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IMPLEMENTATION OF PRIMARY HEALTH CARE POLICY IN THAILAND : AN ANALYSIS OF STRENGTHS AND WEAKNESSES IN THE MANAGEMENT SYSTEM

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The development strategy of Thailand during the first, second and third national economic development plans was fundamentally based on the assumption that economic growth may lead to other aspects of development. The developmental outcomes appeared to be successful to a certain degree. However, some unintended consequences emerged. The growth of gross national product resulted in a wider gap between the rich and the poor, and the urban and rural areas. The true gains from development were still in the hands of a few powerful persons. The powerless ones, especially the rural poor, are still poor and poorer. They remain in the vicious circle of poverty (ignorance, poverty and sickness). Facing this problem, the Goverment has, therefore, shifted to a new development strategy, with the emphasis on the acceleration of rural development, since the fourth national economic and social development plan. And primary health care policy, as a main segment of rural development, has been formulated and put into practice since then.

Apart from the Thai situation, in 1977 the resolution of the 30th World Health Assembly also called for the commitment among member countries to "Health For All by the Year 2000". The concept of Health For All implies every citizen regardless of age and occupation should have the right and opportunity to participate in health promotion, disease control, curative and rehabilitative services. Furthermore, all existing resources should be reoriented in such a way as to generate social equity and directly benefit the majority of the people.

In September 1978, the International Conference on Primary Health Care which was held at Alma Ata in the Soviet Union also came up with the Alma Ata Declaration on primary health care. The declaration clearly pointed out primary health care as the key to attaining the social goal of "Health For All by the Year 2000." The conference

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also asked for the commitment of every country to make their own policies, strategies, and plans for action to achieve this goal of "Health For All by the Year 2000."

Affected by the aforementioned internal and external pressure, the significance of primary health care has considerably increased. The fifth national economic and social development plan (1982 - 1986) expanded the targets of implementing primary health care programmes and projects to the rural population all over the country. The sixth plan (1987 - 1991) aims at the improvement in the quality of primary health care operation. Of central concern is the improvement of the management system that remains critical to the successful implementation of primary health care policy in Thailand. However, it should be worth mentioning that thus far there have been very few studies that directly concern the management system of primary health care as a whole (both at the macro and micro levels). Past studies tended to be either of specific cases at the micro or macro levels, or technical-oriented ones.

This study is therefore very significant in itself. It is an attempt to develop some recommendations for implementation towards improvement of the Ministry of Public Health's policy on primary health care as well as the adjustment of the administrative arrangements of various MOPH mechanisms both in the central and provincial administration.

Objectives of the study

The objectives of this study are threefold :

(1) To identify key areas of strength and weakness in the existing management system of primary health care at the macro level;

(2) To identify key areas of strength and weakness in the existing management system of primary health care at the micro level (provincial, district, and sub-district or *Tambon*), using *Sisaket* province as a case study; and

(3) To develop pragmatic policy recommendations for the improvement of the management system of primary health care at the macro and micro levels.

Methodology

Methodologically, the study can be divided into two levels : the first level consisting of an in-depth study of the management system of primary health care in the central administration, and the second level being an in-depth study of the management system of primary health care in *Sisaket* province.

Macro level. Four investigative tools were used in the study. These are :

1. In-depth Interviews : in-depth interviews of key executive officials of the MOPH.

2. Documentary Analysis : analysis of background materials, minutes of meetings, and other materials related to primary health care at the macro level.

3. Literature Survey : survey of research reports, technical papers, and other related materials.

4. Informal Meetings and Interviews : informal meetings and interviews of key persons in the office of the Primary Health Care Committee and other related agencies.

Micro level. Sisaket province was designated as the case-study area. The study covered three levels : provincial, district, and sub-district. The following investigative tools were enployed :

1. In-depth Interviews : in-depth interviews of key health officials in Sisaket and other provinces. They can be classified into four groups. The first group consists of (1) the provincial chief medical officer; (2) the director of the technical and health service promotion office; (3) section heads of the provincial public health office ; (4) the director of the provincial hospital; and (5) the head of the health section of the provincial hospital. The second group is of district health officers and a number of their assistants as well as directors of district hospitals in five selected areas (Muang, Kantaraluck, Koonharn, Namklieng, and Sriratana). The third group comprises health officers in *Tambon* health centers and village health centers. Two key executive central officials : director of the northeastern regional training for primary health care development (located in *Khonkaen* province), and director of the center for communicable disease control 7th zone, form the final group.

2. Documentary Analysis : analysis of Government materials, research reports and other materials related to primary health care at the micro level.

3. Participative Observation : participative observation at the points of health service delivery in three Tambon health centers, namely *Nongvar* health center in the *Kantaraluck* district, *Srikaew* health center in the *Sriratana* district, and *Guntrom* health center in the *Koonharn* district. Observation periods cover five working days.

4. Informal Meetings and Interviews : informal meetings and interviews of relevant officials in the primary health care implementation process.

The research project began in May 1988 and was completed in March 1989.

Conceptual Framework

To carry out this study, the following models and theories are employed.

1. A framework for thinking about policy implementation difficulties.
2. Organization theory.

A framework for thinking about policy implementation difficulties

Public policies or specific Government programs may be formulated, analyzed and evaluated without necessarily taking into account the actual organization, interest groups, key actors or political and administrative environment that will undoubtedly influence the program or policy once it moves from a plan to reality. This research project highly recognizes the essence of the implementation process. Its key analytical framework is based on two conceptual models of the implementation process (Voradej Chandarasorn, 1984 : 535-551). They are summarized as follows :

1. The Management Model. The model hypothesizes that success of an implementation depends upon the capacity of responsible implementing organizations. The ability to implement policies, therefore, may be hindered by the following factors :

- inappropriate design of organization and work systems ;

- inadequate and poorly trained staff ;
- the agency's inability to deploy the personnel to their appropriate places ;
- under-utilization of resources as well as the utilization of resources in the wrong direction.

2. The Political Model. The model views implementation as a process of bargaining, confrontation, conflict management, propaganda and support seeking. The process, in other words, pictures individuals and subunits with specific interests competing for relative advantage in the exercise of power and the allocation of scarce resources. The failure of social programmes occurs because no single unit of government is sufficiently powerful to force others to conform to a single conception of policy. From this perspective implementation difficulties may be sharply increased if :

- there is a fragmentation of governmental authority ;
- there are many transactions needed to deal with overhead agencies ;
- there are many organizations and inter-organization procedures needed to implement a policy.

Concepts of closed and open systems of organization theory.

These are used as a basis for the analysis of organization interaction with the environment, internally and externally. Charts I and II illustrate comprehensive organization networks of the management system for supporting primary health care at the macro and micro levels, respectively.

Related Literature

Apart from the aforementioned models and theories, this study also benefits from a review of related literature, in particular the Lampang Health Development Project (Mikhanorn and Ningsanonda, 1981).

According to the project, effective health service delivery for rural villagers requires a new management approach. The approach stipulated that : (1) basic health services could be delivered more cost-effectively if integrated; (2) the demand for medical care services could be met, to a great extent, by up-grading existing health personnel to be clinically competent paraphysicians; and (3) the need for health promotion and disease prevention services could be more broadly and effectively met through community participation. This participation could be achieved by training village health volunteers, traditional birth attendants and village health communicators as well as by involving the private sector.

The approach proved to be a successful one. Under its guidance Lampang Project planners and personnel developed a number of innovations and modifications of the existing health system which constituted the key features of the Project, as summarized below.

1. Reorganization and strengthening of the provincial health service infrastructure by :

- Integrating curative, disease prevention, and health services by coordinating and administering them under a single provincial health administration;

Chart 1

Organization Networks of the Management System for Supporting Primary Health Care at the Macro Level

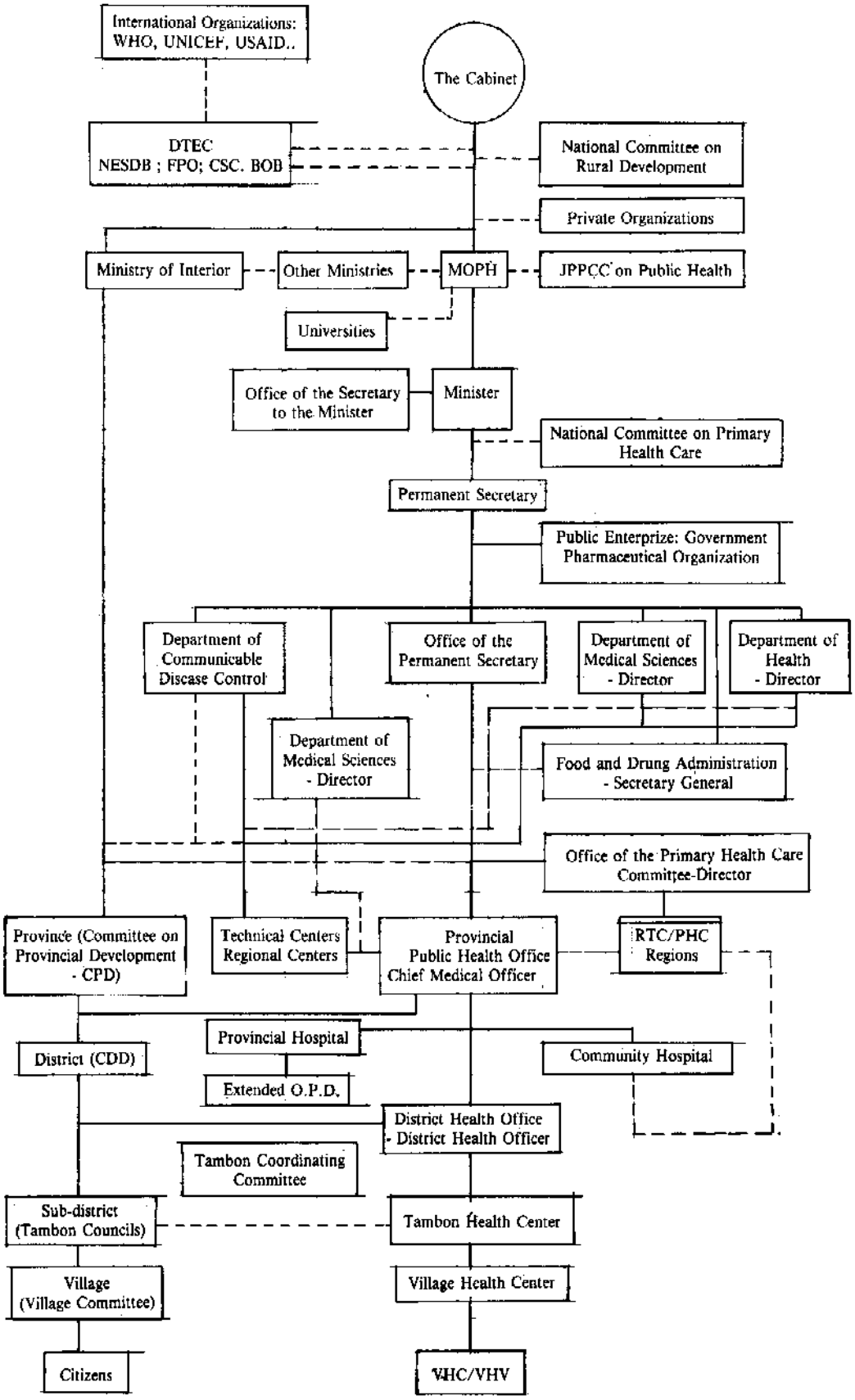
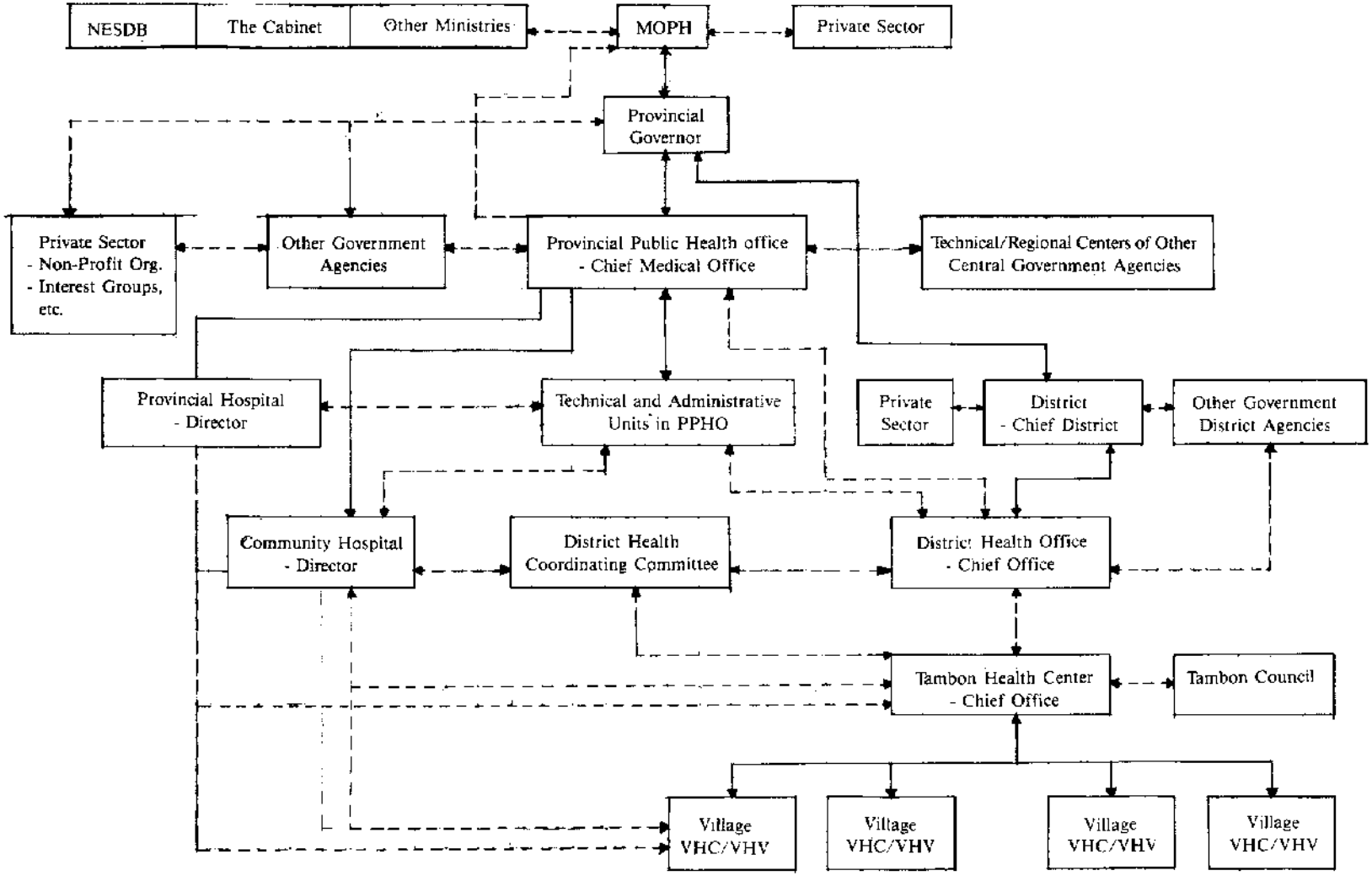


Chart II

Organization Networks of the Management System for Supporting Primary Health Care at the Micro Level



- Establishing a department of community health within the provincial hospital; and
- Improving management and supervisory practices, in part by developing a practical management information system.

2. Development of community health paraphysicians *(Wechakorn)* from existing health service personnel, to be deployed to every district hospital and sub-district health center.

3. Development of community health volunteers in every village, including training of a village health volunteer in every village, training of traditional birth attendants in every village where qualified candidates could be identified, and training of village health communicators for every 10-15 households in every village.

4. Stimulating other community and private sector involvement by establishing health committees in every village and at every administrative level, and by eliciting the interest and support of other private sector groups.

Findings at the Macro Level

Strengths

1. The concept of primary health care has the support and blessing of international organizations and the Royal Thai Governemt.

The concept of primary health care has its origin in the 1961 MOPH malaria control project. At that time experimentation on the use of volunteers for controlling malaria was initially conducted. Since then a number of similar projects and the concept of citizen participation in health care at the community level were put into action and tested in various places such as the 1962 *Pitsanuloke* experimental project, the 1966 *Chiangmai Sarapee* district experimental project, the well-known *Lampang* project during 1974-1979, the 1977-1980 *Samcrg* project. Besides, the 1977 resolution of the 30th World Health Assembly and the 1978 International Conference on Primary Health Care at Alma Ata in the Soviet Union came up with the Declaration on primary health care indicating primary health care as the key to attaining the social goal of "Health For All by the Year 2000." Furthermore, the 1978 Conference also asked for the commitment of every country to put the concept of primary health care into action in its own way for the achievement of the "Health For All by the Year 2000" goal.

These aforementioned developments internally and externally, had combined to strengthen the concept of primary health care. Hence, the Government has put a primary health care program within the national economic and social development plan since 1977. Most importantly, primary health care has been continuously declared as Government policy since 1980. This, in short, reflects the achievement of the MOPH in gaining primary health care support from its external environment.

2. The MOPH achievement in gaining adoption and cooperation from the external environment.

Two major events reflected this achievement. First, the Cabinet in the July 1979 meeting approved in principle the MOPH's recommendation to from a national body

responsible for primary health care policy which was, for the first time, put in as a part of the fourth national economic and social development plan. Secondly, the first National Committee on Primary Health Care was appointed on October 29, 1982. The Committee consists of representatives from four key ministries, namely, Public Health, Education, Agriculture and Cooperatives, and the Interior, as well as other relevant agencies. Major functional responsibilities of the Committee are :

1. formulating primary health care policies and programs ;

2. serving as a consultative body of the office of the Primary Health Care Committee on administrative and operational matters ;

3. promoting, supporting, monitoring, and coordinating the implementation of primary health care policies and programs ; and

4. appointing, as necessary, any committee, sub-committee, working-group, or person for assisting primary health care operation.

The establishment of the National Committee, among other events, has been widely accepted as an excellent strategy of the MOPH in managing the external environment. Hence, cooperation and support for primary health care has been achieved through the so-called "cooptation" concept. To further elaborate, representatives from various agencies both public and private who sit on the Committee are appointed to help the MOPH in various ways such as over technical and implementation issues, budget and equipment support, as well as other forms of cooperation. More importantly, primary health care activities are to be assimilated into other ministries. In other words, those relevant ministries are to regard primary health care policy and activities as their own.

3. The organization network of primary health care at the macro and micro levels.

The organization network of primary health care has been gradually strengthened. Before the establishment of the Office of the Primary Health Care Committee (OPHCC) in December 1980, primary health care issues and activities had been taken care of by Divisions of Rural Health Education, Health Training, and Health Planning. Since the establishment, the OPHCC acts as a secretariat of the National Committee on Primary Health Care and as a core agency in coordinating with other relevant public agencies and private organizations.

Linking the macro and micro levels, there are also four regional training centers for primary health care development situated at *Nakorn-Sawan* in the North, *Chonburi* in the east, *Khon-Kaen* in the northeast, and *Nakorn-Sithammarat* in the south. Each regional center serves as a coordinator and technical supporter for primary health care activities within the region and also as a unit for conducting studies and research on model development for primary health care in the area, suited to the rural-economic situation, etc.

The primary health care policies have also been adopted and implemented in various forms of activities by a number of central agencies in the MOPH. This reflects the significance of primary health care in itself as well as its potential contribution to the citizens as a whole. However, the OPHCC still faces some limitations in its operation which are to be elaborated later.

Weaknesses

1. The under-utilization of the National Committee on Primary Health Care (NCPHC).

In principle, the establishment of the NCPHC is regarded as an excellent strategy in managing the external environment as well as a great hope for the MOPH. But in the process, the usefulness of the NCPHC has gradually diminished. Since the establishment, there have been only a few NCPHC meetings. This reflects the lack of continuity in support of primary health care policies at the national level and hence the under-utilization of the NCPHC. Perhaps, an explanation for this under-utilization is the commitments of the Committee members. Those members are, of course, public figures. They engage in many businesses and activities. They chair or sit in a number of committees of national importance. So it is extremely difficult for them to devote their limited time to primary health care issues considered simply as of equal importance to, if not less than, other issues or functions.

2. The constraint on integrating plans of the MOPH departments and resources for the support of primary health care activities.

Since the primary health care activities consist of 10 elements, those elements are simply separately performed by a number of divisions and departments of the MOPH as well as other Government agencies. Each agency tends to have its own plans, programs, and projects as well as objectives and approaches. In addition, their programs and projects usually overlap in area and time period. Some projects conflict with each other in terms of their problem priority. In addition, some agencies may report plans or activities to the OPHCC, while others do not care to. Furthermore, some agencies do report but too late for OPHCC to do anything meaningful, Thus, it is very difficult, if not impossible, for the OPHCC to streamline and integrate the plans and activities of those agencies. Besides, the status of the OPHCC as a division in the office of the Under Secretary of Public Health also makes those things more difficult to accomplish.

3. The inability of the OPHCC to fully perform as the secretariat of the OPHCC.

This kind of constraint is primarily due to the division status of the OPHCC, Hence, the OPHCC is not in the position to monitor the primary health care activities performed by the MOPH's departments, let alone to coordinate and deal equally with those departments. This weakness, of course, may increase the degree of problems mentioned earlier in (1) and (2). However, it should be worth noting that this kind of phenomenon is not a new one. It happened in the past as in the case of the Office of the Under Secretary of Public Health's Division of Food and Drugs.

4. The limited relevance of primary health care policy at the macro level.

The primary health care policy at the macro level has some limitations in terms of its application to the problems of particular provincial areas. This has occurred because of several reasons. First, the management information system of primary health care is still incomplete and lacks reliable data about the characteristics of primary health care problems confronting particular areas. Second, a number of uncoordinated and

innovative projects on primary health care have been imposed on the provincial units during the last seven years. These have created the problem of adoption at the implementing level. Moreover, the usefulness of innovative concepts has been communicated ineffectively and only to a limited number of implementors. In short, the combination of these factors has led to a decrease in the effectiveness of primary health care policy implementation at the points of service delivery.

5. The scope of primary health care activities.

The too broad scope of primary health care activities tends to become their weakness. Since it is extremely difficult to define the exact scope of primary health care activities, the concrete outputs of particular activities are difficult to specify or standardize. Furthermore, the cooperation among units in utilizing resources is therefore limited. Overall, this kind of problem is also the consequence of other problems discussed earlier in (2), (3) and (4).

6. The limitation in quality development of primary health care management.

Primary health care, according to the MOPH definition, is a health strategy aiming to achieve the following objectives :

- To utilize community resources and to encourage community participation in order to solve individual health problems and eventually to establish self-help programs at the village level ;
- To promote the dissemination of health information to local people, as well as to integrate all the data that will reflect the needs and health problems of communities ;
- To make basic health services available, accessible and acceptable to the people ; and
- To decrease malpractice, especially in medical care.

Considering the above objectives, the MOPH has come a long way. Many kinds of output have been achieved such as the number of VHCs and VHVs trained, several sorts of health funds established. However, the achievement has been considered in terms of quantity rather than quality. There seem to be some remaining unanswered questions as follows :

(1) What is the quality of VHCs and VHVs?
(2) What is the kind of citizen participation? Are the citizens forced to participate by Government officials?
(3) How much do the citizens have their own power to make decisions for the management of self-help programmes?

It is believed that the quality development of these issues will help strengthen the achievement of the MOPH's primary health care programme.

7. The contradictory roles of the health private sector and the MOPH.

This is considered to be another area of weakness. The major part of the health private sector is still aiming at profit-making. Many private hospitals and clinics tend to encourage citizens to become "dependent" rather than "self-reliant." This direction goes obviously opposite to the MOPH's goal.

However, this is not to deny the great contribution of some private organizations towards the MOPH's primary health care policy. But again, the number of such private organizations is very few at present. Mobilization or seeking support from the private sector to change its role is therefore essential to the achievement of primary health care objectives in the long run.

8. The MOPH supervision, monitoring, and evaluation system.

The weakness at this point can be considered from two specific points of view. First, it is found that the MOPH supervision system has been diversely implemented. Some supervisory teams have focused on the rules, regulations and financial checks rather than on technical matters which in principle are supposed to be instrumental towards helping inprove the performance of provincial health officers. Secondly, the MOPH monitoring and evaluation approach tends to concentrate less on : (1) the quality and utilization of VHCs/VHVs in particular areas ; (2) the level of citizen participation in primary health care activities ; and (3) the capability of health service units in supporting primary health care. In other words, the MOPH has given more emphasis to the monitoring and evaluation of quantitative outputs than to the performance quality.

9. Inequality of resource distribution.

Inequality of resource distribution is found at many levels from the central administration to the province and from the province to districts and sub-districts. The same pattern of resource distribution has been used for the sake of administrative and budget allocation convenience, despite the differences between particular areas in terms of health problems, population density, and numerous kinds of socio-economic conditions. Hence, health service units receive budget and financial support approximately in the same proportion. This kind of weakness also reflects the problem of the management information system for support of primary health care as illustrated earlier..

Findings at the Micro Level

The findings at this level are divided into three parts : (1) provincial level ; (2) district level ; and (3) *Tambon* level. Each part deals with the strengths and weaknesses of the management system at each level.

Provincial Level

Strengths

1. Organization and management system of the Sisaket Public Health Office

The Sisaket Public Health Office, like other provincial public health offices, has its well-organized structure and management system for the support of primary health care. To elaborate, the Sisaket Public Health Office consists of a number of sections. Each section is in charge of supporting primary health care in various ways and by various activities. Among these, the Health Training and Service Promotion Section plays an central role in training of VHCs/VHVs, village committees, etc., as well as in serving as a technical and supporting unit for the development of self-reliant villages, etc.

More importantly, the Chief Medical Officer was found to have given strong support to primary health care activities. The evidence from minutes of meetings and other official documents also confirmed the said statement. In more detail, major emphasis has been given to support of primary health care elements such as health education and immunization.

2. Training the trainers for the development of primary health care.

The Sisaket Public Health Office has given a priority to training the trainers for the development of primary health care. Several teams of trainers at provincial, district, and *Tambon* level have been continuously trained both in theory and practice of primary health care. The objective is to develop the trainers for the transfer of primary health care knowledge to the VHCs, VHVs, the village committees and other key village figures. Thus far, this has been a serious and admirable attempt.

3. The establishment of a coordinating mechanism for health planning and evaluation at the provincial level.

The mechanism was established in the form of an Executive Committee. The Committee, chaired by the Sisaket Chief Medical Officer, consists of :

- Director of the provincial hospital (vice-chairman)
- Director of the office of public health technical promotion and service (vice-chairman)
- Chief of *Muang* district municipality
- Directors of the community hospitals
- Section chiefs of the Sisaket public health office
- V.D. unit chief
- Chiefs of health district offices
- Malaria unit chief
- Leprosy unit chief
- Chief of health planning and evaluation section (member and secretary)

The Committee is in charge of planning, monitoring and evaluating Sisaket's health performance. According to organization and administrative theory, this mechanism is considered a very useful one in streamlining various provincial health activities. In reality, the degree of its usefulness remains to be seen. Nevertheless, the establishment of this kind of coordinating mechanism, in principle, should be supported and encouraged.

Weaknesses

1. The under-utilization of the Governor's leadership in mobilizing resources, support and cooperation from other government agencies.

The ability to fully utilize the Governor's leadership is a key to the successful implementation of primary health care policy. In the Sisaket case, it was found that the Governor had given a top priority to agricultural development and had paid moderate attention to primary health care. Therefore, the ability of the Sisaket Public Health Office in mobilizing resources, support, and cooperation from other government agencies for primary health care activities is somewhat limited. This is unlike the *Pichit* case, where

the Governor has played the leading role in the implementation of primary health care policy. As a result, support and cooperation from other government agencies in *Pichit* province for primary health care activities are extremely high.

2. Limited success in mobilizing private sector cooperation and resources.

The degree of successful primary health care implementation will be higher, if there is support from the private sector such as business firms and associations, as well as international organizations. This is not the case in Sisaket. The attempt to gain such support from the private sector is found to achieve limited success due to several reasons :

(1) The inability to fully utilize the Governor's leadership as illustrated earlier has led to uninspired attempts, if any, to gain public sector support through his leadership ;

(2) The Sisaket public health administrators are too busy with their workload to devote adequate time to such mobilization ;

(3) Some administrators possess closed-system views and strongly hold that the so-called dependency approach should be the right way for the management of primary health care.

3. Lack of agencies' cooperation and co-use of resources.

There has been very little cooperation between the Sisaket Public Health Office and other agencies such as the regional training center for primary health care development at Khon-Kaen. This has led to the under-utilization of resources for primary health care activities. Some cooperation did occur in the past but eroded due to communication problems and lack of understanding of one for the other.

4. Inadequacy of participation in policy formulation and policy inconsistency.

A number of innovative policies and projects on primary health care have been formulated primarily from the top without adequate participation from the responsible implementing units as well as implementors. Many innovative projects are not only imposed on the implementors but also demand urgent action and immediate output. This has resulted in the implementors' misunderstanding and confusion. More confusion occurs when the central administration orders a shift in the policy or project priority as well as the introduction of new ones with the same level of demand. For the case of Sisaket, the implementors experienced the inconsistent demands of MOPH for the TCDV project and the health care project over the years. This had led to confusion and inefficiency in project administration and resources management.

5. Constraints on the primary health care management information system.

From the in-depth interviews and documentary analysis, the researcher found two major constraints on the management information system of primary health care. First, the Sisaket information system lacks quality information on primary health care activities and performance such as (1) level of community participation ; (2) capacity of *Tambon* health centers in health service delivery, and (3) level of health district support towards primary health care in a particular community. Secondly, there is a gap in the process of problem analysis and problem-solving management. To take a concrete example, after the monthly meeting of the Sisaket Health Officer, a number of agreements, resolu-

tions, and measures were adopted. But no responsible units were assigned to instruct the relevant sub-units particularly at the district and *Tambon* levels to follow, let alone to monitor and evaluate, the implementation of those resolutions and measures. The effectiveness of problem solving management, in short, relies on the commitment and responsibility of each member at the meeting.

6. Internal coordination problems.

Another area of weakness concerns internal coordination problems. It is found that each specialized section in the Sisaket Public Health Office tends to concentrate merely on its own work. This is probably due to : (1) the section's lack of understanding and commitment to the overall objective or the ultimate goal ; and (2) personnel conflict and competition among sections. Despite the establishment of the coordinating mechanism for health planning and evaluation at the provincial level, the problem still persists. Again the internal coordination problem is likely to create more workload and confusion for health workers at the lower level. Hence, every section views its work as of top priority, thus stressing and simultaneously and continuously giving the lower units--district health offices and *Tambon* health centers in particular--a lot of, perhaps unnecessary, workload with urgent demands for action.

District Level : Strengths

The Coordinating Committee for Public Health at the district level is the sole area of strength, according to the researchers' findings. The structural composition of the Committee constitutes typically a good mechanism for coordinating various activities in the project planning, implementing, monitoring, and evaluating process, Nevertheless, the Committee's performance depends upon the working relationship between the community hospital director and the chief of the district health office.

Weaknesses

Similar weaknesses to the provincial level were found at the district level, as follows :

1. The under-utilization of the district chief's leadership in mobilizing resources, support and cooperation from other Government agencies.
2. Limited success in mobilizing private sector cooperation and resources.
3. Inadequacy of participation in policy formulation and policy inconsistency.
4. The lack of quality information on primary health care activities and performance.
5. Work overload as well as unnecessary workload with urgent action demands, coupled with the quality problem of health district personnel.
6. **Management confusion.**

The functional responsibilities of the District Health Office can be classified into approximately 48 jobs or activities. Each job is always requiring urgent action from particular upper hierarchical sections in the Sisaket Public Health Office. As a result, the District Health Office is in a difficult position to determine the work priority. In day to

day situations, the work priority depends upon the demand from the Sisaket Public Health Office. This kind of management confusion weakens the District Health Office's capability to supervise the *Tambon* health centers effectively, let alone work as a typical model for the *Tambon* health centers.

7. Problem on quantity and quality of district health personnel.

The District Health Office's workload, coupled with the management confusion described above, easily outweighs the number of district health personnel. Sometimes the District Health Office has to second one or two *Tambon* health officials to work in the district. Furthermore, the quality of district health personnel is somewhat limited. Many of them lack analytical ability and planning knowledge.

8. Inadequate support on financial resources and equipment.

The District Health Office has still faced the problem of inadequate support on financial resources and equipment. Delay of support from the top also happens sometimes. Of central importance is the support related to performance expenses such as per diem and fuel expenses which is very limited. This kind of problem is more critical at the *Tambon* Health Center. This can be considered from the Table below.

Tambon or Sub-District Level : Strengths

1. The utilization of Tambon organization linkage.

At the district level, there are two key bodies ; (1) the Tambon Council ; and (2) the Village Committee. These two key bodies have been used extensively for the benefit of primary health care development. Mobilization of people's support for the establishment of health funds and for participating in primary health care activities has been assisted through these mechanisms. This has thus far been the right direction for the development of primary health care. And, of course, this kind of effort should be continuously supported and echoed.

2. Cooperation among Tambon health centers.

A number of connected Tambon health centers have worked together harmoniously in the operation of primary health care activities. They have occasionally shared health information as well as resources. This is a good example of cooperative effort that should be promoted and expanded throughout the province.

Weaknesses.

1. Problems over the roles and performance of Tambon health officials.

1.1 The role of most *Tambon* health officials is somewhat contrary to the concept of primary health care. They tend to play down their role in medical care service, stay at the office, and devote not much time to health promotion and health prevention activities. Much of this weakness has been caused by the conflicting demands placed upon the Tambon health officials and for other following reasons.

1.2 As stated earlier, the working time of *Tambon* health workers is devoted to medical care service at the *Tambon* health center. Community visitation, supervision

of VHCs/VHVs' activities, as well as monitoring the operation of health funds have rarely been done.

1.3 Most of the *Tambon* health officials lack knowledge on subject matters such as planning, time management and resources management.

1.4 The behavioral pattern of most Tambon health officials has sometimes deviated from the real philosophy of primary health care. To elaborate, citizens were frequently asked to play the game of primary health care when sometimes they were not ready to and were not willing to. This has resulted in the slow progress in many elements of primary health care activities at the village level.

1.5 Work overloads and management confusion similar to the district level illustrated earlier.

2. The lack of personnel both in quantity and quality.

The average number of personnel at each Sisaket Tambon health center is two. The number, of course, is far short for the amount of work. Most of them have received secondary diplomas while *Tambon* officials from some ministries hold bachelor's degrees.

Combined with the Tambon health centers' workload, management confusion and conflicting demands placed upon them, as well as the relatively low quality of personnel, make the situation extremely serious. Urgent action must be taken in order to increase not only the number of personnel but also the quality, especially in the subject matter of management.

3. Inadequate support on financial resources and equipment.

3.1 One of the most severe problems of the *Tambon* health centers is the lack of the so-called "offensive resources." As implementors of primary health care at the lowest level, their village visitations for mobilizing support for primary health care, for educating people on health prevention and promotion, etc. are limited due to the shortage of financial resources and equipment. For an example, each *Tambon* health center budget for gasoline and motorcycle-repair expenses is only in the range of 1,000-1,500 baht. The figure is, of course, very unrealistic (See Figure 1).

3.2 Unequal distribution of resources. It is found that the distribution of resources in Sisaket do not reflect the severity of primary health care problems in many areas.

4. Problem on VHCs/VHVs.

The utilization of VHCs/VHVs tends to decrease in many Tambons. This is due to several reasons. First, the lack of continuous interaction between the *Tambon* health officials and the VHCs/VHVs has led to the decline in primary health care commitments of these volunteers. Secondly, the quality of training projects for VHCs/VHVs may be another determinant of the utilization of VHCs/VHVs. There might be other reasons but the first one is the most important.

Table 1 : Budget Appropriation by 1988 District Health Service (including remuneration, services other than personnel, and supplies)
Objects of Expenditure : For Tambon Health Centers (HC.) and Village Health Stations (VHS.)

No.	District	No. of HC./VHS.	No. of Officials				No. of Village Visitors H.Workers	Total Budget	Services other than Personnel and Supplies					Supplies			
			Total	Out side	Office	Asst. Officer/ Health Worker			Per Diem (Outside Office)	Per Diem (Village Visit)	Per Diem (Asst. Officer/ H.Worker)	Motorcycle Repair Expenses	Health Center Repair Expenses	Medical Equipment	Medical Supplies	Office Supplies	Information Center Supplies
1	Huan	22	171	149	40	10	51	507638	89400	11000	18390	Administered	by Sisaket	339878	33000	11000	5000
2	Kantaraluck	31/3	215	184	73	5/6	23/15	583050	110400	15500	13680	Public Health	Office	361470	57000	17000	8000
3	Utoompornpisai	23	264	241	42	10	55	499190	144600	11500	19800			271290	34500	11500	6000
4	Kukun	27	196	169	43	10/5	42/12	597667	101400	13500	19440			403327	40500	19500	6000
5	Kantararom	15	113	98	27	6	34	272071	50800	7500	12240			159531	22500	7500	4000
6	Rasisali	15	148	133	30	7	42	359176	79800	7500	15120			222756	22500	7500	4000
7	Parangkoo	12	75	63	23	4	18	245580	37800	6000	6480			168300	18000	6000	3000
8	Koonharn	15/1	91	76	24	2/2	10/5	263403	45600	7500	5400			160903	32000	8000	4000
9	Praibung	7	48	41	13	3	11	153909	24600	3500	3960			105849	10500	3500	2000
10	Hyuaytubtun	6	46	40	13	4	15	127207	24000	3000	5400			81807	9000	3000	1000
11	Yangchoomnoi	4	35	31	8	2	9	78705	18600	2000	3240			45865	6000	2000	1000
12	Nhoonkoon	6	36	30	11	1	5	135801	18000	3000	1800			100001	9000	3000	1000
13	Srirattana	6	50	52	13	1	4	183502	31200	3000	1440			134862	9000	3000	1000
14	Bungboo	1	8	)	2	-	-	19587	4200	500	—			118877	1500	500	1000
15	Namklieng	5	45	40	15	5	17	104471	24000	2500	6120			60851	7500	2500	1000
16	Wanghin	7	54	47	12	3	13	124378	28200	3500	4680			71990	10500	3500	2000
	Total	202/1	1603	1401	389	72/13	349/32	4496635	840600	10100	137160	127500	113800	2700575	323000	10300	50000

Source : Planning and Evaluation Section, Sisaket Public Health Offices (1988).

Conclusion and Recommendations

Major Findings

At the macro level, major strengths of management support for primary health care (PHC) include : the PHC concept and the support and blessing of international organizations as well as the Government, the MOPH achievement in gaining adoption and cooperation from the external environment i.e., the establishment of the National Committee on PHC. Major weaknesses are : the under-utilization of the NCPHC : the inability of the Office of the PHC Committee (OPHCC) to fully perform as the secretariat of the NCPHC ; the limited relevance of PHC policy ; the limitations in quality development of PHC management ; and the inequality of resource distribution.

At the provincial level, major strengths of management support for PHC are : the well-designed organizational structure and management system ; the establishment of a coordinating mechanism for health planning and evaluation. At the district level, the key strength is the structure of the district coordinating committee for public health. At the *Tambon* level, key strengths include the utilization of *Tambon* organization linkage and the cooperation among connected *Tambon* health centers.

Key weaknesses at the provincial level are : the under-utilization of the Governor's leadership in mobilizing resources, support and cooperation from other Government agencies ; the limited success in mobilizing private sector cooperation and resources; and the lack of agencies' cooperation and co-use of resources. At the district level, the weaknesses are quite similar to the provincial level. Among those differences are : work overloads as well as unnecessary workloads with urgent action demand from the top hierarchy, coupled with the quality problem of health district personnel ; management confusion ; and inadequate support on financial resources and equipment.

At the *Tambon* level, key weaknesses concern : problems on the roles and performances of *Tambon* health officials; the lack of personnel both in quality and quantity; and the inadequate support on financial resources and equipment.

Recommendations.

The study provides a series of recommendations to strengthen the management support for the development of PHC at the macro and micro levels. They are as follows :

1. The MOPH should play a more offensive role in seeking Government support and cooperation from other relevant ministries and departments. The first step of implementing this is to give more recognition to the NCPHC. The second step is to fully utilize this national mechanism through the continuous arrangement of NCPHC meetings. Hence, resolutions endorsed by such meetings can be used as an undisputed ticket for seeking more PHC budget and support from the Government.

2. More mobilization of support and cooperation from the private sector is also urgently needed. This could be done in number of ways :

(1) More utilization of the joint public and private health consultative committee ;

(2) The national health assembly ;

(3) Setting up a public-private working sub-committee within the NCPHC. The sub-committee is to be in charge of coordinating the policy directions and actions of all relevant agencies both in the public and private sectors. This, of course, would benefit the development of PHC both in the rural and urban areas.

3. For increasing the likelihood of successful implementation as recommended in (1) and (2), the capacity of the Office of the Primary Health Care Committee (OPHCC) should be strengthened so as to fully serve as the secretariat of the NCPHC and as the central agency in coordinating and supporting primary health care activities.

As illustrated earlier, the OPHCC at present is an agency of divisional status under the Office of the Under Secretary for Public Health. Hence, the OPHCC is neither in the position to effectively monitor the primary health care activities performed by the MOPH departments, nor to coordinate and deal equally with those departments as well as other ministries' departments.

To be straightforward, the MOPH's decisions to upgrade the OPHCC as an agency of department status is timely. Consider other justifications :

(1) Primary health care has been a top priority objective and policy of the MOPH for more than a decade.

(2) The need to improve and strengthen the capability of the PHC management system is indeed one of the top objectives addressed in the sixth national economic and social development plan.

(3) The upgrade of the OPHCC is unlikely to effect the increase in budget and personnel. On the other hand, it will boost the morale of many public health officials. At present, at least 800 C-8 public health officials are lining up for promotion. They can go nowhere. If some promotion occurs as a result of the OPHCC upgrade, there will be no effect on salary increase because many of them have been fully paid within the salary range for years. Similarly, the upgrade also benefits and boosts the morale of many C5-C7 public health officials who are being blocked or are facing the same situation as C-8 officers.

4. For the improvement in quality development of primary health care management, termination of some unsuccessful innovative projects on PHC should be encouraged. Furthermore, the provincial public health offices should be granted more freedom in initiating and implementing their own projects.

5. MOPH's project supervision, monitoring, and evaluation should be conducted more often or as much as possible at the points of service delivery, especially at the Tambon level. In addition, performance indicators concerning citizens' satisfaction with health services should be given more emphasis and more objectivity.

6. For tackling the problem of inequality in resource distribution, the following are recommended ;

6.1 The OPHCC should prioritize its research project on the topic of PHC problems situated in particular provinces. The research output should

be used as a basic criterion for MOPH budget allocation. The research, of course, should be continuously conducted every two-three years similarly to the past NESDB research project on the indentification of poverty areas.

6.2 Relevant MOPH agencies which play major roles in the planning and budgeting process should cooperate and share more information on this issue. Those relevant agencies include six divisions in the office of the Under Secretary of Public Health : (1) Health Planning Division ; (2) Epidemiology Division; (3) Rural Health Division ; (4) Provincial Hospital Division ; (5) Health Statistics Division ; and (6) the POHCC (as secretariat).

6.3 In the process of resource allocation from the provincial level to the district and sub-district levels, a working committee for each province should be set up. The committee is to be in charge of grading the degree of health problems in particular areas. Through this mechanism, the allocation of resources, especially per diem and gasoline expenses, is likely to be done in accordance with the nature of the problem. More decentralization in financial management and more relaxation of some regulations and procedures are also needed to help strengthen the management capacity at particular levels in dealing with PHC development.

7. The Provincial Chief Medical Officer should work more closely with the Governor and should try to gain the Governor's adoption of the crux of PHC policy. In this way, the Governor is likely to play a leading and active role in the implementation of PHC policy. In other words, the Governor's leadership will be fully utilized in the process of mobilizing resources, support and cooperation from other Government agencies as well as the private sector.

8. A joint public and private health consultative committee should be urgently established at the provincial and district level. Such a mechanism is believed to enhance public and private cooperation in various ways that are beneficial to PHC policy implementation.

9. The capacity of the district and Tambon health offices in particular should be improved. This could be done in the following ways :

9.1 Increase in the number of personnel.

9.2 Adequate financial and physical resources should be provided so that these officials can perform necessary functions.

9.3 Policy and work assignments to the district and Tambon health officials should be reviewed so as to reduce the unnecessary workload and to let them have more flexibility in adjusting their roles in accordance with the problems of particular areas.

9.4 Training and personnel development. The recommended subject matter includes :

- Resource management ;
- Applied organization design at the District and Tambon level ;
- Planning and implementation strategy ;
- Analysis of PHC management problems at the points of service delivery ; and
- Concepts and fundamental principles of supervision, monitoring and performance evaluation.

9.5 Another alternative option for the development of Tambon health personnel is to bring back the so called *Wechakorn* (community health paraphysicians) training program which was implemented successfully in Lampang a few years ago. The program will increase not only the health workers' performance but also the health workers' linkage to the physicians and nurses in the provincial and community hospitals. However, a lot of work must be done before launching the *Wechakorn* program. First, a clearly stated MOPH directive should be issued that clearly specifies the roles and responsibilities of the new medical health care providers. Secondly, the respective role of *Wechakorn* should be given a legal basis and MOPH regulations should be modified to accommodate these new health care providers. Finally, a quality control measure as well as an appropriate monitoring and evaluation system should be established.

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