Health Workers' Perspectives Towards Health Services Performance in Subdistrict Administrative Organizations: A Cross-Sectional Study in Region Nine Health Area of Thailand

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ABSTRACT

Thailand has moved towards a decentralized system. The responsibilities and authorities in health have been transferred to the local administrative organizations, including Subdistrict Administrative Organization (SAO). Therefore, health workers in SAO should have ability and motivation to perform health services comprising decentralized duties and responsibilities. We conducted a cross-sectional study to investigate health workers' perspectives towards health services performance in SAO in Region Nine Health Area of Thailand. Respondents comprised 201 health workers with the primary responsibility for health services performance of SAO in all four provinces in the area, sampled by Stratified Random Sampling. Data were collected by self-administered questionnaire and analyzed using percentage, means, standard deviations and paired T-tests. Results indicated that the health worker's perspectives towards the importance of SAO health services performance were at a high level, 74.1%. Meanwhile the perspectives towards their current competencies were at a moderate level, 62.2%. The average score of perspectives towards the importance was significantly higher than towards their current competencies ($p<0.001$). The results indicated the issues needed capacity strengthening towards health services performance among health workers in SAO. The findings suggested that awareness and motivation of working should be raised together with strengthening the capacity on health services performance with related parties, especially about infectious waste management, oral diseases and dental health and waste management.

Keywords: health services performance, sub-district administrative organization, health workers' perspectives

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Introduction

Decentralization is an essential approach of transferring functions, responsibilities, authority, financing, management, resources and so forth from a central government to different levels in an organization, in particular the Local Administrative Organizations (LAOs)[1, 2]. Thailand had five types of LAOs before the full-fledged decentralization process started[3]. These included Thesaban (municipality) in urban areas, sanitary districts (Sukhaphiban) in semi-urban areas, Provincial Administrative Organizations (PAOs) in provincial rural areas, the Bangkok Metropolitan Administration (BMA) for Bangkok, and the Pattaya. The first three types comprised an ordinary local authorities distributed throughout the country. The decentralization process in Thailand represented an effort to transfer administrative services and financial and human resources to LAOs and develop their capacity[3, 4]. However, before the 1997 Constitution of the Kingdom of Thailand (the 1997 Constitution)[5] was established, the local authorities did not play an important role in public services delivery compared with the central government and its branch offices. All the LAOs accounted for less than 10% of the total national expenditures. Likewise, the ratio of their employees to those at the central government and its branch offices was one to more than 10[3, 4]. Decentralization was a major issue in the general election held in September 1992, a system of publicly electing provincial governors and the idea of granting status of a local autonomous entity, including the Tambon (Subdistrict) Council, was advocated and driven and led to the establishment of the Tambon Council and Tambon (Subdistrict) Administrative Organization (SAO or TAO) Act of 1994[6]. The SAOs were established in rural areas and gained autonomous status.

The 1997 (B.E. 2540) Constitution of the Kingdom of Thailand[5] required the state to decentralize local self-reliance and self-determination in local affairs and has promulgated a law requiring plans and procedures for decentralization to the LAOs in 1999 (B.E. 2542)[7, 8]. The Decentralization Act in Thailand (the Decentralization Act of 1999) became effective in November 1999 and the National Decentralization Committee (NDC) was convened at the beginning of 2000[7, 8]. Thereafter, the decentralization plan was developed and approved by the Cabinet in 2000 and 2001. Various acts, the Decentralization Plans, as well as plans for participation from the LAOs were also issued and implemented[9, 10]. The Decentralization Act of 1999 set the fiscal decentralization target of increasing the percentage of LAOs' expenditures to at least 20% by 2001, and further to at least 35% by 2006[8-10]. This meant that not only the intergovernmental transferred only administrative

services but also the associated financial and human resources; therefore, the LAOs were restructured with many responsibilities and much of the budget transferred to them[8-12]. In fact, the proportion of LAO revenues to total government revenues stood at 24.1% in 2006 (target was 35%), which prompted the government to lower the target to 25% to be attained by the end of 2007[4, 9]. The Decentralization Action Plan has a three-tier structure; upper, middle, and lower. The upper-tier divides services to be transferred in six categories: (i) infrastructure, (ii) quality of life, (iii) order and security of communities and society, (iv) planning, investment promotion, commerce and tourism, (v) natural resources and environmental protection, and (vi) arts and culture, traditions, and local wisdom. The services of quality of life to be transferred include livelihood promotion, social security, sports promotion, education, public health, inner city improvement, habitat development etc[3, 4].

Health systems comprise all activities, organizations, institutions, and resources devoted to producing health actions with the primary goal to improve the health of the people[13, 14]. Section 52 of the Constitution of the Kingdom of Thailand established that *"A person shall enjoy an equal right to receive standard public health service and the indigent shall have the right to receive free medical treatment from public health centers of the State, as provided by law"*[5], which provides processes of re-orientation for health and makes clear demands for health sector reform. The Plans and Process for Decentralization to Local Administrative Organizations Act of 1999 called for ministries including the MOPH to develop action plans for decentralization of functions, resources and staff to the local authorities by 2010. Devolution of health decentralization was initiated in the Second Action Plan for decentralization under the guidelines set by the MOPH. Devolution of health centers (HCs) to the LAOs only occurred where the following criteria were met: (1) the LAOs (SAO/ municipality) met "readiness" criteria to manage the HC (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), and (2) at least 50% of HC staff support devolution of their HC and were willing to transfer to a LAO for employment, including HC head. Additionally, the local community was surveyed or consulted to ensure the majority of the community supported devolution[10, 15, 16]. The mission to be transferred to LAOs stated in the 2002 Action Plan were 10 issues on infrastructure and 32 issues of promotion of quality of life covering (1) staff and assets including physical assets and officers and

contractual staff, (2) health responsibilities including public health duties and responsibilities and administering and managing the health centers according to regulations, criteria, standards and public health work methods set by MOPH and (3) fiscal transfers including budget allocation for basic salaries, benefits to government officers and funds for capital expenditure and staff training[3, 4].

Due to procedures of transferring health facilities to LAOs, only 28 (0.3%) of health centers (HCs), currently known as Subdistrict Health Promoting Hospitals (SHPHs), were transferred to LAOs from 2007-2008[2, 9-10]. In addition, Hawkins et al[10]. conducted a rapid assessment in 2009 and found that LAOs received substantial fiscal transfers, but had not yet received major transfers of functions and staff. Many LAO functions are "permissive" or "discretionary" functions, rather than mandatory obligations for public service delivery. As a result, LAOs have considerable freedom to provide complementary or supplementary resources for promotion and prevention (P&P) or curative health care delivery when they wished, but were under no specific obligation to do so meaning that they may choose other priorities[10]. Although multiple causes of delayed decentralization were identified such as policy, political instability, inadequate administrative preparation, coordination and system integration, limited resources et, lack of political leadership was considered the most crucial[9]. However, it was agreed that the responsibility for providing primary care could be transferred to LAOs. Transfers based on learning experiences of all local partners could be the best solution with the support of the central ministry. In addition, LAO staff need to have their capacity strengthened to handle the new responsibilities[9]. The current research aimed to investigate the perspectives of health workers towards health services performance in SAOs to assess their competency and motivation are essential for capacity building to achieve the stated health decentralized duties and responsibilities.

Materials and Methods

A cross-sectional survey was conducted in Region Nine Health Area located in northeast Thailand, comprising four provinces, namely, Nakhon Ratchasima, Chaiyaphum, Buriram, and Surin. The 201 (of 674[17]) SAOs were sampled using stratified random sampling, and sample size determination was performed using Epi Info 2002 where population size = 674, expected frequency = 50%, and confidence limits = 6%. The chief of the health section or the officer primarily responsible for health services performance in each SAO (the term used in the current research was 'health worker') was recruited.

Data were collected from January to

March 2010. A self-administered questionnaire was developed by the researchers adapting the guidelines for national health system reform and health decentralization[2, 15], indicators for personnel administration in Thai local governments[18] and health services performance evaluation for health personnel[19]. The questionnaire was pilot tested in a nearby province and modified before sending to the respondents.

The questionnaire comprised two parts covering 1) demographic characteristics and experiences and 2) perspectives of health workers towards important and current competencies on SAO health services performance. The perspectives towards important and current competencies of SAO health services performance comprised 23 rating scale questions. Scores 1 to 5 were assigned to the category important, from least to most important. The total score was divided in 3 levels; 'highly important', 'moderately important', and 'less important'. The same procedures were also applied to perspectives towards their current competencies, of which the total score was divided in 3 levels; 'high-level competencies', 'moderate-level competencies', and 'low-level competencies'.

Data analysis

Data were processed and analyzed using SPSS for Windows® (version 17, Chicago, IL, USA). Variables were described using percentage, means, and standard deviation. Mean differences between perspective towards importance and current competency were tested using paired t-test. A p <0.05 was considered as having statistical significance.

Ethics consideration

The research was conducted in accordance with the principals of the Declaration of Helsinki and approved by the Faculty of Public Health Ethics Review Committee before being conducted [Protocol No. 24L/2009, Certificate of Approval (COA.) No. MUPH2009-082, Date of Approval: 12 May 2009].

Results

Demographic characteristics and experiences

The majority of health workers were male (60.7%), aged 21-40 years (86.1%), and had obtained bachelor degree level education (79.1%). Of the various educational backgrounds, 21.4% of them studied politics, political science and community development, while 16.9% studied health sciences, nursing, public health, environment, and nutrition and 15.9% studied education, language, psychology and educational counseling. The average of their working time in the current position was 4.55 years, in which most (83.0%) worked less than 6 years. Approximately 60% of them had never worked in any organizations before (Table 1).

Table 1 Demographic Characteristics and Experiences of Health Workers in SAOs (n = 201).

Demographic characteristics and experiences	***n***	**%**
Sex		
Female	122	60.7
Male	79	39.3
Age (years)		
21-30	56	27.9
31-40	117	58.2
41-50	25	12.4
51-60	3	1.5
$\bar{x} \pm SD = 34.15 \pm 5.63$		
Education		
Diploma	18	9.0
Bachelor degree	159	79.1
Master degree or higher	24	11.9
Educational areas		
Politics, political science, community development	43	21.4
Health sciences, nursing, public health, environment, nutrition	34	16.9
Education, language, psychology, educational counseling	32	15.9
Administration, accounting, banking, economics	27	13.4
General management, human resource management, project evaluation	18	9.0
Science, geography	14	7.0
Agriculture, animal husbandry	14	7.0
Engineering, electronics, industry	11	5.4
Social sciences, art	8	4.0
Working time in current position (years)		
0-5	167	83.0
6-10	16	8.0
11-15	13	6.5
≥16	5	2.5
$\bar{x} \pm SD = 4.55 \pm 4.82$		
Have worked in other agencies before		
Never	118	58.7
Have	83	41.3

Perspective of health workers towards the importance of SAO health services performance

The average score of the perspectives of health workers towards the importance of SAO health services performance was 92.86 (80.7% of the total score). Most thought that SAO health services performance was highly important (74.3%) while 23.0% and 2.7% thought that SAO health services performance was moderately and less important, respectively (Table 2).

Table 2 Perspectives of Health Workers towards the Importance of and their Current Competencies of SAO Health Services Performance *(n* = 201).

Perspectives towards the importance			Perspectives towards their current competencies			p
Level	**%**	**$\bar{x}$ ± SD**	**Level**	**%**	**$\bar{x}$ ± SD**	
Highly important	74.1	92.86 ± 17.04	High competencies	27.4	74.65 ± 17.74	<0.001*
Moderately important	22.9		Moderate competencies	62.2		
Less important	3.0		Low competencies	10.4		

*Statistically significant

The top 5 average scores of perspectives towards the importance of health services performance were promoting clean and adequate water use (mean = 4.31), promoting clean and adequate drinking water (mean = 4.26), promoting elderly development (mean = 4.24), providing health care in every age group of the population (mean = 4.20), and promoting disabled and disadvantaged people development (mean = 4.18). However, the lowest average scores concerned care and promotion of oral diseases and dental health (mean = 3.80) and care for family planning (mean = 3.80) (Table 3).

Table 3 Perspectives of Health Workers Towards the Importance and Their Current Competencies of SAO Health Services Performance in Each Item (n = 201).

SAO health performance	Average score		
	Importance (I)	Current competencies (C)	Gap (I-C)
1. Infectious waste management	3.87	2.61	1.26
2. Care and promotion of oral diseases and dental health	3.76	2.66	1.10
3. Waste management	3.96	2.96	1.00
4. Prevention and control of non-communicable diseases such as hypertension and diabetes	4.07	3.08	0.99
5. Solid waste management	4.00	3.06	0.94
6. Health care in every age group of population	4.20	3.24	0.96
7. Prevention and suppression of other communicable diseases	4.17	3.21	0.96
8. Prevention and suppression of vaccine preventable diseases	3.95	3.05	0.90
9. Control of pathogenic animals and vectors	4.16	3.22	0.94
10. Cleanliness of roads, water, paths and public places	3.89	3.04	0.85
11. Nutritional surveillance and improvement	3.98	3.13	0.85
12. Promoting service quality in health centers	4.09	3.24	0.85
13. Improving environmental sanitation	3.92	3.12	0.80
14. Care for family planning	3.84	3.05	0.79
15. Promoting clean and adequate drinking water	4.26	3.42	0.84
16. Protection, care and maintenance of natural resources and environment	4.11	3.29	0.82
17. Promotion of primary treatment	4.00	3.20	0.80
18. Promoting clean and adequate water use	4.31	3.48	0.83
19. Promoting good relationships in the family	4.04	3.42	0.62
20. Promoting woman development	3.98	3.38	0.60
21. Promoting child and youth development	4.16	3.56	0.60
22. Promoting disabled and disadvantaged people development	4.18	3.60	0.58
23. Promoting elderly development	4.24	3.70	0.54

Perspectives of health workers towards the current competencies of SAO health services performance

The average score of the perspectives of health workers towards their competencies in SAO health services performance was 74.65 (64.9% of the total score), of which 62.0% reported they had moderate level competencies. However, 27.3% reported a high level of competencies and 10.7% reported a low level of competencies (Table 2).

The top 5 average scores of perspectives towards their current competencies comprised promotion of elderly development (mean = 3.70), promotion of disabled and the disadvantaged people development (mean = 3.60), promotion of children and youth development (mean = 3.56), promoting clean and adequate water use (mean = 3.48), promoting good relationships in the family (mean = 3.42) and promoting clean and adequate drinking water (mean = 3.42). However, low average scores comprised infectious waste management (mean = 2.61), care and promotion of oral diseases and dental health (mean = 2.66) and waste management (mean = 2.96) (Table 3).

Comparison of perspectives towards the important and current competencies of SAO health services performance

The average score of perspectives towards the importance of SAO health services performance was significantly higher than that of perspectives towards current competencies ($p<0.001$) (Table 2). Perceived importance was also higher than the current competencies across all items. The high priorities of health services performances needed to be strengthened among the health workers, indicated by the gaps between perspectives towards the important and current competencies included infectious waste management, care, and promotion of oral diseases and dental health and waste management (Table 3).

Discussion

The health personnel working in LAOs had higher scores of perspectives towards the importance of SAO health services performance, compared with perspectives towards their current competencies. The high priority needs for competency strengthening, indicated by the gap between perspectives towards important and current competencies, concerned waste management, oral diseases and dental health and noncommunicable diseases. These may be due to the following factors.

Waste management, an integral part of every human society[20], is a major environmental burden of many countries[21] parallel to urbanization, industrialization and economic development[22] and continues to be a major

concern threatening the environment and health of the people. In Thailand, by law, local governments are responsible for waste management in their responsible areas. To perform effective waste management, efficient systems, technologies and materials, as well as human resources need to be well planned and prepared. The systems of waste management cover handling, storage, and processing, collecting, transferring and transporting, resource recovery and processing and disposing[22] incorporating the 3R (reduce, reuse and recycle) technologies[20]. These require resources, effective management and highly competent and skilled personnel, even when LAOs hire private companies to dispose of the waste. Highly competent and skillful personnel are still lacking in most LAOs particularly small LAOs.

Oral diseases and dental health were also concerns and major problems in the community. Gingivitis was the most common oral disease while dental caries mostly affected children's quality of life[23]. Solving this problem required oral health and dental services including services, tools, dentists or dental assistants. However, LAOs did not have these services and had no specific personnel for this performance. Because oral diseases and dental health constitute community's needs, it became a priority to enhance the capabilities of health workers in LAOs regarding oral diseases and dental health performance.

Noncommunicable diseases (NCDs) have become more prevalent in developing countries and are gradually increasing, including deaths and WHO has set the target to reduce the mortality rate due to chronic NCDs by an additional 2% each year[24]. The most common causes of the diseases were related to individual behaviors. This required the cooperation of patients, at risk groups and their peers to improve those behaviors. To enhance participation of concerned people and stakeholders in tackling these diseases, skills, and efforts of health workers were required.

To perform those tasks and other health performances in LAOs, health workers need to have knowledge and apply public health strategies as well as health system practices[25, 26]. However, those areas need to be strengthened due to the educational backgrounds because few health workers graduated in health and public health fields, while the rest had education in areas beyond health and public health. Moreover, the findings also indicated that they also had limited working experience in health development and some represented the responsible persons but not the ones who primarily performed those activities.

Although the responsibilities and authorities for health development have been transferred to the LAOs[2, 15] and health service performances were the duties and responsibilities of LAOs, only few LAOs had health centers

or could perform health tasks as health centers or SHPHs[10]. Therefore, health workers in LAOs need to be empowered and strengthen their capabilities to perform better health services performances for people in their responsible communities. As a result, they could achieve the vision of the Thai health system, i.e., *aiming for health system sufficiency in creating good health, good health services, good society and happy/sufficient livelihoods in a sustainable manner*[27].

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มุมมองของผู้ปฏิบัติงานสุขภาพต่อการดำเนินงานบริการสุขภาพในองค์การบริหารส่วนตำบล: การศึกษาแบบภาคตัดขวางในเขตสุขภาพที่ 9 ของประเทศไทย

ทัศนีย์ ศิลาวรรณ[*] อรนุช ภาชื่น[**] วรรณิภา เกี้ยศักดิ์[***]

บทคัดย่อ

ประเทศไทยได้ขับเคลื่อนการพัฒนาสู่ระบบการกระจายอำนาจ รวมถึงการถ่ายโอนความรับผิดชอบและหน้าที่ในการดูแลสุขภาพไปยังองค์กรปกครองส่วนท้องถิ่น (อปท.) ซึ่งรวมถึงองค์การบริหารส่วนตำบล (อบต.) ดังนั้นผู้ปฏิบัติงานสุขภาพใน อบต. ควรมีความสามารถและแรงจูงใจในการปฏิบัติงานบริการสุขภาพตามหน้าที่และความรับผิดชอบที่ได้รับการถ่ายโอน การวิจัยแบบภาคตัดขวาง (Cross-sectional Research) นี้ มีวัตถุประสงค์เพื่อศึกษามุมมองของผู้ปฏิบัติงานสุขภาพที่มีต่อการดำเนินงานบริการสุขภาพใน อบต. ในเขตสุขภาพที่ 9 ของประเทศไทย ตัวอย่างในการวิจัยคือ ผู้ปฏิบัติงานสุขภาพที่เป็นผู้รับผิดชอบหลักในการดำเนินงานบริการสุขภาพของ อบต. ในพื้นที่ทั้งสี่จังหวัด จำนวน 201 คน ซึ่งได้จากการสุ่มตัวอย่างแบบชั้นภูมิ (Stratified Random Sampling) เก็บรวบรวมข้อมูลโดยแบบสอบถามชนิดให้ตอบด้วยตนเองและวิเคราะห์ข้อมูลด้วยร้อยละ ค่าเฉลี่ยเลขคณิต ส่วนเบี่ยงเบนมาตรฐาน และ Paired T-tests. ผลการวิจัยพบว่า มุมมองของผู้ปฏิบัติงานสุขภาพต่อความสำคัญของการดำเนินงานบริการสุขภาพของ อบต. อยู่ในระดับสูง (ร้อยละ 74.1) ในขณะที่มุมมองต่อขีดความสามารถของตนเองในปัจจุบันอยู่ในระดับปานกลาง (ร้อยละ 62.2) คะแนนเฉลี่ยของมุมมองที่มีต่อความสำคัญในการดำเนินงานบริการสุขภาพสูงกว่าคะแนนเฉลี่ยของมุมมองที่มีต่อขีดความสามารถตนเองในปัจจุบัน อย่างมีนัยสำคัญทางสถิติ ($p < 0.001$) ผลการวิจัยระบุถึงประเด็นที่จำเป็นต่อการพัฒนาขีดความสามารถในการดำเนินงานบริการสุขภาพของผู้ปฏิบัติงานสุขภาพใน อบต. ข้อเสนอแนะจากการวิจัยควรสร้างความตระหนักและแรงจูงใจในการปฏิบัติงานร่วมกับเสริมสร้างขีดความสามารถในการดำเนินงานบริการสุขภาพร่วมกับภาคีที่เกี่ยวข้อง โดยเฉพาะอย่างยิ่งในเรื่องการจัดการขยะติดเชื้อ โรคในช่องปากและทันตสุขภาพ และการจัดการขยะ

คำสำคัญ: การดำเนินงานบริการสุขภาพ, องค์การบริหารส่วนตำบล, มุมมองของผู้ปฏิบัติงานสุขภาพ

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