

# “Health for All” or “Health by All (?)” Developing Health Management Capacity Indicators for Local Governments in Thailand

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## Abstract

Local government authorities serve an important role in public health and preventive medicine. Currently, Thailand and other decentralizing countries focus their efforts on developing local governments' administrative and fiscal capacities to manage public health programs. Current research on community development and decentralization emphasizes local governments' administrative and fiscal capacities. However, these local authorities are also expected to work closely with their constituents in fulfilling the public service responsibility. In contemporary public health practice, citizens are not only service recipients; they are important stakeholders in identifying priority needs, implementing policies and programs, and monitoring government performances

This case offers a description of the dilemma facing the National Decentralization Committee—one of Thailand's national policy planning agencies charged with formulating the country's decentralization reform plan. An emphasis is placed on the key aspects of local governments' management capacity that must be nurtured prior to the transfer of basic public health functions. Four community cases from Northeast Thailand are included in this case study to provide comparative insights into the administrative, fiscal, and social dimensions of health-related management capacity.

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The purpose of this case is to enhance students' understanding of the complex policy making process in Thailand, particularly with regard to decentralization. Also, students are expected to understand the complexity confronting Thai local governments, as they attempt to optimize resource utilization to serve their constituents. In this case, students are required to identify the key management capacity indicators that must be included in a checklist of local governments' preparedness measures for the next step in Thailand's public health decentralization reform.

**Keywords:** Decentralization Public Health Local Government Thailand

# “สุขภาพเพื่อทุกคน” หรือ “สุขภาพโดยทุกคน” การพัฒนาตัวชี้วัดศักยภาพในการบริหารจัดการ สุขภาพขององค์กรปกครองส่วนท้องถิ่นในประเทศไทย

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## บทคัดย่อ

องค์กรปกครองส่วนท้องถิ่นมีภารกิจหน้าที่สำคัญทางด้านสาธารณสุขและการป้องกันโรค ติดต่อ ในปัจจุบันประเทศไทยและประเทศอื่นที่มีการกระจายอำนาจให้แก่องค์กรปกครองส่วนท้องถิ่นต่างให้ความสำคัญกับ การเสริมสร้างศักยภาพทางด้านการบริหารและการคลังให้แก่ ท้องถิ่นเพื่อให้ท้องถิ่นสามารถบริหารจัดการงานด้านสุขภาพได้ซึ่งสอดคล้องกับข้อเสนอแนะของ นักวิชาการ อย่างไรก็ตาม องค์กรปกครองส่วนท้องถิ่นจำเป็นต้องทำงานร่วมกับภาคประชาชน อย่างใกล้ชิด ซึ่งประชาชนในปัจจุบันไม่ได้มีสถานะเป็นเพียงแค่ “ผู้รับบริการ” จากภาครัฐและท้องถิ่น เพียงอย่างเดียว แต่เป็น “ผู้มีส่วนได้ส่วนเสีย” ที่สำคัญเป็นอย่างยิ่งในการระบุความจำเป็นเร่งด่วน การกำหนดนโยบาย การนำนโยบายไปสู่ภาคปฏิบัติ และการกำกับดูแลและประเมินผลดำเนินงาน ของหน่วยงานภาครัฐ

กรณีศึกษานี้เป็นกรณีศึกษาเกี่ยวกับกระบวนการตัดสินใจเชิงนโยบายของคณะกรรมการ กระจายอำนาจให้แก่องค์กรปกครองส่วนท้องถิ่น (กกถ.) ซึ่งเป็นหน่วยงานภาครัฐที่กำหนดนโยบาย และแผนเกี่ยวกับการกระจายอำนาจให้แก่ท้องถิ่น ซึ่งคณะกรรมการดังกล่าวจำเป็นต้องกำหนด ภารกิจหน้าที่ถ่ายโอนหน่วยงานส่วนกลางไปยังองค์กรปกครองส่วนท้องถิ่น โดยหน่วยงานภาครัฐส่วนกลางที่เกี่ยวข้องจำเป็นต้องกำหนดประเด็นศักยภาพด้านต่าง ๆ ที่จำเป็นต้องพัฒนาให้แก่ ท้องถิ่นก่อนการถ่ายโอนภารกิจ และส่วนกลางยังต้องปฏิบัติหน้าที่เป็น “พี่เลี้ยง” กำกับดูแลงานภารกิจ ถ่ายโอนให้เป็นไปอย่างมีประสิทธิภาพและประสิทธิผลตามเจตนาของกระบวนการกระจายอำนาจ ทั้งนี้

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กรณีศึกษานี้นำเสนอกรณีศึกษาเปรียบเทียบชุมชนท้องถิ่น 4 ชุมชนในภาคตะวันออกเฉียงเหนือของประเทศไทยในด้าน การบริหารจัดการสุขภาพในมิติหลัก 3 มิติ คือ มิติเชิงบริหาร มิติทางด้านการคลัง และมิติเชิงสังคม

วัตถุประสงค์ของการศึกษานี้ คือ การเสริมสร้างความรู้ความเข้าใจให้นักศึกษาและผู้ที่สนใจ ในเรื่อง ความสับซ้อนของกระบวนการกระจายอำนาจให้แก่องค์กรปกครองส่วนท้องถิ่น โดยเฉพาะอย่างยิ่งในประเด็นเรื่องการกระจายอำนาจด้านสุขภาพและการสาธารณสุข นอกจากนี้ นักศึกษายังต้องมีความรู้ความเข้าใจในอุปสรรค ความท้าทายต่าง ๆ ของการปกครองท้องถิ่นในประเทศไทยโดยเฉพาะข้อจำกัดด้านทรัพยากร ในกรณีศึกษานี้ นักศึกษาต้องสามารถระบุตัวชี้วัดสำคัญ เกี่ยวกับศักยภาพทางด้านการบริหารจัดการงานด้านสุขภาพเพื่อนำไปสู่ การจัดทำแผนและขั้นตอน การกระจายอำนาจและการเสริมสร้างความเข้มแข็งให้แก่ท้องถิ่นในประเทศไทย

**คำสำคัญ:** การกระจายอำนาจ สาธารณสุข องค์กรปกครองส่วนท้องถิ่น ประเทศไทย

*I believe that the right to vote is of paramount importance at the municipal government level. People should be able to exercise control over their local affairs; we must educate them about this right to self-determination. I think it would be a great mistake to introduce a parliamentary system of government at the national level before our people have adequate experience with local democratic practices.*

*King Prachadhipok (Rama VII) of Thailand 1896-1944 A.D.*

## Overview

“I am speechless,” Mr. Visanu lamented. Everyone kept quiet until the Deputy Prime Minister continued to express his thought: “I presided over this decentralization committee ten years ago, but we still argued with one another on the same issues until today.” Several months ago, the Prime Minister had asked Mr. Visanu if he would be willing to serve as chairman of the National Decentralization Committee—one of the key national planning agencies within the Prime Minister’s Office. Having led this committee during its early years (2002-2005), Mr. Visanu could not resist the opportunity to return to complete his unfinished task. For him, decentralization was an important requirement for a high-quality democracy and an experiment with networked governance whereby public services relied on interconnectedness among citizen groups, private sector firms, and government agencies of different levels.

Upon resuming his chairmanship, Mr. Visanu instructed the committee’s secretariat to prepare a progress report on implementation of the National Decentralization Plan, which contained details about the transfer of administrative and fiscal responsibilities from the central bureaucratic agencies to the newly created local government units. The report and supplementary materials were submitted in due time and circulated among committee members before Mr. Visanu’s first meeting as the committee’s chairman. It was Mr. Visanu’s personal plan that decentralization ought to be implemented swiftly and efficiently under his leadership to help support the current administration’s national reform.

However, after Mr. Visanu finished reading the secretariat's progress report on decentralization, he raised his eyebrows in disbelief and exclaimed with a strongly disappointing tone:

*I have been away from the Decentralization Committee for almost a decade and not much progress has been made in terms of devolving administrative functions and authority to local governments. The devolution of health and quality-of-life functions in particular was abysmally slow. Look at all these statistics: only ten out of 34 disease prevention and health promotion functions have been successfully devolved to the local level. And what is this? Only 0.40% of the community health centers were successfully transferred to local jurisdictions.*

In response to the Deputy Prime Minister's concern, one of the committee members opined that the public still had doubts over local government capacity: "people are very concerned about handing over more public service responsibilities to local governments because of widespread political corruption and lack of management capacity at the local level." As a result, the National Decentralization Committee developed managerial capacity indicators, protocols, and strategic plans for the public service functions that would be transferred to local governments. For the public health function, in particular, local governments had to be assessed against these capacity indicators to determine their management preparedness.

Mr. Visanu nodded in agreement and went on to inform the entire committee of what he would like to accomplish in his first 100 days as chairman of this decentralization policy planning body. "The preparedness indicators for each devolved public service function must be reviewed and amended," announced Mr. Visanu. "The committee must work closely with the local governments and related central government ministries to come up with a reasonable number of essential capacity indicators," the Decentralization Committee chairman emphasized. The committee agreed that the indicator review process should begin with the public health function. Several local jurisdictions in Thailand's Northeast were

identified as case studies for developing a set of “workable indicators” for the next step in public health decentralization reform in Thailand.

## **Thailand’s Public Health System Reform and Its Impact on Local Governments**

In Thailand, since the dramatic financial meltdown in 1997, structural reform measures have been adopted to rectify problems caused by a century of centralized administration. Among the reform initiatives, decentralization aims to empower citizens and the local governments to manage their communities<sup>1</sup>. After the ratification of the 1997 constitution and the 1999 decentralization legislation, the first national decentralization plan was formulated to guide the devolution process, including the transfer of health-related functions to the local level. However, compared to other countries in Asia, Thailand has a carefully sequenced decentralization strategy, but has been implementing it slowly. The decentralization of public health functions in particular was interrupted by the national health system reform that resulted in the formation of the National Health Security Fund (NHSF) in 2002.<sup>2</sup>

Before 2002, the public health ministry was responsible for providing public health services and for determining budget allocations for each type of health services. Citizens working in the formal private sector were covered by the National Social Security Fund (NSSF), while government officials were entitled to their medical services paid for by the Ministry of Finance. This system inadvertently left out more than half of the population who were not formal sector employees or government officials. Since the NHSF system was established in 2002, Thailand’s public health system has been governed by the purchaser-provider separation model in which the NHSF office, the NSSF office, and the Ministry of Finance’s Civil Servants’ Medical Benefit Scheme (Figure 1). Under this new system, the Ministry of Public Health no longer controls the funding sources for public health services. However, the ministry remains in charge of government health facilities, including hospitals and community health centers.

In parallel with the national health system reform, the first two public health decentralization plans (2002-2011) were launched with two key features. First, the local health insurance funds were established in 2003 at the sub-district level across the country. Currently co-financed by the NHSF office and local governments, the funds channel resources to citizens and civic groups that carry out physical wellness activities. Yet, although a committee of citizen representatives and local officials manages each sub-district's fund, past studies show that citizens do not actively participate in the fund management process.<sup>3</sup>

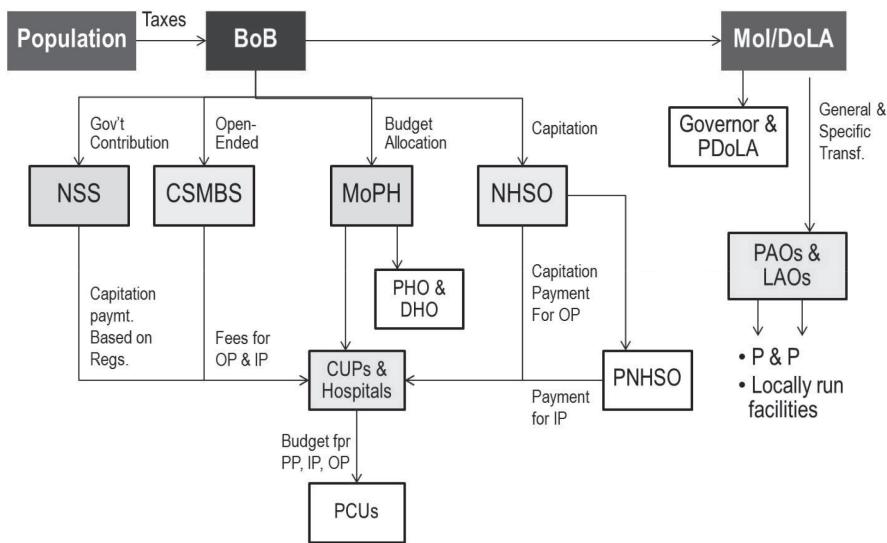
Second, the two public health decentralization plans included the transfer of government-operated community health centers to local governments. However, before the transfer could be authorized, each local government had to satisfy the "preparedness" criteria formulated by the public health ministry. Table 1 presents these criteria and their associated indicators. Empirical studies on health decentralization in Thailand point out that these criteria overemphasize the managerial aspect of local governance.<sup>4</sup> The public health ministry's inadequate attention to citizens' preparedness has been cited as one of the main factors discouraging citizen involvement in the local public health management process.

**Table 1 The Thai Ministry of Public Health’s Criteria for Assessing Local Government Preparedness for the Transfer of Community Health Centers**

Preparedness Dimension	Indicator
1. Local government involvement in health promotion activities	<ul style="list-style-type: none"><li>■ Continuity of a local jurisdiction’s involvement in the Provincial Public Health Office’s activities</li><li>■ A local jurisdiction’s health-related performance output</li><li>■ Number of a local jurisdiction’s health promotion programs</li><li>■ Amount of a local jurisdiction’s financial assistance to the community health centers prior to the transfer</li></ul>
2. Existence of a local government’s public health management plan	<ul style="list-style-type: none"><li>■ Comprehensiveness of a local government’s public health management plan (Does a local government have action/strategic plans related to disease control, health service quality assurance, and health promotion?)</li></ul>
3. Existence of an organizational structure for the public health functions	<ul style="list-style-type: none"><li>■ Number of public health staff</li><li>■ Amount of budget allocations for a local jurisdiction’s public health agency</li></ul>
4. Local revenue generation capacity	<ul style="list-style-type: none"><li>■ Amount of local own-source revenues</li></ul>
5. Citizens’ opinion toward their local jurisdiction’s health management capacity	<ul style="list-style-type: none"><li>■ Number of local residents approving the transfer of community health centers</li></ul>

Similar to other aspects of decentralization in Thailand, the transfer of community health centers was slowly implemented; 39 out of 9,762 community health centers were devolved to the local level. Compared to other regions, the Northeast has the smallest number of localities that passed the public health ministry’s preparedness criteria. Three community health centers were transferred

to two local governments in the northeastern provinces of Udornthani and Buriram. In 2008, the two community health facilities in Buriram were the only decentralized community health centers in the country that were transferred back to the national government. On the other hand, the decentralized community health center in Udornthani has received multiple awards from various agencies since it came under the aegis of local government. These two localities' different experiences in the management of their community health centers raise an important question: in what way must the public health ministry's preparedness criteria be altered for the next step in Thailand's decentralization reform?



#### Key Terms

BoB	Bureau of the Budget
Mol	Ministry of Interior
DoLA	Department of Local Administration
NSS	National Social Security Office
CSMBD	Civil Servants' Medical Benefits Scheme
MoPH	Ministry of Public Health
NHSO	National Health Security Office
PHO	Provincial Health Office
DHO	District Health Office
CUPs	Contracting Units of Primary Care
PP (P & P)	(Health) Promotion and Prevention
IP	Inpatient Care
OP	Outpatient Care
PCUs	Primary Care Units
PNHSO	Provincial-level National Health Security Office
PAOs	Provincial Administrative Organizations
LAOs	Local Administrative Organizations

Figure 1. Current Public Health System in Thailand

## **The Northeast of Thailand: An Experiment with Public Health Decentralization**

The northeastern region in Thailand was the country’s most impoverished region with high infection rates of the neglected tropical diseases (NTDs). These diseases were parasitic illnesses affecting the world’s poorest population.<sup>5</sup> Among the common NTDs, Cholangiocarcinoma (Biles duct cancer) was a serious public health problem in Thailand, affecting 42.5% of the Northeast population.<sup>6</sup> The National Decentralization Committee’s secretariat selected four local communities from the Northeast (Table 2). Two communities in which local governments had taken an active role in health-related matters despite their limited authority were referred to as the “good practice” localities. Also, in these “good practice” communities, primary healthcare centers had been successfully transferred to the local government auspices.

Since the decentralization reform officially began in 1997, Hibiscus city in Udornthani province had garnered many “good governance” and “excellence in public service” awards organized by government agencies in Thailand and abroad. In the same province, Mongosteen city boasted a similarly impressive record of awards from government and educational institutions, such as the “good governance and public management” awards from the Department of Local Administration between 2006 and 2008. Additionally, for the past several years, both Hibiscus and Mongosteen cities had consistently been honored by Thailand’s Office of the Royal Development Projects as model communities for sustainable development and quality-of-life enhancement. The good practice localities were compared against two jurisdictions with the inactive local governments (i.e., a comparison group) from a neighboring province—Nongbua Lumphu.

Table 2. Four Community Case Studies from Northeast Thailand

	Name of Locality	Province	Area (km <sup>2</sup> )	Population (2012)	Population Density (per km <sup>2</sup> )
"Good Practice" Communities	Hibiscus	Udonthani	47.70	138,136	2,895
	Magnolia	Udonthani	59	13,520	229
Comparison Communities	Freesia	Nongbua Lumpu	39.50	51,338	1,299
	Daffodil	Nongbua Lumpu	81	5,560	68

## Lessons Learned from the Four Northeastern Communities

A crucial question for the next steps of decentralization reform in Thailand was how to strengthen local government capacity before devolving substantial administrative responsibilities to a local level. To find out the appropriate measures for determining "local public health management capacity," two "good practice" localities were compared against the neighboring communities with similar demographic attributes.

### Administrative Capacity

Two interrelated issues had been analyzed to expose the administrative dimension of local public health capacity. First, the mayors' understanding and attitudes towards public health reflected the quality of their political leadership in running local government. Second, a local jurisdiction's administrative capacity was determined by whether it had an agency and staff with specific responsibility for public health management.

Mayors from the four jurisdictions showed markedly different levels of public health knowledge. As the Magnolia City health department director opined, "in meetings or during press conferences, the mayor speaks so eloquently and

with sufficient depth of knowledge about public health.” When asked why his city administration has invested so much in public health, the Hibiscus mayor responded:

*I strongly believe that health means the overall quality of life.*

*A healthy person is a happy person. That is why my city administration has concentrated a lot of efforts and resources in health matters because I want Hibiscus city to be a happy community.*

The Magnolia mayor similarly emphasized that good health, including physical and mental health, is essential to sustainable community development.

On the contrary, mayors from the Freesia and Daffodil cities expressed less enthusiasm about local public health. They held the view that public health functions should belong to the public health ministry because of the advanced clinical and medical knowledge involved. The Freesia mayor in particular pointed out that his city government had already been given too many responsibilities: “if we must take over more public health functions, our city would definitely be in deep financial trouble.” Similarly, the Daffodil city mayor stated that: “The public health ministry can provide better health services than us. Of course, we can work with them. But I don’t think my city government is now ready for any more health functions.”

Apart from their mayors’ public health knowledge, each of the “good practice” localities had a well-equipped public health workforce. In an attempt to provide healthcare services for a growing urban population, Hibiscus municipality had both medical and public health departments. All municipal healthcare centers in Hibiscus city were managed and supervised by the medical department, while the public health department was responsible for disease prevention and health promotion activities. Also, in terms of personnel, Hibiscus city health officials made up 25% of the municipal government workforce. In a similar vein, the Magnolia city—albeit its small budget and organizational size—made substantial investment in its city health department which was charged with overseeing a city health center and other health-related activities, such as preventive and promotional healthcare. The Magnolia city health officials accounted for almost 13% of all city government employees.

On the other hand, the Freesia and Daffodil municipalities did not demonstrate as much commitment to public health as the “good practice” localities. Despite the presence of a municipal public health department, there was a limited range of public health services in Freesia city. A lack of locally run health centers drove the Freesia city residents to travel to other areas for healthcare services. Also, unlike the size of municipal public health workforce in Hibiscus city, only 15% of the Freesia municipal government personnel were public health officials. The state of public health services in Daffodil city was equally problematic. Daffodil residents relied on the central and regional agencies for health services because their municipality did not have an agency specifically assigned for health administration. Neither did it have public health personnel on its municipal government payroll.

### **Fiscal Capacity**

Apart from the administrative capacity, local authorities required adequate resources to finance their public health operations. The two “good practice” localities, especially the Magnolia city, appeared to have difficulty with revenue mobilization. Starting in 2009, the Magnolia city government experienced a sharp decline in own-source revenue per capita (Figure 2). This declining pattern stood in sharp contrast to a consistent and growing revenue stream in Daffodil city, which was also a sparsely populated rural community. On the other hand, the densely populated areas—Hibiscus and Freesia cities—did not significantly differ from each other in their per capita own-source revenue between 2008 and 2012. Only in 2009 did the Freesia city government’s own-source revenue per capita clearly exceed the amount of revenue collected by the Hibiscus city government.

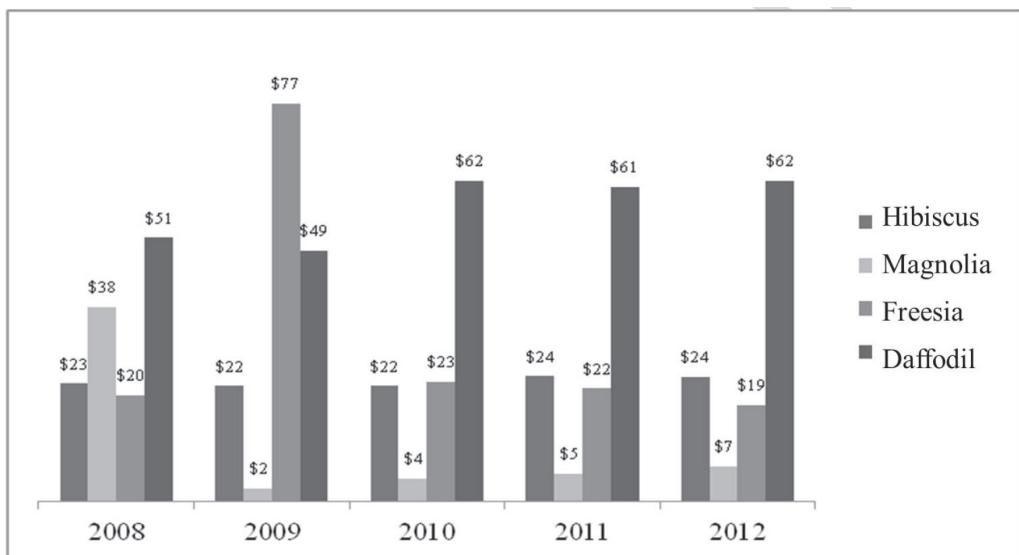


Figure 2. Per Capita Own-Source Revenue Collected between 2008 and 2012

The above analysis suggested that the localities with active local government involvement in public health might not be as financially self-reliant and sustainable as the comparison communities. Magnolia city in particular experienced a serious problem with revenue collection. When each jurisdiction’s own-source revenue was calculated as a percentage of its total revenue, it was found that own-source revenue did not make substantial contributions to the Magnolia city’s coffer between 2008 and 2012 (Figure 3).

Apart from Magnolia city, one of the comparison communities—Freesia city—faced an even worse revenue situation. Since 2008, a dramatic decrease in own-source revenue pressured the Freesia city government to depend on other financing sources, such as the national government grant. Nonetheless, contrary to past empirical works on fiscal decentralization, another comparison city—the Daffodil city government which had been inactive in community health management—enjoyed the strongest fiscal autonomy from 2008 to 2012. During the five-year period, Daffodil city’s financial self-reliance was even higher than that of Hibiscus city—a “good practice” locality from a heavily populous urban area.

Despite much empirical and theoretical support, own-source revenue data alone did not accurately depict the fiscal dimension of local public health capacity. Since decentralization began, local revenue collection had always been an important challenge facing many Thai local authorities regardless of their organizational structure, population size, and local economic conditions.<sup>7</sup> Besides, there is no guarantee that a local government with high fiscal autonomy would earmark substantial funds for public health services. Thus, apart from local own-source revenue stream, it was necessary to consider how much each of the four jurisdictions spent on public health programs.

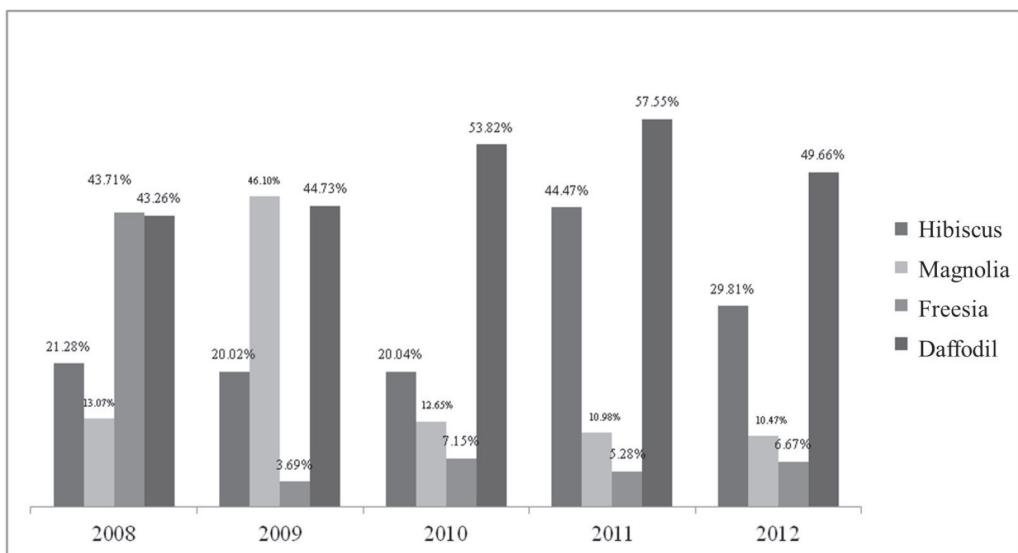


Figure 3. Own-Source Revenue as a Percentage of Total Revenue Collected (2008-2012)

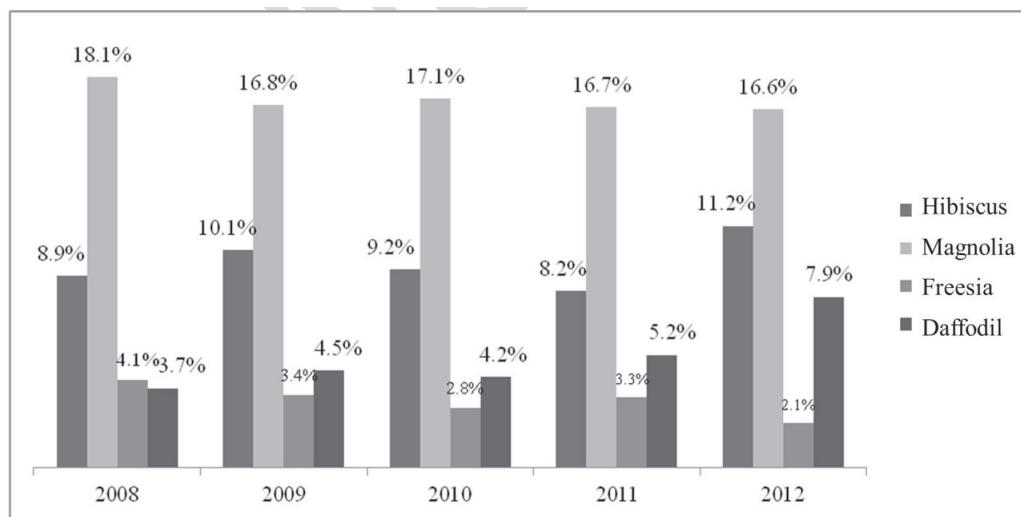


Figure 4. Local Budget Allocations for Public Health Programs as a Percentage of Total Budget Allocations (2008-2012)

Between 2008 and 2012, the Hibiscus and Magnolia city governments allocated more resources to public health programs than the Freesia and Daffodil city authorities (Figure 4). As previously discussed, Magnolia city had the smallest amount of per capita own-source revenue, compared to the other three cities. Yet, calculated as a percentage of each year's overall budget, the amount of resources that the Magnolia city government dedicated to public health was larger than in other localities. Equally well-known for its municipal health programs, the Hibiscus city government also set aside a substantial portion of its annual budget for public health—second only to the Magnolia city government.

### Citizens' Public Health Management Capacity

Formal and informal relationships among individual community members, local government agencies, and civil society groups served as an important catalyst for community development and decentralization reform. Residents in Hibiscus city had a tendency to form a variety of physical wellness activities, such as yoga, aerobic dance, zumba dance, Chinese martial arts, and bicycling. Despite the absence of formal management hierarchy, these exercise groups in Hibiscus city continued to

expand their membership and had succeeded in soliciting financial and/or in-kind assistance from the municipal government. As one Hibiscus resident who regularly attended an aerobic dance group mentioned;

*We get together for an aerobic dance at one of the municipal parks every evening. Our neighbors who do yoga do the same; they go to the parks near their homes and exercise with their friends. The exercises are fun and convenient. Apart from these exercises, it is also a great opportunity for us to socialize with one another.*

Residents in the Magnolia community also attended physical wellness groups on a regular basis. However, there was lesser diversity of wellness groups than in Hibiscus city. Further, instead of being formed by citizen groups, every physical exercise groups in Magnolia city was initiated by the city health department. Citizens were not directly involved in designing and managing exercise programs.

*People in the Magnolia community exercise on a daily basis. But, our exercises are simple. The women get together in an aerobic exercise every evening. The men jog or play soccer. The city government helps find and pay for aerobic dance coaches. Basically, we [the Magnolia residents] don't have to do anything. These physical exercise groups are very useful: we exercise for free and get to chat with our neighbors.*

Not only did the informal physical wellness groups promote healthy lifestyle habits in both communities, they also helped strengthen social capital among the city dwellers. Residents from the Freesia and Daffodil cities, on the other hand, reported limited physical exercise activities in their communities. Also, in stark contrast with residents in the “good practice” cities, the Freesia and Daffodil community members did not participate in physical wellness groups:

*They exercise on their own. But, there were some aerobic dance groups in the past, but they didn't last for more than two months. Though enthusiastic about these wellness groups in the beginning, the people stopped attending them in the following month.*

Moreover, the Freesia and Daffodil governments were not as supportive of the physical wellness activities as the municipal government authorities in the “good practice” communities. The Freesia and Daffodil city mayors were more concerned with road construction projects than other aspects of community affairs, including public health. A Daffodil city resident opined.

*It is difficult to gain support from our mayor for any public health programs. He [the mayor] is more interested in road constructions. I don't know about other places. But, most politicians in Thailand like road construction projects more than other public service programs.*

In a similar vein, one of the Freesia community members pointed out that her mayor always expressed his concern with providing financial support to physical exercise groups. Since local government spending was subject to an annual financial audit by the Public Finance Audit Commission (PFAC), any new financial commitment that was not included in local government plan and budget was likely to undergo a thorough investigation by the PFAC. Fear of the PFAC made the city government reluctant to engage in new public health initiatives.

Apart from participation in physical exercise groups, citizen involvement in government affairs was also a vital aspect of contemporary local governance in Thailand. In addition to the informal wellness groups, citizens in the Hibiscus and Magnolia cities were also involved in local government affairs. Several Hibiscus city residents stressed the importance of attending the community health board meetings. One of the Hibiscus city residents stated:

*The mayor and municipal health officials were active in setting up and financing these community health boards. With these boards, we can propose new health promotion activities and programs and ask the city government for monetary support. So, I think it's very important for us to get involved.*

According to a senior citizen, a large number of Hibiscus citizens willingly served on each precinct's health management board and actively engaged in making important decisions. However, the Magnolia city residents showed a lesser degree of enthusiasm about getting involved in their city government's decision-making process. Several of the Magnolia residents reported that they did not participate in the local government affairs because they had to tend to their cattle and rice paddies. In sharp contrast, the Magnolia resident stated that they "monitor the mayor's policy initiatives, program implementation, and budget allocation on an *ad hoc* basis." They also pointed out that the Magnolia community had not seen any political conflicts for many years. One of the Magnolia youth leaders stated:

*Most people here are farmers and not regularly involved in local government affairs. But, they do check how local officials work. Fortunately, the Magnolia residents never run into conflict. Our disagreements can always be solved through informal interpersonal dialogues.*

Nonetheless, levels of interpersonal relations and social activism were comparatively low in the Freesia and Daffodil communities. These two communities had no dynamic social groups or popular involvement in local government affairs. One Freesia city resident argued that the absence of social activism and citizen engagement in the city was caused by the citizens' inadequate education:

*For instance, it is always a challenge to convince people of the importance of immunization. Even when they are sick, they don't come to see the medical personnel, and the neighbors don't even bother to let municipal government officials know about an outbreak of infectious diseases in their neighborhoods.*

While interpersonal dialogues were instrumental in resolving community conflicts in the Magnolia city, the Freesia and Daffodil residents did not show much interest in collective actions. Many Freesia and Daffodil residents voiced their opinion that conflicts over the city government budget occurred on a regular basis. A key informant from Daffodil community noted:

*Often time, our community and political conflicts over budget allocation cannot be resolved through debate. Over the past several years, for instance, regional government officials had to intervene in our community conflicts. There is always factional politics in the way our community is run.*

Although these conflicts never became violent, the Freesia city residents, particularly the youth leaders and village heads, clearly demonstrated their displeasure against one another, especially when they were asked to comment on disease prevention activities.

In sum, residents in the “good practice” localities engaged in physical wellness activities on a regular basis and were inclined to participate in their communities’ social activities. They also demonstrated a high degree of political participation by attending local health board meetings and by frequently monitoring local public health programs. Local governments in these communities did not directly control, but provided support for their constituents’ physical wellness activities

## Way Forward

Based on these four community cases, the National Decentralization Committee’s secretariat wished to examine which aspect of local government capacity must be nurtured for the next step in public health decentralization. As demonstrated above, three dimensions of local public health management capacity were identified and used to examine four local communities in Northeast Thailand. The “good practice” communities had won a number of awards for good governance, service quality, and active citizen engagement. Despite their budget and administrative constraints, the city governments in these “good practice” localities dedicated resources to develop public health programs and demonstrated the administrative capacity and fiscal commitment to public health. Their mayors possessed an understanding and a positive attitude towards public health and prepared their local governments’ organizational structures for the public health responsibilities. On the contrary, local governments in the comparison communities

had inferior administrative capacity. Unsupportive leadership, inadequate public health personnel, and absence of a local public health agency complicated these local governments' efforts in delivering public health services.

Even though the quality of political leadership and adequate public health personnel were critical components of local public health management, not all fiscal indicators could explain local public health management capacity. Local governments with more own-source revenues were not necessarily committed to public health. Moreover, citizens' health knowledge and behavior expressed through their regular physical exercises led to a high degree of political involvement in local government affairs. In the "good practice" communities, not only did the physical wellness groups provide an opportunity for local residents to engage in physical activities, they also facilitated the group members' interpersonal relations. By participating in these wellness groups, citizens became assertive about the types of assistance they expect from their municipal governments.

As Thailand was approaching the second decade of its decentralization reform process, the Secretariat of the National Decentralization Committee had been commissioned by the Deputy Prime Minister, Mr. Visanu, to develop a set of management capacity and preparedness measures. Based on the four community case studies from Northeast Thailand, the Director of the National Decentralization Committee's Secretariat had asked you and your research team to compare and contrast the strengths and weaknesses of the four local jurisdictions and propose a set of local capacity indicators, as well as policy recommendations for Thailand's ongoing local government reform.

## Endnotes

There are two main categories of local governments in Thailand: special-purpose and general-purpose local governments. Bangkok Metropolitan Authority (BMA) and Pattaya City are the only two special-purpose local governments. The general-purpose local authorities can be further divided into upper-level and lower-level local governments. Provincial administrative organizations are upper-level local governments responsible for the entire provincial areas, whereas municipalities and sub-district administrative organizations fall into the lower-level category with administrative responsibilities for the district and sub-district levels.

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