilful in developing and maintaining the relationship. There must be someone who has clear responsibility for the alliance (Spekman, Isabella & MacAvoy 2000).

Spekman, Isabella and MacAvoy (2000:188-189) review and propose six alliance management roles and responsibilities: i) visionary; ii) strategic sponsor; iii) advocate; iv) networker; v) facilitator; and vi) manager. The responsibilities of each role are shown in Table 2.13.

They propose that the effective and successful alliance manager or collaborator requires a culture and environment that supports alliances and collaborative behaviour (Spekman, Isabella & MacAvoy 2000). They point out a good collaborator requires ‘management skills for the future’ and a ‘mindset’ for collaboration (Spekman, Isabella & MacAvoy 2000:191). In addition, they advise that there are teachable and unteachable competencies required for being a good collaborator.

On the one hand, Spekman, Isabella and MacAvoy (2000:191-197) suggest teachable competencies comprise three groups: i) functional competencies – knowledge and skills about the core business of the alliance, e.g. products, markets, technologies, and general system management; ii) earned competencies – credibility, respect and the ability to undertake networking; and iii) interpersonal competencies – social and communication skills, cross-cultural awareness; language competency; and process skills.

On the other hand, according to Spekman, Isabella and MacAvoy (2000:199-203), the unteachable competencies are:

- 1) the ability to see multiple dimensions
- 2) the ability to learn from the past and not be obstructed by it
- 3) the ability to think across time: know what is and what is not possible and to understand the difference between them
- 4) the ability to see patterns in data and disorder among order
- 5) being clever, creative, and curious
- 6) possessing true wisdom
- 7) being flexible and adaptable to situations
- 8) having a mindset for learning.

Table 2.13: Alliance management roles and responsibilities

Management roles	Responsibilities
Visionary	Serves as the driving force behind the alliance's creation. Paints a picture of the possibilities an alliance creates. Maintains a broad perspective spanning inside and outside the company. Understands the compatibility of strategic intents.
Strategic sponsor	Sells the concepts of strategic alliances inside the company and beyond. Has authority to commit resources and key personnel to the alliance. Is "in" the alliance, not peripheral to it. Puts in motion alliance opportunities. Creates an atmosphere that fosters high energy and personal compatibility. Builds an organisation with dedicated resources. Looks for opportunities across the company to benefit the alliance. Fosters social development for alliance growth. Provides opportunities to strengthen and evolve the alliance. Spans many boundaries and layers.
Advocate	Sells the value of the relationship to alliance participants. Sells the value of the specific alliance in question. Develops support for the alliance. Constantly pushes the vision forward. Rallies the right people at the right time. Makes things happen deep in the company. Creates mechanisms for support and understanding within the alliance. Maintains a vigilant focus on the ongoing business of the alliance. Broadcasts its successes and achievements. Is internal to the alliance, hands-on and tactical. Actively owns the day-to-day alliance. Allows the alliance to be like-minded. Makes a significant emotional investment.
Networker	Relies on frequent contacts to expedite alliance business. Knows who to ask for help. Put the right people together. Accesses resources quickly and efficiently through others. Creates connections between internal networks of partner companies. Puts in face-to-face time to cultivate trust in key relationships. Engages in and encourages informal activities. Sees interpersonal activities as key. Bridges communication gaps.
Facilitator	Encourages open, honest, and straightforward communication among all parties. Facilitates effective reviews of "state of the alliance". Conducts interactions with diplomacy, tact, and objectivity. Creates bridges between diverse parties with different interests. Resolves conflicts effectively. Exhibits sensitivity to the needs of all parties.
Manager	Shoulders responsibility for sustaining the alliance. Ensures that the alliance follows its prescribed path. Maintains relationships critical to alliance success. Maintains alliance momentum. Is daily and constant. Is more tactical than visionary.

Source: Spekman, Isabella & MacAvoy (2000:188-189).

Shaughnessy (1994) proposes that new skills are required for managers to be successful collaborators. The key skills of collaboration management are: partner searching and appraisal; negotiation of allegiances; risk awareness, analysis and management; systematic project monitoring; time management; successful capacity management; dispute resolution; autonomous decision-making; the ability to establish personal credibility in new locations quickly; cultural empathy; and contract acquisition.

A good collaborator should have the quality of 'transcendental leadership', which Cardona (2000:204-205) defines as a 'contribution based exchange relationship'. In this relationship, the fairness of extrinsic and intrinsic rewards is promoted and motivation to do things for others or be willing to contribute is superior.

Many of these requirements will be a challenge for CHDs because of the long history of bureaucratic, rather than visionary leadership in the Thai health system. In addition, Ittithumwinit (1997) argues that CHDs have a dual role, clinician and manager, but they spend too much time in clinical services. This condition is referred to 'role overload' and it is a cause of role stress and conflict (Hardy & Hardy 1988:224; Willcocks 1994:69). According to Hardy and Hardy (1988), role overload refers to a condition where the occupants have difficulty in fulfilling obligations to an assigned role. These obligations are excessive compared to the limited time available. Role stress is a 'structural condition in which role obligations are vague, irritating, difficult, conflicting, or impossible to meet' (Hardy & Hardy 1988:165). The conflict of clinical and managerial roles is unique in its particular expression, but has occurred in other professions where practitioners have assumed a managerial role (Brown & McCartney 2000; McConnell 2002).

Bruce and Hill (1994) point out that doctor-managers tend to maintain their clinical load, because they want to ensure that they can secure the trust of their medical colleagues and keep their status as clinicians. Alexander et al. (2006) and Thorne (1997) warn that most managers who are also clinicians have a clinical mindset and focus on individual patients, rather than the primary health care of the wider community. Kekki (2006) asserts that the failure of the implementation of PHC may be caused by role disjuncture.

Hardy and Hardy (1988) and Willcocks (1994) argue that there are differences in the paradigms and goals for managers and clinicians. The managers make decisions based on

the assumption of the existence of a power hierarchy of coordination and control, which functions on the basis of rules and reliance on the supervisor's approval. On the other hand, the clinicians have authority based on their possessing specialised knowledge and skills. The decision of clinicians is based on their professional autonomy which is quite clearly understood by those equal and subordinate to them (Leggat, Harris & Legge 2006). Hardy and Hardy (1988:197) warn that the competing roles of manager and clinician can cause 'role ambiguity' which causes a lack of clarity regarding those roles. They point out 'incomplete knowledge and inadequate information' about the roles are major sources of that ambiguity (Hardy & Hardy 1988:201). Furthermore, Willcocks (1994) argues that not knowing what is expected of the managerial role for clinicians can lead to ineffective managers and organisations. Boucher (2001) suggests that the role requires clinicians to learn managerial skills in order to make a successful transition to become managers. In order to meet the complex challenges, managers are required to manage their own learning and that of their staff, and to understand the skills, knowledge and development pathways required of themselves and of their organisations (Legge, Stanton & Smyth 2006).

Willcocks (1994:69) argues that 'it is possible that role problems may be caused by either perceptual problems or those of inadequate role definition'. Therefore, in order to achieve the UHC policy and cope with these changes, it is necessary to understand the roles of the CHDs so that they would be able to transform their community hospitals to be learning organisations and meet the health needs of the community.

2.12 Conclusion

Thailand's community hospitals are operated in a dynamic and turbulent socioeconomic, political and health environment, which is both complex and costly. This literature review explored factors that are identified in government reports and in the Thai and international literature on the health care system and its need for reform. The challenges for CHDs implementing the UHC policy in relation to PHC are identified. In order to achieve the goals of the UHC policy, the roles of the CHDs in implementing the UHC policy in relation to primary health care must be clearly understood. The literature reviewed in this chapter has provided a lens through which to consider the working

environments of the CHDs in implementing the UHC policy and PHC. In the next chapter, the methodology and procedures of the research into the roles of the CHD are described.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter discusses the methodology chosen to explore the role of the Thai CHD in implementing the UHC policy in relation to PHC, the barriers to the delivery of PHC at the community hospital level, and strategies for the CHD to facilitate sustainable primary health services administered from the community hospital. A justification for the research design and methodology is presented, and the procedures and techniques used in the study are outlined. The setting and sample of the study and the researcher's role are described, followed by an account of the data collection, the interview schedule and the analysis procedures. The rigour and trustworthiness of the study is addressed and the methodological (including ethical) issues and limitations of the study acknowledged.

3.2 Justification for the research design and methodology

3.2.1 Justification for the qualitative paradigm

This study aims to understand the roles of the Thai CHDs in implementing the UHC policy in relation to PHC through experiences of informants, including the Thai CHDs and the stakeholders in the health services who can influence the CHDs' decision-making. It also aims to identify the barriers to the delivery of PHC at the district level and to propose strategies for CHDs to facilitate sustainable primary health services administered from the community hospital. To understand how the Thai CHDs implemented the health policy, strategically and operationally, there is a need to establish how they view the UHC policy, PHC and their role in implementing such policies (Andrews, Sullivan & Minichiello 2004).

The quantitative or positivist approach focuses on measurement and analysis of causal relationships between variables, validating these through careful observation, within a value-free framework (Denzin & Lincoln 2000, 2005). It offers little information about

complex human experiences (Bassett 2004). Schneider (2003:274) argues the limitation of quantitative research is that it does not fully capture subjective human experience within a cultural or situational context, because qualities of human experience are reduced to quantifiable variables. Subjective human experiences are not the central focus of inquiry, since the priority of quantitative research is generalisation and verification. In contrast, the qualitative naturalistic paradigm can better explore people's unique experiences in their everyday lives (Lincoln & Guba 1985; Silverman 2000). It is concerned with exploring and understanding a range of human experiences holistically and contextually from the informant's perspective and assumes a dynamic and negotiated reality (Liamputtong & Ezzy 2005). The data it generates are descriptive and rich with insight (Minichiello et al. 1995), and provide deep understanding of why people do what they do. This knowledge has the potential to open up new options for action and new perspectives that can change and direct policy (Jackson, Daly & Chang 2003; Steckler et al. 1992).

In this study, a constructionist/interpretive framework is employed. This theoretical tradition provides the most appropriate design to research the responses provided by the CHDs and the intended and unintended consequences of how they interpret the objectives of the Thai health care system. Their understanding of policies and political contexts shape their responses. The study also identifies contradictions in world-views between what the CHDs believe, how they interpret health policies and their intended consequences, and how the health care system supports or does not support the successful implementation of formal policies.

The social constructionist perspective, as described by Cheek et al. (1996), explains that the realities or knowledge we use for analysing and viewing the world or ourselves are collectively constructed and based on interactions with others. In this social constructionist perspective, all knowledge is 'socially constructed' through language and practice (Scott 1995). This knowledge is produced and shaped by cultural, political, social and historical contexts (Cheek et al. 1996) and, therefore, not value free or 'neutral' (Andrews, Sullivan & Minichiello 2004:62). Furthermore, the emphasis of this perspective is on the 'everyday taken-for-granted knowledge', rather than 'technical knowledge' (Scott 1995:112). This knowledge is the product of social process, and

emphasises where this knowledge comes from and how it is accepted as ‘legitimate knowledge’ (Cheek et al. 1996:150).

The term ‘social constructionism’ comes from the work of Karl Manheim (1893-1947) and Berger and Luckman’s (1967) *The Social Construction of Reality*. This then has led to the construction of the ‘sociology of knowledge’ (Crotty 1998:60). According to Nettleton (1995:34), social constructionism is also characterised as postmodernism which denies ‘any single truth or reality’ but, rather, supports multiple realities and takes an ‘eclectic’ approach or a ‘mixing of styles, values and behaviours’ (Andrews, Sullivan & Minichiello 2004:63).

The epistemological stance of social constructionism, according to Crotty (1998:42), is ‘the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context’. Meaning is constructed in both objective and subjective ways through interaction and interpretation (Denzin 1989). Schwandt (2000; 2003) argues interpretation is constructed within common understanding, practice, and language. Crotty (1998:64) claims social constructionism is ‘relativism’, which avoids interpretation based only on the researcher’s own understandings. Instead, research participants are viewed as ‘knowers’, who have their own knowledge and experience that the researcher seeks to gain and wants to examine (Jackson, Daly & Chang 2003:142).

The theoretical perspective embedded within the methodology is interpretivism. This approach is rooted in the work of the German sociologist Max Weber (1864-1920) and known as *Verstehen* (understanding) (Andrews, Sullivan & Minichiello 2004:62; Crotty 1998:67). Interpretivism emphasises an understanding and explanation of human and social reality from each informant’s perspective, which is generated within a specific cultural and historical framework (Crotty 1998). Denzin (1989) claims the interpretivist stance can better explore the assumptions held by various interested parties involved in public policy. It effectively identifies the strategies for achieving the aims of policy implementation. Various points of view can be broadened through an interpretation of these stakeholders’ views, because it focuses on their lived experience. The programme or policy can ‘be judged by and from the

point of view of the persons most directly affected' (Denzin 1989:11). The aims of the UHC policy and PHC in Thailand can only be achieved effectively if the perspectives and experiences of the CHDs and the health services stakeholders involved in implementing this policy are interpreted through the 'interpretist' perspective.

Symbolic interactionism is concerned with the ways that people construct perspectives including realities, societies, and selves through defining their interaction and engagement with their environment and its constituent symbols and artefacts (Denzin 1989); it relies on 'language and communication' (Charmaz 2006:7). It emphasises the importance of taken-as-shared meanings (understanding symbols, events, actions in similar meaningful ways) through which we communicate and the interpretation of meanings in the pragmatic creation of reality (Crotty 1998). Symbolic interactionism allows for the exploration of the roles of the Thai CHDs in implementing health policy by acknowledging the transactional nature of individuals as they actively engage with each other and the health services stakeholders. Through this interaction the researcher is able to construct, conceptualise and recontextualise their world (Liamputtong & Ezzy 2005).

3.2.2 Justification for in-depth interviews

The most commonly used sources of evidence in conducting case studies are: documentation, archival records, interviews, direct observations, participant-observations, and physical artefacts (Yin 2003b:85). In this study, I did not use observation as my method of data gathering because of its impracticability due to time and financial constraints and the CHDs knowledge emerging from my own position as a medical doctor, public health educator and researcher. de Vaus (2001:245) confirms that where the researcher uses the participation technique to gather data, he or she must be aware of the 'effects of reactivity'; that the participants may change their regular behaviour or action. 'The researcher can alter the dynamics of the cases being observed', which may be 'a significant threat to the internal validity of case study designs' (de Vaus 2001:245). The strength of the interviews is that they are targeted and focused directly on the case study topic and that they are insightful, providing perceptible causal inferences (Yin 2003b). However, weaknesses are also present (Yin 2003b) as the interviews may be

biased due to poorly constructed questions and response bias (Liamputtong & Ezzy 2005). They may be inaccurate due to poor recall. Finally, the interviewee may give only what he or she thinks the interviewer wants to hear.

In order to overcome these weaknesses, I followed my own line of inquiry, as reflected by my case study protocol, and used open-ended questions to guide the interviews (Yin 2003b). For example, the informants were asked about the facts of a matter as well as their opinions and insights. Triangulation of data is a crucial strategy in this study and is achieved through the in-depth interviews of all stakeholders who are involved in the implementation of the UHC policy, in relation to PHC, at the district level. In this way, a holistic view of events can be established from the perspectives of different informants (Gummesson 2000).

In his report de Vaus (2001:221) asserts 'the whole is greater than the sum of its parts'. In this study, the insights gained from the subjective opinions of the CHDs and the stakeholders' regarding the implementation of the UHC policy will probably differ and so provide a much fuller, more complex understanding of the whole event than would the perspective provided by one individual. The issues that emerged were also confirmed and validated by a focus group of the participant CHDs. A member checking strategy was used by sending each informant a transcript of their respective interview for their confirmation; the focus group members were also each sent a transcript of the focus group interview (Stake 1995:115-116).

3.3 Setting

3.3.1 Location and place of the study

One can argue that a case study is being used in this study. This is because the data collection concentrates on the role of CHDs, who are working in Nakhorn Ratchasima, a North-Eastern province of Thailand, in implementing the health policy to improve access to quality PHC services for the rural poor. This research study fulfils criteria necessary for a case study (Yin 2003b:13-14), because it is a study of the roles of Thai CHDs in implementing the UHC policy in relation to PHC at the district level, as a contemporary

phenomenon and within a real-life context. This study relies on multiple sources of evidence which were gathered through in-depth interviews with the participants, the CHDs and the health services stakeholders, implementing the UHC policy in relation to PHC in district areas, and from a focus group interview with the CHDs. The aim is to triangulate the data in order to increase its rigour and the trustworthiness of this research (Best & Khan 2006). This type of research is primarily descriptive (Yin 2003a) and presents as complete a description as possible of the CHDs' roles in implementing the health policy since the launch of the UHC policy in 2001. This study is also explanatory in nature, seeking to determine how and why their roles have or have not been successful and how the CHDs can implement this health policy successfully.

Merriam (1998) describes the major characteristics of case studies as follows:

- 1) They are particularistic as they focus on a particular situation, event or phenomenon and are a good design for practical problems.
- 2) They provide a rich, thick description of the phenomenon under study.
- 3) They are heuristic as they illuminate the researcher's understanding of the phenomenon under study through the insight gained into how things get to be the way they are.

This study was conducted during February to July 2006. The study was located in the Nakhorn Ratchasima Province, in the North-Eastern region of Thailand. It is the largest province in that region, and covers approximately 20 493 square kilometres. The central city of this province is about 255 kilometres by road from Bangkok. The population at June 2006 was 2 540 147 of which 441 714 people lived in the city of Nakhorn Ratchasima/Khorat (Nakhorn Ratchasima Provincial Health Office 2006b). The districts outside Khorat has populations ranging approximately from 20 000 people to 140 000 people.

In the 2005 fiscal year, the health facilities were under the supervision of the Nakhorn Ratchasima Provincial Health Office, which is the management unit representing the MoPH. The health facilities include one regional hospital (city hospital), 26 community hospitals, and 395 primary care units (Nakhorn Ratchasima Provincial Health Office 2006b). At the time there were only 76 accredited primary care units and 32 district health offices (Nakhorn Ratchasima Provincial Health Office 2006b). The health facilities

beyond the responsibility and control of the Nakhorn Ratchasima Provincial Health Office, or which belong to other Ministries, are: one 30-bed maternal and child health hospital (under the management of Department of Health, MoPH); one 300-bed regional mental health centre (under the management of Department of Mental Health, MoPH); one 400-bed Army hospital; and one 30-bed Air-Force hospital (Nakhorn Ratchasima Provincial Health Office 2006b). There are also private health facilities which are mostly in the city and towns and in 2005 included ten private hospitals; 170 private clinics (surgeries), and 61 dental clinics (Nakhorn Ratchasima Provincial Health Office 2006b). At the time of this study, there were 5179 health professionals that included 209 male and 138 female medical doctors, and 59 male and 1503 female nurses in the province. There is a severe shortage of health professionals in rural areas. In 2005, the MoPH launched a new classification of health facilities under its management by using the Geographic Information System (GIS) to improve resources allocation and infrastructure investment (Nakhorn Ratchasima Provincial Health Office 2006b). Under the new classification there are six levels of health facilities: i) primary care unit (in 2005, there were 220 main-primary care units and 175 sub-primary care units); ii) low-secondary care hospital; iii) mid-secondary care hospital; iv) high-secondary care hospital; v) Regional Hospital; and, vi) an Excellence Centre (which is the regional hospital).

At the district level, the community hospitals are secondary care units and also the contracting units for primary care (CUP). Each community hospital manages at least one primary care unit either located inside or outside the territory of the community hospital. The other primary care units are located at the other sub-districts outside the central district area where the community hospitals are located. They are under the supervision of the district health offices.

One of the UHC policy aims is to improve quality health services at the primary care units, called 'health centres' (*Sa-ta-nee A-na-mai*) and to upgrade these health centres to quality primary care units, renamed 'community health centres' (*Soon Suk-kha-parp Choom-chon*). There is a CUP Board, which is an administrative committee, to manage primary care services at the district level, and to collaborate with the community hospital and the district health office. The community hospital holds the funding for the UHC policy and the district health office, which receives no funding, controls all primary care units in the sub-districts.

The CHDs report directly to the Provincial Chief Medical Officer (PCMO). Most CHDs are either basic doctors or general practitioners. Some are medical specialists: general surgeons, paediatricians, and obstetricians. No specific health management training is available before becoming a CHD. However, the MoPH does provide intensive management training for some CHDs and health managers who may be promoted to higher positions within the bureaucracy. The Chiefs of District Health Office (CDHOs) report directly to the Chiefs of District (CDs) and are supervised by the PCMO. The CDHOs are responsible for public health and health management at the district level and look after health centres at the sub-district level. Most of the CDHOs are promoted from either the Heads of Health Centres (HHCs) or the Deputy HHCs.

The research province was chosen, because: i) it is a rural province with rural poor living outside a city making up a large percentage of the population; ii) it has the greatest number of districts and, as a result, has the greatest number of community hospitals that vary in size and which reflect the complexity of responsibility of community hospitals; and iii), this province is an exemplar of primary care unit development for the nation (Nakhorn Ratchasima Provincial Health Office 2006b). Figure 3.1 provides the location of Nakhorn Ratchasima Province in relation to the other provinces of Thailand. Figure 3.2 is a map of Nakhorn Ratchasima Province with its districts.

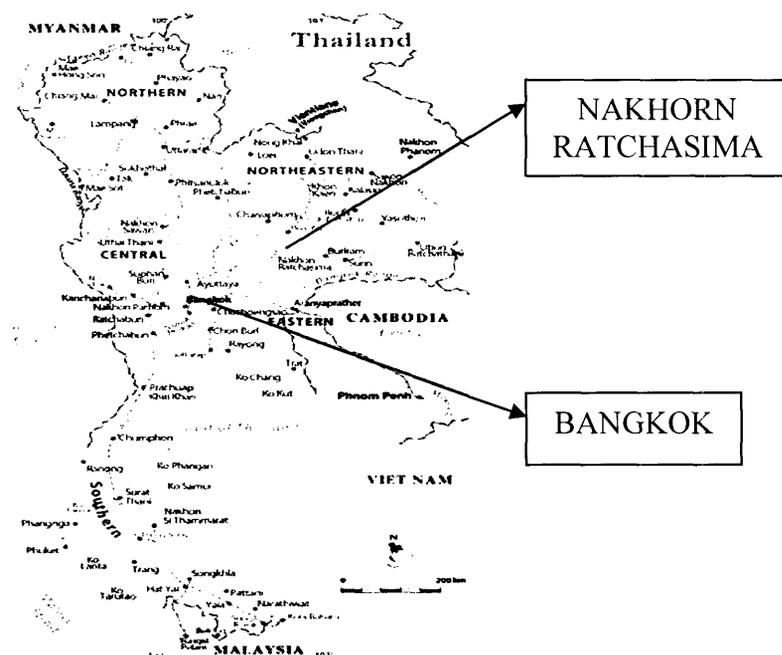


Figure 3.1: Map of Thailand showing location of Nakhorn Ratchasima Province

Source: Adapted from the Tenth International Congress of Ethnobiology (ICE) (2006).

at the CHD level. The stakeholders include the CDHOs and the HHPCUs who report to the CHDs, and the HHCs who report to the CDHOs. Each must be involved in either the management or the delivery of primary health services for the rural poor or have had experience on the CUP Board. The representatives of the VHVs are at the level of community representatives. Some of these representatives have two positions – VHV and Chief of villages or member of the local government.

Figure 3.3 shows a hierarchical diagram of participants in the implementation of the UHC policy in relation to PHC at the district level.

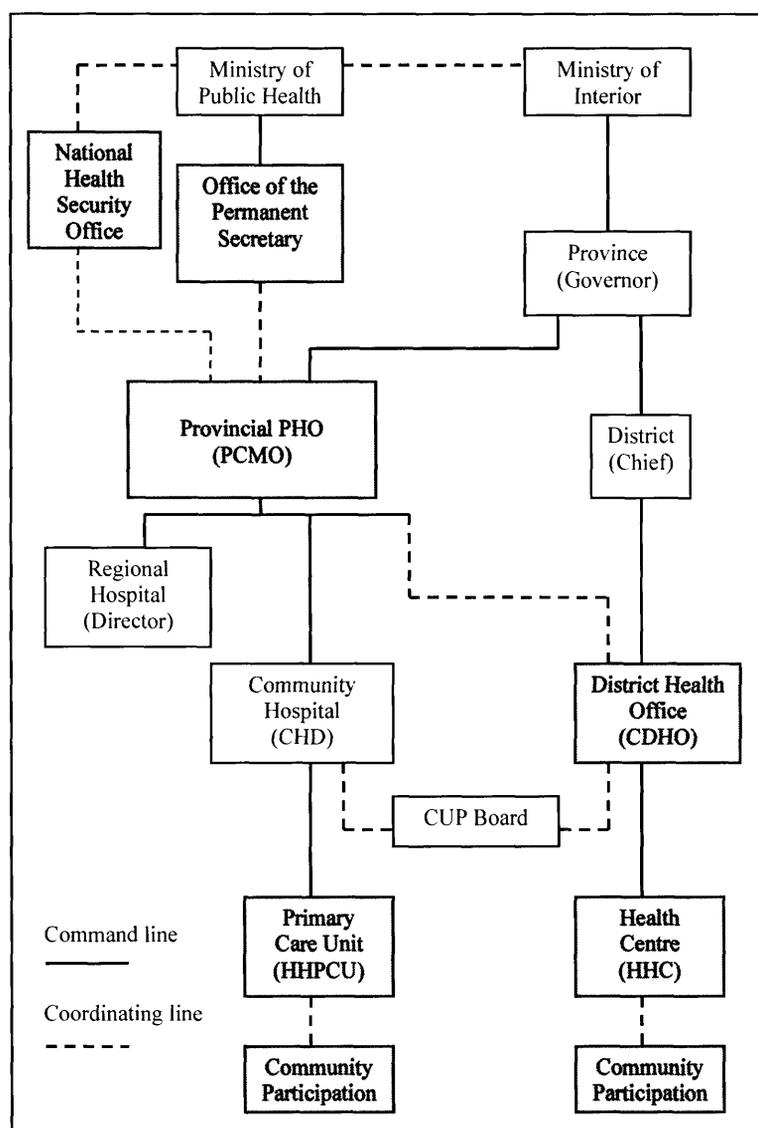


Figure 3.3: The hierarchical structure of the Thai district health system in relation to the implementation of the Universal Health Coverage and Primary Health Care policy
This diagram was developed for this study.

There are 725 CHDs in Thailand. This study comprises a purposive sample of the CHDs of the Nakhorn Ratchasima Province in the North-Eastern region of Thailand. There are 26 community hospitals in this province, classified by level of care and number of hospital beds:

- i) Basic level: 30-bed hospitals
- ii) Intermediate level: 30-, 60-, and 90-bed hospitals
- iii) High level: 120-bed hospitals.

The key principles of purposeful sampling are: the chosen participants are appropriate in terms of having relevant knowledge and experience in relation to the study, and data from those participants are adequate (Morse & Field 1985), relevant and sufficient (Bassett 2004:12). The focus is on providing an opportunity to discover the diversity of ‘responses and ideas that people have’ (de Vaus 1995:77). The strategy was chosen to assist in ‘theory construction’, rather than to provide ‘population representativeness’ (Charmaz 2006:6).

The CHDs were selected from 8 of the 26 sites, based on the hospital level of care, the number of beds, and the number of needy people served under the UHC policy by that community hospital. The selected sites are: i) 3 out of 11 basic level hospitals; ii) 4 out of 12 intermediate level hospitals; and iii) 1 out of 3 high level hospitals. The selection criteria were based on the NHSO report in November 2005 (National Health Security Office 2005) on the number of the people with the right to access care at those hospitals under the UHC policy. However, the CHD selection criteria were partially changed after the first interview, the first informant raising the issue of the financial crisis and resulting challenge facing the CHDs in implementing the UHC policy in relation to PHC. The *Nakhorn Ratchasima Provincial Health Office’s Financial Management Guideline 2005* reported that community hospitals serving more than 35 000 people, had no severe financial crisis; eight community hospitals were classified at the basic secondary care level and did have a financial crisis (Nakhorn Ratchasima Provincial Health Office 2005:53-57). The ‘financial’ issue was covered, because I felt that the diverse range of perceptions of the CHDs needed to be captured.

At the basic secondary care level, of the three hospitals chosen, one had had no financial crisis, and of the other two hospitals one had had a less severe crisis and the second a

more severe crisis. The funding of the small community hospitals is more susceptible to the changes in the per capita funding and the MoPH system of funding salaries before distributing the rest of the funding to the hospitals (these issues are discussed in Sections 2.10.1 and 2.10.2) (Nakhorn Ratchasima Provincial Health Office 2005:53-57).

3.4.1 Sampling procedure for the policy decision-makers

While waiting for replies from the CHDs and their district stakeholders to take part in this study, I approached a policy maker responsible for the UHC policy and PHC at the NHSO, and the representative of the MoPH for the Nakhorn Ratchasima Province. I sent invitation letters and participant information, which included *Participant Information Sheets* (Appendices 1 and 1.1) and *Consent Forms* (Appendices 2 and 2.1) to both. Both agreed to participate. They were the first two male senior executives recruited. Their responses arrived before any from the CHDs. The first two interviews were then conducted.

During the data collection from the first four CHDs, sampling was extended to include a national policy decision-maker from the MoPH. I sent an invitation to the Permanent Secretary to ask for an opportunity to interview him. However, the Permanent Secretary was unavailable and the Deputy Permanent Secretary, who was responsible for the primary care capacity building project, was interviewed on behalf of the Permanent Secretary. The participant is male. Therefore, three policy makers were included in this study.

3.4.2 Sampling procedure for Community Hospital Directors

After gaining ethics approval from the University of New England, Australia and permission from the Nakhorn Ratchasima Provincial Health Office, Thailand, to commence the study, participants were recruited using the following process. The Nakhorn Ratchasima PCMO invited me to participate in the Provincial Health Administrative Committee at the beginning of March 2006 and I was introduced to the committee. The committee were all CHDs and CDHOs. I presented the aims of this study and asked for volunteers to participate in the study. I informed them I would send each

potential participant a letter of invitation with information about the study. Those CHDs willing to participate were asked to contact me so I could arrange an appropriate time and place for an interview.

The invitation and relevant information sent to each potential participant included *the Participant Information Sheet* (Appendices 3 and 3.1) and *Consent Form* (Appendices 2 and 2.1). *The Participant Information Sheet* provided the potential participants with the aims of the study and details about participant involvement, as well as my contact details. Both sets of documents were available in English and Thai. I also had the contact details of the CHDs, which were provided on the website of the Nakhorn Ratchasima PHO and in its documents.

I telephoned each of the potential participants one month after sending out the letters to confirm they had received them and to discuss the possibility of recruiting them for this study. Some CHDs refused to participate. Those willing to participate were then contacted to arrange interviews. Eight CHDs, six male and two female, were selected to participate.

3.4.3 Sampling procedure for Heads of Hospital Primary Care Unit

The CHDs were asked to give permission for me to interview the HHPCUs attached to their respective community hospitals. These people were important to this study, because they had direct responsibility for PHC provision and its management. The CHDs were asked to distribute invitation letters, *the Participant Information Sheets* (Appendices 1 and 1.1), and *Consent Forms* (Appendices 2 and 2.1) to their HHPCUs. Potential participants were asked to contact me directly if they were willing to participate. By asking the CHDs to distribute the letters of invitation, I felt this signalled the potential participants that their CHDs were aware of the study and were happy for them to participate.

Minichiello et al. (1995:161) describe this approach as the ‘snowball sampling’ technique which ‘relies on the researcher’s knowledge of a social situation’. This technique involves using informants, whom the researcher contacts initially, being asked to contact other

potential participants in their networks. Eight of the participants, both HHPCUs or those responsible for the primary care units of the community hospitals, were recruited in this way. Only one participant was a deputy HHPCU; the HHPCU was on leave and the CHD introduced the deputy HHPCU to me. Five female and three male participants were recruited into this study using this sampling strategy.

3.4.4 Sampling procedure for Chiefs of District Health Office

After consulting with the CHDs, I then approached the CDHOs. Permission to recruit the CDHOs was obtained from the PCMO. The relevant material was sent directly to the potential participants. They were asked to contact me in person if they were willing to participate in the study and I then telephoned each potential participant to discuss the details of the study. These people were significant to the study as they were responsible for implementing PHC at the district level. Eight CDHOs participated in the study.

3.4.5 Sampling procedure for Heads of Health Centre

Following consultation with the CHDs, I contacted the HHCs under the supervision of the CDHOs. To be included in the study they had to have experience in participating in the CUP Board or District Health Collaborating Committee (DHCC). Such participation ensured that the potential participants had relevant knowledge of the CHDs' roles in implementing the UHC policy in relation to PHC in their districts.

Most of the CHDs suggested I contact the CDHOs, who are the people responsible for the HCs at the sub-district level, for permission to approach the HHCs to participate in the study. The letter of invitation to the CDHOs included a request to recommend how I might contact the HHCs. This selection evolved as the study was developed, and participants were selected from both accredited and non-accredited health centres/primary care units. A wide variety of health centres needed to be considered to fully grasp the implementation process of the UHC policy and PHC.

After obtaining the names of the potential participants, I sent relevant material to and telephoned each potential participant. Eight HHCs, five female and three male, who were

under the supervision of the CDHOs, participated in this study. Six HHCs were from accredited centres and two from non-accredited centres.

3.4.6 Sampling procedure for community representatives

Community representatives were also invited to participate in this study. To be selected the participants needed to know about the implementation of the UHC policy in relation to PHC. The CHDs advised me to ask the CDHOs to introduce suitable representatives of the VHVs. Relevant material was sent to the potential participants. It is worth noting that all their responses were received through either the HHCs or the CDHOs, even though I provided my contact details.

Eight community representatives, six female and two male, were recruited. Two were both VHVs and members of local government; one was Vice-President of the local government at sub-district level. Two other community representatives were Chiefs of Villages and the rest ordinary villagers. It is worth noting that two of the eight VHVs live in towns which were the service areas of the primary care units under the control of the community hospitals, while the balance live in sub-district areas where primary health services were provided by the health centres or primary care units of the DHOs.

There are 43 participants overall in this study. Following the individual interviews, all of the CHDs interviewed were invited to participate in a focus group. The focus group sought to clarify and explore issues and concepts drawn from the in-depth interviews.

3.5 Pilot study

One pilot interview was conducted in February 2006. The participant, a CHD working in a different province from that chosen for this study, had the appropriate experience and was known to me. With the pilot interview, I sought to gain experience in interview techniques, including the use of the recording equipment, to test the style of questioning and the range of relevant topics, and to determine the appropriateness of the semi-structured questions. According to de Vaus (1995), a pilot study is used to ensure the informants understand the intended meaning of the questions and the researcher

understands the informant's answers. It allows the researcher the opportunity to check the flow of the interview, timing and informant interest and attention.

The interview was conducted face-to-face and was recorded, with the participant's permission, using a portable digital voice recorder. The recording was downloaded to my computer as a sound file and duplicated on a separate external hard drive to ensure the safety and security of the data. I transcribed the interviews. A copy of the typed transcript was forwarded to the participant for feedback.

During the pilot interview, I reflected on whether the participant understood the intended meaning of the questions and whether the questions were flexible enough for the participant to give an account in their own words. This is in accord with what Yin (2003b:34) describes as 'construct validity'. I also checked whether the time allocated for the interview was appropriate and asked for feedback from the participant to determine whether he thought the questions were relevant to the aims of the study and whether the flow of the interview was appropriate. The feedback indicated the flow of the interview guide was relevant to the research question and allowed issues to emerge from the open-ended structure of the questions. The early version of the interview guide is presented in Appendices 4 and 4.1 to show how the questions evolved in response to the pilot study. The results of the pilot study were not used in the final data analysis as the participant is from a different province to those who took part in the case studies.

3.6 Interview schedule

A semi-structured interview schedule, together with a recursive conversational style of interviewing, was adopted as the major means of data collection. This was to ensure that the major issues were discussed at each interview, and to allow the participants the freedom to express their individual experiences and opinions. Throughout the interviews, additional questions 'emerged through the dialogue...[and allowed the interviewer to] alter the line of questioning' (Minichiello et al. 2004:413). These were generally prompting questions to elicit a deeper response or to clarify responses to the questions contained in the guide. However, not all participants were asked all questions. The questions were asked to explore the subjective opinions of the participants, by prompting

them to discuss aspects of their lived experiences regarding the implementation of the UHC policy in relation to PHC at district level and the questions addressed the aims of the study.

While the main purpose of the study is to explore the roles of the CHDs in implementing the UHC policy in relation to PHC, it is noted that none of the questions asked directly about the roles of the CHDs in relation to PHC. This strategy was used to avoid introducing the concept of the roles of the CHDs in relation to PHC into the interviews to prevent possible biases in the interviewees' responses. The interview questions were designed to explore indirectly the roles of the CHDs in relation to the PHC. The participants were asked about their work and experiences in relation to the PHC and the UHC policy, their views on relationships between stakeholders, barriers to health policy implementation, and what they thought could be improved.

Three sources were used to develop the interview questions. The first source was the past experience of the researcher. The second source was the literature review on the Thai health system and the implementation of the UHC policy, and the role of community hospitals in implementing the UHC policy and the challenges that they faced (Bureau of Policy and Strategy 2005; Cohen 1989; Jongudomsook 2005, 2004; Leerapun, Siwiroj & Termsirikulchai 2000; Ramasoota 1997; Supawong & Kadgarnglai 1998; Wibulpolprasert 2002, 2005). Third was the international literature, mainly from the WHO, regarding the roles of community hospitals in implementing PHC, and PHC in developing countries (Cohen & Purcal 1989; LaFond 1995; Phillips 1990; Walsh & Warren 1979; Werner et al. 1997; WHO 1978, 1990, 1992, 1998, 2000b, 2003b).

In the following section, the interview schedules are outlined, followed by a justification for each question in the interview schedules developed from the three sources detailed above. Four different interview schedules were developed, one each for the CHDs, the national and provincial bureaucratic officers, the health managers at the district and sub-district levels, and the community representatives.

3.6.1 Interview schedule for national and provincial bureaucratic officers

The questions for each interview of the national and provincial bureaucratic officers are presented in Appendices 5 and 5.1. The first four questions were broad, seeking to know what these bureaucratic officers thought would be the challenges facing the Thai health system over the next five to ten years. The issues of the health policies and services, and those of the health professionals who need to respond to those challenges, were considered next. These questions aimed to explore the vision of the BOs for the Thai health service system and indirectly explore their view of the appropriateness and adequacy of resources preparation to meet community needs. The views of health policy decision-makers on PHC were indirectly examined by this means. The last question aimed to reveal their views on the capacity of the CHDs in implementing the UHC policy in relation to PHC. However, this question was designed as a general one so the participants could easily answer it and avoid any possible bias.

3.6.2 Interview schedule for Community Hospital Directors

The questions for each interview of the CHDs are presented in Appendices 6 and 6.1. The first question aimed to indirectly explore the roles of the CHDs vis-à-vis primary health services and the possible barriers they face in implementing PHC and how they could improve their PHC services. The Thai literature suggests the community hospitals are the place to deliver secondary care and primary care (National Health Security Office 2005). However, the literature from the WHO suggests that community hospitals should deliver secondary care and only support PHC (WHO 1992). This suggestion is to prevent people bypassing the primary care unit or health centre and going straight to the hospital for primary care. People often believe the hospital has more resources and a better reputation (WHO 1990, 1992). This issue was probed further in order to compare what the CHDs believe or think compared to views expressed in the literature.

The second and third questions asked about the experience of the participants, in relation to being the CHDs and what they want to recommend to others who may be future CHDs. These questions aimed to explore the interviewees' perspectives on being CHDs and what they regarded as the required competencies, skills and knowledge of that position. Even

though this research is intended to explore the roles of the CHDs in relation to PHC and not inside the hospital, these questions can illuminate how the CHDs felt about and saw their roles in relation to what occurred inside the hospital and to PHC outside the hospital. It was part of the strategy of the questions to seek ways to improve the role of CHDs in implementing PHC.

The fourth question addressed the health needs of their community. I aimed to ascertain the directors' views concerning community health needs in order to explore what needed to be delivered for appropriate health services and the barriers to doing so. This question led me to explore how the CHDs integrate secondary care and PHC for their communities.

I have had experience working in public health management, and it is generally known that the Thai public system relies on the direction and power of the higher authorities, such as the ministry and regional levels. Most of the officials in the local areas must adhere to the demands of their superiors, but they realise that some policies do not meet the needs of the local people and officials. The last question was designed to go beyond this barrier by asking if they had power to do what was really needed by the local people. This question was designed to confirm the researcher's argument and explore this issue further, in order that the data could lead to strategies appropriate to the needs of the CHDs, health managers and people at district level.

3.6.3 Interview schedule for health managers at district and sub-district levels

The participants at the sub-district level were the CDHOs, the HHPCUs, and the HHCs. Initially, I did not intend to ask specific questions of the participants at this level. I had intended to explore the emergent themes from the in-depth interviews of the CHDs at this level, as I wanted to have data from these participants for triangulation purposes.

However, the CHDs are also medical doctors and health managers at the district level, and I was aware of their power and authority over the health managers at the district and sub-district levels. If I had asked these participants directly about the emergent issues, they may have had some difficulty in answering. This does not mean I thought those

participants would not be truthful. As the starting point, I asked general questions regarding their experiences in implementing the UHC policy in relation to the PHC. The emergent themes were considered later in the interview. The questions asked at the interview are presented in Appendices 7 and 7.1.

3.6.4 Interview schedule for community representatives

At the community representative level, the aim of the interviews was to explore the context of implementing the UHC policy in relation to PHC at the community level. The open questions concerned the health needs of the community; how people in their community accessed health care, what people said about their health services and what they thought should be improved and how this should be done. The emergent issues from the in-depth interviews from the other participants were presented to the community representative as the study evolved: for instance, the devolution of primary health services to the control of local government is an issue that emerged and I asked their views on this issue. The research questions are presented in Appendices 8 and 8.1.

3.6.5 Focus group interview schedule for Community Hospital Directors

Five issues required clarification and validation. The first was the confusion in understanding the meaning of PHC and primary care. This confusion is world-wide and has led to failure in the implementation of PHC (Abiodun & Wolf 1988; Starfield 1998). My aim was to clarify what the CHDs understood about these two terms.

The next three issues were about what model of PHC was appropriate for the Thai rural context. During the interviews, the issues emerged in terms of organisational structure and power relationships between different stakeholders at the district and national level, as well as the problem of the severe shortage in rural PHC professionals. I sought to clarify and validate this issue with the group of CHDs and to explore how they could improve the quality of primary health services under their authority.

The last issue that emerged from all the interviews involved the devolution of health services to local government. This study was held during a transitional period with no

final solution provided by the MoPH. I raised this issue in order to discover whether the CHDs had any solutions.

3.7 Data collection procedure

After the list of willing participants was completed, all volunteers were contacted to arrange the interviews, which were conducted in either the participants' workplaces or homes and at a mutually convenient time. All of the interviews with bureaucratic officers, CHDs and health managers were held at their place of work except for one participant, a CHD, who preferred to be interviewed at the Provincial Health Office. Three of the community representatives preferred to be interviewed at health centres. Two preferred the meeting rooms of the community hospital's primary care units and the other two preferred their homes. One person wished to be interviewed at the district health office. The community representatives sought to be interviewed in places other than their homes, because those places were more quiet and private. The interviews ranged from 35 to 142 minutes, with an average of 73 minutes. Each participant was informed they were under no obligation to participate, that the interview would be more like a conversation and that I was most appreciative of the great opportunity to learn from them in this fashion, rather than have a question and answer session. All interviews were recorded with the participants' permission.

The interviews were conducted during the participants' working day. Before the day of interview, I always telephoned to reconfirm the arrangements. At the start of each interview I again introduced myself and thanked the participant for agreeing to take part in the study. I gave a brief description of the study, and also described my background as a GP and lecturer at the Faculty of Public Health, Naresuan University, Phitsanulok, Thailand and a Doctoral Candidate of Health Services Management at the University of New England, Australia, and that I was conducting this study as a part of my doctoral requirements.

During the course of the interviews, only one participant asked for the recorder to be switched off because of the issue being discussed. I respected his request and I only took notes of the interview. Several interviews were cut short by the participant being called

away for some matter. The interviews were resumed when the participant was able to continue with the interview. These events are all recorded in the researcher's journal.

I started the interview with the first question, as per the interview guide; the conversation then followed the participants' lead, rather than my seeking to gain answers to specific questions. The guide was used to probe only when it was necessary to do so, but mostly I listened to the participants as they told their stories. By using this approach, the participants were shown respect and fully acknowledged as equals in the study process. The reduced perception of a power difference between the participants and me led the participants to feel free to fully present their story. All the interviews concluded with my asking the following question: 'Is there anything else that you want to add or discuss in relation to any aspect of the interview?'. The participants were thanked, and informed that they would receive a copy of the transcript to review. They were asked to feel free to delete, correct, or approve the text.

Verbatim transcriptions of each interview tape were made as soon as possible after the interview took place, and returned to each informant with a letter of thanks within one or two weeks of each interview. All informants returned corrected and approved transcripts. After the corrections were made to the interview transcript, the transcript was recorded on my computer as a data file and duplicated on a separate external hard drive to ensure the safety and security of the data. After every interview, I entered details in my research journal which I kept in the database. These journal entries are important for reflecting on the research process (Janesick 2000) and keeping me focused on the study and learning from each interview. This served to enhance my interview skills and style so as to improve subsequent interviews (Richardson 2000).

3.7.1 Data collection stages

Data collection in this study was conducted in four stages and these are described below.

3.7.1.1 Stage I: In-depth interviews with national and provincial bureaucratic officers

This was the earliest stage. Two participants were interviewed at this stage. After the amended transcripts were returned by the informants, I translated the transcripts into English as the interviews were conducted in Thai. The translations and initial data analysis were sent to my supervisors at the University of New England for evaluation of my interview skills and style and of the emerging themes. This stage was conducted during February 2006 to April 2006.

3.7.1.2 Stage II: In-depth interviews with eight Community Hospital Directors and thirty two stakeholders at district level

This stage began with the interview of a CHD. After the revised transcript was returned to me it was translated into English and was sent to my supervisors as before. I sent a sample of a Thai transcript to an independent translator, who is an academic in a public university in Thailand. The translation was sent directly to my supervisors in order to verify my translation skills.

I asked a colleague, who is a native speaker of English, at the University of New England to assist in editing the grammar of the texts. I reread the edited drafts and listened to the audiotape to ensure that the original meaning was preserved. After the supervisors acknowledged that they were confident of my interview skills and style, I continued conducting the interviews with the CHDs and the 32 stakeholders at the district level. This stage was conducted during May 2006 to July 2006.

3.7.1.3 Stage III: In-depth interview with the Ministry of Public Health's policy maker

While conducting the in-depth interviews, the emerging data showed many issues involved the MoPH. These included the unclear direction of the policy regarding devolution of primary health services to local government, financial support for primary care, and the shortage of PHC professionals. This data led to my extending the scope of

the study and I decided to include an interview with a health executive at the ministerial level.

3.7.1.4 Stage IV: A focus group interview with Community Hospital Directors

After completing all the face-to-face interviews, I felt no more new data was emerging from the interviews. Each CHD was then asked to participate in a focus group. The aim of a focus group was to clarify and validate the emergent issues from the in-depth interviews. One very dominant and enriching issue (Stringer 2004) was the confusion in understanding 'primary health care' and 'primary care'. The interview guideline was sent to the participants (Appendices 9 and 9.1).

All of the CHDs chose to have the focus group at the Provincial Health Office on the afternoon of the same day they were to attend a meeting there. The PCMO gave permission to conduct the focus group at the PHO and the use of one of the meeting rooms. The room I chose needed to be a small room, 'but not so cramped as to inhibit interaction' (Grbich 1999:109). I listed the issues as they emerged during the discussion.

Before the group met, I telephoned the participants to reconfirm the arrangement. All of the interviewed CHDs were happy to participate. One CHD had another urgent meeting that same afternoon and she had wanted to participate in a focus group, but was only able to do so for half an hour. She apologised and explained the unforeseen situation, which was beyond her control. I assured her that I understood her difficulties, and made sure that I did not pressure her to leave another meeting for the focus group.

At the start of the focus group, I again introduced myself and thanked the participants for agreeing to take part in the study. All the participants knew each other very well and knew me as their colleague, so the rapport was good. There were eight CHDs at the start of the meeting; Two female and the remainder male. The meeting table was set in a U-shape and I sat in the middle. I briefly described the purpose of the focus group, which was to clarify and validate the issues emerging from the in-depth interviews, and I encouraged the participants to speak about issues of interest to them.

Each participant was asked to sign a consent form before the focus group started. The conditions for the gathering were the same as those put in place for the individual interviews. I was the facilitator for the discussion and encouraged the participants to brainstorm on the issues, following their conversation and collating the emergent issues throughout the process.

At the conclusion, I debriefed the group and provided feedback. I thanked the participants for their contributions and informed them that I would send a copy of the transcript to them for review. The participants were assured that all names they had mentioned and their names would be de-identified. They were encouraged to feel free to change, delete or approve anything in the transcript. The focus group interview lasted 160 minutes.

At the University of New England I presented the preliminary findings. All informants returned the transcripts and some parts were amended at the request of some of the participants. This procedure was an essential facet of the analytical process. The transcripts were altered as requested, and recorded on my computer and duplicated on a separate external hard drive to ensure the safety and security of data.

3.8 Participant profile

This section provides a demographic profile of the informants who participated in this project. This information is valuable as it provides background about the age, the years of experience in health care, the education levels, and the current positions of the participants, as well as the CUP Board positions of the CHDs, CDHOs, HHPCUs, and HHCs (see Tables 3.1 – 3.6). Participant's demographic data sheets are presented in Appendices 10 and 10.1.

3.8.1 Policy decision-makers

The policy decision-makers in this study were the national and provincial bureaucratic officers (BO). Table 3.1 provides details of their background. These bureaucratic officers were resident doctors and CHDs at the early stages of their management careers. All were involved in health management at the national level as members of various committees.

They have not practiced as medical doctors for some time, but still hold their medical licences.

Table 3.1: Demographic profile of national and provincial bureaucratic officers

Position	Level	Gender	Age (Yrs)	Education	Experience in the current position (Yrs)	Experience in health care (Yrs)
BO 1	National	M	54	BSc, MD, MPH	3	28
BO 2	National	M	56	BSc, MD, MPH (PHC Management), Thai Board of Preventive Medicine	2	30
BO 3	Provincial	M	54	BSc, MD, MPH, Thai Board of Preventive Medicine, Thai Board of Family Medicine, Cert. for Executives in Health Administration (MoPH)	8	27

Note: BO = Bureaucratic Officer; BSc = Bachelor of Sciences; M = Male; MD = Doctor of Medicine; MPH = Master of Public Health; MoPH = Ministry of Public Health; PHC = Primary Health Care; Yrs = Years.

3.8.2 Community Hospital Directors

There were eight CHD participants in this study. Details of their background are provided in Table 3.2. The MD in Thailand is equivalent to the MBBS in Australia. The government ranks the MD degree as equivalent to a master's degree in terms of salary and career promotion. The Thai Board Certificate in Preventive Medicine and the Thai Board Certificate in Family Medicine are achieved by special examination but without any associated formal training. A year's experience in working in a CH is one criterion for applying for a Board Certificate. This Certificate is regarded as being equivalent to a doctoral level qualification and also relates to salary and career promotion. Currently, all of the CHDs practice either as GPs or specialists, or both, in their CHs or their own private clinics.

Table 3.2: Demographic profile of Community Hospital Directors

Position	Gender	Age (Yrs)	Education	Experience in the current position (Yrs)	Experience in health care (Yrs)	Position in CUP Board
CHD 1	M	56	BSc, MD, Thai Board of Surgery, Cert. for Executives in Health Administration (MoPH)	19	29	Chair
CHD 2	M	42	MD, Thai Board of Preventive Medicine, Cert. for Hospital Administration, Cert. for middle health managers (MoPH)	6	17	Deputy
CHD 3	M	47	MD, Cert. for Hospital Administration	18	23	Chair
CHD 4	M	42	MD	15	18	Chair
CHD 5	M	49	MD, Thai Board of Paediatrics, Thai Board of Preventive Medicine, Thai Board of Family Medicine, Cert. for Hospital Administration	14	23	Chair
CHD 6	F	41	MD, Thai Board of Family Medicine, MPA	13	17	Chair
CHD 7	F	38	B Pharm, MD	5	9	Deputy
CHD 8	M	33	MD, Thai Board of Family Medicine, MPA	4	9	Chair

Note: BSc = Bachelor of Sciences; B Pharm = Bachelor of Pharmacy; CHD = Community Hospital Director; CUP = Contracting Unit for Primary Care; F = Female; M = Male; MD = Doctor of Medicine; MPA = Master of Public Administration; MoPH = Ministry of Public Health; Yrs = Years.

3.8.3 Heads of Hospital Primary Care Unit

Seven HHPCUs and one assistant head participated in this research project. Table 3.3 provides background details of the eight participants. Before this current position, two HHPCUs had worked as ward and operating room nurses in CHs and one HHPCU had worked in tertiary care. The others were either staff or heads of health promotion and community health departments of the CHs. Even those with no nursing degree were involved in the provision of curative care. Six HHPCUs report directly to the CHDs; one

reports to a medical doctor assigned by the CHD to supervise the PCU. The assistant head reports to the Head of the PCU and to the CHD.

Table 3.3: Demographic profile of Heads of Hospital Primary Care Unit

Position	Gender	Age (Yrs)	Education	Experience in the current position (Yrs)	Experience in health care (Yrs)	Position in CUP Board
HHPCU 1	F	42	M Nursing	4	20	Board Member
HHPCU 2	F	44	B Nursing	11	23	Board Member
HHPCU 3	M	49	MPH	2	26	Board Member
HHPCU 4	M	42	BPH	1	20	Board Member
HHPCU 5	F	48	B Nursing	24	25	Board Member
HHPCU 6 (Asst. Head)	M	36	BPH	6	15	Board Member
HHPCU 7	F	39	B Nursing	17	17	Secretary
HHPCU 8	F	40	B Nursing, MPH	8	19	Board Member

Note: Asst. Head = Assistant Head; B Nursing = Bachelor of Nursing; BPH = Bachelor of Public Health; CUP = Contracting Unit for Primary Care; F = Female; HHPCU = Head of Hospital Primary Care Unit; M = Male; M Nursing = Master of Nursing; MPH = Master of Public Health; Yrs = Years.

3.8.4 Chiefs of District Health Office

Seven CDHOs and one Assistant CDHO participated in this study. Their ages ranged from 40 to 55 years. In each district, most of the CDHOs were older than the CHDs, and only two CDHOs were younger than the CHDs. The details to their background are provided in Table 3.4.

The CDHOs are considered to have a lower level of education than the CHDs. The Health Worker Certificate is ranked lower than undergraduate level. The career path of a CDHO begins with being a health worker. They then can be promoted to be an assistant PCMO. Very few are promoted to senior positions in the MoPH in Bangkok, because they do not have the same status as other health professionals, such as medical doctors, dentists, pharmacists or nurses. The CDHOs report directly to the District Chief and are supervised

by the PCMO. Their role is to oversee public health at the district level and supervise HCs and health staff at the sub-district level.

Table 3.4: Demographic profile of Chiefs of District Health Office

Position	Gender	Age (Yrs)	Education	Experience in the current position (Yrs)	Experience in health care (Yrs)	Position in CUP Board
CDHO 1	M	52	BPH	8	30	Deputy
CDHO 2	M	55	MPH	7	30	Chair
CDHO 3	M	51	BPH	9	29	Deputy
CDHO 4	M	55	BPH	7	31	Deputy
CDHO 5 (Assistant)	M	40	MPH	11	19	Board Member
CDHO 6	M	57	Cert. for health worker	10	38	Deputy
CDHO 7	M	40	BPH	3	21	Chair
CDHO 8	M	53	BPH	3	32	Deputy

Note: BPH = Bachelor of Public Health; CDHO = Chief of District Health Office; CUP = Contracting Unit for Primary Care; F = Female; M = Male; MPH = Master of Public Health; Yrs = Years.

3.8.5 Heads of Health Centre

Eight HHCs participated in this study. Table 3.5 sets out details of their background. All of the HHCs had been health workers at HCs before being promoted to HHCs. One HHC had worked in a CH for a short period of time before being transferred to a HC. One had worked at the DHO as a financial officer before being transferred to a HC as a HHC. Besides their management role, all the HHCs have to provide health services to the people of their sub-district; this includes medical care, disease prevention and health promotion, as well as home health care. They report directly to the CDHOs. They are the first contact point of HVHVs and VHVs for coordination and communication. They are all members of the CUP Boards. Some had been elected to the CUP Board but some had been appointed. The elections occurred in the districts with a large population and a greater number of sub-districts and, as a result, a greater number of HCs.

Table 3.5: Demographic profile of Heads of Health Centre

Position	Gender	Age (Yrs)	Education	Experience in the current position (Yrs)	Experience in health care (Yrs)	Position in CUP Board
HHC 1	M	38	BPH	14	17	Board Member
HHC 2	F	49	Cert. for Midwife, BPH	27	31	Board Member
HHC 3	F	50	Cert. for Midwife	30	30	Board Member
HHC 4	M	44	B. Law, MPH	10	24	Board Member
HHC 5	F	39	BPH	3	19	Board Member
HHC 6	F	43	BPH	12	23	Board Member
HHC 7	M	42	Cert. for Health Worker	8	21	Board Member
HHC 8	F	35	B Nursing	2	14	Board Member

Note: B. Nursing = Bachelor of Nursing; BPH = Bachelor of Public Health; B. Law = Bachelor of Law; Cert. = Certificate; CUP = Contracting Unit for Primary Care; F = Female; HHC = Head of Health Centre; M = Male; MPH = Master of Public Health; Yrs = Years.

3.8.6 Community representatives

Eight community representatives participated in this study. Seven were Heads of VHVs in their sub-districts, while four were also Heads of VHVs at district level. Only one was an assistant to a sub-district HVHV. Table 3.6 provides details of their background and other positions. At the time of this study, the informant who is a Vice-President in local government did not hold a position of HVHV. The other community representatives were ordinary villagers. Some of the HVHVs have links to local level politics. One community representative told me being a HVHV meant he could influence local people to vote for particular people in local government. Their role in health care is to coordinate and communicate between the health staff at HCs or PCUs and the villagers.

Table 3.6: Demographic profile of community representatives

Position	Gender	Age (Yrs)	Education	Other positions	Experience being Head of VHV (Yrs)	Experience being VHV (Yrs)
HVHV 1	F	49	Matayom 6	Member of Local government	8 (3)	8
HVHV 2	F	46	Prathom 6	Chief of Villages	6 (6)	20
HVHV 3	M	60	Prathom 4	Chief of Villages	3 (3)	10
HVHV 4	M	45	Prathom 7	Vice-President of Local government	10* (2)	10
HVHV 5	F	51	Matayom 3	-	13	13
HVHV 6	F	53	Prathom 6	-	2	17
HVHV 7 (Assistant)	F	47	Prathom 4	-	10	10
HVHV 8	F	45	Matayom 6	-	23	23

Figures in brackets represent number of years of experience in another position.

* At the time of this study, this informant was not a Head of VHV since he has been appointed to be a Vice-President of local government.

Note: Prathom 4 is equivalent to Year 4 (NSW, Australia's education); Prathom 6 (new) is equivalent to Year 6; Prathom 7 (old) is equivalent to Year 6; Mathayom 3 is equivalent to Year 9; Mathayom 6 is equivalent to Year 12; F = Female; HVHV = Head of Village Health Volunteer; M = Male; VHV = Village Health Volunteer; Yrs = Years.

3.9 The researcher's role

The aim of this section is to declare the researcher's previous knowledge and experience as a means of enhancing the rigour and trustworthiness of this study (Patton 1999). I have worked as a GP for 13 years, and as a medical and public health lecturer at the Naresuan University, the public university in the Lower-Northern region of Thailand, since 1997. I have also played an active role in the Thai Hospital Administrator Association, as the chair for academic affairs. Currently, I am employed as a lecturer in health services management at the Faculty of Public Health, Naresuan University and as a scholar of the Thai government, studying for my doctoral degree in health services management at the University of New England, Australia. I am the first Thai medical doctor and scholar to study health services management as formal training at the doctoral level.

There is no formal health services management programme in Thailand and there is no formal training required to become a health manager or hospital director. I believe future

Thai health managers must be professional health managers. I also hold PHC as the appropriate strategy for Thailand to strengthen and sustain its health system and, as a result, the quality of life of its people, particularly the lives of those who are rural poor (Atun 2004; WHO 2003b). These factors have brought to me a passion for health services management and PHC.

It was important for me to establish a relationship with each participant based on mutual respect. Potential participants at the district level were approached as a fellow rural health practitioner, rather than an academic. Each CHD and the other participants were told that while I have never held a CHD position, I have the greatest admiration for the valuable role they play in the rural healthcare system and I want to learn from them. The intention of this research is to inspire constructive change in the management of the Thai rural health services. However, I am also aware that, as an academic working outside the healthcare system, while my role is to encourage and support the need for change, I am not the one who should drive that change process. Grbich (1999:235-236) suggests that 'acting as an advocate to facilitating change' is one of the techniques to reduce the researcher's authority over the participants.

At the end of interviews, some participants who are CHDs and health managers of the primary care units told me they believe this study to be the first in Thailand focusing on the roles of CHDs. They were grateful I listened to their stories and would present them to the world, or at the least they wanted the authorities to listen to and acknowledge their stories, as they perceive themselves to be a marginal group. One participant, a female health manager of a primary care unit, was in tears when she talked to me, because she feels oppressed by the MoPH's bureaucracy. She feels very few see her PHC work as valuable and she has little opportunity to express her feelings of discomfort with the health system. However, I told her I felt privileged to meet all the participants because of what I learned from them.

I approached the national and provincial policy decision-makers as my professional seniors, rather than as formal authorities. The flow of the interview was more conversational, instead of being formal questions and answers. I believe this approach was the best way to establish a strong rapport with the participants and it is the way of Thai culture.

3.10 Data analysis techniques

Thematic analysis was used in this study. The nature of thematic analysis is inductive and it is consistent with the tradition of qualitative research that theories are guided by the emergent data, rather than preconceived existing theories (Hansen 2006). The data must be approached with an open mind and the emerging themes sought. Hansen (2006) suggests that there are two important characteristics of thematic analysis: thematic analysis is iterative and uses coding. These characteristics mean the researcher is immersed in the data in such a way that new features are readily identified (Grbich 1999).

Thematic analysis was used to analyse the data since this study involved an interpretative and inductive process. The weakness of thematic analysis is the possible bias on the part of the researcher. Hansen (2006:150-151) suggests that the strategies to avoid such biases or assumptions are: i) using more than one analyst; ii) reading widely; and iii) using clear examples from the data which demonstrate the context of the themes. Miles and Huberman (1994) argue good qualitative research can increase its trustworthiness by showing how the researcher obtains the findings, rather than emphasising only what the findings or descriptions are.

The data analysis was guided by the thematic analysis techniques (steps) of Aronson (1994) and Colaizzi (1978). In addition, strategies outlined by Miles and Huberman (1994) and Hansen (2006) helped to frame the analysis. In this study, these steps have been closely followed for the data analysis, which is presented below. The interviews were conducted and then transcribed by the researcher. The transcripts were analysed using two strategies as described by Miles and Huberman (1994). The qualitative data analysis software package, NVivo 7, was used to store, organise, sort, code and retrieve data.

The analysis was conducted at several levels. The first level was the analysis of data from each interview. The second integrated the analysis of the data from informants who are stakeholders associated with the CHDs. The third level was the analysis of data from the focus group. The final stage of analysis was a triangulation of the data from the three sources.

The researcher read each transcript as a whole, re-reading all transcripts several times to acquire an overall sense of each case study. Significant concepts were noted on the transcripts. Important sections were highlighted and other notes recorded as memos in the case study project files. Following the re-readings, the major concepts were collected and listed. A code was given to each concept.

To support the researcher's coding, the first eight transcripts were also read by one of the research supervisors and another supervisor read the first three transcripts and conducted an independent preliminary coding. The results of the preliminary codings by the researcher and the supervisor were compared; any differences were discussed until agreement was reached. The criterion for assigning a code was that the particular concepts were related to some aspects of the aims of the study.

After the eight transcripts were analysed, the second level of analysis, data from the interviews with stakeholders associated with CHDs, was integrated with the analysis of data from the interviews with CHDs. Possible themes were derived from the composition of the categorisation of codes. In this second level of analysis, the similarities between coded concepts were identified and common concepts across informants were reviewed. The codes were grouped together to formulate themes and sub-themes. Each theme describes an aspect of the phenomenon under study, and was shared by all informants. When the analysis of the codes resulted in distinct but related components, sub-themes were established to express each component within the themes. Each of the sub-themes describes a different facet of the one theme, and enhances the total description of that theme.

The second criterion utilised for the formulation of themes and sub-themes was that the concepts described were shared by informants, and that those concepts were related to each other in some way. Each theme and sub-theme was given an identifier which expressed the experience described in the theme or sub-theme. The resultant thematic analysis has two-stages, comprised of the development of a set of codes, followed by the development of themes and sub-themes from those codes.

Each transcript was coded in the same way as described above. After each subsequent analysis, the codes, themes and sub-themes were revised to include any new concepts

from later interviews. Major themes were presented to the CHDs who participated in a focus group to validate and further discuss these themes. After the focus group meeting, the focus group transcripts were read and re-read. The data were analysed as before. The final stage of data analysis integrated the analysis of the focus group with the previous themes and sub-themes derived at the second level of analysis.

At the conclusion of the forty-three interviews and the focus group, it was considered that saturation had occurred. To ensure consistency, all transcripts were then re-read and re-analysed to ensure the themes explained the concepts developed from the earlier interviews as well as the later interviews and the focus group. A preliminary description of each of the themes, with supportive quotations to illustrate the respective themes, was sent to each participating CHD. This ‘member check’ process helps to increase the trustworthiness of the data (Devers 1999:1171; Stake 1995:115-116).

Finally, to develop a valid argument for choosing the themes, I reviewed the literature in relation to the themes and sub-themes that had emerged. The story line was developed by interweaving the findings and literature. This is to assist the reader to have a deep understanding of the process and motivation of the researcher (Aronson 1994). The four themes that emerged are described below (Figure 3.4). Table 3.7 displays the connections between the themes which have emerged from the data and the aims of the study.

Theme one:	Duality of the role – clinician and manager
Sub-theme 1.1:	Longevity and seniority in clinical practice
Sub-theme 1.2:	Lack of effective management training and support
Theme two:	The CHD perception of the implementation of the UHC policy in relation to PHC
Sub-theme 2.1:	The Thai bureaucratic management style in the context of the implementation of the Universal Health Coverage policy
Sub-theme 2.2:	Understanding of PHC as primary medical care (PMC)
Sub-theme 2.3:	Problems and challenges in implementing the UHC policy in relation to PHC
Theme three:	The impact of structural interests
Sub-theme 3.1:	The impact of political bureaucratic interests
Sub-theme 3.2:	The difference in professional sub-cultures
Sub-theme 3.3:	The repressed community
Theme four:	Possible strategies
Sub-theme 4.1:	Single authority for district health services management
Sub-theme 4.2:	Role of the CHD as PHC facilitator
Sub-theme 4.3:	Skills and knowledge required by CHDs
Sub-theme 4.4:	Professional development of CHDs

Figure 3.4: Themes and sub-themes that emerged from the data analysis

Note: CHD = Community Hospital Director; PHC = Primary Health Care; PMC = Primary Medical Care; UHC = Universal Health Coverage.

Table 3.7: Table showing the connections between the themes and the aims of the study

Theme	Aims of the study		
	1	2	3
1	X	X	
2	X	X	
3		X	
4			X

3.11 Rigour and trustworthiness of the study

The impact of qualitative research rests upon ‘the trustworthiness of the data and the research process’ (Ellis 2004:108). The traditional meanings of rigour as it relates to quantitative research refer to validity and reliability (Hansen 2006:47-48). Hansen (2006:48) contends that these terms are difficult to use in qualitative research, as researchers assume that reality is socially constructed and that different meanings of truth exist when the study is conducted in different settings. However, Devers (1999:1163) argues qualitative research holds a post-positivist philosophical position, which is different from positivistic quantitative research and believes that ‘social reality can never be fully apprehended, only approximated’. According to Devers (1999) and Lincoln and Guba (1985), qualitative research requires a different set of evaluation criteria for its validity and reliability. Lincoln and Guba (1985:300) established a set of criteria which include credibility, transferability, dependability, and confirmability. These criteria were used to evaluate the rigour and trustworthiness of this study. Credibility was ensured through triangulation. The researcher used this procedure in searching for ‘convergence among multiple and different sources of information to form themes or categories’ (Creswell & Miller 2000:126).

Data triangulation was achieved through individual interviews and the focus group discussion. The information from these informants was used to present a holistic view of the roles of the community hospital directors in implementing health reform in the rural areas. Triangulation was effected through the use of ‘multiple analysts’ (Patton 1999:1193). The researcher’s supervisors independently analysed and interpreted the data. The triangulation of perspectives in order to interpret the same data set, which Yin (2003b:99) describes as ‘theory triangulation’ was conducted by me and my supervisors. Next, I searched through the data for evidence that might undermine the themes’ validity. This procedure is called ‘disconfirming evidence’ (Creswell & Miller 2000:127). This

issue is discussed fully in the data analysis and discussion chapters. Another procedure used to increase the credibility of this research was to conduct ‘member checks’ (Devers 1999:1171).

My prolonged engagement in the field was another measure used to increase the validity (Creswell & Miller 2000). I stayed at the research site for about five to six months and had very good cooperation from the participants. As a result, I gained a plurality of views from these participants which enabled me to better understand the contexts of the participants’ views (Creswell & Miller 2000).

The dependability of this study was enhanced through using an ‘inquiry audit’ (Hoepfl 1997:60). The aim was to ‘examine the process and product of the inquiry, and determine the trustworthiness of the findings’ (Creswell & Miller 2000:128). This procedure was to justify the resulting themes from the data analysis, which are described in detail in the data analysis chapter. Two of my supervisors read and analysed the data and coded the themes independently. My supervisors and I then discussed whether the inclusion of all emergent themes was appropriate. Documentation of the categorisation of themes was kept to ensure the rigour of the thematic development. As a result, the trustworthiness of data analysis was enhanced. Furthermore, the above procedure assisted the enhancement of confirmability as it reduced any potential bias that may come from a single researcher collecting the data (Patton 1999).

3.12 Methodological issues and limitations

The following concerns are not limited to case studies. Some may be compensated for with an awareness of the issues and proper preparation. A limitation normally associated with the development of case studies is the investment of significant amounts of resources in terms of time, energy and funding (Stake 1995). Some issues that emerged were beyond the immediate scope of this study. In this study, the problems that did arise were partially relieved by excellent cooperation on the part of the participants.

Limitations imply potential weaknesses in a study and these are invariably attached to the design of that research. de Vaus (2001:237) points out: ‘a case is just that – a case – and cannot be representative of a larger universe of cases’. Although the case study research

approach was the most appropriate design for this research, several limitations exist. The Nakhorn Ratchasima Province is only one of the 76 provinces of Thailand. Only eight CHDs were interviewed out of a possible of 26 CHDs in this province and of 722 CHDs in Thailand. The sub-cultures of consumers and health professionals in different regions of Thailand may not be reflected in the perceptions of the sample in this study, which was conducted only in the North-Eastern region.

Only 35 more stakeholders were interviewed in this study. At the national level, politicians, such as the Minister of Public Health, were not included. There were other senior figures, who were not included, who were involved with the UHC policy and PHC at the Department level and in the Bureau of Investigation of the MoPH. The representatives of the rural doctors' association were not approached and neither were representatives of the Thai Medical Council, the medical schools, or the Thai Nursing Council. Furthermore, there are still other potential stakeholders, especially at the provincial, district and the sub-district levels, both inside and outside the health services field, who were not considered for inclusion, such as the Governor or his representatives, the representatives of local government at the provincial level, members of the CUP Boards, representatives of municipal authorities, and representatives of other government agencies at the district level, e.g., Chiefs of District, teachers, representatives of the Ministry of Human Security and Social Development, and those of the Ministry of Agriculture. Also, representatives of the city hospital and other public and private hospitals were not included.

A further potential limitation was that I have worked in a Thai public university and am involved with this health reform as a manager and an academic. The possibility of distortion in the selection and analysis of the data was a factor, given the way the study was conducted. As a result, regular checks were put in place to try and reduce the likelihood of such distortion. However, it should be noted that experience in the Thai health system for many years allowed me to attain a much deeper understanding of what the informants discussed, such as their jargon, as well as improving emotional access to the informant's working world.

3.13 Ethical considerations

Prior to commencing this study, the University of New England Human Research Ethics Committee granted permission for the study to take place: Approval Number *HE06/009*, valid until 06/02/07 (Appendix 11). I was also granted permission by the Nakhorn Ratchasima Provincial Health Office, Thailand (Appendix 12) to conduct this study. Fraser and Alexander (2006) argue that, before conducting any research dealing with human beings, the researcher must appropriately consult the relevant human research ethics bodies and carefully consider the possible advantages to be gained and any risk which may cause the participants discomfort or disadvantage.

In planning and conducting this research, I used the bioethical framework provided by Beauchamp and Childress (2001). Four principles underpin their framework: i) non-maleficence; ii) beneficence; iii) autonomy; and iv) justice. Non-maleficence is about doing no harm to the participants. Beneficence refers to the fact that the research process and findings are good for the participants and their communities. Autonomy is about the rights and freedom of choice of each participant to participate voluntarily in the study. Lastly, justice refers to fairness towards the participants.

There is very limited research about the roles of CHDs in implementing health reform in Thailand, so this research has the potential to benefit the communities which were studied. The study aims to provide constructive strategies to improve the CHDs' roles in administering and delivering PHC services to the rural poor, who are the neediest of the general population.

The anonymity and the confidentiality of participants' responses were assured. However, because of the small amount of demographic information, the participants were warned that it is possible someone may still be able to identify them. I was mindful of the importance of autonomy for the participants in order for them to give informed consent. It is worth noting that Hofstede (2001) contends there is inequality of power in all organisations, particularly the hierarchy between 'boss' and 'subordinates'. I do not have such power over the participants as I work in a different region and for a different ministry.

At the transcription stage, each participant was allocated an identifying code used to de-identify the participant in the transcription from the original digital sound file. In addition, I deleted place and organisational names that might assist in the identification of the participants from the transcriptions and used pseudonyms to further ensure the anonymity and confidentiality of the participants. The identification codes were kept separately in a locked cupboard in my office, as were the transcribed 'hard' copies of the interviews. The audio files were kept on my personal computer with a secure password access which was backed up on an external hard drive and located within my locked office. Only the supervisors and I had access to the data. Audio files and transcripts will be retained for five years, after which they will be destroyed, consistent with the Ethics approval and the National Health and Medical Research Council Guidelines (NHMRC 1999).

3.14 Conclusion

This chapter commenced with a justification of the qualitative case study approach as the research design. It then addressed the research methodology, including the setting, sample, pilot study, interview schedule, data collection and the role of the researcher. Ethical issues, and the rigour and trustworthiness of the study were explored as were those regarding the methodological issues and its possible limitations. The results and analysis of the interviews are presented in the next chapter.

CHAPTER FOUR

FINDINGS

4.1 Introduction

The research paradigm and methodology for this case study were described in the previous chapter. This chapter presents the themes emerging from the data, with supportive quotes to illustrate the concepts. The themes are discussed within the contexts of the influences of structural interests, the organisational culture and the difference in professional sub-cultures.

This chapter provides insight into how and what CHDs and the health services stakeholders involved in the implementation of the UHC policy in relation to PHC think about the role of the clinician-manager. The complexity of the role and the challenges to the health care system and health care reform are explored. The chapter indicates how the UHC policy has been implemented, and the subsequent consequences to the stakeholders who have to play an active part in the policy implementation. There is a need to consider the good intentions of the policy and the limitations in the practical implementation of the policy. The effects of the structural interests in the Thai health care system that shape and impact on the policy implementation and the health system are discussed in relation to the literature. The analysis of the findings is embedded in the experiences of the people who are involved with the rural health care reform policy. Their combined viewpoints, usually not heard, are valuable to develop a global picture of PHC. The rich insights of the participants on the implementation of the health care reform policy (UHC policy) give further incentives to refine both policy and practice and may enable further refinement of both policy and practice.

Qualitative case study research provides an account that captures as fully as possible the meanings of participant responses, allowing common experiences and opinions to be recognised and acknowledged (Ellis 2004). In this chapter, the themes emerging from the data are presented and illustrated by text specifically selected to describe the shared experiences and perceptions of the informants who contribute to the themes. Each theme

builds on the previous theme to describe the phenomenon under study: the role of the CHD in implementing the UHC policy in relation to PHC.

4.2 Theme 1: Duality of the role – clinician and manager

The following section explores the complexities inherent in the role of a CHD. This major theme seeks to inform the reader about the background of the role of CHDs. When asked how he became a CHD, a senior male CHD (3) replies:

I've been a doctor since 1983 and I've been here [in this province for] twenty-three years so far. I was an intern physician for one year, then a resident physician for four to five years. I was then appointed to be a CHD at various hospitals for the past 18 years. (CHD 3)

Another senior male CHD, with a background as a paediatric specialist, reports that most CHDs lack specific knowledge about health promotion and disease prevention:

Usually medical doctors, who are primarily concerned with medical services, are selected as Directors. Health promotion and disease prevention don't seem to be as important as medical services. (CHD 5)

A senior national bureaucrat, who has a medical background and has been a CHD, shares his view regarding the pros and cons of having medical doctors as CHDs:

The pros are that they will have excellent medical skills and knowledge and can have a deep understanding of medical matters. The con is that, if they are trained purely in medicine, they may understand the epidemiology and environmental contexts less. Therefore, I think that there are both pros and cons. (BO 1)

A senior provincial bureaucrat, who had been a CHD in the Nakhorn Ratchasima province and is a very experienced rural doctor, adds:

As I said earlier, doctors in the Thai context tend to emphasise secondary and tertiary care, rather than holistic care in the primary care context. So, being a Director has a different paradigm of thought to being a doctor, and we don't prepare our Directors for that primary care task. (BO 3)

He also argues that medical schools do not prepare CHDs for primary care, because they focus on acute care, not on management:

... Directors who are also doctors have to do clinical work; therefore, they don't have time to think strategically and don't have time to manage health centres, or even visit health centres. This may be the result of the system of doctor education, which teaches medical students to put more emphasis on medical treatment at the hospital level, and not at the primary care level. Most medical graduates focus on

their hospital and the number of beds, and are disease-oriented. So, it's quite difficult to encourage them to be interested in primary care. (BO 3)

A male CHD states that most CHDs lack specific knowledge about disease prevention and the broader social contexts of health. In his view, they lack knowledge about management and intersectorial and community engagement:

There are just a few Directors who know about these things, especially about disease control. There are Directors who know only about diseases, but don't know about the community or about how much funding they have. They know nothing about the involvement of the DHO, the HCs and local government. They don't know even how the villagers are, what is the health status of people in their communities, and what are the villagers' financial and economic status and lifestyle. (CHD 4)

A young female CHD makes a similar observation:

When asked what happened after I became the Director, I would say it was the same. I spent my efforts on diagnosing the patients for the most part, and devoted very little attention to administration. (CHD 7)

Tension between roles

The senior provincial bureaucrat (BO 3) argues: '*being a Director has a different paradigm of thought from being a doctor...*'.

A senior male doctor describes his initial discomfort about assuming a managerial role:

Being the Hospital Director is like driving a car; you can control your car, but you are not the car itself. You may sometimes be a part of the car, but sometimes [you're] not. There are many factors regarding the position of Hospital Director. You have to manage everything, and everyone should be involved to make the car [or the organisation] run smoothly ... I am uncomfortable about myself and sometimes I am depressed and discouraged [as I cannot control everything] ...
(CHD 2)

An experienced female CHD supports this view:

Supposing I was young or even a resident doctor, it would seem that anything asked of me would be possible to do. Now that I am a Director, I realise that many things that may seem to be possible can't be done because of a particular obstruction. (CHD 6)

Another senior male doctor expresses the view that when he became a CHD, success in work depended on others:

Fifty percent of the success comes from the Hospital Director's competency and the other half depends on the support of others. (CHD 1)

When the CHDs have to handle management work that is more complex than clinical work, they feel they lack the necessary management skills. This leads to a lack of confidence in their ability to manage and there is a sense that their work is not effective.

This is seen in the statements of three senior CHDs:

I still find myself getting into trouble with it [communication skills]. Sometimes, I speak about one thing, but others [appear to] hear another message – yet the speech is very effective. Sometimes, I speak smoothly, with no emotion, but [then] they think that I am scolding them. (CHD 6)

It seems to me that being a Hospital Director is more difficult than being a doctor. Many times, I feel discouraged ... I don't have many management skills... (CHD 3)

I am uncomfortable about myself [in this role] and sometimes I am depressed and discouraged [as] I can't get the organisation to move forward to meet the changing situation. The CH cannot provide standard health care to people; cannot provide equity of health care to them ... [and] the villagers do not understand us; doctors are often sued by them. (CHD 2)

A male senior CHD suggests that working with others, as a team, is critical to being a successful or effective CHD:

... the Hospital Director should learn to work collaboratively as part of a team, because the Director alone can't ensure the organisation's success. It requires teamwork. (CHD 2)

He stated that CHDs often have a clinical mindset towards management:

... doctors are always trained to be health team leaders. They need to be comfortable in giving orders, and everybody should follow their direction. The manager with a medical background may be a "quick-tempered person" [is used to being decisive and having a quick response to their directives]. Carrying out a manager's order doesn't show results as quickly as carrying out a medical order. The manager with a medical background would probably not be initially able to accept others' opinions. There might be some problems that they might not be consciously aware of ... so they would not accept others' opinions. They always believe that their idea is absolutely right. (CHD 2)

The senior provincial bureaucrat expresses the belief that this is because medical schools do not prepare CHDs for management. He stresses management training is needed to change the health system to be more effective in PHC:

Doctors learn about diseases, epidemiology, and social problems, but not management, so they don't know how to be effective managers ... I think that this is because of the nature of Thai medical education, which produces doctors as medical technicians, but forces them to work as Directors. I think we have to put more effort into changing the system. We have to change the Directors' personality and behaviour ... we need to train those medical students to be skilled in management ... To have such skills, I think that they need to study

management. I don't think that they will have such skills without education; they can't have it by themselves. It has to start at the medical school. (BO 3)

The data show that there is a tension and a difference between the two roles — clinician and manager. When medical doctors become CHDs, they feel that their work environment is changing and is different from that of the clinician.

Professional managers

A male and a female CHD express the wish that, if things could be changed in their role as CHD, they would like to be solely professional managers, with CHDs only undertaking administrative work:

The Hospital Director should be a professional manager; he should be professional [not just an amateur], and he should especially know about financial matters. (CHD 4)

If change were possible, the Director should be an administrator only, while doctors should only undertake clinical work ... [if the doctors must be CHDs] we [doctors] should meet qualification criteria, such as the requirement of a certain degree and specific training before one can be appointed Director. (CHD 7)

However, there is another view from one female CHD and one senior male CHD. Both insist that the CHD should be a medical professional since they are responsible for patient care and the provision and management of clinical services:

In my opinion, it is necessary that a Director needs to be a doctor. I think it's essential, particularly for a Community Hospital, as the Director has to deal with patient care management and services management. (CHD 6)

The hospital can be fully developed if the Director has professional qualifications in both management and medicine; such a person will be readily accepted by the hospital staff. (CHD 5)

All of the informants state that professional managers for hospitals should have management training to be CHDs. However, most of them believe that a CHD should come from among health professionals, particularly medical doctors.

4.2.1 Sub-theme 1.1: Longevity and seniority in clinical practice

The role of the CHD is generally earned over time and by seniority and experience in clinical work, rather than by management training or having management qualifications. A senior male CHD, who is a general surgeon and has been working in his CH since it became a 60-bed hospital, reported that he reluctantly became a CHD because of his seniority:

I graduated in General Surgery ... I decided to work as the general surgeon at this 60-bed hospital. Shortly afterwards, the ex-Director moved to work in another province; at that time I was the most senior [staff member] at the hospital, so I had to take up the position of Hospital Director ... I was quite unwilling to take the position though. I had graduated in General Surgery and I would have liked to be the best general surgeon [not the Hospital Director]. However, I am ten years senior to the other resident doctors at the hospital. I took the position with reluctance. (CHD 1)

Another senior male CHD confirms that becoming a CHD is related to seniority and that he has lost the opportunity to continue his study in a speciality, because he holds a CHD role:

I was appointed to be the Hospital Director; because [of this] I have not continued with any specialist medical courses. Moreover, I am older than everyone in the hospital, so I was appointed to be Hospital Director. (CHD 3)

The situation for another male CHD is similar. He also lost his chance to continue his specialist medical training when he became a CHD:

I became a Community Hospital Director accidentally. I had decided to continue my specialist studies, when, in the meantime, the former Hospital Director resigned, so that Dr. M [the former PCMO] asked me to replace him [the former CH Director]. I took his position and lost the chance to continue my studies [in a specialist medical field]. (CHD 4)

However, an experienced female CHD says she wanted to become a CHD, because she feels this position allowed more scope for professional development. She also acknowledges that her position depended on seniority and coincided with the resignation of the former CHD.

I've been here as Director since 1993, when I was promoted from being a resident doctor. That I came to be the Director dates back to the time when I was a resident doctor. In the early days, there were only two doctors – me and the ex-Director who was living with his family and didn't like to see patients outside of the hospital – and the number of patients was not too high. I usually went to see patients at the health centres and the hospital staff referred to me mockingly as the health centre's doctor, because they thought that I visited the health centres too often, every month. The Director had been replaced by another doctor. I found that there were some tasks that I could do and develop, and this made me

consider whether I should remain a resident doctor or [whether I] would be able to do more if I changed my position. I became interested in applying for the position of Director. Coincidentally, the existing Director had moved, so the PCMO appointed me to the position. (CHD 6)

A young female CHD also reports that she became a CHD automatically. She had already spent a long time at the CH as a clinician when the former CHD resigned to continue his own study:

At first, I served as a resident physician, because there was another doctor still holding the Director's office ... About two years later, the then Director resigned and I was automatically promoted to fill the position since I had been there quite a long time. (CHD 7)

A senior male CHD states that he was interested in becoming a CHD. He feels that he is altruistic and had volunteered to help develop a newly-opened small CH. He moved from Bangkok, his hometown, and gave up city life to spend time in a rural area.

It's my special interest to become a hospital manager. I volunteered to be the Director at a newly-opened hospital. At that time, there were many newly-opened 10-bed hospitals in rural areas. I was working as the Director at the Community Hospital. (CHD 5)

He is, however, uncomfortable with his role since he had no preparation for his new responsibilities:

However, the doctors who devote themselves to becoming a Director might not be happy as the Hospital Director, because they haven't been trained in management, but rather to take care of patients, which is what we are taught at our medical school. (CHD 5)

Clinical practice is the number one priority of all CHDs. One male CHD comments on his dual role:

Regarding the position of Hospital Director, if you are working in a Community Hospital, you need to provide both medical services and administrative management. It is as if you handle two tasks at the same time. (CHD 4)

Even though some of the CHDs are specialists, their clinical work is more that of a generalist through seeing patients at the Out-patients Department. One male CHD discusses the competing interests and duality of roles. It appears as though he regards his CHD role as part-time, even though his position is full-time:

In the morning, I provide services to the patients; sometimes I am asked to take care of a referral case, or monks. ... I mean I work as a GP [generalist] and I have to examine the patients for common diseases, as well as providing

consulting services for the [few] paediatric cases ... In the afternoon, I spend time managing the hospital. (CHD 5)

One young male CHD, who works in a remote area where there is shortage of experienced doctors, has to perform most surgery himself, because he always had junior doctors appointed to his hospital and they are usually less confident in performing such procedures. He says:

... a newly graduated doctor who didn't like to perform any surgical procedures [was appointed], and I had to cover for him, even during public holidays and outside hours. If the junior doctor came to me with a patient with acute appendicitis, who needed appendectomy, I'd say OK, I'll take it for you or I would help him with cases that he hadn't yet mastered. (CHD 8)

An experienced female CHD and a young female CHD believe that clinical work is the first priority of a CHD due to the shortage of doctors:

The Director is surely the main person who oversees the many tasks in the hospital and that they are done properly. In instances where there is a lack of resident doctors, the Director has to treat patients. (CHD 6)

When asked what happened after I became the Director, I would say it was the same. For the most part, my efforts were spent on diagnosing patients with very little attention devoted to administration. Administration is usually in the form of meetings ... regular committee meetings. I usually sign official documents after office hours. During office hours, I always help with clinical work. (CHD 7)

However, Bruce and Hill (1994) point out that doctor-managers maintain their clinical load, because they want to ensure that they can secure the trust of their medical colleagues and keep their status as doctors. A participant (CHD 7) confirms this viewpoint:

Previously, I didn't understand administrative matters, because I had only been a physician. I think it is too much, much beyond my simple administrative knowledge. Fortunately, other people honour and believe in my profession as a Doctor of Medicine, and this allows me to keep going. (CHD 7)

The senior provincial bureaucrat shares the above view that being a doctor has greater status than being a manager, and this derives from the perceptions and expectations of the community. The Thai health system also lacks a role model for doctors who are skilled in both management and primary care.

The other issue is where the majority of people accept and believe, excessively, in the superiority of doctors ... and what happens depends on what the doctors do ... We have to educate people in Thai society to acknowledge doctors as only one of the health professionals, and also that they are only ordinary people, not gods ...

we have to produce a new breed of doctors who ... are skilled in management, ... I think that we should establish a role model like that. So, we will have doctors who are not only competent in hospital and medical care skills, but are also skilled in primary care and management. (BO 3)

The sense of being ‘part time’ prompts the CHDs to feel that they are inefficient and ineffective as CHDs. This is demonstrated in the following comment:

I have spent about 60 percent of my time providing curative services and no more than 40 percent working on the administrative management, since I became the Hospital Director thirteen years ago ... If there are enough doctors, I do not need to do much clinical work. As a result, I can have about 80 percent of the time for administration, which would make me work more effectively and efficiently.

(CHD 4)

However, one of the senior national bureaucrats expresses a different expectation of the CHD role. This informant believes that CHDs should be more managers of the district health system and focus on the communities, rather than on provision of clinical services:

It's not necessary for the doctor who is the Director to provide primary care services by themselves. In fact, they must be a system manager to organise services for their members as their members expect. (BO 1)

4.2.2 Sub-theme 1.2: Lack of effective management training and support

A young female CHD was asked how the MoPH assigned her to the role and responsibility of a CHD; her reply shows the lack of support for the CHD role:

Since I've been here, I've not known about the responsibilities involved in this position. Nothing has been written about it. The letter of appointment, however, will be signed by the Provincial Chief Medical Officer designating a person to hold the post of CHD with such and such duties. Only one line and that's it! I've never seen any concrete handbook materials. (CHD 7)

The second aspect of the lack of support for the management role of CHDs is that there is no formal management training before becoming a CHD.

However, the doctors who devote themselves to being Directors might not be happy as Hospital Directors, because they haven't been trained in management, but [instead] to take care of patients, which is what we are taught at medical school. (CHD 5)

CHD 7 confirms this view. She feels that the position of Director really needs specific qualifications, such as ‘a certain degree and specific training’. Her experience in enrolling in two short courses in management after she had become a CHD did not meet her practical needs. This is similar to the experiences of other CHDs:

If we had a course or had an up-to-date briefing concerning regulations for new Directors in the training session, it could be quite good. Actually, the training I attended didn't have these details ... we didn't learn much about the small details we must know. (CHD 7)

Consequently, the CHDs in this study have had to learn their management skills either through their own mistakes or through experience. Two senior male CHDs describe this 'learning':

However, time can make things better and I can learn from my mistakes. When you gain a lot of experience, your work becomes more efficient. (CHD 1)

I don't have many management skills and I've had to learn many new things from my mistakes. (CHD 3)

The female CHD (7), who has had less management experience, also reports that she learnt management practices by following the practices of her former CHD, but she feels discouraged about learning in this fashion:

It is important to know the real nature of the regulations, because, in practice, when I became the Director, I just did what had been done traditionally. I hope you understand; I just follow the way the ex-Director handled things. However, during his time it might have been OK, but it isn't [necessarily] OK now. I might have learned about a traditional practice and carried it on, but without really knowing the correct way. (CHD 7)

Boucher (2001) discusses this aspect of learning to become a manager. Besides the lack of training to prepare the CHDs for their role, they are disadvantaged by the lack of continuing education to help them keep up-to-date in both management and medicine. This is shown in an interview with a senior male CHD who expresses his wish for changes that would make the CHD role more effective:

If the Hospital Director is a doctor, he should be provided with both medical knowledge and management knowledge. They should not be left behind, because there is no one to evaluate their performance. (CHD 4)

Another senior male CHD states that he has been unable to keep his medical knowledge and skills up-to-date since becoming a CHD, because he has had no continuing medical education. Such education is not compulsory for retaining a medical licence in Thailand, but it will be for graduates after 2009.

Aside from management knowledge, the Director should have [access to] continuing medical education. I have been working here for ten years; I accept that my knowledge of Paediatrics is out-of-date, because I don't have time to keep my knowledge up-to-date. (CHD 5)

However, the senior provincial bureaucrat, who has had experience in rural medical education and management training in his province, as well as at the national level, considers that CHDs do not have a real interest in management training. He feels they perceive their role as that of being a medical doctor who has too heavy a workload in medical clinical treatment:

When the doctors were medical students they said that it's not the time to learn management, because they were not managers yet. However, after they graduated and worked in the real setting, they said that they had to see too many patients and work hard, so they didn't have time to concentrate on studying management and didn't think that management was important for clinical work anyway. So, they tended to concentrate on treating patients. (BO 3)

This interviewee also believes that the executives do not support formal management training for CHDs, because the CHDs would have to be absent from their regular work, causing a shortage of doctors. This shows that there is a lack of systematic support for the management role of CHDs.

If we ask them to study for a formal training course or programme of management, this causes another problem. That is, we lose the doctor from the services system, so many executives don't allow doctors leave to do that. (BO 3)

Two senior CHDs, male and female, state that there is a lack of effective performance assessment for CHDs:

If we don't work efficiently [and effectively], we could remain in business because of the support provided by the MoPH. Once in a blue moon the PCMO would put pressure on us; for example, if your hospital doesn't meet the HA standards, the PCMO might put pressure on you by making a comparison between your hospital and the others. You might feel that you are not considered an honourable man in society for not accomplishing the assigned tasks. However, if I don't want to hear his speech [the PCMO's speech] at the PHO, I don't attend the meeting. Then, I won't know which hospitals have passed the HA standard of quality. Nothing would happen if I didn't attend the meeting. Even now, some Hospital Directors haven't attended any meetings at all and nothing has happened to them. They remain in their positions. (CHD 4)

Once one is a Director, it [the role] can be viewed as easy, because it can be a really happy time. There is no need to do anything because of the position of authority that one has there. I've also heard that some Hospital Directors are not concerned with patients at all. Maybe they think too much about their own comfort. (CHD 6)

Regarding the lack of appropriate financial reward, a senior male CHD, who is also a general surgeon, reports: ‘... *there is a heavy workload, and I haven't received better pay.*

I get paid the same as the general doctors' (CHD 1). Two senior male CHDs make the following comments regarding monetary rewards:

If you want to be a Hospital Director, ... You should accept the fact that you might receive only an empty box and not one full of money [You should be able to work very hard without good pay]. It requires a lot of understanding, otherwise, you might be upset waiting, because there seems to be nothing in return.

(CHD 4)

Our salary is lower than that of teachers. I think it's unfair ... The Director-to-be needs to be prepared for the fact that he will have an extra workload without extra payment. (CHD 5)

In summary, this theme describes how the CHDs in this study entered their positions. They became CHDs with only a medical background and no preparation or support system for their new role as managers. They maintain a clinical mindset towards management and thus they feel their work is not effective. There is an urgent need for management education. The next theme explores how they perceive the health system, the UHC policy, and the PHC when they have had to implement this health reform. The confusion that arises because of the duality of their role is compounded by their medical mindset.

4.3 Theme 2: The Community Hospital Director perception of the implementation of the Universal Health Coverage policy in relation to Primary Health Care

The second theme explores the role of CHDs in implementing the UHC policy in relation to PHC.

4.3.1 Sub-theme 2.1: The Thai bureaucratic management style in the context of the implementation of the Universal Health Coverage policy

According to a senior male CHD: '[i]n Thailand, the UHC programme has been initiated for only four or five years' (CHD 1). Another senior male CHD adds that the policy makers expect CHs to be important in delivering a full range of services:

I think the NHSO or the supervisor of the UC [UHC] programme would expect the Community Hospitals to do their best to be the front-line health facilities which provide the full range of services. (CHD 5)

The major aim of the UHC policy, whose slogan at the launch of the project was '30- baht cures all diseases', is to improve people's access to quality health care. A senior CHD (5) and a junior CHD (8) report on this aim:

... the story begins with 30-baht UHC programme, which emphasises the importance of the first contact health facility by launching the policy called "Health Centre Near Your Home, Close to Your Heart"⁶ to take care of people in the catchment area ... The patients can have access to health services which are provided close to their homes, so that they don't need to go too far from their areas to receive health services. (CHD 5)

We use the concept of "access to care" as the criterion. I mean if they are members of our catchment area, they can access our care easily. (CHD 8)

A younger male CHD continues that idea saying: 'the objective of the 30-baht policy...[is] equality in accessing quality health care' (CHD 8). A senior national bureaucrat (BO 1) asserted that the UHC policy employs a new bureaucratic management philosophy emphasising efficiency. However, the strength of the UHC policy is that it preserves equity in health insurance coverage for all citizens.

Let me start with the current philosophy, which is about the new bureaucratic management system, and how this impacts on the whole system as a big picture. This philosophy emphasises efficiency. Roughly speaking, it is about how to efficiently use the existing budget. This makes people overlook the issue of equity, right? However, I think that our country has attempted to address this by introducing Universal Health Coverage (UHC), and I think this is our strong point. As a result, all citizens are covered by health insurance and this ensures equity for all. The new management approach in the world emphasises more financial management, and this leads to many challenges. (BO 1)

All of the CHDs perceive the UHC policy as the government introducing a sudden change to the health services system in terms of the distribution of funding:

The UHC funding is calculated on a per capita basis. (CHD 4)

Before the UHC policy, funding was allocated by the number of hospital-beds, not the population of the area ... [and our hospital] had been given a budget, as had other 30-bed hospitals, of 20 – 30 million baht annually. After the UHC policy, we were given a budget of only 16 million baht per year, while everything remained the same, hospital-beds and staff. (CHD 8)

The primary intention of the new funding formula is to create a more equal distribution of health resources within the health services system. It aims to redistribute health resources, which are mostly concentrated at tertiary care in big cities, to the secondary and primary

⁶ This is a literal translation from the Thai, but the focus is to promote the PCU as being both physically and emotionally close to the client/community.

care facilities in more rural and remote areas. A young male CHD says this formula responds to the needs of the community:

... the aim of the financial management strategy ... is ... to use that mechanism to redistribute human resources, money, and the materials needed to respond to the health care requirements of the people. (CHD 8)

A senior male CHD asserts the Thai health services system lacks unity and is not focused on the patient. As a result, there is no integration of the different levels of care.

In my opinion ... each organisation is still working independently; we lack unity ... [and health care provided] is not based on a people-centred concept. (CHD 5)

He believes that the new funding distribution formula is a benefit in terms of forcing all health services within a province to provide patient-centred care through the patient referral system. All health services have to communicate with each other in order to share the funding, as they have to focus on how to look after people living in the same area. He believes that this financial strategy leads all health services to have a similar goal, which is to provide medical services to the population.

Now, the 30-baht UHC programme is trying to provide patient-centred care by allocating the budget [to health providers] in accordance with the number of people and letting health providers be linked by joining the patient referral system ... So, I think that money may be the only right answer. This means that we use money as our tool to encourage more communication between all of us. This leads us to share the budget in a better and clearer manner ... This financial strategy would automatically force the separate organisations to cooperate with each other in order to mutually manage the budget ... I think they could be bound at some levels, though not necessarily reaching a satisfactory level of teamwork. It's better than before, since we have the same goal and the per capita-based budget provides for the population we are to serve as our goal. (CHD 5)

Another senior male CHD confirms this view: *'I accept finance is a really important factor to keep the organisations moving forward'* (CHD 3). All of the CHDs perceive that the UHC policy has forced them to change their roles and responsibilities. Besides their two roles as medical doctors and CHDs, the CHDs believe they have to be responsible for all health services in their districts. A young female CHD (7) feels: *'I feel I shoulder quite a heavy load, because the entire Amphur [District] seems to be under the administration of one person, which is me'*. A senior male CHD states:

I have to develop my policy for the CUP Board, not only to be applied to the Community Hospital, but also to the PCUs and the HCs in the whole district. (CHD 4)

Another senior female CHD adds that her role has expanded beyond that of the hospital manager. She has to manage all health services in her district. This includes primary health care at health centres, which are the responsibility of CDHO, because the CH is a CUP and she is the chair of a CUP Board.

My duties as the CHD are as follows: i) take care of the patients; ii) look after the health centres; iii) support the health centres; and, iv) be the chair of the CUP Board. (CHD 6)

All CHDs interviewed perceive their major responsibility is to improve medical services at the HCs.

The [community] hospital has been ... improving [the] capacity of the health centres, in order to assure patients that they can rely on the health centres. This solution has been partially successful. (CHD 6)

They believe that they have a new responsibility in relation to health promotion and disease prevention. This responsibility overlaps with that of the DHOs and the HCs, and creates confusion and barriers to implementing the UHC policy, with a mismatch between authority and responsibility.

This is just the same as with the CHD who can't say that health workers are responsible for health promotion alone. That couldn't happen, because the budget is transferred to the CHD. (CHD 4)

In this past two years, the hospital has become involved with disease control outside the hospital, such as with DHF and other diseases as well ... In this way, the Community Hospital does more on health promotion and disease prevention. (CHD 8)

CHD (8) argues that the government has tried to emphasise health promotion in the UHC policy four years after the launch of this policy by changing the slogan; this he feels is only 'manipulating words':

It's still not working even though the government has changed the slogan for this policy from "30-baht cures all diseases" to "30-baht helps all Thais get away from disease" to show that the government really emphasises preventive health care, rather than fixing health problems. (CHD 8)

The CHDs from CHs located in large population centres and less remote areas feel that they have more funding than before. They have an advantage in terms of a greater number of staff paid by the MoPH.

We are receiving more funding from the UHC programme than before due to the different way in which the budget is calculated. Previously, the budget was calculated by the size of hospital [based on number of beds], but now the budget

is calculated by the population in the catchment area ... We have a lot of core personnel, who are paid directly by the MoPH; so that we don't have a serious problem regarding a shortage of funding ... Therefore we have more money than before to develop the organisation. (CHD 3)

The CHDs from CHs located in remote and lightly populated areas, however, feel that they suffer as a result of this new funding formula and the operation is more complicated with a dependence on higher authorities:

Well ... [the more complicated things are the more] money matters. Previously we collected hospital fees and we saw what we had in hand, then made plans and spent as we could afford. Moreover, the [government] budget would be transferred to us periodically. Now that I am the Director, we can earn very little money ourselves; we have to wait for others [the MoPH and the NHSO] to send us money and we don't know whether they will send it or not ... It is because of the 30-baht [UHC] programme. In the recent past, we received 6 million baht in annual income. However, when the 30-baht [UHC] programme was implemented, our income, which was our self-generated fund, dropped dramatically and immediately to two million baht. Debts increase year by year and accumulate. (CHD 7)

A young male CHD (8) reported his 30-bed hospital 'was hit quite hard', going from a budget of 20 – 30 million baht to 16 million baht under the UHC policy. Despite this reduction, the number of beds and staff numbers had not changed.

It affected the hospital markedly, because only 16 000 people were registered in our catchment area under the UC [UHC] scheme, but there were other patients from the bordering district who used our services, which made the real figure around 30 000 people [but we received funding for only 16 000 people].

(CHD 8)

Even though the Community Hospitals have funding problems, their staff have not stopped working, because the MoPH provides assistance in terms of extra funding and the staff sees the UHC policy to be of benefit to local people.

I explained to them that we should not resist the government [policy], because it was a national policy, and people would benefit from the UHC policy. (CHD 8)

However, all of the CHDs have found that they have to work harder as the number of patients increased, both at the OPDs of the CHs and the HCs and there is an imbalance between rising demand for curative care and the number of hospital staff. Two senior male CHDs report:

The problem is that the number of out-patients has increased seventy to eighty percent this year. ... from around 400 in 2000 to 700 in 2006 ... As a result, the CHD has to handle a very heavy workload ... in the provision of curative services and to deal with the patients' complaints and lawsuits. The number of patients

increased by eighty percent, but the number of doctors and nurses remained unchanged. (CHD 1)

After the launch of UC [UHC] programme, we thought that the number of patients at the PCU⁷ [HC] would have increased, and those at the hospital would have decreased. In fact, the number of the patients at the hospital is still increasing. This increase is found not only at the Community Hospital, but also at the HC [or PCU]. Despite the fact that the HC has been upgraded to a PCU, patients still come to the hospital. The number of patients in the hospital is still high, perhaps higher than before. (CHD 5)

CHD (5) believes that the cause of this increase is that CHs only provide medical care to people, not advice on preventive care:

However, it seems we made a small mistake by providing only medical services; we should also encourage them [the villagers] to look after themselves. The villagers are very happy to have the UHC gold card, and they know to use it only for medical services. They don't know how to protect themselves from getting diseases. (CHD 5)

Another senior male CHD argues: '*The HCs and the CHs should have developed their services. However, the [central] government has not provided sufficient manpower to the HCs or to Primary Care*' (CHD 1). As a result, people do not trust the quality of curative services at HCs and instead go directly to CHs '*thinking that these would provide better care*' (CHD 1).

A senior female CHD adds that the root cause of this increased unrealistic demand on medical services is the outlook and activity of some politicians:

It was looked upon as a political policy, of which the politicians took advantage; wasn't it? (CHD 6)

All of the CHDs feel that the government rushed this policy change and there are still many unclear issues creating barriers to the implementation of this policy. A senior female CHD states: '*The first difficulty is the government policy*' (CHD 6). A young male CHD adds: '*The changes should be made clearer*' (CHD 8). The issue of barriers to the implementation of UHC policy in relation to PHC are explored further in the later discussion of the other themes.

A young female CHD tells of her experience in implementing the UHC policy:

⁷ The PCU is being developed to upgrade the existing HC.

... it was the transitional period of the system when I became the new Director. If I had done the same things as the ex-Director had done, things would probably not work out, because it was a new matter and confusing. (CHD 7)

A senior male CHD gives his opinion that the government and the MoPH do not provide very clear direction for all CHDs to sustain the implementation of the UHC policy in relation to PHC:

In Thailand, the UHC programme has been initiated for only four or five years ... Both the MoPH and the central government should carefully carry out the necessary overall plans and strategies ... We could be successful if the top management, the Minister, provides clear direction ... If the policy is clear, the practice is easy ... There should be an obvious policy and precise directions to follow ... The policy assigned by the MoPH is not clear. For example, the UHC programme should focus on health promotion, especially in an undeveloped country like Thailand. People cannot access medical information on the Internet, so that we have to assist them in providing curative services instead. (CHD 1)

Another senior male CHD asserts that the policies of the MoPH are sometimes vague and frequently changing. The CHDs face difficulties in exercising their roles, because they are uncertain about what to do, and how far to go in the policy implementation.

I think that at the moment some of the policies assigned by the MoPH are vague, and, as a result, we don't know what we are supposed to follow ... This is due to the intangible policy enacted by the MoPH. The policy does not include any directions, it did not say how far we should go or to what extent. (CHD 4)

As for the policy, I want to see it be stable, so we can see the direction for development. Now the policy varies; somedays it goes this way and on other days it goes that way, such as with the decentralisation to local administration and health financial policy regarding payment to hospitals and health centres.
(CHD 6)

A senior female CHD expresses her views on the lack of a clear policy on resource distribution:

There ... should be certain direction for issues with the number of staff and amount of funding. I think that the MoPH should have a clear direction on these issues, instead of constantly changing and causing instability. (CHD 6)

All the CHDs regard the direction of policy from the MoPH as unclear. A young male CHD reports:

The current financial management strategy is really not meeting the aim of the 30-baht UC [UHC] policy, which seeks to employ the financial management strategy as a tool to redistribute resources ... appropriately to all health facilities to provide services to everyone. This is not the case now, because a larger number of doctors and nurses are pooled in the central region, especially, the urban area ... Although the hospitals in the central region look after a smaller

population, they have less of a shortage of doctors and nurses than those in other regions, especially the North-Eastern region. (CHD 8)

This frustration was expressed by all CHDs interviewed. The lack of clarity in the roles and responsibilities of all stakeholders within the health services system and a lack of direction has made the organisation of health care at the local level difficult, as CHD (3) explains:

The policy makers should negotiate their agreement in order to initiate the health policy as soon as possible. Then, we should have the final plan regarding the way ahead for our health system. This should include: how our health system will be operated; what will be our direction; and, how we are to organise our health services system. (CHD 3)

This informant also said that it is still unclear whether the MoPH will devolve health services to report to local government and which level of care will be involved, as well as how this will happen. It is also unclear what the status of the CHs will be. This creates a major barrier to the implementation of the UHC policy, examined in later themes. ‘Decentralisation’ is also variously interpreted by individuals and all of the CHDs perceive it as decentralisation of decision-making from the central government and the MoPH to either the CHs or the network of health services at provincial and district levels. Two senior male CHDs summarise their perspectives:

This is because the decentralisation [of health services to local government and the MoPH's role in that] is still confusing and there is no final solution ... We don't know yet what the health services management system will look like. They [policy makers] have to decide whether those health care organisations can be managed as a Public Autonomous Hospital or a SDU [Service Delivery Unit]. If those health services are devolved to be managed by local government, what will the ultimate health services management system be? (CHD 3)

... at the moment, the Hospital Directors are uncomfortable with that situation [unclear direction of Health Decentralisation policy]. (CHD 4)

A young male CHD said that this is because the government, the NHSO and the MoPH did not prepare all the staff and people to understand these changes. The result is that all are not ready for change or health reform. The CHDs see many limitations:

There were a lot of complaints, because the government did not explain the changes to the people well enough, and even the staff didn't understand ... The government didn't prepare for the paradigm change for the doctors [health workers], nurses, physicians, or for the people. It's crystal clear that the government did not prepare people to contribute to this new system ... we operated under the constraint [of resources] ... They didn't grasp why there were the changes, or understand what the effects, good or bad, would be in the long term. They were negative about it. (CHD 8)

A senior male CHD asserts that all health staff felt uncomfortable with and frustrated by the shortage of health manpower and that this problem has been partly caused by the government:

When the government won its second election, there was neither a sufficient number of doctors nor supervision from the government ... [and] the MoPH does not have a precise human resource policy about the recruitment of health personnel. (CHD 1)

As a result, the role of the CHDs is about making their hospital staff understand this health reform or change. A young male CHD informant says:

... I had to explain the changes to my staff quite a lot. (CHD 8)

However, a senior female CHD reports that many CHDs do not follow the goal of the UHC policy and have not adapted their Community Hospitals to meet the goal. Most of the CHDs perceive the direction of the policy as unclear.

If there is a clear direction regarding the financial allocation for them [CHDs], they will know what this direction is and they must be prepared to adjust themselves [functions of the hospital]. (CHD 6)

A senior male CHD asserts that the CHDs lack the power to initiate their own ways to achieve the goals, because the MoPH is overcentralised.

In fact, the MoPH should have determined the goals, but we [the Hospital Directors] should have been empowered to choose our own ways to reach those goals. At the moment, the bosses like to draw a line for the subordinates to follow. They like to give directions; if they say left you must go left, if they say right you must go right. It is that bad! (CHD 4)

A young female CHD adds that this overcentralisation occurs not only at the ministerial level, but also throughout the whole system. She reports that when she had to carry out the Family Health Leader (FHL) project ordered by the PCMO, she lacked the necessary independence to implement it:

Like this year's policy on FHL [Family Health Leader], we were required to follow the steps 1, 2, 3, 4. (CHD 7)

A senior male CHD states that his creativity is limited, since he must follow the policy assigned by the MoPH and the PCMO:

We follow only his policy and the one assigned by the MoPH. Mostly, the policy launched by the PCMO is not different from that of the MoPH. We do not need to be creative at all. (CHD 3)

A senior female HHPCU adds that the overcentralisation of the policy from the MoPH makes it impossible for her to carry on her work at a PCU effectively, as the policy does not fit with the situation at that local level:

We have many activities on our hands. There are too many assigned tasks from the MoPH and required tasks on site. It seems to me that even I could not determine what should be the priority tasks or what is less important ... There is also a shortage of manpower. The ratio of nurse to patient at the PCU is excessive, over 1:1250. The PCU also carries the medical service. Under the required proactive health services, the PCU should do a home visit to each family at least once a year. This, I feel, is impossible to do.

Meanwhile, other activities are too prescriptive to apply; for instance, at the moment we are assigned to promote health care in children from 0 – 6 years old [the children at this age should do exercise]. I can't remember the number, but there is an expected percentage of achievement. Instead of having the freedom to execute the health promotion programme by myself, I have to follow the designed programme [from the MoPH]. I will only be the data gatherer [data specified by the MoPH] and will report that data to the policy makers at higher levels. I feel frustrated; it's not practical. (HHPCU 7)

A senior national bureaucrat asserts the MoPH is rigid, overcentralised and has a monopoly in terms of health policy:

However, at present, the policy has only been carried by the MoPH and this leads to activities that belong only to the MoPH. I think the MoPH is only a part of the system so to some extent it can't compete or chase the growing private sector or others [other ministries with responsibilities for medical provision] ... It means that we don't need to limit the referral of patients to only MoPH tertiary care; we can send the needy to other hospitals that belong either to other Ministries or to the private sector. The present situation is one of central overcrowding. For instance, when you want to refer your cardiac patients for heart operations, at present you can only refer them to the MoPH tertiary care hospitals, even though there are many tertiary care hospitals available that belong to medical schools, the army, or the private sector. (BO 1)

CHD (6) expresses her concern about payment regulation, which relies on the central government:

Overall, our work [load] is heavier than that of other hospitals for both in-patients and out-patients. In some hospitals, such as 60-bed hospitals, no one calls them [doctors on duty] when they're on shift. Let's say they work quite comfortably which is different from working here. I heard this from a junior doctor, who has filled the scholarship obligation of 2 – 3 years ... Some possible ways to retain them are... providing more flexible pay, because now the pay rate is fixed, that is we have to pay the staff following government regulations. I wish we could pay them more [than what is specified in the government's regulations] without any complications. (CHD 6)

CHD (7) feels the constraints of too much red tape and too many hierarchies in the Thai bureaucratic system. She comments on delays in government funding to implement the UHC policy:

The problem was that the funding instalment for December, January and February should have arrived on 20 March, but it did not and I had to wait more than a week for it. I have to manage things despite meagre finances, too much work, and great patient demands ... [this is because] the budget passes through the Ministry [of Public Health], then the Provincial Health Office and probably passes through the Bureau of Inspection and Evaluation before it reaches us. That's why it arrives very slowly. (CHD 7)

A senior male CDHO from a remote district has experienced similar problems and he feels this contributes to ineffective PHC services at the HCs:

The problem is there was a delay in the budget allocation; the HCs would probably run out of money to deal with the specific situation ... the delay in budget allocation was caused by the obscure policy regarding the UHC programme; it was not clear about the budget calculation based on the basis of population ... and the HCs encountered the budget shortage. (CDHO 6)

CHD (2) reports:

At present, we are unbalanced, there's still the patronage system in our government operational system. (CHD 2)

Another senior male CHD tells the story regarding the patronage system and the lack of transparency and accountability when he worked at district level:

There are many connecting lines within the public health organisations; for example, there was one straightforward CDHO, who had frozen the salary of a health worker, and that health worker was supported by a politician. As a result, that CDHO was tackled by a more senior authority from the MoPH.

That CDHO had frozen the salary of the health worker, who was found to be at fault at work. The District Chief [DC] agreed with the CDHO and he wrote a letter of complaint to the PHO. However, the health worker did not acknowledge his guilt, and complained to the MoPH. Surprisingly, his case was dismissed by the MoPH and that health worker was promoted to a higher level with an increased salary.

That health worker is an example of a person supported by his patron at the MoPH. The patron might be someone who used to work in Korat [PHO]. His subordinates would tend to support him to advance his career, because he could be helpful to them in the future. (CHD 5)

However, a senior male CHD argues that he would exercise his professional autonomy as a doctor to support only projects or policies he thinks will benefit patients. This informant perceives that, working as a CHD, makes him uncomfortable in dealing with political

issues, and that he is independent from political decisions and from authorities or politicians.

I would not follow policies related to political issues [which politicians ask for in the guise of cooperation, but actually for votes], I am straightforward [honest] ... I will only follow policies that benefit our patients. I ignore and do not follow some vague aspects of policy [which are considered as political decisions]. I consider that the hospital is quite independent. (CHD 2)

Another senior male CHD states his desire to avoid involvement in political issues and only emphasised the development of his CH. He also felt that he is independent of the impact of political issues because of his professional autonomy as a medical doctor:

Moreover, there are political issues involved in the conflict. I am not much affected by those because the Community Hospital is an independent organisation ... [my district] is one area under the strong influence of politicians. It's always been my policy not to fight with those politicians, because there's no point. I am better devoting myself solely to the hospital's development. (CHD 5)

He believes that the staff of DHOs and HCs 'are directly involved in provincial politics; for example, the VHVs serve the politicians as election campaigners' (CHD 5), rather than any political activity by the CHDs.

CHD (2) agrees with this and expresses an interest only in the hospital; he feels he lacks the ability to deal with political issues that encompass the DHOs, HCs and VHVs:

The CDHO would be more experienced in such a project [which is developed through political patronage], because he is involved in the community, while I am involved in the hospital. (CHD 2)

It is the view of most interviewees that the Thai bureaucratic administration limits the ability of the CHDs to think innovatively and to approach problems from 'the right direction'.

They [CHDs] should have the opportunity to show their potential, and show initiative ... (CHD 5)

CHD (5) suggests that CHDs solve their problems by manipulating 'the meaning of the word'. He raises the issue of solving the problem of a shortage of staff. Staff distribution criteria must follow '...the number of beds [which] reflects the workload of the hospital' (CHD 5). In this case, '... some hospitals in Korat [province] expanded the number of the beds without increasing the workload' (CHD 5), that is fabricated those figures.

The way CHDs work in the Thai bureaucratic administration limits their capacity to work innovatively. 'If we [they] take the risk of working in the "wrong way" we [they] may be accused of corruption' (CHD 5). Many just wait for the central government to provide leadership. CHD (5) says of the UHC policy regarding health promotion and self care:

The physical exercise promoted by the government should encourage people to be aware of self-care at some level. However, it is not enough and the government should be the leader in encouraging people to be more involved in self-care. This is really a weak point of this system. (CHD 5)

One young female CHD reports:

As I told you earlier, at the beginning of the 30-baht scheme we were required to establish at least one large Primary Care Unit [PCU] in the first year. The catchphrase of this was "Health Centre Near Your Home, Close to Your Heart" of the people. (CHD 7)

CHD (4) speaks of his goal for implementing the UHC PHC policy:

We tried to set up a model PCU at the hospital and we set up our goal of how many HCs will be upgraded to meet the HCA standard [to become PCUs] during the year. It is our task to develop the primary health care facility. (CHD 4)

CHD (3), however, explains the difference between a HC and a PCU:

The HCs refer to the Health Centres, providing PHC services according to the old standards. The PCU refers to the Primary Care Unit. In fact, following the CUP Board's decision, we would like to upgrade all of the HCs to be PCUs with higher standards of medical care. The PCU's standard is higher than that of the HCs'. Our goal is to upgrade all HCs to become PCUs, and we are making every effort to achieve that goal. (CHD 3)

A senior male CHD stresses that this improvement in curative services at HCs will be of benefit to the CH with a reduction in the number of patients directly accessing hospital services when there is no need to do so:

The HCs should improve their curative services to meet the higher quality demand, in order to reduce the number of patients at the CHs. (CHD 1)

However, CHD (8) points out:

If we want to emphasise [primary health care], we need to change the direction; the paradigm must be changed. (CHD 8)

A senior female CHD adds:

I think the way we have developed the health centres was as if we were trainers [of health personnel] because, actually, we also lack nurses and doctors. We don't intend to train them to cure the patients with the expertise of doctors or to tell them that they need to become a doctor after the health centre is upgraded to

being the PCU. We expect that they should be responsible for the primary health care since they are supposed to take care of common and non-complicated diseases. (CHD 6)

The CHDs perceive their role in implementing the UHC policy in relation to PHC as that of a district health services manager. This is influenced by the medical mindset, the unclear policy, the Thai bureaucratic administration, and health politics. However, the role of the district health services manager is limited to only improving the quality of medical services at the primary health facilities; that is, as a concrete task or requirement from the MoPH and the NHSO. The CHDs are required to establish the model of the PCU, which meets the HCA standard at their hospitals, and to extend this model to all HCs in their districts. This means that HCs will be upgraded to PCUs, an approach shaped by the medical mindset. The next sub-theme presents the CHDs' understanding of PHC, and explores the problems and challenges of the implementation of this health reform.

4.3.2 Sub-theme 2.2: Understanding of Primary Health Care (PHC) as Primary Medical Care (PMC)

When asked about their perspectives on what is PHC in the Thai rural context and under the UHC policy, all CHDs express the view that PHC is about primary health services provision. Some are confused as to the definition of PHC. A senior male CHD says:

... primary health care, according to my understanding, is health care services provided to a specific target group ... (CHD 4)

Another senior male CHD adds:

... PHC should provide four fundamental health care services: curative care for common diseases; health promotion; and disease prevention as well as basic rehabilitative care. (CHD 3)

A senior female CHD shares her view on PHC as self-care:

For PHC, I think it's the means to enable people to maintain good health and to take care of themselves, including members of their family, at a basic level, such as protecting themselves from common diseases. (CHD 6)

However, a senior male CHD (4) admits: 'Regarding PHC services, honestly, I am not so sure what they are' and a young female CHD (7) is confused about the definition of PHC:

'This [my understanding of PHC] is still unclear'. She admits that she has only implemented vertical and selective health programmes given to her by the authorities: 'In most cases, I work according to given policies, such as blood test screening for adults over 40, and Pap smear or breast cancer campaigns. I do not initiate any programmes, but just follow policies' (CHD 7).

A senior female CHD confirms that her health promotion programme given by the MoPH is selective for chronic illness and concerns the monitoring of patients with problems associated with Diabetes Mellitus (DM):

... we search more for people who have a tendency towards DM [Diabetes Mellitus], using criteria from the Provincial Health Office for patients over 35. We have to check their history and ask them in detail about diabetic symptoms. If their symptoms are suspicious, they will have a blood test. (CHD 6)

Before the UHC policy, the HCs were assigned to provide PHC services, focusing on disease prevention. However, after the launch of the UHC policy, the HCs also focus on curative care.

Previously, PHC focused on the health services provided at the HCs, mainly disease prevention and not curative care. I think it is wrong. The HC task area is identified as seventy to eighty percent health prevention and twenty percent curative care. (CHD 1)

CHD (1) also asserts that *'the goal for PHC is to provide prompt and quality health care services to nearby houses'*.

Another senior male CHD explains that, before the UHC policy, primary health care at CHs focused on curative care:

Previously, we [CHs] developed the primary care concept in the wrong direction, emphasising curative care, rather than disease prevention and health promotion. Accordingly, we have highly efficient curative care, but the number of patients coming to the hospital is still rising. (CHD 5)

The UHC policy emphasises both health promotion and disease prevention. However, CHD (4) feels unsure about what the MoPH would like him to do in relation to health promotion:

I'm not so sure about the primary health care policy adopted by the MoPH. ... whether the MoPH personnel are educated enough to lead us to the goal. They talk about health promotion all the time, but the MoPH does not have an in-depth knowledge of health promotion, so the Community Hospitals have not been able to follow up [on this]. (CHD 4)

Another senior male CHD (5) points out that the health promotion and disease prevention roles of the CHs are in conflict with their primary role as curative care providers, because there is a major shortage of manpower:

We have a shortage of manpower; we especially lack [the necessary people] for the medical team, which should be our main priority. The MoPH assigns this role to us. If we spend time in other roles, such as health promotion or disease prevention, hoping that these would reduce the number of patients, and hence reduce our workload, we would lose direction and focus. (CHD 5)

Moreover, a senior male CDHO argues that some CHDs have an inaccurate understanding of health promotion, regarding it as consisting only of medical activities:

In my working experience, I have found the common problem ... to be ... the misconception of health promotion. When I was working at the office of the Board of Provincial Budget Allocation, some Community Hospital Directors interpreted ... health promotion to include only the ANC, vaccination and so forth. (CDHO 2)

The issue of understanding the nature of PHC was put to the focus group of CHDs. It is clear from their responses that the CHDs understand PHC as a focus on self-care issues, even though they use different terms to explain it. Their implementation of PHC in the context of the UHC policy is essentially primary care. They perceive primary care as consisting of curative care, disease prevention, health promotion and rehabilitative care, which are provided by health professionals. Their aim is to encourage people to be responsible for their own self-care, which means '*[health] security ... having good health ... [and] that people have well-being*' (CHD 3). Starfield (1998) considers the term 'Primary Care' as the means to achieve the goal of PHC. However, the emphasis of the CHDs is on medical services. Three senior male CHDs at the focus group express their views on PHC:

Primary Health Care is about basic care and that is ... care in which people look after themselves. (CHD 2)

I understand that Primary Health Care is self-care ... [it] refer[s] to care at the personal or community level. (CHD 5)

I think that the matter of Primary Health Care is about basic health care ... [which] is about health care in general [self-care]. (CHD 3)

Two senior male CHDs give their understanding of primary care:

Primary Care is care provided by a health organisation which organises basic medical services for people. (CHD 2)

I understand that ... Primary Care is connected with primary health services ... [which] is care provided at health facilities. (CHD 5)

A young female CHD (7) and two other CHDs report that:

... since we have had the UHC policy, my main responsibility has been to organise the health services structure or to do whatever we can to make an appropriate structure for providing primary care services. (CHD 7)

Our major responsibility under this UHC policy (or 30-baht cures all diseases campaign) is the provision of secondary care. Secondly, we provide primary health services for people in our catchment [sub-district] and we encourage people to practise self-care. (CHD 5)

We provide four types of services: curative [medical], health promotion, disease prevention, and rehabilitation care. (CHD 3)

Even though the CHDs understand that the UHC policy encourages health promotion, their focus is on improving medical services at HCs and PCUs.

I would like to coordinate the HCs and the CH to provide an advanced curative service, because the patients might have difficulty coming to the CH ... It would be great if the patients could receive such medical services at the HCs. (CHD 3)

A senior female CHD reports that she asks the HCs to suggest improvements for PHC services at these HCs:

... we ask the health centres what kind of medical knowledge they want to improve in a given year. We let them evaluate themselves and send the results to the hospital. (CHD 6)

CHD (7) describes a case when she sent her medical team to improve the quality of health services at a HC; their approach was a medical approach, focusing on curative care:

When we had only one such unit it was very good. I mean, we could attract many patients there ... The patients kept coming to that health centre [sometimes called the PCU] [to get care], especially patients with Diabetes Mellitus and Hypertension; both can be treated by medicines a nurse practitioner can prescribe. (CHD 7)

In addition, when CHD (7) carries out home visits, the focus of those visits is on acute care cases and not primary health care:

If there are interesting cases, such as secondary-care cases in other sub-districts, we will go out [make a home visit] with the [health] officers. (CHD 7)

A senior male CHD describes his approach to disease prevention for his district; he uses a medical approach:

Disease prevention is considered one of the biggest problems. What we do now is, firstly, identify the diseases; we need to know whether there are infectious factors or non-infectious factors causing the diseases. After we know the causes of the diseases, we have two jobs to do. Firstly, we need to educate people to protect themselves from the diseases, and that is the most serious problem for us now ...

(CHD4)

CHD (1) agrees with above approach and proposes health education for people. Again, his approach is a medical one:

In the meantime, people should have the Primary Health Care Guidelines for Individuals. For example, there are twenty diseases found in the community and people in that area should know how the diseases happen and how to take care of themselves at the first step. The guidelines should include specific details, assuring them that they have [can access] curative services at the HCs. (CHD 1)

A senior male CHD presents his approach to health promotion and immunisation for his district. Even though he incorporates a multidisciplinary concept, he focuses on a medical approach:

The special concern of health promotion and immunisation is to determine whether people have enough primary care services. I emphasise these points ... I try to have everyone [in the multidisciplinary team] involved in the medical service to the patients. I have only just started with Diabetes Mellitus patients. I think we could apply the [multidisciplinary] approach to other cases of different diseases later on, couldn't we? We'll wait and see. (CHD 2)

Finally, the senior national health bureaucrat (BO 1) who is responsible for the UHC policy states that: '*[g]enerally speaking, after we started the UHC policy, the health services system has been oriented towards primary medical care*'.

However, he argues:

... we also have problems at the primary care level, or in the service area with a high amount patient-staff interaction. We are still confused about how we arrange our primary care. We classify our primary care into many levels and it is not yet clear. We have primary care where there is a medical doctor working. Another form of primary care has nurses working in it. Lastly, there is primary care where there are only health officers working. So, the differences in qualifications of those health professionals leads to an inability to set the most appropriate primary care level for our people ... currently, it [the management of district health services] is not happening ... because the medical doctor who works at the Community Hospital may not understand that concept. The Director himself may be a senior physician and may understand some of it, but the new graduates are not prepared for it and may not understand the primary care concept very well. (BO 1)

Partial understanding of the attributes of Primary Health Care

How CHDs perceive PHC can be demonstrated as being relevant to the attributes of primary care defined by Starfield (1998): accessibility and first contact, longitudinality or patient-focused care over time, comprehensiveness, and coordination of care. A young male CHD describes PHC as access to care:

We use the concept of “access to care” as the criterion. I mean if they [patients] are members of our catchment area, they can access our care easily ... (CHD 8)

Three senior male CHDs regard PHC as first contact care and accessibility to care:

PHC is very important, because it provides the first contact for services. Most people can access such services. At least, seventy to eighty percent of people can be covered by the primary care services. (CHD 3)

Regarding PHC services ... it is the primary point of contact. It means that all patients must receive primary curative care whether they are in a very serious condition or if they just feel unwell. Usually, curative services should be provided at the primary level, because patients should not visit specialist doctors as their first contact. We should focus on this point. Some of the common diseases can be cured by the primary curative services, but serious cases should be referred to the hospital. (CHD 4)

According to my understanding of primary health care, the story begins with the 30-baht UHC programme, which emphasises the importance of the first contact health facility by launching the policy called “Health Centre Near Your Home, Close to Your Heart” to take care of people in the catchment area ... The patients can have access to health services which are provided close to their homes, so that, they don’t need to go too far from their own district to access health services. (CHD 5)

In addition, the CHDs perceive PHC as comprehensive care. Two senior male and a young male CHDs state their views on this issue:

Actually, we realise that primary health care consists of health care services, including disease prevention, health promotion, and disease monitoring and surveillance. (CHD 2)

The primary health care services should consist of the important elements of a so-called comprehensive care model, including basic curative care, disease prevention and health promotion – something like that. The primary health care services include home health care, rehabilitation, don’t they? I think yes, they’re included. (CHD 4)

First, it [PHC] is comprehensive care between health promotion, disease prevention, curative care and rehabilitation. (CHD 8)

A senior male CHD perceives the concept of comprehensive care as ‘integrated care’:

In addition, the PCU should provide integrated care, which involves all aspects of health care, including disease prevention, health promotion and disease monitoring and surveillance. (CHD 5)

Two CHDs define the continuity of care or patient-focused care over time as an attribute of PHC:

... public health care needs continuity. For instance, we need to provide the care for a woman who is pregnant and assist her with the delivery of her baby, as well as child rearing after that. It is the system that takes care of people as a cycle of life from birth until death. We look after their health forever. (CHD 1)

... it [PHC] is the continuity of care provided by the primary care unit to the community, to the family and to other networks such as the school, temple, and local authorities. (CHD 8)

However, the interviewees answers show that the important long-term relationship between health care provider and patient and family, as proposed by Starfield (1998), is not found in the present system:

The best service quality we should provide is to have patients see the same care providers every time they come back. As a result, the patients would be assured of the service quality ... [but we cannot do that because] [i]here is a shortage of manpower ... because the health personnel do not stay long; they are likely to ask for a rotation of jobs or resign to continue their studies. It is a kind of personal professional aim though. (CDHO 6)

The CHDs define PHC as coordination of care. A senior male CHD reports:

We provide four types of services: curative [medical], health promotion, disease prevention, and rehabilitation care. We try to look after them [patients] by providing them with comprehensive care at primary, secondary and tertiary levels. Regarding primary care delivery, we devolve this role to the primary care unit but with our support. Tertiary care we deliver through coordination with the higher-level-of-care health facilities. (CHD 3)

The coordination of care is presented in terms of a multidisciplinary team approach between staff of CHs and HCs in the form of home visits – ‘Home Health Care’.

We try to enhance the medical service by way of a multidisciplinary team, starting when the patients first walk into the hospital for treatment until they return home. We transfer patients, who live in the hospital’s catchment area, to our PCU for home health care. I also ask health centres to provide home health care for patients in their catchment area. I am primarily concerned with home health care and I send my health team on home visits to patients regularly.

(CHD 2)

In addition, coordination of care is understood as coordination of patient information between different health care organisations. Home visits aim to educate patient's relatives about care instructions. A senior male CHD reports:

Regarding Home Health Care services, nurses would be fully involved in the provision of that care by coordinating with the City Hospital and the Regional Mental Health Hospital to update patient information following a referral. Then we would pass that information to the PCUs. Sometimes, we take health workers [with us] in order to conduct the home visit together. Through the home visits, we can educate the patient's relatives about the care instructions. (CHD 3)

Primary Health Care is described in terms of holistic care and patient-centred care. A senior male CHD points out: *'I think all of us agree that the definition of health is too broad, and requires many people to become involved'* (CHD 4). Another senior male CHD adds:

I try to emphasise to my team that we can't only take care of the disease; we should take into account their [the patients'] social background, environment and mentality. I try to cultivate the idea of a holistic care approach, especially to the community team. (CHD 2)

However, a senior male CDHO argues that most of the primary health care staff have only a notional understanding of 'holistic care' and do not grasp the practicalities:

I can't see any holistic care from all of the health staff [both at the Hospital PCU and at HCs] ... Regarding holistic care, it's not clear to us yet. We don't clearly see the output from holistic care ... Our staff still work in a compartmentalised fashion ... This is because our staff don't understand clearly what is "holistic care". They may know it theoretically, but they don't know it practically. It's quite difficult ... They can provide "holistic care" only superficially. I think that "holistic care" is something that must be understood in depth and it is difficult to practise it. (CDHO 8)

In providing PHC services, the CHDs perceive that patient-centred care is required and that staff need to change their practices from being self-oriented to being patient-focused. A senior male CHD and a young male CHD report:

It takes time to implement the new concepts which mark a change from a self-oriented approach to that of a patient-centred approach. (CHD 2)

With regard to customer focus, the staff regard the patients as being the centre, because we work as a team. (CHD 8)

However, a senior male CHD perceives the UHC policy regarding the new funding formula as a mechanism to have all health organisations working together in patient-centred care.

[T]he UHC programme is an example of a patient-centred care approach which offers per capita funding. This financial strategy would automatically force the separate organisations to cooperate with each other in order to execute a mutual management of the budget. (CHD 5)

Community participation from a medical perspective

A junior male CHD describes PHC as a form of community participation:

Lastly, community participation is important since PHC emphasises making connections with the community to have them participate in thinking about and planning health services. (CHD 8)

At the focus group, he emphasises PHC as a form of empowerment for the community to be able to make decisions concerning policies and activities regarding health promotion and disease prevention:

... we deliver what I call "Empowerment" to our patients, their families and communities, as well as all related sectors, so that they can establish policies or activities which support them with health promotion and disease prevention. (CHD 8)

However, he also says:

The community participation concept is less developed and this is an obstacle for the development of self-care through the empowerment of the community and of the family. (CHD 8)

This young male CHD adds another aspect to PHC, intersectoral collaboration, which 'requires cooperation between different community sectors' (McMurray 2003:43).

Another thing is that we deliver what I call "intersectoral collaboration". That is our role is to coordinate with important related organisations in the community. (CHD 8)

A senior male CHD describes a meeting he intends to organise at his CH to determine the health needs of the community. He intends to invite various important organisations in the district to share their views on what they want the CH to do for them. He describes this as intersectoral collaboration and community participation.

I would organise a Future Search Conference. An experienced keynote speaker would be invited, as well as community representatives, including government organisations, private organisations, local government, the Chief of the Sub-District, the Chief of the Village and the VHV. We would invite the most influential figure available, such as a senior monk to give his opinion about the health care system. Then we gather all of the opinions and draft a picture of the whole district health care system ... (CHD 5)

However, through his experience in organising a similar meeting previously, he feels that the community wants to be involved but is generally concerned with minor issues, rather than being focused on a health vision for the district as a whole.

Even though they [the community] think about many problems, for example, their shoes were stolen at the hospital, their children were bitten by the mosquitoes at the hospital, there are not enough car parks in the hospital or that the doctors should pay more attention to the proactive community services, [t]hey do not think about district health as a whole. However, those [the community's] answers reflect the real health needs of the villagers. (CHD 5)

A senior female HVHV discusses the issue of community participation in terms of the roles of VHVs and she observes that she rarely interacts with the CH. Rather, her work as a VHV usually relates to the health workers at HCs. This is relevant to Cohen and Purcal's report (1989:11) that community participation operationalised in this way is 'compliance with government notions and plan of development accompanied by incorporation of villagers as "participants" in state-controlled institutions'.

The VHVs need help from the health doctors [health workers]; if we don't know something, we ask them ... for example, if we don't know what the basic health needs are, or whether the villages meet the required criteria ... (HVHV 6)

HVHV (6) admits that although she follows the directions of the health workers, she is often uncertain about the reasons for the surveys or activities or the benefits for herself or the community.

[However,] I also don't understand about that [what the basic health needs standards are for], however, the health doctors [health workers] have asked us to follow the basic health needs standards [so we follow them]. (HVHV 6)

Health needs as medical services demand

When asked how to determine the health needs of the population, a senior male CHD answers:

We have a suggestion box, and a post box for feedback and opinions from the patients and their families. We also organised a meeting with the chief officers, and we have sent [hospital officers] to conduct a field survey. Aside from that, we invited a committee from the private sector to provide feedback on our [hospital] operation. (CHD 2)

A senior male CHD admits that his perception of the determination of health needs is based on the assessment of patients. He as yet has had no time to find alternative ways to determine health needs.

Regarding their [people] health needs, I have an idea of conducting a brainstorming workshop [with all stakeholders in the district]. I have planned that for a long time, but there is no action yet ... So far, we have collected data regarding only our patients' assessments. We have not carried out a feedback survey for all people in our catchment areas. (CHD 3)

A young female CHD explains that she determines health needs through patient satisfaction surveys and has found that the respondents only demand faster service and complain about staff:

After we did the survey for patient satisfaction, there are two prominent issues – waiting time and the behaviour of those who provide the services. (CHD 7)

A young male CHD determines the health needs of his population in the following way:

There are two parts ... we carried out a health needs survey, from the people's point of view, and we combined that data with the information we had already. (CHD 8)

A comment by a senior female CHD (6) demonstrates that rather than the health needs of the people being the criteria for improving the quality of health services at HCs, the readiness of the health workers for change is more important:

The health centre which is ready sets the condition that, firstly, the health centre staff must be willing to change and develop the health centre to be a PCU... (CHD 6)

The health needs of people in rural areas are not being met. A senior female HVHV tells a story about a health problem that demonstrates the impact of the social influences in her village:

Recently, the health workers visited us, but there is no concrete solution for this [young students having premarital sex]. The public health workers are concerned about communicable diseases [and teenage pregnancies]. I don't know who should be responsible for this, their parents or who else. I don't know how to solve this problem ... [actually] the major health problem [in our community] is alcoholism. (HVHV 1)

A senior male CHD reports:

I do not deal with those programmes⁸ [Healthy Thailand, Sustainable Health for All, the PHC programme at the village] even though my Community Hospital adopts the programmes assigned by the MoPH and PHO. Instead, the CDHO and staff at HCs, as well as my staff at the PCU, are the ones who deal with those programmes. It is the responsibility of the PHO to control those programmes. I only focus on UHC policy and the HA standard. (CHD 4)

⁸ The details of these programmes are presented in Chapter Literature Review.

The PHC programme at village level is a health programme that aims to enable the community to participate in health provision, particularly self-care (Leerapun, Siwiroj & Termsirikulchai 2000). The DHO distributes the funding for this programme to communities. A senior male CDHO explains the history of the programme:

Even though the Primary Health Care in the Village Programme has been finished [out of our hands] for many years, we still have many preventable health problems. I think that we need to find out how we can make this concept sustainable. It shouldn't be that when the funding of this programme ends, everything else is finished. The most important thing is that all people have good health. The PHC in the Village Programme is a strategy encouraging people to participate in self-care to achieve 'Health for All'. PHC encourages people to look after themselves. It's impossible to have public health officers managing self-care for them. This is why we have VHVs. VHVs look after the community. They learn [about PHC] from us and transmit this knowledge to others. The knowledge is about Primary Health Care [self-care] and how to look after themselves, to remain well and how to protect their own health. We are responsible for giving them the knowledge. We use only a small amount of funding. It is an effective method. At this stage, this VHV structure still exists.

(CDHO 8)

Currently, the MoPH provides funding of about 10 000 baht to each village through the local governments. The community uses this funding to facilitate its participation in health promotion. The health activities are carried out through the Primary Health Care Centre operated by the villagers (PHCCV). A senior female VHV reports:

Previously, the PHCCV was allocated a budget of 7500 baht; budget is 10 000 baht now. We raise funds by selling off shares to the villagers; we use the profits to purchase medicine. It's the circulation of money. In fact, we used to spend the budget of 7500 baht not only to supply medicine, but also for meetings, repainting the building, purchasing chairs for the meeting room for VHVs and FHLs. (HVHV 6)

A senior female HVHV adds:

Currently, this funding has been given through the local governments because of the Decentralisation policy. VHVs submit the health plan once a year requesting funding from the local governments ... Usually, it's only a small amount of money and it's not enough to run health activities in the local area, but we try to manage it as effectively as we can. The villagers volunteer help if we don't have enough money. (HVHV 8)

However, most of the activities are about disease control as required by the MoPH. These activities are led by health workers. A senior female VHV reports on the allocation of funding for health activities at the village level:

It depends on health workers advising us what to use this funding on. We have to divide this funding for many activities, such as, Dengue Hemorrhagic Fever [Mosquitoes] Control, Prevention of Child Malnutrition, Exercise, and Study

Tours for the Elderly. For instance, this year health workers have advised us to promote cervical and breast cancer-screening campaigns. (HVHV 5)

HVHV (6) tells of the regular activities at the PHCCV, regarding common health care for villagers:

If they [the villagers] are not seriously sick, they would come to buy medicine at the PHCCV. The VHV's would recommend what medicine they could take. If they are not getting better, I would suggest they visit the doctors [health workers] at the HC. If the health workers cannot cope with their illness, the patients would be transferred to the hospital. At the PHCCV the VHV also cleans wounds.

(HVHV 6)

However, a senior female HVHV argues that the UHC policy does not integrate with the PHC programme at the village level, as it discourages villagers from using services at the PHCCV. Instead, they go directly to the hospital where only a small or no payment is needed. She reports:

From my point of view as the community leader, I think at the moment we can't make a lot of money from the sale of medicine, because people use their 30-baht UHC gold card to access the medical services at the health centres or hospitals. They rarely come to our PHCCV. Previously, when people needed wound care, they would come to see us. Now that there's the UHC programme, they go straight to the hospital. They do not need to pay or at most they pay only 30 baht.

(HVHV 2)

A senior female CHD asserts that health programmes from the MoPH and PHO are unnecessary. She says:

... we are now working on the assigned policy based on the 'Sustainable Health for All' [SHFA] project launched by the PCMO and the Healthy Thailand project launched by the MoPH. For example, the children should be vaccinated, the elderly should have their annual medical check-up, women should be checked for cervical cancer. In fact, the population for any age group should receive particular health care services. (CHD 6)

A young female HHC adds that health programmes from the MoPH and the PHO are duplicated. She finds this duplication confusing.

The provision of PHC at HCs will be improved if the PHO eliminates the duplication of reports, such as those of 'Healthy Thailand' and 'Sustainable Health for All'. The Healthy Thailand programme is assigned by the MoPH. You have to comply with indicators for health activities, because it's a national policy. The PHO also has its own indicators and they are additional.

This makes us confused. However, I think that both of them are similar, with only the degree of indicators different. The indicators of the PHO are more strict than those of the national policy. I think that they should adjust them to be the same as

those for the national level, so that we don't have to do double the number of reports. (HHC 5)

This duplication has given her a very heavy workload: *'I think that it stresses us so much that some data are fabricated, because we need to achieve those indicators'* (HHC 5).

A senior male CHD asserts that he does not understand how to implement the health policy from the MoPH:

I am not sure about the Healthy Thailand campaign, and whatever other campaigns are launched by the MoPH, I think that they are not clear enough ... I don't know how to implement the policy now. (CHD 4)

A senior male CDHO (2) expresses his view that a common problem is *'the misconception of health promotion'*. When he worked at the Board of Provincial Budget Allocation Office, some CHDs had interpreted the 'Healthy Thailand' project *'as a non-health promotion project'* and had thought health promotion entailed only *'ANC, vaccination and so forth'*. (CDHO 2)

The data show that the CHDs lack the ability and, as explained below, resources to integrate health programmes at district and sub-district level to meet the needs of the rural poor. Furthermore, the fragmentation of health programmes at the local level creates the duplication of tasks and limits the sustainability of PHC services provision. In addition, it prevents communities from being self-sustained and prevents the continuity to learn about sustainable self-improvement.

4.3.3 Sub-theme 2.3: Problems and challenges in implementing the Universal Health Coverage policy in relation to Primary Health Care

The informants describe the problems and challenges in implementing PHC within the context of UHC policy and within the Thai rural context. The problems and challenges are: i) demand for increased curative services; ii) shortage of workforce at the primary care level; and iii) the disparity between responsibility and authority. These obstruct the CHDs in achieving the aims of the UHC policy and sustaining PHC provision at the district and sub-district level. Each of these is discussed below.

Demand for increased curative services

A senior male CHD (5) perceives the UHC policy as increasing the demand by people for curative services. Initially, 'we [had] thought that the number of patients at the PCU [HC] would have increased, and those at the hospital would have decreased'. Instead, '... the number of the patients at the hospital is still increasing' with numbers increasing at both the CH and the HCs, so increasing the workload.

A senior male CHD adds that most of the patients who go directly to CHs have common diseases. This creates a heavy workload for staff.

In fact, you will see that eighty percent of out-patients in the CH have a respiratory or digestive tract disorder, both of which are not that serious that they need to be seen by the doctors. As a result, the doctors have to waste their time with the patients who could have been taken care of at the primary health care facility. (CHD 1)

A senior female CHD shares her view that patients do not take responsibility for their own health:

The weak point is that patients do not take enough responsibility for their self-care. That is why, when they have any simple illnesses, even a cold or fever, they come straight to the hospital. (CHD 6)

She believes that patients go directly to the CH, because the government gave them the 'right' to do so and this overloads the CH:

Now ... patients have a right to go to hospital without any documents being required, so we have to grant them this right. The right is specified by the government, that they are able to have themselves cared for at the hospital. As a result, the hospital is over-loaded with patients ... (CHD 6)

Even though hospitals have been trying to upgrade HCs, this has not been always successful:

The hospital has been trying to solve this problem by improving the capacity of the health centres, in order to assure patients that they can rely on the health centres. This solution has only been partially successful. (CHD 6)

A senior male CHD argues that some patients do not respect the rules and wrongly claim 'their rights':

They [The patients] ask for their rights with no concern about the rules and conditions of the card. For example, some of the villagers [patients] have

relatives working at the XXX Hospital [the University Hospital in Bangkok]; they claim they have the right to go to XXX⁹. (CHD 5)

A young male CHD (8) perceives that patients see their health needs in terms of medical care, with *'health needs, in terms of self-care, receiv[ing] little attention'*.

A senior male CDHO adds that people do not take responsibility for their self-care as they feel that it is the responsibility of health officers:

Regarding the difficulties, most people understand what the health care services provide, however, they are not [prepared to be] responsible for their self-care. They would say that health care should be the responsibility of public health officers, the local government or the district officers; for example, when there's an epidemic, they would say the doctors and the VHVs should be responsible for disease prevention. People don't have the concept of self-care ... There are no rules or laws to force them ... to take care of themselves. (CDHO 6)

A young male CDHO believes that people in rural and remote areas do not have any health consciousness, and do not practise appropriate self-care because of their low level of education:

I think that my greatest concern is the behaviour of people in the community [regarding their health]. They usually have inappropriate health habits, such as eating habits ... They know what they have to do, but they don't do it ... this is the basic problem, low [levels of] education ... They have less education and their behaviour [is less aware of modern health concepts] than people in other areas. (CDHO 7)

A young female CHD (7) adds that, aside from having lower education levels, most are *'just ordinary people, not state officials, so that they don't have much discipline ... Some were elderly people who were illiterate'*.

A senior male CDHO points out that the priority of people in rural and remote areas is economic survival, rather than their health:

I think they are not well-educated, and there's an economic crisis; people have to make a living from working; they pay attention to their jobs, [rather than self-care]. The economy is not so good, the villagers have low-incomes, and most of them are employees. (CDHO 6)

⁹ In fact, they are not Bangkok residents; they are not eligible to bypass the local hospital for the XXX Hospital.

A young male CHD (8), who works in a remote area, expresses similar difficulty dealing with the lack of self-care in the community because of the poor economic situation of villagers: *'There is still a major hurdle, the people's poor financial situation'*.

He believes that there is nobody to look after their health:

They depend on agriculture. The migration of labourers means that only the grandparents and the children remain. (CHD 8)

A young female CHD argues that it is CHDs who fail to make people understand what they need to do for their self-care:

Perhaps, we have not helped the local people to think in the way we do. They may think about how to make their living and not about whatever we want them to consider. This is difficult. (CHD 7)

A senior male CHD, however, points out that the problem is that the district health services system emphasises curative care, rather than disease prevention and health promotion:

However, it seems we make a small mistake by providing them only with medical services, when we should also encourage them to look after themselves. The villagers are very happy to have the UHC gold card, and they know to use it only for medical services. They don't know how to protect themselves from getting diseases. (CHD 5)

Another senior male CHD argues that the major health need of the community is curative care and that HCs should be improved in terms of curative care, so that people can access such care near their home:

However, the expectation of people is different; people don't know what disease prevention is. They expect to have curative care when they come to the HCs. The HCs should improve their services based on people's needs ... I think HCs should focus on curative services, because the prime need of the people is curative care. We should provide whatever people want. (CHD 1)

However, a previous informant, CHD (5), argues that he sent a medical team to provide medical services, and training for the health workers, at the HCs in his district. This was to enable the health workers to increase their medical knowledge, as well as provide medicines for the HCs. It was hoped that this would stop patients going directly to the hospital. After ensuring that the health workers had enough medical knowledge to look after patients at the HCs, he pulled his medical team back to the CH because of the

shortage of manpower. He found that the attempt to improve medical services failed, because the patients do not trust the medical services at the HCs:

... we provided the HCs with knowledge and medicine, but no expert team, so the project failed. The patients were not confident about the medical services at the HCs. (CHD 5)

A senior female HVHV supports this view:

Practically speaking, people do not like to use the medical services at the Health Centres; they are likely to go straight to the Community Hospital. The problem is they do not follow the terms of use of the UHC card ... They go straight to the [Community] Hospital, because they feel that the hospital is better than a Health Centre. They think that the Health Centres have poor services, and give them low-quality medicines. (HVHV2)

A senior male HVHV reports that to receive medical services at public hospitals, such as CHs and City Hospitals, patients have to wait a long time in queues and that their services are provided at the expense of truly needy patients:

Regarding the services at the [Community] Hospital, the patients have to wait in a long queue. Why do the injured have to wait in a queue? They should be treated at the emergency room instead of being treated at the OPD. This is my opinion. The services provided by the hospitals, including the City Hospital, are not good enough. (HVHV 4)

A senior female VHV states that the patients of the UHC programme do not trust the medical services they receive:

Actually, there is inequality in services delivery. It's not the same as when we pay for the health care services ourselves ... It's not only so at the PC Community Hospital, but also the City Hospital, as well as the [public] hospitals in Bangkok ... The hospitals provide different levels of service. Firstly, there is the difference in medicine. Secondly, the diet is different ... That's what I saw and I think it's unfair ... The hospital claims that the medicines are of the same quality, but patients find out that they are not the same. Patients, who can be reimbursed for the medical fee, receive better medicines, and those patients get better more quickly after taking those medicines. Unlike those patients, the 30-baht [UHC] patients feel that it takes a longer period to recover from disease. They feel like that. (HVHV 1)

This lack of trust in the medical services the community receives reflects an unrealistic attitude on the part of the community.

A senior male CHD reports that, as a result of the heavy workload, hospital staff are tired and sometimes make mistakes in the provision of medical services. Patients expect too much regarding the quality of medical services.

Those exhausted doctors or nurses might get into trouble with the patients, the hospital might be sued because of that. It is quite a big problem when they file lawsuits against the hospital. (CHD 1)

Malpractice suits and set standards are issues of concern.

One more thing that depresses me nowadays is that we are living in the era of malpractice suits. The villagers do not understand us, and doctors are often sued by them. (CHD 3)

One more issue that concerns me is that we should have set medical standards for patient examination. If our practices are to be standardised, we should limit the workload for doctors, so that there is a set number of patients per doctor. This is because now there are a lot of complaints. If the MoPH cannot set such standards, it should take responsibility for the litigation, and not allow suits to be filed against doctors. (CHD 7)

CHD (7) gives her opinion about the changes and the rise in malpractice lawsuits in an era of capitalist philosophy:

Perhaps, in the past, doctors were viewed in the light that we came out [to the rural area] to help people, because there was a shortage of doctors. Formerly, people depended on us, but at present people don't need to depend on us. Well, it's like we come to help them. Maybe we are not good enough. Maybe there are more doctors in private practice, [who tend to order unnecessary and expensive tests]. Consequently, villagers view doctors as too focused on making money. They consider that doctors have received a lot of money already. Therefore, they should be able to sue us if they are affected by our [medical] practices. I think that it may be an issue. (CHD 7)

A senior male CHD points out that the problem occurs, because the government does not provide information regarding the real situation in the health services system to people, and that the responsibility of providing the information now rests with the CHDs:

The government doesn't provide the whole facts to people ... [and] I need to explain everything to them. That's the problem; the villagers are likely to use the UHC card without the necessity to do so. (CHD 5)

Shortage in the health personnel

All of informants feel that the major problem in implementing the UHC policy is the shortage of health personnel. A senior male CHD reports:

... it is difficult to be successful, because we [have] found that the shortage of manpower is the limitation ... and the health workers cannot acquire the necessary knowledge to cope with the situation, so that the hospital is flooded with patients just as usual ... The chronic shortage of doctors affects the implementation of the UHC programme. (CHD 5)

A senior provincial bureaucrat points out the effect of the doctor shortage on PHC development:

The shortage of doctors is a major barrier [for PHC development] ... we have a shortage of doctors, so [CH] Directors who are also doctors have to do clinical work; therefore, they don't have time to think strategically and don't have time to manage health centres, or even visit them. (BO 3)

A senior national bureaucrat says that, while Thailand tries to improve primary medical services, as developed countries have, it is difficult, because Thailand has a shortage of doctors:

This problem [places] stresses on Thailand which basically has a shortage of resources. Our demand and supply system is different from that of developed countries. We have a small supply of doctors while the other developed countries have more. (BO 1)

A senior male CHD suggests that the problem of the shortage of health personnel is more severe than that of the shortage of funding:

Moreover, there is the difficulty of the shortage of health personnel. We cannot assign health personnel to the PCUs, which is very awkward. The budget issue is less severe than that of human resources. (CHD 3)

Another senior male CHD argues even though CHs are CUPs, which serve large populations and have more money, they cannot recruit health staff directly, because CHs are not autonomous. The CHs must follow centralised rigid and inflexible bureaucratic regulations to try to meet the needs of local health services.

However, there is a big problem regarding the shortage of health personnel. We are not a public autonomous hospital, so, even if we had the money, we can't recruit health personnel freely in the same way as the BP Community Hospital.¹⁰ (CHD 3)

A senior female CHD, who works in a remote area with a big population, says: 'Let's say we have a problem of human resources, but we don't have financial problems' (CHD 6).

A senior male CHD argues that, besides the number of health professionals required, there is a need for knowledgeable health personnel to meet the health needs of people in the local areas:

We require more health personnel who are knowledgeable academically ... I think that we need more knowledge regarding health promotion ... we need people who have specific knowledge of, for example, occupational health ... So far, there are no occupational health personnel at all. (CHD 4)

¹⁰ It is the pilot for public autonomous hospitals.

The CHDs lack the power to solve the problem of the shortage of health professionals.

Am I to be the one who decides whether or not to employ these doctors, pharmacists, dentists and the department heads? Are we not fortunate enough to have them working at the hospital, because there is a general shortage of health personnel ... Frankly, I have no choice. (CHD 4)

Another senior male CHD observes that the CHDs cannot do anything about this problem:

Due to the launch of the 30-baht UHC campaign, there is an urgent need to fill a lot of positions ... It needs patience to cope with the manpower shortage. (CHD 1)

The shortage of health professionals is not only due to the limited number training positions, but also many other factors. The remote districts are at even more of a disadvantage, with frequent changes in health staff and managers. A young male CDHO points out:

Our area is remote. It is different from other areas. It's difficult even to have executives who want to stay in this area. As a result of the remoteness, most of the executives come here on their way to other areas. This is always the case for both executives and staff. Those who still work here are rarely focused on good service. Everybody waits here in order to leave. (CDHO 7)

A young female CHD who works in the same district as CDHO (7) supports his view:

[We have frequent changes in our manpower]... [b]ecause this district lacks municipal status; it is only a district [a local administration unit]. When compared to XXX District, it's a newborn district which has not progressed very much. (CHD 7)

Moreover, CDHO (7) argues that the personnel change frequently, because the staff who work there are not local people:

The staff who work here are not from the local area. They are from other areas. They want to work near their homes. They think that this area is too remote and uncivilised. I think that it's true that this area is uncivilised. (CDHO 7)

A senior male CDHO expresses the view that the turnover rate in personnel in his remote district is high, because the staff need opportunities to continue their education:

There is a shortage of manpower in this district, because the health personnel do not stay long; they are likely to ask for a rotation of jobs or will resign to continue their studies. It is a personal professional decision though. (CDHO 6)

A young female CHD explains that a frequent change in personnel leads to instability; she always has new graduates as replacements and this is her challenge:

I think this is challenge enough, because there is change in staff every year ... Once, there are changes [in personnel] the problems arise ... Changes mean that we get the new graduates as replacements, not the old hands from other hospitals, who have been trained and are knowledgeable. (CHD 7)

CDHO (2) adds: *'Another problem is the shortage of manpower due to early retirement'*.

Finally, a senior national bureaucrat points out that the shortage in workforce personnel at the primary care level is problematic, because there is still confusion as to what personnel should actually be involved at the primary medical care level.

We have to be clear that, at the primary medical care level, whether we want medical doctors or not, where nurse practitioners will work, and what roles the health centres will have; what are the roles of nurses and what are the roles of the health workers. I think that all of those need to be explored further. (BO 1)

Shortage of doctors

A senior male CHD says, about the barriers to implementing the PHC within the contexts of the UHC policy and Thai rural areas: *'during the past decade, there has been a shortage of doctors at the Community Hospitals all of the time'* (CHD 5). A senior female CHD adds: *'doctors are a particular issue. It's still considered to be a problem,*

especially in [this province], because there have been less doctors available' (CHD 6).

As a result, the CHDs have had to take responsibility for clinical work as GPs (generalists).

Recently, we were short of doctors and there was no doctor to provide medical services in the hospital's OPD except me ... I [the CHD] am working as the main GP [generalist] to provide medical services to people. (CHD 2)

Two senior male CHDs feel the shortage of doctors has prevented the improvement of medical services at the PCUs and HCs:

If we had enough doctors, we could assign some of them to work regularly at the PCU, which would improve the curative services at the PCUs [HCs] ... However, we can't meet their [the PCUs'] needs, because the doctors can only visit the PCUs [HCs] occasionally. (CHD 3)

... the problem threatening at the moment is the shortage of doctors in the Community Hospital. As a result, it prevents both the progressive development of the health services network and the decentralisation of the HC. ... We don't have enough doctors to visit the HCs everyday. We assign a team to visit the HCs only twice a month. (CHD 5)

A senior male HHPCU argues that, if the CHs send doctors to work at HCs [sometimes referred to as PCUs] outside hospital areas, the CHs will be overloaded with patients in the OPD, which will bring about a poorer quality in medical services at the CHs:

There is the shortage of doctors ... Is it possible for the doctors to visit the PCU in the morning? It's probably possible, but it is not likely to happen, because there is a shortage of doctors working at the Community Hospital. If ... the doctor at the Community Hospital ... is sent to work at the municipal PCU, the Community Hospital would become crowded with patients ... there would only be two doctors left to take care of the OPD patients. In the morning, those two doctors examine two hundred patients each; I think that the doctors don't have the time to take a breath. Let's divide sixty by three. The average time that a doctor spends examining each patient in one minute. How could we expect quality from a one minute examination? (HHPCU 3)

A senior national bureaucrat comments: 'We should produce a sufficient supply of health professionals' (BO 1). A young male CHD describes the problem of physicians being poor public speakers. This demonstrates a barrier to sustaining improvement in PHC services in order to achieve the goal of the UHC policy:

When I took the role of a HHC, I realised that physicians have few skills for health promotion and disease prevention. The physician has fewer public-speaking skills with which to encourage people [to undertake self-care] compared to the health doctor [health worker] who is skilled in conducting a general meetings. (CHD 8)

Moreover, he points out that the system of medical education does not support PHC in Thailand and that doctors do not take the lead in the improvement of PHC:

Doctors did not take the leadership role here [in PHC], and not only because we have a small number of doctors in Thailand. We have even less doctors who are skilled in Family Medicine and who love primary care work. It is because of the medical education system, which does not regard this issue to be important.
(CHD 8)

A senior male CHD argues the medical schools provide a negative role model for medical students. The medical schools influence the medical students indirectly to be more concerned about earning money, rather than community service and PHC and this has impacted on the health services system.

The medical students are influenced by negative role models. The medical professors are not positive role models for their students. They do other jobs, for example, consulting jobs as a sideline. I don't mean there are no positive role models at all, there are just a few. I know they have to make a living, but their behaviour can affect the values of the medical students ... the new medical graduates are probably not consciously aware of community services. The ideal of devotion is vanishing; delivering services to the communities in rural areas does not fulfil them. They are more concerned about high salaries and their

personal welfare, rather than helping people. The crisis within health services system is influenced by the values of the medical graduates. (CHD 5)

CHD (5) blames the concern for material gain over community service on westernisation, which is due to globalisation. The media is important in spreading the negative values quickly. His reply reflects the fact that capitalism has spread throughout the nation with people lacking the ability to live comfortably with it; as a result Thai society is changing.

I think the values of people are affected by the changing society. Our education system is westernised and we receive news and information, as well as values from the western world, because we now live in the age of globalisation ... We are too weak to resist the western value of materialism. The media also promote western values, and people are influenced by the media; this includes doctors, especially those in Bangkok and in the big hospitals. (CHD 5)

He believes this, because most of the doctors who resign from CHs to work in private hospitals do so in order to be paid much more:

They [medical graduates] are not likely to stay at the Community Hospital because of ... economic issues; private practice or work in a private hospital would pay them a more competitive salary than we do ... (CHD 5)

A senior national bureaucrat believes that this phenomenon is influenced by globalisation, that is, in terms of a capitalistic management philosophy, and that it has a negative impact on the implementation of the UHC policy:

I think that it is because of the trend towards globalisation, which started from a Keynesian idea ... That idea is about re-organising the system — using more resources and increasing efficiency ... Moreover, the Keynesian idea is compatible with the trend of capitalism ... It led to a trend of emphasising financial incentives — increasing incentives ... I think that the current motivation is based primarily on money ... one example concerns our UHC project.

On one hand, I think that we try to spend less money and find the way to make this work best. This is because we have few budgets that are per capita-based, but we have to find the way to manage them best. On the other hand, ... we have to create incentives for motivating people to work. (BO 1)

There is a shortage of resources and problems in the retention of personnel. As a result, the aim of the UHC policy, in terms of equity, is problematic. He explains:

The problem is that we use resources, which should have been spent directly on health of the people, on incentives. This problem stresses Thailand, which basically has a shortage of resources ... [and] there is the problem of retention of health professionals in the public system ... An emphasis on higher efficiency impacts on the other sectors, for instance, the private sector. Such a concept of efficiency leads to competitiveness in the private sector, which helps develop that sector. However, the more the private sector is developed, the more it draws doctors from the public system ... Finally, this impacts on equity. (BO 1)

A senior male CHD (5) perceives the resignation of doctors from CHs as an expression of the internal brain drain from the public sector to the private. Rural people are at the greatest disadvantage, since they have only new graduate doctors to serve them and these doctors tend to leave when the opportunity of a better position arises.

In fact, the Community Hospital has had a shortage of doctors all the time, because there has been the brain drain of medical lecturers from the medical schools to work at the private hospitals. These provide medical services to wealthy patients as well as foreigners. (CHD 5)

He continues to say the medical graduates who serve people at district level may be specialists but have to work as GPs and are not satisfied with their jobs.

They [medical graduates] are not likely to stay at the Community Hospital because of ... [the lack of] job satisfaction; they might be a Paediatrician, but they [may] have to attend a Caesarean Section or an Appendectomy. (CHD 5)

Lastly, CHD (5) adds that another factor which makes medical graduates resign from CHs is ‘*the [lack of] facility; we might not offer the acceptable support or other convenient facilities...*’ for their development as doctors.

A senior national bureaucrat points out that the lack of social recognition for being a GP is an important factor leading to the failure in retaining rural doctors:

There are two things. The first is a matter of social recognition. I think that right now there is little or no social recognition for primary care physicians. This is because primary care is of no social value. Our society has a hospital-based orientation. Second, are incentives. The incentives to be a primary care physician are few ... This is a result of the first factor. When you have low social recognition, it has an impact on your incentives ... because of the lack of social recognition they will only spend three years in rural areas and then return to the city. Then, they request more money. (BO 1)

Moreover, a young female CHD argues that medical graduates only work in rural areas to complete their scholarship obligations; they have no intention to stay in rural areas when these are not where they come from. Her statement shows the recruitment and selection of doctors is not integrated with the retention and distribution of doctors.

If I consider only the rural context, then the situation is that when the graduate doctors fulfil their scholarship obligations, they leave the hospital. It's normal because this area is not their home. They want to go back to their home town.
(CHD 7)

The government has launched a new campaign, ‘One Doctor for One District’, to increase the number of doctors and to provide scholarships for the training of local high-school

students; after they graduate, the new doctors are supposed to return to serve in their home towns. The government provides one scholarship for each district. CHD (7) believes this campaign is government propaganda, because she has not seen any evidence of the scholarship working in her community. She explains:

However, I live in this district and I've never seen any students who have received that scholarship. It's just like another project called 'one Tambon [Sub-district] one nurse'. It's just the old propaganda. It's [remains] the same as the Ministry has always done for the training of doctors. (CHD 7)

In her view, this new campaign will not be successful as the authority to recruit and select prospects belongs to public officers and does not involve true community participation.

The authority for the recruitment and selection of scholarship holders in the last few years, but not this year, was given to the DHO. The Chief of the District Health Office received a letter from the District Chief and he then passed the information to schools, and conducted the recruitment. The criteria for selection are that we need to consider the candidates' [place of] residence, and their economic status etc. Then we choose one. This is the decentralisation of authority [from the Ministry] to us so that we are able to select the scholar. However, I think that this authority is, in practice, still limited to public health staff [who are bureaucrats]. (CHD 7)

A senior female CHD points out that the shortage of doctors is caused by an unstable health policy. She adds that the root cause of the unstable health policy is that the bureaucrats have to serve the politicians who have only short-term goals:

It [the factor causing the health policy to be unstable] would be politics. When politicians themselves state policy, they try to force us [doctors] to accept and follow it. Some senior executives in the Ministry would agree with their process, and some would not. However, once they get into the position, they all compromise and agree with politicians. I think that's always the way. (CHD 6)

Finally, a senior national bureaucrat adds that the shortage of medical doctors is a major barrier in implementing the UHC policy in terms of upgrading HCs to PCUs:

Last, the challenge of health manpower, which I think is the biggest problem of our current health system. It's that we have a scarcity [of personnel] in the health workforce, especially medical doctors. (BO 1)

He proposes that medical education reform should focus on primary care, in order to sustain the UHC policy and PHC:

I think that our medical education must be reformed towards primary care, and the other specialties made to be supporting areas of study only. (BO 1)

Shortage of nurses

'There is a severe shortage of registered nurses' (CHD 3). A senior male CHD points out that the shortage of doctors leads to nurses substituting for doctors:

In addition, there is a shortage of doctors, who are unhappy working under the pressure of a heavy workload. The shortage of doctors affects the hospital. When there are not enough doctors, the nurses have to be involved in the provision of curative services. The nurses feel stressed. (CHD 3)

Another senior male CHD argues:

In fact, there has been a brain drain of nurses from the public to the private hospitals, because the latter offer better pay. There is a shortage of nurses, which affects the development of the health organisations [both CHs and HCs].
(CHD 5)

A senior female HHPCU asserts that the number of nurses is still low for the PCU standard:

According to the guidelines from the MoPH, it's recommended that the standard ratio of nurses to patients should be 1:1250. Theoretically, I need 7 – 8 staff to take care of a population of ten thousand, but I lack manpower ... The ratio of nurse to patient at the PCU is excessive, over 1:1250 ... There is ... a shortage of manpower ... in order to operate the PCU ... the hospital also needs to change its plan of giving me [only] 6 professional nurses ... to work at the PCU.
(HHPCU 7)

In order to improve the medical services at HCs, support was provided by CHDs and CDHOs to improve the qualifications of health workers at HCs by enabling them to study for the bachelor's degree of nursing. However, a young female CHD reports that this was not completely successful:

Later on we sent senior health officers working at health centres to further their studies in nursing for two years and to come back to work as nurse practitioners and we have done this for almost all ... well ... all health centres. However, it did not work. We still have a manpower problem. (CHD 7)

Another strategy forces new graduate nurses who have worked at CHs for at least one year after graduation to work at HCs. This strategy, however, is not successful because most nurse graduates want to work at the CHs. A senior male HHC reports:

More importantly, we are encountering a shortage of nurses; for example, the new graduate nurses who have worked with the Community Hospital for one year were forced to work at the HCs; they don't stay. Only two years later they ask to move back to work at the hospital, otherwise they resign to work in a private hospital instead. (HHC 4)

A young male CHD points out that all the strategies seem to be unsuccessful. Working under a bureaucratic system in which there are rigid rules and regulations regarding payment and pay rates for nurses at HCs and PCUs means that the nurses are paid at a lower rate than those who work in the OPD or Emergency Room (ER) of CHs.

The problems mentioned are the result of working for a government agency. There are too many regulations, e.g. about their overtime payment when they visit villages. They are like children of a mistress, who are always at a disadvantage in comparison to the staff working in the hospital who have more benefits and more inducement to work. In addition, a while ago, the Thai Nursing Council launched a special pay rate for nurses. According to this rate, the PCU nurses are paid less than the OPD or the ER [Emergency Room] nurses.

(CHD 8)

Shortage of health workers

This shortage of staff includes a shortage of health workers. Health workers are the front-line staff, serving people near their home. A senior male CHD reports:

One thing I would emphasise is that the HCs are lacking health workers. I found that there are only two or three health workers at some HCs. According to the HCA standard there should be eight health workers. Instead, the number of the health workers has fallen below the standard by thirty to forty percent; even more than fifty percent in some places. (CHD 1)

A young female CHD adds: 'there are only 2 – 3 staff members at each health centre, which I think is not sufficient' (CHD 7). A young male CDHO argues:

There is only one health worker, who is stationed at each HC to provide curative care to the patients ... It is too heavy a workload for one person. There should be at least five health personnel at each HC, including the HC manager, nurse, dental assistant and the public health specialist. (CDHO 7)

A senior male HHC argues the shortage of health workers means that HCs do not meet the standard (HCA launched by the MoPH) to become PCUs. This is a major problem for those delivering PHC services to the community.

However, we face a health staff shortage and we have only two health officers working in each health centre. Therefore, it's quite hard for only two people to be ready to do it [maintain Health Care Accreditation¹¹ (HCA)], even though we all want to. (HHC 7)

The statement of another senior female HHC demonstrates the disparity of the number of health staff at her HC and the number of people they served: 'There are 9155 of people in this Tambon [Sub-district] ... but there are only a nurse and three health workers

¹¹ It is a continuous quality improvement of the primary health services system.

[instead of the required eight] ... so that we are disqualified [from the MoPH's standard due to the shortage of manpower]' (HHC 2).

A senior male CDHO adds that aside from the shortage of health workers, the existing workers also lack the knowledge to provide medical services at HCs:

Regarding the HCs, they are considered to be second rate compared to hospitals ... The HCs provide several services, covering almost everything; however, the health workers lack medical knowledge and, in addition to this, the number of health workers is limited. (CDHO 6)

A senior male CHD states that health workers at CHs also lack knowledge regarding health promotion and disease prevention, both not part of their training:

Currently, my public health officers, who are called the public health academicians¹² are available. I don't think they are sufficiently qualified, and I still consider them as community health officers.¹³ I think that they are not experts in disease control at all ... I think that they need more knowledge regarding health promotion [and disease control]. (CHD 4)

Another senior male CHD points out health workers are forced to provide medical services but their training and qualifications are insufficient and their rate of pay is too low for the responsibilities they are given:

The HC [staff] has to provide medical services to patients as well, despite the fact that the health workers are not graduates from medical school. Practically, we force them to do that, but we don't pay them the wages of a health professional, and this lead to the conflicts. The conflict arises from the overlapping tasks.
(CHD 5)

A young male CHD believes there is inequality and inequity in working at CHs and PCUs or HCs:

The PCU and the HC [staff] still lack sufficient knowledge for medical care and the number of staff to match their workload, as well as motivational factors [financial incentives] ... I don't agree with that, because this inequality [and inequity] makes the PCU staff less motivated and discouraged. (CHD 8)

The observation of a senior male CDHO demonstrates the inequity and inequality in the distribution of health staff to work at HCs; the remote areas are the most disadvantaged:

... even though the government could produce enough public health personnel, the government could not assign those people to work in the rural areas, so that there's a huge cluster of health personnel working in the well-established areas and ... there is a high staff turnover[in the rural areas]. For example, most of the

¹² They are the people who graduated from four-year College in Public Health Management.

¹³ They are people who have graduated from a two-year college managed by the MoPH.

new graduates in nursing usually work in a big hospital. They are not happy working in the remote HCs. (CDHO 6)

A young male CDHO thinks there should be equality and equity in the government's funding and distribution of the health workforce:

... the distribution of health manpower is an issue. It should be equally distributed. I feel sympathy for my staff, because there are only two of them working in a primary care unit. They have too much work to do. It's so much for them that they can't stand it. We have less staff than others do. It's not fair. It's not equitable for us. Therefore, there should be an equal and equitable distribution of the budget and health workforce. (CDHO 7)

As a consequence of the unequal and inequitable distribution of resources, 'the employee services can't satisfy the health workers, because the salary and remuneration is not attractive enough' (CHD 1). A senior national bureaucrat agrees that appropriate incentives should be encouraged:

I think that we have a major problem in the severe shortage of health manpower. I think that this is the biggest problem. We should encourage the supply of enough health professionals. Then, while we increase the supply, we need to create incentives (both financial and non-financial) for health professionals, especially for those who work at the primary care level. (BO 1)

A senior female HVHV agrees that there is a shortage of health workers at HCs. However, she points out that health workers have to spend a lot of time on paperwork, rather than in the provision of services to people:

One thing that I dislike and that I would like to see improved is that there are only a few health doctors [health workers]. Moreover, the doctors [health workers] have to manage the paperwork. If they didn't have to waste time filling in documents, they would have more time to provide services to the people. In fact, they are required to report to the District Health Office everyday and so need to spend time on documents, which reduces their time to serve people.
(HVHV 2)

The data show that the interviewees perceive the shortages in the workforce as a major factor preventing sustainability in the provision of PHC services. The shortage of professional health personnel is severe and chronic and it is found across the country, particularly in rural and remote areas. The shortage in the workforce is not only in terms of numbers, but also in personnel with the necessary knowledge and skills for PHC.

Disparity between authority and responsibility

This section explores the disparity between the authority and responsibility of the CHDs and their stakeholders who are engaged in the provision of PHC services at district and sub-district levels. The present organisational structure and the confusion of the Health Decentralisation policy play vital roles in making this mismatch more confused.

When asked about the different terminology regarding the CUP Board, DHCC, and DHAC, a senior male CHD answers:

They [CUP Board, DHCC, and DHAC] refer to the same organisation; the CUP Board is the English name. The DHCC is the old name, derived from the District Health Coordinating Committee. However, in Korat [Province], the PCMO has changed the DHCC to the DHAC. It is not called the Coordinating Committee but the Administrative Committee [instead]. The DHAC would be responsible for the public health services management. The Hospital Director and the CDHO are trying to work collaboratively as per the campaign “Two Becomes One” launched by the PCMO. (CHD 1)

A senior male CHD (3) adds: ‘... the committee of the CUP Board includes representatives from every HC, the CH management team and representatives from the DHO ... I would rotate the chairmanship with the CDHO annually’. However, in other provinces, the chairman of the CUP Board is a CHD. Only in Khorat province is the rotation of the chairmanship between the CHD and CDHO encouraged, according to the ‘Two Becomes One’ policy of the PCMO. Nevertheless, it is not a fixed rule; the rotation is the result of an agreement between CHDs and CDHOs.

The issue is that, only in Khorat province, do we have a contracting unit for the primary care board (CUP Board), whose committee is composed of representatives from the hospital, district health office and health centre coming to work together, at district level, in managing UHC and health care. (BO 3)

The CHDs perceive that that policy is aimed at encouraging CHs, DHOs and HCs to work in a united fashion. However, most CHDs feel the district health system still lacks integration, so the policy is not effective. A senior male CHD reports:

I accept that in fact the “Two Becomes One” policy could facilitate coordination between the health care service system at a low level of management. In reality, however, there is no integrated health care system. We are not working harmoniously, because we are not the same family. We are working independently instead ... We don’t look after our people’s health in a truly holistic way. (CHD 3)

A senior male CHD states his dissatisfaction at working together with the DHO and HCs under the CUP Board management structure:

I cannot confess that I would like to ban the CUP Board. It is very weird for people who have different backgrounds to work cooperatively in a multidisciplinary team or to work cooperatively with other professionals ... In reality, when the hospital staff and health centre staff, who are from different functional lines, have to work together, or when they have to attend a meeting together, they do not perform effectively. (CHD 4)

A senior male CHD (1) feels there are two leaders, the CHD and DHO, at the district health management level; even though they both work under the same CUP Board, and ‘it is difficult [for them] to develop truly collaborative teamwork’.

A young female CHD expresses her view:

I think that the organisation chart for the CUP Board is still complicated as it comprises two different organisations. This is a very sensitive issue. The organisational structure is still separate, but they [health workers in health centres and CDHO] are forced to work with us as one team under the CUP Board structure. (CHD 7)

A senior male CHD points out that it is ineffective working together under the CUP Board structure, because ‘working cultures and conceptual paradigms between the two organisations [CH and DHO] are different ... ’ (CHD 2). A young female CHD and a senior male CHD provide examples of different working styles between hospital and HC staff:

Instead of coming together helping each other to improve the overall performance, it turned out we worked alone [for the medical services]; they [the HC staff] just disappeared [left to do something else] and I don't know why? (CHD 7)

... hospital staff who work at the HC when assigned to do community services don't want to go into the community ... when the HC staff share the population in the catchment area with hospital staff, the hospital staff don't want to be involved in the community services, because they are trained to provide medical treatment in the centres, not out in the community. This is one more aspect of the difference between the two organisations. (CHD 5)

A senior provincial male bureaucrat offers his view:

I think that health officers in health centres are taught about and born with the holistic concept of health. This means they can work more closely with the community than doctors and officers in hospitals can. I think that doctors don't understand this feeling of working closely with the community. (BO 3)

However, a senior male CHD argues that there is conflict because of the overlap of responsibility between the DHO and CH. He gives as an example responsibility for health promotion; the CH is expected to look after the whole district, but lacks staff at the sub-district level and the DHO lacks staff at the district level where the CH is located.

Having two organisations working in the same district is quite awkward. For example, we should have encouraged health promotion and disease prevention for the whole district, but hospital staff are available only at the sub-district level in our catchment area. However, the DHO would say that the responsibility for health promotion and disease prevention should be given to the HC, so who is to take care of the population in the hospital area [where there is no HC]. (CHD 5)

Besides the difference in working culture, all CHDs feel that it is impossible to control health workers. A senior female CHD reveals that she cannot control health workers at the HCs:

As you know health workers rarely work. Some health centres work, but others don't; some are open, but others are closed. We can't control them anyway. (CHD 6)

A young female CHD admits that she had no authority over assigning tasks to health workers nor their assessment because of the separate organisations involved:

However, if the Health Centres [HC] during the implementation process either couldn't or didn't do good work, then it's quite difficult for me to intervene. It's not appropriate for the Director to question them. This is because their head is the CDHO ... This situation arises because of the separated organisational structures. (CHD 7)

A senior male CDHO points out that HC staff have many commitments, because they have to serve the Chief of District as well. He explains:

Regarding task assignment, sometimes we have to follow up on tasks not related to public health. Sometimes, the Chief of District asks health workers to assist with a district project. Sometimes, the health workers are not available because of other projects being run by local government and they can't join the district project. (CDHO 2)

A young female CHD agrees that this issue may increase conflict between the CH, DHO and HCs and the final result is a failure in health care provision:

The health centre is not only involved in public health affairs. I think it is a part of the district office. The staff [at health centres] have to participate in all other activities in the district, such as various campaigns and cultural activities ... They have to provide health care services and do administrative work at the office. They have to do things that interfere with their normal work. However, according to the Provincial Health Office's requirements they had to do a certain

job otherwise there were no outputs to report. Instead, they made up the report ... Perhaps, they had many other commitments so that they failed to do this job.

(CHD 7)

However, a young male CHD, who is the CEO of his CUP Board, has a different view of working under the CUP Board structure, which he regards as an advantage, because it reduces the gap between the two report lines. He says:

Previously, in many districts, the work between hospitals and the HCs or the DHOs had gaps. Sometimes, it was called the cultural wall, so that many of them could not be fine-tuned. We have found this to be diminishing as we introduced the CUP Board structure ... By working under the CUP Board structure, we are reducing the gap between the two agencies [the DHO and the CH] and also between the professions. (CHD 8)

A senior male CDHO has a similar view of the advantages of working under the CUP Board structure:

Actually, we have had a structure like the CUP Board, [which was called the "DHCC"] for years. However, initially it had no authority regarding district health resources administration. It was done only through collaboration. It was a matter of the DHCC or District Health Collaborating Committee, which comprised the Community Hospital and the District Health Office. We only coordinated when required, such as when we informed others about various matters through this committee. However, now the CUP Board is the DHAC or District Health Administration and Development Committee, which manages manpower, funding, supplies, and health services. (CDHO 3)

Taking a contrary view, a senior male CDHO describes the CEO management style that worked at his CUP Board; he feels the hospital staff gain greater benefit than the HC staff and the conflict still exists, because both organisational lines in the structure follow different paradigms.

Our CUP Board is different from the others. It is unique in that we apply "CEO" management to the CUP Board administration; it has been pilot project in this province for some years. I think that there are both positive and negative aspects. The CEO has much more power.

The organisational structure is divided down medical and public health lines. The CHD is the CEO. I look after the public health line. I have to look after all HCs and the Hospital PCU in terms of public health care [primary health care]. Regarding medical care, the head of the medical line [CHD] has to look after the HCs as well. However, I think that we still have conflict, because the contexts of working at the hospital and at HCs are different.

If you use the hospital paradigm, you may think that you can do everything if you have more resources. In reality, the financial incentives for hospital staff (including the HPCU) are higher than those for health workers at HCs or PCUs outside the hospital; health workers report directly to the CDHO. It is unfair ... I don't think we work as a united team as the hospital still works in a reactive

mode. The hospital staff don't know the difference between health promotion and fixing health problems. (CDHO 8)

A senior female HHPCU regards the decision-making at her CUP Board is not 'true participation', with the authority to make decisions resting with either the CHD or the CDHO:

However, only two of them — the CHD who is the chairman of the CUP Board and the CDHO are the real decision-makers regarding who will be assigned to work where. Their decision was absolutely different from [that of] the screening committee. It was as if you have to have your patron if you want to work near town. (HHPCU 5)

A senior provincial male bureaucrat asserts that the CUP Boards decisions are dominated by the CHDs. The conflict in working under the CUP Board arises, because the CHDs pay more attention to their hospitals, rather than to the overall health facilities in the district.

We sent the budget directly to the CUP Board, of which the Hospital Director is the most powerful [member] and they can influence the others. The Director wanted that budget to be extra [funding] for the hospital and not for the health centres. Consequently, health officers working in health centres did not receive their salaries and overtime payments. So, is it fair, do you think? When I asked them why they didn't pay those health officers, the Director said that they [the hospital] had run out of funds and had a negative account balance, and they had to pay for medicine and [pay] other debts as a priority. However, I found that some hospitals did the same thing even though they had still had a positive account balance ... Most of those Directors still think that the hospitals belong to them and those budgets have to be spent at their hospitals and that health centres are not part of their direct responsibilities. (BO 3)

A young female HHC (5) regards the agenda of a CUP Board meeting in her district as being solely concerned with sharing of finances – 'the issue is only a financial matter'. The CH, DHO, and HCs, even though they all have a similar CUP Board structure, have separate work structures. For example: 'the improvement in academic qualifications for health workers is only a matter for the DHO and it's not part of the CUP Board agenda ...' (HHC 5).

A senior male CHD feels that the CHD is the only one responsible for financial management:

The PCMO tells us [the CHD, CDHO and health centres] to help each other and become involved in tasks, right? However, in my opinion, it's only the Hospital Director who shoulders the burden. (CHD 4)

A senior male CHD argues that working under the CUP Board structure will only be effective if there is one single authority to control health centres:

It [the “Two Becomes One” policy] is not practical, because we [the hospital] need to have the administrative authority to supervise and monitor them [health workers]. (CHD 2)

All CHDs agree with his proposition. A young female CHD supports this view:

They [the MoPH] should clarify this issue; for example, they should let the [Community] Hospital take care of Health Centres, and let the District Health Office be the only [organisation] to set standards. We can't do very much unless we reorganise the district health services system. (CHD 7)

A senior male CHD agrees with CHD (7) that it is critical a new district health services management structure be put in place if the PHC services are to be sustained. He states:

In conclusion, I would like to propose changes for ... the structure of the district health care system. The MoPH should create a new organisational structure for me. (CHD 4)

A second level of disparity exists between the Community Hospital and the municipality and local governments at sub-district level regarding the authority and responsibility for the provision and administration of PHC services. A senior national bureaucrat (BO 1) points out that this disparity may be caused by a different interpretation of *the Decentralisation Act* by different governments — previous and current:

The past government [Chuan Government] proposed a Decentralisation Act, but the current government [Thaksin Government] has different directions and views on that. This government wants to have governors, who are bureaucrats, as CEOs of provinces, to integrate all work in the province. However, the former government emphasised decentralisation to the local government elected by local people. So, these are different directions for decentralisation. (BO 1)

A senior male HHPCU reports an overlap in responsibility for community health between the Hospital PCU and the municipality. This reflects a disparity between the responsibility and authority of the CH and the municipality, as well as a conflict between the two organisations in terms of the mismatch in their respective populations and funding, and the lack of integration.

Firstly, there is an overlap in responsibility regarding community health between the municipal authority and the Hospital PCU, because both cover the same area. According to the Municipal Act, the municipal authority is responsible for community health.

Secondly, although we are trying to divide the area of responsibility, there is an inequality in the distribution of workload. For example, there are thirteen villages in

NS [District]; the Hospital PCU is responsible for six villages and the municipal authority for seven villages.

However, practically, the municipality claims that since there are only seven villages under its responsibility it will provide most of the funding for community health to people in the villages that it is responsible for, and it argues that the CH should provide funding for community health for the remainder. Indeed, I want to tell them that the CH receives only a small amount of funding.

For example, regarding the milk budget, which is directly allocated to the municipality: the municipality authorities stated that they would spend that budget to purchase milk only for children in the seven villages. The six villages under the responsibility of the hospital would receive some small part of the funding for milk. That will lead to conflict between the organisations. (HHPCU 3)

Moreover, a senior female HVHV reports on the lack of understanding and integration between the CH and a representative of the MoHSSD which is responsible for social services. Her report shows that the CH and HCs are only responsible when people get sick:

When the [HIV-infected] patients are diagnosed...I sign the confirmation letter to the Ministry of Human Security and Social Development [MoHSSD] to assure them that they are really infected with HIV. It was very time consuming, because I need to ask for many documents, including medical certificates. The MoHSSD asks a lot of questions before they allocate the funding to us ... I have to sign a confidentiality agreement, that I will protect the confidential data of the patients and then they allocate the budget to us.

I have to submit the documents [for HIV-infected patients] in order to receive the financial support from the MoHSSD. Anyway, the [whole] procedure in the MoHSSD is very slow. I submitted the information of three or four cases a long time ago, and three of the patients have since passed away [they didn't received the help from the MoHSSD] ... The one survivor is now receiving treatment at [our] CH. A doctor is looking after him now. (HVHV 1)

A senior male community representative, who is a Vice-President of the local government at sub-district level, tells a story regarding funding of pensions for the elderly in his sub-district. Each year, not all needy elderly receive pensions and he believes that this is an example of an unequal funding distribution:

The elderly do not receive equal care; for example regarding the pension, not every [needy] elderly person is paid the pension ... the [central] government does not provide us [the DLA] with a sufficient budget; I wish we could have a larger budget, because four to five hundred people in this sub-district are elderly, more than sixty years old. Only five or six of the elderly receive financial support from the government ... At present some of them get paid, some do not. It is like a long queue, everybody waits for their turn. (HVHV 4)

Another concern is that there is no representative of the HCs or from local governments on the CUP Board. A senior male CHD reports: *'the municipal authority [and DLAs] has not been appointed to the committee of the DHCC [CUP Board] yet'* (CHD 1).

A senior male CHD regards communication between CHD and Mayor as ineffective. He says:

It needs to be noted that eighty percent of the communication between the Mayor and the Hospital Director is quite problematic, because the Mayor often changes in the four-year election cycle. As a result, health care services could not be successfully determined [the health care policy could not be successfully determined, because the Mayor has changed so often]. (CHD 1)

CHD (1) reports a lack of coordination in health planning at the district level between the CH and municipality:

Regarding the coordination of human resources, there is a marked separation between the municipal officers and others. Planning meetings are organised separately. The Mayor would be responsible for the [public health] plans in the municipal area and he asks for the manpower from the CH to assist in executing the plan. The [public health] plans for the area outside the municipality are conducted by other committees. There is no coordination at all. (CHD 1)

A young female CHD observes that local governments do not want her to get involved in district health and budget planning:

They [Local government authorities] sent the notice to me in the morning, and the meeting regarding planning and budgeting was set to begin at the same time. It's as if they block me out whenever there is a discussion regarding money ... They didn't want us to get involved ... it's not only the local government area in which the hospital is located, but all local governments in the District. (CHD 7)

A senior female CHD points out that it is likely that local governments spend the funding on infrastructure improvement, rather than on health of communities. She reports:

It should be beyond the DLA concerns for itself. If they were aware, they would broaden their vision. Those who never care about these issues, might do things differently and would possibly spend the budget to construct roads and dig ponds, which would be to their advantage with the community. When we contact them, they say that the money has been already spent, and despite the fact that they could [still] enjoy their annual bonus. What could we do about that? (CHD 6)

A senior male CHD argues that this confusion arises, because the roles and responsibilities of the CH and municipality are not clear. As a result, the health needs of the disadvantaged cannot be met.

If the role and responsibilities of the CH are specific and clear, the healthcare services system would be more integrated, regardless of whether the patients are the residents of the municipal area. I am especially concerned about the health of slum dwellers, because their health is worse than [that of] people outside the municipal centre. There are some problems regarding administrative management, so that the healthcare services delivery does not cover those slum dwellers. (CHD 1)

The PCMO has tried to solve the problem of the uncertainty about authority and responsibilities for the provision and administration of PHC services by encouraging all health officers, including CHDs and HHCs, to cooperate with local governments by acting as health consultants for them. However, a young female CHD regards this informal measure as ineffective because of a lack of communication between local governments at sub-district level and the CH. Local governments (DLAs) are likely to contact the HCs instead of the CH. She feels that a CHD, as a district health manager, should be informed by those local governments about any meetings. She says:

...when my boss [PCMO] told me that I had to be a Health Consultant for the local governments [there are five local governments in my area], I expected that the local governments needed to invite me in or at least let me know whenever there are local government Board meetings. Then, I could attend their meetings. I should have been informed every time. Only some local governments let me know when they have set up a meeting. They called the staff at Health Centres instead of me ... You know we have to look after the whole district ... (CHD 7)

A senior male CHD gives another example of the mismatch of authority and responsibility at district level. The municipality is responsible for VHV recruitment, while the CH is responsible for having these VHVs carry out community health activities. He wishes that the CH will be empowered to recruit and select VHVs in the municipality so he can integrate all health activities in his area. It is worth noting that VHVs in sub-district areas are recruited by the HCs and the DHO. He argues:

... the VHVs are the key people who manage the health care delivery to people at the grassroots level, especially the VHVs in the municipal area ... If the CHD was empowered to select the VHVs, the administrative management system would become more efficient and effective. (CHD 1)

A young female CHD states that there is a misunderstanding about roles and responsibilities between the CH and local governments. She understands that according to *the Decentralisation Act*, funding for some health promotion activities is devolved to local governments, but they do not provide that funding to the CH and HCs to carry out necessary activities.

So, I think it's quite weird that each local government doesn't understand the concept of decentralisation. For example, we told them that we had devolved health promotion work to them already but they didn't understand and then didn't set up the budget for that. So, even if we wanted to help and work with them, when we went to ask for funds, they didn't give any money to us. (CHD 7)

She also points out that the local governments recognise the CH as the provision of medical services to the community as the only role for the CH and not health promotion and disease prevention.

The member of our staff, who went to ask for budget support, came back to me and complained that the local governments didn't show her any respect; it's as if we begged them for money. They [Local government authority] didn't understand and were not concerned about the outcomes or impact of public health in their communities. They considered that the hospital was the place for medical treatment only. They didn't consider the hospital as a unit for health promotion or for disease prevention. (CHD 7)

However, a senior male CHD points out that all of health officers should realise that district health should include all stakeholders at the same level, but he is not sure about the relationship of these organisations and the CH at present. He says:

We [CH, DHO and HCs] do not work alone now; there is the trend towards achieving better integration of responsible key persons, including the District Chief, the local government's representatives and the municipal representatives. I don't know whether we are friends or enemies [laughing]. (CHD 4)

A young female CHD tells of her negative experience regarding cooperation with local governments; that they do not recognise her role as a part of their team.

When the PCMO asked me to join the local government's Board as an advisor, I complied. However, on a practical level, the local government did not provide me with office space. I felt that I'm not part of the same team as its permanent staff, who work in that office. They didn't pay much attention to me. (CHD 7)

A senior male CHD proposes that the MoPH should specify clearly the roles and responsibilities of stakeholders at district level. He states:

If this cannot be done, then the MoPH should clearly specify functions and responsibilities regarding who will do what. (CHD 4)

A senior male HHPCU proposes that there should be only one leader in the district:

In my opinion, I think whatever organisation it is; there should be only one leader. If there are two leaders, according to Thai culture, these will get into a dispute over their areas of responsibility. When they lack unity, the organisations do not function properly, and they will not work efficiently because of the conflict. (HHPCU 3)

All CHDs agree with this proposition and regard a single authority for district health as crucial. A CHD should control the CUP Board, and the authority of the CUP Board should cover all health tasks in the district, including those of the municipality and local governments at sub-district level in order to achieve the goal of the UHC policy. A senior male CHD says:

I understand that if there is only one authority, all problems could be solved successfully ... In other words, there would be only one boss to be responsible for all of the public health tasks, both inside and outside the municipal area, and nothing would be divided into two parts like [they are] at present ... Therefore, I think it would be terrific if the DHCC [CUP Board] could consolidate all health care activity and centralise all administrative power in order to manage the health care services alone. I think the UHC programme will become more successful than ever with a centralised decision-making process. (CHD 1)

In summary, there is a lack of integration of health policies and activities at the district level. Even though they perceive that their responsibility was expanded so that they act as if they are district health services managers, the CHDs' 'medical approach' limits them in exercising that role. Their perception of PHC is that it is Primary Medical Care (PMC), and the UHC policy-makers dominate PMC. The health needs of the rural poor are interpreted only as medical services to ensure the absence of disease. Their approach to PHC is a 'medical approach'. The major barriers in sustaining PHC are: i) increased demand for curative services; ii) a shortage of personnel at the primary care level; and, iii) a disparity between the responsibilities and authority of stakeholders. The last point leads to a lack of clarity for the roles and responsibilities and a lack of integration of stakeholders at both policy and operational levels.

4.4 Theme 3: The impact of structural interests

The third theme explores the politics of Thai health care and the impact of structural interests on the implementation of the UHC and PHC policies. The sub-themes that emerge from theme three are: the impact of political bureaucratic interests, the difference in professional organisational cultures, and the repressed community.

4.4.1 Sub-theme 3.1: The impact of political bureaucratic interests

The CHDs perceive that the difficulties in implementing and sustaining the UHC and PHC policies arise from a lack of long-term health planning by the MoPH. The cause of

such a lack of planning is considered to be the result of political instability. A senior male CHD (1) reports: '*...the Minister for Public Health has been replaced regularly; as well as that, the Central Government is not stable and, as a result, the long-term public health plan is not well organised*'. Another senior male CHD (4) adds: '*... the MoPH is strongly influenced by politicians*'.

A senior provincial bureaucrat reveals that the lack of strategic planning results from the health policy changing as often as there is a change of the Minister of Public Health. As a result, his unit can only operate day-to-day. He points out:

... there is uncertainty regarding governmental policies ... the administrative direction of the central ministries ... is not clear ... We change our national health policies and plans too often. This happens every year and makes us confused ... They depend on who the new Health Minister is, and on what and how he or she wants. Therefore, we have no strategic planning — just day-to-day operation. (BO 3)

This lack of a long-term health plan prevents the sustainability of PHC provision at the local level, because it leads to ineffective health workforce planning. As a result, there is a severe and chronic shortage of personnel at the primary health care level. The politicians are viewed as not taking any responsibility for such a critical problem seriously. Rather, they launch policies that generally favour their supporters. This frustrates the CHDs and other health staff. A senior national bureaucrat believes that the government does not really pay attention to the health sector:

I think that, even though this present government pays more attention to UHC policy as one of its major national policies, the government is not clear about the total structure of the health system. This may be because the government is too interested in economics ... In terms of politics, I think that this government only has the UHC policy in mind and no policy regarding the whole picture of the health system. (BO 1)

All CHDs perceive that the UHC policy arose from political decisions that advantage the politicians. There is no appropriate preparation for the implementation of this policy so that the health staff cannot work effectively. As a result, real health needs are not met effectively. A young male CHD argues that people were not given adequate time to prepare to contribute to the new system:

It was looked upon as a political policy, of which the politicians took advantage; wasn't it? So, the implementation was so rushed that there was no communication with those affected by this policy to help them understand how they should prepare for its implementation. The government didn't prepare for

the paradigm change with the health doctors [health workers], nurses, physicians, or for the people. It's crystal clear that the government did not prepare people to contribute to this new system. (CHD 8)

A senior provincial bureaucrat and a senior male CHD state that the politicians did not prepare structural support for implementing the UHC policy. It is obvious that the upgrading of HCs to PCUs was only a name change from HC to PCU, but the change did not create an increase in the quality of services.

These different terms [PHC, PC, PCU] confuse Thais, especially the single word for 'primary care unit' when it is translated into Thai. As the former Health Minister said, it is quite difficult for the ordinary lay person to recognise that name and understand the real meaning. Therefore, the Thai word for 'primary care unit' has been changed to the single Thai word meaning 'community health centre', although it refers to the primary care unit, or, as we call it, the PCU.

(BO 3)

However, even though we call them [HCs] PCUs, we do not feel that they [HCs] could really meet the required standard of a PCU. I feel that we will not achieve even the lowest standards of quality of PCUs; therefore I switch between the terms HC and the PCU. (CHD 3)

A young female CHD gives an example of 'manipulating language' when the politicians announced an increase of per capita funding in order to improve the quality of health services. However, she finds that the final funding for patient care to her Community Hospital has decreased:

The government told us that it would provide a greater budget for us of about 1650 baht per capita from the 30-baht UHC programme. However, it deducted our salary from this budget. Then, the government has raised staff salaries by about 6% each year. In fact, it's cheating. (CHD 7)

Another example of 'manipulating language' relates to increasing the number of rural doctors and nurses to improve the quality of health services for rural people. CHD (7) states:

It's just the old propaganda ... However, I think that they may only change the wording in order to make it look good, but practically there is no difference between past or present efforts ... there is only the change in the public relations approach and in the way of speaking to people using new terms. (CHD 7)

The conflict between two public agencies – the MoPH and NHSO – is seen as a barrier to the implementation of the UHC policy and the sustainability of PHC provision. This conflict prevents effective communication from the policy level to the operational level.

A senior male CHD reports:

The primary difficulty [in implementing the UHC policy] is the conflict between the MoPH and the NHSO. As a consequence, the policy regarding budget allocation is unclear; this includes the investment fund, the budget allocation and salaries paid to all health officers at the national level. (CHD 3)

A young male CHD cites the difficulty in dealing with the two national policy agencies, because both issue differing instructions to the front-line services about the same matter:

Now, it's like there is a difference between organisational structure and financial management structure. There is one structure for financial management, the NHSO, and another structure for human resources management, the MoPH. This makes it unclear for us as the operator. As a consequence, we can't do as much as we would like, because the organisation [MoPH] which looks after human resources management says one thing, the organisation [NHSO] which looks after financial management says another thing. (CHD 8)

CHD (3) confirms the views of CHD (8). He speaks of his own experience:

For example, with the system managing the health budget, the NHSO takes the major role and allocates the budget to [CUP] through the MoPH. The MoPH, in turn allocates the budget to [CUP] through the General Inspector at the regional level. Then, the General Inspector allocates the budget to [CUP] through the PCMO [the key man responsible at the provincial level]. However, when the budget arrives at the district level, I found that the information presented by the MoPH is different from that of the NHSO. (CHD 3)

A young male CDHO from a remote district reports problems where political bureaucratic interests reflect ineffective communication between the policy level and the operational level. As a result, PHC services provision at HCs is not effective.

The NHSO has launched the new regulation. Sometimes, it's too much; we don't have time to study it. For instance, we didn't know that there is money to assist the family of a patient who dies during the treatment. It's quite a new regulation. We and our staff didn't know that [about it]. This is our problem ... communication and coordination between the NHSO and us may be not well-developed. (CDHO 7)

A senior provincial bureaucrat points out that conflict between the MoPH and NHSO contradicts the aim of the UHC policy regarding equality in the distribution of resources. The NHSO provides funding under a per capita formula, but the MoPH adjusts this formula and centralises this funding. Before the MoPH provides this funding to hospitals or CUPs, it allocates salaries from this per capita funding to core staff at each hospital. As a result, the hospitals with more staff, but serving a smaller population, do not redistribute their health manpower to other hospitals serving a larger population. In addition, the manipulation of the funding for the UHC programme by the MoPH is seen as resistance to health care reform.

The budget in the UHC programme should be provided on a per capita basis, and enough [money] should be provided. Now, there are more health professionals in the Central Region. The Ministry has put more money into salaries for that region. I don't agree with that. The MoPH provides all areas with a similar per capita budget; that is 1659 baht per person. However, practically, it doesn't work like that, because the MoPH allocates salaries to all health professionals and others from that per capita amount. For this reason, it's not fair to areas with a larger population but fewer health workers. I think this is against the philosophy of equality, as stated in the new Constitution. What happens is that the Central Region has a higher budget, and this has been the case since the beginning ... We wanted to change that ... so that it provides more funding to the North-eastern and the Northern [Regions]... Then, we could improve or develop quality of care. (BO 3)

A young male CHD comments on the increasing conflict between the MoPH and NHSO; these two organisations have different paradigms regarding health care reform. He uses the metaphor of 'father and mother' to explain the conflict between the MoPH and NHSO:

Maybe, it's different ideologies ... I regard that the father [the MoPH] and the mother [the NHSO] have different concepts. The MoPH has a more conservative concept, but the NHSO has more innovative ideas – [they] think outside the square. The NHSO thinks that the health system should not be cumbersome and that all health services systems should not be consolidated under the MoPH. The health system should have a more self-managed system [more decentralised] to distribute resources to meet the problems we are now facing. Whereas the MoPH thinks that we have overcome many problems and have survived up to now because of such a strong [bureaucratic] structure. So, the main thing is that they hold different concepts [about health care reform]. (CHD 8)

A young male CDHO perceives that the NHSO introduces the UHC policy by means of a market-oriented approach to management and he feels frustrated by this, because there is an unequal distribution of resources. All staff are stressed since they cannot adjust to the change to a private sector style practice. His argument relates to Alford's (1975) definition of a 'market model' of health care reform. He states:

It is a services business. There is serious competition between different CUP Boards, different areas and between different hospitals ... I think that the present system is more complicated than the past system ... We have to be more concerned about business management, something we were never seriously concerned about in the past. Now, we work more like the private sector, like businessmen. We talk only about cost benefits. We have to work competitively with other CUPs. We have to do business under a public administrative structure. This makes us confused. (CDHO 7)

A senior national bureaucrat argues that 'the problem is that the MoPH has not ... reformed ... its role yet ... from that of sailing the ship to steering the ship; it's very

difficult to make other things happen ... ' (BO 1). He points out the MoPH does not devolve its role in health provision to other organisations and it does not effectively carry out its major responsibility as the health policy maker and monitor. He also asserts that the MoPH protects its own interests:

I think that this is a big problem ... there is no willingness from the ministry staff [of the MoPH] to make it happen. It is still too centralised to be able to solve the problems ... It is quite difficult to force people in the MoPH to want to change without them feeling that they are losing their power over others ... This is because ... the MoPH is still the major health provider in Thailand ... when you [the MoPH] act as the owner, you may be too concerned about your own survival and may be too self-oriented. This is not caring for people ... I think that MoPH should change its role. (BO 1)

Another senior national bureaucrat expresses an alternative view to that of BO (1). He points out the problem occurs, because the decentralisation policy has not been applied and described clearly and any change should fit within the organisational culture:

The big problem is the Decentralisation policy, which has had a serious impact on hospital management for the future. At the present time, we don't definitely know what that is going to be. This will impact on all health services that belong to the public sector and the MoPH, because we are the major health provider in the country. Eighty percent of health services belong to the MoPH ... This depends on how change will be relevant or appropriate to our culture. Sometimes, we want to follow the developed countries, but [sometimes] we follow what is not appropriate for us. (BO 2)

He argues that restructuring the MoPH and creating a new structure for public health services management may not be necessary. However, BO (2) believes that improvements in health are achieved because of the present bureaucratic structure. This demonstrates his approach to health care reform as a 'bureaucratic model' (Alford 1975). He states:

The MoPH has health facilities serving people at provincial, district and sub-district level and they are connected [by the MoPH's order]. This may be good for Thailand. However, management may be weak as the structure may be too big and there are too many regulations. These weaknesses may cause us problems and [we may] want to abandon the old structure. However, I think that is why we don't just change the regulations, but we want to create a new structure ... It is as if we have a thing which has too many components. There may be a defective part and we can actually fix it, but this may be difficult. Then, we give up and we don't want it. We want to change to something new that we think is better. However, in the reality, the new thing, the new system is not necessarily any better. (BO 2)

Finally, he points out that the real problem is the lack of coordination between the MoPH and NHSO:

Regarding the UHC policy, the concept is good, but the management right now isn't good yet. The best aspect of this policy is financial management; it is the cornerstone. We don't use [any] more funding than previously [we can control the budget] ... but the negative aspect is that there is a lack of effective coordination [between the MoPH and NHSO]. The NHSO acts as if it were the MoPH, because they provide orders and set their own policies, and these cause confusion. (BO 2)

However, the CHDs find the implementation of the policy difficult because of the conflict between the MoPH and the NHSO. They cannot develop a long-term plan for the development of their services. A young male CHD states that this uncertainty makes it difficult to mentor new CHDs:

So, it is really difficult for me to give advice to any new CHDs, because we never know what the MoPH and the NHSO think, or what the future direction is likely to be. Frankly, it's like parents [the MoPH and the NHSO] fighting; the children [hospitals] have to struggle to survive. If the parents can find a consensus and be committed, then the children know how to live without having to solve problems day-by-day ... I, as a CHD, cannot make any long-term plans for 5 or 10 years, because we do not know [what] the future [direction will be]. (CHD 8)

A senior male CHD points out that communication between the MoPH and hospitals is another important issue. In addition, he proposes that the MoPH should empower the CHDs to implement the policy:

Firstly, I would like the MoPH to be clear with its policy ... Also, the MoPH should clearly communicate with [us] ... However, the Hospital Directors should be empowered to initiate their own plans ... let us do things our own way so long as we meet their criteria and goals. (CHD 4)

A young female CHD (7) argues that if the MoPH and the NHSO do not change their approach to the CHDs it is likely that CHDs may implement policy 'just for the sake of getting it done', but not to really address the real health needs of the rural poor.

Finally, a senior male CHD proposes: 'the MoPH should create a new organisational [reporting] structure for my CH [that is, between the HCs and the CH]. If this cannot be done, then the MoPH should clearly specify functions and responsibilities regarding who will do what' (CHD 4).

A senior male CHD perceives that the PCMO and the CDHO are another group of interests that prevent the restructuring of the health system, because they want to protect their own status. He says:

In fact there are two positions that would be in deep trouble if the new health services system structure is to be adopted. Those two figures would not have any place in the new health services system. One of them is working at provincial level, and another works at district level. They are the PCMO and the CDHO ... They might not have any jobs ... Yes, I think the PCMO and the CDHO are afraid that there would be no one to supervise the HCs, in case the HCs have to report to the CHs. They might be afraid that the CHs would criticise the HCs' previous performance. (CHD 4)

CHD (4) points out that there are many interest groups that may prevent the restructuring of the health system to be more integrated, so the sustainability of PHC service provision may be problematic. He believes that all of these interest groups will protect themselves against the restructuring. To support his views, he remarks:

It depends on us to determine what the hidden agenda is. It could be many things, for example, someone might worry about quality of health care services, while another may worry about his position. Some might be concerned that they might lose the chance to show off their ability, their competency, and they might lose the chance to initiate their own projects. They would become insignificant, and might lose their supporting benefits. These people may include the CDHO, the Hospital Director, the PCMO, Permanent Secretary of the MoPH, the Minister, as well as the Chief of District [CD]. However, only the HCs can follow up the CD's assignments effectively. The CD considers the HCs as useful tools to further his own interests. That is what I think ... (CHD 4)

A young female CHD has a similar view to CHD (4). She believes that the CDs use health workers, VHVs and the CDHO for their own interests, rather than to promote the community's health. She comments:

However, if we consider the issue from the point of view of the Chief of District [CD], he might say it's impossible to let this happen. This is because he needs the CDHO and health workers to help him to carry out some activities that are extra and not related to health services. The CDHO and his team [health workers in health centres] are the key people for the CD; they are often asked to help the CD with the District's activities for the Ministry of Interior. In addition, they have a lot of work involving health volunteers. (CHD 7)

A senior male CHD states that another person with special interests is the Provincial Hospital Director. They can prevent the provision of PHC services by influencing the allocation of doctors within the province. He points out that:

The interest groups try to influence the decisions about the manpower issue ... They maintain control of the allocation of doctors. A small number of doctors is allocated to us ... if I were the Director of the City Hospital, [and] I was assigned by the Permanent Secretary of the MoPH to run a project training rural doctors, and I have to organise more seminars for interns ... I would ask for more tutors. Who are those tutors In fact, those tutors are the doctors who are supposed to work at the Community Hospitals ... In fact, the City Hospital could ask those

interns to stay at the City Hospital, instead of placing them in the District Hospitals [Community Hospitals]. (CHD 5)

A senior male CHD observes that the medical school is another interest group that prevents the successful implementation of the UHC policy and PHC in rural areas. He argues that the medical school fails to support the UHC policy when it does not include the UHC and PHC policies in medical courses:

However, the new medical graduates might not realise the importance of the PHC policy, because the medical schools do not educate them about PHC issues. (CHD 1)

Another senior male CHD (5) agrees with CHD (1) and adds that the Medical Council of Thailand (MCoT) is another interest group which hinders the UHC policy and PHC. He points out:

The first point of contact is the Medical Council of Thailand [MCoT]. They should reform all of the medical school programmes. Nowadays, the MCoT has set a massive quota of medical graduates to study specialised medical courses. Each year, all medical institutes can provide 1200 internships, and there would be about 1000 doctors from the Community Hospitals ready to fill the vacant positions provided by those medical institutes.

If all of the doctors [medical graduates working at the Community Hospitals] are eager to continue studying, there would be no doctors in the rural areas ... It is very difficult for the Community Hospitals to develop without doctors. We are so preoccupied [with many assignments] that we can't think about the reform. This is our weak point which prevents our progress and development. (CHD 5)

Another senior male CHD adds that another interest group are the local governments. They protect their interests, but not necessarily the health of people. He states that the local governments are more concerned about votes:

... [possible] problems, e.g. an epidemic [are not planned for] or a policy such as "Healthy Thailand" which has only one indicator – cleanliness of the Fresh Food Market – have been simply abandoned by the local municipality, because they [politicians] don't want to lose votes among market women and fresh market merchants on account of this policy. (CHD 4)

A young male CDHO believes that the local governments are not ready for the responsibility of community health, because they are only interested in building infrastructure. These projects are of more interest to them than health. He argues:

I think that local government is for politicians. It is unstable. There is often a change of administrators. This makes it difficult for us to work ... In my experience, even though I encouraged community participation ... I found that many local governments are not ready for that ... Second, I think that budget

support is another problem. They provide less of the supporting budget for health. They emphasise more the budget spent on basic infrastructure such as roads, water, as in the old days ... They don't have a concept of health [provision]. (CDHO 7)

A senior male CHD points out that the CHDs are another interest group that protect their own interests in the sharing of funding between the CH and HCs:

The UHC budget is allocated to both of them [CH and HC], but through the hospital. The hospital would like to reserve an amount of money for improving medical services at the hospital, for building maintenance and for bonus payments for its staff. (CHD 5)

He adds:

They [CH and HCs] seemed to be a cooperative team but, in fact, there is a lot of conflict from the overlapping duties. Each of them would like to protect their interests, which means that they focus solely on their own duties and their organisations ... Mostly, we share the budget, but our health services are not integrated. We might not share the same administrative vision and we lack unity because of the different organisational cultures. (CHD 5)

Furthermore, he points out that no one is responsible for change. In another words, there is no one to take rural health care reform and the health needs of the rural poor seriously.

He says:

It is true that we can't force anyone to follow our style. You don't want to change yourself for anyone else. This is the culture of Thai organisations. (CHD 5)

Finally, a young male CHD proposes that participation by more stakeholders might be a solution:

So, regarding the barriers, which will be present where any policy is to be implemented, I'd like the government to include more participation from practitioners and from people in general. (CHD 8)

4.4.2 Sub-theme 3.2: The difference in professional sub-cultures

A senior male CHD perceives that CH staff and HC staff do not accept each other and working as a team is seen as problematic, because 'they have a different work...[and] organisational culture' (CHD 5). He points out:

In fact, both of them [CH staff and HC staff] have different organisational cultures. The hospital staff don't perceive those in the health centres as co-workers, and the health centres don't perceive the hospital as their superior. (CHD 5)

CHD (5) uses the conformity and punctuality of hospital staff as examples of the difference between hospital staff and health worker culture. He argues that '*people at the hospital play by the rules and are punctual for their appointments. Unlike them, the HC staff culture is different*' (CHD 5). He adds:

I think the differences [between hospital staff and health worker staff culture] might be formed by their work experiences, and their educational background. Health workers receive only a 2-year certificate, and they are trained by the senior local health workers. The hospital staff have graduated from university in the big city at a high standard, especially regarding hospital management ... Their organisation [hospital staff] is influenced by modern city culture and the hospital has developed in a different way which is influenced by the new generation. (CHD 5)

A young female CHD points out that, particularly in remote areas, hospital staff are of a younger generation of new graduates, while HC staff are those who are more experienced, but not necessarily good staff:

You have to understand that this district is a remote area. The issue is that doctors expect the health centre and the hospital situations to be different. The hospital will get only the young graduates from nursing colleges, but the health centres and the DHO [District Health Office] will get those who are being punished or on probation from other places to fill the posts. It is rare for health centres to get good staff. (CHD 7)

Another senior male CHD points to the difference between hospital staff and health worker culture in terms of different forms of autonomy. Hospital staff have more independence than the HC staff. He argues:

My subordinates [hospital staff] are ready [for any changes], but we can't expect the same readiness from the health workers. We [at the hospital] possess a strong sense of self-confidence [we are quite independent]; we will comply with the policy which we consider significant, but we won't engage with every given project. Unlike us, the health centres have to follow all of them. (CHD 2)

A senior female Head of HC states:

The higher authority [PCMO] does not have a real insight into our situation. We have to follow up both new and old policies assigned to us by the higher authorities. We need to complete all of the assignments ... We cannot avoid the assigned policy [even if it is not related to public health]. You might be able to say no, but you should still follow the given policy. The operations people fully realise that. (HHC 2)

A senior male CHD comments on the difference in working style between hospital staff and health workers. Health workers are seen to be more able in community engagement than are hospital staff.

... the health workers could get along better with the villagers than the hospital staff, because they might have a good time with the villagers at a drinks party after their office hours, but they can count that as their work time. Unlike the health workers, the hospital staff tend to do home visits during working hours. We would not visit people after working hours, except in an emergency. This is [the] difference [between the two]. (CHD 5)

CHD (5) notes one more example of the difference in the working nature of the hospital staff and of the health workers:

They [HC staff] are not likely to be on duty for exactly the time that they have been rostered; for example, the hospital staff would stay on duty for their full shift [or two concurrent shifts if needed], while the health workers may be on duty in the HC, but sometimes they use the allocated duty time at the HC to instead carry out community services. (CHD 5)

This shows the CHD's medical mindset where he regards that rostered time for the HC staff entails a presence at the HC, even though he is aware they have other duties outside the HC. Admittedly, some HC staff do use the excuse for community duties to leave their rostered shift early and not actually carry out any community work.

A senior male CHD compares the effectiveness of the hospital staff and HC staff when they have to work together. He asserts: '*our health personnel are more effective than the general health workers, who are the subordinates of the CDHO*' (CHD 1). He compares the qualifications and medical skill of hospital staff and health workers and points out that the health workers are less skilled:

The [hospital] health team provides the health care to the poor patients who have no money to travel to the Community Hospital, and the elderly are looked after by our physicians, instead of the health workers who might not be as skilled.
(CHD 1)

A senior male CDHO (6) agrees that the health workers lack the medical knowledge of hospital staff. However, he points out that health workers have to provide comprehensive services and that there is only a small number of them working at each HC. He says that HCs are considered '*second rate compared to hospitals*'.

A senior male CHD argues: '*...we [the hospital staff] do not have as much experience as health workers at health centres, in the provision of primary health care services*' (CHD 2). A senior female Head of HC adds that there is a difference between the Hospital PCU and HC in the focus of their work:

I would like to explain that the HC would focus on health promotion ... while the Hospital PCU would focus only on ... curative care. (HHC 6)

However, hospital culture is seen to be superior to HC culture. A senior male CHD recounts that, when he sends his nursing staff to the HCs, the nurses have to work under the supervision of the Head of the HC; they are uncomfortable with that.

It is unacceptable for them [nurses] to have a boss with a lower qualification, since they [the nurses] graduated from a four-year nursing course. They are not sure about this issue. (CHD 1)

Moreover, a senior male CDHO points out that new nursing graduates place a greater value on working in hospitals, rather than working in HCs. At HCs there is a lack of support and a lack of medical supervision.

New nursing graduates are not good at engaging with communities. They may be good for medical services ... When they have to work alone at HCs, there is nobody to supervise them, so that they may feel insecure. Then, when they compare their situation with their colleagues who work at hospitals where there are many supervisors and it is more civilised, they usually leave the HCs.

(CDHO 1)

A senior male CHD argues that health workers have a subordinate status: *'I still insist that we cannot change the differences in working culture between the hospital and the health centres. As long as they [health workers] follow the assigned framework, I think it will be OK'* (CHD 2). Another senior male CHD agrees with CHD (2) and believes that the integration of care between hospital and HC will not be easy:

In my opinion, however, the Community Hospital and the Health Centres would be hard to integrate, because their organisational cultures are dramatically different. (CHD 5)

A young male CHD perceives that health workers at the HCs feel inferior:

Actually, the PHC is a tough job. It's quite difficult to convince them [health workers] that if they do their job in primary care well, it will help the hospital focus on secondary care; instead, they all think that their job is inferior.

(CHD 8)

A senior male CHD insists health workers have to adjust their work culture in PHC services provision to comply with hospital rules under the UHC policy:

...[H]owever, the nature of the work at the PCU [means] health officers [health workers] are expected to provide services at the PCU in the morning, and they might be scheduled to conduct home visits in the afternoon. If health officers do not adjust their work culture to comply with this rule, they will have problems.

(CHD 5)

However, CHD (8) points out that the health workers have better public speaking and community engagement skills than the hospital staff and these skills are their cornerstone.

He states:

I used to attend when the health doctor [health worker] spoke with villagers and I felt as encouraged as the villagers, to work for the country ... However, this skill hasn't been employed by every health doctor [health worker], because there's not enough motivation for them to use this skill. (CHD 8)

A young male CDHO argues that some CHDs do not pay attention to health promotion and do not support health workers in such activities:

Some CHDs who are medical graduates are only concerned with what happens in their hospitals or are self-oriented. Some CHDs are not interested in proactive health care. They don't come to see how we work at health centres. As a result, they put more emphasis on the budget for medicine at the hospital, and for laboratory development. Some of them laugh at us when we ask for funds for physical exercise activities. (CDHO 7)

Nevertheless, health workers have to improve their medical knowledge so they can provide medical services and prevent patients from going directly to the hospital when it is not necessary. The shortage of doctors and nurses to provide medical services makes this even more important. Even though a senior male CHD (1) regards health workers as secondary to hospital staff, he points out: '*[t]he health workers do not lack the necessary competences at all, since most of them hold a bachelor's or master's degree. It is not difficult to educate those who have the basic knowledge*' (CHD 1). He asserts that health workers are important to PHC services provision in terms of curative care:

Do not worry about the shortage of doctors; we should utilise the available health workers more effectively. If we provide the opportunity for the local health workers to develop their knowledge, they are likely to stay and not resign to work anywhere else. When the local health workers are educated, the community can develop progressively. (CHD 1)

A senior female CHD agrees with CHD (1). She believes that health workers are able to look after patients with uncomplicated conditions:

For [medical] treatment, I think the health centre staff are able to take responsibility for uncomplicated illnesses without transferring patients to hospital, so that the hospital has enough time for the treatment of more serious illnesses. (CHD 6)

She recalls the training programme to improve the medical knowledge of health workers at her hospital:

After the evaluation, the health workers at health centres said they lacked confidence and [medical] knowledge, and that the people didn't trust them much, so we set up a new training programme for them to refresh their [medical] knowledge ... Now we have new health workers trained at the hospital. We will rotate them to every department ... (CHD 6)

Despite the fact that CHD (5) feels it is impossible for hospital and HC staff to work in an integrated manner, he says that health workers are important for PHC services provision and that the hospital staff need health workers to help them.

The HCs network should be involved in these roles [medical services, health promotion and disease prevention], because the GPs or Family Practitioners alone are not enough to implement health promotion. We need the HCs to help us. (CHD 5)

However, a senior female Head of Hospital PCU points out that improving only the medical knowledge of the health workers is not enough, because they are not accepted as health professionals. As a result, they do not receive the financial incentives that health professionals do, even though their work is similar. This is because they do not have their own professional body to certify them.

However, those who graduate from Public Health School, such as Health Academics, or Public Health Officers [health workers], or Heads of HC have no status as health professionals as there is no professional body to certify them. As a result, they cannot be paid [as health professionals]. Now, only doctors, dentists, pharmacists, and nurses are [that is, receive special payments as health professionals]. (HHPCU 5)

A young male CDHO asserts the dominant professional organisations, such as the Medical Council of Thailand (MCoT) and the Thai Nursing Council (TNC) obstruct the certification of health workers. The MCoT does not support health workers being certified as health professionals, because 'health officers don't need to do skilled work since they only do menial work' (CDHO 7). He expresses disappointment with the response of the professional organisations:

In our PCU, there's not even a nurse practitioner. We have only health officers who have no professional license. When we try to obtain a professional licence for these staff, the Medical Council of Thailand and the Thai Nurse Council disagreed and objected to this move ... The health staff face double pressures, with financial problems [poor pay] and being undervalued as professionals. They want to have their own professional body; however, the Secretary General of the Medical Council of Thailand said that it is not appropriate for them to have a licence, because health workers don't need to do skilled work since they do only menial work. We interpret that as if he said that we don't need to use our brain in doing the job. I think that this is bad for us. (CDHO 7)

A senior male Head of HC adds:

The Medical Council of Thailand works in Bangkok only. They [the members of the Medical Council] have never worked or lived in rural and remote areas. They have never known how we work and live. I think that they don't know anything and their objections are biased. (HHC 7)

A young male CDHO reports on the situation: 'As a result, it demands more of the health officers who want to work under the management of the local government. This is political' (CDHO 7). However, he notes that health workers are more frustrated because of a lack of clear direction with the decentralisation of health:

Having been pressured, most health staff want to work with local government ... They don't feel happy working under the CUP Board. Some Directors of Community Hospitals who dominate the CUP Board don't provide the necessary support to the health centres as they should ... [and] some Directors don't trust health officers. (CDHO 7)

A senior female Head of HC adds:

I am the Head of the HC and the public health administration officer. There is only one nurse. According to the MoPH's health personnel framework, there should have been eight health personnel ... Instead, there are only three of us. My workload is the same as the Hospital Director who has a lot more subordinates. Despite the fact that I have only 2 subordinates I work as hard as him ... We are already overloaded with tonnes of work: the administration job, management, academic work, coordination within the organisation, as well as health promotion projects and everything regarding community services ... Sometimes, we do not have enough time to conduct a survey so that we need to fabricate the data. (HHC 2)

She tearfully expresses her feelings of being ignored and kept in a subordinate position:

Health workers at the HC devote themselves to work. Sometimes, working here is dangerous; we need to protect ourselves. We manage ourselves and make decisions about everything. The PCU in the hospital is supervised by the Hospital Director, [but] we have to take care of everything ourselves. They [health workers] do everything, but they receive neither promotion nor rewards. For example, a Head of HC has been working for 10, 10 to 20 years, she is a C6 [level 6] officer, and it would be very hard for her to be promoted to a higher level, even if she gained a university degree. (HHC2)

A senior female Head of Hospital PCU reports that the inequality is not only at the HC level, but there is also inequality in terms of financial incentives among hospital staff – Hospital PCU and other staff. The PCU staff are seen to be more disadvantaged.

The incentive for nurses who work at the Hospital PCU is also different from those who work in patient wards and ICU. Nurses who are classified as belonging to the Nursing department will have overtime payments for afternoon and night shifts. It's 200 baht for each shift. Nurses who work at the Hospital

PCU will not obtain this overtime, because we are classified as working for morning shifts only. (HHPCU 5)

Finally, she points out that the work at the PCU is different from what other hospital staff do for secondary care and very few will want to do this work if there is no change to the system:

Most of the hospital staff do not want to work at the Hospital PCU, because there are many problems, such as low wages, and that they may have to go out into the community. Travelling to the villages may be difficult, because you may have to ride a motorbike by yourself. Another thing is that we have to contact the municipality and office of Chief of District and any other public agencies. Some CDs are easy going, but some are tough. This may cause some difficulties for those working at the Hospital PCU. (HHPCU 5)

4.4.3 Sub-theme 3.3: The repressed community

A senior male CHD reports:

People have not been made aware of the need for self-care, and they don't know how to choose the correct quality products, because they're not clever consumers. (CHD 5)

When a young female CHD is asked about the problems regarding sustaining PHC services in the Thai rural context, she answers:

The weak point is that patients do not take enough responsibility for their self-care. That is why, when they have any simple illness, even a cold or fever, they come straight to the hospital. (CHD 6)

A senior male CHD argues that the root cause for the lack of responsibility in self-care of the villagers is poverty:

In addition, people here have low-incomes. I think a vital part of problem comes from their poverty. They do not think systematically by making connections between the various factors. They focus on concrete issues. (CHD 5)

A young male assistant to the CDHO states that there has been no gatekeeper system in Thailand before and people still believe that when they are sick they go directly to hospital. The new policy expects the upgraded HCs [PCUs] to act as gatekeepers.

Theoretically, I would like them [patients] to access health care at the HC as their first contact before they go to hospital. However, it is impossible to do that as we haven't had such a system [of having a gatekeeper] before. As a result, we cannot change people's belief that when they feel sick they have to see only a medical doctor and we cannot prevent them from going to hospital directly. Even though we advise them about conditions that can be treated at HCs, they don't

believe us. They believe that care at the hospital is better, because there are doctors, and sophisticated medical equipments there. That's why the hospital has to provide primary care services. (CDHO 5)

A young female CHD points out that the real health needs of needy patients are not met, because the community tends to bypass the HCs/PCUs and this makes health care ineffective and inefficient. She also shows that health services provision is at the expense of patients:

At one time, I saw a patient using a gold card [for the UHC] who had ten diseases [complaints]; I prescribed medicines only to ease the symptoms. I didn't do any tests [includes symptomatology and blood tests etc.]. However, I will only do tests for patients who have one disease [complaint] and who come to see me regularly. (CHD 7)

However, a young male CDHO argues that the perceived lack of concern about self-care is really due to the villagers' poor food hygiene and poor education about health matters:

I think that my greatest concern is the health behaviour of people in the community. They usually have poor food and poor hygiene practices when eating, such as the way food is eaten. There was severe diarrhoea last year. People like to have raw food. They don't use spoons for common dishes. (CDHO 7)

A senior male CHD agrees that health education is important for the community; he notes: '*...we need to educate people to protect themselves from diseases, and that is the most serious problem for us now ... [as] we are not sure how to do it [educate people]*' (CHD 4).

Nevertheless, a young male CHD argues that villagers can change their behaviour if they are provided with the right information. He tells of his experience:

However, their perception is now changing after we showed them their health status data ... They have been encouraged and have started to see that they can gain from health promotion and disease prevention, and that they need to be more involved in self-care. (CHD 8)

CHDs require skills in community engagement so they may improve health services provision to meet the needs of the community and provide a balance between available resources and people's expectations.

Under our [hospital management] reform plan, there was the hospital restructuring plan that involved the improvement of services. We went to the people and consulted the villagers in a general meeting. We gave them information about our hospital's crisis and asked them what were their expectations of the hospital, so that we could improve our services accordingly. (CHD 8)

A senior male CHD agrees with CHD (8) and says: '*...the VHVs are the key people to manage health care delivery to people at the grassroots level, especially the VHVs in the municipal area*' (CHD 1). Moreover, a senior female Head of HC tells of the importance of VHVs in helping health workers conduct a health survey:

We ask our support team of VHVs to conduct the survey for us, especially the survey of population. We designed a survey form based on the data we would like to know, and asked the VHVs to conduct the survey for us. (HHC 2)

A senior female HVHV perceives that her work, as a part of disease control, is in carrying out health data collection. Also, she regards that a part of her role is to give her villagers advice to solve health problems:

Regarding disease control, the VHVs are dispatched to collect health data; for example, [how many people suffer from] Diabetes Mellitus [DM] or Hypertension... We [the VHVs] keep the records of this [health] data ...
(HVHV 1)

However, the social determinants of health needs for the community are not met by the health workers. HVHV (1) reports:

The health workers try to alert them to the danger of HIV spreading; however, the HIV-infected women do not know what to do for a living ... As a result, they are likely to work as prostitutes. (HVHV 1)

She points out that the root cause of many health problems is the poor education level of the villagers and the MoPH should be more concerned about this:

The MoPH announced that the role of the health centres is to control the outbreak of epidemics, and to take care of people's health. However, how do we try to solve the root of the problems by providing [health] education to people so that they'll know how to take care of themselves? The villagers are not very well educated and some are illiterate. (HVHV 1)

However, a senior male Head of HC argues that communicable diseases are the major rural health challenge:

I think that communicable diseases are the main challenge. We had more epidemics before I came to work here. This occurred in the past because of ineffective coordination. Since I have been in this position, I have encouraged health volunteers to help me in working with the community. I have a meeting with health volunteer leaders every month to explain to them what to do. We go to the villages together. (HHC 7)

However, a female VHV who is an assistant to an HVHV argues:

Every time we have a meeting with health workers, they stress communicable diseases, such as Dengue Hemorrhagic Fever, Diarrhoea, and Scrub Typhus ...

However, we have a lot of elderly with Diabetes Mellitus [DM], but I don't know how to help patients prevent complications from DM ... Then, when they have blood sugar [levels] that are too high they need to be admitted to hospital.

(HVHV 7)

A senior female HVHV describes the difficulty of villagers in her community accessing health care, even though they had access to free care:

In this sub-district, there are many elderly who live alone. They have their health problems, such as Diabetes Mellitus and Hypertension. Even though they have a special card for free health care, they have no money for transportation, so that they can't access health care. (HVHV 8)

A young male Head of HC states that his approach to health education in the community is medical; he focuses mainly on 'disease control':

After the Head of Villages and local government authority finish their agenda, it's our turn. We provide health education and this depends on the seasons. For instance, Bird Flu, Dengue Hemorrhagic Fever, there are nine important diseases for disease control in our province, such as Scrub Typhus, Polio, Rabies, and Tetanus. We usually teach the community ourselves. (HHC 1)

A senior female VHV argues that health activities in her community depend on the initiative of the health workers:

Health workers tell us what to do. For instance, this year there is a health campaign screening for cervical cancer and breast cancer; health workers inform us and ask us to encourage villagers to come to the HC. We make appointments for them and tell them that there is a doctor coming to carry out health checks for them. Most of the health activities in the community are initiated by the health workers. For instance, they tell us when to spray mosquito larvae. (HVHV 5)

However, a young male CHD argues that the VHVs should have more of a role in encouraging villagers to be responsible for self-care. Their role should not be limited to carrying out health activities as ordered by bureaucrats, such as data gathering.

... I have told them [VHVs] so many times that I have asked them [VHVs] to consider seriously that everything to do with health care is also a responsibility of the people ... For instance, VHVs should not just follow the central policy as ordered, and do half a job ... [nor should they only] collect data for us. (CHD 8)

He proposes, VHVs should be provided with more knowledge and their role should be expanded to sustain PHC services provision to meet the health needs of community. The community should be responsible for their self-care.

So, what I want to do is to change their [people's] attitude to regard their health as their own business and [consider] what degree of self-care that they should

have, and what should be the role of their community, regarding participation and activities ... The VHVs should be the driving force for people's self-care and they can provide more assistance to the doctor than just by spreading the news ... They [VHVs] should have a greater knowledge of self-care issues and more developed concepts [about self-care], and become more modern [in their approach]. (CHD 8)

A senior male HVHV considers that the Family Health Leader (FHL) is an assistant to the VHV. He regards the approach to provide health education to the FHL is a 'medical approach' and that the FHL is also told what to do by 'bureaucrats'.

We recruit a member of a family to be a FHL. There is a FHL for each family. They are told to share the responsibility for [family] health with the VHV, because we [VHVs] can't look after everyone. They [FHL] only learn about eight important diseases [as assigned by the PHO], so they can look after themselves and their family members. For instance, how they can prevent the family from [getting] Diarrhoea, and being infected by TB [Tuberculosis], Dengue Hemorrhagic Fever, Polio, Scrub Typhus, and Rabies. (HVHV 3)

A senior male CHD states that his concern for health promotion is about protecting people from infectious diseases:

If we could educate people in the community about the diseases, for example, the knowledge about DHF or diarrhoea, we could protect them from those at some levels. (CHD 1)

However, a senior female Head of HC points out that the community should understand that self-care is about keeping healthy, not just treating illness:

I think that it's necessary that the community has to look after their own health not only in terms of sickness. Rather, they should include the way they live what they eat and everything ... However, villagers do not think in this way. They [only] think about their health needs when they are sick and that they need doctors whenever they get sick. (HHC 3)

A senior male Head of HC argues that nowadays people have more rights and health staff must work more carefully and respect patients' rights. He recounts his experience:

There was a case of an infected wound from an injection. We only apologised to the patient and explained to him what happened. After we treated him, he accepted our apology and it was finished. However, we are now in the Information and Technology age, media are everywhere, and communication is very fast. Patients can ask for their rights and may complain about us through the mass media. As a result, we have to work more carefully. (HHC 7)

Finally, a young male assistant to the CDHO states that the community should participate in making decisions about health care at the district level. He points out that there is no community representative on the CUP Boards:

I agree that all stakeholders in the district besides the health professionals should be involved in the CUP Board. There are only health professionals and we may consider only our side [of issues]. If we include more stakeholders, we may see many [different] views from them and this will benefit all groups. If we don't listen to people's opinions, which we don't now, we may not meet their real health needs. (CDHO 5)

In summary, the structural interests are seen to be using the patients to serve their own interests, rather than the health interests of the rural poor. These influences contribute to preventing the integration of the health services system. This theme also presents how the differences in the cultures of professional organisations have a similar impact to each other for the implementation of the UHC policy and PHC. It explores the difference of working culture, working style, and the disparity in the educational background of the health workers at HCs and the hospital staff, which prevents teamwork between the hospital staff and the HC staff.

Finally, CHDs perceive patients and the community as unintelligent consumers, because they do not take responsibility for their own health. The CHDs interpret community participation as medical activities to cure diseases. As a result, the real health needs of the community and the sustainability of PHC may not be achieved.

4.5 Theme 4: Possible strategies

This section presents the theme of possible strategies proposed by the CHDs to facilitate sustainable PHC administered by Community Hospitals.

4.5.1 Sub-theme 4.1: Single authority for district health services management

When asked how CHDs can sustain PHC services within the context of the UHC policy in order to meet the health needs of the rural poor, a senior male CHD answers:

... primary care is considered to be the most important, as it can prevent people from having health problems. At least, it [primary health care] can relieve the health problems quite efficiently. Actually, primary care costs less than secondary and tertiary care. (CHD 3)

Another senior male CHD points out that integrated district health care is the answer:

I am concerned with the district health services system. I think Thai Public Health would be successful if we have a strong district health system. I think that it's the most valuable and most appropriate approach to developing integrated care at the district level. (CHD 2)

He believes that the Community Hospital is the most appropriate organisation in the district to be responsible for PHC management.

I think the Community Hospital should be the most appropriate unit [for PHC administration]. The Community Hospital is ready, considering its resources and potential. They [the MoPH] should empower the districts to have their own authority in health care management. (CHD 2)

The previous male CHD (3) agrees with his statement and believes that the Community Hospital has to function as the centre of the PHC network.

The Community Hospital would be the corporate headquarters, and manage the many branches of PCUs providing health care services to people ... It means the HCs and the Community Hospital would be part of the same health services network, and the Community Hospital could function as the corporate headquarters. (CHD 3)

A senior male CHD argues that the MoPH should amalgamate Community Hospital and Health Centres:

I think if the MoPH would like us to work more efficiently, the MoPH must eliminate one organisation or the other in order to consolidate the district health services system. The MoPH should solve this problem for us. (CHD 4)

A young female CHD notes that she would like the MoPH to clarify the role and responsibility of health providers at the district level and she believes that Health Centres should report to CHDs.

They [the MoPH] should make this issue clear, for example, they should let the Community Hospital manage Health Centres ... I think that if the Health Centres were under our direct responsibility, they would be upgraded very fast. (CHD 7)

Two senior male CHDs agree with this idea. Moreover, one of them proposes that the CDHO should report to the CHD as a head of a department of the Community Hospital.

However, regarding the CUP Board, there should be only one authority to coordinate all health activity between the CH and the HCs ... I mean there should be only one authority figure with the absolute power to oversee the provision of integrated care, including holistic care, curative care, disease prevention, as well as health promotion for people in the entire district. (CHD 3)

The district health care services system could become more successful if there is only one leader with absolute power, instead of two leaders with equal power ...

In my opinion, if we want to continue the UHC program, the DHOs should be a department of the Community Hospitals ... [T]he CDHO should be a head of the community health care department and report to the Hospital Director. Working in this way, the hospital staff would be willing to be transferred to work at the HCs, which would contribute to a truly comprehensive health care service.

(CHD 1)

Another senior male CHD believes that if the CHDs are given absolute power over the district health services management, they can investigate and evaluate the performance of HC staff more effectively.

We can discuss with the DHCC board [CUP Board] whether it needs to inspect the HC but that action depends on the committee's decision. The inspection of a HC is a very sensitive issue ... (CHD 5)

A senior male CHD asserts that the amalgamation of the Community Hospital and the HCs will improve medical services at the HCs, if CHDs are their managers, because they can then send their nurses to work there. Moreover, the CHDs can help promote health workers on their career path.

If the Hospital Director could be the single boss who takes care of their career promotion, they [the nurses] would be happy to be transferred to work at the HCs. It would take only three to five years to reform the health care system successfully. (CHD 1)

A young female CHD and a senior male CHD propose that the government should reorganise the district health services system. They suggest a single management authority to manage district health services.

... I think that we can't do very much unless we reorganise the district health services system. (CHD 7)

I still insist on the approach of "one district one [health services] system". I think that the "one district one system" approach could stimulate progressive development in our public health system, but only if we have strong management implementing that development. It's quite restrictive for doctors as it stands.

(CHD 2)

A senior male Head of HC argues that health workers would like HCs to amalgamate with the Community Hospitals and report to CHDs as their single boss:

It's quite difficult, because we still have CDHOs in the system. I think that they are like dinosaurs. I would like to have CHDs as our bosses, because they are responsible for funding of the UHC programme. So, they can both manage funding and promote all staff. We wouldn't need to listen to two bosses anymore. One boss is enough. (HHC 4)

At the focus group discussion on the issue of how CHDs can facilitate sustainable PHC for the rural poor a senior male CHD reaffirms his previous argument that the Community Hospital is in the most appropriate position to administer PHC at the district level:

If there is to be unity for primary care management at a single organisation at district level, I think the community can have more access to health care and that we [the CH] can better facilitate villagers to be more involved in self-care. Moreover, the Community Hospital can better link with other health facilities which offer a higher level of care. I think that it is more effective for Thailand, if there is a single authority for district health management. As a result, the district health team can work more effectively and efficiently. . (CHD 2)

Another senior male CHD agrees with his argument. He adds that the MoPH needs to be flexible:

... the MoPH has to be flexible enough to let hospitals have their own management to fit with their needs. For instance, we may not need to establish PCUs for all areas, because there are different needs in each area and there are different sizes of area and population. (CHD 4)

The issue of the decentralisation policy makes the CHDs confused about whether and how the MoPH will devolve the HCs to report to the local governments. A young female CHD argues the need for clarity in the role and responsibilities of stakeholders, through having a single authority for district health services management, whether or not the devolution of health services to local governments eventuates:

If we have too many leaders, such as DLA authorities or others and work separately, the coordination of care will not be effective. I think that if we have only one leader and we divide our work, our health care will be more effective.
(CHD 7)

A senior male CHD points out that local government and other related organisations, as well as VHV, are important stakeholders:

I am thinking of a lateral coordination model. Another model is that of VHV. This will enable us to communicate with villagers at the family level. (CHD 3)

A senior male CHD expresses the view that local government is not ready for health management:

If we devolve the HCs to local governments, communication may fail; for instance, if we had a Cholera epidemic and the local government ignored it, because they didn't understand [the disease]. I have to educate them. They are likely to not understand and cause the epidemic to spread. (CHD 1)

He states that CHDs should be the leaders of district health teams:

The PCMO tries to unite our team. It is as if we share a similar heart. In another words, we have a single boss. However, the CHD should be the boss, because we are very capable ... and we are responsible for the funding of the UHC programme. (CHD 1)

Despite the fact that a senior male CHD (5) feels uncomfortable at the prospect of working with HC staff, he agrees that HCs should be combined with the hospital:

At the present, there are two bosses for our health services network and the coordination is not effective. This is a major barrier for our health care administration ... To be honest, I prefer HCs to be in our health services network, because [then] there is a unity and effective communication. (CHD 5)

However, he proposes that the second choice is that, if HCs must be devolved to the local governments, a new organisation should deliver primary medical care. This demonstrates his medical approach to solving the problem.

Our current problem is that most patients go directly to the hospital to access care [without this being necessary] even though we have improved medical services at the HCs, so they have become PCUs. If those PCUs belong to the hospital, we can look after them systematically. If HCs were to be devolved to local governments, we would need to create a new organisation for PHC provision at district and sub-district level, which hospitals can manage systematically. (CHD 5)

Another senior male CHD (2) agrees with his proposition:

If we [Community Hospital and HCs] need to be separated, we should only devolve health promotion and disease prevention to the local governments ... Local governments will also take responsibility for environmental health. PCUs will be responsible for curative and rehabilitative care and we can coordinate them. (CHD 2)

However, CHD (3) has a different view on this issue to that of the previous CHD: HCs should be responsible for comprehensive care. He argues: *'I think that HCs should provide holistic and integrated care. If health care is separated it will fail, the same as has happened in the past'* (CHD 3).

One senior male CHD (4) does not agree with the idea of creating a new structure to carry out curative care. He points out that health is not only about medical care:

I think that at the present the definition of health is broader. It is difficult to have one best way to manage health ... Actually, health is about people having good food, happiness; that they can live well in their homes. I don't know if there is any research about this. People's happiness may not be what doctors give to them at all. I am afraid that [if we establish a new structure for PCUs], we are

creating too many systems ... Therefore, don't create any new structure ... it will confuse us even more. (CHD 4)

He argues that local governments should be responsible for their communities, including their health management. He points out the important issue is that local government should be accountable and transparent. In addition, their role and responsibilities must be clear.

They (people) have their own communities. We interpret their communities as 'local governments', so that we have a negative feeling [towards this]. I think that in the future in Thailand, communities must do everything by themselves including health management. However, what we are afraid of is that local government may not be accountable and transparent ... I think that we need to tell them what their responsibilities are and that they need to be assessed and evaluated. (CHD 4)

However, a senior male CHD (1) had a negative experience in dealing with the local governments and does not agree with devolving the HCs to local governments.

According to my experience, I had my staff move to work with the local governments – Municipality and DLAs. They did not work for the medical services, but only served the politicians. Whatever the politicians order them to do they must do. Finally, they [who moved to work with the local governments] couldn't stand it and asked to be moved back to work for the MoPH. This is a failure. (CHD 1)

A young female CHD points out that having a single authority that can coordinate all health services in the district is the important issue. She supports the Chief of District. In addition, she argues that having the role and responsibilities of the stakeholders clear is important.

I think that if our health care is fragmented, we will fail. We need a single leader for the district health services even though we devolve HCs to belong to the local governments so that we are only responsible for secondary care. I think that whoever is that leader, they must be capable of facilitating these groups to work together for similar goals. (CHD 7)

A senior male CHD agrees with this and says: *'I agree that, if there is nobody acting as a centre point at the district level, our health care will be fragmented. This will cause a lot of trouble, especially when there is an epidemic'* (CHD 2). However, another senior male CHD (1) does not agree with CHD (7) about who should be in charge and he argues: *'I would like that boss to be a medical doctor [CHD]'* (CHD 1). 'Medical dominance' influences his approach.

If the Chief of District is the leader of district health care, we will have a permanent headache all of our lives, because he will act in the Ministry of

Interior fashion ... In addition, he is not a health professional. As a result, he may not understand public health. (CHD 1)

I want a CHD as the boss for the district health services, because they are a health professional who is accepted by all ... Doctors will trust doctors. Only doctors can work with doctors. (CHD 1)

Despite commenting about the negative aspects of a medical approach to PHC provision, young male CHD agrees with the previous male CHD (1) about having CHDs as a single authority for district health services management. His view on devolving HCs to the local governments contrasts with that of CHD (1). He proposes the local governments need to be educated about health management:

If we devolve HCs to belong to the local governments, I would not like that ... Therefore, I think that the responsibility for health can be devolved to them in phases. This may be a better solution, rather than we force HCs to be move to their authority in the next three years [through the Decentralisation Act].

There may be three phases for preparing the local governments in terms of knowledge, attitude, and health management skills. The first phase is that we continue what we are doing. The second phase is that we develop a pilot model for the district health services management. There will be a district health board and CEO to manage health services. The leader must be a public health professional at this stage ... I think that the chair must be a CHD. Then, the last phase is that we devolve HCs to them [local governments]. (CHD 8)

Finally, a young female CHD points out that what CHDs need to be clear about in order to manage PCUs is the focus of the PCU:

The policy must be clear as to what is the focus of the PCU. The policy said that the focus of the PCU is on health promotion, but actually it is as if we have lost the way. The high authorities [the MoPH] want the PCU to have sophisticated medical equipment for curative care, such as a laboratory, and an X-Ray machine. They want the PCU to be a super medical centre. So, I am confused. If the policy gives us a clear direction, we will know what kind of staff we need for the PCU. Currently, the policy is unclear about the PCU focus: curative care or health promotion. As a result, this impacts on planning for personnel. (CHD 7)

A young female CHD argues that there are different types of local governments in each district. There is no formal structure for all local governments at the district and sub-district level for them to work in a coordinated fashion with the agencies of the MoPH. In addition, she feels that there is a lack of accountability and transparency in evaluating the performance of the local governments. She says: '*[n]o one evaluates them. No one is responsible for this*' (CHD 7).

A senior male CHD agrees with her statement. He suggests that it is the role of the Provincial Governor to enable all of stakeholders in the district and sub-districts to work together:

Since I have worked at district level, it's unclear what local governments have to do. They sometimes do [know what to do] but sometimes don't [know what to do], for instance, with Dengue Hemorrhagic Fever prevention, food-safety, and assessment of the fresh food market. They don't do these, even though the PCMO sent them a formal letter [to coordinate their work with us]. I think that this is because we are not the ones who control them ... I think that it is only the Provincial Governor who should control the municipality and local government. He must be strong enough to order them [local governments] to do what needs to be done [comply with policy], and to cover the important health policies.

(CHD 1)

Another senior male CHD agrees with CHD (1). He explains that the coordination of all stakeholders at district and sub-district level is informal and depends on personal relationships:

We lack a structure to have collective meetings between us and all local governments in our district. As a result, we coordinate with them in an informal fashion and we only coordinate with them when they set the budget. They give funding to us only if they agree with some activities, not all. Some activities are important for their areas, but they don't [necessarily] support those ... Therefore, we should have a formal organisational structure in which there are their staff and our staff involved in a network. (CHD 5)

A young female CHD states that there is a lack of coordination between the local governments:

For my district, which is remote and small, we have a meeting for all public organisations every month. The Chief of District is chairperson of the meeting. The problem is we invite the presidents of local government, but they never come to the meeting by themselves. They usually send the heads of their administrative office as their representatives [who do not have any power and do not commit to doing anything]. It doesn't work when we ask them to help implement health programmes. Even though the Chief of District is the one who has the greatest power in the district, he cannot ask the presidents of the local governments to do things in the same way as we do. (CHD 7)

Even though a senior male CHD supports community participation, he proposes that the bureaucratic organisations – CH, DHO, and HCs – should be the central organisations responsible for district health. This is because he has had negative experiences working with local government.

We need to have our way. I mean we need to use bureaucratic power. We need to coordinate with the DHO and HCs to set a central organisation for our district.

(CHD 3)

He suggests engaging people directly in making decisions for district health policy.

What is best is that we need to start [exploring] this concept of a central organisation with people, because they are the most important power. We work for their health. We listen to their opinions. We know their real contexts very well. (CHD 3)

Despite the fact that CHD (1) perceives that the people's voice is important, he does not agree with CHD (3) that engaging people directly in the decision-making process will enable all stakeholders to work together. He believes that only a bureaucratic authority can make this happen.

[W]e need to understand the real situation in Thailand. If we look at the study from the MoPH regarding the 'Food-safety' programme, this programme is especially important for districts where there are tourists visiting. There was an order from the ministries to every sector including the Provincial Governor, the Vice Provincial Governor, CHDs, and Presidents of local governments that the government wanted to succeed with this programme. (CHD 1)

He insists that the Provincial Governor is the only one who has the authority to make all stakeholders work together:

Initially, I would like the MoI to be strong enough to order local government to engage in health care provision. The PCMO should take the lead and explain this to the Provincial Governor, so that he understands. From now on, the Community Hospitals have to be involved with the local governments more and more. Even if we had a meeting with them every month, it won't work, because they don't understand our work. (CHD 1)

CHD (4) proposes a 'District Health Board' with all stakeholders within the district working together. He refers to the present structure of the CUP Board or DHCC as a model:

I am thinking of the model of the District Health Board. This may be a structure that can engage all stakeholders in each district in health care provision. We may do it informally. We can use this Board for the coordination of all stakeholders ... (CHD 4)

However, he points out there may be a barrier to engaging the local governments in the DHCC, as he is very concerned about the committee's interests in sharing the budget:

However, what happens in our DHCC or CUP Board now is only about financial sharing between us and HCs. If we include local governments in this Board, I think there may be some difficulties. Financial matters are very sensitive for us in relation to local governments. (CHD 4)

In addition, he shows that there is confusion about the role and responsibilities of the district health team and the District Health Board. The CUP Board or DHCC only administers the district health team, because the agenda is more about the routine operation of the CH, HCs and DHO in implementing the UHC policy and PHC.

At present, there are only the CHD and the CDHO working for district health, and we have many conflicts. If we have more organisations involved in district health we may be in even more trouble. This is because we are too focused on the financial aspects of the UHC programme and this causes us too much worry.

(CHD 4)

A senior male CHD (1) argues that including the local governments in the DHCC is not effective, as the presidents of the local governments ignore meetings and there are often changes in the personnel of the local government authorities who are responsible for health:

Actually, what CHD (4) proposed about including local governments in the DHCC, I've done that. However, they sent their representatives, such as nurses who have little authority. When I asked them to do something, they came back with unsatisfactory results, because their bosses did not support my request. Another issue is that the Deputy Mayor, who is responsible for public health, often changes. When they have a new election, they always change this person [in this position]. We really don't know who will come next. This gives me a headache. (CHD 1)

Moreover, his statement demonstrates the hierarchy of authority and complexity of the workings between bureaucratic and local government structures. He insists that the Provincial Governor is the key person to order the local governments to meet with the CHDs.

When I invited the Mayor to be a member of the DHCC, he didn't dare meet with me. I think he thought that his rank is higher than that of the CHD, so that if the CHD is the chairperson, and he is only a member of the Board, he would lose status. His authority is higher than mine. Another thing is that if he agrees with something and he then can't do it successfully, he may lose face; so he has his subordinate attend the meeting for him. (CHD 1)

A senior male CHD (4) proposes that the District Board may be able to be a centre for the District Health Board. However, he has found that there is a barrier to this because of the lack of real interest regarding health.

At the district level, the Chief of District calls meetings for the 'Board of the District'. We could use this channel. However, there are many agenda items for this meeting. The Chief only addresses those that interest him, speaks about them and then leaves the meeting. (CHD 4)

A young male CHD (8) agrees with the statement of CHD (1) and CHD (4). He disagrees with CHD (7)'s proposition regarding the Chief of District being the leader of the District Health Board. He recounts his experience:

I had a meeting with local government representatives at the Local Government Council. I used to ask the president if he would agree to have a District Health Council. He agreed, but nothing happened. I tried to invite him to the DHCC, but he never came by himself. He sent a lower-rank member of staff and nothing happened ... If the Chief of District is the chair, I think it will fail. I worked with a CD. He tried to integrate his work with that of health. His work was related to our work, but he focused on everything else. For instance, we had programmes to promote well-being, and for the disabled. His programmes involved other groups, such as the elderly, and the underprivileged. He only focused on the underprivileged, and they were not our interest at that stage. (CHD 8)

A young female CHD expresses the view that the District Health Board's role should be to provide a long-term health plan at district level, because of the differences in the budgetary cycle between the bureaucratic organisations and local government:

I think that we need to realise that the budgetary cycle of the local governments is different from that of ours ... We need to have a long-term plan so that we and they can work together well. (CHD 7)

A senior male CHD (5) proposes that meetings for the District Health Board should be held twice a year, because all CHDs have too many commitments. He is worried about the effectiveness of the District Health Board:

My real basic problem is that, as a CHD, I have too many commitments. I can't think about anything which is beyond the scope of the hospital. If we had such a central organisation (District Health Board), can we really manage a meeting every month? I am not quite sure that I can. We have too much work. We can only solve our problems at hand. If the meetings are only twice a year, it should be OK, but you cannot expect that much will be gained. (CHD 5)

Despite the fact that all CHDs view having the District Health Board involved as one of the strategies for them to facilitate sustainable PHC for the rural poor, they do not have any vision or a real intention to make this happen. That is because they perceive that there are too many barriers which prevent them from acting beyond their interests as clinicians and hospital managers. Two of the senior male CHDs specify these barriers. The first CHD (5) presents the issue of the heavy clinical workload and the shortage of medical staff. Another CHD (3) fears working under a bureaucratic structure, which is not transparent or accountable to the community, will impede the aims of the District Health Board. His argument reflects the lack of accountability and transparency on the part of the bureaucratic organisations.

The major problem of the Community Hospital is a severe shortage of medical staff. If you can solve this problem, we can improve our medical care. At present, we are thinking about doing research. However, unfortunately, we don't have much time to do it. We are very busy with the routine work at hand, because we have less staff ... I think that we don't have much time to look ahead. We focus only on solving our problems at hand. (CHD 5)

I think that the idea of the District Health Council or Board is possible. However, I am afraid that working under a bureaucratic administration will be a barrier. The regulation and culture of working in bureaucratic organisations will prevent the aims of this Board. We are limited by rigid regulations, and the old paradigm of working [to rules]. (CHD 3)

4.5.2 Sub-theme 4.2: Role of the Community Hospital Director as Primary Health Care facilitator

This sub-theme presents the role of the CHD as the PHC facilitator. When asked as to how he can continually improve PHC services provision for the rural poor, a senior male CHD takes a positive view:

It doesn't matter about the changing policy. Even though it changes, we have to work and we have to realise that everything happens because of us. We [CHDs] are a part of the health system. It is as if we are a small wheel nearest to the ground. If we make our wheel move forward, I believe we can influence other wheels, which are bigger and are at a higher level, to move forward, even though they may have greater influence than we do ... because we are capable and we have the annual funding for the UHC programme for every year ... we can do more than half of what we think or dream (CHD 3)

A senior male CHD (2) suggests: '*...even though the policy from higher authorities will be changed, our duty is the same – looking after people's health. I think that it is our [the CHDs] responsibility, to support and facilitate primary [health] care*'. A senior male CHD (5) points out: '*[y]ou [CHDs] need to be a positive role model to others*'. CHD (1) argues: '*... the CHDs are required to have a highly developed ability to adapt themselves to perform the multiple roles*'. In addition, a young female CHD's statement demonstrates the characteristic of a visionary leader of the CHDs:

We [CHDs] should look at the large picture, or present a vision as to which direction we should take and emphasise, and then try to achieve the goals. Draw a strategic plan to reach the goals ... (CHD 7)

A senior male CHD (5) believes that CHDs can exercise their role as clinicians to facilitate effective PHC services' provision. He argues:

... [a] doctor [CHD]...[is] the leader of district health team... They can cooperate with and facilitate that health team... They are respected by the villagers...and they are capable, trusted and can lead the team. (CHD 5)

A senior female CHD argues that, as hospital manager, she can help her hospital staff to understand PHC and be able to integrate primary and secondary care for patients. She states:

First, all health staff must have the same vision. In my opinion, to deliver primary care not all staff need to go out and see people in the community since they can incorporate primary care into their secondary care. Even though some of them work in the ward, which is secondary care, they can be active in primary care as well ... To do this, they can educate the patients in their ward about primary care. (CHD 6)

A young male CHD tells of his experience as a hospital manager in assisting his staff to understand the change due to the UHC policy:

... I had to make my staff understand the changes quite a lot ... [their] paradigm must be changed ... I explained that under the 30-baht health policy, there was a change in financial management ... After my explanation, they saw both good and bad sides to the policy ... Then, they started to show some initiative. (CHD 8)

A senior male CHD argues that, through his role as a hospital manager, he can send his Hospital PCU staff to educate people about health promotion. In addition, he can provide sustainable PHC services through the coordination of care to improve the quality of PHC delivery. He states:

Regarding my role as a CHD, I send a team to take care of disease prevention and rehabilitative care, and to educate people on how to be free from sickness and illness, so they don't need medical treatment in the hospital. (CHD 2)

I ... [can] improve the coordination of care between the primary and secondary levels through continually improving quality [in care delivery]. (CHD 2)

A senior male CHD (3) and a young male CHD (8) suggest that CHDs should facilitate hospital staff to work cooperatively with health workers through teamwork, so reducing the differences between the professional sub-cultures and the organisational cultures of the hospital staff and HC staff. The CHDs should lead them to focus on patient-centred care. They point out:

... [I can] motivate my colleagues to work cooperatively [with HC staff] in order to provide the best health care services to people. (CHD 3)

[CHDs can facilitate] the reduction of the professional gap ... [through] a system of teamwork with a focus on patient-centred care ... (CHD 8)

Another Hospital Director suggests that CHDs can exercise the role of district health services manager through the CUP Board's policy development:

I ... [can] develop my policy for the CUP Board, not only to be applied to the Community Hospital, but also to the PCUs and the HCs in the whole district ... I can develop the management policy, including budget management policy, human resource management policy and policy about the organisation's performance assessment. (CHD 4)

A senior male CHD (3) points out: '*the Community Hospital is responsible for health services financial management*'. CHD (4) confirms this and observes: '*I [as a CHD] am fully in charge of the budget ... It is my duty to manage the budget*'. Despite the disparity of responsibilities and authority between CHD, CDHO and health workers, CHD (3) and a young female CHD (7) suggest that CHDs could assist the DHO and HCs in improving PHC through their participation in the CUP Board administration. They argue:

Regarding the financial management system, or the overall resources management system, we emphasise the involvement of everybody ... In other words, the committee of the CUP Board includes representatives from every HC, the CH management team, and representatives from the DHO. They are all engaged in financial and resources management. (CHD 3)

... there must be participation by all parties ... in decision-making ... [E]very stage has to begin with contributions from or participation of all staff members regarding ideas and their development along the determined direction. (CHD 7)

A senior male CHD (4) agrees with this and argues that CHDs can enable the CHD and the CDHO to work together as a team. He says: '*[b]oth of them [the CDHO and the CHD] must work cooperatively as a team ... If either of them is not fully cooperative there will be no successful collaboration*' (CHD 4). Furthermore, another senior male CHD (2) suggests CHDs can empower HC staff to be able to manage funding by themselves. He believes that this would initiate transparency for the CUP Board administration. As a result, they can work together with trust. He argues:

Transparency is my policy for work. For example, I would empower the health centres to manage themselves by allocating the funding to them, and they then take care of that funding by themselves. (CHD 2)

Moreover, the CHDs could allocate funding for human resources development for health workers. A senior male CHD (3) says: '*[w]e [CHDs] would allocate a human resources development budget ... for ... the health workers at the PCUs [HCs]*'. A senior male

CHD (1) suggests the CHD as '*[t]he Chair of the CUP Board must be responsible for clearly determining the role and responsibilities of staff*'.

In health services delivery at HCs, CHDs can facilitate quality primary medical services by '*... assign[ing] a team of doctor, nurse and pharmacist to visit the HCs*' (CHD 5). A senior male CHD (3) adds: '*[w]e [CHDs] need to empower our primary care nurses to gain more medical skills, so they can look after patients with chronic conditions at HCs and so stop them going directly to hospital*'. A young male CHD argues CHDs should support nurses in HCs in not only improving their medical knowledge, but also in '*...[having] a good attitude to working in community health and [that they] can coordinate with health workers for health promotion*' (CHD 8).

Another senior male CHD (2) argues:

We [CHDs] have to go to visit, to supervise them [health workers] at their HCs. This will facilitate the provision of sustainable PHC. We need to have good communication with them ... and increased communication ... and network with them ... This will make the continuity of supervision easier. (CHD 2)

A young male CHD (8) adds: '*[t]he more we communicate, the more teamwork is established*'. Furthermore, a senior male CHD (2) argues: '*[w]e [CHDs] should provide support to the HCs so they are capable of providing PHC services*'. Another CHD (3) adds:

We [CHDs] supervise the HCs to improve their services ... [for instance] regarding patients with chronic diseases, academic seminars were organised to educate the health workers at the PCU [HC], so that patients with chronic diseases can be referred to the PCU [HC]. (CHD 3)

Finally, a young male CHD proposes that CHDs could facilitate the hospital staff and the HC staff working together through an accreditation system to unite the many systems. He argues:

Regarding our quality [accreditation] system, we have a quality working group at the HC level and the hospital level working together to ensure that there is one standard in the various settings, such as HA [Hospital Accreditation], HPH [Health Promoting Hospital], and HCA [Health Centre Accreditation]. We have only one committee to supervise health care quality ... This proves to be a better system. (CHD 8)

A senior male CHD (2) suggests that, even though CHDs and local government authorities are not collaborating very well, to have sustainable PHC provision for rural

poor, the CHDs should encourage the local governments to provide PHC through health promotion. His reply reflects that CHDs must have an outward-looking approach.

If we would like the local governments to be responsible for health promotion we need to go to talk with them and educate them gradually, maybe one by one.
(CHD 2)

Another senior male CHD (4) agrees with this statement and proposes: '*[d]uring the transitional period, the CHD could educate the DLAs [local governments] about PHC*' (CHD 4). A young male CHD recounts his experience in approaching local government authorities to have them participate in health services provision:

There is the Local Government Council ... They meet every two months ... I went to a meeting and presented health data and policies ... and asked them to participate ... I acted as a PHC facilitator ... [If] we can talk to the local governments this way [provide information] ... they will understand more ... and participate in implementing the district health policy. (CHD 8)

A senior male CHD (5) argues that the CHDs can facilitate the understanding of PHC by providing information to the community. He states that when he implemented the UHC policy and PHC he found:

The government didn't provide all the facts to people ... [so that] I needed to explain everything to them. (CHD 5)

CHD (2) suggests that the CHDs should practise the role of PHC facilitator to encourage the community to practise self-care and participate in health promotion. He says:

I would say that we [CHDs] should empower or support or encourage the community to participate more in self-care ... We can only act as facilitator to encourage them and I think that we should do this. (CHD 2)

CHDs could facilitate sustainable PHC provision by relieving the shortage of PHC staff in rural areas through a role in human resources development. A senior male CHD gives his views about his responsibility regarding this role:

My first priority is to solve the shortage of health personnel, especially the nurse shortage. (CHD 3)

CHD (2) states that CHDs have no role in recruitment and selection of health staff. He proposes an expansion of the CHDs' role to include an involvement in the recruitment and selection of students who want to study medicine or nursing. He argues:

If we are empowered to select and recruit high-school students who are scholars [in order to increase the number of] rural doctors and nurses ... and to choose who will work with us in the future ... primary care will be sustainable. (CHD 2)

Regarding career development of PHC staff, CHD (8) realises that, working in the public sector, CHDs cannot provide much financial incentive to staff, because they have to comply with the central government's regulations. However, he believes that CHDs can facilitate the retention of PHC staff by improving their work skills through adopting and practising the concept of a 'learning organisation'. He says:

... [W]e continue to improve and prepare our organisation to become a learning organisation in the future ... It's like an organisation which has its own brain. The CUP Board acts as its 'brain' to help a solve problem. The people in the team can learn from the problem and share the knowledge as part their life-long learning. Then, people can maximise their potential. (CHD 8)

A senior male CHD adds that CHDs have the capacity to retain PHC staff though staff development. CHDs have the authority to provide funding for staff education so they can support the career development of PHC staff. They can facilitate the development of appropriate curricula and training programmes for PHC staff at educational institutions. In addition, CHDs can deliver training to PHC staff by using the facilities and resources in their own hospitals. He notes:

Regarding the role of CHDs in the education of health personnel, ... now we have funding ... we can provide funding for training new graduates ... and for postgraduate training for our existing staff ... we provide funding to support our staff to continue their study. We can contact educational institutes about their study [programmes] ... and we can collaborate with such institutes to develop training programmes for our staff ... We can deliver training programmes within our district through our health team ... We can do many things ... if we really want to do. (CHD 4)

A senior male CHD (1) proposes that CHDs can take up the role of PHC facilitator to explain the UHC policy and PHC to medical students when they are rotated to be trained in their hospitals. He recounts his experience and his opinion:

... I talked with medical students and they said that their medical school did not teach them about the UHC policy, and I believe this is the same for the nursing schools ... I propose that we need to facilitate the understanding of this policy so medical students will be able to speak the same language as we do ... I think that this is the first priority. (CHD 1)

A senior male CHD (4) and a young male CHD (8) point out that CHDs can facilitate the adjustment of the curriculum and training for students at educational institutes in the MoPH and with other related stakeholders to fit with PHC provision.

We [CHDs] should inform the Health Manpower Development Institute (which belongs to the MoPH) and its Nursing Colleges to review their curriculum to comply with the UHC policy direction [that is PHC] ... We have never known what they teach nursing students. (CHD 4)

Despite the CHDs perceiving they have a smaller voice in the MoPH, a young male CHD suggests that CHDs should exercise their role as PHC facilitators by informing the higher authorities of their problems and opinions. He says:

Regarding the role of CHD for the UHC policy, we can indicate the problems of policy implementation and our recommendations to the higher authorities.

(CHD 8)

A senior male CHD (3) argues that there is a channel to express their voice through a bureaucratic structure at the provincial level:

We usually can report problems that impact on our management through the Provincial Health Administration Committee, or we can talk directly with the PCMO. (CHD 3)

A young female CHD points out that many problems cannot be solved at the provincial level because of the unclear policy and resulting confusion of direction. She suggests that CHDs should consolidate their power through a group process, so that they could express their voice to the higher authorities. She argues:

We should get the higher authorities to understand our problems ... Primary care is the MoPH's policy, isn't it? ... CHDs are capable and we can work together as a group to inform them of our problems and opinions ... but we require a leader.

(CHD 7)

A senior male CHD argues that the higher authorities do not listen to CHDs, because CHDs lack evidence-based information to support their complaints. He suggests that CHDs could conduct active or practical research, because they have gained extensive experience of the health system through their work, yet what they have learned not shared with policy makers and other CHDs. He points out:

I think that we need to have evidence-based research to present to them. At present we rarely conduct research. Actually, we can learn many things from the Community Hospitals. However, we rarely use what we learn from CHs to inform the policy makers ... This is our weakness ... We have a lot of experience and we have learned this over a long time. We know what is wrong or right. However, what we learn from our practice never reaches the policy level ... CHDs should do one research project for each [CH]. (CHD 4)

However, another senior male CHD (2) points out that CHDs lack research skills:

I think that we have a lot of experience but we lack research skills ... we have never researched anything seriously. It is as if we lack evidence-based reasons to support our initiatives. (CHD 2)

A young male CHD encourages CHDs to start conducting research through a local CHD group. He believes that CHDs should expand the networking of CHDs from the local area to the national level. He suggests:

... We [CHDs] can start at our province ... we have a [local] CHDs' group ... we can set the academic department ... to conduct research ... regarding the development of the medical and health system ... and health management, such as financial management, and policy development ... [T]hen, another group can study improving the quality of health care ... We can start by ourselves ... Then, we should contact the CHD Group of Thailand to urge them to conduct research regarding evaluation of the UHC policy in order to inform the MoPH, the NHSO, and all CHDs. (CHD 8)

A senior male CHD adds: '[w]e [CHDs] can inform the higher authority through the Rural Doctor Club [Group] or the media' (CHD 2). However, CHD (3) points out that there was no formal structure to require CHDs to conduct research or publish their work.

He states:

Actually, our staff conducted research for their masters' degree, but there's no incentive for them to publish their research. Even the CHDs don't have any incentive to do research. The higher authorities don't require us to do any. It doesn't matter to us whether we do research or not. There's no regulation or rule to say that we need to conduct research or publish our work. (CHD 3)

Moreover, a senior male CHD suggests that CHDs can support other health staff and the next generation of CHDs by being positive role models. He argues:

... CHDs can influence many policies, because we have authority ... we should be able to do more things. We need to encourage this and we should be role models for the next generation of CHDs. We should be role models for health workers ... so we work happily in the rural district. (CHD 4)

Finally, he raises an interesting issue for all CHDs: do CHDs want to act as agents for change? He points out:

... We [CHD] can do many things ... if we really want to do them. (CHD 4)

In summary, within the limits of their authority, CHDs can influence their stakeholders in and out of the health sector through their dual roles, clinician and manager, in order to continuously improve PHC services provision for the rural poor. Despite the CHDs' role as PHC facilitator being seen as part of the collaboration between other stakeholders, it appears the CHDs consider their role to be superior to that of the other stakeholders at the district level.

4.5.3 Sub-theme 4.3: Skills and knowledge required by Community Hospital Directors

This sub-theme presents the professional skills and knowledge required by the CHD to sustain the UHC policy and PHC services provision for the rural poor.

Core business and general system management

A core part of the role of the CHD is to ensure the provision of health services, and CHDs need to be competent in medical services and management. A senior male CHD (5) argues: *'I think that to be a successful Community Hospital Director [CHD], they require [both] [medical] academic knowledge and competence, and management competence'*. However, a young male CHD contends: *'the first thing the Directors have to know is that the 30-baht scheme helps all Thais avoid disease'*. *'The [UHC] policy concerns health promotion ... [and] CHDs lack knowledge about health promotion and need knowledge about PHC'* (CHD 8). He suggests: *'... the paradigm for the new generation of CHDs should be built around primary care'* (CHD 8).

A senior male CHD points out: *'[t]he CHD should have an essential knowledge of the health care system ... They should have knowledge of public health'* (CHD 3). CHD (4) gives epidemiology as an example of public health knowledge. CHD (3) adds that CHDs *'... should also understand the government administrative system'*. A young female CHD (7) argues: *'a CHD must know all [government] laws or regulations'*.

CHD (1) argues CHDs need to be competent in general management:

The CHDs should also possess management knowledge and skills to handle all possible problems. (CHD 1)

All of the CHDs suggest competency in financial management is crucial for CHDs. A senior male and a senior female CHD express this view:

Since the launch of the 30-baht UHC programme, it is essential that the CHD should have knowledge of financial issues. (CHD 4)

... they [CHD] should have a particular knowledge about financial management.
(CHD 6)

CHDs require knowledge of management tools, such as performance assessment of health services provision, to manage their organisations. However, a young CHD and a senior female CHD argue CHDs lack such competencies:

These [management tools for controlling the quality of health services] are things I have to control, but I don't know how to do that, because I lack knowledge about it. (CHD 7)

I'm still searching for other indicators that they could follow; at least, they would be assured that we know that they have done home visits in the community. I'm still adjusting the indicators. This year, I've promised Hospital PCU staff that there would be a new assessment of their performance in community visits, but I still cannot find satisfactory indicators, so I have made an agreement with them to use the same criteria as before. (CHD 6)

Networking competency

CHDs need to be able to network, because they have to work with other stakeholders in their districts to deliver sustainable primary health services for the rural poor. The argument of a senior male CHD reflects this need:

I would like them [CHDs] to be coordinators. They don't need to be good at everything, but they must be able to link up with others and to ask others to collaborate with them. (CHD 2)

CHD (3) and CHD (1) agree with his argument and suggest that teamwork skills are necessary:

One more thing, the CHD should learn to work collaboratively as part of a team, because the CHD alone cannot assure the organisation succeeds. It requires teamwork ... and they [CHD] should know how to work in a team ... (CHD 3)

Teamwork is required, otherwise the health care service system would not function. (CHD 1)

CHD (4) adds: '*... I think the ... skill for the manager [CHD] is that of coordination ...*'.

Furthermore, CHD (5) argues: '*[h]uman relationships should be enhanced*'. CHD (4) suggests that CHDs should be skilled in managing human relations, to get along well with their stakeholders, particularly the CDHO, because both the CHD and the CDHO are important leaders of the CUP Board. He argues:

I think everything comes from these two people [CHD and CDHO]. If the two heads get along well, they should manage the CUP Board successfully. (CHD 4)

A senior male CHD agrees with this argument and proposes:

If a CHD performs this human management skill well, they can move their work forward very quickly. (CHD 6)

In addition, Austin (2000) argues that building trust is central to establishing effective collaboration. A senior male CHD agrees: '*[w]hen we [CH, DHO, and HCs] trust each other, we can work cooperatively, and build up transparency in the budget allocation*' (CHD 2). He also argues accountability and transparency can strengthen trust:

I think there's no problem, as long as I can be accountable and transparent in my work. I could answer any questions regarding my role. (CHD 2)

An effective collaboration between all stakeholders in the CUP Boards can be achieved through the involvement of all partners. As a result, trust is created through mutual interests.

... the committee of the CUP Board includes representatives from every HC, the CH management team and representatives from the DHO ... We try to include everybody in management, so that they don't feel left out ... They are all engaged in financial and resources management. (CHD 3)

Regarding money issues; we have discussed money since the beginning [of the year] and we have guaranteed that the HCs and the PCUs will receive the money we promised. It is not money from the hospital, but it is a budget to be shared.
(CHD 3)

CHD (2) believes that health centres should be '*empowered*' to manage their own funding and he would like to allocate funding to them, so '*the health centres [can] manage themselves*'.

Interpersonal competencies

A senior male CHD reports CHDs lack communication and interpersonal skills:

Doctors [CHDs] lack skills, both teamwork and interpersonal skills. If doctors [CHDs] can learn human relationship and interpersonal skills, I think that doctors [CHDs] could be good managers, because they are well-educated.
(CHD 2)

A senior male CHD argues CHDs require social skills.

Moreover, you [CHDs] should be conversant with, not just medical knowledge, but also life [social] skills. (CHD 5)

A senior male CHD reports that he encourages two-way communication between stakeholders at the CUP Board meetings: '*...I try to initiate bottom-up management by calling everyone to the [CUP Board] meeting. We could discuss matters in the meeting*' (CHD 4). '*At least, the CHD is required to have [the] skills to run meetings ...*' (CHD 5).

A senior male and a young male CHD state CHDs require analytical and priority setting skills:

... however, analytical skills are required [for CHDs], because otherwise we would only pick up the practical policies that apply to the CUP Board. (CHD 3)

... in primary care, we divide it [the PCU] into the Main-PCU and the Sub-PCU ... We have to do this, because we have to set a priority on which HC will be developed; taking into consideration the factors of staff, budget, and equipment, which are all limited, to see how we can develop the HCs to become PCUs and how we can improve HC facilities, buildings and service provision systems. This is a matter of priority setting. (CHD 8)

Unteachable competencies

CHDs believe that they should possess competencies which Spekman, Isabella and MacAvoy (2000:199-203) define as ‘unteachable competencies’. Two senior male CHDs offer their views that these competencies are about flexibility:

The CHD should be very capable and flexible in order to maintain the organisation and to assure people of its reputation ... The future CHD should be competent, patient and capable of solving the problems by way of compromise ... The manager needs to be the one with a high level of flexibility to manage his subordinates; a manager should be sociable and friendly. (CHD 1)

The manager should not be strict in his authority all the time; otherwise there would be no progress. (CHD 2)

Leadership

The CHDs suggest that, for a CHD to be effective in implementing and sustaining the UHC policy and PHC, they should have leadership skills. Some participants argue that these include skills below:

... how to make people work and do as we wish. This is hard, because everyone has their individual perspective or own needs. (CHD 6)

They [CHDs] should practise ... team leading skills, staff motivation skills, speaking skills and people skills. (CHD 5)

... management knowledge, especially how to be a leader and what techniques to use. (CHD 8)

The successful CHD possesses many characteristics. He should be a good leader. Firstly, the good leader must have leadership skills. He should be able to convince his subordinates as well as others. (CHD 4)

The assertion of CHD (4) demonstrates that CHDs should have the skill to enable others to use their initiative and should delegate their authority to their staff to make decisions independently. He argues:

In my opinion, first of all I would encourage my subordinates by empowering them to make their own decisions in certain situations ... I believe that it is very important to encourage them by providing them with the authority to make decisions ... They need to be allowed to be creative and implement their own ideas ... (CHD 4)

However, he contends that CHDs should also empower the community to practise self-care:

We [the CHDs] are not knowledgeable about the techniques for empowerment, especially how to empower the villagers about self-care. (CHD 4)

The participants discuss their views on the key skills in collaboration management (Shaughnessy 1994:23-33); this knowledge and these skills are needed by CHDs to sustain PHC services provision for the rural poor. Two senior male CHDs indicate that negotiation skills are necessary for a CHD to be effective:

... I think the ... [principal] skill of a manager is that of ... negotiation. The CHD must know how to negotiate for the greatest benefits ... (CHD 4)

They need to spend time in effective negotiation. (CHD 5)

Cardona (2000:23-33) defines a systematic approach to management as essential. The two senior male CHDs above and CHD (3) state a systematic approach is a necessary skill for effective collaboration and management:

... they [CHDs] need to develop their management knowledge in a systematic manner. (CHD 5)

I try to systematically manage the organisation, which involves more a sense of timing. (CHD 4)

I need to change my attitudes. I need to think more positively. I need to apply a systematic approach to solving problems. (CHD 3)

A young male CHD's comments CHDs require the characteristic of a 'learning mindset' (Spekman, Isabella & MacAvoy 2000:203). He (CHD 8) describes the hospital organisation as having a 'brain' that helps to solve problems. The staff 'can learn from the problem and share the knowledge' and so 'maximise their potential' as they continue to learn.

In addition, skills in dispute resolution are necessary for CHDs to be effective collaboration managers. CHD (4) and CHD (5) assert:

The Hospital Director must know how to negotiate for the greatest benefits and he must be able to solve conflict between the organisations. (CHD 4)

They should compromise in order to lessen the conflict. (CHD 5)

According to Alexander et al. (2006), to be effective CHDs require political skill. However, CHD (5) asserts CHDs lack such a skill, and where there are political issues he tries to distance himself from them, ‘*because the Community Hospital is an independent organisation*’. His policy is ‘*not to fight with those politicians, because there’s no point*’ and he instead intends to only ‘*devote myself to the hospital development*’ (CHD 5).

Furthermore, two senior male CHDs argue CHDs should be able to engage the community:

You [CHD] should be willing to stay close to the people in the community, which is uncomfortable sometimes. (CHD 5)

The CHDs should have a good attitude towards community engagement ... so that they will be successful in PHC. (CHD 2)

Visionary manager

A young male CHD suggests the model of the CHD as a visionary manager, because CHDs require a long-term goal mindset. He recounts his experience encouraging local governments to advocate health activities in the region. Even though the local governments offer little support at present, he believes that he has to continue to encourage them for future support.

Although they [local governments] still don’t provide much support in terms of funding, they have started to see its benefits more and more. I believe that they will help by advocating for next year’s budget, to support us especially in regard to primary care, which is related to their work. (CHD 8)

A senior male CHD observes that CHDs require strategic thinking:

The organisation’s manager [CHD] should know what their priority is in order to improve health care services; what is the overall health care system, and how can they design the organisation to match the current health care system.

(CHD 3)

A young male CHD states that to sustain the UHC policy and PHC, CHDs need to be able to plan strategically:

Now, after we have solved the internal crisis, we have started to undertake strategic planning to take care of the outside, that is the people in our area.
(CHD 8)

... we have begun to collect information about their personal data and their disease data and everything to carry out a SWAT analysis, and then to establish strategies for better ways of looking after the patients across primary care and secondary care. (CHD 8)

However, a young female CHD argues that she lacks the necessary skill:

Only the plans expedited at the provincial level can be realised. The plans in my head are of low priority. I have to expedite the Provincial Health Office's requirements. (CHD 7)

Besides being a visionary manager, a senior male CHD (5) believes that, to be an effective CHD and sustain PHC services provision for the rural poor, a CHD requires self-control and common sense skills. He points out:

Moreover, the CHD needs to practise self-control, they should be calm and patient as well as being decisive in solving problems, otherwise they fail.
(CHD 5)

They [CHD] should use common sense to solve problems. (CHD 5)

In this sub-theme, the CHDs offer their views on the required skills and knowledge to be effective in collaborating with other organisations, stakeholders and staff.

4.5.4 Sub-theme 4.4: Professional development of the Community

Hospital Director

This sub-theme explores the professional development options for CHDs, so they can sustain PHC provision for the rural poor administered from the Community Hospital. A senior male CHD and a young female CHD argue that the MoPH should change the way it appoints CHDs. They suggest:

We should screen the applicants based on their qualifications, and we would be able to select the best qualified person ...It's not correct to choose the Hospital Director based only on their seniority. (CHD 1)

There should be an established qualification for the candidate for the Director's position, which should be determined by the Ministry [of Public Health], ... some specification or background for this position. (CHD 7)

CHD (1) argues: '*[t]here should be a test, an assessment system or an examination ... to determine which of those who apply for the position of the CHD [are suitable] ... The test should be able to tell whether or not the candidates have the willingness and capacity to do the job*'.

A senior male CHD (5) recounts his experience in hospital management at district level, where he learnt management through experience and practice. He thinks this method of learning is inappropriate.

I solved the problem in an amateur way by trying out different approaches and, I gained a lot of experience, but it was a time-consuming method. (CHD 5)

The CHDs express the view that new CHDs should be professionals and trained in hospital management, so that the new CHDs are more focused on hospital administration. A senior male CHD (3) points out: '*they should be trained in hospital management for a short period*'. CHD (1) adds: '*[t]here should be hospital management courses organised by a school or university which has an excellent reputation in health management for CHDs*'. However, CHD (5) argues that CHDs should be trained for general management: '*They [CHDs] should be provided with management courses to enhance their management skills, so that they will understand the whole management process in order to facilitate development [of the CHs and PHC]*'.

Most of the CHDs agree and propose that prior to taking up a position a new CHD should have hospital management training. CHD (2) states:

Regarding hospital management, I think having a management school for the new Directors would be better than letting them find a teacher by themselves ... If they found a good teacher, the teacher could be a CHD with a positive attitude [towards the position]. If [the teacher did not set a positive example] they [the new CHDs] could end up imitating the bad example and follow the same corrupt ways. (CHD2)

I think if the new Director is a newly graduated doctor, they should be trained at the [hospital] management school first. We should not let them [newly graduated doctors] encounter the 'foxes' in the hospital, such as experienced department heads, because those people may discourage them. (CHD 2)

However, only one CHD believes that CHDs should have some years of experience in hospital management before entering the management school:

After one to two years of working, when the director is experienced enough, they should be offered a management course to better understand their role. (CHD 5)

In addition, he proposes: '*...some of the CHDs [who have less knowledge of PHC] should continue the public health course to gain more knowledge of PHC in order to work here [at the district level]*' (CHD 5).

Regarding the method of training, the CHDs suggest that it should be flexible, because CHDs have limited time to study with their heavy workload, particularly the clinical aspects of their work. A senior male CHD (1) suggests:

The course provided to the CHDs should be part-time, otherwise they would not have enough time to work. (CHD 1)

The CHDs would be able to attend the course only on weekends. (CHD 1)

He recounts his experience of attending a short course in hospital management where there was no formal assessment. He suggests: '*[a]fter the course, there should be a comprehensive exam*' (CHD 1).

A young male CHD proposes that the medical schools should include a hospital management programme in the curriculum for medical students and let them have experience in management when they have their internship. Many of them become CHDs in rural and remote areas as soon as they graduate. He says:

In addition, besides adding a hospital management programme to the [Basic doctor] curriculum, when they [medical students] come for their internship, I'd like them to see what the dimensions and direction of future management should be. (CHD 8)

A senior male CHD suggests that incentives are needed to retain professional CHDs in rural areas. He points out that CHDs should receive more appropriate and reasonable financial incentives:

First, it would be the salary; the CHD should be paid well enough. (CHD 5)

The CHDs suggest that there should be a formal structure with mentors or advisors available for new CHDs. A senior male CHD argues:

We should also provide mentors or advisors to the new CHD; they could be former CHDs who act as positive role models for the new CHD. When the new CHD has problems, they need to consult with other senior CHDs regarding possible solutions. (CHD 5)

In addition, the CHDs suggest that CHDs should be able to access professional development through continuing education for health or hospital management, in order to retain CHDs in the rural areas. A senior male CHD contends:

Besides the incentives and being appreciated by management, the third factor is professional development; continuing development of their knowledge is necessary for doctors [CHDs] ... they should be provided with ... [continuing] education about management. They should not be left behind, because there is no one to evaluate their performance. (CHD 4)

Another senior male proposes that CHDs should attend seminars on hospital management regularly, to update their management knowledge to meet any changes:

They [CHD] should attend seminars on [hospital] management regularly to catch up with new management strategies, since the world and society is continuously changing. (CHD 3)

A senior female CHD agrees with him and suggests: '[w]e have to prepare them [CHDs] well and to let them experience various management models' (CHD 6). In addition, she proposes that continuing management education could be conducted as a study tour:

For instance, let them go on a study tour to other places, so that their horizons may be broadened. If they see a [management] model which suits them, they can pick it up and apply it for their further development as a CHD. (CHD 6)

Besides continuing education in management, the CHDs suggest that they should be provided continuing education in medical matters, because they have to continue their medical practice and keep up-to-date. Two senior male CHDs argue:

Aside from the management knowledge, the CHD-to-be should have continuing medical education. (CHD 5)

The CHDs must be provided with the up-to-date medical knowledge. If the CHD-to-be is a doctor, he should be provided with both medical knowledge and management knowledge [continuing education]. (CHD 4)

The CHDs suggest that the MoPH should have a more rigorous performance evaluation for CHDs which needs to be based on people's health status or the output of the CHDs' work, rather than following the processes of government administration. In addition, they suggest that the CHD's term of office should be fixed, rather than permanent. A senior male CHD offers his suggestion:

There should be regular Staff Performance Assessments as well as that of management. There should be a fixed period of employment. It would not be like today where you can be a CHD until your retirement. (CHD 3)

The PCMO evaluates the general performance of the CHD; for example, if there are no big problems, the CHD continues working. He does not evaluate the effectiveness of your performance; for example, he does not evaluate whether or not people are healthier. In other words, as long as you understand how the government administrative management system works, and there are no complaints of corruption filed against you, you can keep your position as long as you want. (CHD 3)

In this sub-theme, the informants contribute to the concepts of recruitment, training, and retention of the CHD, so that Community Hospital Directorships can be developed professionally. The CHDs believe that a professional CHD should have a specific qualification in health management. There should be a specific requirement, such as a standard and formal process from the MoPH for the recruitment and selection of CHDs.

In summary, the CHDs require clarity for the role and its responsibilities through a single authority in managing the district health services system. Despite their comments about the medical model, they suggest that the chair of such an authority must be a doctor. The ability to collaborate with staff and stakeholders is revealed as an important characteristic of future CHDs. The required skills and knowledge to achieve the role of PHC facilitator are also presented. The crucial knowledge is that of management and PHC. Teamwork, communication, leadership and financial management skills are necessary. Developing management competency, through flexible learning, medical education reform, and professional development, is explored.

4.6 Conclusion

Two significant findings emerge from the data analysis. First, the role of the CHD as the CUP (district health services) manager in implementing rural health care reform (UHC policy) is ambiguous and lacks support. The second finding shows several major barriers impede the effectiveness of the district health services manager's role; these barriers are: i) the structural interests in the Thai health care system; ii) the misinterpretation of PHC as PMC; iii) the Thai bureaucratic management style; and iv) the differences in the sub-professional cultures between CHs and HCs. As a result, the CHDs perform their role according to their medical background and have a medical approach to implementing the UHC policy in relation to PHC. The next chapter provides the discussion of the findings of this study and the implications to rural health care reform.

CHAPTER FIVE

DISCUSSION, CONCLUSIONS AND IMPLICATIONS

5.1 Introduction

In the previous chapter, the views and experiences of the Community Hospital Directors (CHDs), who participated in this study of the implementation of the Universal Health Coverage (UHC) policy in relation to Primary Health Care (PHC), were explored using thematic analysis. In this chapter, the conclusions from this study are discussed. The implications for policy and practice, and recommendations for further research are also presented. These are directly related to the purpose and aims of the study: to understand the role of CHDs in implementing the UHC policy in relation to PHC; to explore the barriers in implementing health care reform at district level; and to propose strategies for CHDs to be able to facilitate sustainable primary health services administered from a Community Hospital (CH).

There are two major conclusions. The first is there are many barriers at both the policy and operational levels which prevent CHDs exercising their role as district health service managers. The goals of the UHC policy in relation to PHC are not, therefore, achieved effectively. This is reflected in the medical approach to the implementation of this health care reform and the lack of systemic support for the CHDs' management role.

The second relates to the finding that the CHDs in this study have dual roles, clinician and manager, in implementing these health policies. Their medical background dominates the integration of these roles. Their managerial role is not effective, because they were unprepared for, and unsupported in making, the transition from clinician to manager, and from hospital manager to the broader role of manager at the district health services level. In addition, the unique elements of the Thai bureaucratic system inhibit their expanded role as district health services managers.

The implications for policy and practice relate to the recommendations CHDs need to facilitate sustainable primary health services administered from their CHs. First, the roles

and responsibilities of CHDs, as district health services managers, and other stakeholders who take part in district health services management should be clearly determined. Second, the structure of the District Health Board in which the local governments should be included as members is proposed. Third, CHDs need a collaborative management role as a facilitator for PHC in their districts. The required skills and knowledge for such a role are discussed. Last, the possible ways to support the professional management role for CHDs to sustain PHC services for the rural poor are presented. The first and second recommendations require support from the Central Government and the Provincial Governor, while the third can be only initiated by the CHDs if there is support for PHC and management development.

Prior to this detailed appraisal, it is important to note some additional general points regarding the development of policies, their implementation and the potential environments of the policy and health care systems in Thailand. The various cultural strands of those involved, relating to fundamental social mores (those which are often unconscious yet have a powerful effect on practice) and those specific to particular institutions (the medical profession and bureaucrats), were not considered sufficiently by the policy makers when the policy was proposed and implemented. Such strands help shape and focus the scope of the individuals' interpretation of health reform policies.

5.2 Discussion of major conclusions

The case study design used in this study has assisted the exploration of the role of the CHDs in implementing the UHC policy in relation to PHC, barriers to that implementation, and strategies to assist CHDs in facilitating the PHC services holistically at district level. Furthermore, by using thematic analysis to analyse the data, four themes have emerged that reveal the implementation of the district health care reform as ineffective, and how the CHDs' medical approach and other barriers at the policy and operational level limit the effectiveness of CHDs as managers. The strategies offered by the CHDs for sustaining PHC services at district level are also identified.

5.2.1 The barriers to the implementation of the Universal Health

Coverage policy in relation to Primary Health Care

The first conclusion from this study is that there are barriers at the policy and operational levels, which inhibit the role of CHDs as district health services managers and thus, the effective implementation of the UHC policy in relation to PHC. This conclusion addresses the second study aim, to understand the role of CHDs in implementing the UHC policy in relation to PHC. The findings show that, in implementing the UHC policy in relation to PHC, the CHDs face three specific problems/challenges: i) increased demand for curative services; ii) the shortage in the health workforce; and, iii) the disparity between authority and responsibility. The causes of these problems/challenges are many complex barriers. It is beyond the scope of this study to explore how these barriers interact or which barrier has the greatest effect in inhibiting the role of CHDs in implementing this health care reform. This study identified four barriers: i) structural interests; ii) understanding PHC as PMC; iii) organisational cultural contexts; and iv) differences in professional sub-cultures. Each barrier, in relation to the three problems/challenges in implementing the UHC policy in relation to PHC, is described below.

5.2.1.1 Structural interests

The data from this study suggest that rural health care reform, regarding the health needs of the rural poor, is not addressed seriously. Alford's (1975) theory of structural interest is invaluable in helping to understand why health care reform is fatigued and why many reform strategies have not achieved their full impact and why some have simply failed (Hunter 2004). The barriers to this reform can be viewed as the outcome of conflict between the political bureaucratic interests or corporate rationalists, medical monopolists, and community interests (Alford 1975). As previously discussed in Section 2.10.2, these structural interest groups are also classified as being challenging, dominant, and repressed (Alford 1975:14). All of these factors are compounded by the unique features of Thai culture, especially respect for status and hierarchy.

The change in the political environment when the Thaksin Government won the election in 2001 led to the launch of the UHC policy (Jongudomsook 2004). The intention of this policy is to increase the power of the corporate rationalists, in this case, the government

itself, health bureaucrats, and Hospital Directors, to manage resources more efficiently (Hughes & Leethongdee 2007; Jongudomsook 2005). The power from the tertiary-care-based hospitals in the big cities shifted to the secondary-care-based hospitals in rural areas; the historical funding distribution formula changing to a per capita basis and hospitals assigned to be Contracting Units for Primary Care (CUPs) (Hughes & Leethongdee 2007). The CUPs are intended to network with municipalities in the cities, and the District Health Offices (DHOs) and Health Centres (HCs) in rural areas, to enable the rural poor to access primary health care and integrated care through an effective referral system (Nakhorn Ratchasima Provincial Health Office 2006a, 2007). This policy aims to shift resources indirectly from higher care levels to lower ones, especially at the primary care level, to achieve efficiency and cost-effectiveness (Health Care Reform Project Office 2001; Jongudomsook 2005). In other words, it aims to solve the existing inequitable distribution of resources in the health care system, particularly for the rural community hospitals, which serve more underprivileged people, but are disadvantaged through lack of resources (Bureau of Policy and Strategy 2007).

However, this study shows that this well-meant intention has not been effective, because of political instability and lack of political commitment by the government. As a result, both the health policy and its direction are unstable and there is no long-term health plan. Health policies are also not integrated. For example, the Health Decentralisation policy which follows the *Decentralisation Act B. E. 2545 (2002)* is not integrated with the UHC policy. Moreover, other related policies, such as human resources production and development, funding distribution at the local level, health services provision, and performance assessment are fragmented.

The lack of integrated health programmes is perceived as these programmes having a different aim to the UHC and PHC policies. Thailand adopted the PHC concept and the WHO goal of 'Health for All by the Year 2000' incorporating these into the *4th National Social and Economic Development Plan (1977–1981)*, after the declaration of the concept of PHC at Alma Ata in 1978 (Bureau of Policy and Strategy 2007). Some Ministry of Public Health (MoPH) health programmes, such as the PHC programme at the village level and the 'Healthy Thailand' project launched in 2005, are related to PHC (Bureau of Policy and Strategy 2005). These MoPH programmes emphasise health promotion and disease prevention and aim to achieve the Millennium Development Goals (MDG)

(Bureau of Policy and Strategy 2007). In the Nakhorn Ratchasima province, the ‘Sustainable Health for All’ programme aims to cover the basic health needs of the people (Nakhorn Ratchasima Provincial Health Office 2006a). These programmes and projects, implemented since Alma Ata, have not been fully integrated with the UHC programme. The informants in this study feel that these health programmes increase the workload of front-line health workers by duplicating reports and indicators, rather than reinforcing quality health care. This illustrates the complex consequences of the hierarchical Thai bureaucracy and the lack of cohesion among the various ministries regarding primary health care. The bureaucratic system tends to override the delivery of services. LaFond’s (1995) study shows that the failure to reform the health system and sustain primary health care for the poor in less developed countries occurs, because the bureaucrats serve the requirements of the donor countries/agencies, rather than the real health needs of the population. She points out that the failure is caused by ‘the weakness of hierarchical systems ... that investment decisions emanate from the centre’ (LaFond 1995:107).

The lack of strategic planning results from the frequent changes in health policy reflecting the changes in the appointees to Minister of Public Health. This lack of a long-term health plan prevents the sustainability of PHC provision at the local level, because it leads to ineffective health workforce planning. As a result, there is a severe and chronic shortage of staff at the primary health care level. Pachanee and Wibulpolprasert (2006:312) argue that the shortage of health professionals may result from the competing demands from the dual track policy of the Thaksin Government. The UHC policy emphasises providing health care for all, especially the rural poor, while the Government at the same time has promoted a policy on trading in health services, serving the rich and foreigners. These two policies have increased demand for health services and thus a shift of health professionals from rural to urban areas. Again, this shows a lack of strategic planning to integrate other health policies with the UHC policy.

All CHDs perceive that the UHC policy as arising from political decisions which advantage the politicians. Since there was no appropriate preparation for the implementation of this policy, the health staff cannot work effectively. In addition, the community has not been informed about their responsibility in the implementation of the policy. Rather, the community are only told they have the right to access health services as they want. This creates demand for curative services and the real health needs of the

community cannot be met effectively. The politicians make pledges or promises about UHC, but do not prepare the necessary support structures to implement the UHC policy. As an example, the politicians announced an increase of per capita funding to improve the quality of health services, but the funding for patient care at the CHs decreased.

The lack of integration of health policies results from political instability. It is doubly difficult that the goal of health care reform requires a radical reform at a time when Thailand has political uncertainty (Hughes & Leethongdee 2007). A lack of political commitment can also be seen through the disparity between the authority and responsibility of the CHDs and the stakeholders engaged in the provision of PHC services at district and sub-district levels. The present organisational structure and the confusion of the Health Decentralisation policy play a vital role in making this mismatch more complex. As a result, the CHDs feel uncomfortable working in a network under such unclear conditions and with different organisations which they cannot control. They cannot exercise their role as district health services manager effectively and their 'medical' mindset means they feel the need to control everything in the role. The report of the Working Group on Quality of Life and Health Development (2004) reveals some CHDs had a negative attitude towards the health centre staff as not providing quality medical services. This results in a conflict between medical teams from the community hospitals, including CHDs, who go to see patients at health centres, and health centre staff. The conflict is due to a lack of clarity in the roles and responsibilities of the two groups (Working Group on Quality of Life and Health Development 2004). Thus, an effective district health team is problematic.

The first mismatch of authority and responsibility is at the district health team level. With the CH acting as a CUP responsible for per capita funding, the CHDs have to establish a prototype Primary Care Unit (PCU) in their sub-districts, at the same time needing to collaborate with Chiefs of District Health Office (CDHOs) to improve the quality of health care provision at all HCs located at sub-district level. Before the UHC policy, all local stakeholders collaborated informally through the 'District Health Collaborating Committee' (DHCC). Under the UHC policy, the 'CUP Board' structure is intended to promote collaboration; however, the 'CUP Board' is essentially the same structure as the 'DHCC'. In the research province, the 'DHCC' has been renamed the 'District Health Administration Committee' (DHAC), in the Provincial Chief Medical Officer's (PCMO)

strategy to promote the sense of a united district health team for the three health organisations, CH, DHO, and HCs, at district and sub-district levels. There is a slogan for this project: ‘Two Becomes One’, described in Section 2.11. It refers to having health organisations from two distinct functional lines working together as one united team.

Most CHDs feel this strategy is not effective and does not solve any problems; another case of a new initiative being launched without any real understanding of existing problems. This study confirms Alford’s (1975) assumption that corporate rationalisers attempt to serve their own interests by creating new organisational structures such as the CUP Board or DHAC. This may make an impression that some new structure is created, but the crisis in the district health team still remains. The findings of this study show that the CHDs want the government to create a new structure for them which will be a single authority to manage district health services. However, only one CHD in this study feels happy about this structure as he was appointed to be ‘Chief Executive Officer’ (CEO) of his district. His case, a pilot project in the province and different from the other districts, is exceptional. It is worth noting that, crucially, his role and responsibilities are clearer than those of the other CHDs.

Before the launch of the UHC policy, the DHO was responsible for disease prevention and health promotion through the HCs at sub-district level and the CH was responsible only for medical services for the whole district and the community in which the hospital is located. Health Centres, though responsible for health promotion and disease prevention, provided simple curative care and were loosely connected with the CH through the referral of patients with complicated conditions. WHO (1990:30) names this management model as an ‘authoritarian model’. The advantage is that it provides good possibilities for the management of a district as an integrated system; the drawback is that in reality it does not work (WHO 1990). However, the UHC policy has led the CHs, as CUPs, to be responsible for comprehensive care — curative care, health promotion, disease prevention, and rehabilitative care — for the whole district including sub-district areas. This forces the CH to work more collaboratively and closely with the DHO and HCs. This is another mismatch, because the CHs focus on curative care, not health promotion and disease prevention, but they still have to oversee such health activities. Different skills are needed to engage the community in health promotion and disease prevention. The DHOs and HCs have these skills and the necessary experience but their

abilities are overlooked by most of the CHDs, as they try to comply with the expectations of improved medical services through the programme. This shows that the CHDs cause DHO and HC staff '[to] become repressed interests' (North & Peckham 2001:437). This mismatch also reinforces the 'primary medical care' model in implementing the UHC policy. Phillips (1990:161) argues that 'primary medical care' is disease-oriented. It is a narrow techno-centric approach that does not address the social causes of disease (Cueto 2004). Therefore, the social health needs of the population cannot be met. The UHC policy which emphasises more health promotion may not be achieved. Thus, the problems of the implementation of PHC at the present time are still similar to the problems of the implementation of PHC before the implementation of the UHC policy, as discussed in Section 2.6.2.

The second level of disparity in authority and responsibility for PHC services provision and administration exists between the CH and the municipality and local governments at sub-district level. As a CUP, a CH is expected to oversee all health services. However, at district level, the municipality is responsible for some health services. For instance, each municipality owns a HC which is located in the same sub-district area as the hospital. The municipal HC and the community hospital PCU both provide PHC services to the sub-district population. The coordination between the municipal HC and CH is very informal.

The three levels of local government, provincial (PAO), district (municipality) and sub-district (TAO or DLA), are loosely connected to each other and this loose connection stultifies cooperation. The CH is involved with local governments at two levels — municipality and TAOs. These local government bodies have a partial responsibility for health and education, since the Central Government has not devolved absolute authority and responsibility, as well as funding, for those activities. They are responsible for infrastructure, such as road construction, clean water, garbage collection, and social and cultural development. Only municipalities own HCs. The TAOs use the health services at the HCs of the DHOs. It is worth noting that these local governments do not have a role in health planning and evaluation of health services at the district level. This role still belongs to the Provincial Health Office.

The *Decentralisation Act*, enacted by the previous government (Chuan Government), aimed to devolve all bureaucratic services to the communities through local governments.

However, the Thaksin Government interpreted this decentralisation as empowering the Provincial Governor to have absolute power at provincial level. It was envisaged that, once the Provincial Governor had more power, he would be able to integrate all public services in his province to provide an efficient service to the community. The Provincial Governor was named 'Provincial CEO'. Because of the decentralisation of some health services to local governments, it is not clear who is responsible for what.

According to the *Decentralisation Act*, funding for some community health activities is provided to the municipalities and local governments at the sub-district level through either the MoPH or other ministries. For example, the funding for 'milk for school children' and some disease control activities is provided to local governments through the MoPH. Initially, this funding was provided to the DHO. Other funding for the elderly, for the disabled and HIV-infected people is provided through the Ministry of Human Security and Social Development [MoHSSD]. The municipality is responsible for providing this funding to the community in its area and the local governments at sub-district level are responsible for providing the same funding to the communities in their areas. The integration of these health activities lacks cohesion. Beyer (1998) reports the failure of the implementation of the district health system reform in the Republic of Benin was due to a lack of analysis of the 'actors' and contexts of the implementation of the reform.

In the 'milk for school children' programme, the sole role of the CH is to monitor for any malnourished school-aged children and inform the relevant schools. The municipality distributes the 'milk' to the school children. The CH staff feel the municipality distributes the milk inequitably to children in the area where the Hospital PCU is responsible, compared to children in the municipal HC area. Furthermore, milk is distributed to all children, regardless of need, because the municipality seeks favour with their voters.

Another example of the lack of integration involves funding for the elderly and disabled as well as the HIV-infected in the community. The CH provides health services to treat or relieve the illnesses of these people and also issues certificates to the disabled or HIV-infected to present to the local governments to obtain financial assistance. However, this process is loosely integrated. Receipt of funding does not depend on who is the most needy. According to Werner et al. (1997), such a practice does not comply to the equity principle of the PHC. Furthermore, the information at the CH and HCs is not linked with

how these people are to receive financial assistance and not all the needy can obtain support each year, because funding depends on an allocation from the Central Government to each local government.

There is a lack of effective communication between the CH, as a CUP, and the local government bodies. Funding and all activities relating to health of the community are not integrated. The responsibility for integrating health activities at the local level rests with either the health workers or Village Health Volunteers (VHVs) through their personal contact with each local government that provides funding to them. The health care at the local level is fragmented and the goal of PHC – sustainable and equitable access to health services for the community – will not be readily achieved. This, again, highlights the influence of Thai cultural elements embedded in bureaucratic practices and relationships between individuals and between individuals and institutions.

All CHDs in the study experience difficulty in collaborating with local governments. It seems there is no communication from the Central Government to clarify the roles and responsibilities of the CH and local governments, particularly in terms of health promotion. The CHDs believe the local governments are not knowledgeable enough or interested in community health. In addition, they think that local governments do not recognise the CH as having a role in health promotion for the district. They perceive that the confusion arising from the Health Decentralisation policy makes this situation worse. Ermacora (2004) contends that health services should reflect the needs of the population as experienced by the community, rather than by professionals or bureaucratic agencies and that the community can make rational decisions regarding health services. Phillips (1990) argues that health managers should adjust their attitudes and approaches towards the community development approach, as described by Rifkin (1985), which has its origin in the community development tradition. This community development approach sees health in the broader context of improving living conditions and the environment and is recognised as having a ‘bottom-up’ orientation. In Phillips’ (1990) view, the community development approach is underpinned by the holistic concept of PHC described by WHO (1978).

The data analysis reveals that political instability and the lack of political commitment, as well as the lack of a strategic national health plan, have resulted in conflict between two

public agencies — the MoPH and the National Health Security Office (NHSO). The data indicate this conflict is seen as a barrier to the implementation of the UHC policy and the sustainability of PHC provision. It prevents effective communication between the policy level and the operational levels. In addition, it is seen to contradict the aim of the UHC policy regarding equity of resource distribution. The NHSO provides funding on a per capita basis, but the MoPH adjusts this formula and centralises this funding. Before the MoPH provides this funding to hospitals or ‘CUPS’, it allocates salaries from this per capita funding to core staff at each hospital. Hospitals with more staff, but serving a smaller population, are advantaged and do not allocate staff to hospitals serving larger populations. This manipulation of the funding for the UHC programme by the MoPH is seen as resistance to health care reform. Hughes and Leethongdee (2007:1006) point out that the resistance is from the ‘old-style physician-administrators who control the MoPH and hospitals’ and there is a ‘cultural resistance’ of the systems to the concept of purchasing health care. They report that these medical doctors used their power to mobilise support and influence the decisions of the senior bureaucrats at the MoPH to change the way the NHSO funded health services. This is relevant to what Alford (1975:14) discusses about the dominant structural interests, medical monopolists, that they are ‘those served by the structure of social, economic, and political institutions as they exist at any given time’. He points out these interest groups do not need to act or organise to defend their interests; rather, the other institutions, in this case the administrators who are also physicians, will act or organise to defend these interests for them.

By using Alford’s (1975) typologies of health care reform as a theoretical framework in analysing the data, the findings from this study show that the conflict between the NHSO and the MoPH is believed to arise from their different approaches to health care reform. The NHSO employs a ‘market approach’, while the MoPH employs a ‘bureaucratic approach’, according to Alford (1975). The NHSO introduced the UHC policy, which employs a new bureaucratic management philosophy and emphasises efficiency, as a market-oriented approach to management, defined by Alford (1975) as a ‘market model’ of health care reform.

A national bureaucratic officer responsible for the UHC policy believes the strength of the UHC policy is that it preserves health insurance coverage equity for all citizens.

However, LaFond (1995) and Meads (2006) argue that health care reform which depends solely on the market will fail, especially in a society which has an unequal distribution of power, as does Thailand. They point out underserved people may be disadvantaged (LaFond 1995; Meads 2006). Organisations in such a society are not sufficiently autonomous to create integrated services to serve poor people who have less voice in the society, but who are really in need (Alford 1975). This study shows the critical health needs of the rural poor are not being effectively met and clearly confirms the views of Alford (1975) and Lafond (1995) and establishes the uniqueness of the Thai situation. Policies are formed at sites far removed from those most in need of a reformed approach to PHC.

One informant criticises the MoPH, because it did not devolve its role as the health provider to other government ministries, levels or organisations, including the private sector, and that it did not effectively carry out its major responsibility as the health policy maker and monitor. The MoPH protects its own interests, rather than being concerned for ordinary people. This criticism is relevant to what Alford (1975) discovered in his thesis, that powerful interest groups are central in the resistance to health care reform. This issue is also described previously.

However, another national bureaucratic officer, who works for the MoPH, takes the view that improvements in health are achieved efficiently because of the present bureaucratic structure and central planning. Many informants, particularly CHDs, propose the restructuring of the MoPH and the creation of a new structure for public health services management; they feel this would resolve the conflict between the MoPH and NHSO. However, one executive of the MoPH views this as unnecessary. Globerman et al. (2006) point out the restructuring of health care organisations may not be a final answer to meeting the health needs of people. However, Alford (1975) argues that health care reform which depends solely on bureaucratic interventions will fail. This is because 'they do not account for the way in which this type of reform stresses certain core functions in the health system and regards other functions as secondary' (Evans, Han & Madison 2006:11).

The data indicate the MoPH and NHSO lack coordination because of their different organisational philosophies. The CHDs, therefore, have difficulty in implementing the

policy, because they cannot develop a long-term plan for their service development. The data also show a lack of effective communication between the MoPH and CHDs. This is seen as a part of the overcentralisation of the MoPH and its top-down management style limiting the ability of CHDs to show initiative in implementing health care reform. The same issue is presented in-depth in the discussion on organisational culture.

Alford's (1975) theory is invaluable for this study in identifying the influential interest groups whose power is either visible or invisible but who can resist health care reform. It assists in exploring sub-groups of medical monopolisers and those of corporate rationalisers. North and Peckham (2001:426) argue the medical monopolisers always claim that 'they represent the community's interests'. Besides the government, the senior members of the MoPH and the NHSO are seen as barriers to the implementation of the UHC policy in relation to PHC. The other bureaucrats, the PCMO and the CDHO, are also perceived as barriers, being considered as another group of interests preventing the restructuring of the health system, because they want to protect their status. There are many interest groups that may prevent restructuring and integration of the health system, so that the sustainability of PHC service provision may become problematic. These interest groups include the: CDHO, Hospital Director, PCMO, Permanent Secretary of the MoPH, Minister, as well as Chief of District. The CHDs perceive all of these interest groups to be focused on protecting themselves. For example, the CHDs believe that the Chief of District uses health workers, VHV's and the CDHO to carry out work not directly related to the health care needs of the community, but which furthers his own interests. Another person with special interests is the Provincial Hospital Director, who can influence the allocation of doctors within the province, so affecting PHC services provision. New medical graduates may be retained at the Provincial Hospital to accommodate training programmes, rather than being sent to CHs.

Local government bodies are another interest group obstructing the CHDs implementing the UHC policy and PHC. They protect their interests by keeping in favour with their voters, but not necessarily with regard to people's health. Local governments are not ready for the responsibility of community health, because they are more concerned with building infrastructure, which is more attractive to voters. The CHDs themselves can be viewed as yet another barrier through their clinical interest and their focus on the well-being of their hospitals, so that resources are not moved to the primary care sector. As a

result, the health services system is still fragmented and the real health needs of needy people are still not met.

The role of CHDs in this study in managing primary care services is similar to that of GPs in managing Primary Care Groups/Trusts in the UK, as a hybrid of medical monopoliser and corporate rationaliser (North & Peckham 2001). North and Peckham (2001:437) argue the concept of Primary Care Groups/Trusts requires medical doctors to be involved in primary care management. The Primary Care Groups/Trusts are:

the creation of corporate rationalizers at the centre, [and are] designed to incorporate professional monopolizers at local level who will be steered by health improvement and clinical governance programmes, constrained by budgets and nudged in the direction of greater plurality in decision making.

Unfortunately, this study highlights and re-focuses the findings of Alford (1975), that the powerful interest groups only serve their own interests and ‘resist change by creating and maintaining an impression, over many years, of a healthcare system in crisis’ (Evans, Han & Madison 2006:11). Alford’s (1975) study shows that the reform by the corporate rationalists did not challenge the power of the medical/professional monopolists, who legally and institutionally control the health system.

Other scholars report similarities to Alford’s (1975) argument that the dominant interest group are medical doctors and that the community rarely has a voice; Harrison (1999), North and Peckham (2001), and Addicott and Ferlie (2007) studied health care reform in the UK; Evans, Han and Madison (2006) studied health care reform in rural Australia. Cohen and Purcal (1989) studied primary health care reform in South-East Asian countries and found medical hegemony dominated the health system, resisting health care reform. Bureaucrats use the rhetoric of community participation to get the community to comply with their interests (Cohen and Purcal 1989). LaFond (1995) adds bureaucrats in less developed countries fail to reform the health system and sustain primary health care for the poor, because they serve their own interests, rather than the real health needs of the population. Beyer (1998) reports the failure of the implementation of the new district health system in the Republic of Benin was due to resistance from medical monopolisers.

Furthermore, the data suggest that new medical graduates and specialists working in hospitals ignore the UHC policy and PHC, that is, they do not support rural health care

reform. They emphasise curative care provision, with health promotion and disease prevention poorly understood. These data reflect the findings in the study of rural GPs in Australia by Evan, Han and Madison (2006:175). As with the rural GPs in Australia, some CHDs also only focus on curative care. This can be viewed to result from a lack of coordination between the health policy and the medical school. Medical schools do not appear to support the UHC policy and PHC, because they do not encourage their medical students to understand the change in the direction of the health care system. Medical schools are satisfied with the status quo (Alford 1975), which has a particular quality in Thai culture, and continue to produce more specialists who focus on curative care. The population health approach and new public health perspective, which is concerned with health and illness, interventions, and outcomes as they occur in population and seeks to understand the social systems influencing them (Berkman & Kawachi 2000), is of far less concern.

Even though the government has tried to solve the problem of the shortage of medical doctors by launching a programme to increase the numbers of rural doctors (Pachanee & Wibulpolprasert 2006), the programme is unfortunately not implemented in an integrated fashion. There are different constructions of the concept of health care reform (UHC policy) and the ways to increase rural doctor numbers. More doctors do not necessarily mean that there will be more doctors retained in rural areas. The training of medical graduates does not fit with the aim of the UHC policy and PHC, which requires Board Certified GPs or Family Physicians (FPs), who must understand the broader social determinants of health, rather than just its bio-medical aspects (Boonyapaisarncharoen & Pongsupap 2005). The programme to increase the number of rural doctors is focused narrowly on producing basic doctors. After graduation they have to work for six years in rural areas, usually their hometowns. However, during this period there is no effective retention strategy to keep them in those areas and turn their attention to becoming Board Certified GPs/FPs. The experiences of CHDs in this study show that most medical graduates leave their practices in rural areas to continue their specialist study in the cities or to practise in the private sector after they complete their scholarship obligations. As a result, the shortage of GPs/FPs in Thailand remains and there seems little chance of changing this situation (Thanapaisarnkit 2002).

The data also indicate the informants perceive the Medical Council of Thailand (MCoT), of which the majority of the board members are professors who form the medical elite, as another barrier. The Medical Council not only inhibits training of primary care doctors, but also prevents health workers, who are the front-line personnel serving the rural poor, from acquiring the status of health professionals. This study demonstrates there is no one challenging these medical monopolists and confirms Alford's (1975) theory and other studies (Addicott & Ferlie 2007; Beyer 1998; Evans, Han & Madison 2006; Harrison 1999; North & Peckham 2001; Smith & Goodwin 2006) that the interests of the medical monopolists may be served without the need to organise or act collectively to present demands or grievances. As previously discussed, these dominant groups are served by the 'social, economic and political institutions, as they exist at any particular point in time' (Evans, Han & Madison 2006:12). Addicott and Ferlie (2007:396) argue: 'the key feature of structuralism is that dominant groups may control agendas to promote or protect their dominance, even if not responding to a direct challenge – the powerful remain so without having to act'.

Furthermore, this study demonstrates that Thai medical knowledge is subject to a positivist and mechanistic ideology, in which the cause of disease is a scientifically observable phenomenon, such as a germ or specific causative agent (Willis 1989). This in turn supports the 'medical hegemony' of the medical elites (Evans, Han & Madison 2006:10). The positivist, scientific ideology of medicine has subsequently diverted attention away from the social and structural causes of disease to individual phenomena that medicine can produce a cure for (Navarro 1986). The findings of this study reflect that most of the CHDs in this study are pre-occupied with this ideology and that it dominates their clinical and managerial work.

This study also demonstrates the CHDs perceive patients and the community as unintelligent consumers who do not take responsibility for their own health. The community lacks the depth of knowledge required to determine how health services should be distributed to provide them with the greatest benefits and places value on acute medical and hospital services and the concern they have for being able to receive urgent and emergency care. Participation in health activities is carried out mainly through Village Health Volunteers and Family Health Leaders (FHLs) (another type of VHV). The aim of having this group of VHVs is to encourage all

villagers to be responsible for self-care. However, the approaches to this strategy are ‘medical and bureaucratic’. Community participation in this study is related to Cohen and Purcal’s report (1989:11) that community participation is operationalised in such a way it focuses on ‘compliance with government notions and plan of development accompanied by incorporation of villagers as “participants” in state-controlled institutions’.

In this study, one senior female VHV suggests that health workers are only interested in implementing health activities as ordered by higher bureaucrats. In her community the emphasis is on disease prevention programmes for communicable diseases. At the same time, there are many health needs in her community in relation to the broader social determinants of health, such as HIV-infected patients, alcoholism, mental disorders, early teenage pregnancy, and these health needs are not being addressed. This supports Alford’s (1975) theory in which there are structural explanations for the repression of community interests. Their interests will rarely be served unless ‘extraordinary political energies are mobilized’ (Alford 1975:14).

Moreover, the data indicate that the scope for decentralised decision-making at the CUP Board level is limited and there is no representative from the community to share in this decision-making. The interaction between the community and health professionals is limited to specific instrumental activities at the sub-district level, such as receiving a service from a health worker, participating in activities in relation to health promotion and disease prevention, or in proposing their needs at meetings regarding the community health plan at village level. However, whether their proposals are implemented or not depends on the CUP Board’s decision. Ife (1995) argues this form of relationship views the community less holistically and maintains the existing hierarchical structures and structural inequalities. As a result, the community is still repressed and powerless. Alford (1975) argues structural interests in health should ensure an effective power balance so community and users of health services have more power and influence on health services. In addition, Evans, Han and Madison (2006:186) point out:

Decentralised decision making will have far greater potential within the concept of community where people interact with each other in a variety of roles and as

whole people, where people are encouraged to contribute their full range of talents and abilities for the benefit of the entire community.

In the Thai context, this would require major shifts of power within the hierarchy (political, bureaucratic and social). Furthermore, community health needs are interpreted as concerning only an absence of disease or illness. As a result, the real health needs and sustainability of PHC may not be achieved. This issue is discussed in the next section.

5.2.1.2 Understanding of Primary Health Care as Primary Medical Care

The second barrier is the CHDs' understanding of PHC, within the context of the implementation of the UHC policy, as Primary Medical Care (PMC). The data indicate CHDs are confused about the definition of PHC. They understand PHC as only a level of care in isolation from the principles of PHC as described in the *Declaration of Alma Ata* (WHO 1978). They have a partial understanding of the attributes of PHC as defined by Starfield (1998), because they do not perceive the long-term relationship between health care provider and patient and family as an important domain. This results in a lack of coordination of care (Chan 2002). They also perceive that the UHC policy emphasises improving accessibility to Primary Care, by which they understand primary health services are to be delivered by health professionals, either in health facilities or in communities.

The data indicate the CHDs understanding of Primary Care is either confused with or different from that of PHC. The report of the Alberta Association of Registered Nurses (2003:1) shows that 'there is some confusion about the terms primary care and primary health care'. They explain that primary care refers to the first contact through which people enter into the health system and it is a core component of primary health care. Primary Health Care is broader and encompasses all the determinants of health (Alberta Association of Registered Nurses 2003; Keleher 2001; WHO 2003b). In addition, Starfield (1998:11), in her book *Primary Care: Balancing Health Needs, Services, and Technology*, states: 'the change required to convert conventional primary medical care in industrialized nations to broader primary health care as defined at Alma-Ata...' is essential. She also explains that the terminology of Primary Care in her book is to 'connote conventional primary medical care striving to achieve the goals of primary

health care' (Starfield 1998:11). WHO (1998) advocates a reorientation of health services to focus on population health in order to reduce health inequalities and achieve 'Health For All'. WHO (2003b) recommends all countries to revitalise PHC as described by WHO (1978) to achieve 'Health For All' in the 21st century.

However, this study demonstrates CHDs focus on medical services for individuals, rather than on population health. There is no single definition of population health (Friedman & Starfield 2003); Keleher and Murphy (2004) argue population health is involved with the health improvement of the whole population, or of a specific population sub-group in order to reduce health inequalities. Strategies to improve health outcomes for a population are different from those designed to improve individual health problems (Johnson & Paton 2007). In addition, CHDs perceive PHC focuses on self-care, which helps to ensure people look after themselves as individuals to remain free from common diseases. McMurray (2003:35) argues the actual goal of PHC is 'to build community capacity to achieve sustainable health and wellness'. Johnson and Paton (2007:33) add that one of the key goals of community participation is to reduce 'information asymmetry', where health professionals view health from their own perspective without being aware of the community's and patient's perspectives. Ermacora (2004) reports that providing access to service information for the community is one of the strategies to develop community capacity and also promote more effective health care.

In this study, the data indicate that the concept of 'community participation' is encouraged to facilitate people in taking more responsibility for their own health. The data also indicate that the community is in fact excluded from the decision-making process in the health systems and health services, even though some CHDs understand the definition of health is more broad and they should help empower the community to be able to participate in health delivery. They should, as well, establish intersectoral collaboration. The data indicate CHDs have a partial understanding of these issues and one that is not very practical. Furthermore, their approach to these issues is based on a 'medical mindset'. For example, they see health as 'the absence of disease, to be brought about by medical interventions based on modern science and technology' (Asthana 1994:190-191) and perceive the health needs of the people as an immediate demand for curative services. This is not a new realisation in itself, but it is expressed in a uniquely Thai manner. This constitutes an entirely fresh locus of complexity in both health

education and health services provision. According to Keleher and Murphy (2004), this approach is widely known as a medical or bio-medical approach. Rifkin (1985) and Labonte (1992) describe the medical approach as reductive and narrowly precise in focus.

However, the concept of health is much broader than the absence of disease or infirmity for individuals and communities (Bunton & Burrows 1995). There are many factors which influence health, stemming from the complexity of the social and environmental determinants of health. A determinant of health is a 'factor or characteristic that brings about a change in health, either for the better or for the worse' (Keleher & Murphy 2004:4). Population health is strongly influenced by the social and environmental determinants of health (Hawkes & Ruel 2006). They include income, employment, access to food and social capital, and exposure to agents in air, water and soil (Marmot 2005). Thailand presents a unique expression of this process. There is a series of mismatches between policy formation and implementation, between perceptions and constructions of the social and environmental determinants and a sense of fatalism limits actual practice.

Johnson and Paton (2007:22) argue health managers (in this case CHDs) should view health more broadly and seek different and more far-reaching solutions to health problems; they require a new approach such as the 'social model of health' in order to meet these complex health needs. Labonte (1992) explains that this model is underpinned by the concept of community development, more inductive than reductive, is much more holistic, and seeks explanatory relationships and ways of planning to address health problems. Moreover, Johnson and Paton (2007) advocate that a holistic understanding of the determinants of health will enable CHDs to reduce health inequities. The notion of a holistic grasp of social health issues is foreign to the particularity of the medical model which focuses on a doctor's autonomy regarding curative care. Such care takes no account of the broader contexts of the person's (patient's) life. It objectifies a certain set of symptoms with no consideration to a broader causal background.

The findings show that the health needs of community, which result from the interaction of the 'hierarchy of associated factors with behavioural, social, political and environmental bases' (Johnson & Paton 2007:27), are not being met. The health services in this study are focused on the individual and have a bio-medical approach. This is despite the CHDs having turned their focus to concentrate more on high-risk and chronic

non-communicable diseases, such as Diabetes Mellitus and Hypertension, by sending medical teams to provide medical care and to train health workers to improve the quality of medical care at HCs. As a result the health promotion campaigns in the community have a bio-medical and individual focus, rather a population approach (Baum 2002; Labonte 1992). Schmittiel et al. (2006:122) point out: 'chronic illness places a great burden on health care system resources and has a tremendous negative impact on population health'. Moreover, Rose (1992) argues treating diseases or high-risk individuals does not have much of an impact on health improvement of the population.

The data also denote that health inequities in the communities still exist. Therefore, CHDs should reorient their health services to 'change aspects of the social and environmental determinants of health that are promoting ill health, rather than continuing to focus on illness after it appears, or trying to get individuals to change their lifestyles and behaviours' (Johnson & Paton 2007:22). In addition, Schmittiel et al. (2006) report the organisations that have a PHC orientation may lead to better chronic care management.

Furthermore, this study shows the community is limited in its capacity to truly participate in all aspects of decision-making concerning health care, even though CHDs understand community participation is required to achieve the aim of the UHC policy and PHC. However, their approach to this issue is autocratic and medical in fashion. Community participation seems only to be a code for health officers to use the community as a means to allow them to deliver services in a top-down, vertical structure that is seen by health workers as more efficient (Asthana 1994; Cohen & Purcal 1989; Leerapun, Siwiroj & Termsirikulchai 2000). The data show the community and individual patients have very little input into service planning, development and evaluation. They are seen as passive and dependent recipients of health services (Gawston & Barbour 2003). This passivity and dependence reflects some core elements of Thai cultural values which helps to account for the difficulty in making effective structural changes in the health system. Passivity and dependence have various refractions throughout the system, from the top down.

The data also illustrate that the health needs of the population in this study are determined by data from patient satisfaction surveys, and CHs and HCs service records. Some CHDs organised meetings as a way to have feedback about the health needs of the people. The

emphasis is on hospital operation. Health needs, as such, are perceived as immediate demand for medical care. Johnson and Paton (2007:30) argue that such an approach originates in the 'consumerist approach' and is individualistic in focus. This approach is dominated by the need for improvement in efficiency, economy, and effectiveness of health services (Beresford 2002). Gawston and Barbour (2003) contend this approach focuses on data from individuals, rather than from the wider community, and can increase the unrealistic expectations of consumers, which are beyond the capacity of the health services, and has little impact on quality improvement because of difficulties in interpreting findings. In addition, Beresford (2002) argues this approach does not redistribute power or challenge dominant structural interests, because health professionals and authorities still control decision-making. For example, the PHC programme at village level is a health programme that aims to enable the community to participate in health provision, particularly self-care (Leerapun, Siwiroj & Termsirikulchai 2000). This programme is funded by the MoPH, the funding distributed, via the DHO, by the local governments. The community should use this funding for health promotion. Most health activities (through the Primary Health Care Centre Operated by Villagers (PHCCV) are about disease control (as required by the MoPH) and dominated by health workers, rather than resulting from the collective initiative of the communities (Ramasoota 1997). The real health needs of community are only partially met, if at all.

Johnson and Paton (2007:30-33) propose the 'democratic approach', which seeks to redistribute power from dominant structural interests to the repressed community, is central to the principle of PHC. This approach involves effecting change through collective and individual action. Atkinson et al. (2005) demonstrate this approach impacts on reconstructing the health system and better the health of the whole population. Greater and more real participation of the community is achieved by true democratic means (Sennun et al. 2006). Such an understanding of democracy has yet to be established in Thailand.

Gawston and Barbour (2003) propose the concept of partnerships between patients, families and health care providers. Johnson and Paton (2007:31) refer to this as a 'partnership' or 'patient-centred' approach and show that it is aligned with PHC. The aims of this model are to encourage sharing of information, responsibility, evaluation, and decision-making (Gawston & Barbour 2003). Johnson and Parton (2007:31) point out

there are two levels of partnership: 'individual relationships between practitioners and patients, and through the involvement of the community and consumers of health services in health service planning, development and evaluation'. They argue this approach fits in between ideologies of the 'democratic approach' and the 'consumerist approach'. In addition, they warn: 'if a singular ideological approach dominates the community and consumer participation strategy within a health service, there will be limited benefits for the community, consumers and the health service' (Johnson & Paton 2007:33). The current situation in Thailand, from these study findings, appears to be an example of this warning.

The data show the CHDs lack the ability to integrate health programmes at the district and sub-district levels in order to meet the needs of the rural poor. As a result, the fragmented health programmes at the local level creates duplication of tasks and limits the sustainability of PHC services provision. In addition, this fragmentation prevents communities from being self-sustaining and having the continuity of content by which to learn about sustainable self-improvement. In his study, van Oosterbos (2006) points out that what is needed is an approach to PHC which is integrated and more organised and coordinated. There must be agreement on 'who supplies which treatment or gives which care and where, as well as who communicates with whom and who is responsible for the coordination' (van Oosterbos 2006:1). The current Thai bureaucratic outlook militates against this.

Moreover, some of the CHDs understand that PHC is about intersectoral collaboration, which 'requires cooperation between different community sectors' (McMurray 2003:43). However, the data indicate their approach on this issue is autocratic and top-down in practice; they treat patients and community in a paternalistic fashion. Most of them have a superior attitude in their approach to local governments or other government agencies in the local areas and, as a result, intersectoral collaboration is not effective in any practical sense. This may result from the health services being seen to have sole responsibility for the public health care system with no links to other sectors and to focus on the individuals who present for care (Alberta Association of Registered Nurses 2003). However, Johnson and Paton (2007:36) argue: 'there is no place in modern health policy for such a compartmentalised view'. All health services, including hospitals, should be reoriented to

address population health and work together with other sectors and the communities in an integrated way to reduce health inequities (Johnson & Paton 2007).

It is worth noting that WHO (2005a) emphasises the importance of intersectoral collaboration with regard to an integrated health policy in the *Bangkok Charter for Health Promotion*. During the past twenty years WHO has tried to promote intersectoral co-ordination at community level, but there are many constraints, such as tension between selective PHC and capacity-building approaches, reluctance to decentralise authority to local levels and improve the balance of resources between curative and promotive and preventive care activities, and weak capacities in health services research (WHO 2000b). The report also suggests: ‘decentralisation of institutional responsibility and accountability in the health system coupled with capacity development at local services are most important factors for implementation of PHC’ (WHO 2000b:18). The very structure and process of the current Thai systems prevent such capacity development, because there is no real sense of institutional responsibility or clear desire for accountability. Traditional Thai concepts of hierarchy, deference and passivity augment the obstacles to such fundamental changes.

One CHD explains that PHC is about vertical and selective health programmes given to her by the authorities. For example, a health promotion programme from the MoPH is selective for chronic illness and concerns the monitoring of patients with Diabetes Mellitus (DM) problems. The concept of selective PHC is different from that of PHC described in the *Alma Ata Declaration* (Banerji 1984; Cueto 2004; Magnussen, Ehiri & Jolly 2004). Walsh and Warren (1979) argue for a ‘selective PHC’ strategy which focuses on cost-effective medical interventions through priority setting. They and their supporters contend that the form of comprehensive PHC described in the *Alma Ata Declaration* is costly and unrealistic, especially for developing countries (Cueto 2004; Magnussen, Ehiri & Jolly 2004).

Banerji (1984) asserts that, in practice, the results of selective PHC do not live up to expectations. Werner et al. (1997) add that many key concepts of PHC are stripped away by the selective PHC approach. The broader meaning of health in terms of social and economic development, intersectoral collaboration, and community participation disappear. They argue most interventions are determined by external health experts not by

communities. Banerji (1984:314-315) also argues selective PHC contradicts PHC philosophy, because it ‘adopts an authoritarian or paternalistic approach in “selecting” for others a number of limited vertical health programmes and leaves the other causes of ill-health untouched’. It is a narrow technocentric approach that does not address the social causes of disease (Cueto 2004). Magnussen, Ehiri and Jolly (2004) add that there is little coordination among those vertical programmes in a selective PHC approach, leading to duplication and waste in health services. LaFond (1995) studied the implementation of PHC in less developed countries and found the selective PHC approach led to an unsustainable provision of PHC services regarding the health needs of the rural poor in all of those countries. She argues that those countries cannot integrate existing vertical health programmes nor build the capacity of local health workers to serve both current and new challenges to meet the health needs of the rural poor (LaFond 1995). Her study reflects to the finding of this study, where the Thai health staff only concentrate on vertical programmes, and there is a lack of integration of available services from existing facilities. WHO (2003b) recommends that vertical health programmes should be integrated to horizontal capacity development and both of these approaches should be synergised to achieve the full impact of PHC.

In this study, the data indicate the health needs of the rural poor are not being met and the sustainability of PHC provision administered from the CHs is problematic. The researcher believes that a selective PHC approach is one of the key factors that prevent sustainability of PHC provision to the rural poor. Another key inhibitor is that CHDs have only a rigid and single approach to address health needs and implement rural health care reform and this approach is medical, authoritarian, and compartmentalised. An over-arching feature of the issues surrounding the concept of the ‘medical mindset’ is that it is not confined to the CHDs, but that is inherent in the whole bureaucratic fabric, from the MoPH to village health volunteers, that is, the bureaucratic and medical practices and the expectations of those receiving medical care. Scholars recommend that health managers should adjust their mindset to be relevant to the principle of PHC, which is comprehensive, so that they have the right understanding and right approach to the implementation of the PHC (Kekki 2006; Keleher 2001; Phillips 1990; Werner et al. 1997).

5.2.1.3 Organisational context

The third barrier is the organisational context. It is crucial for the strategic management and sustainability of PHC provision that cultural dimensions affecting the implementation of UHC policy and PHC are identified and understood (Carney 2006). All of the CHDs complain that working under the Thai bureaucratic system limits their capacity to successfully implement the UHC policy; they are uncomfortable with overcentralised regulations, red tape, too much hierarchy, and an almost complete lack of coordination between agencies. Dixon (2005) reports the failure of performance-based reform in Thailand because of the highly-centralised control of budgeting by the Bureau of Budget in relation to other public agencies, and this reflects the findings of this study. In addition, Gamage and Suksomchitra (2004) report this style of management has led to failure in the Thai education system. This factor also highlights the unique nature of the problems in Thailand. Effectiveness in this type of bureaucratic environment depends on the degree of benevolence shown by superior to inferior and not on a clearly delineated professional practice.

Samudavanija (1987) argues the Thai bureaucracy is hierarchically organised, and reflects the differentials in status and power, rather than a rational division of labour or chain of command. This situation is based on personal relations of patronage and dependency, in which deference and loyalty are more important than merit (Samudavanija 1987). The security of its members is the priority, rather than functional rationality (Painter 2005). In addition, Siffin (1966) points out the Thai bureaucracy is typified by corruption, factionalism, departmentalism and low responsibility for, and lack of courage in, decision-making. Bureaucrats aim to preserve the status and autonomy either of their cliques and departments or of themselves and their 'clients' (Siffin 1966).

This study illustrates that CHDs are tired of the patronage system and the lack of transparency and accountability within the Thai bureaucracy. In addition, they perceive that decision-making in the Thai bureaucratic system is political in its basis and centred on its own needs, rather than focusing on the real health requirements of the people. The data indicate CHDs are uncomfortable dealing with this situation, both from the perspectives of being agents and as well as victims of the system. This is also related to the negative attitude of CHDs towards politicians. The impact of this bureaucratic system

on the implementation of programmes is twofold: CHDs avoid confrontation by 'retreating' to their professional autonomy, and HC health workers and DHO staff deal with the power differential by deferring, waiting for orders to act (Bloor & Dawson 1994). These two responses bring key features of Thai cultural practice into the foreground in a dramatic fashion. Systems that are self-serving lead to a terminal form of crisis-stasis.

This finding is supported by Wasi's (2000:106) statement: 'many academicians shun politicians, thinking that they are bad people and do not wish to do anything with them'. At the same time, he argues the development of the health system requires political commitment and CHDs require the skills necessary to be effective in that environment. This is because politicians are powerful and have authority in resources' allocation and law promulgation (Wasi 2000). The data indicate CHDs avoid confrontation with politicians and decision-making which is politically based. This fits very well with Thai culture which avoids confrontation (Cooper & Cooper 1992; Holmes & Tangtongtavy 1995). Thai values shape and control the way CHDs and people think, approach problems, and make decisions (Thanasankit 2002). Hofstede (1991) suggests the management culture of Thais has a high degree of the following attributes: i) power distance; ii) collectivist culture; iii) uncertainty avoidances; and, iv) femininity.

Thai culture is one with high power distance. Thais accept wide differences in power in their organisations (Komin 1990) and subordinates are unlikely to approach and contradict their bosses directly (Thanasankit & Corbitt 2000). This channels the behaviour of CHDs and people to 'show unusually high deference towards those of senior status in all social relationships' (Hallinger & Kantamara 2000:192). This study demonstrates seniority and long clinical experience are valued attributes for becoming a CHD. These concepts also are applied to other stakeholders in this study.

According to Thanasankit (2002), high power distance results in a hierarchical organisational structure for most organisations across Thailand and the leaders of organisations are viewed as father figures. Due to paternalism and dependence, the flat management structure approach is not effective in and does not accelerate decision-making in Thai organisations (Rohitratana 1998), where decision-making commonly does not have a team approach (Thanasankit & Corbitt 2000), but is authoritarian (Holmes & Tangtongtavy 1995). In addition, the leader's role is perceived as that of a controller,

rather than a colleague (Thanasankit 2002). However, Holmes and Tangtongtavy (1995) contend the Thai authoritarian style is different from that of a dictatorial style, because it allows leaders to decide what they think is correct.

The authoritarian management style creates a 'superior-inferior' concept, which is already dominant in Thai culture (Rohitratana 1998:190). Hallinger and Kantamara (2000) explain this results in an acceptance that decision-making should be made by leaders who are in positions of authority and discourages subordinates 'to dare to make mistakes, or to take initiative' (Thanasankit & Corbitt 2000). Furthermore, Komin (1990) and Thanasankit (2002) demonstrate that power in Thai society is constructed by position, title and status related with position and rank, rather than by personality or education. These arguments are relevant to the findings of this study, because they denote that which makes the problems facing PHC in Thailand unique. The findings of this study reveal that the CHDs in this study had to wait for the decision from their higher authorities in solving the problems emerging at the local level.

Second, Thais have an intensely collective culture, which constructs and locates the context for change in group or social interests, rather than individual interests. They look primarily to their referent social groups in order to make sense of their role in change (Holmes & Tangtongtavy 1995). Thais are likely to express their views or opinions as a group, rather than as individuals (Thanasankit & Corbitt 2000). Decision-making, management and promotion are based on group performance (Hofstede 1991). Moreover, Thai culture values trust and relationships (Thanasankit & Corbitt 2000). Thanasankit and Corbitt (2000) argue personal relationships are stronger than work relationships and relationships between superiors and subordinates are considered to be as family relationships. The findings from this study address the latest issue by showing the perception of the CHDs that the promotion to a higher position of the staff at local level was based on personal relationships.

Third, the high level of avoidance, which results from uncertainty in how to respond to a given situation, can be demonstrated by the way 'Thais are strongly socialised to conform to group norms, traditions, rules and regulations' (Hallinger & Kantamara 2000:192). Thais base their relationships on trust and emotion. Last, the high level of feminine qualities lead Thais to place a high value on stability and harmony in social relationships

and avoid conflict as much as possible (Hallinger & Kantamara 2000; Thanasankit & Corbitt 2000). The data indicate CHDs and their stakeholders act according to these two values.

Moreover, Thanasankit (2002) argues that the four attributes of Thai values described by Hofstede (1991) are not sufficient enough to frame all aspects of culture that influence management. He explores four other Thai values as described in Section 2.10.3: i) *Pu Yai*; ii) *Kreng Jai*; iii) *Face Saving*; and, iv) *Bun Khun* (Thanasankit 2002:32-33). Thanasankit (2002) also points out that these four values induce the patronage system.

Chungsathiensup (2002) discusses the Thai public health management system as one which rests on patronage and the power ritual attached to that. This system is very open to corruption. It is beyond the scope of this study to explore these issues deeply. However, the data illustrate that the patronage system, which embraces these four values, prevents CHDs from effectively implementing the UHC policy and PHC.

The management of CHs is made more difficult by the centralisation of decision-making within the MoPH. The data illustrate the national health programmes ordered by the Ministry are not relevant to health needs at the local community level. This is similar to what Hasuwankij (2004) reports in his book, *Rural Health*. Supawong and Kadgarnglai (1998) explain that this is because health programmes generally are planned centrally and implemented at the community level, but with no real consultation with the communities where they are implemented. The data indicate the bureaucratic structure of the Thai health services is reflected in the management style characterised by an authoritarian approach, with little responsibility, independence and initiative. It is highly controlled by the MoPH, focused on bio-medical services for in-patients, and lacks flexibility regarding the disbursement of funding. Moreover, the authoritarian management style contradicts the principles of PHC regarding democracy and impedes true participation of stakeholders, particularly the community (Werner et al. 1997).

This management style is much more in line with Fayol's general principles of management, cited in Megginson, Mosley and Pietri (1992:54), which emphasise demand and control of employees, 'a scalar chain of command: organisations should have a chain of authority and communication that runs from the top to the bottom and should be

followed by managers and subordinates’, and a centralisation of authority and responsibility. Subordinates are expected to work to a plan without questions and accept and obey authoritative managers (Megginson, Mosley & Pietri 1992). Consequently, creativity and innovation are not valued. This limits the CHDs’ scope to show leadership through an innovative implementation of the UHC policy in relation to PHC. In addition, the data demonstrate that this management style limits the ability of other health staff, especially front-line services, to be innovative. This results in ineffective meetings of the CUP Board. Consequently, management of primary health services at the district level is limited to only doing what is laid down by the higher authorities at the provincial and national levels.

This study shows that the administration of the Thai health services is bureaucratic and centralised around the MoPH. Weber (1968) discusses the power and limitations of bureaucracy, characterised by: i) specialised jobs; ii) a rigorous set of rules; iii) clear authority-responsibility relationships; iv) an impersonal approach; v) a merit system for reward and employment; and, vi) lifelong employment. Petersen (1994) adds that within the control and hierarchy of bureaucracy the manager is superior and the employee is subordinate.

The drawback of this management approach is a rigid, inflexible and often inefficient organisation. However, one of the participants, who is a national health bureaucrat, perceives the strength of the health services bureaucracy allows health care delivery to continue throughout politically turbulent times. Nevertheless, the data indicate the rigidity of the health services does not accommodate the changing health needs of end-users and communities (Megginson, Mosley & Pietri 1992).

The UHC policy was one of the tools for the Thaksin Government in relation to public administration reforms. Primary care development is designed to achieve the ‘modernisation’ of the national health system (Meads, Iwami & Wild 2005:253). Modernisation is defined by Meads, Iwami and Wild (2005:257), as: ‘decentralisation, regulation, governance, partnership, and stewardship’. These form the framework of New Public Management (NPM) (Dunleavy & Hood 1994), although this conceptual structure is not the focus of this study. According to Painter (2005:7), the administrative reforms of the Thaksin Government used the ‘model of executive government’, which mimics the

NPM's language. However, Painter (2005:24) contends that NPM was used in a 'symbolic role' by the government. Much of the language of the reform programmes is 'managerialist' in tone. Painter (2005:3) argues this reform is 'best understood as a politicisation programme, rather than as a managerial one'. Furthermore, he points out the managerial reform of the Thaksin Government 'is being deployed in order to redistribute bureaucratic power to the political executive' (Painter 2005:4). Bowornwathana and Poocharoen (2005) criticise this reform, because it was not true decentralisation. Rather, it is a shift of power away from bureaucratic channels to a consolidation and centralisation of power of the political executives, especially that of the Prime Minister (Bowornwathana 2004; Painter 2005). This type of outcome reveals one of the problems specific to Thailand regarding policy development and its implementation. The particular nature of the Thai health politics leaves the system open to ever-increasing politicisation. The language used to promote change has, in fact, an inverse relationship to the realities of the political outcomes of policy change.

This study reflects Painter's (2005) arguments about bureaucrats, observed in the frustration CHDs and their colleagues feel at district level concerning the 'managerialism' imposed on them. The CHDs were not given any training to prepare for their managerial roles in the transition from working in a bureaucratic culture to a more managerial culture. The bureaucratic and managerialist become conflated in day-to-day practice. It is difficult to separate the emotional relationships between superiors and inferiors (a characteristic of Thai culture) and the rational relationships which the bureaucrats need to function efficiently (Samudavanija 1987). They feel, as a result, that they lack power in making decisions. The politicians' decision about the UHC policy was passed down through the senior officers of the MoPH and the NHSO, and does not meet local needs. Furthermore, the data indicate that there was little political commitment on the part of the government to reform the health care system. The change of language suggests that there is such commitment on the government's part, but the reality is quite opposite to this. This finding is similar to Pathmanand's report (2001:39), which shows that, despite the Thaksin Government offering a social programme which included 'cheap' health care as their election strategy, once in power, they concentrated on economic development with big capital, rather than establishing capacity development and democratisation. As a result, there is an unequal distribution of resources and all staff are confused and stressed, since they cannot adjust themselves to the change to the managerialist style of practice.

This reform does not fit with the Thai bureaucratic organisational culture and there is a lack of preparation, such as organisational and community development (Evans, Han & Madison 2006).

Bowornwathana (2004:248) argues reform requires ‘cultural change’ and a long-term, rational strategy. *Reform* according to Siklsana, Dlamini and Issakov (1997) (quoted in Mills & Ranson 2005:549) refers to: ‘a sustained process of fundamental change in policy and institutional arrangements, guided by government, designed to improve the functioning and performance of the health sector, and ultimately the health status of the population’. Furthermore, CHDs are subject to traditional Thai cultural values, assumptions, and norms when they implement the new ‘modern’ health reform policy. Rural health care reform will only be effective if the CHDs and their stakeholders understand in-depth how organisational culture and traditional cultural norms influence their strategic involvement and the implementation of organisational change in the Thai social system (Carney 2006; Hallinger & Kantamara 2000). The data continually re-iterate this need and the lack of ability or confidence of the CHDs and others to address these issues constructively.

5.2.1.4 The difference in professional sub-cultures

Besides the disparity between the authority and responsibilities of the CHDs and CDHOs impacting negatively on establishing teamwork between the CH and HCs, the data indicate the differences in professional sub-cultures between CHs and HCs has a similar negative impact on the implementation of the UHC policy and PHC. As previously mentioned, the community hospitals and primary care units are under the authority of the Ministry of Public Health, while the district health offices and health centres are under the authority of the Ministry of Interior. The complicating factor is staff at the district health offices and health centres believe themselves to be under the authority of the Ministry of Public Health. The CDHOs are in charge of staff at health centres. The CHDs, while in charge of CH staff, have no official authority over health workers and they perceive this as a lack of control. Before health reform policies can be introduced, the bureaucratic structures need systematic reform. Yet, without true political will to accomplish such change, the institutional stasis brought on by the convergence of Thai traditional values

and those of the bureaucracy will remain an obstacle to change in health care provision to the rural poor.

Moreover, the CHDs regard the organisational culture of their hospital staff as different from that of health workers; they have different working styles, experiences and educational backgrounds. They perceive this as a barrier to establishing effective teamwork between hospital and HC staff. As a result, the integration of health care and the effectiveness of PHC services provision are problematic. This situation gives rise to a sense of professional discomfort on the part of the CHDs, who, in turn, then feel they do not have adequate control over the quality of medical care at health centres. 'The primary cultural system [in Thailand] currently supports a medically dominated operating system which is integrated with general medical services provided at the [community hospitals]...' (Bloor & Dawson 1994:284). Bloor and Dawson (1994:284) also state:

A major part of the ideology of the medical authority is the need to maintain high standards of professional practice and, in particular, to make accurate professional assessments and diagnoses of patients' conditions before deciding what services to provide to meet their needs.

This highlights that the '... principle of professional dominance ...' (Freidson 1970:128) has a pervasive influence on the bureaucratic organisational structure and culture. At the same time, it is not just the actions of the medical staff in the hospitals that impose the concept of medical dominance on the health workers; rather, it is the attitude of those workers who ascribe pre-eminence to that concept. This approach by the health workers enhances the concept of medical dominance (Bloor & Dawson 1994).

The health workers have tried to develop their own professional body to maintain and develop their standards of practice and professional commitment, as well as improved salary scales. However, their efforts have been thwarted by the most dominant profession – medical doctors – through the Medical Council of Thailand. The Thai Nursing Council and other professional health organisations as well do not support a new professional body for health workers. Disease prevention and health promotion are not regarded as requiring specialised knowledge or training. Consequently, health workers are perceived to be subordinate in status to hospital staff, because they lack sufficient medical skills. Health workers are seen as being unable to prevent villagers bypassing health centres and instead going directly to the hospital, even when there is no real need to do so.

Another concern is about the difference in the perceived ‘value’ of health workers to that of hospital staff. Health Centre staff are able to engage effectively with the community, but this is compromised by the imposition of the ‘medical approach’, where they are forced to change their culture to reflect a ‘hospital culture’ or a ‘medical culture’. The WHO report (1992) on the *Functions of Hospitals at the First Referral Level* supports increasing the medical knowledge of HC staff. However, this action will be undermined if the increased knowledge is limited to the concept and practice of curative care, rather than including health promotion and disease prevention. This kind of perplexing nexus demonstrates the fundamental inadequacy of policy development and the implementation process. The narrow interpretation of PHC yields a nearly unworkable situation where that very interpretation undercuts and neuters the intent of PHC. The WHO’s (2000b) vision of professional cooperation across the health services system requires: ‘... other health workers [be given] greater responsibility, autonomy, and dignity in a truly collaborative relationship’ (Freidson 1970:232). A similar dynamic exists in the relationships between the staff who work in the community hospitals and those who work in those hospitals’ primary care units.

5.2.2 The role of Community Hospital Directors in implementing the Universal Health Coverage policy in relation to Primary Health Care

The first aim of this study was to explore the role of CHDs in implementing the UHC policy in relation to PHC in the context of the Thai rural public health care system. Both conclusions address this aim. The second major conclusion is that collectively the CHDs in this study found the duality of their role – clinician and manager – challenging. The findings indicate the informants felt distressed as a result of trying to be effective managers, while attempting to provide care for patients. Furthermore, their role as district health services manager is obstructed by many barriers. The CHDs describe having an expanding role in which they see themselves primarily as medical doctors, spending far less time on the managerial aspects of their job than on their clinical duties. Bruce and Hill (1994) point out doctor-managers tend to maintain their clinical load, because they want to ensure that they can secure the trust of their medical colleagues and keep their status as clinicians.

Many CHDs work as if they are ‘part-time’ clinicians and ‘part-time’ managers, and some view management as something they must do but for which they get very little reward, even though they are employed as full-time CHDs. They feel their time is valuable and they are obliged to contribute some of that valuable time to management, which at times feels like an imposition. This sense of being ‘part time’ prompts them to feel that they are inefficient and ineffective as CHDs. The conflict of clinical and managerial roles is unique in its particular expression but has occurred in other professions where practitioners have assumed a managerial role (Brown & McCartney 2000; McConnell 2002).

The CHDs perception of their role as clinicians, rather than managers stems from their formal training in the bio-medical sciences. They have less knowledge of health promotion and disease prevention and of broader social contexts and management. Because of this clinical mindset CHDs focus on the individual patient, rather than the primary health care of the wider community (Alexander et al. 2006; Thorne 1997). This shows the impact and interrelationship of Thai cultural (implicit) values on the complexity of the Thai bureaucracy.

There is a tension and a difference between the two roles, clinician and manager. When medical doctors become CHDs, they feel their work environment is changing and different from that of the clinician’s role. As CHDs, they have to depend on others while still being medical doctors. When a clinician gives orders to the other staff they follow them. Their professional autonomy and responsibility as the medical doctor is quite clearly understood (Leggat, Harris & Legge 2006). However, when a doctor becomes a manager, without any support in that role, they carry their mindset as a doctor into the complexity of management work. As a result, they feel uncomfortable and stressed and cannot carry out their work effectively. They feel frustrated and uncomfortable with their minimal management knowledge and skills and, as a result, lack confidence in their capacity to manage. The CHDs’ feelings of inadequacy in the role of manager hamper their ability to implement PHC effectively. Again, the key is the consequences of the intertwining of Thai cultural norms and bureaucratic practices.

The role of CHD is generally earned over time and gained by seniority of clinical experience, rather than through management training or having management

qualifications. Some CHDs believe they have sacrificed opportunities to train as specialists. Most CHDs enter the position either in an accidental or coincidental manner and tend to feel pressured by events to become a CHD. Few actually seek the position. The concept of the doctor as manager and not primarily a clinician is new in the Thai context. This study shows there is no clear formal expression of the CHD's role as manager; there is instead, what Hardy and Hardy (1988:197) and Willcocks (1994:69) describe as, 'role ambiguity'. The high regard for doctors compared with CHDs as managers makes the clinician role of the CHD more attractive. The CHDs' peers, subordinates, supervisors, and communities, as well as government agencies, such as medical schools, also do not have a clear view of the role of the CHD as manager. Not knowing what is expected of their managerial role can lead to ineffective CHDs and organisations (Willcocks 1994). The primacy of medical autonomy and the way in which it is construed in the Thai setting is a core aspect of the systemic uncertainty about PHC.

The CHDs lack support to be effective managers. Their job definition is not clear. Moreover, there is no formal management training to prepare them for their new responsibilities as CHDs. Even though some short courses are available after they have become CHDs, the majority of informants feel the programmes do not meet their practical management needs. Rather, they have learned management skills through personal daily experience. In addition, the CHDs have very few opportunities for continuing education, either in the medical or health management fields and as a result, they perceive they are failing to keep up-to-date with clinical skills and lack professional management skills. Unfortunately, a CHD's performance is not assessed formally, and there is no appropriate financial reward for being an effective CHD. Boucher (2001) discusses the above aspects of learning managerial skills. Once again, the unique elements of Thai social practice create a very distinctive context for these experiences and their outcomes.

The lack of systemic support to enable CHDs to be effective in their roles can be described in terms of the lack of: effective assessment of CHD performance, significant management training, and appropriate financial reward. CHDs can remain in their positions as long as they want, unless they are charged with corruption. They can remain in their positions even if they do not comply with the UHC policy (they tend to make judgements in line with their understanding of medical autonomy and the Thai cultural practice of avoidance), even if their work is ineffective, or even if the end results of their

work are different from the policy's aims. The CHDs report they are paid as general doctors, despite their extra responsibilities as CHDs, and feel the management aspect of their work is essentially a 'voluntary' contribution to the CHs. Doctors in CHs have greater promotion prospects than CHDs and the level of promotion can be higher. CHDs wishing to transfer to other hospitals may even need to accept a demotion to achieve transfer. CHD positions may be rotated at the provincial level only if two CHDs agree to the rotation. The rigidity of the Thai bureaucratic system obstructs the development of a career path for professional CHDs. Even though there now is a Hospital Accreditation (HA) standard to assess the performance of the CHs and the CHDs, there is no integration of these assessments. There are no rewards for effective CHDs, nor penalties for those who are ineffective. This means a CHD is more disadvantaged, from the perspectives of social status and financial reward, than had they remained practising as a doctor.

The CHDs in this study became CHDs with only a medical background and no preparation or support system for their new role as managers. They maintain a clinical mindset towards management and they feel their work is not effective. There is an urgent need for high quality, advanced, management education for these CHDs in general. Moreover, the CHDs are overloaded by clinical work and have insufficient time for their role as manager. As a result, the CHDs do not fulfil their management obligations. This condition is referred to 'role overload' and it is a cause of role stress and role conflict (Hardy & Hardy 1988:224; Willcocks 1994:69). The particular history and nature of the Thai social framework is also played out in this struggle. Role overload in regard to the CHDs is compounded by the strong tendency of the culture to homeostasis.

Willcocks (1994:69) adds: 'it is possible that role problems may be caused by either perceptual problems or those of inadequate role definition'. In this study, both conditions exist. The first issue is presented earlier. The latter is expressed in the evidence that the CHDs themselves have presented; they perceive their role as more clinician than manager. Clinicians have a much higher social standing than managers.

These problems arise from a lack of formal and informal expectations of the CHDs as managers on the part of government, supervisors, peers, subordinates and community, and from their own perception that they are only clinicians. This situation may have developed either consciously or unconsciously. The importation of PHC practice, which

evolved in developed countries and which lacks a precise 'fit' with Thai cultural realities, is part of the complexity of the current situation.

The CHDs have had to implement this health reform under the context of the UHC policy and PHC. The duality of their roles, compounded by their particular medical mindset being applied in a much more complex bureaucratic and cultural environment, confuses the CHDs. They are now in transition not only from doctor to hospital manager, but to the broader role of district health system manager implementing the UHC policy and PHC.

In the context of the UHC policy, CHDs have to act as managers of CUPs in order to provide primary and secondary care for those in their district population who may need that care. In addition, they have to coordinate with the DHO and HCs in their districts to provide primary care for people who live in peripheral areas of those districts. Moreover, they have to commission tertiary care by coordinating with the tertiary-care hospitals in the regions and Bangkok. The UHC policy imposes managerialism on the CHDs through managed care; they have to manage health services that they provide to their population in a more cost-effective manner. Also, it forces CHDs to work as a team with other health care providers. Their work environment is now expanded beyond their clinical and hospital management territories. Both of these factors challenge their clinical and hospital manager roles (Smith & Goodwin 2006). This study indicates the CHDs cannot exercise their role as managers of CUPs or district health services effectively, because there are many barriers at the policy and operational level inhibiting their ability to fully exercise such roles, and there is a lack of systemic support for those roles. Those barriers were discussed earlier in Section 5.2.1. It is the nature and social construction of these barriers which render them unique to the Thai setting.

5.3 The implications for policy and practice

The implications for policy and practice are presented in relation to the CHDs' recommendations to facilitate sustainable primary health services administered from their hospitals. This conclusion addresses the third aim of the study, to propose strategies for CHDs to be able to facilitate sustainable primary health services administered from a CH. The recommendations are: i) a single authority for district health services management; ii)

a district health board; iii) a defined role for the CHD as a PHC facilitator (collaborator), and definition of the required skills and knowledge; and, iv) professional development for the CHD. The first two proposals are beyond the current powers of the CHDs. The second two are within the present authority of the CHDs, but they need the Central Government's encouragement to exercise that authority more fully. Each recommendation is presented below.

5.3.1 Single authority for district health services management

Due to the unclear direction of the decentralisation policy, CHDs are confused as to whether and how the Central Government will devolve some health facilities and staff at district and sub-district level to local governments. They prefer health centres be placed under their management. If the Central Government decides to devolve health centres to work under the control of local governments, the CHDs still have doubts about the roles and responsibilities of staff at the HCs and how to coordinate care between those centres and the CHs.

The data illustrate some CHDs do not agree with the devolution of management of the health centres to local governments. These CHDs have had negative experiences in working with local governments and health workers, such as a lack of concern for and knowledge of health services management, a lack of transparency and accountability on the part of local governments, and a lack of medical (curative) knowledge on the part of health workers. As a result, some of the CHDs propose a new organisation, under their management, to deliver primary medical care. However, Globerman et al. (2006) argue creating new organisations may not be an appropriate solution for meeting the health needs of people. Some CHDs agree with this argument and suggest the Central Government should ensure local governments have the capacity to manage health services autonomously in their communities in the near future. There must be a very clear and definite plan for this.

In addition, the CHDs point out that the most important issue is about a lack of clarity in the roles and responsibilities of all stakeholders at the district and sub-district level. This lack of clarity derives from the nature of the associated policies and happens not only at

the level of CHs and health centres, but also between the hospitals, health centres, the district health offices, and local governments, as well as other sectors within the district and sub-district. The Central Government needs to address this issue urgently. It should clarify the roles and responsibilities of all stakeholders from different Ministries and local governments so that the coordination and integration of health care at district level can occur. The Central Government needs to overcome its own inertia resulting from compounding issues linked to group interests, as well as that arising from the Thai cultural values embedded in bureaucratic practice.

Moreover, the data show that, in suggesting solutions, some CHDs are aware the principles of PHC, in regard to the definition of health, are broader and do not solely focus on medical care, and the community needs to be empowered to participate in taking responsibility for their own health care needs. However, the data also indicate that other CHDs believe the community is not yet capable of participating in this way. They feel the community is not sufficiently educated to manage and evaluate health services. As a result, these CHDs are reluctant to support the community to manage their own health resources and facilities; they want to manage health care for the community instead. In the view of the CHDs, the community is only an end-user of health services. At the same time, they perceive health workers have little medical knowledge. As a result, they want to control health centres closely so they can preserve a high standard of medical (clinical) care (Bloor & Dawson 1994). This reflects the CHDs' authoritarian and medical approach on this issue (Rifkin 1985). Rifkin (1985) argues CHDs should have a 'community development' approach based on the actual needs of the community, rather than on what is imposed by the health service authorities. Scholars support an approach underpinned by the principles of PHC regarding community participation and the decentralisation of decision-making, since these factors will sustain primary health services for the community (Johnson & Paton 2007; Phillips 1990). This, of necessity, will require a gradual, but major, shift in cultural priorities (for Thai doctors, health workers and community members).

The study shows the CHDs would like the Central Government to appoint them to be the single authority in district health services management. They would prefer health centres to be amalgamated with their hospitals and that health workers should report to them. Some CHDs suggest the District Health Office should also be amalgamated to be one of

the departments in their hospitals and that the staff of district health offices should report to them as well. The data also indicate Thai medical doctors (CHDs) are part of an elite highly respected by the community and other health professionals. Hallinger and Kantamara (2000:199) point out Thais have a 'high power distance' characteristic. It is this ascribed, charismatic (in the Weberian sense) perception of doctors' power that needs to be replaced by a more inclusive distribution of that power. This is an instance in which charismatic leadership is nullified by its own capacity to adapt. CHDs are also responsible for the per capita funding provided for health services to the population in their districts. The data indicate the CHDs perceive their CHs are ready and appropriate to be the management centres for the primary health services for the whole district. This is because the CHs have more resources than the other organisations. The resources, however, need to be more decentralised and distributed to the outlying facilities to meet the health needs of the community in an equitable fashion (WHO 1992).

The CHDs can play a critical role by creating an initial stimulus for change and active implementation (Hallinger & Kantamara 2000). The leader's role as a catalyst for change seems even more necessary now that district health services are undertaking reforms that run counter to deeply-rooted Thai cultural norms. Early, firm support from the CHDs is necessary for creating and sustaining the transformation of the Thai district health system into a 'modern organisation'. CHDs as formal leaders must use strategies that counter traditional norms of deference and bring staff concerns to the surface, so they may understand and address staff resistance. However, CHDs must 'disarm' themselves of the most powerful tool at their disposal, power, in order to promote lasting change (Hallinger & Kantamara 2000). Informal types of leadership need to be promoted in conjunction with the formal. CHDs should regard those on the health board and the health team as equals, which, in turn, will enhance true participation. Transparency and accountability are central to effecting and maintaining these practices.

5.3.2 District health board

This study reveals that there is loose coordination between the health sector and local governments, and between different local governments. As a result, health services are fragmented at district and sub-district levels. The responsibilities regarding health for the

districts rest solely with the agencies of the MoPH, including the CHs, district health offices and health centres. These responsibilities include health planning, health services provision, management and evaluation of health services, resources, facilities, and staff. Within the UHC policy, the CHs hold a dominant position. These agencies are mainly responsible for programmes and policies and perceive their actions as altruistic in the light of what is imposed on them by the MoPH. As a result, there is a lack of true district health plans. This results from the misapplication of the concept of deference just as much as it does from the potent sense of professional superiority on the part of the medical staff.

The data highlight CHDs perceive there is no central body for making decisions regarding district health management were the Central Government to devolve health responsibility to local governments. Each local government will be separately and only responsible for their sub-districts. If there is an epidemic, there may be no organisation to look at the health of the district as a whole. Currently, the coordination of all stakeholders at district and sub-district level is informal and depends on personal relationships. The CHDs in this study would like the government to clarify the roles and responsibilities of each stakeholder who will participate in the district health board. They believe that this will improve collaboration between the health sector and local governments as well as other stakeholders. Also, they believe the district health board can be the place where the local governments contribute to the health of their communities and for the true participation of the community. The government should strengthen the capacity of the local governments to be able to participate in such a board, so that they can make decisions in relation to essential health services for the people in their community. In the Philippines, local health boards are the main mechanisms for broader community participation and involvement in local health development (Ramiro et al. 2001). The local governments, through functioning local health boards, can influence increased consultation with the community, fund-raising activities, health initiatives and higher per capita health expenditure (Ramiro et al. 2001). In other developing countries, such as Brazil, Nigeria, Tanzania and Uganda, the local governments, through local health councils, play an active role in decentralizing health care from the central government by defining, planning, developing and implementing their own policies and activities, especially primary health care delivery in response to local health needs (Atkinson et al. 2005; Atkinson & Haran 2004; Gilson, Kilima & Tanner 1994; Khemani 2005; Steiner 2007). Furthermore, La Fond (1995)

demonstrates that bottom-up management is the most effective strategy to meet the actual needs of the community and to protect health teams from unrealistic demands on the part of higher authorities.

However, the CHDs suggest the Provincial Governor is the only person who can use his authority to legitimate the district health board and influence local governments to participate on such boards. For this participation to be real and productive, the heads of local governments need to be the actual representatives, rather than them relying on delegates sent in their place (who lack power to speak on behalf of their community). This tendency also focuses on the nature of the cultural value of deference and its enormous negative power – what you do not like or understand, you ignore.

However, the data indicate the CHDs are confused with the differences between the roles and responsibilities of the district health team and the district health board. The district health board is envisaged as the entity to provide long-term planning, so the priorities of the district health team and of the national health agenda are directed efficiently to the actual needs of the rural people. In this context, the board has oversight of the health team, but does not dictate their day-to-day operation. The make-up of the board and its terms of reference are a topic of further research. In addition, even though CHDs see the district health board as one of the strategies for them to facilitate sustainable PHC for the rural poor, they do not have any vision or a real intention to make this happen. This is because they perceive themselves powerless against the many barriers that prevent them acting beyond their positions and interests as clinicians and hospital managers. In order to improve this situation, the CHDs should adjust their mindset from one that is authoritarian and medical to be one that is more democratic through the principles of PHC and management training.

5.3.3 Role of Community Hospital Director as a Primary Health Care facilitator (collaborator) and the required skills and knowledge

The study reveals that, within their area of authority, the CHDs can exercise their dual roles – clinician and manager – by extending their role as a collaborator to facilitate sustained primary health services provision for their communities. The CHDs propose

that they should exercise such a role to influence staff within their district health team, other organisations and communities in their districts, higher authorities in the health sector, and other related sectors, such as the educational sector.

The CHDs suggest that they can use their clinical and managerial leadership to enable their district health team to work closely with their communities. Thorne (1997) argues clinical leadership provides empowerment and support, rather than control. She adds it supports effective change agents and transformational leaders who work within organisations which are influenced by professional cultures (Thorne 1997). The CHDs also can be a link between the staff of their hospitals and those of district health offices and health centres to work together as a team through patient-centred care. Johnson and Paton (2007:31) argue the 'patient-centred approach' must be developed at two levels: individual and collective. At the individual level, it is between health providers and patients. The collective level is the involvement of the community and users of health services in district health service planning, development and evaluation. This allows the participation of the community, the collaboration between different sectors, and the integration of health services at district and sub-district levels. In addition, the CHDs can help their hospital staff working in secondary care understand the principles of PHC and the changing environment resulting from the UHC policy, so those staff understand this change and have less resistance to its implementation. This approach can ensure a shared vision and core values among all staff (Johnstone, Dwyer & Lloyd 2006).

The CHDs can also support the improvement of quality PHC provision at outlying centres by sending their medical team to provide medical services, promote health and disease prevention, and providing medical supplies and funding for services. They can support collaboration between hospital staff and staff of district health offices and health centres through the true participation of all staff in CUP Board meetings. These discussions would include such issues as the decentralisation of funding management to health workers, transparency and accountability in the management of district health services and the creation of trust among stakeholders. This can only happen if the CHDs accept the differences in the roles and responsibilities of all staff. The health promotion skills of the health workers must be enhanced. Furthermore, they can work with their CUP Board members to clarify the authority and responsibilities of each stakeholder.

During the transitional period of the decentralisation policy, the CHDs can act for the government in providing information to local government members, so these members understand their future roles in, and responsibilities for, their community's health. Local governments and related organisations need to grasp the principles of PHC (WHO 2000b). However, they should encourage a democratic process and be the role model of agents who bring democracy to communities. Moreover, they can encourage their community to practise self-care and health promotion through providing information to patients and their families as well as communities as a whole. This means the CHDs can highlight the need for equality of status between health providers and communities by reducing the asymmetry of available information (Johnson & Paton 2007). This will also promote sustaining PHC through patient-centred care at individual, family and community levels (Johnson & Paton 2007).

The data indicate the CHDs can provide the motivation for the retention of primary health care workers by improving their staff's professional development through adopting and practising the concept of a 'learning organisation' (Senge 1992). The CHDs can provide funding for staff to continue their education. In addition, they can deliver on-the-job training for the local staff by using the resources of their CHs. For accredited primary health care training, the CHDs suggest recognised educational institutes contribute to curriculum development. The skills and knowledge of graduates can then meet the real needs of the community being served. For staff development, the researcher suggests the CH and educational institutions (medical and management) need to devise and implement this formal training at the local level.

However, the CHDs are aware that they have less voice in influencing the other stakeholders involved with the health services system, particularly their superiors. They propose consolidating their power through a group process to help them have a stronger voice to express their opinions. They also perceive that they lack evidence-based information. As a result, they think they should conduct research on improving PHC delivery and then inform the Central Government and higher bureaucratic officers of their findings and recommendations. However, they feel they lack the academic skills and available time to do so. Next, they propose they should be positive role models for the next generation of medical doctors and CHDs. Despite proposing many of these

strategies, some CHDs show they have no real intention to go through with these changes, because they are overwhelmed by the perceived barriers (Section 5.2.1).

To be effective in their role, the CHDs perceive they need collaborative skills and knowledge. Austin (2000) argues an effective collaborator is able to manage relationships. According to Spekman, Isabella and MacAvoy (2000:191-1997), an effective collaborator requires three competencies, all of which can be learnt: knowledge and skills regarding their core business and general system management, the ability to network, and interpersonal skills. The CHDs perceive their core business as health services provision, and that they require medical and management competencies. They also emphasise an understanding of PHC, the Thai public health system, epidemiology, and the government administration system and regulations. They need knowledge and skills in relation to health promotion. The financial management and management tools to control their services provision are crucial for them as part of the general system management. This is because they have to manage the UHC policy's funding to commission primary health services at sub-district level, the provision of primary and secondary care at their hospitals, and commission tertiary care at the City Hospitals and other equivalent hospitals.

The data show the CHDs perceive the ability to network requires human management skills and team building, as well as the ability to build trust. Austin (2000) argues building trust is central to establishing effective collaboration. Trust would help CHDs work well together with other stakeholders at the district and sub-district level. The CHDs believe effective collaboration between all stakeholders in their CUP Boards is achieved through involvement of all partners. This is supported by the study of Huxham and Vangen (1996) and that of Nicholls (1997). Huxham and Vangen (1996) point out the continued involvement of all partners, a shared vision and goal of what the alliance (of stakeholders) may achieve, and listening to each other, are necessary to sustain strong trust. 'Mutuality, trust, respect, and equality' (Nicholls 1997:50, 113-115) are elements which encourage each party to talk to each other frankly and openly and would help reinforce trust.

Most of the CHDs perceive they lack the interpersonal competency needed to be an effective collaborator (Spekman, Isabella & MacAvoy 2000). Austin (2000) points out

sustained collaboration can exist through communication and interpersonal cohesion. The CHDs regard interpersonal competency includes social skills and believe two-way communication, which is intrinsic to interpersonal competency, is crucial to their collaborative practices. Huxham and Vangen (1996) suggest two-way communication between partners in each organisation and with the external stakeholders is important to sustaining collaboration. Despite this, the CHDs view their own status as higher than that of the other stakeholders. This self-perception militates against the atmosphere of equality needed for collaboration to exist and thrive.

Spekman, Isabella and MacAvoy (2000) point out frank communication, and regular opportunities to speak equally, are essential for effective collaboration. At present this type of opportunity is not perceived to be readily available. The CHDs, however, agree transparency and accountability would help to promote trust and better team work. Nevertheless the links between equality, transparency and accountability are not recognised. Moreover, Spekman, Isabella and MacAvoy (2000) suggest an effective collaborator should be aware of cross-cultural issues and have the necessary language competency and process skills they refer to as knowing the importance of ‘what’ and ‘how’. This latter issue is demonstrated with the CHDs perceiving they need processing skills in relation to analysis and priority setting.

Furthermore, the CHDs believe they should possess competencies, which Spekman, Isabella and MacAvoy (2000:199-203) defined as ‘unteachable competencies’, and be flexible and adaptable in response to any given situation (Spekman, Isabella & MacAvoy 2000). The CHDs suggest that, for a CHD to be effective in implementing and sustaining the UHC policy and PHC, they should have leadership skills. Cardona (2000:204-205) suggests an effective collaborator should have the quality of leadership at a ‘transcendental’ level. This means CHDs should be self-motivated to do things for others. Some CHDs feel they should be prepared for staff to make independent decisions within their jobs and they should delegate authority to their staff so they can be autonomous in decision-making.

The knowledge and skills required for a CHD to be an effective collaborator are described by Shaughnessy (1994:23-33) as the key to collaboration management. The CHDs suggest these should include: negotiation skills; skills needed for a systematic approach,

such as is discussed by Cardona (2000:23-33); a 'learning mindset' (Spekman, Isabella & MacAvoy 2000:203); and dispute resolution skills. According to Alexander et al. (2006), effective collaborators need political skill, which is central to dispute resolution. This study identifies CHDs as lacking such a skill. Moreover, the CHDs perceive they should be skilled in community engagement but most lack this.

A CHD also needs to be a visionary manager, as described by Spekman, Isabella and MacAvoy (2000:188-189). The data show the CHDs require the capacity for strategic thinking and planning, that is, a mindset to develop long-term goals, something some of the CHDs perceive they lack. Furthermore, some CHDs believe, to be an effective CHD and sustain PHC services provision to the rural poor, self-control is necessary and their decisions must be clear and make sense to the staff. Lewis and Boldy (2006:187) argue that making sense is the basis for decision-making.

5.3.4 Professional development of the Community Hospital Director

The CHDs perceive and propose the need for professional CHDs to sustain PHC provision for the rural poor administered from the CHs. Their proposal covers the recruitment, training, and retention of CHDs, so that they become professional CHDs. The data indicate a professional CHD should have a specific qualification in health management and they should fulfil specific requirements, such as a standard and formal process from the Ministry of Public Health for the recruitment and selection of CHDs. The CHDs require the Ministry of Public Health to change the way it appoints CHDs.

This study reveals there is a lack of support and inadequate formal preparation and training for those who become CHDs. They learn their management skills on-the-job, and the CHDs think this is unsatisfactory. Most of the CHDs recommend the new generation of CHDs should be professionally trained in general management and hospital management before entering the position. The CHDs who know little of PHC should undertake further study to learn about PHC so they can work effectively at the district level. However, most of the CHDs still emphasise hospital management training. This may be because the health services management in Thailand is still in an early stage of

development and the CHDs focus on the development of their hospitals, rather than the whole range of services within their districts.

The suggestions for training advocate educational institutes should be flexible when offering training to CHDs. Most CHDs have limited time for learning because of their heavy workload, particularly the clinical aspects of their work. Legge, Stanton and Smyth (2006) suggest an adult learning approach for managers as distinct from undergraduate teaching. They provide a framework for management training as individual learning, organisational learning, and management development (Legge, Stanton & Smyth 2006:3). The CHDs also suggest that there should be a formal and realistic assessment for attending training, both short-courses and longer formal courses.

This study shows the CHDs think the medical schools should include a hospital (health services) management programme in the curriculum for medical students. Students also need to have management experience during their internship, because many become CHDs in rural and remote areas as soon as they graduate. In addition, the medical schools should provide thorough training about the principles of PHC and the UHC policy. However, the participants of this study did not discuss the concept of multi- or inter-professional training. Cooper, Braye and Geyer (2004) argue inter-professional education (for management) can increase communication and cooperation between different professions and the organisations in which they work, so that the services can be improved. However, they warn that the process is complex and not straightforward or linear (Cooper, Braye & Geyer 2004).

In this study, the CHDs propose retention strategies to encourage professional CHDs to work longer in rural and remote areas. First, the government should provide more appropriate and reasonable financial incentives to CHDs. Second, there should be a formal mentoring structure or formal advisors available for new CHDs. Third, professional development, in the form of continuing education for health and hospital management, should be available. The CHDs also need the opportunity for continuing medical education to keep their medical skills and knowledge up-to-date. Last, the Ministry of Public Health should have a more rigorous performance evaluation for CHDs, based on the community's health status or the output of the CHDs' work, rather than following the processes provided by the government. The CHDs suggest that the CHD's

term of office should be fixed, rather than life-long. The government should have an urgent agenda for reforming and integrating the recruitment, selection, training, and retention processes, so high quality CHDs can be retained in rural and remote areas.

5.4 New directions for further research

The limitations of this research were discussed in Section 3.12. However, this study has paved the way for further research into this field, and as a result of the findings of this study four recommendations for new research directions are proposed. The first important area of investigation would be to explore the role of, and recommendations proposed by, CHDs working in other regions of the country. As discussed previously in Section 3.12, the sub-cultures of consumers and health professionals in different regions of Thailand may not be reflected in the perceptions of the sample in this study, which was conducted only in the North-Eastern region.

The second potential area of future research that would build on the findings of this study could be interviewing a sample of other interest groups who are influential and powerful in the Thai health care structure. Their perceptions and understanding of their roles and the CHDs' role in implementing rural health care reform could be examined. This includes their understanding of PHC and UHC policy as well as the possible implementation of the proposed recommendations offered in this study. These interest groups, medical monopolisers and corporate rationalisers, clearly identified by this research, can influence the sustainability of PHC administration and PHC services provision for the essentially voiceless 'repressed' community. They can exert their visible and invisible, but equally influential, power to either support or inhibit the implementation of the health policies and programmes. Understanding what and how these people think about rural health care reform will help the policy makers formulate the interventions strategically and help the managers at the front-line services implement those programmes effectively and efficiently. The lists of stakeholders for future research are those from the national, provincial, district and sub-district levels and were presented in Section 3.12.

Third, a study that could also be conducted to build on the findings of this research is an exploration of the roles and responsibilities and the structure of the district health board and its terms of reference. How to make up this board is crucial. The relationship between this board and the different levels of care and related ministries, particularly the MoPH and MoI, is important. This will further show how PHC and the health services system at district and sub-district levels are organised and managed effectively and efficiently to meet the needs of the rural poor under the decentralisation policy and the new *2007 National Health Act*. In addition, the issues or models on how to balance the power of medical monopolisers, corporate rationalisers, and community interest, and to shift power from the previous two interest groups to the latter group, will be useful for sharing initiatives with the national and international health community. In the UK, even though community representatives sit on the Primary Care Group/Trust Board, scholars found medical professions dominate decision-making (Harrison 1999; North & Peckham 2001). In Australia, and in some developing countries, researchers also found the dominant interest groups are those of the medical doctors; they dominate decision-making, rather than let the community have autonomy in making decisions regarding their needs and how their needs can be met effectively (Beyer 1998; Cohen & Purcal 1989; Evans, Han & Madison 2006; LaFond 1995). Cohen and Purcal (1989) propose that the philosophy and methods of participatory action research (PAR) can offer considerable potential for the development of genuine community participation. They argue that it assists in stimulating the repressed community to become critically aware of their social reality and their ability to transform it by conscious action, and that this is achieved through interaction between intellectuals and the repressed community.

Finally, the fourth potential area of future research to build on the findings of this research is curriculum development for rural health services management. The curriculum development includes content, training processes, and evaluation. Such a study would shed further light on some of the findings in this study, particularly in relation to capacity building for health managers in rural areas. This study has revealed only skills and knowledge required by CHDs who are both medical doctors and managers. The future research should explore how the curriculum will fit with other professions who work in the district health system in order to prepare and promote these professions to become professional health services managers. This may also help some medical doctors who do

not want to work as managers but want to be excellent clinicians taking care of their patients to meet the health needs of community more effectively and efficiently.

5.5 Conclusion

This chapter has identified and discussed the two major conclusions of this study. The results of this study have shown that the CHDs in this study have dual roles, clinician and manager, in implementing the UHC policy in relation to PHC. Their medical background dominates the integration of these roles. Their managerial role is not effective, because they were unprepared for, and unsupported in making, the transition from clinician to manager, and from hospital manager to the broader role of manager at the district health services level. The reasons for such ineffectiveness are that there are many barriers at both the policy and operational levels that prevent CHDs exercising their role as district health services or CUP managers. The goals of the UHC policy in relation to PHC are not, therefore, achieved effectively. This is reflected in the medical approach to the implementation of this health care reform and the lack of systemic support for the CHDs' management role.

Following a discussion of the major conclusions, implications for policy and practice were discussed. Being aware of the ineffectiveness of the district health services or the CUP manager's role, this study recommends changes to policy and practice, from a macro- and micro-perspective. These changes would assist CHDs to facilitate the sustainability of PHC services provision administered from the CHs to meet the needs of the rural poor.

In summary, the first chapter of this thesis introduced the topic and the purpose, aims and significance of this study. This study focused on an exploration of the complexity of the role of CHDs in implementing the UHC policy and in facilitating the sustainability of PHC services provision administered from their CHs. From the literature review in Chapter Two, it was seen that Thailand's community hospitals are operated in a dynamic and turbulent socioeconomic, political and health environment, which is both complex and costly. There are many complex factors and challenges which influence and prevent the CHDs implementing rural health care reform. The theoretical issues underpinning this study, PHC as described by WHO (1978), structural interests, the Thai management style,

and professional sub-cultures, are discussed in relation to the implementation of the UHC policy and PHC. The qualitative design and data collection procedures, as well as the technique of data analysis described in Chapter Three, assisted in exploring the various perceptions of the participants, and enabled this study to uncover the role of the CHDs in implementing the UHC policy and PHC. Chapter Four, an analysis of the CHDs and the other stakeholders' stories based on four different but related themes, highlighted the barriers to the CHDs' role in implementing rural health care reform, their ineffective managerial role, and their proposed recommendations to help them facilitate the sustainability of the PHC services for the rural poor in their districts.

This study has made a significant contribution at the theoretical level in identifying the gulf between policy formation and policy implementation. It shows the people's understanding of the rhetoric behind policy formation, for example, managerialism, evidence-based strategies, social equality and equity, and radical policy implementation. However, it also shows the views of people who live with rural health care reform, the value of these health policies and the way the implemented health policies were shaped by structural interests, medical monopolisers and corporate rationalisers, who use their power to influence others to serve their interests. This study shows that the winners are medical monopolisers and corporate rationalisers. The community, those who live in rural and disadvantaged areas, benefit less. Looking at it from the perspective of structural interests, this study provides further evidence that, despite the UHC policy rhetoric of increasing the accessibility to quality care for all people, especially the underprivileged, dominant structural interests have proven too powerful in resisting the reform so it will not survive in a meaningful way. The contributions of this research have reflected and reinforced the findings of earlier studies, while providing further evidence that structural interests influence the implementation of the health policy. They negatively impact on the effectiveness of the policy implementation and, as a consequence, there are poorer outcomes for the quality of life of the rural poor.

This study contributes to the body of knowledge on the negative impacts of organisational culture and professional sub-cultures on the effectiveness of implementing health care reform. The study found CHDs are one of the structural interests preventing effective and sustainable PHC services provision. They are not prepared to change the organisational culture, dominated by the biomedical sub-culture and autocratic management style, to a

more democratic style and so be more adaptable to meet the needs of rural people. This study explains why the CHDs behave in such way and so as a result cannot facilitate collaboration between other organisations. There is a lack of teamwork in the district health services area. Again, this leaves the CHDs acting according to their medical and managerial autonomy for their own hospitals. The majority of the community, which requires quality PHC services at HCs and PCUs, does not benefit from the CHDs' actions.

In an effort to understand more about the CHDs' healthcare role, this research also set out to explore the world of CHDs in implementing the health policy from a holistic perspective. This study is one of very few qualitative research studies focusing on the role of CHDs, who are middle health managers of the health services system in middle-to-low income countries such as Thailand. The previous studies on the role of health managers and their required knowledge and skills, as well as their management development, were mostly conducted in developed countries, where most managers were at a senior level with very few having a dual role, such as the CHDs in this study (Guo 2003a, 2003b, 2004a, 2004b, 2005; Harris & Bleakley 1991; Harris, Harris & Tapsell 1993; Leggat, Harris & Legge 2006). The roles of clinicians who have become managers have been studied, but all of these clinicians were at the secondary care level and were clinical directors (Allen 1995; Boucher 2001; Buchanan et al. 1997; Forbes, Hallier & Kelly 2004; Llewellyn 2001; Willcocks 1994). To my knowledge, there is one qualitative research study about district hospital management in a developing country, but the study was not specific to the role of the hospital director nor specific to a situation in which they had to manage both primary care and secondary care at the same time (Couper & Hugo 2005). There are studies about the role of district hospitals and PHC, but not specific to the role of hospital managers (Macagba 1984 ; WHO 1990, 1992). Other research is available about management at primary care level, but again this is not specific to the role of health managers (Meads 2006; Politzer et al. 2003; Smith & Goodwin 2006). Research about involving hospitals in health promotion in developing countries is again not specific about the role of health care managers in those countries (Johnson & Baum 2001; Johnson & Paton 2007).

This study provides specific and comprehensive information regarding the skills and knowledge required by CHDs in implementing health care reform and how to effectively

develop and retain rural health managers who have dual roles – clinician and manager. The specificity of this study is that CHDs work as clinicians in secondary and primary care settings and as managers of community hospitals and of CUPs. The main contribution of this study is a compelling insider view of how a group of CHDs experience the implementation of health care reform and sustaining PHC services provision within a rural healthcare context, in a province in the North-Eastern region of Thailand.

Finally, the results of this study have provided valuable insights from a qualitative study vantage point. This research shows qualitative research has the potential to present the same results as quantitative research using structural analysis (cost-effective analysis) by looking at the perceptions of the CHDs and the other stakeholders. It mirrors the structural analysis that shows the ineffectiveness of the implementation of the health policies. The experiences of the people, who live with the rural health care reform, who have less opportunity to express their voices are revealed. It gives them the opportunity to express their views separate for the higher authorities and academic worlds. They are repressed by Thai culture and the bureaucratic system. Their invaluable insights will shed light on closing the gap between policy formulation and implementation. Thus, effective policy implementation, which is about the aim of health care reform, may be more likely to be achieved.

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APPENDICES

Appendix 1
Participant Information Sheet
Individual Interviews

**Understanding the role of Thai Community Hospital Directors in
implementing the Universal Health Coverage policy in relation to
Primary Health Care**

Participant Information Sheet
Individual Interviews

You are invited to participate in the above research project, which is being conducted by Dr. Prawit Taytiwat (Doctor of Health Services Management student) at the School of Health, University of New England, Australia. Your name and contact details have been provided by either the Chief of District Health Office in your area or the Director of your community hospital, which has been drawn from databases of the Ministry of Public Health and the National Health Security Office, which can be accessed through their websites: www.moph.go.th and www.nhso.go.th respectively. This project will form part of Dr Taytiwat's doctoral thesis, and has been approved by the Human Research Ethics Committee.

The aims of this study are to understand the strategic and operational roles of directors of community hospitals in implementing the UHC policy; to explore barriers to the delivery of primary health care at the community hospital level; and to develop a model of sustainable primary health services administered from the community hospital. It is hoped that what is learned from this study will contribute to knowledge and practices in strengthening primary health care for rural communities in Thailand.

Should you agree to participate, you would be asked to participate in an in-depth interview of about one to two hours, regarding your own opinion about topics that deal with the implementation of the Universal Health Coverage policy and primary health care at the community hospital level and any topic that deals with the substance of those particulars, at a time convenient to you. With your permission, the interview would be tape-recorded so that I can ensure that I make an accurate record of what you say. When the tape has been transcribed, you would be provided with a copy of the transcript so that you can verify that the information is correct. I estimate that the time commitment required of you as for the interview and reading the transcript would not exceed three hours.

I intend to protect your anonymity and the confidentiality of your responses to the fullest possible extent, within the limits of the law. Your name and contact details will be kept in a separate, password-protected computer file from any data that you supply. This will only be able to be linked to your responses by the researcher, for example, in order to know where to send your interview transcript for checking. In the final report, you will be referred to by a pseudonym. I will remove any references to personal information that might allow someone to guess your identity; however, you should note that as the number of people I seek to interview is very small, it is possible that someone may still be able to identify you.

Once the thesis arising from this research has been completed, a brief summary of the findings will be available to you on application at the School of Health at the University of New England, Australia. It is also possible that the results will be presented at academic conferences. The data will be kept securely in the School of Health at the University of New England, Australia for five years from the date of publication, before being destroyed.

Please be advised that your participation in this study is completely voluntary. Should you wish to withdraw at any stage, or to withdraw any unprocessed data you have supplied, you are free to do so without prejudice. The researcher is not involved in the ethics application process. Your decision to participate or not, or to withdraw, will be completely independent of your dealings with the ethics committee, and we would like to assure you that it will have no effect on any applications for approval that you may submit.

If you would like to participate, please indicate that you have read and understood this information by signing the accompanying consent form and returning it in the envelope provided. The researcher will then contact you to arrange a mutually convenient time for you to participate in an in-depth interview.

Should you require any further information, or have any concerns, please do not hesitate to contact the researcher, Dr. Prawit Taytiwat, at 067341409 or at his e-mail addresses: taytiwat@yahoo.com, or at Faculty of Public Health, Naresuan University, Muang, Phitsanulok 65000 Tel. 055-261900 ext. 5525 or at his principal supervisor, Professor Victor Minichiello, at +61 2 6773 3862 or at his e-mail address: vminichi@une.edu.au.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No. HE06/009, Valid to 06 February 2007).

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: (02) 6773 3449
Facsimile (02) 6773 3543
Email: Ethics@pobox.une.edu.au*

Appendix 1.1
Participant Information Sheet
Individual Interviews (Thai version)

**การศึกษาวิจัยเรื่อง ความเข้าใจในบทบาท และ หน้าที่ของผู้อำนวยการโรงพยาบาลชุมชน
ของประเทศไทยในการนำนโยบายหลักประกันสุขภาพถ้วนหน้าในการให้
การดูแลสุขภาพระดับปฐมภูมิไปปฏิบัติ**

เอกสารชี้แจงข้อมูลสำหรับการสัมภาษณ์ผู้เข้าร่วมงานวิจัย

กระผม นายแพทย์ ประวิทย์ เตชะวัฒน์ นักศึกษาปริญญาเอก สาขาการจัดการบริการสุขภาพ มหาวิทยาลัยนิวอิงแลนด์ ประเทศออสเตรเลีย โค้ชขอเรียนเชิญท่านให้เกียรติเข้าร่วมในงานวิจัยดังกล่าวข้างต้น กระผมได้รับชื่อและรายละเอียดของท่านจากผู้อำนวยการ โรงพยาบาลชุมชนและหรือจากสาธารณสุขอำเภอ(ในพื้นที่ของท่านซึ่งกระผมได้ข้อมูลของโรงพยาบาลชุมชนดังกล่าวจากฐานข้อมูลของกระทรวงสาธารณสุข และ สำนักงานหลักประกันสุขภาพแห่งชาติ โดยอยู่ในเว็บไซต์ www.moph.go.th และ www.nhso.go.th โครงการศึกษาดังกล่าวนี้เป็นส่วนหนึ่งของวิทยานิพนธ์ระดับปริญญาเอกของกระผม และได้ผ่านการอนุมัติจากคณะกรรมการวิจัยในมนุษย์ของมหาวิทยาลัยนิวอิงแลนด์แล้ว

งานวิจัยนี้มีจุดมุ่งหมายเพื่อที่จะเข้าใจบทบาท หน้าที่ในเชิงกลยุทธ์และปฏิบัติการของผู้อำนวยการ โรงพยาบาลชุมชนในการนำนโยบายหลักประกันสุขภาพถ้วนหน้าไปปฏิบัติ และต้องการจะค้นหาอุปสรรคของการให้การดูแลสุขภาพระดับปฐมภูมิ (primary health care) ที่ระดับโรงพยาบาลชุมชน รวมถึงต้องการที่จะพัฒนารูปแบบของการให้การดูแลสุขภาพระดับปฐมภูมิที่มีความยั่งยืนโดยมีการบริหารจัดการโดยโรงพยาบาลชุมชน นอกจากนั้นสิ่งที่ได้เรียนรู้จากการศึกษาครั้งนี้ยังถูกคาดหวังว่าจะนำไปสู่ความรู้และการปฏิบัติในการสร้างความเข้มแข็งในการให้การดูแลสุขภาพระดับปฐมภูมิแก่ชุมชนชนบทของประเทศไทย

หากท่านยินดีที่จะเข้าร่วมในงานวิจัยนี้ ท่านจะถูกขอให้เข้าร่วมในการให้สัมภาษณ์เชิงลึกแบบตัวต่อตัว กระผมจะขออนุญาตเข้าสัมภาษณ์เชิงลึกโดยใช้เวลาประมาณ 1-2 ชั่วโมง โดยจะถามท่านเกี่ยวกับความคิดเห็นของท่านในการนำนโยบายหลักประกันสุขภาพถ้วนหน้าและการให้บริการสุขภาพปฐมภูมิมาปฏิบัติที่ระดับโรงพยาบาลชุมชน รวมถึงประเด็นต่างๆที่เกี่ยวข้องกับเรื่องทั้งสองนั้น โดยจะดำเนินการในเวลาที่ท่านสะดวก ในการสัมภาษณ์ กระผมจะขออนุญาตบันทึกเสียงของท่านเพื่อที่กระผมจะสามารถบันทึกสิ่งที่ท่านได้ให้ข้อมูลและคำแนะนำอย่างถูกต้อง เมื่อผมทำการถอดเทปที่บันทึกเป็นลายลักษณ์อักษรเรียบร้อยแล้ว กระผมจะส่งสำเนาของเอกสารดังกล่าวให้ท่านเพื่อกรุณาตรวจสอบความถูกต้อง กระผมคาดว่าในการร่วมงานวิจัยดังกล่าวตั้งแต่การสัมภาษณ์เชิงลึกแบบตัวต่อตัวและการอ่านเอกสารเพื่อยืนยันข้อความถูกต้อง กระผมจะขอรับกวนเวลาของท่านโดยรวมแล้วไม่เกิน 3 ชั่วโมง

ในการเข้าร่วมในการให้สัมภาษณ์ของท่าน ข้อมูลต่างๆที่ท่านให้ รวมถึงชื่อและรายละเอียดของท่านจะถูกเก็บเป็นความลับ โดยข้อมูลที่ท่านให้กับชื่อและรายละเอียดของท่านจะถูกเก็บในที่ที่แตกต่างกัน โดยจะทำการใส่รหัสลับในคอมพิวเตอร์ในการสืบค้นข้อมูลเพื่อให้มั่นใจว่าจะไม่มีผู้อื่นทราบรายละเอียดของท่านนอกจากกระผมซึ่งเป็นผู้วิจัย นอกจากนั้นในรายงานผลของการวิจัยจะไม่มีชื่อจริงของท่านปรากฏอยู่ นักวิจัยจะกำหนดชื่อสมมติเพื่อใช้แทนชื่อของท่าน ผมจะไม่ใส่รายละเอียดอื่นๆของท่านเพื่อให้ผู้ที่มาอ่านงานวิจัยไม่สามารถคาดเดาได้ว่าท่านที่ให้ข้อมูล ทั้งนี้เพื่อเป็นการรักษาความลับในการให้ข้อมูลของท่าน แต่กระนั้นก็ตาม กระผมขอเรียนให้ท่านได้

ตระหนักถึงว่าจำนวนผู้เข้าร่วมให้สัมภาษณ์ในงานวิจัยนี้มีจำนวนน้อย ดังนั้นอาจมีความเป็นไปได้ที่บางคนอาจสามารถคาดเดาได้ว่าท่านเป็นผู้ให้ข้อมูล

เมื่อเสร็จสิ้นงานวิจัยครั้งนี้และวิทยานิพนธ์ได้ถูกทำเสร็จสมบูรณ์ ท่านสามารถขอขบถัดออกจากการศึกษาครั้งนี้ได้จาก School of Health, University of New England, Australia ผลลัพธ์จากงานวิจัยนี้อาจจะถูกนำมาเผยแพร่ในการประชุมทางวิชาการหรือการตีพิมพ์ในวารสารทางวิชาการต่างๆ ข้อมูลต่างๆที่ได้จากการสัมภาษณ์จะถูกเก็บไว้ในที่ปลอดภัยและเป็นความลับที่ School of Health, University of New England, Australia ประมาณ 5 ปีหลังจากวันที่ได้ลงตีพิมพ์แล้ว หลังจากนั้นจะถูกทำลาย

กระผมขอเรียนให้ทราบว่า การเข้าร่วมในการให้สัมภาษณ์ของท่านในงานวิจัยครั้งนี้ต้องเป็นไปโดยความสมัครใจของท่าน ดังนั้นท่านสามารถที่จะถอนตัวจากการให้สัมภาษณ์ในระยยะใดก็ได้ หรือยกเลิกข้อมูลที่ท่านได้ให้แก่กระผมได้ โดยจะไม่มีการดำเนินการใดๆกับท่าน นอกจากนี้การดำเนินการวิจัยของกระผมไม่เกี่ยวข้องกับภาคการเมืองหรือส่วนราชการใดๆ ดังนั้นการเข้าร่วมงานวิจัยหรือไม่จะขึ้นอยู่กับการตัดสินใจของท่านประการเดียว

หากท่านยินดีที่จะเข้าร่วมในงานวิจัยดังกล่าวข้างต้น กระผมใคร่ขอความกรุณาท่านได้โปรดลงนามในหนังสือยินดีเข้าร่วมงานวิจัยเพื่อเป็นการยืนยันว่าท่านได้อ่านและเข้าใจข้อมูลเบื้องต้นที่กระผมได้นำเรียนชี้แจงและสงคินให้แก่กระผมในของจดหมายที่กระผมเตรียมไว้ให้ และกระผมจะได้ดำเนินการติดต่อนัดหมายเวลาที่สะดวกสำหรับท่านในการให้สัมภาษณ์เชิงลึกและการสัมภาษณ์กลุ่มต่อไป

หากท่านมีข้อสงสัย หรือคำถามที่เกี่ยวข้องกับงานวิจัยดังกล่าว ขอได้โปรดติดต่อ นายแพทย์ ประวิทย์ เตชวิวัฒน์ ที่ 067341409 หรือที่อีเมล taytiwat@yahoo.com หรือที่อยู่ คณะสาธารณสุขศาสตร์ มหาวิทยาลัยนเรศวร อ.เมือง จ.พิษณุโลก โทรศัพท์ 056-261900 ต่อหมายเลข 5525 ท่านอาจจะติดต่ออาจารย์ที่ปรึกษา งานวิจัย ศาสตราจารย์ วิคเตอร์ มินิเคิลโล่ ที่หมายเลข +61 2 6773 3862 หรือที่อีเมล vminichi@une.edu.au

หมายเหตุ

โครงการวิจัยนี้ได้ผ่านการอนุมัติจากคณะกรรมการจริยธรรมในการวิจัยในมนุษย์ของมหาวิทยาลัยนิวอิงแลนด์ ประเทศออสเตรเลียแล้ว (หมายเลขอนุมัติ HE06/009 อนุญาตถึง 06 กุมภาพันธ์ 2550)

หากท่านมีข้อร้องเรียนเกี่ยวกับพฤติกรรมในการดำเนินการวิจัยนี้ กรุณาติดต่อเจ้าหน้าที่จริยธรรมในการวิจัยตามที่อยู่ข้างล่างนี้

*Research Services
University of New England
Armidale, NSW 2351.
Telephone: (02) 6773 3449
Facsimile (02) 6773 3543
Email: Ethics@pobox.une.edu.au*

Appendix 2
Consent Form

Consent Form

I, (the participant) have read the information contained in the Information Sheet for Participants and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I may withdraw at any time. I agree that research data gathered for the study may be published, provided my name is not used. I realise that the interview will be tape recorded.

.....
Participant or Authorised Representative

.....
Date

.....
Investigator

.....
Date

Appendix 2.1
Consent Form (Thai version)

ใบแสดงความยินดีในการอนุญาตให้เข้าสัมภาษณ์

ข้าพเจ้าได้อ่านรายละเอียดในเอกสารชี้แจง
ข้อมูลสำหรับการสัมภาษณ์ผู้เข้าร่วมงานวิจัยและยินดีที่จะตอบคำถามต่างๆด้วยความสมัครใจ คำตอบต่างๆของ
ข้าพเจ้าจะเป็นไปตามความยินดีและความพึงพอใจของข้าพเจ้า ข้าพเจ้ายินดีที่จะเข้าร่วมงานวิจัยครั้งนี้โดยตระหนักถึง
การมีสิทธิในการยกเลิกหรือถอนตัว ณ.เวลาใดก็ได้ ข้าพเจ้ายินดีให้เผยแพร่ตีพิมพ์ข้อมูลในการวิจัยครั้งนี้โดยห้าม
เปิดเผยชื่อ นามสกุลจริงของข้าพเจ้า ข้าพเจ้าตระหนักดีว่าในการให้สัมภาษณ์ของข้าพเจ้าจะมีการบันทึกเสียงไว้

.....
ผู้ให้สัมภาษณ์หรือผู้แทน

.....
วัน/เดือน/พ.ศ.

.....
นักวิจัย

.....
วัน/เดือน/พ.ศ.

Appendix 3

Participant Information Sheet for Community Hospital Directors

Individual Interviews and Focus Group

**Understanding the role of Thai Community Hospital
Directors in implementing the Universal Health
Coverage policy in relation to
Primary Health Care**

***Participant Information Sheet for Community Hospital Directors
Individual Interviews and Focus Group***

You are invited to participate in the above research project, which is being conducted by Dr. Prawit Taytiwat (Doctor of Health Services Management student) at the School of Health, University of New England, Australia. Your name and contact details have been drawn from databases of the Ministry of Public Health and the National Health Security Office, which can be accessed through their websites: www.moph.go.th and www.nhso.go.th respectively. This project will form part of Dr Taytiwat's doctoral thesis, and has been approved by the Human Research Ethics Committee.

The aims of this study are to understand the strategic and operational roles of directors of community hospitals in implementing the UHC policy; to explore barriers to the delivery of primary health care at the community hospital level; and to develop a model of sustainable primary health services administered from the community hospital. It is hoped that what is learned from this study will contribute to knowledge and practices in strengthening primary health care for rural communities in Thailand.

Should you agree to participate, you would be asked to contribute via an interview and a focus group. First, I would ask you to participate in an in-depth interview of about one to two hours, regarding your own opinion about topics that deal with the implementation of the Universal Health Coverage policy and primary health care at the community hospital level and any topic that deals with the substance of those particulars, at a time convenient to you. I also would ask you to introduce me to your stakeholders who are involved in implementing the UHC policy in relation to PHC at your district level, such as, your Head of Primary Care Unit, Chief of District Health Office, Head of Health Centre, and community representative.

Then, I would ask you to participate in a focus group with the other seven directors of community hospitals in your province to discuss the results of the study and obtain further feedback. The group meeting will last for about two to three hours and will be held at a time convenient to you and other directors. The aim of the focus group is to clarify issues and concepts that are elucidated from the in-depth interviews.

With your permission, the interview and focus group would be tape-recorded so that I can ensure that I make an accurate record of what you say. When the tape has been transcribed, you would be provided with a copy of the transcript so that you can verify that the information is correct. I estimate that the time commitment required of you as for both the interview and focus group and reading the transcript would not exceed five hours.

I intend to protect your anonymity and the confidentiality of your responses to the fullest possible extent, within the limits of the law. Your name and contact details will be kept in a separate, password-protected computer file from any data that you supply. This will only be able to be linked to your responses by the researcher, for example, in order to know where to send your interview transcript for checking. In the final report, you will be referred to by a pseudonym. I will remove any references to personal information that might allow someone to guess your identity; however, you should note that as the number of people I seek to interview is very small, it is possible that someone may still be able to identify you.

Once the thesis arising from this research has been completed, a brief summary of the findings will be available to you on application at the School of Health at the University of New England, Australia. It is also possible that the results will be presented at academic conferences. The data will be kept securely in the School of Health at the University of New England, Australia for five years from the date of publication, before being destroyed.

Please be advised that your participation in this study is completely voluntary. Should you wish to withdraw at any stage, or to withdraw any unprocessed data you have supplied, you are free to do so without prejudice. The researcher is not involved in the ethics application process. Your decision to participate or not, or to withdraw, will be completely independent of your dealings with the ethics committee, and I would like to assure you that it will have no effect on any applications for approval that you may submit.

If you would like to participate, please indicate that you have read and understood this information by signing the accompanying consent form and returning it in the envelope provided. The researcher will then contact you to arrange a mutually convenient time for you to participate in an in-depth interview and subsequently a focus group.

Should you require any further information, or have any concerns, please do not hesitate to contact the researcher, Dr. Prawit Taytiwat, at 067341409 or at his e-mail addresses: taytiwat@yahoo.com, or at Faculty of Public Health, Naresuan University, Muang, Phitsanulok 65000 Tel. 055-261900 ext. 5525 or at his principal supervisor, Professor Victor Minichiello, at +61 2 6773 3862 or at his e-mail address: vminichi@une.edu.au.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No. HE06/009, Valid to 06 February 2007).

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: (02) 6773 3449
Facsimile (02) 6773 3543
Email: Ethics@pobox.une.edu.au*

Appendix 3.1

Participant Information Sheet for Community Hospital Directors

Individual Interviews and Focus Group (Thai version)

**การศึกษาวิจัยเรื่อง ความเข้าใจในบทบาท และ หน้าที่ของผู้อำนวยการโรงพยาบาลชุมชน
ของประเทศไทยในการนำนโยบายหลักประกันสุขภาพถ้วนหน้าในด้านการให้
การดูแลสุขภาพระดับปฐมภูมิไปปฏิบัติ**

เอกสารชี้แจงข้อมูลสำหรับการสัมภาษณ์ผู้อำนวยการโรงพยาบาลชุมชน

กระผม นายแพทย์ ประวิทย์ เตชะวัฒน์ นักศึกษาปริญญาเอก สาขาการจัดการบริการสุขภาพ มหาวิทยาลัยนิวอิงแลนด์ ประเทศออสเตรเลีย
ใคร่ขอเรียนเชิญท่านให้เกียรติเข้าร่วมในงานวิจัยดังกล่าวข้างต้น กระผมได้รับชื่อและรายละเอียดของท่านจากฐานข้อมูลของกระทรวง
สาธารณสุข และ สำนักงานหลักประกันสุขภาพแห่งชาติ โดยอยู่ในเว็บไซต์ www.moph.go.th และ www.nhso.go.th
โครงการศึกษาดังกล่าวนี้นี้เป็นส่วนหนึ่งของวิทยานิพนธ์ระดับปริญญาเอกของกระผม และได้ผ่านการอนุมัติจากคณะกรรมการวิจัยใน
มนุษย์ของมหาวิทยาลัยนิวอิงแลนด์และได้รับอนุญาตจากสำนักงานสาธารณสุขจังหวัดนครราชสีมาแล้ว

งานวิจัยนี้มีจุดมุ่งหมายเพื่อที่จะเข้าใจบทบาท หน้าที่ในเชิงกลยุทธ์และปฏิบัติการของผู้อำนวยการ โรงพยาบาลชุมชนในการนำนโยบาย
หลักประกันสุขภาพถ้วนหน้าในเรื่องที่เกี่ยวกับการดูแลสุขภาพระดับปฐมภูมิไปปฏิบัติ และต้องการจะค้นหาอุปสรรคของการให้การดูแลสุขภาพ
ระดับปฐมภูมิ (primary health care) ที่ระดับโรงพยาบาลชุมชน รวมถึงต้องการที่จะพัฒนารูปแบบของการดูแลสุขภาพ
ระดับปฐมภูมิที่มีความยั่งยืนโดยมีการบริหารจัดการโดยโรงพยาบาลชุมชน นอกจากนั้นสิ่งที่ได้เรียนรู้จากการศึกษาครั้งนี้ยังถูกคาดหวังว่า
จะนำไปสู่ความรู้และการปฏิบัติในการสร้างความเข้มแข็งในการให้การดูแลสุขภาพระดับปฐมภูมิแก่ชุมชนชนบทของประเทศไทย

หากท่านยินดีที่จะเข้าร่วมในงานวิจัยนี้ ท่านจะถูกขอให้เข้าร่วมในการให้สัมภาษณ์เชิงลึกแบบตัวต่อตัวและให้สัมภาษณ์แบบกลุ่ม อันดับ
แรก กระผมจะขออนุญาตเข้าสัมภาษณ์เชิงลึกโดยใช้เวลาประมาณ 1-2 ชั่วโมง โดยจะถามท่านเกี่ยวกับความคิดเห็นของท่านในการนำ
นโยบายหลักประกันสุขภาพถ้วนหน้าและการให้การดูแลสุขภาพระดับปฐมภูมิมาปฏิบัติที่ระดับโรงพยาบาลชุมชน รวมถึงประเด็นต่างๆที่
เกี่ยวข้องกับเรื่องทั้งสองนั้น โดยจะดำเนินการในเวลาและสถานที่ที่ท่านสะดวก และจะขอรบกวนให้ท่านกรุณาแนะนำหัวหน้าหรือผู้ที่
ท่านมอบหมายให้ดูแลศูนย์สุขภาพชุมชนของท่าน ท่านสาธารณสุขอำเภอ ท่านหัวหน้าสถานีอนามัย และผู้แทนชุมชน เพื่อนักวิจัยจะได้ขอ
เข้าทำการสัมภาษณ์ด้วย หลังจากเสร็จสิ้นการเก็บข้อมูลด้วยการสัมภาษณ์เชิงลึกแบบตัวต่อตัวแล้ว กระผมจะขอเรียนเชิญท่านเข้าร่วมการ
สัมภาษณ์แบบกลุ่มร่วมกับผู้อำนวยการ โรงพยาบาลชุมชนอีก 7 แห่งซึ่งอยู่ในจังหวัดของท่าน เพื่อพูดคุยและแลกเปลี่ยนความคิดเห็น
เกี่ยวกับผลลัพธ์ที่ได้จากการสัมภาษณ์เชิงลึกแบบตัวต่อตัวเพื่อให้เกิดความเข้าใจและแนวคิดที่ชัดเจนมากขึ้น รวมถึงขอคำแนะนำและ
ความเห็นต่างจากท่านและกลุ่ม การจัดการประชุมกลุ่มจะใช้เวลาประมาณ 2-3 ชั่วโมงและจะทำการนัดหมายตามเวลาและสถานที่ที่
ท่านและผู้อำนวยการ โรงพยาบาลชุมชนท่านอื่นๆเห็นว่าเหมาะสม

ในการสัมภาษณ์ทั้งสองแบบดังกล่าวข้างต้น กระผมจะขออนุญาตบันทึกเสียงของท่านเพื่อที่กระผมจะสามารถบันทึกสิ่งที่ท่านได้ให้
ข้อมูลและคำแนะนำอย่างถูกต้อง เมื่อผมทำการถอดเทปที่บันทึกเป็นลายลักษณ์อักษรเรียบร้อยแล้ว กระผมจะส่งสำเนาของเอกสาร
ดังกล่าวให้ท่านเพื่อกรุณาตรวจสอบความถูกต้อง กระผมคาดว่าในการร่วมงานวิจัยดังกล่าวตั้งแต่การสัมภาษณ์เชิงลึกแบบตัวต่อตัว การ
สัมภาษณ์แบบกลุ่มและการอ่านเอกสารเพื่อยืนยันความถูกต้อง กระผมจะขอรบกวนเวลาของท่านโดยรวมแล้วไม่เกิน 5 ชั่วโมง

ในการเข้าร่วมในการให้สัมภาษณ์ของท่าน ข้อมูลต่างๆที่ท่านให้ รวมถึงชื่อและรายละเอียดของท่านจะถูกเก็บเป็นความลับ โดยข้อมูลที่ท่านให้กับชื่อและรายละเอียดของท่านจะถูกเก็บในที่ที่แตกต่างกัน โดยจะทำการใส่รหัสลับในคอมพิวเตอร์ในการสืบค้นข้อมูลเพื่อให้มั่นใจว่าจะไม่มีผู้อื่นทราบรายละเอียดของท่านนอกจากคณะซึ่งเป็นผู้วิจัย นอกจากนั้น ในรายงานผลของการวิจัยจะไม่มีชื่อจริงของท่านปรากฏอยู่ คณะจะกำหนดชื่อสมมติเพื่อใช้แทนชื่อจริงท่าน ผมจะไม่ใส่รายละเอียดอื่นๆของท่านเพื่อให้ผู้ที่มาอ่านงานวิจัยไม่สามารถคาดเดาได้ว่าเป็นท่านที่ให้ข้อมูล ทั้งนี้เพื่อรักษาความลับในการให้ข้อมูลของท่าน แต่กระนั้นก็ตาม คณะใคร่ขอเรียนให้ท่านได้ตระหนักถึงว่าจำนวนผู้เข้าร่วมให้สัมภาษณ์ในงานวิจัยนี้มีจำนวนน้อย ดังนั้นอาจจะมีความเป็นไปได้ที่บางคนอาจสามารถคาดเดาได้ว่าท่านเป็นผู้ให้ข้อมูล

เมื่อเสร็จสิ้นงานวิจัยครั้งนี้และวิทยานิพนธ์ได้ถูกทำเสร็จสมบูรณ์ ท่านสามารถขอพบพูดคุยจากการศึกษาครั้งนี้ได้จาก School of Health, University of New England, Australia ผลลัพธ์จากงานวิจัยนี้อาจจะถูกนำเสนอเผยแพร่ในการประชุมทางวิชาการหรือการตีพิมพ์ในวารสารทางวิชาการต่างๆ ข้อมูลต่างๆที่ได้จากการสัมภาษณ์จะถูกเก็บไว้ในที่ปลอดภัยและเป็นความลับที่ School of Health, University of New England, Australia ประมาณ 5 ปีหลังจากวันที่ได้ลงตีพิมพ์แล้ว หลังจากนั้นจะถูกทำลาย

คณะขอเรียนให้ทราบว่า การเข้าร่วมในการให้สัมภาษณ์ของท่านในงานวิจัยครั้งนี้ต้องเป็นไปโดยความสมัครใจของท่าน ดังนั้นท่านสามารถที่จะถอนตัวจากการให้สัมภาษณ์ในระยะใดก็ได้ หรือยกเลิกข้อมูลที่ท่านได้ให้แก่คณะได้ โดยจะไม่มีมีการดำเนินการใดๆกับท่าน นอกจากนั้นการดำเนินงานวิจัยของคณะไม่เกี่ยวข้องกับภาคการเมืองหรือส่วนราชการใดๆ ดังนั้นการเข้าร่วมงานวิจัยหรือไม่จะขึ้นอยู่กับการตัดสินใจของท่านประการเดียว

หากท่านยินดีที่จะเข้าร่วมในงานวิจัยดังกล่าวข้างต้น คณะใคร่ขอความกรุณาท่านได้โปรดลงนามในหนังสือยินดียินยอมเข้าร่วมงานวิจัยเพื่อเป็นการยืนยันว่าท่านได้อ่านและเข้าใจข้อมูลเบื้องต้นที่คณะได้นำเรียนชี้แจงและส่งคืนให้แก่คณะในซองจดหมายที่คณะเตรียมไว้ให้ และคณะจะได้ดำเนินการติดต่อหมายเวลาที่สะดวกสำหรับท่านในการให้สัมภาษณ์เชิงลึกและการสัมภาษณ์กลุ่มต่อไป

หากท่านมีข้อสงสัย หรือคำถามที่เกี่ยวกับงานวิจัยดังกล่าว ขอได้โปรดติดต่อ นายแพทย์ ประวิทย์ เตชะวิวัฒน์ ที่ 067341409 หรือที่อีเมล taytiwat@yahoo.com หรือที่อยู่ คณะสาธารณสุขศาสตร์ มหาวิทยาลัยนเรศวร อ.เมือง จ.พิษณุโลก 65000 โทรศัพท์ 056-261900 ต่อหมายเลข 5525 หรือท่านอาจจะติดต่ออาจารย์ที่ปรึกษางานวิจัย ศาสตราจารย์ วิคเตอร์ มินนิคิชิ โล่ ที่หมายเลข +61 2 6773 3862 หรือ ที่อีเมล yminichi@une.edu.au

หมายเหตุ

โครงการวิจัยนี้ได้ผ่านการอนุมัติจากคณะกรรมการจริยธรรมในการวิจัยในมนุษย์ของมหาวิทยาลัยนิวอิงแลนด์ ประเทศออสเตรเลียแล้ว (หมายเลขอนุมัติ HE06/009 อนุญาตถึง 06 กุมภาพันธ์ 2550)

หากท่านมีข้อร้องเรียนเกี่ยวกับพฤติกรรมในการดำเนินงานวิจัยนี้ กรุณาติดต่อเจ้าหน้าที่จริยธรรมในการวิจัยตามที่อยู่ข้างล่างนี้

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Appendix 4
Guideline for Interview

Guideline for Interview

Q1. Could you tell me something about your background and work experience in this field? What particular skills are required to do your job?

Q2. What sort of things do you have to do in your job; and how do you feel about what you do?

Q3. What are your main goals and objectives for working in your present position?

Q4. What factors assist or hinder you from achieving your objectives in this position?

Q5. How do you see your role in delivering of primary health services?

Q6. How do you see your role in delivering of public health services?

Q7. Could you tell me about how you deliver primary health services at the community level?

Prompt: The key issue that emerge will be followed up with clarifying questions focusing on understanding the role of the director vis-à-vis the health service.

Q8. What are the issues you experience with delivering these services?

Prompt: will be asked to seek clarification; focusing on and understanding how policies are understood and implemented.

Q9. How do you think that these services could be improved and what are the barriers at the moment to improving services? In your opinion how can policies be improved?

Q10. In your opinion how can the Thai health services system be improved?

Q11. What are the challenges to delivering services to the rural people who are disadvantaged economically and live in rural areas?

Appendix 4.1
Guideline for Interview (Thai version)

แนวคำถามสำหรับการสัมภาษณ์เชิงลึก

1. ช่วยกรุณาลำเกี่ยวกับประสบการณ์ทำงานและประวัติพื้นฐานของท่านในการทำงานด้านการดูแลสุขภาพระดับปฐมภูมิ ทักษะเฉพาะอะไรที่ท่านจำเป็นต้องมีในการทำงานของท่าน
2. ในการทำงานของท่าน ท่านทำอะไรบ้าง และ ท่านรู้สึกอย่างไรเกี่ยวกับสิ่งที่ท่านปฏิบัติอยู่
3. อะไรคือเป้าหมายและวัตถุประสงค์หลักของท่านสำหรับการทำงานในตำแหน่งปัจจุบัน
4. ปัจจัยอะไรที่ช่วยหรือต่อต้านท่านจากการทำให้ท่านประสบความสำเร็จตามวัตถุประสงค์ของท่านในการทำงานในตำแหน่งปัจจุบัน
5. ท่านมองว่าบทบาทของท่านในการให้บริการสุขภาพระดับปฐมภูมิเป็นอย่างไร
6. ท่านมองเห็นบทบาทของท่านในการให้บริการทางด้านงานบริการสาธารณสุขเป็นอย่างไร
7. กรุณาลำเรื่องเกี่ยวกับว่าท่านทำการให้บริการสุขภาพระดับปฐมภูมิแก่ชุมชนของท่านอย่างไร
คำถามย่อย: ประเด็นสำคัญซึ่งได้จากการสัมภาษณ์จะถูกถามต่อเพื่อทำความเข้าใจโดยเน้นเรื่องความเข้าใจในบทบาทของผู้อำนวยการในเรื่องของบริการสุขภาพ
8. ประเด็นอะไรที่ท่านพบหรือมีประสบการณ์ในการให้บริการสุขภาพเหล่านี้
คำถามย่อย: คำถามจะถูกถามเพื่อทำความเข้าใจที่ชัดเจนขึ้น โดยเน้นในเรื่องความเข้าใจเกี่ยวกับว่าเข้าใจนโยบายอย่างไรและมีการนำนโยบายไปปฏิบัติอย่างไร
9. ท่านคิดว่าบริการเหล่านี้ควรจะมีการพัฒนาอย่างไรและอะไรเป็นอุปสรรคในปัจจุบันในการพัฒนาบริการสุขภาพ ในความเห็นของท่านควรจะมีการพัฒนานโยบายอย่างไร
10. ในความเห็นของท่าน ระบบบริการสุขภาพของประเทศไทยควรจะถูกพัฒนาอย่างไร
11. อะไรคือสิ่งท้าทายในการให้บริการสุขภาพให้แก่ประชาชนในเขตชนบทซึ่งเป็นคนที่ประสบความสำเร็จอื่น
ด้านเศรษฐกิจ

Appendix 5

Questions to National and Regional Bureaucrats

Questions to National and Regional Bureaucrats

Q1. I'm interested in what you see as the major challenges in health care over the next 5-10 years.

Prompts:

- These challenges that you have just identified are they adequately identified or addressed in current Thai health policy?

or

- What you have described are the current identified health priorities, do you agree with them? Are there others? Are they changing?

Q2. What do you see needs to be done to change policy to meet these needs and emerging needs? Are we being flexible enough to meet changing needs?

Q3. Is our current health system adequate to meet the needs of the Thai people? If not, why? What changes would you make?

Q4. Health services are provided by a range of health professionals. Are they adequately prepared to meet the challenges and change that we have discussed? What more is needed.

Q.5 I'm interested in the capacity of directors and rural community hospitals being the responsible for delivering PHC under the Universal Coverage. What are your views in this area?

Prompts:

- What needs to be done to address your concerns? (If expressed).

- (If they are not supportive). How would you organize it differently? What would be your recommended course of action?

Appendix 5.1

Questions to National and Regional Bureaucrats (Thai version)

คำถามในการสัมภาษณ์ผู้บริหารระดับนโยบายในระดับประเทศและระดับภูมิภาค

๑. ท่านคาดการณ์ว่าปัญหาท้าทายที่สำคัญที่เป็นปัญหาหลักในการให้บริการสุขภาพของประเทศไทยในระยะ ๕-๑๐ ปีข้างหน้าเป็นอย่างไร
คำถามย่อย:

- ปัญหาที่ท่านได้พูดมานั้น ได้ปรากฏอยู่ในนโยบายสุขภาพของประเทศหรือไม่ อย่างไร
- สิ่งที่ท่านได้อธิบายมานี้ ได้ถูกจัดอยู่ในลำดับความสำคัญทางด้านสุขภาพ (Health priorities) ของประเทศในปัจจุบันหรือไม่ อย่างไร ท่านเห็นด้วยกับสิ่งต่างๆเหล่านั้นหรือไม่ อย่างไร มีปัญหาอื่นๆที่ท้าทายการให้บริการสุขภาพอีกหรือไม่ มีการเปลี่ยนแปลงหรือไม่ อย่างไร
- ท่านคิดว่าควรจะต้องทำอะไรบ้างในการเปลี่ยนแปลงนโยบายเพื่อให้สามารถตอบสนองต่อปัญหาที่ท้าทายหรือต่อความจำเป็นด้านสุขภาพต่างๆที่มีอยู่ในปัจจุบันและที่อาจจะเกิดขึ้นแบบกะทันหัน ท่านคิดว่าระบบบริการสุขภาพของเราในปัจจุบันมีความยืดหยุ่นเพียงพอหรือไม่ในการตอบสนองต่อความจำเป็นด้านสุขภาพหรือปัญหาท้าทายที่เปลี่ยนแปลงไป

๒. ระบบสุขภาพในปัจจุบันของไทยสามารถที่จะตอบสนองความจำเป็นทางด้านสุขภาพของประชาชนอย่างเพียงพอแล้วหรือไม่ อย่างไร
- ถ้าไม่เพียงพอ ท่านคิดว่าท่านจะเปลี่ยนแปลงอะไรบ้าง

๓. การให้บริการสุขภาพประกอบด้วยการทำงานของผู้ประกอบวิชาชีพทางด้านสุขภาพในสาขาต่างๆ ท่านคิดว่าในปัจจุบันได้มีการเตรียมตัวให้พวกเขาในการตอบสนองต่อปัญหาท้าทายและการเปลี่ยนแปลงดังกล่าวที่ท่านได้พูดถึงแล้วหรือไม่ อย่างไร ควรจะต้องมีอะไรที่จะต้องทำมากขึ้นกว่านี้ กรุณาอธิบาย

๔. ผมมีความสนใจในศักยภาพของโรงพยาบาลชุมชนและตัวของผู้อำนวยการ โรงพยาบาลชุมชนเองในการเป็นจุดสำคัญในการให้การดูแลสุขภาพขั้นปฐมภูมิ (Primary health care) ภายใต้นโยบายหลักประกันสุขภาพถ้วนหน้า ท่านมีความเห็นหรือมุมมองในเรื่องดังกล่าวอย่างไรบ้าง

- ควรจะต้องทำอะไรในการสนับสนุนสิ่งที่ท่านได้พูดถึง
- ถ้าพอ. ไม่ได้รับการสนับสนุน ท่านจะมีการดำเนินการหรือจัดการในเรื่องนี้อย่างไรที่แตกต่างจากปัจจุบัน ท่านจะแนะนำแนวทางการปฏิบัติอย่างไร

๕. ผู้อำนวยการโรงพยาบาลในภาครัฐของประเทศไทยส่วนใหญ่หรือทั้งหมดมาจากวิชาชีพแพทย์ แต่กลับไม่ได้มีการฝึกอบรมหรือการศึกษาในด้านการบริหารสุขภาพอย่างจริงจัง ท่านมีความเห็นต่อประเด็นดังกล่าวอย่างไร

คำถามย่อย:

- วิชาชีพอื่นๆควรจะได้รับการส่งเสริมให้สามารถดำรงตำแหน่งบริหารดังกล่าวหรือไม่ อย่างไร
- ผู้อำนวยการรพ. ควรจะมีความเข้าใจและทักษะในการบริหารด้านสุขภาพหรือไม่ อย่างไร
- ในการเตรียมผู้อำนวยการรพ. ให้สามารถตอบสนองต่อปัญหาท้าทายระบบสุขภาพไทยต่างๆที่ได้พูดถึง ควรจะต้องมีการศึกษาหรือการฝึกอบรมที่จำเป็นอะไรบ้าง

Appendix 6
Questions to Community Hospital Directors

Questions to Community Hospital Directors

Q1. I would like to talk to you about primary health care but, of course, we sometimes have different views or understandings about what primary health care is. Could you start by describing your understanding and perspectives of PHC in the Thai rural context and that of universal health coverage?

Prompts:

- What are the current difficulties in delivering PHC in your community?
- How would you go about improving service delivery? What would you do differently if it was within your power to do so?
- What are the barriers that you face?
- Do you think that community hospitals are best placed to deliver PHC to the community? If yes, why? If not, why? What changes are needed to make this happen?

Q2. Tell me about your experience as a Director of XXXX community hospital

Prompts:

- How long have you been in this or similar positions?
- How/why did you become a community hospital director?
- What do you feel about the role?
- What do you find most satisfying about the role?
- What are the frustrations of this role?
- What are the challenges?

Q3 Would you recommend this role to others looking for a career in rural health

Prompts:

- What advice would you give to them?
- If it were possible what changes would you make to the role?
- What else do you think is necessary to support the role and to improve service delivery?
- Are there particular skills and competencies that you see as essential?

Q4. Can we now just talk about the health needs of your community? From your point of view, what are they?

Prompts:

- How do you determine health needs? Are they changing? What are the priorities?
- Are health needs being met? What are the gaps? Why do they exist? How can they best be addressed in your view?
- How would you organize service delivery to address these priorities?
- Can the Directors of community hospitals effectively deliver both hospital and PHC services in a better, more integrated, way to communities than is presently done? How?

Q 5 Much of what you do depends on Health Ministry and government policy and direction. If your role was reversed and you were the Minister or Permanent Secretary what would you do differently? What changes would you make?

Appendix 6.1

Questions to Community Hospital Directors (Thai version)

แนวคำถามสำหรับการสัมภาษณ์เชิงลึกผู้อำนวยการโรงพยาบาลชุมชน

1. ผมขออนุญาตพูดคุยกับท่านเกี่ยวกับเรื่องการดูแลสุขภาพระดับปฐมภูมิ (primary health care) ซึ่งบางครั้งเราก็มีมุมมองหรือความเข้าใจที่แตกต่างกันไปเกี่ยวกับว่าการดูแลสุขภาพระดับปฐมภูมิคืออะไร ท่านจะกรุณาเริ่มด้วยการบรรยายว่าความเข้าใจของท่านและมุมมองของท่านในเรื่องของการดูแลสุขภาพระดับปฐมภูมิในบริบทของนโยบายหลักประกันสุขภาพถ้วนหน้าและในบริบทของชนบทไทยเป็นอย่างไร

คำถามย่อย:

- อะไรคือความยากลำบากในการให้บริการสุขภาพระดับปฐมภูมิแก่ชุมชนของท่านในปัจจุบัน
- ท่านจะทำการทำให้การให้บริการเหล่านี้ดีขึ้นได้อย่างไร ท่านอยากจะทำอะไรที่แตกต่างจากในปัจจุบันถ้าสิ่งนั้นอยู่ภายใต้อำนาจหน้าที่ของท่านที่จะกระทำได้
- อะไรคืออุปสรรคที่ท่านเผชิญอยู่ในปัจจุบัน
- ท่านคิดว่าโรงพยาบาลชุมชนเป็นจุดที่ดีที่สุดในการให้บริการสุขภาพระดับปฐมภูมิต่อชุมชน ถ้าท่านตอบว่าใช่ ทำไม และถ้าท่านตอบว่าไม่ใช่ ทำไม การเปลี่ยนแปลงอะไรที่จำเป็นต้องมีหากต้องการให้โรงพยาบาลชุมชนให้บริการสุขภาพระดับปฐมภูมิ

2. กรุณาเล่าประสบการณ์ของท่านในฐานะที่ท่านเป็นผู้ผู้อำนวยการ โรงพยาบาลชุมชน

คำถามย่อย:

- ท่านดำรงตำแหน่งเป็นผู้ผู้อำนวยการ โรงพยาบาลชุมชนทั้งที่โรงพยาบาลนี้และที่อื่นมาแล้วนานเท่าไร
- ทำไมและอย่างไรท่านจึงมาเป็นผู้อำนวยการ โรงพยาบาลชุมชน
- ท่านรู้สึกเกี่ยวกับบทบาทของท่านอย่างไร
- อะไรที่ท่านพึงพอใจมากที่สุดเกี่ยวกับบทบาทของท่าน
- อะไรที่ท่านรู้สึกอึดอัดลำบากใจเกี่ยวกับบทบาทนี้
- อะไรคือสิ่งที่ท้าทายในการทำงานของท่าน

3 ท่านจะแนะนำบทบาทของผู้ผู้อำนวยการ โรงพยาบาลชุมชนต่อคนอื่นที่ต้องการทำงานในชนบทหรือไม่

คำถามย่อย:

- คำแนะนำอะไรที่ท่านจะบอกกับเขา
- ถ้าเป็นไปได้ท่านอยากจะเปลี่ยนแปลงอะไรต่อบทบาทของผู้ผู้อำนวยการ โรงพยาบาลชุมชน
- ท่านคิดว่ามีอะไรที่จำเป็นต่อการสนับสนุนบทบาทของผู้ผู้อำนวยการชุมชนและจำเป็นต่อการพัฒนาการให้บริการสุขภาพ
- มีทักษะเฉพาะหรือความสามารถเฉพาะอะไรที่ท่านเห็นว่าจำเป็นที่ผู้อำนวยการ โรงพยาบาลชุมชนต้องมี

4. เราเปลี่ยนไปพูดคุยกันเรื่องเกี่ยวกับความจำเป็นทางด้านสุขภาพของชุมชนของท่าน ในมุมมองของท่าน ท่านคิดว่ามันคืออะไร

คำถามย่อย:

- ท่านจะพิจารณาความจำเป็นทางด้านสุขภาพได้อย่างไร มันมีการเปลี่ยนแปลงหรือไม่ อะไรเป็นความสำคัญที่ถูกจัดไว้เป็นอันดับแรกๆ
- ความจำเป็นทางด้านสุขภาพได้รับการตอบสนองหรือไม่ อะไรคือช่องว่าง ทำไมจึงยังมีช่องว่างนั้นอยู่ ปัญหานี้จะถูกจัดการได้ดีที่สุดอย่างไรในมุมมองของท่าน
- ท่านจะมีการจัดการส่งมอบบริการสุขภาพเพื่อตอบสนองต่อปัญหาที่ท่านจัดว่าเป็นความสำคัญเหล่านี้ได้อย่างไร
- ผู้อำนวยการ โรงพยาบาลชุมชนสามารถให้บริการทั้งบริการระดับปฐมภูมิและบริการระดับ โรงพยาบาลทั้งสองอย่างในรูปแบบที่มีการบูรณาการที่มากขึ้นหรือในหนทางที่ดีขึ้นกว่าในปัจจุบันนี้ต่อชุมชนของท่านอย่างมีประสิทธิภาพได้หรือไม่ อย่างไร

5. ส่วนใหญ่สิ่งที่ท่านปฏิบัติงานอยู่ที่นี่ขึ้นอยู่กับนโยบายและการขึ้นของกระทรวงสาธารณสุขและรัฐบาล ถ้าท่านเป็นรัฐมนตรีหรือปลัดกระทรวงสาธารณสุขท่านอยากจะทำอะไรที่แตกต่างจากปัจจุบัน การเปลี่ยนแปลงอะไรที่ท่านจะทำให้เกิดขึ้น

Appendix 7
Questions to Health Managers
at District and Sub-district Levels

Questions to Health Managers at District and Sub-district Levels

Q1. Can you tell me your experience in implementing/delivering primary health services for your community?

Prompts:

- How long have you been in this or similar positions?
- What sort of things do you have to do in your job; and how do you feel about what you do?
- How you deliver primary health services at the community level?
- What are challenges?
- What are the current difficulties in delivering PHC in your community?
- What do you think you can do well? Why?
What do you think you can do less of or intend to do, but cannot do?
Why?
- What are the barriers that you face?
- How would you go about improving service delivery?

Q2. Can we now just talk about the health needs of your community? From your point of view what are they?

Prompts:

- How do you determine health needs? Are they changing? What are the priorities?
- Are health needs being met? What are the gaps? Why do they exist? How can they best be addressed in your view?
- How would you organize service delivery to address these priorities?

Q3. Much of what you do depends on the Health Ministry and government policy and direction. If your role was reversed and you were the Minister or Permanent Secretary what would you do differently? What changes would you make?

Appendix 7.1
Questions to Health Managers
at District and Sub-district Levels (Thai version)

แนวคำถามสำหรับการสัมภาษณ์ผู้บริหารสุขภาพระดับอำเภอและตำบล

1. ช่วยกรุณาลำประสบการณ์ของท่านในการดำเนินการให้บริการสุขภาพระดับปฐมภูมิแก่ชุมชนของท่าน

คำถามย่อย:

- ท่านดำรงตำแหน่งนี้หรือทำงานในลักษณะนี้มีมานานเท่าไรแล้ว
- ในตำแหน่งของท่านมีงานอะไรที่ท่านต้องทำบ้าง และท่านรู้สึกอย่างไรเกี่ยวกับสิ่งที่ท่านทำอยู่
- ท่านให้บริการสุขภาพระดับปฐมภูมิต่อชุมชนของท่านอย่างไร
- อะไรคือสิ่งท้าทายในการทำงานดังกล่าว
- อะไรคือความลำบากในการให้บริการสุขภาพระดับปฐมภูมิต่อชุมชนของท่าน
- ท่านคิดว่าอะไรที่ท่านทำได้ดี ทำไม อะไรที่ท่านคิดว่าเป็นสิ่งที่ทำได้ไม่ดีหรือท่านตั้งใจอยากจะทำแต่ไม่สามารถทำได้ ทำไม
- อะไรคืออุปสรรคที่ท่านเผชิญอยู่
- ท่านอยากจะทำให้การให้บริการของท่านดีขึ้นได้อย่างไร

2. เราเปลี่ยนไปพูดคุยกันเรื่องเกี่ยวกับความจำเป็นทางด้านสุขภาพของชุมชนของท่าน ในมุมมองของท่าน ท่านคิดว่ามันคืออะไร

คำถามย่อย:

- ท่านจะพิจารณาความจำเป็นทางด้านสุขภาพได้อย่างไร มันมีการเปลี่ยนแปลงหรือไม่ อะไรเป็นความสำคัญที่ถูกจัดไว้เป็นอันดับแรกๆ
- ความจำเป็นทางด้านสุขภาพได้รับการตอบสนองหรือไม่ อะไรคือช่องว่าง ทำไมจึงยังมีช่องว่างนั้นอยู่ ปัญหานี้จะถูกจัดการได้ดีที่สุดอย่างไร ในมุมมองของท่าน
- ท่านจะมีการจัดการส่งมอบบริการสุขภาพเพื่อตอบสนองต่อปัญหาที่ท่านจัดว่าเป็นความสำคัญเหล่านี้ได้อย่างไร

3. ส่วนใหญ่สิ่งที่ท่านปฏิบัติงานอยู่นี้ขึ้นอยู่กับนโยบายและการชี้แนะของกระทรวงสาธารณสุขและรัฐบาล ถ้าท่านเป็นรัฐมนตรีหรือปลัดกระทรวงสาธารณสุขท่านอยากจะทำอะไรที่แตกต่างจากปัจจุบัน การเปลี่ยนแปลงอะไรที่ท่านจะทำให้เกิดขึ้น

Appendix 8
Questions to Community Representatives

Questions to Community Representatives

Q1. Can you tell me your experience in relation to health services?

Q2. Can we now discuss about health needs of your community?

Prompts:

- What are health needs of your community?
- Are your community's health needs being met? If not, why?
- How do people access health care when they need to?
- What do you think makes your community feel satisfied with the health services in your area? Why?
- What do you think that your community feels unsatisfied about with the health services at your area? Why?
- Are there any difficulties in accessing health care? If yes, why?
- What aspect of the health services in your area do you want to be improved? Why? and How?

Appendix 8.1

Questions to Community Representatives (Thai version)

แนวคำถามสำหรับการสัมภาษณ์เชิงลึกผู้แทนของชุมชน

1. กรุณาเล่าให้ฟังเกี่ยวกับประสบการณ์ของท่านในเรื่องเกี่ยวกับการให้บริการสุขภาพ

2. ผมขอพูดคุยกับท่านเกี่ยวกับเรื่องความจำเป็นทางด้านสุขภาพของชุมชนของท่าน

คำถามย่อย:

- ความจำเป็นทางด้านสุขภาพของชุมชนของท่านคืออะไร
- ความจำเป็นทางด้านสุขภาพของชุมชนของท่านได้รับการตอบสนองหรือไม่ ถ้าไม่ ทำไม
- ประชาชนในชุมชนของท่านเมื่อจำเป็นต้องเข้ารับบริการสุขภาพ เขาทำอย่างไร
- ท่านคิดว่าอะไรที่จะทำให้ชุมชนของท่านรู้สึกพึงพอใจต่อบริการสุขภาพในพื้นที่ของท่านได้ ทำไม
- ท่านคิดว่าอะไรที่ทำให้ชุมชนของท่านรู้สึกไม่ค่อยพอใจต่อบริการสุขภาพในพื้นที่ของท่าน ทำไม
- ชุมชนของท่านมีความยากลำบากในการเข้ารับบริการหรือไม่ ถ้าใช่ ทำไม
- ท่านอยากจะทำให้การบริการสุขภาพในพื้นที่ของท่านมีการพัฒนาขึ้นในด้านใดบ้าง ทำไมและจะพัฒนาอย่างไร

Appendix 9
Focus Group Schedule

Focus Group Schedule

- Q1. Primary Health Care and Primary Care
What are your perspectives or understanding of both terms? What do you think are the similarities or differences?
- Q2. Which model of primary health care which is appropriate for rural Thailand and is able to be continually improved?
- Q3. What other competencies of health professionals and health managers are needed for strengthening primary health care. What are your views on this issue? How you can enable a rural area of Thailand, such as your community, to have such capable people?
- Q4. Much of what you do depends on Health Ministry and government policy and direction. Within your power as the community hospital directors, what you can do to improve quality of primary health care?
- Q5. Can we now discuss local government in relation to primary health care. What are your views on local government being involved in the provision of primary health care? In what ways can they help strengthen primary health care? What are the barriers? How would you overcome those barriers?

Appendix 9.1
Focus Group Schedule (Thai version)

ประเด็นสำหรับการสัมภาษณ์กลุ่มสำหรับผู้อำนวยความสะดวกโรงพยาบาลชุมชน

1. ความหมายของคำว่า Primary Health Care and Primary Care

มุมมองท่านหรือความเข้าใจของท่านต่อคำสองคำนี้ ท่านคิดว่าอะไรคือความเหมือนและอะไรคือความแตกต่าง

2. รูปแบบของการให้การดูแลสุขภาพระดับปฐมภูมิแบบไหนที่เหมาะสมต่อบริบทสังคมไทยในชนบทที่จะสามารถทำการพัฒนาได้อย่างต่อเนื่อง

3. ความสามารถอื่นๆอะไรที่ท่านคิดว่าผู้ให้บริการสุขภาพและผู้บริหารบริการสุขภาพจำเป็นต้องมีในการสร้างความเข้มแข็งให้แก่การดูแลสุขภาพระดับปฐมภูมิ. อะไรคือมุมมองของท่านต่อประเด็นนี้ ท่านจะสามารถทำให้ชุมชนในชนบทของประเทศไทยดังเช่นในชุมชนของท่านมีคนที่มีความสามารถอย่างนั้นได้อย่างไร

4. ส่วนใหญ่แล้วท่านจะต้องขึ้นอยู่กับนโยบายของรัฐบาลและกระทรวงสาธารณสุขและทิศทางที่ถูกกำหนดมา ภายใต้อำนาจหน้าที่ของท่านในฐานะผู้อำนวยความสะดวกโรงพยาบาลชุมชน ท่านสามารถทำอะไรได้บ้างที่จะพัฒนาคุณภาพของการดูแลสุขภาพระดับปฐมภูมิ

5. ผมจะขอถามประเด็นเกี่ยวกับองค์กรปกครองส่วนท้องถิ่นในเรื่องที่เกี่ยวข้องกับการดูแลสุขภาพระดับปฐมภูมิ มุมมองของท่านในเรื่องที่องค์กรปกครองส่วนท้องถิ่นเข้ามามีส่วนในการให้บริการสุขภาพระดับปฐมภูมิเป็นอย่างไร ท่านคิดว่าองค์กรปกครองส่วนท้องถิ่นสามารถเข้ามาช่วยทำให้การดูแลสุขภาพระดับปฐมภูมิเข้มแข็งขึ้นได้อย่างไร อะไรคืออุปสรรค ท่านจะสามารถแก้ไขปัญหานี้ได้อย่างไร

Appendix 10
Participant's Demographic Data

Research Project: Understanding the role of Thai Community Hospital Directors in implementing the Universal Health Coverage policy in relation to Primary Health Care

Participant's Demographic Data

1. Gender Male Female

2. AgeYear(s)Month(s)

3. Educational background
.....
.....
.....
.....

4. Present position Director of Community Hospital Chief of District Health Office Head of PCU at Community Hospital Head of Health Centre or PCU at sub-district level Community representative Others.....

5. How long have you been in that position?
.....Year(s).....Month(s)

6. How long have you been involved in health field?
.....Year(s).....Month(s)
(Please give a brief information regarding what have you done about health field, such as , what position you were)
.....
.....
.....
.....

7. Have you involved with CUP Board or District Health Coordinating Committee
 No Yes (please give details)
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.....
.....

Appendix 10.1
Participant's Demographic Data (Thai version)

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7. ท่านเป็นผู้ช่วยของคณะกรรมการบริหารสุขภาพระดับอำเภอ (CUP Board) ไม่เป็นผู้ช่วย เคยช่วย เป็น

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.....
.....

6. ท่านมีส่วนกำหนดสุขภาพทั้งหมด(จนถึงปัจจุบัน).....ปี.....เดือน
(กรุณาให้ชื่อเมืองที่ท่านอาศัยอยู่หรือชื่อโรงพยาบาลประจำตัวของคุณเป็นต้น)

5. ดำรงตำแหน่ง.....ปี.....เดือน

4. ตำแหน่งในปัจจุบัน ผู้อำนวยการโรงพยาบาล ผู้อำนวยการศูนย์สุขภาพชุมชน หัวหน้าสถานอนามัยหรือศูนย์สุขภาพชุมชนที่อยู่ในข่ายใต้การบังคับบัญชาของ
สาธารณสุขอำเภอ ผู้นำชุมชน อื่นๆ.....
.....

.....
.....
.....
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.....
.....

3. วัตถุประสงค์ของท่าน

2. อายุ.....ปี.....เดือน

1. เพศ ชาย หญิง

ชื่อของหน่วยงานที่ท่านปฏิบัติงาน

ชื่อโครงการ การศึกษาแบบทบทวนและค้นหาพื้นที่ของผู้อำนวยการโรงพยาบาลชุมชนในการนำนโยบาย
หลักประกันสุขภาพถ้วนหน้ามาใช้และจัดการดูแลสุขภาพระดับชุมชนปฏิบัติ
Informant Code

Appendix 11

The Letter of Approval from the University of New England

Human Research Ethics Committee

THE UNIVERSITY OF NEW ENGLAND
HUMAN RESEARCH ETHICS COMMITTEE

MEMORANDUM TO: Prof. V Minichiello/Adj. Prof. J Fraser/Mr D Briggs/Dr P Taytiwat
School of Health

This is to advise you that the Human Research Ethics Committee has approved the following:

PROJECT TITLE: Understanding the role of the Thai community hospital directors in implementing the Universal Health Coverage Policy in relation to primary health care

COMMENCEMENT DATE: 6/2/06

COMMITTEE APPROVAL No.: HE06/009

APPROVAL VALID TO: 6/2/07

COMMENTS: Nil. Conditions met in full

The Human Research Ethics Committee may grant approval for up to 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 renewal/Final Report Form is available at the following web address: http://rs-nt-10.une.edu.au/Home/V_2_1/ecforms.html

The *NHRMC 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.

Fiona Prater
Secretary

6/2/06

Appendix 12
The Letter of Permission from
the Nakhorn Ratchasima Provincial Health Office

***The Letter of Permission from the Nakhorn Ratchasima
Provincial Health Office***

Nakhonratchasima Provincial Health Office

255 Moo 11 Tombon kokgroud,
Amphur Muang, Nakhonratchasima
30280, Thailand
Tel. 0011-66-4465-016
Fax. 0011-66-4465-021

28th December 2005

Dear Dr. Taytiwat,

It is my pleasure to inform you that your request on conducting the research, *Understanding the Role of the Director of the Community Hospital in Implementing the Universal Health Coverage Policy*, in Nakhonratchasima Province has been granted for the permission.

Please note that before you start conducting the research you have to report yourself at the Research and Development Department, Nakhonratchasima Provincial Health Office. You can prepare for an arrangement with Mrs. Phatthanachat Phatharasatsawatwong by telephone: 0011-66-4465-016.

Should you have any questions, please contact Mrs. Kanokrat Supparanont at the Provincial Health Office, telephone number 0011-66-4465-017.

I am looking forward to having you visit and do your research in our area.

Sincerely yours,



Samreng Yanggratoke, MD.

Provincial Chief Medical Officer
Nakhonratchasima Province