An Evaluation Research Study on the Management and Development of Human Resources at Sub-District Health Promotion Hospitals Transferred to the Thai Provincial Administrative Organizations

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Abstract

This research aims to evaluate the management and development of human resources at sub-district health promoting hospitals transferred to Thai provincial administrative organizations. It focuses on the impact on workforce post-transfer, reviewing literature to develop a conceptual framework with nine guiding research questions. A qualitative methodology was used, gathering data from 32 SHPHs across eight provinces in four regions. Findings indicate a positive change in workforce numbers post-transfer, ongoing issues with workforce shortages, and facing skill deficiencies and morale. The findings express that an urgent need of state-led workforce development to equip local health personnel, in both quantity and quality, to meet professionally established standards. Both academic and managerial recommendations for those involved are finally provided.

Keywords: Manpower management, human resource development, subdistrict health promotion hospital

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Introduction

Background

The fundamental goal of the primary healthcare system is to reform the population's health status towards complete well-being, resilience, and disease immunity. Besides addressing the service strain at primary and secondary healthcare levels, this system is widely recognized both academically and practically as capable of providing comprehensive and accessible services, reducing disparities, promoting fairness, and efficiently reducing healthcare costs. Previously, Thailand primary healthcare system fell under the overseeing of the Ministry of Public Health (MoPH), with operational units at the local area level by the so called the Sub-district Health Promotion Hospitals (SHPHs). The effort helps to fulfill a practice of country-wide decentralization of the SHPHs to be under the Ministry of Interior (MoI).

However, in 2021, the Thai local government organization committee announced an empowering policy transfer of the SHPHs to the Provincial Administrative Organizations (PAOs) which are under the supervision of the MoI. The voluntary health service transfer to local administrative organizations was approved by the Thai cabinet twice on March 15, 2022, and July 26, 2022, respectively. The aforementioned resolutions have had significant implications on the PAQs implementation on human resource management and development. This has led to five key questions regarding the transfer to the primary healthcare service system as follows:

1). What are the essential systems and activities of the initial management/development of human resources for the PAOs in response to this transfer?

2). How should the PAQs human resource development efforts be structured to meet the needs of transferred personnel?

3). What compensation and welfare systems do transfer personnel desire when compared to the PAOs existing compensation policy?

4). What roles and support mechanisms should relevant stakeholders provide to enhance the PAQs management and human resource development functions desired by the SHPH in alignment with their needs?

5). To what extent have the transferred SHPH healthcare services satisfying meet the local needs which depending a great deal on people factors?

The Objectives of This Outcome Evaluation Research Study

After evaluating the policy of decentralization and transfer of the SHPHs to the PAOs from a human resource management perspective, this research aims to suggest a more efficient human resource activity designed for the PAOs. The transfer practices of human resources were guided by three essential principles: 1). ensuring that the transferred SHPHs personnel and PAOs-affiliated personnel are treated fairly. 2). enabling the PAOs managers to understand the pros and cons, weaknesses, and strengths of their context regarding the first point and make quick and informed decisions, and 3). empowering the PAOs and the SHPHs managers to address problems, foster satisfaction, and evaluate patterns and standards that prevent negative impacts resulting from managerial decisions.

A major objective of this research is to explore and evaluate the outcomes of personnel management and development of the SHPHs that have been transferred from the MoPH to the PAOs. The focus is on: 1). changes in the workforce as a result of the transfer, whether the workforce status has improved or deteriorated after the transfer, 2). the current status of issues regarding workforce shortages, skills, abilities, and motivation of the workforce, 3). problems, obstacles, or weaknesses in the management and development of human resources of the SHPHs, and 4). strategies for improving the practices of human resource management and development for the transferred SHPHs.

Literature Review

The transfer of SHPH authorities from the MoPH to the PAQs created changes in its human resource management and development. This transfer intention is to align with the principles outlined in the announcement on the criteria and procedures for transferring the duties of health stations in honor of the 60th anniversary of Queen Sirikit. This announcement became effective on October 19, 2021. Within this framework, there are detailed guidelines for the PAOs preparation and operation during the transfer, as well as procedures to follow post-transfer. Regarding the human resource management and development, the review includes the following points: 1). adherence to the subsequent transfer-out principles of "tasks, funds, positions, and willing personnel." If the positions are not fully filled, the PAOs can conduct recruitment to meet the required positions. 2). continuity of civil service tenure and benefits, confirming that transfer to civil service or local government employee’s results in increased benefits compared to when they were civil servants, 3). options for the SHPHs personnel rights include: (1) transferring to other SHPHs under the PAOs, (2) assisting in government work for one year, with the

PAOs able to request two extensions of six months each, totaling two years, before returning to the MoPH, (3) participating in early retirement programs, and (4) still being affiliated with the MoPH, but assigning positions at SHPHs and other government offices in the area.

The transfer of the SHPHs to the PAOs means changing authorized responsibilities from the MoPH to the MoI. The change efforts began since 1999 and continued until 2017, resulted in only 51 transfers to municipalities, sub-district administrative organizations, and Pattaya City. A significant challenge encountered was that many decentralized service units varied in quality and incurred high costs in providing services to the public. Transferring responsibilities to the PAOs was deemed appropriate due to their strong financial status, ability to manage services equally across provinces, ease of coordination with central and local authorities, and flexibility in transferring personnel among service units within the provinces. (Kulthanmanusorn et al., 2018), This led to the decision by the Committee on the Decentralization of Authority to Local Administrative Organizations (CDALAO) to approve the voluntary transfer of the SHPHs to the PAOs. As of February 8, 2024, a total number of 4,274 SHPHs have been transferred, accounting for 43.29 percent of all the SHPHs nationwide, while remaining 5,598 SHPHs have not yet been transferred, accounting for 56.71 percent of all the SHPHs. Out of a total of 9,872 country-wide SHPHs, 23,023 personnel have expressed willingness to be transferred accordingly (Health System Research Institute, 2024).

The management of human resources involves various tasks. However, in the initial stages of the transfer, important activities include workforce planning to determine the appropriate number of employees for the specified workload. These employees must have sufficient capabilities to successfully perform their duties. Additionally, there should be provisions for rewards, advancements, motivation, and maintaining valuable employees within the organization. Establishing a human resource management system that aligns with the internal and external environment is crucial for sustainability and achieving organizational goals, leading to employee service, satisfaction and loyalty. Punnitamai, Jongaramrueng, and Sanpanich (2024) emphasized the need to find a right balance between firstly centralized planning and then decentralized execution for effective strategic HRD practices.

The reform of healthcare systems has occurred in various countries throughout history. One interesting case study is the reform in the United Kingdom's National Health Service (NHS) during the 1980s and 1990s. Buchan (2006) noted that the NHS reform stemmed from the recognition of a significant

problem, which was the continuously increasing cost of healthcare services. One of the reasons for this was the labor-intensive nature of healthcare services, leading to personnel costs comprising 60-80 percent of total operating costs. Additionally, the strong bargaining power of healthcare workers' unions made it challenging for the government to control costs (cost containment). These challenges led to three main objectives in the healthcare system reform: 1) decentralizing management power to local healthcare units, 2) establishing autonomous organizations with authority over primary healthcare management (Autonomous primary care unit or NHS trusts), and 3) creating an internal market mechanism by separating service providers from service purchasers (Provider/Purchaser split).

Buchan (2006) found that the reform of the National Health Service (NHS) in the United Kingdom led to changes in workforce dynamics. There was an increase in administrative staff to support tasks delegated due to decentralization of management power. Regular staff were reduced by hiring temporary employees and outsourcing non-core functions such as cleaning and nutrition services. As for changes in capabilities, there was a shift towards hiring personnel with new skills (skill mix alterations) to replace traditional personnel. For example, healthcare assistants (HCAs) in the support sector were tasked with supporting general healthcare services. They were multi-skilled and could perform various tasks, without clear distinction into a specific profession. This was because the training costs were lower, they could perform diverse tasks, and then compensation was lower. Additionally, there were changes in labor relations, transitioning from national-level negotiations to unit-level negotiations due to NHS Trusts attempting to negotiate cost control measures. However, this led to differences in benefits and job stability among healthcare units. Notably, some units designed compensation systems aligned with the general civil service pay system, integrating performance-based pay and reward strategies to control costs and compete with other service providers. These differences in compensation and benefits allowed healthcare units to control costs and compete effectively (Buchan, 2006).

In Thailand, both studies conducted by Tangcharoensathien et al. (2016), and Thanormchayathawat et al. (2023), found similar data. After the transfer of responsibilities, in the initial phase, only one in six public health facilities had complete staffing according to the Service Plan, and almost every public health facility had staffing shortages according to the MoPH's set staffing levels. Particularly, pharmacists and dentists faced significant shortages. Additionally, it was discovered that a majority of healthcare workers (60-70 percent) spent more time on nursing duties than on primary

healthcare promotion and disease prevention tasks. Furthermore, a large number of personnel performed tasks unrelated to their professions, such as nurses having to handle financial matters, procurement, logistics, and reporting tasks, which consumed up to 30 percent of their working time as per the MoPH's performance indicators. Other issues included problems with transfers, resignations, or changes in job roles, assigned workloads associated with other ministries, and extra tasks beyond regular duties. All of these burdens contributed to reduced time available for providing healthcare services to the public.

To achieve successful work outcomes according to the organization's goals, it requires personnel with appropriate competencies on duty. Competencies consist of knowledge, skills, abilities, as well as other necessary attributes for successfully performing tasks. These competencies can be categorized into two types: core competencies, which desirably required behaviors for all employees in an organization and functional competencies, which are the top-up specific competencies additionally needed in carrying out specific responsibilities effectively. Studies by Charoenchang, Kerdmuang, and Kalampakorn (2016) and Sarakshetrin et al. (2022) found that professionals in primary healthcare units should have core competencies in five areas: health promotion, disease control and prevention, nursing care, health recovery, and other competencies such as task performance, coordination with various departments, interdisciplinary teamwork, understanding others, integrated service delivery, proactive work, and understanding differences between individuals, among others. Functional competencies for specific groups of work can be categorized based on job characteristics or professions. For instance, nurses should have competencies in health promotion, basic nursing care, disease treatment and prevention, as well as other competencies such as understanding others, understanding differences between individuals, integrated service delivery, among others.

The transfer of sub-district health-promoting hospitals to provincial administrative organizations has led to changes in various aspects for the personnel. One of the issues that researchers are particularly interested in assessing is how the personnel perceive changes in progress and job stability. A study by Sueasaengthong and Kaewwichian (2012) found that before the year 2011, Subdistrict Administrative Organizations (SAO) and transferred municipalities provided good care for personnel. They made efforts to promote progress and benefits for transferred personnel. However, due to challenges and confusion arising from this new situation, problems emerged, such as feeling unsupported in professional progress due to limitations in assistance from the original organization MoPH. There were

feelings of disparity in compensation and benefits between personnel in local agencies and those in transferred agencies. However, as communication and coordination improved, these problems gradually eased. Regarding job stability, all transferred personnel have realized that the benefits they used to receive have remained unchanged despite the transfer, and in some cases, they have even received more. Therefore, there is no need for undue concern.

Thiwakarakot (2022) reported on the healthcare personnel satisfaction after the PAOs transfer. He found that the transferred health personnel were quite satisfied with their work. They appreciated the more adaptably flexible service management system of the PAOs, which supported the development of service quality. There was clarity regarding progress in their work and they received better benefits compared to before the transfer. However, there were concerns about the workload, due to insufficient staff, that required them to perform tasks outside their professional expertise. For instance, public health dental personnel had to handle financial and accounting tasks, among others. This dissatisfaction highlights a lack of understanding among transferred personnel from the district hospitals about the collaborative work they needed to engage in with the PAOs, leading to delays in tasks. Additionally, there were complaints from personnel in the original local government units (LGUs) about reduced cooperation due to the transferred hospitals no longer being under the direct authority connection of the MoPH.

A Conceptual Framework for this Evaluation Research

Transferring district hospitals from central government management to local government organizations involves moving from a centralized governance model with concentrated power to a decentralized governance system that is independent in managing itself to align with the needs of the local population. Therefore, under the framework of power utilization theory in public administration, it is assumed that when district hospitals are transferred to local government organizations, practices of human resources in these hospitals will eventually change according to the specific needs of each area.

The transfer of the SHPHs from the MoPH, which is a centralized administration, to the PAOs, under the MoI, which is principally the decentralized local administration system believed to have freedom to manage itself to fit in with the needs of the people in an SHPH area. Therefore, it can be

assumed that when the SHPHs is transferred to the PAOs, the management and human resource development of the SHPHs will change according to the needs of each SHPH area. Based on such assumptions, the research team has therefore established the research questions to guide data collection and analysis. To what extent, after the transfer 1) has *the nature of* the SHPHs changed compared to before the transfer? If so, has it changed for the better or for the worse? Any underlying reasons? 2) has *the nature of work* responsibilities for the SHPHs employees changed from states what had been before? 3) in terms of c*apabilities and opportunities for development of the SHPH workforce h*as it changed from what had been before? 4) the work m*orale of the SHPH transferred workforce h*as it changed? What is the direction of change? For better or worse? 5) has the perceived career *advancement of the transferred employees* changed from what had been before? For better or worse? 6) has *the personnel management of the SHPHs* changed? Is the change for better or worse? 7) has the SHPH p*ersonnel's job satisfaction* changed? For better or worse? 8) What are the pros and the cons *of SHPH human resource management and development* due to the transfer? And lastly, 9) What are suggestions of SHPH personnel for improving *human resource management and development?*

A conceptual framework diagram can be drawn as shown in Figure 1. After review relevant documentaries, the process framework depicts six antecedent factors prior the transfer. The transferring procedures should meet three agreed upon principles and as stated in the transfer handbook initiated by the transfer committee. Lastly, human resources aspects of post-transfer development were proposed.

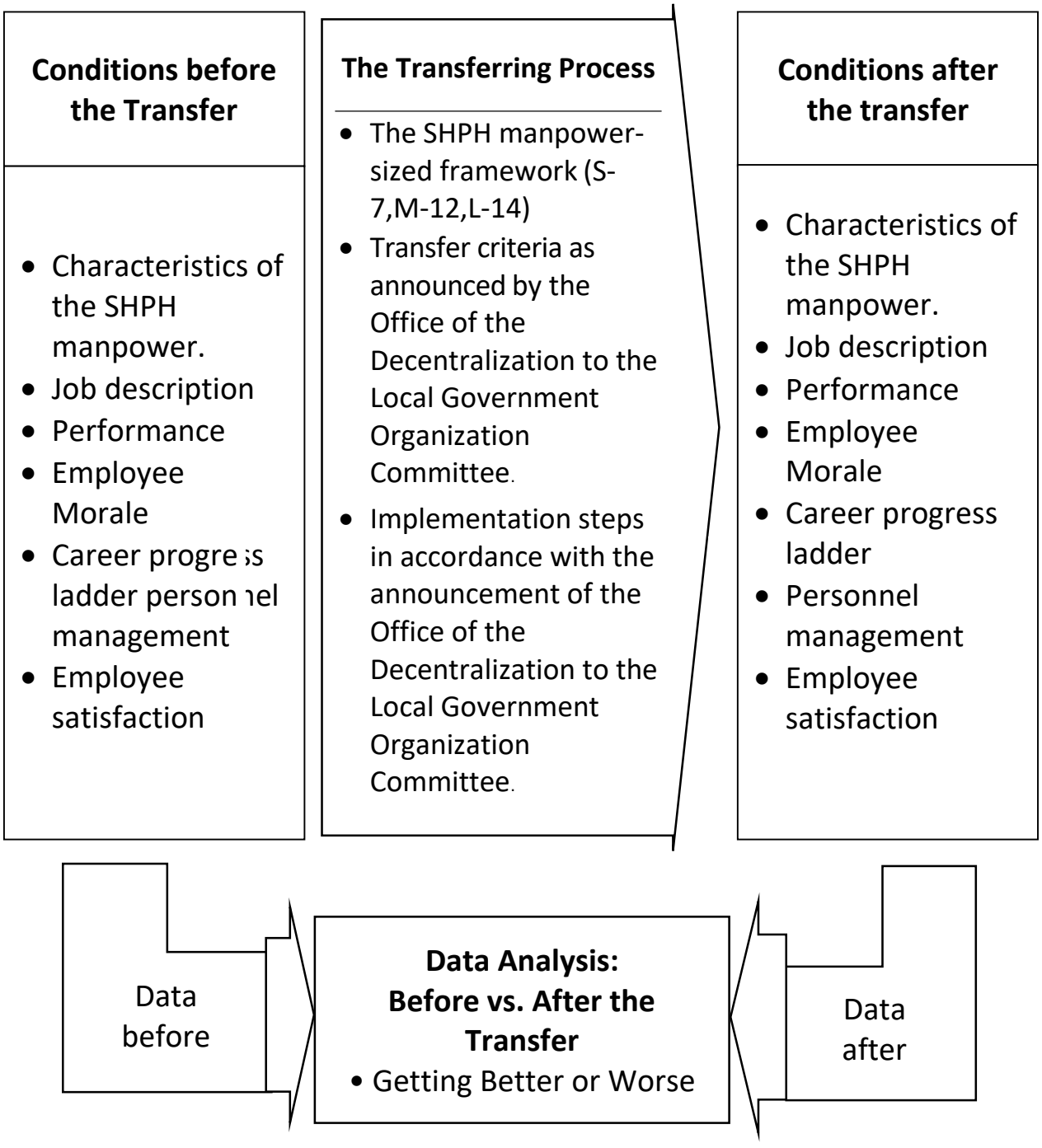

Figure 1. An Evaluation Conceptual Framework

Research Methodology

Research Methods

This research employs an exploratory and descriptive narrative approach of an evaluative research method, specifically a case study. It involves an in-depth exploration of events and covers the issues that need assessment. Subsequently, data analysis and interpretation are conducted, followed by an explanation of the discovered narratives along with extracting insights for policy development in a comprehensive manner.

Units of Analysis, Data Sources and Target Samples

The analytical units in this research are structured into two organizational levels. It utilizes the sampled PAOs responsible for post-transfer policy options as units of analysis at the provincial level. Then, the use of the sampled SHPHs as units of analysis is at the operational level. These two levels of analysis are mutually interrelated. Key data sources come from both organizational levels, including work records, experiential opinions of key informants, policy executives such as governors, provincial executives, public health department heads, and provincial public health physicians.

The purposive sampling method was used to select the sampled SHPHs for a qualitative study, comprising eight provinces across four regions, totaling 32 SHPHs. The selection was conducted by the Health Systems Research Institute (HSRI) based on the following criteria. 1. It must be from provinces granted local hospital transfer in 2023. 2. These local hospitals expressed voluntary participation in the data collection process. 3. They do not concurrently participate in any other similar project. These local hospitals willingly participated in data collection and were not part of other research projects with similar objectives. The results of the selected eight PAOs across four regions of Thailand are as follows:

Northern Region: Nakhon Sawan Province and Phichit Province
Northeastern Region: Nakhon Ratchasima Province and Sakon Nakhon Province
Central Region: Rayong Province and Kanchanaburi Province
Southern Region: Nakhon Si Thammarat Province and Krabi Province

Development of Research Tools

1) Types of Research Tool

The research team has designed the evaluation checklist as a tool derived from policy issues. This checklist was then used to create a research instrument; developing it into a progress assessment *survey of post-transfer operations by those eight PAOs.* The designed survey comprehensively covers the activities and responsibilities of the SHPHs post-transfer across the five missions. The survey was designed to uncover various facts about the phenomena or events that occurred, along with delving deep into identifying the causes of these events. This effort aims to address the research framework. Most of the survey questions are open-ended and semi-structured. A group of locally trained field staff is responsible for gathering the facts alongside the research team. Regarding accessing the facts, interviews were conducted, along with relevant documents from agencies were investigated. Focus group discussions were also held. In this process, it was necessary to primarily rely on official documents that were recorded by staff of both the sampled SHPHs and the PAOs. In cases where there were doubts about the significance of the data, in-depth interviews with relevant stakeholders were conducted to obtain inside information about the causes and impacts of various issues related to the consequential transfer of the SHPHs to the PAOs. Additionally, opinions and feedback on the events were sought, especially regarding future improvement or development. The research team received good cooperation and was allowed to access necessary data from the agencies as requested.

2) Drafting the Tool and the Validity of the Research Tool

In order to ensure that the developed tool is aligned with the actual practices in the field, the research team used a method of site visits in the area, along with interviewing experienced health personnel in the area. This was done to ensure that the questions and data items were relevant and aligned with the actual practices in the field. The areas where site visits were conducted as follows:

(1) A site visit to the SHPHs Bueng Kam Phroi, Prathumthani province on August 30, 2022,

(2) A site visit to the Medical Center and Rehabilitation Municipality of Yitho, Prathumthani province on September 2, 2022, and

(3) A site visit to the PAOs of Nonthaburi province and exchange of opinions with personnel of the Nonthaburi PAOs on January 10, 2023.

3) Online Administrative Conference with the Heads of the SHPHs to Confirm the Relevance and Reliability of the Instrument

To ensure that the survey tool developed is accurate, comprehensive, and aligned with the realities in the field, the research team, after drafting the survey, sought collaboration from the Association of Hospital Directors for SHPHs. They requested a review of the survey's alignment with the field's realities and its overall reliability. This review was conducted through three Zoom meetings on December 2, 2022, December 13, 2022, and December 17, 2022, each lasting no less than 3 hours. The collaboration was fruitful, and the research team compiled feedback and opinions on the revised content and confirmed that the survey content was relevant, accurate, and highly reliable. Therefore, it is considered that the survey instrument is appropriate to use in terms of content relevance and coverage.

4) Preparation for Using the Tools in the Field

Due to the comprehensiveness and depth of the survey tool that requires valid data covering various aspects, the majority of data sources need to be analyzed from the record files of the SHPHs and PAOs. Therefore, to ensure that the data collection process can access the data smoothly and obtain reliable and comprehensive information as needed, the research team has taken the following steps:

(1) The research team has issued a letter explaining the objectives and requesting cooperation for data collection from PAOs in all 8 provinces. These requests were positively cooperated to, and each PAOs has assigned its staff, both at the provincial and district hospital levels, as coordinators to facilitate the research process. This collaboration aimed to ensure the accuracy, completeness, and usability of the research outcomes for enhancing the efficiency of the transfer process.

(2) The research team conducted discussions with representatives from the PAOs of all 8 provinces (2-4 representatives per province, as assigned by each PAOs) through a series of hybrid meetings, including both onsite and online discussions, held on January 7-8, 2023.

(3) To ensure thoroughness and practicality in using the survey tool in the field, the research team organized practical workshops involving the research team members and representatives from the PAOs and the SHPHs Directors' Association of the eight research areas on January 19-20, 2023.

(4) The outcomes of the discussions and practical workshops concluded that:

Firstly, the data collection items in the survey tool mainly focus on management-related data from the PAOs and service delivery techniques from district hospitals, as reported to the PAOs. Therefore, it was collectively agreed during the practical workshops that experienced personnel from the SHPHs should get involved in data collection to ensure the accuracy, completeness, and timeliness of the data. The research team oversaw the accuracy and completeness of the data and provided guidance in the field.

Secondly, due to the vast and detailed nature of the data stored by the PAOs and the SHPHs, it was estimated that each province required a two-day data collection per the research survey.

Thirdly, to expedite the data collection process, the research team has formed data collection teams for each province. These teams consist of central researchers who will work alongside provincial data collection personnel, with each province assigned a specific timeframe for data collection to ensure simultaneous data collection efforts.

Staff Training for Field Data Collection

After developing the research tools, the research team spent efforts on recruiting and appointing field data collection staff as mentioned above. Next, data collection staff were trained in order to understand every aspect of the tool such as questionnaire items, information sources, interview guidelines, and guidelines for interpretation. It was found that training the SHPHs employees to collect data brings significant changes to the new data collection operations as follows.

Selection of Data Collection Staff

From the operational plan, the data collection teams consisted of personnel from the PAOs and the SHPHs, totaling 8 teams from 8 provinces. These field personnel were selected based on their qualifications via collaboration ability between the research team, provincial administrative organizations, and the association of hospital directors. The selection criteria include: (1) holding a bachelor's degree or equivalent in public health, (2) having at least 5 years of direct work experience in the SHPHs, (3) expressing interest in participating in the project, (4) being ready to work outside regular office hours, and (5) completing training in data collection from research project staff. The selection process resulted in a number of 24 qualified personnel for the 8 provinces.

Training Timelines on Data Collection in the Field

The field training of data collection took place from February 3rd to 10th, 2023. The data collection training was conducted to the selected PAO and SHPH staff as follows:

(1) February 3-5, 2023: Explanation of the survey questionnaire was conducted via Zoom Meeting for three hours each day.

(2) February 6-9, 2023: Field personnel used the survey questionnaire to collect data until completion, from 17:00 to 18:30 daily, with meetings held for consultation via Zoom Meeting.

(3) February 10, 2023: Data editors refined and corrected the data, making adjustments if necessary, before making a copy for themselves and sending the original data to the central research team.

(4) February 14-17, 2023: The central research team reviewed the completeness of the data. If the review was successful, the training was considered complete.

(5) If any deficiencies were found during the review, a Zoom Meeting was scheduled for February 18, 2023, between the central research team and the data collectors to discuss and resolve them.

(6) Once the research ethics certification was obtained, data collection in the PAOs and the SHPHs continued as planned. It was estimated to take about one week per SHPHs. However, since in each province, the staff had to collect data from the 3-5 SHPHs, this phase consumed longer time approximately 40 days.

(7) From February 6-8, 2023, the central research team observed the field data collection training in Rayong province and gathered additional information about the SHPHs transfers in Rayong province. They also conducted in-depth interviews with the governor of Rayong province and the management team of the SHPHs to gain perspectives on future healthcare policy directions and primary healthcare service development.

Data Collection and Analysis

After developing the tool and training the data collection personnel successfully, the research team preceded with data collection at the selected PAOs provinces. The data collection process involved the following steps:

(1) Requesting permission from the PAOs management to conduct the data collection. The request letter was dated December 21, 2022. Upon receiving approval, appointments were scheduled for the next data collection sessions.

(2) Prior to the data collection activities, the data collection personnel and central research team sent out Part 1 of the survey in advance to each selected PAO. Three sets of surveys were sent to each PAO to allow for prior preparation and review.

(3) Holding three Zoom meetings to explain the survey and data requirements to the directors and officials of the MoPH and the SHPHs. This activity was aimed at preparing documents and gathering data in advance.

(4) Requesting the directors and officials of the MoPH and the SHPHs to prepare part of the data in advance. Once this preparation was completed, they awaited the central research team and sought data collection personnel to join meetings scheduled in advance.

(5) The data collection of the SHPHs was done by the data collector staff. Then, the data triangulation was subsequently conducted as follows: (1) from the data records, (2) a series of in-depth interviews with the data recorders and the SHPH heads, and (3) field observations of practice.

(6) The research team traveled to each targeted province to collect data, collaborating with the directors and officials of the MoPH and the SHPHs. The data collection process took approximately two days, including interviews with hospital directors for half a day and interviews with provincial public health offices for another half day. The research team also monitored the data collection process at various targeted SHPHs for a few days.

Group Discussion with Data Collection Staff

To ensure the three meanings of data, the central research team studied the data collected and edited by field data collectors according to the survey template. In order to achieve a deep and accurate meaning, in case the data received seemed unclear, the research team joined a seminar group on-site with each provincial data collection team. The seminar group session lasted for one day, focusing on the importance of accuracy and completeness in the seminar's agenda. It aimed to gain a profound understanding of critical issues faced by the SHPHs and included field visits to an actual working environment at the PAO offices.

Interview with the PAO Presidents and PAO Executives.

To obtain in-depth information, the central research team conducted interviews with the provincial executive teams of all sampled eight provinces; the provincial governors, the deputy provincial governors responsible for transfers and the provincial secretaries. The interview topics covered

various aspects such as (1) attitudes toward past and future transfers of authority. (2) current challenges and obstacles, particularly those that may be unsolvable at the provincial level. (3) management models for the SHPHs at the provincial level. (4) perspectives of provincial executives regarding the future development of the provincial healthcare system. (5) collaboration with provincial public health departments. (6) expectations from the central authorities. and (7) any other relevant topics.

Provincial Public Health Interview

To ensure comprehensive information coverage, the research team requested interviews with the provincial public health physicians and the health promotion team from all eight sample provinces. The interviews lasted approximately three hours and covered similar topics to those discussed in the interviews with the provincial executives.

Qualitative Data Analysis

The qualitative data analysis methods used by the research team were as follows: (1) utilizing the Atlas.ti software as the analysis tool (2) cleaning and editing the dataset for the software (3) data processing for each dataset and field data collection effort (4) analyzing and interpreting the results integrating both the analytical outcomes and relevant theories

Research Results

General Information of the SHPHs under the Study

General information on the sampled SHPHs includes manpower management and development classified by the three sizes across four geographical regions, two provinces each, for a total of eight provinces, detailed as follows.

Table 1. General Information of the SHPHs under this Study.

Region	Province	Number of SHPHs studied, classified by size			
		small	medium	large	Total
North	Nakhon Sawan	0	3	1	4
	Phichit	1	2	1	4
Northeast	Nakhon Ratchasima	2	1	1	4
	Sakon Nakhon	1	1	2	4
Central region	Rayong	1	2	1	4
	Kanchanaburi	1	2	1	4
South	Nakhon Si Thammarat	1	2	1	4
	Krabi	0	3	1	4
Sum		**7**	**16**	**9**	**32**

The table above shows a number of seven small-sized SHPHs, 16 medium-sized SHPHs, and nine large-sized SHPHs, a total of 32 SHPHs across the eight provinces. The majority of the SHPHs under study was considered the medium-sized SHPHs, while those with the lowest number of were small-sized SHPHs.

Key Research Findings

Characteristics of the SHPHs Personnel after the Transfer

The study on healthcare personnel focuses on addressing three key questions: (1). how is the status of manpower of the SHPHs personnel compared to the number of manpower standards set in the transfer framework? (2). after the transfer, has there been any change in the number of manpower? And how? (3). what are the main reasons or causes for these changes? This comparison aims to understand how the transfer supervision from the MoPH to the PAOs has affected personnel capacity approximately six months post-transfer. The results were presented in Table 2. The number of personnel according to the prescribed standards is as follows: the small-sized SHPHs, the medium-sized SHPHs, and the large-sized SHPHs should have a total number of no more than 7, 12, and 14 personnel, respectively. Mathematically, if we multiply the numbers of the first two data column, a small-sized SHPH will get a total of 49 personnel (7 hospitals x 7 personnel), a total of 192 personnel (16 hospitals

x 12 personnel) for the medium-sized SHPHs, and a total of 126 personnel (9 hospitals x 14 personnel) for the large-sized SHPHs. However, based on the collected data, it is evident that both before and after the transfer, the hospitals have a lower current manpower than the required standards set. It can be said that the medium-sized and the large-sized SHPHs show promising trends. Because after the transfer to the PAOs, there has been an increase in personnel by 13 and six individuals, respectively. However, they still do not meet the prescribed personnel standards. As for the small-sized SHPHs, besides not meeting the personnel standards, there has been a reduction of two personnel after the transfer. Even due to a small sample specificity, this indicates a general basic issue of personnel shortage affects the quality of healthcare services provided by the hospitals. The result also has implications for the effectiveness of the national primary healthcare policy.

Table 2. Comparing the SHPH Manpower According to the Standard Framework with the Actual Manpower between Before and After Transfer

The Sampled SHPHs classified by size	SHPH Manpower: Framework vs. Current Number		Actual number of current manpower		Change of manpower: before-after
	Manpower framework allowed	Total manpower	Before transfer	After transfer	
Small (n= 7)	7	49	36	34	-2
Medium (n= 16)	12	192	125	138	+13
Large (n= 9)	14	126	102	108	+6

The in-depth data collection revealed changes in personnel numbers in each SHPHs, with both increases and decreases. Among the hospitals that experienced an increase, there were a total of 17 (53.13 percent) SHPHs. The reasons for this increase were related to voluntarily personnel transfers as part of the transfer mission. There was a large increase in non-health personnel, for example, in positions such as professional nurses, traditional medicine doctors, finance and accounting officers, and administrative staff. Some increases were positions that in according to the personnel standards. Additionally, there were personnel from finance and accounting departments and procurement officers who were transferred according to their mission and due to their position numbers. On the other hand, there were five hospitals (15.63 percent) that experienced a decrease in personnel. The reasons for this

decrease were due to personnel dissatisfaction or requests to transfer to other units, such as district health offices or other SHPHs. These transfers did not align with the announcements made previously by the MoPH. Overall, a number of 10 SHPHs that maintained the same personnel numbers (31.24 percent).

Summarizing the comparison of actual personnel numbers before and after the transfer: the small-sized SHPHs showed a decrease in personnel by an average of 0.29 individuals per SHPHs or 5.88 percent of the personnel capacity (of small-sized SHPHs) after the transfer. The medium-sized SHPHs experienced an increase in personnel by an average of 0.85 individuals per SHPHs or 9.42 percent of the personnel capacity (of medium-sized SHPHs) after the transfer. While the large-sized SHPHs also encountered an increase in personnel by an average of 0.67 individuals per SHPHs or 5.56 percent of the personnel capacity (of large-sized SHPHs) after the transfer.

Work Responsibilities of the SHPHs Personnel Before and After the Transfer.

In this part of the research, we want to answer two questions: (1) at present, to what extent have the existing personnel job responsibilities changed from before the transfer? and (2) were there any SHPH work hours changed after the the transfer? It was found that there were a number of 21 (65.63 percent) of the *SHPHs* reported that the nature of their work had changed. One of the reasons was due to changing responsible staff mobility during the first 4-6 months. As a result, some positions have a reduced workload in contrast to other positions have an increased workload. Therefore, new work groups and division of duties have been reorganized internally and informally. Most of these work changes mainly included administrative work (people, money, goods), while health service sections (promotion, prevention, treatment, rehabilitation) exhibited little change. However, because the number of SHPH personnel is less than the standard manpower framework, efforts have been made to spread responsibilities to cover the core missions of the SHPHs according to a new policy of the PAOs. As for the SHPHs with the same job description, there are a number of 11 SHPHs (34.38 percent) remained no job changes.

In terms of time spent performing work, it was found that a number of 13 SHPHs (40.63 percent) had been changed. Before the transfer, most of their working hours were spent on achieving key performance indicators determined by the District Public Health Office or Provincial Public Health Office

performance agreement. The staff also reported that, after the transfer, extra work assignments and meetings had been decreased. Such changes have a positive effect, devoting working hours for more health promotion, that is, (1) having time to visit the elderly and the disabled, (2) having time to check office accounting and financial work, and (3) having time to provide advice and health education to local service recipients. There were a number of 19 SHPHs reported no work changes (59.38 percent).

In conclusion, after the transfer, the nature of the work responsibility of the workforce has been changed. One of the reasons was due to the PAOs has a policy on multiskilling personnel and job rotation available for the SHPH manpower. In terms of the time spent on work, most SHPHs reported not much changed. However, some SHPHs reported changes in their mission, enabling them to perform core mission of health promotion, prevention, and basic health treatment visits.

Changes in the Capabilities of SHPH Manpower after the Transfer

With regard to the capabilities of SHPH employees after the transfer, we would like to address two questions: (1) at present, how have the capabilities of personnel changed after the transfer? and (2) when the transfer takes place, the SHPH staff have been given or sought the opportunities for developing their work capabilities or not? The results of the study found that the. There were 12 SHPHs reported there was some changes (37.50 percent). For example, changes of SHPH personnel are learning about local regulations, PAQ management system, organizational culture, training to increase their skills and knowledge in finance, materials, drugs treatment. From the inspection, it was found that personnel reported (1) time available to develop oneself. Study textbooks. Search for more information on knowledge from digital technology (2) managed time to prepare for professional self-development project plan and the maintenance spending plan for 2023-2024. and (3) had more time to consult and exchange knowledge. The SHPHs staff remarked that they learned new tasks that had never done before such as NCD work, However, the new-comer personnel often have less expertise in working than the old-timer staff. This causes some bumpy work operations. However, it is seen that there there were 20 SHPHs (62.50 percent) reported no change in their work capacity.

As for the opportunity to develop the personnel capabilities of 17 SHPHs (53.13 percent), they agreed that they *were* still the same. There was not much action. As for the SHPHs that reported receiving more opportunities to develop their capabilities, there were 10 SHPHs (31.25 percent) because the SHPHs had enough budgets to develop personnel and organize capacity development

training. This enables them to learn work that has never been done or work that does not correspond to the position . This is therefore an opportunity to develop the abilities and work potential. From the inspection, it was found that the SHPH staff (1) had more time to develop their work capabilities for self-development, (2) created what to be develop their own capabilities, and (3) had a budget/subsidy for development. However, some five SHPHs (15.63 percent) saw that since the transfer had just occurred for only 3-4 months, so they could not clearly determine what the direction of personnel development would be.

It can be concluded that after the transfer, most of the SHPHs personnel still lack the skills and ability to perform their jobs. It is very important in medical services, especially in a public health hospital. Some of the SHPH manpower had been trained to enhance their skills and knowledge at work. However, an opportunity to develop one's work capabilities of the SHPHs was found that it considerably remained the same.

The SHPH Staff Morale after the Transfer

Data analysis revealed that a number of 15 SHPHs (46.88 percent) reported that they *were* too early to tell whether the staff work morale would improve or decrease during the transition period. Some human resource issues still lack clarity, such as requests for promotions of civil servants and special selection examinations for professional employee. A number of 8 SHPHs (25.00 percent) mentioned changes for the better due to the allocation of special bonuses being tied to their abilities. Some staff expect a connection between personnel's abilities and their professional advancement to the level of special expertise. Salary rates are now increased for every professional group. This kind of career progress was hard to get when the SHPHs were under the rigid auspice of the MoPH. The top ceiling of pay schemes of the PAOs is considerably higher than of that of the Civil Service Commission for the same position and level. More importantly, the staff compensation can be fairly increased according to their workload. However, some SHPH personnel reported that their work morale had decreased. There was a number of 4 places (12.50 percent) for several reasons: (1) career progress was still hindered or not clear given the conditions for promotion to the expert level. Delays in recruiting temporary employees who are eligible to become permanent civil servants still remain. Additionally, there is vagueness in granting that the position of Director of the SHPHs is equivalent to that of the Division Director. (2) remuneration has decreased. For example, the comparison of positions from civil servants

to those of the local government officials has caused some positions to be undergraded, resulting in reduced benefits. Or the method of raising the salary from what the Civil Service Commission calculated to increase in the percentage of 100 to in steps, resulting in a lower salary received than before. and (3) a delay in disbursing the yearly budget and welfare according to the relevant rights.

In terms of changes in opportunity to receive morale boosting: A number of the 15 SHPHs staff (46.88 percent) informed that there was an opportunity for a better change. The PAOs executives has a clear policy to improve compensation. Everyone who transfers will receive the same compensation and may receive more if there is a support budget available. In fact, presently, there is a budget for special disbursement of remuneration approximately one or two million baht under special circumstances for public health workers. There was a call for easing regulations for the positions of special expertise and senior positions such as senior public health experts and professional nurses.

However, staff of a number of 13 SHPHs (40.63 percent) reported that they are not sure their work morale will be improved. Budget allowance from relevant agencies still has the same obstacles as before, given an example of reduced per capita lump-sum medical services. Fringe benefits were lesser than before. Reimbursement in the e-claim system receives little return. As for the SHPHs, it is seen that morale may decrease for the following reasons: After the transfer, paid time off is reduced. Employees' opportunities for advancement are difficult and unclear. Progress does not conform to the declared structure. Salary increase is less shift money benefits and compensation are not the same as before. There is also a problem of medical treatment rights that are not the same as before. The treatment rights previously provided by the MoPH are more stable than those of PAQs.

It can be concluded that after the transfer, the personnel's morale of most health care hospitals had an increase. Professional advancement ladder was perceived better than before, including career promotion and a merit-based bonus allocation. But there are still some SHPHs where morale is still seen as decreasing. This is due to unclear rules leading to their compensation being reduced and disbursements are delayed. Opportunity to enhance work morale depends a great deal on the compensation and benefits received and increased professional advancement. However, some SHPH staff were still uncertain about the morale of their personnel. Since there was still a lack of budget support from relevant agencies. But there are still some SHPHs staff who reported that the morale of

personnel has decreased. due to decreased compensation opportunities for advancement are unclear and treatment rights decreased.

Perceived Change of the SHPH Personnel Advancement Ladder after the Transfer

The data collection revealed that staff of the 14 SHPHs (43.75 percent) described that they currently have better advancement ladders because the PAOs places importance on the advancement of personnel. This evidenced from the fact that personnel can be promoted to expert, senior, and specialist levels when they meet all the qualifications. An obvious example is the promotion of a specialist to a specialist for the director of a public health hospital, which is very difficult to do when compared to when the staff was under the MoPH. In addition, after the transfer, personnel in every position have the merit-based opportunity to advance their careers according to their potential. Consequently, salary is increased progressively till the top ceiling. However, there were 12 SHPHs (37.50 percent) expressed uncertainty that the opportunity for advancement would be better. Respondents were temporary employees who see uncertainty in their career stability. In case of academic employees who granted the right to be instated at the expert level due to the COVID situation when under the MoPH. But after the transfer to the PAOs, the right had been cut off. Evidently, the SHPHs staff who just being instated recently reported that their career ladder is seen to be *worse*. Staff of 2 SHPHs (6.25 percent) described their salary increases were originally calculated in percentage proportions, but when they joined the PAOs, the increasing amount given was less than before. In addition, it was mentioned that after the transfer to the PAOs, their previous service years of recently instated employees were not included for the pay level adjustment.

There was a mixed perception of career advancement from staff employees of the 15 SHPHs (46.88 percent) and a number of 14 (43.75 percent) expressed uncertainty. More promotion opportunities were given to a civil servant academic group especially for a specialized position than for a temporary staff group. It was also found that the transferred senior public health officials received lower salaries than when being with the MoPH. Approximately, newly hired employees from a number of 3 SHPHs (9.37 percent) agreed that their advancement opportunities were getting worse after the COVID-19 situation. A major reason was their previous years of service will not be counted. Instead, the length of service criterion would be counted from the date of their PAO appointment.

In conclusion, after the transfer, the advancement ladder for personnel has changed in a better direction. The PAOs gave priority to the promotion and career advancement of personnel. However, some recently employed PAOs staff still saw that their advancement ladder was unfairly considered.

The SHPH Personnel Management System after the Transfer

Employees of a number of 13 SHPHs (40.63 percent) agreed that presently the personnel management system under the PAOs was better than that of previously under the MoPH. One of the reasons was the PAOs allocated additional manpower enabling them to perform on core duties and responsibilities. It was also reported that, after the transfer, the SHPHs was able to organize its personnel system more precisely with optimal key performance indicators. Responsibilities and supervision are clearly divided according to hierarchies. There are 8 SHPHs that are seen to be the same (25.00 percent). The reasons are as follows: There is still a problem of not having enough staff like before the transfer. However, the eight -SHPHs employees (25 percent) expressed no difference of satisfaction because it was just a 6-month transit, too early to tell. The Budget Bureau Office is gradually providing budget support for recruiting manpower in accordance with the announcement of the Office of the Decentralization to the Local Government Organization Committee. The committee board determined the staffing structure to the SHPH according to its size (S-M-L). While employees of a number of 3 SHPHs (9.38 percent) saw worse changes. Manpower alocation to the SHPHs is not yet complete. At present, the SHPHs employees were hired from maintenance funds of the PAOs which is not enough in the long run

In terms of compensation and benefits management, it was found that the SHPHs employees' opinions as being better, uncertain, and the same were about the same. There were employee opinion of the 10 SHPHs reported some improvement (31.25 percent). They mentioned that the salary ceiling is set higher lead to possible promotion. For example, one's salary before the transfer was 58,390 baht per month compared what previously received at 58,560 Baht. After the transfer, employees have free time for 3-4 hour per day compared to before transfer at 2-3 hrs./day. After the transfer, temporary employees of every work group regularly received additional pay for extra work. However, there was a number of 10 SHPHs (31.25 percent) reported that the benefits remained *the same.* The reasons were as follows*:* some fringes are beneficial, but others are detrimental. That is, salaries have increased but the benefits of borrowing money from savings cooperatives have disappeared. They can't request an extension of the installment payment period for the cooperative. House rental benefits were no longer

allocated by the Budget Bureau Office. Another reason was a changing criterion of salary promotion from a percentage ratio to a lower step rate approach. As for the SHPHs employees answered *not sure* , there were a number of 8 SHPHs (25.00 percent). Their current salary is not according to the Remuneration No. 11. Special remuneration of public health workers has not yet been received from the allocation from the Budget Bureau. Part-time compensation decreased but additional work increased 2 hours from 16.30 p.m.to 18.30 p.m. or from. 18.30 p.m. to 20.30 p.m. with a delayed part- time pay. The delay was due to the incomplete transfer of information from the Provincial Public Health Department. As for the SHPHs that were seen to be *worse*, there were 4 SHPHs experience (12.50 percent) due to the PAOs step-based salary raise. The step-based raise made them earns less than when working with the MoPH where the salary was adjusted by a percentage ratio.

What is interesting to delve is there any change in personnel relations between the SHPHs staff and its secondary service link units. It was found that about half of the 17 SHPHs (53.13 percent) reported the same interpersonal relationships in terms of work cooperation and assistance. Health coordination with the host hospital remains the same, such as having a meeting every 1-2 months and participating in sports events or New Year's events together. Staff of 2 SHPHs (6.25 percent) viewed that, after the transfer, the chain of command being treated partially differed. Employees of eight SHPHs (25.00 percent) reported that cooperation activities were seen getting worse. A host hospital did not provide health support as before. Moreover, there is more competition for service recipients. This matter affects the budget to be annually allocated. Employees of a number of five SHPHs expressed uncertainty (15.63 percent) regarding the changing work relationship.

In conclusion, after the transfer, it could be stated that the personnel management systems of most SHPHs have been changed in a better direction. Additional manpower have been allocated in concert with improving systems of work responsibilities. While some SHPH staff reported that the personnel management system was the same, meaning there were staff shortages as before the transfer. In terms of management, compensation and benefits of personnel remain the same and some get improved accordingly. Obviously, the salary ceiling increased and salary increments could be accounted for. There are still some SHPHs expressed that decreasing compensations and fringe benefits which have not been allocated by the Budget Bureau Office.

Changes in SHPH Personnel Satisfaction after the Transfer

Satisfaction is an attitude that occurs when needs are met, which affects performance behavior and retention in an organization. Data from the research found that most SHPHs employees (14 places, 43.75 percent) reported their work satisfaction and experiencing less stress. The reason is after the transfer the PAOs has allocated additional personnel and adjusted the work structure. The burden of unrelated work is reduced and being able to do work that is more relevant to health profession. The coordination process is reduced. Key performance indicators had been used that are still consistent with the MoPH. It was also found that gaining a higher salary due to switching to the Salary Scheme no. 5 with a higher salary ceiling than that provided by the Thai Civil Service Commission. More importantly, the PAOs policy places priority on personnel development and better advancement opportunities. Employees of a number of 8 SHPHs (25.00 percent) agreed that they were still satisfied as before even their workload had not been changed. Some other eight SHPH employees expressed uncertain (25.00 percent). Reporting that four months just passed by, it is still in a transition period after the transfer. There were no clear changes have been seen yet. However, there was only a small number of two SHPHs (100 percent 6.25 each) with decreased satisfaction due to the decrease in personnel number. However, there were still some SHPH employees who were not willing to transfer. Consequentially, resulting in increased workload made those who transferred facing fatigue. In addition, the allocation of medical supplies is delayed, causing a decrease in health service quality.

Employee friendly policy and attention from the PAOs is another important factor affecting satisfaction. It was found that as many 13 SHPHs (40.63 percent) reported uncertain over a better care. It was hard to tell in a short period of time, no clear change has been seen. While a number of 11 SHPHs (34.48 percent) agreed that they received better care and support from the PAOs, especially work materials and equipment necessary for operations. In contrast, employees of a number of 7 SHPHs (21.88 percent) expressed the same level of work satisfaction since they had not yet seen clear changes. In addition, they reported that the PAOs have not yet allocated additional personnel support. Employees of one SHPHs (3.13 percent) thought satisfaction was worse, for being lonely and abandoned.

In conclusion, it can be concluded that after the transfer, most of the personnel of the SHPHs felt more satisfied. That is, the SHPHs was allocated additional personnel and reducing the burden of unrelated work. The coordination process is reduced. In addition, personnel receive increased salaries. Importantly, the PAOs places importance on personnel development, which results in better

advancement opportunities. However, there are still health care hospitals. Some view that the satisfaction of personnel remains the same, that is, the workload remains the same. Some employees reported there is still not much clarity on how the PAO administration expressed care and attention.

Advantages and Disadvantages of the SHPH Manpower after the Transfer

The results from the SHPHs data analysis revealed that the transfer has resulted in many benefits in terms of manpower, namely:

1). Flexibility in personnel management. The transferring guidelines announced by the CDALAO shorten the PAOs to carry out many personnel matters such as positioning classification, hiring, promotion, and employee development by directly submitting requests to the PAOs Civil Service Commission (CSC). These human resource practices are conditional to each PAO situation on its annual maintenance budget.

2). Provision of additional SHPH personnel under the CDLAO staffing framework. The guidelines empower the PAOs authority over the SHPH personnel management to improve and allocate staff on its local needs, especially professional nurses and Thai traditional health medicine which are in high demand. Getting qualified staff therefore enables the SHPHs to serve better health service.

3). Better career opportunity for advancement. Again, the CDLAO guidelines provide a principle for manpower transfer from a civil servant track to a local government employee of getting fringe benefits at an equal or greater amount to what previously received. Therefore, it was found that personnel transferred employees had more opportunities for advancement. For examples, those SHPH employees whose salary meets a minimum salary of an expert level can be eligibly promoted for a specialist level.

4). Increased benefits. As a result of established regulations by the MoI regarding an annual rewards for local government employees, the PAOs can considerably provide monetary incentives to the SHPH employees based on merit-based pay linked to performance such as bonuses.

However, the research results also found some disadvantages arising from the transfer to the PAOs which need improvement as follows.

1). Changing regulations from the MoPH to under the MoI that are not yet complete. As a result, the transferred personnel experience delayed and unfairly deemed compensation and benefits in acordance with the rights they previously received. Examples of extra compensation are for working

outside of official hours. (According to the regulations of the Mof PH regarding the payment of remuneration to staff working for service units under the Ministry of Public Health (No.5) in 2009 lump sum allowance is in according to the regulations of the MoPH regarding the payment of compensation for officials who perform work for service units under the MoPH in 2001 (Issue. 11) 2016) and extra pay in according to the Civil Service Commission regulations on extra pay for positions with reasons special civil service allowance in 2009.

2). Lack of optimal SHPH manpower. Since the transfer was done on a voluntary basis, some SHPH personnel who remain working with the MoPH. Some SHPHs encounter disproportionally workload and appropriate manpower headcount. While recruitment is undergoing to fill positions according to the workforce framework.

3). Job insecurity among employees who still remain working for the MoPH and subsidized employees of the SHPHs who have been transferred to the PAOs. There is still no clarity on the policy regarding improving employment contracts or their career stability.

4). Regulation for position progress. This problem specifically happened to the transferred employee who obtained so called a senior public health official and supposed to receive a high salary eligible for moving up to a specialist level, however the PAOs did not have this position or level classification to support them. Alternatively, if trying to seek a special expert level instead, this makes them get a lower salary and rights.

In summary, the transfer brought many good results as mentioned above. However, for some disadvantages**,** it was found that (1) the personnel of the SHPHs were not yet familiar with various regulations of local administration. (2) some personnel did not receive reasonably the transfer of welfare rights and benefits. It has not yet been resolved. (3) the fact that a number of personnel did not voluntarily transfer and their positions were also changed. This creates a lot of subsequent work problems. (4) in the case of employees of the MoPH, it is not clear whether or not they will continue to be hired after the employment contract is completed. And (5) the work relationship between the MOPH and SHPHs is getting lower than before. This makes coordination more difficult.

Opinions of the SHPHs Personnel Regarding Future Workforce Development Guidelines

From the information and comments regarding future manpower development guidelines of the SHPHs, the research team has summarized the opinions of the SHPHs under study as follows:

1). Manpower allocation should be expedited according to the standard manpower framework established by the CDALAO to alleviate the over workload of current SHPH personnel. Some positions urgently needed to provide public health services to local people are professional nurses, traditional Thai medicine, and dentists. Fulfilling the SHPH staffing is supposed to be consistent with the changing population.

2). There is a clear need for informal and formal development of the SHPH supporting personnel. Determining their job-related competencies and development techniques such as creating individual development plans, skill training, study visits and further supervision or education related to the professional health standards and expertise. The more mastery health skills they have, the better primary health service will be delivered improving local people health status.

3). Developing the health service system for the people means the SHPH organizational development. In addition, it leads to better service behaviors of the potential SHPH staff both professionally and personally such as morality, love, and kindness towards fellow humans.

4). A direct way helps to lift up the SHPH staff morale is through fair compensation and benefits. Counting their length of year service continuously enhances opportunities for being appointed as a civil servant and providing flexibility in career opportunities to move back to work in their hometowns.

5). Policy clarity in terms of budget and financial support is much needed. A yearly budget allocation by the Budget Bureau Office will expedite the manpower staffing to complete as the structural framework of the SHPHs. However, as of the fiscal year 2023, the Budget Bureau Office has not yet allocated the subsidies for the SHPHs to hire replacement personnel.

In conclusion, the health standards of the SHPHs in almost every aspect are still lower than those of the primary health system**.** Therefore, the SHPHs deserve to be improved and developed as follows: (1) procurement of health staff which qualifications meet the standard manpower framework. (2). development of manpower skills and abilities which suits the health core mission on a regular basis. (3) most of the services of the SHPHs must cope with immediate local needs mostly of basic medical treatment. Their basic health skills are still insufficient. The PAOs management should give high priority on these urgent solutions. (4) the main mission of the SHPHs is health promotion and prevention, but in practice it is still unable to fully perform these duties. This is due to a lack of resources, time, and unpreparedness in many aspects. (5) the allocation of the subsidized budget according to the SHPHs size is not yet tangible. If it is materialized, success in local health service will be achieved. (6) the

morale of the SHPH personnel is important for the local health interventions. The PAOs top management should give a high priority on the issue.

Discussion of Results

The purpose of this research is to evaluate the after-transfer situation of the SHPHs manpower management and development. Data collection and analysis focused on (1) the changing nature of SHPHs manpower after the transfer (2) the SHPH manpower shortage problem affecting morale of the workforce (3) current manpower status of the SHPHs in terms of their strengths and weaknesses, and (4) guidelines for strengthening the SHPH personnel development. To achieve these purposes, the research team reviewed the literature, established a conceptual framework and formulated a set of nine research questions. Then, qualitative research methods were used. Structured interviews, focus group discussion and survey questionnaires were employed. Employees of the 32-SHPHs of eight provinces in all four regions of Thailand are reasonably selected. The research unit of analysis is done at an organizational basis.

The SHPHs are considered as a primary health service unit of the public health service system which is closest to the health needs of local people. The SHPHs core missions cover in five main public health roles: health promotion, disease prevention and control, provision of primary medical care, rehabilitation, and consumer protection. In order to perform these duties efficiently and effectively, an appropriate amount of qualified SHPH personnel is essentially required. The Primary Health System Act of 2019 requires that for each unit of a primary medical system, specifically- the SHPHs to perform health interventions effectively, there must have a family physician and a team of primary health care providers. This requires the SHPH service units and service unit networks must have at least a family physician and a group of two or more health professionals specializing in primary health service providers such as licensed nurses, midwifery professionals, and community public health professionals. However, due to manpower shortage, it was found that the SHPHs classified their personnel into two categories. One is considered as a regular personnel group such as professional nurses and public health academia, Thai traditional medicine practitioners, and general administration officials. Another personnel group is called a rotating staff such as doctors, dentists, pharmacists, and physical therapists which still in a chronic shortage. These rotating personnel will provide medical services at the SHPHs on a scheduled

date basis. For example, medical doctors will be in service two times a week. A physical therapist will be stationed on duty in each SHPH once a month.

The above manpower solution does not indicate that staff turnover is a major problem in primary health care. But it points to a short-term dilemmatic solution trying to maximize primary health services by using limited health professionals for the benefits of local people needs. On the one hand, when considering a main mission of health promotion, it is really hard for each SHPH will have a permanent family doctor. Sharing medical resources is really therefore a more appropriate method in practice. Establishing a health network among the primary care units technically supported by the host hospital is therefore deem necessary. This medical care practice will be implemented until Thailand is able to produce enough medical professionals to meet the demand. In practice, factors that need to be carefully considered are the doctors from the host hospital who rotate to provide medical treatment. Another factor is the distance between the SHPHs and the host hospital that must not be no more than 30 kilometers apart. In terms of the costs of accessing primary health services, especially in areas where public transportation is inaccessible. The SHPHs services help a great deal for people suffering from minor illnesses. If getting an initial diagnosis, there would be no need to travel to the host hospital. While in reality, many ill local people have to rent a car for a sum of several hundred baht, leave homes early in the morning to make a health service reservation. They received a medical check-up and doctor diagnosis for just less than 10-15 minutes, then spending the whole afternoon waiting for medical supplies. Reportedly, it was found that many SHPHs are very far from the host hospital do not have circulating doctors. As a matter of fact, there are few professional nurses who do an initial check up and symptoms analysis via the telemedicine to consult with doctors from the host hospital. Subsequent dispensing medicines as prescribed by the doctor were done via the telemedicine basis.

Guidelines for setting up a network of primary care units and telemedicine treatments via the support of advanced telecommunications technology are significantly beneficial. The guidelines maximize the use of existing human resources to achieve health service goal. A question that arises with this fashion is how to proceed appropriately with the social context and in line with the law that guarantees citizens access to quality public health services. Common goals of the Primary Health Act 2019 and the announcement of the Primary Health System Committee regarding the characteristics of service units and service unit networks that require family medicine physicians in SHPHs are to: people

have access to quality health services provided by the government. The heart of this issue is the equal distribution of public health services to meet the needs of people in an equity service. Primary health services that inclusively cover everyone in every group in order to alleviate the existing high inequality in Thai society. This practice is generally welcome by many medical schools. One is the Praboromrajchanok Institute. Thailand is in an urgent need to develop a curriculum for family medicine doctors to work in primary health care units (Hfocus News Agency, 2023). However, it is a pity that the manpower structure set out in the SHPH transfer manual (pages 41-46) does not include instating a family medicine doctor. Even there were family medicine doctors stationed at SHPHs, there will be causing the PAOs more financial burden for not being able to employ family medicine doctors in SHPHs. Therefore, it would be good if the laws related to the staffing manpower structure were revised. The revision should be consistent with the production of medical doctors in current and future need as well.

From the research results, it would be safe to conclude that quantitatively there was a positive manpower changes. Small-sized SHPHs had an average of 0.29 fewer people per SHPHs, while medium-sized SHPHs had an average increase in manpower of 0.85 people per SHPHs. Meanwhile. large SHPHs had an average increase in manpower of 0.67 people per SHPHs. According to the data analysis, after the transfer, the SHPHs had more manpower which is considered a good sign for the SHPHs. The administrative capacity and various services of the SHPHs will be considerably improved, and beneficial to clients. Consideration in terms of the SHPHs competence and commitment, it was found that the status (1) of the number of personnel of the SHPHs is still lacking when compared to the standard framework for manpower for all eight personnel categories. (2) quality of their primary health services depends a great deal on upskilling their professional skills and abilities. (3) in terms of work commitment, it was found that employee morale was better than before the transfer. Evidently, we saw that the personnel advancement ladder was better than before. A main obstacle of the SHPH is a manpower shortage especially when compared to the required numbers according to the manpower standard framework. This inevitably results in quality of providing primary health services to the clients in every aspect of health promotion, prevention and medical treatment.

Summary of Research Results and Recommendations

Key Research Findings

The results of this research found that after the SHPHs transfer under the PAOs authority as follows:

1). Manpower numbers of the SHPHs after the primary health services transferor seem higher than before. Namely, small-sized SHPHs had an average of 0.29 fewer people per SHPHs, while medium-sized SHPHs had an average increase in manpower of 0.85 people per SHPHs. Meanwhile. large SHPHs had an average increase in manpower of 0.67 people per SHPHs.

2). The nature of the work responsibility of most SHPHs personnel has positively changed. The PAOs encourage a policy of using people in a more multiskilling at work and flexibility of more manpower mobility than ever before. In terms of time spent performing work, most SHPHs employees still have the same amount of time spent performing work as before. However, some SHPHs reported spending more time on core health prevention and promotion. For example, more work hours are spent on visiting the elderly and the disabled in the responsible area, and fewer meetings or travel outside the work area.

3). Most of the SHPHs employees still lack the necessary skills and abilities to provide basic health services. Even though, there is still some SHPHs personnel who received health service training. There was also mentioned that development opportunities for the SHPHs staff remained the same.

4). Most PAOs have a morale-boosting policy, for instance career advancement, widening upper salary ceilings, and greater fringe benefits, for the SHPHs personnel more than before the transfer. However, policy continuity and clarity are much needed to make fair support across all employee levels. The career ladder of the SHPHs employees is more flexible under the PAOs supervision. When their minimum qualifications are met, employees can make a request for their advancement.

5). More manpower allocation for the SHPHs has been initiated in the personnel management system. This effort greatly facilitates the health service, staff satisfaction and encouragement.

6). However, there are found many other disadvantages:

- Personnel at the SHPHs were not yet familiar with various rules and regulations of Thai local administration.

- Some personnel did not receive the welfare rights and benefits. The issue has not yet been resolved.

- The fact that several SHPHs personnel did not voluntarily transfer and their positions have been already changed. This creates an over-workload problem for others.

- In the case of SHPHs employees who prefer to work under the MoPH, no guarantee thus far has been made whether they will be hired after their employment contract is over.

- The work relationship with the SHPHs with other rural health stations is considerably lower than before. This makes work coordination more difficult.

7). Guidelines for developing manpower include:

- Recruiting manpower to meet the standard manpower framework.

- Regularly developing manpower skills and abilities appropriate to each SHPH mission.

- Since primary health services of most SHPHs are expected to address immediate medical needs, the capabilities of personnel are greatly insufficient.

- Major health mission of the SHPHs is promotion and prevention, but in practice, it is still unable to fully perform these duties. A lack of resources, time, and unpreparedness is all performance obstacle.

- Regarding a subsidy budget allocation to the SHPH is not complete yet. A matter of manpower, budget, and core mission should be taken into consideration simultaneously for service improvement of each SHPH management.

Policy Recommendations

These suggestions closely tied to the results found. First and foremost, action plans by the PAOs to upskilling health service capacities of the SHPHs workforce under a professional cooperation with the MoPH should be quickly determined. In a short term, a matter of how to fill up vacant staff of positions mostly needed for each SHPH according to the amount of preestablished SHPH manpower allocation should get resolved. In a long run, action plans as had long been addressed on the following have to be executed: (a) accelerate the production of health professionals sufficient for needs as a nation agenda. (b) develop health service skills for the SHPH employees capabilities that match up current health needs of the local people. (c) build morale among personnel to be enthusiastic and proud of the work they do. To achieve an ultimate goal of well being for all, a committedly professional cooperation between the MoPH and the PAOs is urgently needed.

Academic Recommendations

Essentially, the SHPHs are like the vanguard of public health in Thailand. If the vanguard stays strong, there is a chance of victory. Strengthening the SHPH capabilities and equip them with sufficient

resources is therefore enhancing the success of primary health care services. The success of SHPHs operation depends not only on its personnel alone, but also a great deal on the offensive strategy and tactics which come from a careful and deep academic intelligence. Various mechanism of administrative activities by the professionals involved is still in the process of being revised to be in line with resolutions and agreements regarding personnel management. Since presently health situations change a great deal. Thus, two foundation efforts for the sake of a sound primary health system are proposed. One is conducting a SHPH nationwide survey of its manpower needs assessment. Then, based on these data analytics, determining jobs or positions in need, updated appropriate characteristics and an optimal number of health professionals for each SHPH. In terms of the staffing arrangement of each SHPHs, manpower analysis that reflects the actual demand for quantity and quality of appropriate health workforce according to not only the size of the SHPHs but also local problems, needs and volume of services provided in the geographic area are taken into consideration. Several human resource planning methods such as Markov analysis should be performed (Mathew, Ramannathan, & Arabhi, 2017) together with the Full Time Equivalent (FTE) method. In addition, sensitivity analysis in quantitative terms should be employed for each SHPH. (Phanthunen et al., 2018) such analysis will not only show the movement of manpower in each SHPHs over a period in the area but also be useful to set a framework for manpower at the policy level. Second, in terms of the so-called "RUN (Reskilling-Upskilling and New Skills)" model for the SHPHs personnel development, designing a curriculum for a non-degree health professional covering all five missions of the SHPH primary health services. Different curricula have to cover not only technical and digital capabilities but also interpersonal skill in network cooperation serving both SHPH operational staffs and the SHPHs administrators.

Conflict of Interest

This research received funding from the Public Health Research Institute (IPST), which is part of a series of projects on evaluating policies for transferring sub-district health-promoting hospitals to provincial administrative organizations.

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