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# THE PROVINCIAL RURAL HEALTH PLANNING PROCESS AND ITS IMPLEMENTATION IN THAILAND

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## INTRODUCTION

This paper discusses the planning and implementation of rural health services on the provincial level and district levels in Thailand. By focusing on the opinion of the government officials concerned an assessment is made of the effectiveness of the process as it has been designed on paper in actual operations. So far few studies have dealt with the public health officials; the most recent study emphasizes on multiple superiors within the bureaucracy comprising formal and informal systems of linkages (1) Earlier reports have been focusing on activity patterns of officials (2) or on sector or policy reviews on a macro-level (3, 4, 5, 6, 7). Since the rural development system-of which health delivery is part-has been undergoing an overall reform starting in 1982, considerable adaptation have been made to the planning and administrative framework for health services delivery.

In this paper, an attempt is made to sketch the recent reforms in Thailand. The new management system for rural development in Thailand does indeed comprise rural health services (in the Ministry of Public Health), community development (in the Ministry of Interior), activities in nonformal education in particular (in the Ministry of Education) and serveral departments' activities in the Ministry of Agriculture and Co-operatives. These four ministries have been designated as main actors in an attempt to coordinate planning and implementation

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of rural development on a more self-reliant basis (8). Thus, the issue of people's participation in the planning and management of the rural health services has become more important.

## PLANNING AND IMPLEMENTATION IN THE MINISTRY OF PUBLIC HEALTH

### Tke Ministry of Public Health

As a part of the Thai bureaucratic apparatus, the Ministry of Public Health (MOPH) is responsible for providing public health services in the country. Established in 1942, the MOPH has grown to the point where it now consists of two main offices and four departments, with a total of 83 divisions. The health administration can be divided into two major categories, the central and the provincial health administration.

The central health administration is organized into six major components (see Chart 1) and it directly supervises and controls the Provincial Health Administration which is headed by the Provincial Chief Medical Officers (PCMOs), who are 72 in number (9) All these departments give technical support to the Provincial Health Office (PHOs) in their respective fields. Some of the departments have their own regional offices located in some provinces.

Chart 1 about here

At the provincial level, the public health sector is administered by the Provincial Chief Medical Officer (PCMO) who directs the Provincial Health Office (PHO). The PCMO is directly responsible to the Governor if the province, as well as to the Permanent Secretary of State for Public Health. The PHO comprises 8 major sections, i.e. the Administration Section, the Planning and Evaluation Section, the Health Promotion Section, the Communicable Disease Control Section, the Environmental Sanitation Section, the Health Education, Training and Supportive Service Section, the Medical Services Section, and the Dental Health Section. The Administration Section and the Planning and Evaluation Section are administered by the PCMO directly whereas the remaining offices are under the administration of the Director of the Health Technical Office. In addition to the eight sections, there is a Regional or Provincial Hospital whose director is responsible to the PCMO (see Chart 2) (9).

Chart 2 about here

The district-level health sector is divided into two major agencies, the Community Hospital (CH) and the District Health Office (DHO). The District Health Officer (DHOer) is directly responsible to the (Chief) District Officer and he

or she is related to the Community Hospital Director (CHD) in terms of cooperation and supervision. The Health Centers (HCs) are the health service facilities located at the subdistrict *(tambon)* and village *(muban)* levels. But, they are within the responsibility of the DHO.

To implement its activities the MOPH has a rather limited *annual health budget.* Table 1 presents the comparison between the annual budget of the whole country and the MOPH (fiscal years 1972–1986).

Table 1 about here

**The health planning machinery**

A Health Committee consisting of top executives in the MOPH and the National Economic and Social Development Board (NESDB) exercises overall control over national health policies and priorities. The Social Planning Committee of the NESDB has responsibility for integrating all health projects of the Ministry of Public Health with other social projects and plans. On the basis of the national development plan, the various departments of the MOPH prepare annual plans on the basis of proposals received from the Provincial Health Administrations. They submit them to the Permanent Secretary, who after involving the Health Planning Division, would forward them to the NESDB and the Budget Bureau. These two offices process the proposals among themselves and then give their approval. The Budget Bureau will then include the necessary funds as part of the annual budget, which is presented to the Parliament for final approval. The implementation of the annual operating plan is carried out at the provincial level by central and/or provincial health officers.

**The rural health delivery system**

Thailand's health delivery system includes not only the MOPH network, which is the largest and fastest growing network for services, but also a number of private hospitals and clinics operated by other Government agencies and a smaller number of privately run hospitals and clinics including those operated by foreign church missions and by private voluntary organizations (10). In addition, there are many unlicensed physicians who practice extensively in the rural areas (11) and numerous commercial pharmacies, although the latter are usually found in towns. Buddhist monks have also been trained to provide basic health care (12).

The MOPH has developed a standardized pattern for the delivery of rural health services in which health care is provided through a hierarchy of facilities. Each level of health care has been organized administratively to provide a distinct set of services to a defined population group. The key institution providing

specialized medical care in each province is the Provincial Hospital, usually located in the provincial capital. Each province typically has about nine districts (amphoes) and each district with 30,000 or more population is intended to have a 10, 30 or 60 bed Community Hospitals (CH). Districts are typically divided into about 10 tambons and each tambon with 5,000 or more population is intended to have a Health Center staffed by two paramedicals. At the lowest level, each village (muban) or cluster of villages with a population of 2,000 was intended to have a Midwifery Center, but, in 1982, all the Midwifery Centers were upgraded to become Health Centers. Chart 3 shows the hierarchy and lines of referral of this system (9).

Chart 3 about here

## METHODS

### Sampling methodology

In order to take stock of the implementation of the new system as it has been put on paper in actual reality, the opinion of government officials working in the system was sampled. The sampling was carried out in 18 provinces in 9 MOPH regions. On the district level, two districts with a district hospital in each province are selected. Both districts where the District Health Officer and the District Hospital Director are actively involved or are inactive were included in the sample. The district study areas were selected by consulting with the Chief of the Health Planning and Evaluation Section in each selected province. On the provincial level, the Chief of the Health Planning and Evaluation Section (18 resp.), the Chief of the Health Promotion Section (16 resp.), and the Chief of the Sanitation and the Environmental Health Section (17 resp.), were interviewed. Within each selected district, the District Health Officer (35 resp.) and the District Hospital Director (28 resp.) were interviewed. Some questionnaires had to be left and were subsequently received by mail due to absenteeism. Structured questionnaires were used to collect data from the selected respondents. Field research for this study began on May 20th, 1985 and ended at the beginning of July 1985.

### Hypotheses

A general hypothesis of this study can be formulated, i.e. the annual provincial rural health services plan can be effectively implemented if the existing (new) system of management is functioning well. Under this general hypothesis, a number of characteristics based on the literature of development administration and implementation analysis were taken into consideration (13-30). It is assumed that if these characteristics exist or conditions are fulfilled, there will be an effective annual provincial rural health services plan. The characteristics related to planning and implementation are as follows :

1. The public health personnel at the provincial and district level possess a good knowledge of and positive attitudes towards the health planning process.
2. The Provincial Governor and the District Officer play a prominent role in the rural health services planning.
3. The Provincial Chief Medical Officer (PCMO) takes an active part in the rural health services planning process.
4. The annual provincial rural health services plan is formulated through involvement of the Provincial Health and Evaluation Committee (PHPEC).
5. There is flexibility in planning on the basis of plan adjustment.
6. There is an effective monitoring and evaluation system at the provincial and district level.
7. There is effective coordination between the health sector and other sectors in annual provincial rural health services planning both on the provincial and district level.
8. There is effective coordination between the Provincial Health Office (PHO) and the Regional Health Technical Centers (RHTC) in annual provincial health planning.
9. There is coordination among Health personnel in the PHO.
10. There is coordination among the PHO, the DHO, and the DH.
11. There are reliable data and information available for health planning both on the provincial and the district level.
12. The plan is responsive to the needs of the local people.

## THE PLANNING PROCESS FOR PROVINCIAL RURAL HEALTH SERVICES

### Thai Public Health Bureaucrats

The present Thai bureaucracy as discussed by Bowornwathana (1) is a highly centralized administrative system. In Bangkok the Office of the Prime Minister controls the administrative activities of other ministries through the National Economic and Social Development Board (NESDB), the Budget Bureau, and the Civil Service Commission. The NESDB's main function is to make national five-year plans which outline national policies (see 21). These also include five year and annual health plans. Bowornwathana's study on public health bureaucrats in rural Thailand emphasizes on intra-organizational coordination among health personnel as an interaction system in terms of the formal and informal patterns of multiple superior-subordinate relationships (1). The superiors who interact with subordinates can be divided into those who are involved in a general way in all interaction areas,

and those who interact with subordinates along specific functional areas such as nutrition, sanitation, and family planning, etc. The 'general' superiors include the Provincial Chief Medical Officer (PCMO), the Director of the Health Technical Services Office (DHTSO), the District Hospital Director (DHD) and the District Health Officer (DHO). On the other hand, the 'specific' superior actors are the heads of sections from the provicial health offices. Each of them interacts with the subordinate officials within the public health areas they are working in.

According to Bowornwathana the informal patterns of multiple superior-subordinate relationship are of two types : traditional and bureaucratic (1). The 'traditional' superior-subordinate interactions are primarily based on kinship, friendships and seniority considerations. These three factors constitute three interaction areas within the traditional social system.

Public health officials are also hierarchically classified and ranked according to their professional expertise in the Civil Service Commission system. Medical doctors (MDs) seem to have a strong control over the entire public health apparatus in Thailand. At present, key administrative positions in the provinces are held by officials with M.D.s. In Bangkok, most of the positions from the directors of divisions upwards are occupied by M.D.s. Administrative problems can be frequently seen as the effects of this system of professional hierarchy. Seniority, that is 'age' and 'length of employment' also seems to play an important role in structuring the relationship among bureaucrats who belong to different professional groups.

Bureaucratic relationships consist of three types of interaction areas : the triangular relationships among the PCMO, the DHTSO, and the Provincial Hospital Director (PHD), politics within provincial offices, and the interaction between the DHO and other superiors. There is a strong belief among public health experts that if the PCMO, the DHTSO and the PHD cooperate with each other, then the management of public health activities within that province will be successful. According to Bowornwathana, the political struggle among public health officials within a province tends to be a struggle between a political clique led by the PCMO, and another clique led by the DHTSO (1). The relationship between the DHO and other superiors is another bureaucratic interaction area. The relations between the DHO and the DHD may also become very bitter. The DHO may feel that the DHD, though a well-trained doctor, lacks the necessary administrative skills. On the other hand, the DHD regards the DHO as a not-so-qualified health and unimportant official.

**Training in Health Planning**

The data collection comprise the training in health planning under the new management system of rural development, an assessment of the new management system versus the previous system, and various operational aspects of health planning.

The Ministry of Public Health (MOPH) has been carrying out the health planning process under a new system and organization of rural development since the beginning of the Fifth National Economic and Social Development Plan (fiscal year 1982/1983). The new system of planning is based on an entirely different concept as compared to the previous strategies : the Provincial Health Officers are now the 'focal point' of the process. They now formulate the provincial health plan which can be said to be the outcome of the national health policies at the central level passed down as guidelines and the health workers' input at the district and local level. At the PHO, the key persons concerned with the provincial health planning process are the Chiefs of each section. The key person is the Chief of the Health Planning and Evaluation Section.

In view of these profound changes in the planning process one must consider whether the officers involved understand their new role and, hence, whether there has been any instruction on the new system. Most of the officers at both the provincial and the district level (89.5%) had at least one opportunity to attend training and/or to participate in a course concerned with the provincial health planning process. However, if we compare the provincial with the district level, we find that the frequency of opportunity at the provincial level is significantly higher ($p<0.5\%$). The opportunity for training should be reflected in the level of understanding of the officers in the planning process, but, 47% of the respondents dare not score their understanding of the process beyond 'indifference'. The group of the Chiefs of the Health Planning and Evaluation Section had the highest confidence in their understanding of the planning process. The understanding of provincial officers seems to be slightly better (Chi-square=10.95; $p<0.5\%$).

A majority of the respondents, both at the provincial and district level, perceive that the new system is different from the previous system. The important differences between the systems are the attempt to foster self-help and bottom-up planning, and also the more systematic planning process is mentioned. Moreover, 87% of all the respondents perceive that the provincial rural health services planning under the new management system is better than the previous system. The reasons supporting this favourable comparison are mostly related to a better response to needs and the resulting more correct definition of the role of officials which also allows for more accurate evaluation.

**Planning for the Provincial and District Health Plan**

There are four levels of organization under the new management system for rural development. They are : the national, provincial, district, and subdistrict (tambon) level. In the annual provincial rural health services planning, the process is started at the national level by the MOPH. The Health Planning Division (HPD) acts as health planning coordinator among various departments and divisions of the MOPH, as well as the coordinator between the MOPH and the NESDB and the Budget Bureau. The MOPH will prepare 'policy guidelines' and these being approved by the NESDB, the MOPH will send these to the provinces for them to adjust or reshape their activities. In practice, the details of the annual health plan formulation are considered by a specific committee, i.e. the Provincial Health Planning and Evaluation Committee. This committee comprises of key persons of the provincial health sector at both the provincial and district level.

After consideration by the more comprehensive Provincial Development Committee, the 'policy guidelines' from the central level will be adapted to become the 'provincial policy guidelines' for the distict level. At the district level, the District Development Committee (DDC) will take the 'provincial policy guidelines' into consideration and incorporate them with the felt-needs of local people at the subdistrict (tambon) and village (muban) level. Thus, the DDC will develop the 'district policy guidelines' or the 'district health plan'. The MOPH will reconsider the annual provincial health plan which is a part of the provincial development plan and finally it will be approved by the NESDB. The plan can be implemented after the financial approval of Parliament and the Budget Bureau have been received.

Table 2 presents the actual impacts of the health policy guidelines on provincial and district health planning as the respondents at the provincial and the district level perceive them. About 83% of the choices are cast on positive view-points about these guidelines. Therefore, they do not seem to be felf as directives forcing the provincial and district planning work into an undesirable direction.

Table 2 about here

**The role of key actors**

In view of the potential for conflicts between key actors in the planning process, the respondents were asked about the role of several of them. Most of the respondents (89.5%) perceive that the role of the Provincial Administrative Office as the coordinator of the provincial development plan is a pertinent one. The overwhelming reason supporting this ranking is its position of direct responsibility to the Provincial Governor, who himself has far--reaching responsibilities in the new rural development system, as well as its function of secretariate of the Provincial Development Committee.

AS the chairman of the Provincial Development Committee and the administrative superior in the province (the public health sector is also one of his responsibilities) most of the respondents at the provincial level (90%) believe that the Provincial Governor is important in the annual provincial rural health services planning process. Similarly, the District Ofifcer is the chairman of the District Development Committee and he takes responsibility for all govermental activities in a district including the health sector. The majority of the respondents at the district level are supportive of his role. However, some respondents (approx.13%) said that the District Officer would be important only if he is active or seriously takes action in health activities.

At the provincial level, the Provincial Chief Medical Officer (PCMO) seems to be very important in all health-related activities including the health planning process and its implemetation. In the provicial health sector, all of the health activities are the responsibility of the PCMO. In respect to his position of 'preliminary superior' of all the provincial health workers, the PCMO has a closer relationship with the health officers than the Provincial Governor. Moreover, in the present public health bureaucratic system in the province, the PCMO is very important in the perception of the public health workers at both the provincial and the district level (approx.96% rate him important or very important). However, the district level officers rate his importance significantly lower (Chi-sq.=106.01, $p<0.1\%$). Particularly health planning in the district hospital may be more independent. The reason for the less favourable response of district officers may be their relatively stronger belief that the PCMO is not doing much about district planning work as opposed to his involvement on the provincial level. Obviously, one wonders whether the PCMO would be given a chance for large-scale involvement by those same district officers.

At the beginning of the Fourth National Economic and Social Development Plan (1977-1981) in December 1976, the MOPH's organization and administration system was improved during a major overhaul of the structure of the health administration. At the provincial level, the Provincial Health Planning and Evaluation Committee (PHPEC) was established to formulate the provincial health plan, to verify and follow-up on the implementation and to evaluate the provincial health plan, as well as for intra-and intersectoral coordination. The PHPEC is chaired by the PCMO and it consists of the major key actors on the provincial and distric level. The Chief of the Health Planning and Evaluation Section was a committee member and he or she ran its secretariat. Officially, the PHPEC has been in operation since its establishment : in practice, there have been some modifications. On the district-level there is a district level committee that has a similar function to the PHPEC in the annual district health planning process. When asked about both these planning committees, some 94% of the provincial and some 87% of the

district officers believe they are (very) necessary. On the question whether these committees actually work out the planning, the response is less affirmative : only 63% state that the PHPEC is always involved and only 21% say a district level committee would be appointed to work out the health plan. Some provinces (16%) do never work out their plans through the PHPEC. The plans are formulated by assigning the work to each section and then combining each section of the plan. The result is to be the provincial plan. Another method is to assign to the Health Planning and Evaluation Section to work out the plan, with cooperation of each concerned section in terms of providing data. On the district level, plan formulation is assigned to each of the Health Centers (HC) and then each plan is combined to be the district health plan. In this case, the District Hospitals (DH) formulate their own plan with very little coordination with the District Health Office (DHO).

**Overall planning flexibility and follow-up**

The compatibility of the District Health Plan with the Provincial Rural Health Services Plan should be considered first. As previously discussed, the district health plan is formulated at the district level guided by the 'provincial policy guidelines', and then it will be reconsidered by the provincial level. In the opinion of a significant majority of the respondents of both the provincial and the district level (82.5%) the district health plan is thus made to be compatible with the objectives of the provincial health plan. Nevertheless, some 'errors' occur, e.g. the district plan proposes unnecessary activities or duplicates target areas, as well as an excessive budget request occurs frequently.

After being completed and approved at the central level, the annual provincial rural health plan can be implemented. During the implementation, adjustment is possible. The process of plan adjustment is also a hierarchically controlled process starting from the district level up to the central level. Most of the respondents at both the provincial and the district level (92.5%) believe that they have at least once adjusted the plan during implementation. The most important reasons why the plan had to be adjusted is that the target areas are changed probably due to the lack of reliable information at the village and the sub-district level. The other reasons are that the proposed budget has been cut, to rewrite the plan so that it suits the outcome of the work undertaken, and because the plan is incompatible with the existing conditions of the target areas. However, there are some respondents, particularly at the district level, who stated that they never adjust the plan (7.5%). In regard to the frequency of plan adjustment, 62% of all the respondents point out that the plan should be adjusted once a year (at mid-year), whereas 19% believe that it should be adjusted 3 times a year (once in four months).

In order to obtain data for the annual provincial/district planning process 77% of the respondents at both the provincial and the district level have evaluated the plan The plan is evaluated by using the official forms of reporting and recording. Basically, the evaluation of the provincial health plan is a job within the responsibility of the Chief of the Health Planning and Evaluation Section. The style of the health plan evaluation depends on each province. Most of the respondents believe that the plan is evaluated by comparing the target figures incorporated in the plan and the actual outcome. Only a few provinces take qualitative analysis into consideration when they evaluate the plans. Likewise, the frequency of plan evaluation also varies. Some provinces evaluate the plan once in four months, whereas the others evaluate twice a year. In general, every province evaluates its plan once a year at the end of the fiscal year. The quality of the annual provincial health plan evaluation paper depends on the quality of information and the officers who are dealing with plan evaluation.

At the district level, the health plan seems to generate less inierest than on the provincial level. Nevertheless, 90% of the respondents stated that they use the Provincial/District Operational Health Plan as a tool for controlling monitoring. However, a few provinces have created their own system of controlling and monitoring by simplifying the operational plan. Although the operational plan reveals a lot of details on activities, e.g. targets, schedules and target areas, the indices for quality control and monitoring are very limited. There is no significant difference between the provincial and the district level use of the operational health plan (5% level).

## COORDINATION AMONG HEALTH-RELATED AGENCIES

One of the major issues emphasized in the new management system for rural development is the work system of inter-sectoral coordination at every level of rural development (8). Lack of coordination and cooperation among government agencies is one of the recurring problems throughout every National Plan since the First Plan until the Fifth Plan (21). Approximately half of the respondents at both the provincial and the district level in our sample perceived that there is a duplication of work or activities between the health sector and the other sectors. Among the duplicated activities, the water supply programme is most prominent. Other duplications occur in activities such as nutrition programmes and child development centers. The problems of duplication of work were already indicated in the Fifth National Economic and Social Development Plan (1982-1986) :

> "There are many agencies which are working without systematic planning and coordination. This can be illustrated by the following :

- On population control, there are 13 government agencies and 3 private agencies responsible for research and collection of data. Also there are 10 government agencies and 4 private agencies responsible for the implementation of work on population.

- There are 21 government agencies responsible for environmental development.

- There are 21 government agencies and 6 private agencies working on food and nutrition activities" (21).

Thus, the Government proposed remedies and a new management system for rural development-including rural health services-in the Fifth Plan emphasizing on the problem of coordination and cooperation. In the public health sector, not only other related governmental organizations (Gos) must be embraced by the coordination effort, but also non-governmental organizations (NGOs) which are contributing significantly to public health. For the related GOs, as recommended in the Fifth Plan, the public health sector must coordinate with the other three major ministries, the ministry of Agriculture and Cooperatives, the Ministry of Education, and the Ministry of Interior. This may be called 'inter-sectoral coordination'. In addition, coordination within the health sector or 'intra-sectorol coordination' is also important.

**The coordination with the NGOs**

There seem to be more contacts with NGOs at the provincial level than at the district level, only about half of the respondents answer that they had contacts with NGOs in their area. The NGOs in rural health services are mostly involved in family planning activities. The other concentration is in rural sanitation activities, i.e. rural water supply, and nutrition related projects (31).

Most of the government officers interviewed agree with the concept that GOs must coordinate with the NGOs in rural health services. The reasons for such coordination given by the respondents are that the GOs and NGOs together can strengthen implementation of public health activities because the GOs have limited resources. Morever, the provision of public health services can cover a larger group of people and prevent as well as reduce the duplication of activities and conflicts in addition to obtaining correct health statistics. Out of sixty-six per cent of those that do coordinate in practice the provincial officers seem to be significantly ($p<5\%$) more active in coordination. In coordination with the NGOs, 67% of the respondents who answered that they coordinate with the NGOs report the methods of coordination between GOs and NGOs : 54% of the officers are the initiators of the coordination process, another 29% follow the orders of their superiors.

**The coordination with the other three major ministries**

The necessity of coordination with each of the other three major ministries at the provincial level is more varied than at the district level. Among the three ministries, cooperation with the Ministry of Agriculture and Cooperatives seems to be required more than with the others. This is particularly the case at the provincial level because there are some health-related programmes in both ministries which are closely related to each other, e.g. nutrition programmes. Likewise, the Ministry of Interior is also required for coordination at both levels for some similar projects, e.g. rural water supply. A highly required degree of necessity is more frequently given for the Ministry of Interior because of several similar projects, and also because of the bureaucratic administrative procedures that frequently involve this ministry. Although the Ministry of Education is not required prominently at the provincial level as compared to the others, its coordination requirements are not rated so different from the others at the district level. There is a significant difference in the opinion on the necessity of coordination between the MOPH and each of the other three major ministries in health planning at the 0.1% level of significance (Chi-sq. = 25.00 for testing with the Ministry of Agriculture and Cooperatives, df = 2; with the Ministry of Education, Chi-sq. = 38.91, df = 3; and with the Ministry of Interior, Chi-sq. = 27.84, df = 2).

Table 3 presents the frequencies of formal and informal coordination of the MOPH with the other three major ministries in the annual health planning process. This table excludes the District Hospitals because in practice, the District Hospitals do take much less action on district health planning. Informal coordination seems to be employed more often than formal coordination, particularly at the district level. This seems to correspond to Bowornwathana's findings on informal relations and authority structures (1). There is little difference in frequency of coordination between the provincial and the district level. But there is a significant difference in the frequencies of formal and informal coordination of the MOPH with the other three major ministries in health planning ($p<0.1\%$).

Table 3 about here

**Intra-sectoral coordination**

Among the important intra-sectoral relations would be the technical advice requested or given by technicians to the administrators and implementors of MOPH projects. For example, coordination between the Provincial Health Office (PHO) and the Regional Health Technical Centers/Offices (RHTC/O) can be expressed as the RHTC/O's requirements for coordination. In this study, only four types of RHTC/Os are taken into consideration. They are the primary Health Care Centers

which were established in four parts of the country in 1985, the Nutrition Centers which are located in nine regions, the Sanitation Centers which are also distributed over nine regions, and the Family Planning Centers which are located in four parts of the country. Among these RHTC/Os, the Sanitation Centers and the Nutrition Centers seem to be more required for coordination than the others. This is probably because of the recent establishment of the Primary Health Care Centers and the Family Planning Centers' centralization.

In addition, the RHTC/O provides support to the PHO in the provincial health planning process in terms of target-setting and resource allocation in certain programmes and projects related to each RHTC/O. In the cases were no support from the RHTC/O was received, most of the respondents inform that there are no problems or constraints in the provincial health planning which we are inclined to doubt.

In district health planning, the District Health Office (DHO) has to rely on each section of the Provincial Health Office (PHO) and the Health Technical Service Office (HTSO) because the district health plan usually is the integration of various health activities. Opinion on the necessity of some sections of the PHO and the HTSO is presented in Table 4. Among the sections, the Health Planning and Evaluation Section seems to be more needed by the DHO than the others. This information confirms the important role of the Health Planning and Evaluation Section in district health planning. Most of the DHOs perceive that they are supported by the PHO and the HTSO. However, within this group, only about one fourth highly value the usefulness of the support received; 66 per cent are 'satisfied' with it.

Table 4 about here

It is accepted that the quality of relationships among staff is the basis of coordination in an office. Such relations have been studied in the Thai health bureaucracy context (1). The quality of relationships among staff of the PHO was rated 'good' or 'very good' by some 62% of the officers. At the district level, the relationships among staff of the DHO and the relationships among staff of the DH seem to be better than at the provincial level : 17% as compared to 6% rated them 'very good'. The quality of relationships probably depends on the number of staff and the variety of their activities. Thus, this explains the better relationships among personnel at the district level, which is smaller in numbers of staff and where the scope of work compared to the provincial level is more limited.

Next we turn to the respondents' opinion on the necessity of coordination between the District Health Office (DHO) and the District Hospital (DH) in district rural health planning. Most of the respondents at both the provincial and

the district level believe that the coordination between the DHO and the DH is neccessary. Out of this group, more than half think coordination is 'very neccessary'. The reason for such coordination is that the district plan has to cover all of the target areas in the district, therefore, the DH takes responsibility for the sub-district in which it is located. Speculating on the reason for the negative answers, one would assume that in a number of cases the DH is not interested in district health planning. Moreover, the DH is directly responsible to the PCMO, thus it is quite difficult to coordinate with the DH. It should also be noted that there is a significant difference between the provincial and the district level (chi-sf. = 139.68, $p < 0.1\%$).

Another aspect relating to coordination between the DHO and the DH is the extent of the coordination : only 14% of the respondents at both the provincial and the district level rank the degree of coordination between the DHO and DH as 'very extensive'; 40% as 'extensive' 39% as 'indifferent', and 7% as 'limited'. One of the reasons for this limited coordination is that some of the District Hospital Directors do not understand their function in the District Development Committee. Another reason is the personal conflicts (seniority) between the District Health Officer and the District Hospital Director. A considerable distance between these officials is also one of the reasons for the limited coordination between the DHO and the DH.

## PROVINCIAL HEALTH PLANNING AND ADMINISTRATION AND MANAGEMENT

Administration and management activities intervene in every step of the planning process and thus, they cannot be separated from other aspects. In this study, the administration and management aspects of the provincial health planning are investigated through the conflicts among the members in the office, the attendance in the Development Committee meetings, the sources of data for Provincial Health Planning, the period of time provided for plan formulation, and the comments received from respondents for improvement of planning in the future.

**Conflicts between members in the office**

The conflicts among members in the PHO, the DHO and the DH are likely to resort a direct impact on the administration and the management of the office. Judging from our interviews, it seems that at the provincial level there are more conflicts than at the district level; respectively only 45% and 70% of the officers believe there are no conflicts.

Moreover, staff of the PHO possess a variety of qualifications much more than it is the case for the district level offices. Therefore, the provincial-level competition for better positions is stronger than on the district level and this

may generate conflicts. Among these three offices, the DHO seems to have on the least conflicts perhaps because of the narrower scope of work and less variety in staff qualifications. However, most of the conflicts do not seem to impede the planning process although 27% are management conflicts and 25% are personal conflicts. The remainder are conflicts arising in plan operation and implementation.

**Attendance in development committee meetings**

As has been discussed above, in the new rural development management system the Provincial Chief Medical Officer (PCMO) is one of the members of the Provincial Development Committee whereas the District Health Officer (DHOer) and the District Hospital Director (DHD) are representatives of the district health sector in the District Development Committee. This is useful to ensure that health interests are represented in general rural development plan formulation. The frequency of attendance in the meetings shows the degree of importance among some key-persons in the provincial health planning. At the provincial level, the Chief of the Health Planning and Evaluation Section seems to be more frequently in attendance (no statistical difference however). At the district level, the DHOer attends the meeting every time or often, whereas a high percentage of the DHDs never attend the meetings. The district level officers seem to attend their meetings more frequently ($p<0.1\%$).

**The sources of data for provincial health planning**

Since the beginning of the Fifth Plan, a Provincial Health Information Center (PHIC) has been established under the responsibility of the Health Planning and Evaluation Section. The functions of this center are to collect and analyze health data. At the district level and under the DHO, a District Health Information Center (DHIC) has been established with similar functions to the PHIC. In most of the respondents' opinion the PHICs (84%) and DHICs (76%) are useful. However, many DHOs seem to be dissatisfied with the operation of their DHIC.

Among the provincial level respondents, 37% believe that the PHIC is 'highly utilized', and 33% say it is 'utilized quite a lot'. The less frequent use is probably due to the availability of information in each section of the PHO. For planning of certain projects, each section collects and analyses specific information by itself. The DHIC is mostly utilized by the DHO only.

**The period of time provided for plan formulation**

The NESDB and the MOPH have recommended a schedule between July and September each year for the formulation of the provincial health plan. The district health plan has to be formulated between July and August. Almost half of the respondents at both levels say that these periods of time are sufficient for formulating the provincial and district health plan, but this opinion depends on

the arrival of the 'policy guidelines' from the central level. The policy guidelies from the central level are always delayed, therefore, the plan formulation process at the province and the district has to be compressed in a short time. Thus, some respondents at both levels say that this actual, shortened period is not sufficient.

**Comments from government officers for future improvements**

Asked about the provincial/district rural health planning under the new management system 59% of the respondents at both levels believe provisions for health planning in the system are adequate. But, still 39% believe improvements are feasible. The suggestions for improvements to planning covered timely delivery of more area specific policy guidelines from the central level and a simplified coordination among the four major ministries for the purpose of obtaining an effective plan. In contrast to a call for more decentralization, a number of respondents questioned decentralized policy formulation and ineffective local councils : target area setting is not practical and data are not used to accurately formulate activities and projects.

## PEOPLE'S PARTICIPATION IN THE PLANNING PROCESS

One of the new rural development policy guidelines stated by the Government in accordance with the Fifth National Economic and Social Development Plan (1982–1986) is to encourage maximum participation of the people in solving their problems. The study attempted to assess how this policy guideline was perceived by the government officials that have to implement it. People are participating through the sub-district and village entities : the Tambon Council (TC), and the Tambon Advisory Committee (Working Group for the Support of Tambon Rural Development Operations, TDWG). The TC prepares development projects to be proposed to the District Development Committee (DDC) and coordinates implementing agencies. The TDWG assists the TC in carrying out development projects or assignments. Health development is included in rural development projects. The tambon health official or midwife is also a TDWG member. In this study, people's participation in health planning process is investigated through the requirement of people's participation in health planning and the responsiveness of the plan to the people's needs.

**The requirement of people's participation in health planning**

Most of the respondents at both the provincial and the district level (95%) believe that people's participation is required in the annual health planning. The requirement is ranked by 60.5% of the respondents as 'highly required' and by 34% as 'required'. The important reasons for participation are that by participating

people realize their problems and hence will support planning and implementation of remedial actions (54%) and that data collection will be better reflecting felt needs of people (31%).

**The responsiveness of the district health plan to the needs of the local people**

In our sample, 57% of all the respondents believe that the district health plan responds to the local people's needs. Another 4% believes that only some part of the district health plan or only some district health plans respond to the needs of the people. But, 21% of the respondents answer that the district health plan does not respond to the needs of local people. The reasons for negative perceptions are as follows :

1. The Government has a limited budget. Thus many projects cannot fulfil people's needs.
2. People do not understand what their needs are.
3. People's felt needs are always very difficult to achieve.
4. Many projects are not considered by the TC, they are formulated by the officials because of lack of time.
5. Lack of coordination among the four major ministries.
6. The TC formulates the plan before receiving the policy guidelines.
7. Some district health plans are formulated without data analysis.

There is no significant difference between the provincial and the district level in the opinion on the responsiveness of the district health plan to the needs of local people (at the 5% level of significance).

## CONCLUSIONS : REVIEW OF HYPOTHESES

A general hypothesis of this study was formulated and several characteristics related to its proof were taken into consideration. It was assumed that if these characteristics existed or conditions had been fulfilled, the annual provincial rural health services plan would be effectively planned. At this stage, a review of these characteristics can be undertaken.

The first characteristic relates to public health personnel at the provincial and the district level : a good knowledge of and positive attitudes towards the health planning process would contribute to effective planning. Reviewing the evidence discussed above, this characteristic can be taken into consideration in two aspects, the officers' knowledge of health planning and the positive attitudes towards the health planning process. For the first aspect, there is not enough evidence to conclude that most of the respondents possess a good knowledge of health planning because only around one-half of them believe themselves that they possess a good understanding. Moreover, the evidence used for this aspect is merely subjective

information. Contrary to this aspect, it can be concluded on the basis of the evidence that the health officers possess a positive attitude towards the existing health planning process.

It was further assumed that if the Provincial Governor and the District Officer play a prominent role the rural health services planning process would run more smoothly. The overwhelming majority of the provincial level respondents agree that the Provincial Governor is important in the annual provincial rural health services planning process and its implementation. Similar to the provincial level, the large majority of the district level respondents believe that the District Officers are important in the annual district planning. The available data show that if these two key persons play a prominent role in the provincial and district health planning, an effective plan will be obtained.

The third characteristic relates to the Provincial Chief Medical Officer's (PCMO) role in the rural health services planning process. Some 95% of all respondents state that the PCMO is important in the health planning process. It is furthermore accepted that the PCMO is the officer predominantly in charge of heath planning. This is accepted by more than 80% of all respondents. With this evidence, it may be concluded that the PCMO is very important in health planning and takes an active part in the rural health services planning process.

In the annual provincial and district health services plan the involvement of a Provincial Health Planning and Evaluation Committee (PHPEC) and its equivalent at the district level was assumed to be crucial. While, both for provincial and district level planning, support for the committees is very large indeed, in actual fact the situation of planning is different. About 85% of the provincial-level respondents testify that the health plan is worked out through the PHPEC. But, at the district level, only some 20% of the respondents said that the district health plan is worked out through a committee that is appointed specifically for working out the plan and that would have similar functions to the PHPEC.

Flexibility in planning, resulting in periodical adjustment, has been advocated as one of the important bases for successful planning, especially at the lower echelons. However, more than 90% of the respondents believe the plan should be adjusted during implementation. Adjustments are undertaken to obtain a more practical plan for implementation. This indicates that there is flexibility in health planning.

When discussing flexibility in the planning process for rural health services, the issue of an effective monitoring and evaluation system emerges. Most of the provincial level respondents state that they have a planned evaluation system, in particular all of the Chiefs of the Health Planning and Evaluation Sections who

take responsibility for this job. This means that each province has its own evaluation system. At the district level, most of the District Health Officers who take responsibility for the district health plan said that they have evaluated the district plan. It also needs to be noted that many District Hospital Directors did not answer whether they have evaluated their plan or not. It may be assumed that they did not evaluate the district plan. The Operational Health Plan is most frequently used as a tool for monitoring. On the aspect of the quality of the evaluation and monitoring system, further information on the methodology and reliability of the system is needed.

It was assumed that there is effective coordination between the health sector and other sectors in rural health planning both on the provincial and the district level. Some 95% of all respondents realize that coordination between GOs and NGOs in rural health services is necessary. In practice, around 67% of all respondents coordinate with the NGOs, whereas 33% did not coordinate mostly due to the lack of NGOs in certain locations. It can be concluded that there is coordination between GOs and NGOs working in the rural health service. In terms of coordination within the government, most of the respondents require coordination with the other three major ministries in the rural development management system, but the urgency of this requirement is different for each ministry. The Ministry of Agriculture and Cooperatives is required for coordination by 89%, the Ministry of Education is required by 78%, whereas the Ministry of Interior is required by 87% of the respondents. Most of the respondents 'seldom' coordinate formally with other sectors. But even informal coordination is most frequent at the district level. It may be concluded that there is coordination between the health sector and other sectors in health planning at both the provincial and district level. However, the frequency and extent on each level is different.

To consider the 'effectiveness' of the coordination, some additional data are needed. If the duplication of work between the health sector and other sectors is a parameter for measuring the effectiveness of coordination, such coordination is not effective because there is a duplication of work between the health sector and other sectors according to half of the respondents.

It was also assumed that there is effective coordination between the Provincial Health Office (PHO) and the Regional Health Technical Centers (RHTC) in the annual provincial health planning. The requirements for support from RHTCs vary from province to province. However, 82% of the provincial level respondents believe that the RHTCs support the PHO in provincial health planning and most of those supported are satisfied. In case of no support from the PHO, most of the respondents said that it did not cause any problem or resulted in any constraints to the provincial health planning. In view of these data and if effective

coordination between the PHO and the RHTC is taken into consideration on the basis of the desirability to have a RHTC as expressed by the PHO, we must reject this assumption. It seems that without any support from the RHTCs, the provincial health planning process can still be undertaken without too many constraints.

A more general assumption concerns coordination among health personnel in the PHO. Around 62% of the provincial-level respondents report that the relations among staff of the PHO are good whereas the relationships among staff of the DHO and the DH is believed to be good by 54%. These percentages are not high enough to be able to accept this assumption. Good relationships and conflicts among staff in the PHO can indicate a situation of proper coordination.

Another assumption on coordination concerns the PHO, the DHO and the DH. Only about half of our sample indicated the the coordination between the DHO and the DH is extensive, although 92% of all respondents realize that coordination between them is necessary. Once again it cannot be concluded that coordination between these offices is sufficiently smooth.

Reliable data and information for health planning both on the provincial and the district level were assumed to be available. More than three quarters of the sample stated that the PHIC and the DHIC as main data collection centers are useful. At the provincial level, the PHIC is utilized quite a lot. The utilization of the DHIC is not as prominent as the PHIC.

Finally, according to our data on the opinion of government officers people's participation is believe to be required in the health planning process. However, only 57% of all respondents perceive that the district health plan is responsive to the needs of local people. Whereas 21% felt that it is not responsive. More than 80% of all respondents believe that the district health plan is compatible with the objectives of the provincial rural health services plan. With the collected data, it cannot yet be definitely concluded that people's participation influences the success of the provision of rural health services. Further data on people's satisfaction with the implementation of the health plan are needed in order to shed light on this.

In conclusion, the most serious problem and constraint to effective rural health planning is the lack of coordination at all levels. To coordinate with other sectors is rather difficult because of the bureaucratic structure which has long existed in Thai culture and which persists today. Bowornwathana has analysed some of the mechanism that prevent rapid change in behaviour (1). Some other indirect mechanisms contribute to this lack of coordination, e.g. poor relations among key staff. Some officers uttered reservations about some practical implications of the new planning style. A number of these reservations find their origin in the

lack of training in using the new system and the resulting implementation, administration and management problems. But, in spite of some shortcomings which are inherent in the short period the new system has been implemented, many characteristics of the system in operation can help the provinces to implement an effective rural health planning process and obtain good services.

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## APPENDIX : LIST OF ABBREVIATIONS

| | | |
|---|---|---|
| BB | = | The Budget Bureau |
| CH | = | The Community Hospital |
| CSC | = | The Civil Service Commission |
| DDC | = | The District Development Committee |
| DHO | = | The District Health Office |
| DHOer | = | The District Health Officer |
| DPC | = | The District Planning Committee |
| HC | = | The Health Center |
| HTSO | = | The Health Technical Service Office |
| MOAC | = | The Ministry of Agriculture and Cooperatives |
| MOE | = | The Ministry of Education |
| MOI | = | The Ministry of Interior |
| MOPH | = | The Ministry of Public Health |
| NESDB | = | The National Economic and Social Development Board |
| NRDC | = | The National Rural Development Committee |
| NRDCC | = | The National Rural Development Coordination Center |
| PCMO | = | The Provincial Chief Medical Officer |
| PDSC | = | The Provincial Development Sub-Committee |
| PHO | = | The Provincial Health Office |
| PPC | = | The Provincial Planning Committee |
| TDWG | = | The Tambon Development Working Group |
| VDC | = | The Village Development Committee |

**Chart 1. Organization Chart of the Ministry of public Health in Thailand (9)**

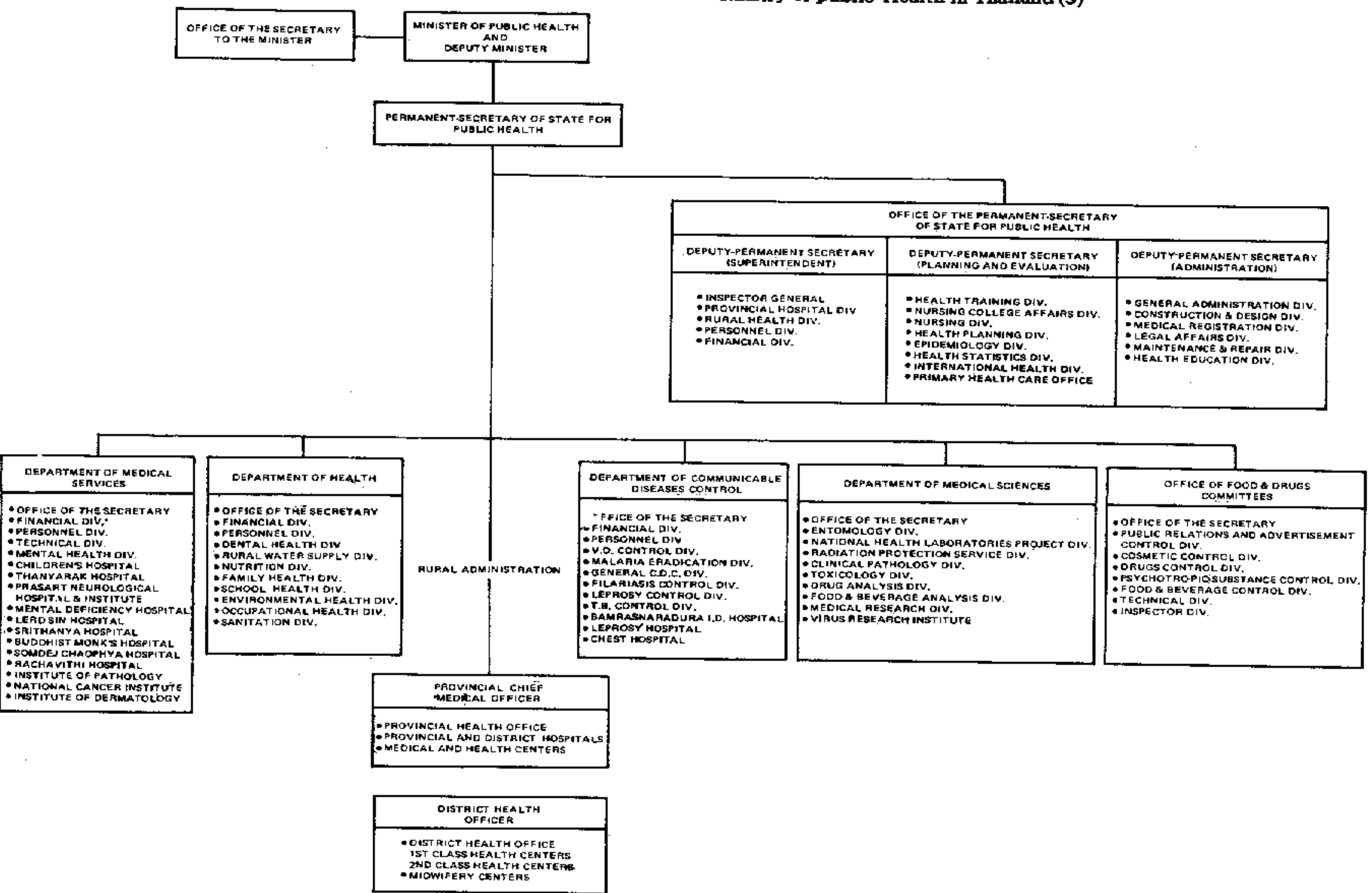

**Chart 2. Organization Chart of the Provincial Health Administration in Thailand (9)**

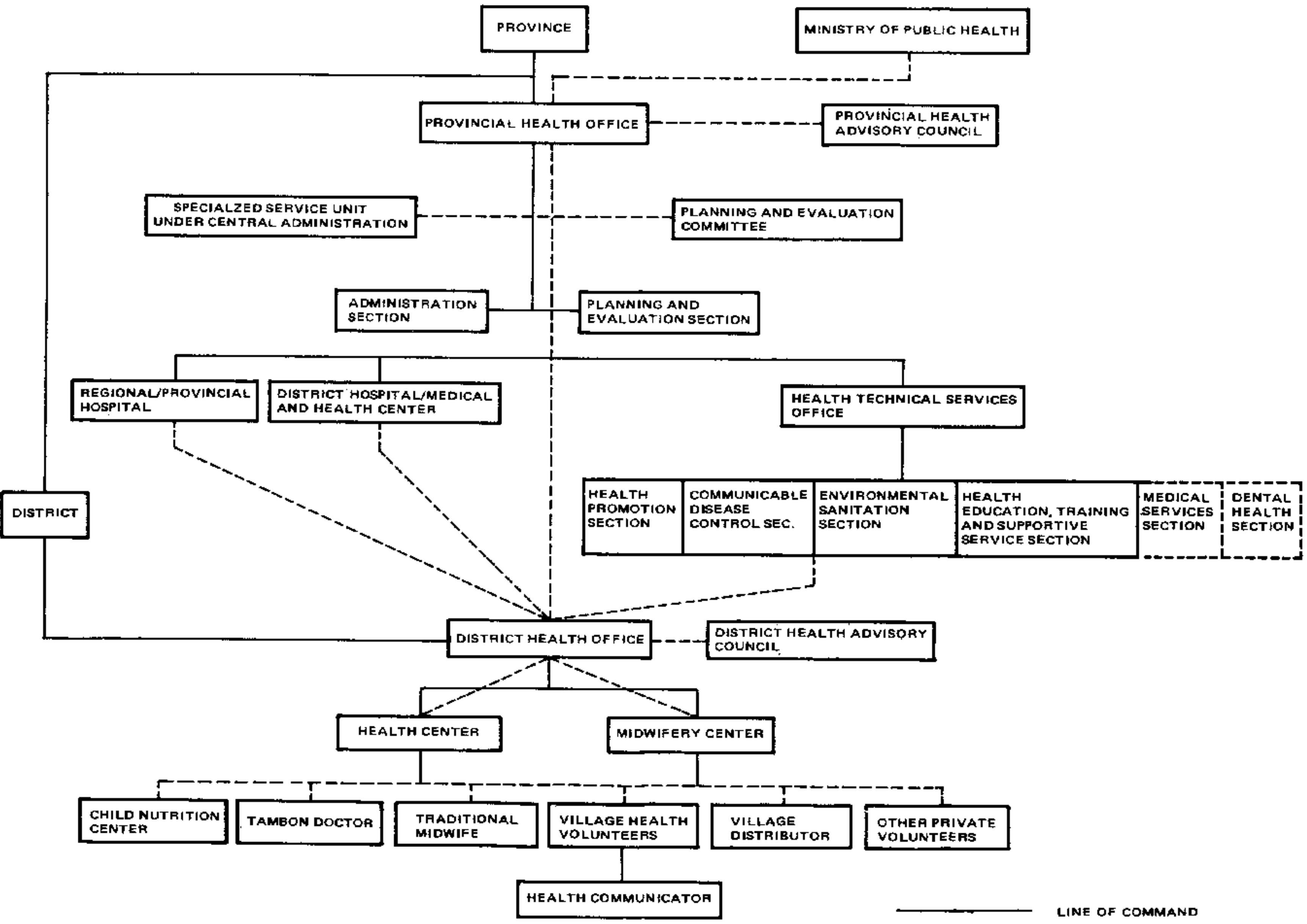

**Chart 3. The Hierarchical Structure of Rural Health Delivery in Thailand (9)**

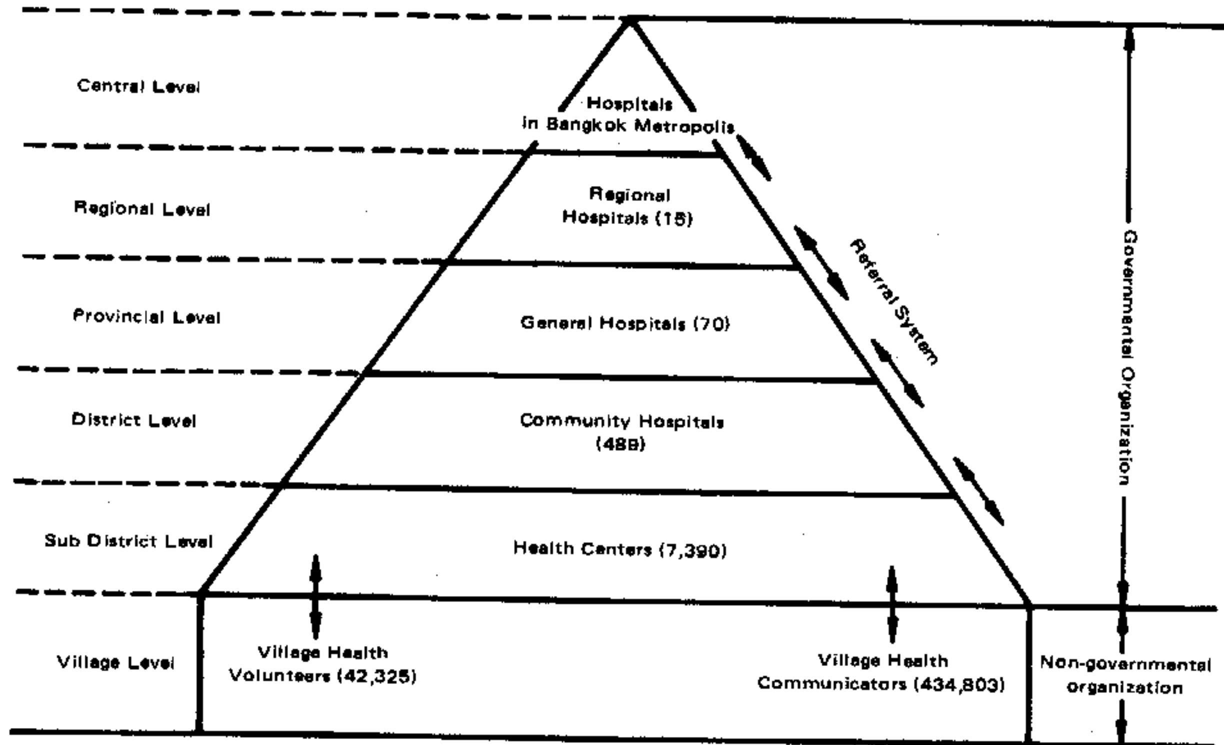

**Table 1. Comparison between the Annual Budget of the Whole Country and the Ministry of Public Health (1972-1986) (9)**

| Fiscal Year | Country (Million Baht)* | MOPH (Million Baht) | Non-MOPH (Million Baht) | Percentage |
|---|---|---|---|---|
| 1972 | 29000.00 | 953.10 | 28046.90 | 3.29 |
| 1973 | 31600.00 | 1023.20 | 30576.80 | 3.24 |
| 1974 | 36000.00 | 1114.30 | 34885.70 | 3.10 |
| 1975 | 50000.00 | 1533.40 | 48466.60 | 3.07 |
| 1976 | 62650.00 | 2725.29 | 59924.71 | 4.35 |
| 1977 | 68790.00 | 3520.61 | 65269.39 | 5.12 |
| 1978 | 81000.00 | 3405.77 | 77594.23 | 4.20 |
| 1979 | 92000.00 | 3976.90 | 88023.10 | 4.32 |
| 1980 | 109000.00 | 4494.58 | 104505.42 | 4.12 |
| 1981 | 140000.00 | 5671.79 | 134328.21 | 4.05 |
| 1982 | 161000.00 | 6652.32 | 154347.68 | 4.13 |
| 1983 | 177000.00 | 7902.40 | 169097.60 | 4.46 |
| 1984 | 192000.00 | 8617.60 | 183382.40 | 4.49 |
| 1985 | 209000.00 | 9044.30 | 199955.70 | 4.33 |
| 1986 | 218000.00 | 9447.30 | 208552.70 | 4.33 |

* in June 1986, 1 US $ was valued at 26 Thai Baht Source : Rural Health Division 1986.

**Table 2. The impacts of the policy guidelines set up by the Ministry of Public Health on the provincil/district rural health services planning**

| Opinion | Freq* | % |
|---|---|---|
| -to facilitate the provincial/district health planning process | 98 | 35.25 |
| -to contribute to strenghten the coordination between the health sector and other sectors | 71 | 25.54 |
| -to be a tool for reducing the conflicts among the provincial/district health sector | 62 | 22.30 |
| -to limit and inhibit the initiated activities of the province and the district | 20 | 7.19 |
| -to draw attention to the unnecessary steps in the provincial/district health planning process | 6 | 2.16 |
| -to policy guidelines are not pertinent to proper provincial/district health problems | 21 | 7.55 |
| Total | 278 | 100.0 |

* multiple-choice question

**Table 3. The frequency of formal and informal coordination of the MOPH with the other three major ministries**

| Coordination | Frequency of Coordination | Respondents f (%) | | |
|---|---|---|---|---|
| | | MOAC | MOE | MOI |
| Formal | -often | 24 (27.91) | 20 (23.26) | 31 (36.05) |
| | -seldom | 54 (62.79) | 59 (68.60) | 50 (58.14) |
| | -never | 8 ( 9.30) | 7 ( 8.14) | 5 ( 5.81) |
| | Total | 86 (100.0) | 86 (100.0) | 86 (100.0) |
| Informal | -often | 48 (55.81) | 43 (50.00) | 50 (58.14) |
| | -seldom | 32 (37.21) | 38 (44.19) | 33 (38.37) |
| | -never | 6 ( 6.98) | 5 ( 5.81) | 3 ( 3.49) |
| | Total | 86 (100.0) | 86 (100.0) | 86 (100.0) |

Notes : MOAC = Ministry of Agriculture and Cooperatives,
MOE = Ministry of Education, MOI = Ministry of Interior

**Table 4. The necessity of some sections of the Provincial Health Office (PHO) and the Health Technical Service Office (HTSO) in the annual district rural health services planning process**

| Degree of necessity | | Sections of the PHO and the HTSO | | | | |
|---|---|---|---|---|---|---|
| | | Planning & Evaluation | Health Promotion | Sanitation & Envi. Health | Health Edu. Training & Supportive Services | Comm. Disease Control |
| highly required | f | 20 | 9 | 10 | 10 | 9 |
| | (%) | (57.41) | (25.71) | (28.57) | (28.57) | (25.71) |
| required | f | 12 | 19 | 17 | 14 | 19 |
| | (%) | (34.29) | (54.29) | (48.57) | (40.00) | (54.29) |
| indifferent | f | 2 | 6 | 6 | 8 | 5 |
| | (%) | (5.71) | (17.14) | (17.14) | (22.86) | (14.29) |
| not so required | f | 0 | 0 | 0 | 1 | 0 |
| | (%) | (0) | (0) | (0) | (2.86) | (0) |
| not required at at all | f | 1 | 1 | 1 | 1 | 1 |
| | (%) | (2.86) | (2.86) | (2.86) | (2.86) | (2.86) |
| n.a. | f | 0 | 0 | 1 | 1 | 1 |
| | (%) | (0) | (0) | (2.86) | (2.86) | (2.86) |
| Total | | 35 (100.0) | 35 (100.0) | 35 (100.0) | 35 (100.0) | 35 (100.0) |