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RESEARCH ARTICLE

The Elderly as Providers and Recipients of Primary Healthcare: A Case Study of Subdistrict Health-Promoting Hospitals in Thailand

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Abstract

Rapid growth of Thailand's elderly population presents challenges for the country's healthcare system, particularly regarding the equity and accessibility aspects of the primary healthcare services. This research investigates the impact of Thailand's primary healthcare decentralization policy on these services, focusing on the dual roles of an elderly individual as both a provider and a healthcare recipient. The decentralization reform in Thailand, which began in 12001, has resulted in the gradual transfer of the subdistrict health-promoting hospitals to local governments, including the popularly eleted provincial administrative organizations, municipalities, and subdistrict administrative organizations. These subdistrict health-promoting hospitals serve an instrumental role in taking care of the elderly population health. This study seeks to identify the specific challenges faced by the primary healthcare service system in catering to the diverse needs of the elderly and to explore the effectiveness of decentralized subdistrict health-promoting hospitals in delivering appropriate care. A mixed-methods approach was employed, combining qualitative and quantitative data collection techniques. In-depth interviews and focus group discussions with healthcare professionals, elderly individuals, community representatives, and local policymakers were conducted alongside surveys to gather specific data on healthcare access, service utilization, and health outcomes among the older population. The study results reveal critical barriers to effective service delivery, including a shortage of healthcare personnel trained in geriatric care, imbalances in health resource distribution, and a lack of integrated healthcare service delivery. While the subdistrict health-promoting hospitals are integral in providing accessible healthcare, they often lack the necessary resources and skilled staff to adequately support the elderly. The study concludes that a

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collaborative approach is essential, particularly the integration of the contributions of elderly individuals and neighborhoods in community health planning and policy implementation. This integration fosters ownership among stakeholders and enhances health interventions. The findings contribute to the field of public health administration by advocating for comprehensive strategies that prioritize the elderly's health and well-being while addressing systemic deficiencies within the primary healthcare system. Ultimately, the research highlights the need for policies that improve healthcare access and service integration, ensuring that the elderly population in Thailand receives the quality care necessary for their health outcomes.

Keywords
devolution; primary healthcare; Subdistrict Health-Promoting Hospitals; older adults; community participation; local health governance; Thailand

Introduction

Population ageing is transforming the demands placed on local health systems (World Health Organization, 2015). Older adults often require continuous, integrated, and geographically accessible services because many live with chronic conditions, functional limitations, and social vulnerabilities (World Health Organization, 2020). These needs are particularly important in primary healthcare, where health promotion, disease prevention, chronic disease management, rehabilitation, and referral coordination must be organized close to where people live.

In Thailand, these demographic pressures intersect with a long-running reform agenda to decentralize public services (Jongudomsuk et al., 2012). Primary healthcare has historically been organized through the Ministry of Public Health and district health networks, with SDHPHs serving as frontline providers in subdistrict communities. The devolution of SDHPHs to local governments, especially PAOs, is intended to make services more responsive to local needs, increase community participation, and strengthen local accountability (Uansri, 2024). However, devolution also creates governance risks when roles, budgets, personnel systems, information flows, and referral responsibilities are not clearly coordinated across central, provincial, district, and local agencies (Saltman et al., 2007).

The case of Lampang Province is important because the province has a high proportion of older residents and has experienced the transfer of SDHPH responsibilities to the Lampang Provincial Administrative Organization (LPAO). The original study reports that older adults account for 27.49 percent of the provincial population (Ministry of Public Health, 2023a) and that non-communicable diseases, respiratory diseases, musculoskeletal conditions, dental problems, and chronic disease management are major service concerns (Ministry of Public Health, 2023c). These conditions make Lampang a useful case for examining whether

devolution can improve service responsiveness and whether older adults can be engaged not only as service recipients but also as contributors to community-based primary healthcare. Provincial healthy-ageing initiatives have also emphasized organizing health-care services for older adults (Thai News PRD, 2023).

Existing studies of healthcare decentralization in Thailand and other countries show that transferring authority can improve responsiveness only when local organizations have sufficient decision space, resources, professional capacity, and mechanisms for accountability (Bossert, 1998). Studies of community-based primary healthcare similarly emphasize stakeholder participation, intersectoral action, and service integration (Sudhipongpracha, 2013). Yet fewer studies examine how these ideas work together after SDHPH devolution, particularly in relation to older adults' dual position as users of care and potential contributors to health promotion, peer support, local wisdom, and community mobilization.

This study addresses that gap by asking three research questions: (1) How has the devolution of SDHPHs to the PAO affected local primary healthcare governance in Lampang Province? (2) What roles do key stakeholders, including LPAO, LPPHO, district public health offices, SDHPH personnel, village health volunteers, and older adults, play in the post-devolution system? (3) To what extent are older adults willing and able to participate as contributors to community-based primary healthcare, and what barriers or supports shape that participation?

The article contributes to public administration and local health governance in two ways. First, it clarifies how the devolution of SDHPHs is mediated by intergovernmental coordination, workforce capacity, and local service needs. Second, it develops an integrated framework that links devolution, community-based primary healthcare, age-friendly communities, productive ageing, and public-private-people partnerships to explain the practical conditions under which older adults can become meaningful contributors to local health systems.

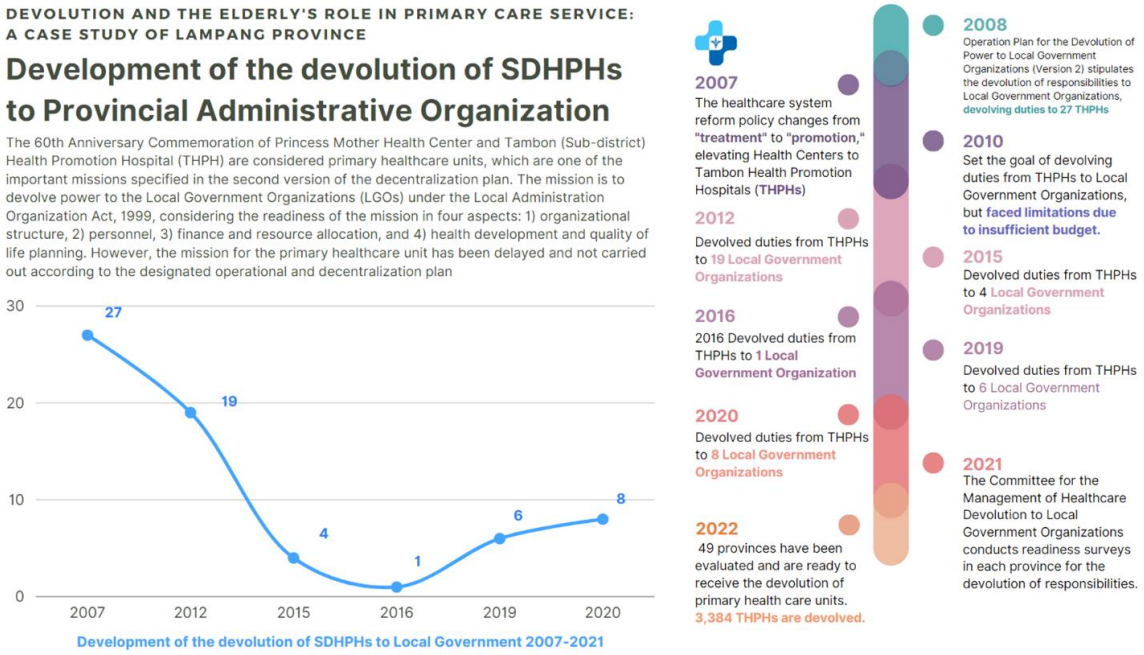


Figure 1. Development of SDHPH/THPH devolution to local governments and Provincial Administrative Organizations, 2007-2022.

Literature Review and Conceptual Framework

Health decentralization, devolution, and primary healthcare governance

Decentralization refers to the redistribution of authority, responsibility, and resources from central government to lower levels of government or semi-autonomous organizations (Rondinelli et al., 1983). Devolution is the strongest form of decentralization because it transfers decision-making authority to elected local bodies rather than merely relocating central administrative functions. In health systems, devolution is expected to make services more responsive to local needs, improve accountability, and encourage locally adapted resource allocation (Lewis et al., 2001). However, these benefits are not automatic. Devolution can also create fragmented accountability (Costa-Font et al., 2011), uneven capacity, and new inequalities when local governments inherit responsibilities without adequate budgets, personnel, information systems, or technical support (Nishtar et al., 2013).

Bossert's decision-space framework is useful for this study because it asks not only whether authority is transferred but also what choices local actors can actually make over finance, personnel, service organization, access rules, and governance (Bossert, 1998). Applied to SDHPH devolution, this framework directs attention to whether PAOs can allocate resources, recruit or retain health workers, coordinate referrals, support health promotion, and design

services around local population needs. It also highlights the need to examine how central and provincial agencies continue to shape local action through regulations, professional standards, and supervision.

Primary healthcare reform also emphasizes equity, community participation, intersectoral collaboration, and accessible services (Kato et al., 2019). The Declaration of Astana reaffirmed primary healthcare as a foundation for universal health coverage and called for integrated, people-centered services (World Health Organization & United Nations Children's Fund, 2018). For a devolved SDHPH system, these principles require a governance arrangement that connects local political accountability with public health expertise, professional standards, and community participation.

Community-based primary healthcare and stakeholder participation

Community-based primary healthcare treats local residents, community organizations, volunteers, and service users as participants in health improvement rather than passive beneficiaries (Arnstein, 1969). This approach is consistent with public administration literature on collaborative governance and new public governance, which emphasizes networks of public, private, and civic actors in solving complex social problems (Osborne, 2006). In the SDHPH context, stakeholders include PAOs, provincial and district public health offices, district hospitals, SDHPH personnel, village health volunteers, older adults, families, local community organizations, and private or civil society partners.

The public-private-people partnership, or 4Ps, approach extends conventional public-private partnerships by explicitly recognizing citizens and community groups as co-producers of public value (Seddighi et al., 2021). For local health governance, the 4Ps approach is relevant because SDHPHs cannot address ageing-related health needs through clinical services alone. They require cooperation with local governments, families, community volunteers, traditional wisdom networks, and older adults themselves.

Age-friendly communities, productive ageing, and older adults' roles

The age-friendly cities and communities approach emphasizes that older people should be able to live in environments that support health, participation, security, mobility, social inclusion, communication, and access to services (World Health Organization, 2007). This approach is directly connected to SDHPH devolution because local governments are responsible for many determinants of older adults' health, including community infrastructure, transportation, social participation, welfare services, and local development planning (Rasanathan et al., 2010).

Productive ageing further recognizes that older adults can continue to contribute to families, communities, and public services when institutions provide appropriate roles and

support. In primary healthcare, older adults may contribute as health owners who manage their own health, peer supporters who encourage other patients, local wisdom carriers who transmit health-related knowledge, community health volunteers, advisors to service planning, and connectors between SDHPHs and households. However, participation depends on health status, economic security, family support, confidence, perceived value, and trust in public institutions (Yee and Capitman, 1996).

Integrated analytical framework

This study integrates the concepts above into an analytical framework. Devolution changes the formal governance of SDHPHs by shifting authority and responsibility to the PAO. The practical effects of this transfer depend on local decision space, intergovernmental coordination, workforce and budget capacity, and relationships among public health actors. Community-based primary healthcare and the 4Ps approach explain how these governance arrangements can be connected to local stakeholders. Age-friendly communities and productive ageing explain why older adults should be analyzed not only as vulnerable service users but also as potential contributors to local health promotion and community support. The framework therefore links governance inputs, community participation processes, older adults' roles, and service outcomes.

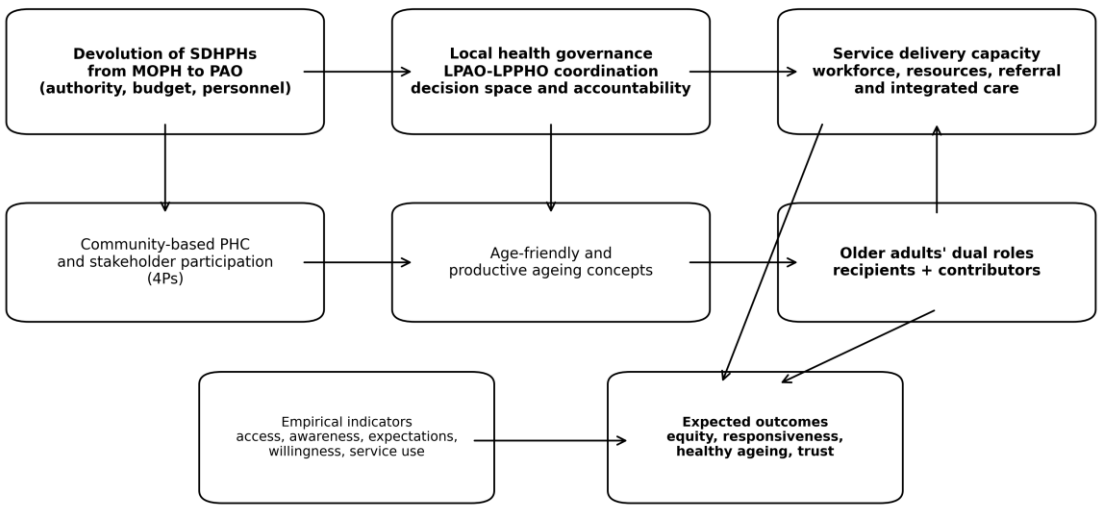


Figure 2. Analytical framework linking devolution, local governance, community-based primary healthcare, and older adults' roles.

Table 1. Concepts, analytical dimensions, and empirical indicators

Concept	Definition in this study	Analytical dimension	Empirical indicators
Devolution	Transfer of SDHPH authority and responsibility from central health agencies to local government, especially PAOs.	Decision space and accountability	Role clarity, budget allocation, personnel authority, formal agreements, reporting lines
Local health governance	Coordination among PAO, provincial/district public health offices, SDHPHs, hospitals, and community actors.	Intergovernmental coordination	MOU arrangements, referral coordination, technical support, conflict/cooperation
Community-based PHC	Primary healthcare organized around local needs, community participation, prevention, and integrated care.	Service responsiveness	Access, health promotion, disease prevention, chronic care, rehabilitation, dental care
Age-friendly communities	Local environments and services that enable older adults to maintain health, participation, security, and dignity.	Older adults as service users	Awareness, service utilization, expectations, perceived accessibility
Productive ageing	Older adults' continued contribution to community life and public value when appropriate support is provided.	Older adults as contributors	Peer support, volunteering, local wisdom, health ownership, advisory roles
4Ps partnership	Collaboration among public, private, and people sectors in planning and delivering local health services.	Co-production and participation	Stakeholder networks, community activities, family and volunteer support, local partnerships

Methodology

Research design

This study used a mixed-methods case-study design. The qualitative component examined how key stakeholders understood the devolution of SDHPHs, intergovernmental coordination, service capacity, and older adults' roles in the local health system. The quantitative

component summarized the characteristics, awareness, expectations, and participation preferences of older adults, as well as SDHPH personnel's perceptions of service priorities and potential roles for older adults. The mixed-methods design was appropriate because the study sought both to describe patterns in survey responses and to explain the governance processes behind those patterns.

The design is best described as a convergent mixed-methods case study: qualitative and quantitative data were collected from related stakeholder groups, analyzed separately, and integrated during interpretation. The integration focused on whether older adults' self-reported willingness to participate aligned with SDHPH personnel's expectations and with the governance conditions created by devolution.

Study area

The study was conducted in Lampang Province, Northern Thailand. Official population statistics provide additional context for Lampang's demographic profile (National Statistical Office, 2022). Lampang was selected because it has a high proportion of older adults and because SDHPH devolution to the LPAO creates a relevant case for examining local health governance after transfer. The original study refers to older adults in districts including Ko Kha, Hang Chat, Mae Tha, and Mueang Pan. Lampang also presents area-specific service needs, including chronic non-communicable diseases, respiratory and environmental health concerns, musculoskeletal diseases, dental care needs, and rehabilitation demands. Local documentation from Mae Tha also illustrates team-based efforts to strengthen health literacy within the NPCU model (Tabutrawong, 2023).

Participants and sampling

Participants were selected to represent the main governance and service-delivery actors in the devolved primary healthcare system. Qualitative participants included representatives from the LPAO, Lampang Provincial Public Health Office (LPPHO), district public health offices, SDHPHs, district hospitals, health professionals, village health volunteers, community representatives, and older adults. A purposive sampling strategy was used to identify participants with direct knowledge of SDHPH devolution, primary healthcare service delivery, and older adults' health needs.

The quantitative component included two survey groups. First, an older-adult survey measured awareness of SDHPH devolution, service utilization, expectations for SDHPH services, and willingness to participate in health-related roles. (n = 230) Second, an SDHPH personnel survey captured operational status, staffing, service priorities, and views on older adults' possible roles. The original tables suggest n = 65 SDHPH personnel; this number should be verified and stated explicitly.

Table 2. Data sources and analytical purpose

Data source	Participants / units	Purpose	Analysis
Document review	Devolution plans, laws, policy documents, local reports, and SDHPH records.	Reconstruct policy timeline and formal responsibilities.	Content analysis and timeline development.
In-depth interviews	LPAO, LPPHO, district public health offices, SDHPHs, hospitals, and community representatives. (n = 4) Interviews with SDHPHs including 4 participants (directors and staff) from 2 units in Mae Tha District and Hang Chat District, with the doctor at Mae Tha Hospital, head and staff of Healthcare Division and staff Lampang Provincial Administrative Organization (LPAO).	Examine perceptions of devolution, coordination, resources, and accountability.	Thematic coding.
Focus group discussions	Older adults, village health volunteers, community representatives, and/or health personnel. (n = 22) 3 panels, *the first panel* with 12 participants in LPAO, *the second panel with representatives from* 4 local governments including Chiang Mai Provincial Government, Pathum Thani Provincial Government, Mueang Nonthaburi Municipality, and Hat Yai Municipality, and *the last* with 6 representatives from Lampang Provincial Public Health Office (LPPHO).	Explore community perceptions, barriers, expectations, and participation roles.	Thematic coding and comparison across groups.

Table 2. Data sources and analytical purpose

Data source	Participants / units	Purpose	Analysis
Older-adult survey	Older adults in selected districts, n =230.	Measure awareness, expectations, service use, and willingness to participate.	Descriptive statistics: frequencies, percentages, means.
SDHPH personnel survey	Personnel from SDHPHs, n = 65.	Assess operational status, staffing, priorities, and views on older adults' roles.	Descriptive statistics and cross-checking with qualitative themes.

Data collection instruments

Semi-structured interview and focus group guides covered five themes: (1) experience of SDHPH devolution; (2) division of responsibilities among LPAO, LPPHO, district public health offices, district hospitals, and SDHPHs; (3) service-delivery capacity and resource constraints; (4) older adults' health needs and service expectations; and (5) possible forms of older adults' participation in community-based primary healthcare.

The older-adult questionnaire included demographic characteristics, SDHPH service use, awareness of the transfer policy, expectations for service improvements, and willingness to participate in health-related roles. The SDHPH personnel questionnaire included operational format, service priorities, personnel availability, resource needs, and attitudes toward involving older adults in health-promotion activities.

Data analysis

Quantitative data were analyzed using descriptive statistics, including frequencies, percentages, and mean scores. Because the survey results were used to describe stakeholder perceptions and service conditions rather than test causal effects, the analysis focused on the distribution and interpretation of key indicators.

Qualitative data were analyzed thematically. Interview and focus group data were reviewed, coded according to the analytical framework, and then refined inductively to capture emerging issues such as uncertainty about role division, budget constraints, workforce shortages, local political concerns, community awareness, and the mismatch between policy expectations for participation and older adults' readiness to participate. Findings were triangulated across document review, interviews, focus groups, older-adult survey responses, and SDHPH personnel survey responses.

Validity, reliability, and research ethics

Several procedures should be reported to strengthen rigor and replicability. For the qualitative component, the manuscript should specify whether interview guides were reviewed by experts, whether data were recorded and transcribed, how codes were developed, whether multiple coders were used, and whether member checking or peer debriefing was conducted. For the quantitative component, the manuscript should report the sampling frame, response rate, instrument validation, pilot testing, reliability statistics, and data-cleaning procedures. Ethical approval was obtained from The Human Research Ethics Committee of Thammasat University Social Sciences, Certificate of Approval No: 129/2566, date of approval: November 14th, 2023, and all participants provided informed consent.

Results

Governance transition after SDHPH devolution

The devolution of SDHPHs to the LPAO changed the governance environment of primary healthcare by introducing new responsibilities for a locally elected organization while maintaining important technical and regulatory roles for public health agencies. Stakeholders generally recognized the potential benefits of devolution, including more locally responsive budgeting, faster procurement of supplies, closer attention to community needs, and improved opportunities for personnel development within the local-government system. These perceived benefits were strongest among stakeholders who believed that the LPAO could mobilize resources more flexibly than central agencies.

At the same time, the transition created uncertainty and resistance. Some stakeholders expressed concern about possible interference by local politics, uneven professional development opportunities, data protection, corruption risks, unclear transfer plans, and the capacity of local governments to manage health services. The findings indicate that resistance was not simply opposition to decentralization; it reflected uncertainty about whether devolution would be accompanied by adequate finance, human resources, technical support, and regulatory clarity.

The relationship between the LPAO and LPPHO emerged as a critical condition for successful devolution. Where the LPAO, LPPHO, and district public health actors shared expectations regarding which SDHPHs should be transferred and how services should be supported, the transition was perceived as more feasible. Where perspectives diverged or relationships were weak, the process was expected to experience greater friction. A formal memorandum of understanding (MOU) between LPAO and LPPHO can clarify the division of responsibilities for supervision, technical support, personnel development, referral coordination, data reporting, and quality assurance.

Table 3. Stakeholder roles in the post-devolution SDHPH system

Stakeholder	Post-devolution role	Key issues identified
Lampang Provincial Administrative Organization (LPAO)	Local owner/manager of transferred SDHPHs; budget support; personnel administration; local development planning.	Requires adequate budget, workforce flexibility, and technical support.
Lampang Provincial Public Health Office (LPPHO)	Technical supervision, professional standards, disease control support, coordination under the Primary Health System Act.	Needs clear MOU with LPAO to avoid duplication or gaps.
District Public Health Offices and district hospitals	Referral coordination, clinical support, linkage between SDHPHs and higher-level services.	Essential for integrated care and continuity for older adults.
SDHPHs	Frontline primary healthcare providers; health promotion, prevention, chronic care, rehabilitation coordination, community outreach.	Face personnel shortages, resource constraints, and expanded expectations after devolution.
Village health volunteers and community organizations	Household outreach, health communication, community mobilization, support for older adults.	Need training, incentives, and coordination with SDHPHs.
Older adults and families	Recipients of care; potential health owners, peer supporters, wisdom carriers, volunteers, and advisors.	Low awareness of devolution and limited willingness to take formal service roles.

Service-delivery capacity and area-specific health needs

The findings show that devolution occurs in a context of substantial service demand. Lampang's population structure is ageing, and the province faces high demand for chronic disease management, health promotion, dental services, rehabilitation, and prevention. Respondents reported that health needs vary across districts. For example, some areas experience environmental and respiratory health concerns, while others have higher burdens related to circulatory diseases, endocrine diseases, oral health, or accidents. These differences support the rationale for local decision-making but also require stronger local data systems and resource planning.

The SDHPH personnel survey indicates that most sampled units operated as providers or members of a Network of Primary Care Units (NPCU), while smaller proportions were linked to

Primary Care Centers (PCCs) or Contracting Units for Primary Care (CUPs). Personnel prioritized health promotion, disease prevention and control, and nursing care. These priorities are consistent with the preventive and community-based mandate of SDHPHs, but they also expose gaps in specialized geriatric, dental, pharmacy, rehabilitation, and medical staffing.

Workforce shortages were one of the strongest findings. The original results indicate that most SDHPHs lacked full-time physicians and dentists, and that pharmacy, dental/public health, and physical therapy positions were also limited. Although part-time medical and pharmacy support was available in some areas, SDHPHs remained dependent on district hospitals and public health networks for technical and referral support. Devolution therefore requires not only a transfer of facilities but also a workforce strategy that aligns local service responsibilities with human-resource authority and financing.

Table 4. Selected quantitative findings on SDHPH operations and personnel capacity

Indicator	Original reported result	Interpretation for devolution
Operating as provider/member of NPCU	83.1% (54 of 65)	Most SDHPHs are embedded in primary care networks and require coordination across units.
Operating as PCC provider/member	12.3% (8 of 65)	PCC integration is more limited and should be clarified by area.
Operating as CUP contracted service unit	21.5% (14 of 65)	Referral and contracting relationships remain important after devolution.
Priority on health promotion services	76.9%	Prevention and health promotion remain core SDHPH functions.
Priority on disease control/prevention	58.5%	Local capacity for public health response is central to SDHPH performance.
Priority on nursing care services	55.4%	Nursing capacity is critical for chronic disease and older-adult care.
No full-time physician	98.5%	Clinical support from district hospitals and network physicians is necessary.
No full-time dentist	98.5%	Dental expectations among older adults may exceed available capacity.

Table 4. Selected quantitative findings on SDHPH operations and personnel capacity (Cont.)

Indicator	Original reported result	Interpretation for devolution
No full-time pharmacist/pharmacy staff	96.9%	Medicine management and chronic disease care require network support.
No full-time physical therapist	96.9%	Rehabilitation needs may be underserved without referral and outreach systems.

Older adults as recipients: awareness, service use, and expectations

The older-adult survey presents a mixed picture. Most respondents used SDHPH services, especially for general disease treatment, blood pressure and diabetes checks, dental care, wound care, and vaccination. However, most had no formal community role and had limited awareness of the SDHPH transfer policy. The original results report that 89.6 percent of older adults did not know about the policy to transfer SDHPHs to PAOs, and more than 90 percent did not know whether the SDHPH in their area had been transferred. This low awareness indicates that devolution was not yet widely understood by one of the most important user groups. The salience of primary-care use is also reflected in provincial monitoring of outpatient service use at primary care units (Ministry of Public Health, 2023b). Despite low awareness, older adults expressed high expectations for service improvement after devolution. Expectations were particularly visible in health promotion, long-term care and day care, disease control and prevention, chronic disease clinics, rehabilitation, dentistry, and consumer protection. These expectations suggest that older adults judge SDHPH performance through concrete service experiences rather than through formal knowledge of administrative reform. For local governments, this means that the legitimacy of devolution will depend on visible improvements in access, continuity, service scope, and quality of care.

Table 5. Older adults' awareness, expectations, and participation preferences

Dimension	Original reported result	Analytical implication
Female respondents	69.6%	Older women may be central users of SDHPH services; gender should be considered in outreach.
Age 60-69 years	64.8%	Many respondents were early older adults and may still be active in community life.

Table 5. Older adults' awareness, expectations, and participation preferences (Cont.)

Dimension	Original reported result	Analytical implication
Primary education	74.3%; no education: 16.1%	Health communication must be simple, accessible, and repeated through trusted channels.
No community role	86.1%	Formal participation cannot be assumed; engagement must be built gradually.
Use SDHPH services	86.1%	SDHPHs remain important points of access for older adults.
Unaware of SDHPH transfer policy	89.6%	Devolution communication to service users is insufficient.
Uncertain whether transfer improves services	84.8%	Perceived legitimacy of devolution depends on actual service improvements.
Higher expectation: health promotion	57.4%	Older adults expect more preventive and supportive services.
Higher expectation: dentistry	57.0%	Dental capacity should be aligned with demand.
Higher expectation: consumer protection	54.8%	Local health governance should include food, medicine, and product safety concerns.
Desire to encourage patients	Mean = 1.65, moderate	Peer support is the most feasible initial contribution role.

Older adults as contributors: contrasting expectations of older adults and SDHPH personnel

A central finding is the gap between policy aspirations for productive ageing and older adults' stated willingness to participate in SDHPH service provision. Overall willingness to participate in service provision and development was low. Older adults generally did not want to take formal roles such as health professional, SDHPH management advisor, dental service participant, mobile service assistant, health educator, or organizer of health-wisdom activities. The main exception was the role of encouraging patients, which reached a moderate level.

In contrast, SDHPH personnel expressed strong interest in expanding older adults' roles in community health. Personnel supported developing older adults as part of community health mechanisms or primary healthcare service units, exchanging knowledge and wisdom with older adults, involving them in traditional Thai medicine and herbal medicine activities, developing them as companions in caregiving processes, and hiring retired personnel with medical or public health knowledge. This contrast suggests that the main challenge is not whether older adults

have potential value, but how institutions design realistic, voluntary, supported, and differentiated roles.

Table 6. SDHPH personnel's interest in older adults' roles in health service development

Proposed role for older adults	Mean score	Interpretation
Develop older adults as part of community health mechanisms or primary healthcare service units	4.52	Strongest support; requires training, role clarity, and supervision.
Exchange and enhance health knowledge from older adults	4.46	Supports a local-wisdom and peer-learning role.
Participate in activities such as traditional Thai medicine, wisdom-based care, and herbal remedies	4.49	Potentially feasible where local knowledge networks exist.
Develop older adults as companions in caregiving processes	4.40	Can support homebound or socially isolated older adults.
Hire retired personnel with medical or public health knowledge	4.40	Useful for areas with retired professionals and budget capacity.
Overall interest	4.45	SDHPH personnel support older-adult participation, but implementation must match older adults' readiness.

A differentiated participation model for older adults

The results indicate that older adults should not be treated as a single group. Their ability and willingness to participate differ by health status, family support, economic security, previous community roles, education, skills, and confidence. A practical model should therefore classify older adults into differentiated roles rather than expecting broad participation in formal SDHPH work. Three groups are suggested below.

Table 7. Differentiated roles for older adults in community-based primary healthcare

Group	Main characteristics	Appropriate role	Support required
Group 1: Health owners	Older adults with health, economic, family, or mobility limitations; often see themselves mainly as service users.	Self-care, chronic disease management, participation in health education, household-level health planning.	Proactive home visits, simple health communication, family engagement, village health volunteer follow-up.

Table 7. Differentiated roles for older adults in community-based primary healthcare (Cont.)

Group	Main characteristics	Appropriate role	Support required
Group 2: Wisdom carriers and peer supporters	Older adults with local knowledge, occupational skills, cultural capital, or experience in health practices.	Share local wisdom, support health-promotion activities, mentor peers, contribute to community learning centers.	Recognition, documentation of wisdom, collaboration with local cultural/education offices, small incentives.
Group 3: Community health mechanism participants	Older adults with stronger health, education, savings, time, or prior professional/community experience.	Volunteer roles, patient encouragement, advisory roles, support for health campaigns, retired professional assistance.	Training, clear task boundaries, supervision by SDHPHs, coordination with PAO, formal recognition and safeguards.

This model connects productive ageing to practical governance. Older adults with limited capacity should not be pressured to provide services; rather, they should be supported to maintain their own health. Older adults with relevant wisdom can contribute to culturally appropriate health promotion. A smaller group of highly prepared older adults can participate more directly in community health mechanisms, provided that their roles are voluntary, safe, supervised, and clearly distinguished from professional clinical duties.

Discussion

Devolution requires coordination, not only transfer

The findings show that devolution should be understood as a governance process rather than a one-time administrative transfer. SDHPHs may become more responsive when PAOs can align services with local needs, but local responsiveness depends on clear division of labor among PAOs, public health offices, district hospitals, and SDHPHs. The LPAO-LPPHO relationship is especially important because the PAO holds local administrative authority while the public health office retains technical expertise, standards, disease-control functions, and links to the Ministry of Public Health.

These findings are consistent with decentralization theory. Local decision space is meaningful only when local governments have the resources and capacity to exercise it. If SDHPHs are transferred without sufficient budget, personnel flexibility, information systems, and referral arrangements, devolution may increase administrative burden without improving service

quality (Albreht and Klazinga, 2010). An MOU between LPAO and LPPHO should therefore define responsibilities for supervision, technical support, data sharing, referral pathways, procurement, workforce development, and quality assurance (Fleischer, 2015).

Older adults' participation must be built gradually

The study also shows a tension between the policy ideal of productive ageing and the realities of older adults' readiness to participate. Although SDHPH personnel see older adults as valuable contributors, most older adults in the survey did not want formal service or management roles. This mismatch may reflect low awareness of devolution, limited confidence, economic pressures, health limitations, lack of prior community involvement, and the historical pattern of SDHPHs providing services primarily from the facility rather than through sustained community co-production.

A realistic participation strategy should begin with low-burden roles that align with older adults' interests, such as patient encouragement, self-care groups, health literacy activities, local wisdom sharing, and peer support. More demanding roles, such as community health volunteer work or advisory roles, should be offered only to older adults who are willing, capable, trained, and supported. This gradual approach respects older adults' autonomy while still creating channels for meaningful participation.

Implications for public administration and local health governance

For public administration, the study demonstrates that local health governance must bridge political accountability and professional public health capacity. PAOs can help tailor services to local priorities, but they must also sustain technical standards, personnel development, and coordination with the district health system. Community participation should be institutionalized through planning forums, community health committees, village health volunteer networks, older-adult clubs, and feedback mechanisms rather than treated as an ad hoc activity (Maluka, 2011).

The 4Ps approach is useful because it recognizes that public agencies, private or civic partners, families, volunteers, and older adults all contribute to health outcomes. However, partnerships require clear responsibilities and accountability. In the SDHPH context, the people dimension of 4Ps should include not only consultation with service users but also supported co-production through roles that match older adults' capacity.

Limitations

Several limitations should be acknowledged. First, the study is based on a case in Lampang Province, so findings may not represent all provinces or all PAO-transferred SDHPHs in Thailand. Second, the quantitative analysis is descriptive and does not test causal effects of

devolution on health outcomes (Katikireddi et al., 2014). Third, the older-adult sample and district subgroup totals must be verified because the original manuscript reports inconsistent numbers. Fourth, the manuscript should provide more detail on the number and composition of qualitative participants, data collection period, instrument validation, reliability, and ethics approval. Addressing these issues will improve transparency and replicability.

Conclusion and Policy Implications

Thailand's devolution of SDHPHs to PAOs creates an opportunity to make primary healthcare more locally responsive, but the success of this reform depends on governance capacity, intergovernmental coordination, workforce planning, and community participation. In Lampang Province, stakeholders recognized the potential benefits of devolution, including more flexible local budgeting and services tailored to local health needs. At the same time, they identified significant risks, including unclear role division, budget constraints, personnel shortages, and limited public awareness.

Older adults are central to the future of SDHPHs because they are major service users and potential contributors to community-based health promotion. The findings show that older adults have high expectations for improved services but generally low willingness to assume formal SDHPH roles. This does not mean that older adults cannot contribute; rather, it means that participation must be designed gradually, voluntarily, and according to different levels of readiness. The most feasible strategy is a differentiated participation model in which some older adults focus on self-care, others share wisdom and peer support, and a smaller group participates more directly in community health mechanisms.

Policy implications are summarized as follows:

Clarify governance through formal agreements. LPAO and LPPHO should develop an MOU specifying responsibilities for supervision, data sharing, referral coordination, quality assurance, personnel development, and emergency response.

Align budgets and personnel with transferred responsibilities. Devolution should be accompanied by workforce planning for nursing, dentistry, pharmacy, rehabilitation, geriatric care, and chronic disease management.

Improve communication with older adults and families. Because awareness of SDHPH transfer is low, PAOs and SDHPHs should explain what has changed, what services are available, and how older adults can provide feedback.

Develop differentiated participation pathways. Older adults should be invited into roles that match their health, skills, time, and willingness, ranging from self-care and peer encouragement to local wisdom sharing and volunteer roles.

Strengthen community-based data systems. SDHPHs and PAOs should use local health data to identify district-specific service priorities and monitor whether devolution improves access, equity, service quality, and satisfaction.

Institutionalize community feedback. Older-adult clubs, village health volunteers, family caregivers, and community organizations should be represented in planning and evaluation processes.

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