

## **Getting Committed Health Workers to the Underserved Areas: A Case Study of Health Decentralization Reform in Thailand**

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### **Background**

It is an undeniable fact that there is a disproportionate distribution of health workers throughout Thailand, with the majority of health personnel working in urban areas, and a serious lack of health workforce in rural areas, despite decades of government's efforts trying to address the problem. Since early 1960s, the Thai government has initiated several strategies to tackle the shortage of health workers in the rural areas, including (i) Education strategy, aiming to increase the production of health workers, with a recent focus on local recruitment, local training, and hometown placement, and reform of curricula to suit the rural environment; (ii) Compulsory strategy, whereby students in medicine, nursing, and primary care trained by public colleges could obtain government scholarship in exchange for signing contracts for compulsory public service between 3 and 8 years after graduation; (iii) Motivation and management strategies, which include non-financial incentives such as career development and residency training opportunities for rural health workforce, and financial incentives such as hardship allowances, no-private practice allowances, over-time payments, and non-official hours special service allowances.<sup>2</sup>

Even though the implementation of above-mentioned policies by the government over the past decades have shown some positive results, the strategies have been found to be largely the reactions to problems at hands, with only short-term effects. In addition, many strategies target only a particular health profession, e.g. doctors, which have sometimes created conflict within health teams. Despite decades of efforts to improve the situation, only 16.5% of doctors and 28% of nurses in the whole country

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<sup>2</sup> Nonglak Pagaiya and Thinakorn Noree, "Thailand's Health Workforce: A Review of Challenges and the Experiences", A Synthesis Paper, 2008.

work in rural parts of Thailand today.<sup>3</sup> This number is very small given that two-thirds of Thai citizens live in rural areas. Worsening the situation, rapid development of medical tourism in Thailand and growing domestic demand from the Thai middle class have contributed to the growth of the private sector, and a strong pull for health professionals from rural areas to the private sector in urban areas.

While much of the analytic work addressing human resources in health issues tend to focus on direct strategies to retain health workforce in rural areas such as education strategy, compulsory strategy, financial/ non-financial motivation and management strategies, it is worthwhile to think out-of-the-box and to explore other strategies which may not have direct health workforce goals in themselves, but may have the potentials to yield positive side-effects on retention and increase of health professionals in rural areas.

This paper is to analyze the effects which the health decentralization reform in Thailand, namely the devolution of health centers to local administration, has upon health workforce in rural areas. The main reason that has driven the health decentralization reform in Thailand is very much political, rather than health. Based on an assessment, this paper argues that the devolution of health centers in most sites visited was producing early positive results in human resource aspects, including the increase in the number of health workers. Key “lessons learned” and success factors are analyzed in this paper.

## **Methodology**

Qualitative research method is used for this study. The information used in this paper is mainly based on results of the rapid assessment, which was conducted during the period 18 March – 8 April 2009.<sup>4</sup> The main objective of

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<sup>3</sup> Suwit Wibulpolprasert (ed.), *Thailand Health Profile 2005-2007*, Bangkok: Express Transport Organization, 2008; Nonglak Pagaiya and Thinakorn Noree, “Thailand’s Health Workforce: A Review of Challenges and the Experiences”, A Synthesis Paper, 2008.

<sup>4</sup> The assessment team comprised Ms. Loraine Hawkins (Team Leader), Dr. Jaruayporn Srisasalux, and Dr. Sutayut Osornprasop.

the study is to assess the current status of decentralization in the Thai health sector, and to identify issues, including issues related to human resources in health at devolved health facilities. It must be noted that the policy intervention – health decentralization reform – has so far happened only in 28 health centers in Thailand, and hospitals are not part of the policy intervention. Therefore, devolved health centers are the focus of this paper.

The assessment team conducted interviews with staff of Provincial Health Offices (PHO), District Health Offices (DHO), a Contracting Unit for Primary Care (CUP) hospital, Tambon Administrative Organizations (TAO), five devolved health centers, five non-devolved health centers, and a hospital-own primary care unit (PCU). The research team used semi-structured questionnaire as guidelines during the interviews with health center staff and TAO leadership. Key questions included changes in terms of utilization rate, changes in the level of outreach activities, changes in the number of staff, changes in service delivery and evidence of responsiveness, changes in revenue and other resources, changes in incentives, changes in terms of supervision and training, and changes in management flexibility, etc.

The assessed health centers are located in five provinces in different regions of Thailand to reflect regional diversity – Udon Thani in Northeastern Thailand, Chiang Mai in Northern Thailand, Phuket and Nakorn Sri Thammarat in Southern Thailand, and Samut Songkram in Central Thailand. Criteria for the selection of the devolved health centers are as follows: - (i) At least one devolved health center located in each of 4 main regions of Thailand – Central, North, Northeast, South – to reflect regional dynamics of the decentralization process; (ii) Visit successful cases (“good practice”) as well as cases with problems with respect to devolution process and transition period; (iii) Availability of key people to be interviewed in the province; (iv) transportation logistics.

To gain broader policy perspectives on health decentralization reform in Thailand, interviews were also conducted with policy makers, advisers, and researchers from Ministry of Public Health, Health Systems Research Institute, International Health Policy Program, National Decentralization Committee (NDC), Ministry of Finance, and Bureau of Budget.

Apart from interviews, this paper also incorporates information from a review of relevant literature.

It is important note that there are some *prima facie* evidence that devolution makes staff recruitment and retention more difficult. The data that the assessment team received from NDC about all the devolved HCs shows a fall in the number of government officers from 83 before devolution to 63 after devolution in 2008; and a fall in contractual from 24 before devolution to 19 after devolution. The assessment team does not have any comparison data with national average turnover and staff loss in non-devolved HCs. However, the team found different data in some of the HCs visited in 2009 – generally a higher number of contractual staff than before devolution, and a higher number than reported to NDC. The difference in data may reflect the fact that the devolved HCs are still in a transition phase so between NDC data gathering in 2008 and the team’s visits in 2009, they were rapidly making progress in implementing changes with the new fiscal resources and managerial flexibility.

However, the team has to take into account that the devolved HCs have “selection bias” toward being HCs where staff were more willing to shift to TAO employment. The team’s qualitative information found staff who chose to shift to TAOs liked living in the locality, liked working for the local community, and wanted to stay in that community. By contrast, one of the reasons the team was told why some staff voted not to transfer to TAOs was because they were concerned about the lack of job mobility to other areas. Therefore, this small qualitative study has limitations in terms of generalizability. Nonetheless, the qualitative study indicates some positive dynamics in HR management, including increased motivation and freedom to reward good performance, penalize poor performance, and use flexible ways of obtaining additional doctor, dentist, and nurse practitioner services in HCs.

### **Description of Devolution Process and Model**

The Plans and Process for Decentralization to Local Administrative Organizations Act of 1999 called for Thailand’s government ministries, including the Ministry of Public Health (MOPH) to develop action plans for the decentralization of functions, resources and staff to the elected Local Administrative Organizations (LAOs) by 2010. The Act also set a target for increasing the share of the central government budget that should be

transferred to LAOs from 9 to 35 percent by 2006.<sup>5</sup> In 2006, the law was amended to remove the 2006 deadline, and set the minimum share of national budget to be transferred of 25 percent, with a target of 35 percent.<sup>6</sup>

Devolution of health centers (HCs) to Tambon Administrative Organizations (TAOs) and municipalities was initiated in the second Action Plan for Decentralization, prepared in 2006. Under the guidelines for devolution developed by MOPH, devolution of HCs only occurs where the following criteria are met: (1) the TAO/municipality meets “readiness” criteria to manage the HC: the LAO must have received a good governance award, and demonstrated capacity for and commitment to health by establishing a Public Health Section and contributing funds to a Community Health Fund (an initiative of the National Health Security Office – NHSO – to encourage local governments to lead and commit resources to disease prevention and health promotion activities, with NHSO co-financing); (2) at least 50 percent of HC staff, including the HC head, support devolution of their HC and are willing to transfer to an LAO for employment. Additionally, the local community is surveyed or consulted to ensure there is majority community support for devolution.

*Transfer of staff and assets:* The devolution process transfers the HC’s physical assets to LAO ownership, and transfers willing MOPH government officers and contractual staff working in the HC to employment by the LAO.

*Transfer of health responsibilities:* A memorandum of transfer is signed by the permanent secretary of MOPH, the PHO, and LAO chief executive officer (CEO) formally documenting the transfer of the “public health duties and responsibilities” of the HC to the LAO, and committing the LAO to “administer and manage the health center according to regulations, criteria, standards, and public health work set by MOPH” and the relevant PHO.

*Fiscal transfers:* The devolution process transfers the MOPH’s budget allocation for HC salaries to the LAO, via the Ministry of Interior (MOI), as a specific (earmarked) grant. This budget allocation covers the basic salaries and benefits of government officers in the HC – typically two to three staff.

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<sup>5</sup> Plans and Process for Decentralization to Local Administrative Organizations Act, 1999.

<sup>6</sup> Plans and Process for Decentralization to Local Administrative Organizations Act (2<sup>nd</sup> Edition), 2006.

Funds will continue to be transferred as a conditional grant to guarantee salary payment for ex-MOPH employees until they retire. Any newly hired HC staff will be paid from the LAO's general revenues (which consist of a general grant, shared tax revenues and varying amounts of local revenues).

Changes in decision rights: LAOs – whether or not the HC is devolved – have some freedom to develop new health services using their own revenues, as long as they comply with MOPH regulations. Major developments, such as the establishment of new health facilities, however, are subject to licensing approval by the MOPH. Additionally, the Office of the Auditor General discourages LAOs from spending on any curative care services that are deemed to duplicate the MOPH's mandate. Following devolution, LAOs have rights and power to hire, promote, reward and discipline HC personnel. Local government officers enjoy protection of employment; firing permanent LAO staff is difficult, just as it is for MOPH's permanent staff. However, LAOs may hire and fire contractual staff.<sup>7</sup>

## Findings

The assessment of five devolved health centers in Northern, Northeastern, Southern, and Central Thailand shows early positive results in human resources aspect, including an increase in the number of health workers, and an increase in responsiveness to the community and to patients. Please refer to Table 1.

***Increase in the number of health workers:*** Four out of five devolved HCs have seen an increase in the number of health workers, part-time and full-time. Following the transfer, the number of full-time health workers at Naphu HC has increased by 25%, while that at Pakpoo HC has increased by 83%. It is important to note the marked increase in the number of contracted staff at devolved health centers.<sup>8</sup>

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<sup>7</sup> Loraine Hawkins, Jaruyaporn Srisasalux, and Sutayut Osornprasop, "Devolution of Health Centers and Hospital Autonomy in Thailand: A Rapid Assessment", *Journal of Health Systems Research*, Vol. 3, No. 2, Apr-Jun 2009.

<sup>8</sup> Interviews by the assessment team in five provinces, 23 March – 3 April 2009.

The increase in the number of health workers in devolved health centers is not only due to increased resources from the TAO budget, but also increased management flexibility, particularly on decisions to hire contracted staff. As health centers are devolved to TAOs, there is a shorter chain of authority for most decision making, and TAOs have the flexibility to spend up to 40% of its budget on human resources.<sup>9</sup>

Nevertheless, one health center noted a negative change in hiring civil service personnel after the transfer. Banprok HC commented on delays and difficulty in gaining approval for a new nurse practitioner post from the Provincial Administration, and for the exam for selection and hiring.<sup>10</sup> In part, this seems to reflect the fact that these agencies are dealing with these procedures for the first time, and are not drawing upon the expertise of the MOPH. In addition, another health center – Salabangpoo HC – registered a reduction in the number of full-time staff, because three out of five government officers have been transferred to other MOPH posts. While the HC is in the process of recruiting additional staff to replace those who were transferred to MOPH, it is arranging back-up staffing from the CUP hospital.<sup>11</sup>

It is interesting to note that while most of the non-devolved HCs visited did not experience changes in the number of staff since the devolution started, the assessment team found that one non-devolved HC - Laem Chan HC in Phuket – was able to tap resources from Wichit TAO to hire a doctor (as well as to construct new building and buy necessary drugs). Even though Laem Chan HC remained under MOPH, it was highly autonomous and able to raise revenue from a variety of resources to hire and reward staff. The close partnership with the TAO perhaps gave Laem Chan HC “the best of the both worlds.”<sup>12</sup>

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<sup>9</sup> Ibid.

<sup>10</sup> Ibid.

<sup>11</sup> Loraine Hawkins, Jaruyaporn Srisasalux, and Sutayut Osornprasop, “Devolution of Health Centers and Hospital Autonomy in Thailand: A Rapid Assessment”, *Journal of Health Systems Research*, Vol. 3, No. 2, Apr-Jun 2009.

<sup>12</sup> Interviews by the assessment team in five provinces, 23 March – 3 April 2009.

***Increase in responsiveness to the community and to patients:*** The majority of the health centers visited could point to a number of ways in which service delivery had already improved and new services had been provided in response to the needs and preferences of the community. These include a stronger client service orientation, increased curative care services, and increase in promotion and prevention (P&P). All five TAO CEOs and TAO Councils have been active in obtaining community inputs on health and health services.

Since the transfer, two health centers have been able to provide additional health services in response to the needs of the community, i.e. dental services, by hiring part-time dentists to operate at the health centers. In particular, Banprok TAO has invested over one million baht for the health center to create a new dental section and purchase necessary equipment for dental care and treatment, so that people in the community do not need to travel to hospitals or private clinics in the city center. Several devolved health centers also plan to use the increased budget from relevant TAOs to hire part-time doctors and nurse practitioners to operate out of the health centers.<sup>13</sup>

Four out of five devolved HCs have increased either utilization or outreach or both for people in the community. One HC has experienced transitional reduction in output (about 5% reduction in visits) because three out of five government officers have been transferred to other MOPH posts. However, this HC still has high utilization and a very visible patient/ community service orientation.<sup>14</sup>

It is also important to note that there is a tendency for staff of the devolved health centers to be service-minded. For MOPH health centers, complaints from people in rural communities that some health center staff are not service-minded or behave in a “bossy” way are not uncommon. The advantage of democracy at the local level is that the TAO leadership, including the TAO CEO and council members, is elected by people in the community. Hence, as soon as health centers are under the management of TAO, TAO leadership tends to do their best to ensure that people in the

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<sup>13</sup> Interviews by the assessment team in five provinces, 23 March – 3 April 2009.

<sup>14</sup> Ibid.

community have good impression after visiting the devolved HC. In some TAOs, devolved health center staff who do not have service-oriented attitudes or behavior have been reprimanded by the TAO leadership, or, if there is no improvement in behavior, the TAO leadership has asked the MOPH to transfer the poorly performing staff back to MOPH.<sup>15</sup> In some TAOs, the public health section of the TAO has conducted health needs assessment in the community by surveys, together with public consultation, and has initiated changes in services in response to needs assessment and/or consultation.

The assessment team also finds that the fiscal devolution and giving TAOs the optional permission to provide health services contributed to the improvement of health services, even before or without formal devolution of HC. For example, Don Kaew TAO in Chiang Mai had used its resources to negotiate with the CUP hospital to establish a PCU staffed by nurse practitioners and visited by a doctor from the hospital to improve quality of local services. Laem Chan's partnership with its LAO to provide contracted doctors services from a retired local doctor could also be referred to here as an example of how devolution has improved service delivery.

**Table 1 Staffing Before and After Transfer of HCs to LAOs**

Devolved Health Centers	Before Transfer		After Transfer	
	Government Officers	Contracted Staff	Government Officers	Contracted Staff
<b>Naphu HC, Udon Thani</b>	4 (2 staff joined just before the transfer)	4	4 (and plan to hire a dentist and a pharmacist)	6
<b>Ban Pa Ngo HC, Chiang Mai</b>	5	2	5	2
<b>Pakpoon HC, Nakorn Sri Thammarat</b>	3	3	3	8
<b>Salabangpu</b>	5	2	2 (plus 2 part-	4

<sup>15</sup> Ibid.

<b>HC, Nakorn Sri Thammarat</b>			time nurse practitioners and part-time dentist)	
<b>Banprok HC, Samut Songkram</b>	5	0	5 (plus part-time dentist; and plan to hire a nurse practitioner and part-time doctor)	0

A similar, positive conclusion on human resources in health outputs was also reached by a team, led by Mr. Sampan Techaatik, which conducted a comprehensive study to evaluate the devolution of 22 health centers to LAOs in Thailand. Mr. Sampan's team explored five aspects of human resources in health, including (i) sufficient personnel, (ii) knowledge and capability in delivering services, (iii) service-mindedness of staff, (iv) sufficient time for service delivery, and (v) transparent operations. The team agreed that there is improvement in all five aspects of human resources in health outputs among the devolved health centers in general.<sup>16</sup>

### **Key success factors and "lessons learned"**

First, the high and strict criteria for the devolution only leave a small number of TAOs with (i) good governance and commitment in health records, and with (ii) health center staff who are committed and willing to stay in their local areas, eligible in the devolution process. Out of over 7,300 TAOs and municipalities in Thailand, just over 500 had received good governance awards. And out of this smaller number of local government units, just over 100 were able to show evidence of commitment to health by establishing a

<sup>16</sup> Sampan Techaatik et al, A Study and Monitoring of the Development of the Transfer System of a Public Health Center to Local Government Organization, 2008.

Public Health Section and contributing funds to a Community Health Fund.<sup>17</sup> The strict criteria against potential LAOs help assure that the health centers would be devolved to the LAOs which are interested in health issues and would be willing to contribute more of its resources for health, including for health workforce.

Another criterion that HCs could be transferred to LAO only if at least 50 percent of HC staff support devolution of their HC and are willing to transfer to LAO employment ensures that the devolved health centers are likely to be staffed with health workforce who are committed to work and stay in that local areas in the long term. While health center staff with MOPH employment may be rotated to other MOPH positions in urban areas over time, most staff with LAO employment, aware of the limited job mobility that come with such employment, tend to be people who are committed to serve their own communities in the long term.<sup>18</sup> Nevertheless, this aspect of the devolution implementation introduces an unavoidable sample bias into any comparison of recruitment and retention of permanent government staff between devolved and non-devolved HCs.

Second, higher LAO bonuses and perceived higher prospects for promotion (to TAO Public Health Section head) are the incentives for health center staff to choose to stay with the TAO, and to be committed to working for the people in their rural communities. Annual bonuses for LAO staff could be up to five times his/her monthly salary, depending on staff performance and LAO policies. The LAO bonuses are significantly higher than the financial incentives provided by MOPH to health center staff. In addition, many health center staff in the MOPH system does not see the prospects of their promotion beyond health center heads, due to tougher competition from MOPH staff who come from urban areas and have better education and work credentials. Hence, the prospects of promotion within the TAO (to TAO Public

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<sup>17</sup> Only larger and/or better resourced TAOs are able to meet this criterion, given the limits on the share of TAO budgets that can be spent on personnel. This means that the current criteria prevent the majority of small TAOs from participating in HC devolution unless they merge with other TAOs.

<sup>18</sup> Human resource policies of the LAO make it difficult for staff to move between LAOs or between LAOs and central government.

Health Section head) convinced some health center staff to stay with devolved health centers.<sup>19</sup>

Third, many TAOs have earmarked their budget for education and training of their staff. While MOPH does not have sufficient resources to promote higher or specialized education for their staff in every health center, many TAOs have the resources to support staff in higher education, which may include nursing or public health. Thus, once a health center is devolved to a TAO, the staff of the health center could be eligible to receive TAO support for their further education in the areas of health needed by the communities, with the commitment to come back to serve the community after their studies. This incentive not only creates the potentials of bringing human resources who are committed to advanced study and learning to the devolved health centers, but also to commit these people to serve the communities for the long term.

Fourth, many TAOs have been able to recruit doctors and dentists as well as other healthcare workers on shorter term part-time or full-time contracts. This raises some questions about the relative effectiveness of relying on the traditional “civil service model” of HR management for recruiting and deploying healthcare workers to rural locations. The civil service model relies more heavily on central administrative direction and on long term career path and job security as incentives for staff recruitment and deployment, and less on short-term financial reward than the contractual approach used successfully by devolved TAOs. The civil service model of employment is much less agile at tapping the local health labor market, as there are strict central limits on civil servant hiring – such that the MOPH too is relying on contractual healthcare workers to an increasing extent.

## **Conclusion**

Even though this assessment and other studies on devolved health centers shows positive conclusion on human resources in health outputs, the devolution model cannot just be replicated anywhere, and not all health centers would be devolved with the same positive results. Based on the

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<sup>19</sup> Interviews by the assessment team in five provinces, 23 March – 3 April 2009.

assessments of interviewees, continued implementation of the current guidelines for voluntary devolution may result in only 10-20 percent of HCs transferring to LAOs over time. Budget and capacity constraints in the large number of smaller TAOs will prevent a substantial share of TAOs from ever meeting readiness criteria, unless these TAOs are given additional funding and/or unless there is a further revision of the statutory limitation of 40% on the share of LAO budget that can be spent on personnel compensation, and/or an initiative to merge small TAOs or promote joint service delivery units that manage health functions for more than one TAO.

The unwillingness of a large share of HC staff to transfer to LAOs may be another binding constraint. Interviews indicated that depending on the province, the proportion of HC staff supporting devolution ranges from 20-50%. The most frequently cited reasons among both health sector and non-health sector interviews for unwillingness to transfer HCs to TAOs are: lack of career path and job mobility, uncertainty or lack of clarity about MOPH policy on devolution, uncertainty about future TAO funding for health, and risk of increased political influence as a result of increased proximity of the HC to political decision-making. In response to the fact that many MOPH staff do not want to transfer to LAOs because of concern about job mobility, it would be helpful for the Thai government to create some common frameworks to make it easier for staff to transfer between LAOs (e.g. portable pensions, common job grading systems, etc).

Nevertheless, given that an average MOPH health center is staffed by only around 3 workers (despite an official health workforce structure of 5 staff per health center), the devolution of health center initiative presents a viable alternative for some rural communities in Thailand to improve their own human resources in health status, with significant potentials to benefit the health of people in the communities.