Public Sector Reforms and Human Resources for Health in Thailand: An Exploration of Impacts, Issues and Options for Moving Forward[1]

Table of Contents

[1] This report was prepared by Jana Orac (consultant) and Sutayut Osornprasop (Human Development Program Specialist, World Bank) under the guidance of Magnus Lindelow (Senior Economist and Country Sector Coordinator for South East Asia, World Bank), with inputs from Pattara Lellahavarong (Researcher) and Roongnapa Khampang (Research Assistant) of the Health Intervention Technology Assessment Program of the Ministry of Public Health. We wish to thank the many individuals who supported this work, and graciously shared their time and expertise with us, including Dr. Suwit Wibulpolprasert (Senior Advisor, MOPH), Dr. Yot Teerawattananon (Program Leader, HITAP) and others. See annex 11 for a full list of contributors.

Abbreviations

CS	Civil Service
CSC	Civil Service Commission
CSMBS	Civil Service Medical Benefits Scheme
CUP	Contracting Unit for Primary Care
GE	Government Employee
HRH	Human Resources for Health
LAO	Local Administration Organization
MOPH	Ministry of Public Health
NGO	Non-governmental Organization
OCSC	Office of the Civil Service Commission
OPDC	Office of the Public Sector Development Commission
PHO	Provincial Health Office
SSS	Social Security Scheme
TE	Temporary Employee
UC	Universal Health Coverage
WHO	World Health Organization

Executive Summary

This report responds to a Ministry of Public Health (MOPH) request to the World Bank to conduct exploratory work to examine the impacts of public sector reforms on human resources for health (HRH), with the aim of identifying areas where further analytical work may be useful. Most notably, over the past decade and a half, the Government has implemented a "rightsizing" policy that restrains civil service growth and also introduced universal health coverage, which has raised demand for health services. While some steps have been taken toward decentralization and autonomization, these have affected only a limited number of health facilities.

The report starts with an overview of Thailand's health sector human resources and the broader context of Thailand's civilian government employment, as well as referencing the complex dynamics that affect health sector human resources. While interest in the reverberations of recent public sector reforms is high, these measures are part of a complex system with many confounding factors. Indeed, there is a shortage of evidence to comprehensively assess the impacts, particularly given the limited scope of this exploratory work. To delimit the exploration of impacts specific to public sector reform and present findings in a manageable manner, the report borrows from an analytical framework for civil service human resource management that, in the case of Thailand's HRH, leads to three fundamental and complex questions. First, what constitutes an appropriate HRH staffing complement for Thailand overall and, more specifically, is the *current* staffing complement suitable and how it is influenced by public sector reforms? Second, what kinds of recruitment and retention challenges (including compensation) have been posed by recent public sector reforms? And third, to what extent is affordability of concern, overall and for individual facilities?

Stakeholders interviewed for this study held divergent views regarding the suitability of the staffing complement, suggesting that further analysis in a number of areas would be worthwhile. Similarly, on recruitment and retention issues, MOPH managers emphasized an interest in seeing greater numbers of civil service posts (which are more attractive in terms of in-kind benefits, prestige and job security than other types of employment status) allocated to the health sector, while other stakeholders noted both that health faces lighter restraints than other sectors and that, with the continuation of the rightsizing policy, the solution lies in revising ways of doing business rather than focusing on increased employment. While stakeholders were committed to their views, evidence on the impact of public sector reforms on HRH (e.g. data on HR dynamics for civil service versus other types of positions, the motivations of staff who leave the public sector, compensation differentials with the private sector and other public services) is scarce. Finally, affordability of HRH – while critically important to decisions from the national level down to facility level - was rarely if ever mentioned explicitly by stakeholders, suggesting that additional analysis and costing of options could be beneficial.

The aim of this exploratory work is not to make policy recommendations but rather to suggest practical opportunities for moving forward. To that end, the report proposes diagnostic work that would review statistical and projections frameworks for HRH; monitor practical indicators of HRH dynamics; and probe worker perspectives via surveys and qualitative research. Policy-focused work could examine modes of service delivery with a view to identifying opportunities to revise practices; evaluate ongoing innovative initiatives such community nursing programs; analyze compensation packages and public-private differentials; and model the costs of possible interventions. Such work would best be undertaken in close partnership between stakeholders within and outside of government, with international support as appropriate. It would also benefit from an integrated perspective on HRH that encompasses all organizational and employment

categories, as well as the use of a variety of analytical tools (e.g. one-off studies, ongoing monitoring).

1. Introduction

This report responds to a Ministry of Public Health (MOPH) request to the World Bank to conduct exploratory work to examine the impacts of public sector reforms on human resources for health (HRH), with the aim of identifying areas where further analytical work may be useful. A World Bank team interviewed a range of stakeholders: senior officials of MOPH, the Office of the Civil Service Commission (OCSC), the Office of the Public Sector Development Commission (OPDC), and the Nursing Council; directors and managers of district, provincial, and regional hospitals and one health center; health care workers; nursing instructors and students; as well as expert observers and academicians. Interviews were conducted in Bangkok and three provinces (Mae Hong Son, Khon Kaen, and Songkhla) in February-March 2010, with participation of researchers from MOPH's Health Intervention and Technology Assessment Program (HITAP).
`

Four noteworthy reforms have been unfolding over the past decade and a half: (i) a government-wide "rightsizing" policy that includes among its features restraints on government employment[2]; (ii) the introduction of universal health coverage (UC) which has resulted, *inter alia*, in higher utilization of services by the public and changed the system of funds flows; (iii) a decentralization policy that, in the health sector, has seen a small number of health centers transferred from the Ministry-run system to local governments; and (iv) autonomization of certain public bodies, including one hospital. In addition, other dynamics have been playing out in the health sector, including the rise of privately-provided health services (spurred in part by an explicit policy promoting "medical tourism" to Thailand) and an evolving population health profile and needs.

While interest in the impact of these reforms on health sector human resources is high, these measures are part of a complex system with many confounding factors. Indeed, there is a shortage of evidence to comprehensively assess the impacts, particularly given the limited scope of this exploratory work. While the scale of decentralization and autonomization in the publicly funded health sector has been limited, the same cannot be said for the first two reforms. The majority of UC scheme contractors are public facilities, which have seen demand for their services increase as a result. However, any new hiring to meet perceived needs has been constrained by the central government's rightsizing policy, with the result that the bulk of new hires have been offered so-called "temporary employee" contracts, with terms that are less attractive than those provided to civil servants and financing from facility (rather than MOPH) budgets. Views on how these factors have affected HRH – including the public sector's ability to recruit and retain needed staff – as well as perceived solutions differ across stakeholders. Robust evidence regarding impacts resulting specifically from these two significant reforms (which are, admittedly, difficult to disentangle from broader dynamics) appears to be lacking, leaving unanswered questions about the exact nature and gravity of any difficulties, as well as how they might best be addressed. In response to these challenging circumstances, this exploratory work probes the resulting issues and policy questions – in particular to highlight points of stakeholder disagreement and evidence gaps -- and proposes analytical work that would enable an improved understanding of these complex dynamics.

Given the exploratory nature of this assignment and the limited scale of decentralization and autonomization in the health sector, our work focuses on implications of the rightsizing and UC reforms. It is, however, difficult to examine these two policies in isolation from other HRH dynamics (such as recruitment and retention concerns in remote areas, and the perceived appeal of private sector employment) and higher-level health policies or cross-cutting phenomena; these were interwoven into stakeholders' remarks and are thus mentioned in this report as appropriate.

[2] For more information on civilian government workforce and employment categories, see Annex 2.

It should also be noted that, while Thailand is rightfully concerned by its health sector human resources challenges, many of the issues – such as ensuring an appropriate staffing complement even in remote areas, appropriate and affordable compensation, and effective human resource management – are faced not only by low-and middle-income countries but also by many high-income nations. The difficulties of tackling them, and the limited evidence base and assessment tools, have been documented internationally.[3] With its decades-long experience in designing and implementing HRH interventions and substantial domestic expertise, Thailand is in many respects in the forefront of this area. Looking ahead, Thailand is thus well positioned to make progress not only on its own needs but also to contribute to the international dialogue.

The information in this report is based on interviews, and a review of key pieces of legislation and available English-language literature and some Thai-language literature. We were not able in this brief initial foray to conduct a comprehensive in-depth review of regulations nor of all related Thai-language research that has been conducted by a variety of entities. With this in mind, we ask for readers' forbearance and welcome comments.

This report consists of a concise main text that presents key issues and stakeholder perspectives, and suggests further analytical work for consideration. A series of annexes provide background about the fundamental structure and features of health sector employment, sample earnings data, and short profiles of individual health workers interviewed by the team. Readers who are not familiar with the main features of Thailand's HRH may wish to review the annexes prior to reading the main text.

2. Health Sector Human Resources and Civilian Government Employment

This section presents a brief overview of the structure and employment categories of health sector human resources and key HRH issues, in the context of Thailand's civilian government employment. Annexes to this report contain more detailed information about employment categories, provisions of the Civil Service Act that regulates personnel management, the processes for allocating posts and staff across facilities, compensation of health workers in the MOPH system, and a summary of personnel management in facilities that have been devolved to local governments.

HRH work within multiple employment regimes: While attention tends to focus on the MOPH-run health system, health professionals also work for four additional types of employers, as described in Table 1 below: local governments, other public sector bodies (including the university system), the private sector, and non-governmental organizations. Based on available data, MOPH is by far the largest employer, accounting for some two-thirds of employment in these five spheres.[4]

[3] See for example *Effects of policy options for human resources for health: an analysis of systematic reviews*, the Lancet vol. 371 February 23, 2008; and the proceedings of the November 2009 Asia-Pacific Action Alliance for Human Resources for Health and Meeting of the WHO expert group on increasing access to health workers in remote and rural areas through increased retention (available at www.aaahrh.org/4th_conf_2009/conf_doc.php).

[4] This should be taken as a preliminary estimate since data are from different sources, which may have different coverage and methodologies.

Table 1: Overview of HRH Structure and Staff Numbers

MOPH	Local Administration	Other Public Sector	Private sector	Non-governmental organizations and other
299,522 persons (FY2008). Facilities: 9,765 sub-district health centers, 95 general / regional hospitals, 725 district hospitals	*Staff of facilities operated by local governments, including 28 health centers devolved from MOPH to sub-districts and municipalities*[5]	*Includes University system, Ministry of Defense, Police, State-owned enterprises*	*429 hospitals and some 16,800 outpatient clinics, concentrated in Bangkok & urban areas. Clinics include small practices run by public sector staff during off hours.*	
Ordinary civil servants 169,044 56%	Local Administrative Organization (LAO) employees	52,715 (2007)	76,007 (2007)	
Temporary Employees 89,936 30%	Local Temporary Employees			
Permanent Employees 38,440 13%				
Government Employees 2,102 1%				

Notes: Data for "other public sector" include local administration. Private sector data exclude dual practice by government staff and may include non-governmental organizations and others, for which separate data were not available..
S*ources:* MOPH staff numbers are from *Ordinary Civil Servants in Thailand 2008*, Office of the Civil Service Commission. Facility numbers are from *Thailand's Health Workforce: A Review of Challenges and the Experiences, International Health Policy Program*, 2007. Numbers of health personnel in the non-MOPH government sector and in the private sector are from Human Resource Management Report System, Bureau of Policy and Strategy: Ministry of Public Health.[6]

Within the MOPH system, the largest employment category remains civil servants (169,044 individuals in 2008, 56% of MOPH total employment). However, Temporary Employees are second, with 89,936 individuals, many of whom are nurses and other service providers. The third largest category, Permanent Employees, largely encompasses "blue collar" service positions and is meant to be phased out as services are contracted out, while the smallest category, Government Employees, includes jobs similar to the civil service with limited-term contracts. These four categories of staff are treated differently, with different employment regulations, compensation and benefits (see annexes 2 and 5).

Temporary Employees in MOPH bodies are governed by ministry-issued regulations and the labor code. The Office of the Civil Service Commission is the personnel agency responsible for "Ordinary" Civil Servants and Government Employees.[7] Health workers in other public sector bodies fall under the relevant personnel agency (which may be the Civil Service Commission or another dedicated commission) and compensation regime.[8]

[5] Detailed data on local government employees were not available at the time of writing.

[6] MOPH data cited are available at: http://hrm.moph.go.th/res51/res-01.rb, http://moc.moph.go.th/Resource/Personal, http://bps.ops.moph.go.th/Resour/doc-49.pdf and http://bps.ops.moph.go.th/pla1.1.html

[7] The 2008 Civil Service Act distinguishes between ordinary civil servants (hired under provisions of the Act) and royal household civil servants, whose appointment is governed by royal decree.

[8] In addition to the Civil Service Commission, distinct Commissions exist for the following groups of public employees: Judicial Service, Teachers, University Officials, Public Prosecutor Service, Legislative Body Officials, Police Officials, Provincial Administration, Municipal Administration, Bangkok Metropolitan Officials, and Tambon Administration. Distinct pay regimes were introduced in the 1990s.

MOPH staff are an important component of Civil Service and Civilian Government Employment: Table 2 below presents data on civilian government employment and MOPH employment by type of employment status. The Thai government's civilian workforce is made up of 2.04 million employees (2008), representing around 3 percent of the population and just over 5 percent of the Thai labor force. Approximately 62% of the civilian government workforce is categorized as government officials, a designation that includes OCSC-regulated Ordinary Civil Servants as well as other categories that are covered by separate regulatory regimes. Teachers are the largest of these categories, followed by Ordinary Civil Servants and police. Of the remaining civilian government workforce, 12% are designated Permanent Employees and 5% Government Employees, while Temporary Employees of central and local authorities account for 14% and 7% respectively.

MOPH employment accounts for roughly 15% of civilian government employment and dominates the Civil Service category. According to OCSC data for fiscal year 2008, MOPH staff accounted for almost half (47%) of Thailand's 362,767 Ordinary Civil Servants. While these shares remained relatively constant over 2004-2008, it is possible that some flux in categories occurred in earlier years, when facilities faced increased service demands resulting from UC and, concurrently, constraints on hiring of Civil Service-designated staff.[9]

Table 2: Civilian Government and MOPH Workforce by Employment Status, 2004-2008

	2008		2007		2006		2005		2004	
Employment	**Persons**	**%**	**Persons**	**%**	**Persons**	**%**	**Persons**	**%**	**Persons**	**%**
Civilian Government Workforce, Total	**2,037,505**		**1,939,158**		**1,919,080**		**1,980,276**			
Of which:										
Government officials	**1,271,620**	62%	**1,275,350**	66%	**1,258,919**	66%	**1,221,262**	62%	**1,206,573**	n/a
Central & Provincial Administration	*1,100,636*		*1,113,325*		*1,117,131*		*1,102,792*		*1,106,365*	
Ordinary civil servants	362,767		364,486		365,083		362,660		364,357	
Teachers	456,979		463,565		463,354		452,029		465,412	
University officials	51,569		53,084		53,940		54,717		43,081	
Legislative branch	2,518		2,366		2,348		2,089		2,001	
Police	207,918		211,604		215,106		214,872		215,460	
Public Prosecutors	2,951		2,854		2,808		2,575		2,560	
Judges	4,008		3,813		3,718		3,543		3,436	
Autonomous Organization	11,926		11,553		10,774		10,307		10,058	
Local Administration	*170,984*		*162,025*		*141,788*		*118,470*		*100,208*	
Bangkok Metropolitan Administration:	35,250		35,417		34,866		32,221		31,409	
Ordinary civil servants	*20,859*		*20,526*		*20,394*		*19,900*		*18,040*	
Teachers	*14,391*		*14,891*		*14,472*		*12,321*		*13,369*	
Provincial Administration Organizations	7,774		8,160		6,713		6,043		5,639	
Subdistrict Administration Organizations	63,544		64,736		51,587		39,991		26,061	

Administrative Reforms: Country Profiles of Five Asian Countries. United Nations Public Administration Network, 1997.

[9] Data for earlier years were not available at the time of writing. In table 2, the apparent increase in MOPH Civil Servants from 2004 to 2005 is not due to new hiring but rather to a one-time decision that allowed MOPH to convert existing staff from Government Employee to Civil Service status.

Municipalities:	64,416		53,712		48,622		40,215		37,099	
Ordinary civil servants	*39,475*		*34,257*		*30,459*		*20,366*		*23,368*	
Teachers	*24,941*		*19,455*		*18,163*		*13,849*		*13,731*	
Permanent employees	**237,786**	12%	**248,547**	13%	**258,494**	13%	**258,600**	13%	**268,086**	
Temporary employees	**281,381**	14%	**196,299**	10%	**203,348**	11%	**298,141**	15%	n/a	
Government employees	**100,992**	5%	**92,138**	5%	**85,752**	4%	**59,481**	3%	n/a	
Local temporary employees	**145,726**	7%	**126,824**	7%	**112,567**	6%	**142,792**	7%	n/a	
Ministry of Public Health, Total	**299,522**		**296,147**		**295,505**		**294,850**			
Ordinary Civil Servants	169,044	56%	169,164	57%	169,228	57%	167,568	57%	149,369	n/a
Permanent Employees	38,440	13%	40,051	14%	41,218	14%	42,418	14%	44,222	
Temporary Employees	89,936	30%	85,060	29%	84,106	28%	84,341	29%	n/a	
Government Employees	2,102	0.7%	1,872	1%	953	0.3%	523	0.2%	n/a	

Source: *Ordinary Civil Servants in Thailand* and *Civilian Workforce in Thailand*, 2008 and earlier years, OCSC.

Table 3 below presents data on health sector employment in key professions by type of employer.[10] While data on other types of professional and support staff were not available, these groups appear to form a sizable proportion of total health sector employment. For example, the 101,568 physicians, dentists, pharmacists and nurses on MOPH rolls in 2006 accounted for 34% of total MOPH employment of 295,505 according to OCSC data for that year. Similarly, the employment roster for a district hospital visited in the course of our interviews shows that physicians, dentists, pharmacists and nurses comprised 41% of staff while the remaining 59% consisted of other professionals and support staff.

Table 3: Employment in Selected Professions, 2006

Profession	MOPH	Other ministries	SOEs	Municipalities	Independent institutions	Private	Total
Physicians	11,311	4,173	45	666	547	4,309	21,051
Dentists	2,838	516	17	166	215	435	4,187
Pharmacists	5,841	567	10	190	98	1,234	7,940
Registered nurses	70,708	11,492	186	3,372	2,065	13,320	101,143
Technical nurses	10,870	1,504	10	239	10	249	12,882
Subtotal	**101,568**	**18,252**	**268**	**4,633**	**2,935**	**19,547**	**147,203**
Distribution across Type of Employer							
Physicians	53.7%	19.8%	0.2%	3.2%	2.6%	20.5%	
Dentists	67.8%	12.3%	0.4%	4.0%	5.1%	10.4%	
Pharmacists	73.6%	7.1%	0.1%	2.4%	1.2%	15.5%	
Registered nurses	69.9%	11.4%	0.2%	3.3%	2.0%	13.2%	
Technical nurses	84.4%	11.7%	0.1%	1.9%	0.1%	1.9%	

Source: MOPH Monitoring and Management System

Note: The category "independent institutions" includes non-governmental organizations. Private sector data exclude individuals who hold full-time government posts but engage in dual practice.

[10] Although not specified in the source data, we have assumed that these figures include all contract types (civil servants, government employees, and temporary employees) in these professions.

Within the MOPH system, most health facilities are under the overall authority of the Office of the Permanent Secretary in MOPH. As a result, the bulk of MOPH's civil servants – some 89% (151,061 individuals) in 2008 - are administratively mapped to that Office as, presumably, are most staff in the other employment categories. This has implications for HR decision-making authority (as stipulated in the 2008 Civil Service Act; see Annex 3 for summary).

Table 4: Ordinary Civil Servants by MOPH Department, 2008 (Persons)

Ministry Department	Number of staff	Percent of total
Office of the Minister	24	0.01%
Office of the Permanent Secretary	151,061	89.4%
Medical Services	7,128	4.2%
Disease Control	2,919	1.7%
Traditional Thai and Alternative Medicine	151	0.1%
Medical Sciences	973	0.6%
Health Services Support	970	0.6%
Mental Health	3,220	1.9%
Health	1,994	1.2%
Food & Drug Administration	604	0.4%
MOPH total	169,044	

Source: *Ordinary Civil Servants in Thailand 2008*, Office of the Civil Service Commission.
Note: Percentages do not add to 100 due to rounding.

Thailand faces complex HRH dynamics: Many of Thailand's HRH dynamics have been examined elsewhere and are familiar to analysts. The dynamics are complex and differ by factors such as profession and stage of career, as well as evolving over time. In general, the most attention is paid to three priority groups (reflecting professional standing and numbers): medical doctors, nurses and primary care workers. We summarize only the broad outlines of HRH issues here and refer readers to more nuanced analyses.[11]

These are, briefly:

- The geographic distribution of health workers is deemed to be unbalanced and poorly aligned with population needs. Medical doctors and nurses are disproportionately concentrated in urban areas, whereas the majority of the population lives in rural areas.
- Like many other countries, Thailand is concerned with overall shortages of certain skills, including medical doctors and nurses, and struggles to recruit and retain health care workers – notably medical doctors - in rural or remote areas where professional opportunities, infrastructure and lifestyle are generally seen to be less appealing than in urban settings. The tendency for medical doctors to prefer specialist careers also adds to turnover among, and reduces availability of, general practitioners as young doctors leave to undertake specialist training.
- The publicly run health system has, over recent years, seen increasing competition for staff from a growing private sector. This has been spurred by factors that include policies to encourage investment in private health facilities and promote Thailand as a destination for medical tourism. On a related note, 'dual practice' by health professionals who work

[11] See in particular *Thailand's Health Workforce: A Review of Challenges and Experience*. Nonglak Pagaiya and Thinakorn Noree, International Health Policy Program, Ministry of Public Health. August 2008.

concurrently in both public and private capacities is recognized to be common, though detailed analysis of its extent and implications appears scarce.

- The "production" system for educating health care workers is dominated by government–supported schools. Admissions quotas are set and managed to respond to perceived needs for personnel.
- To address concerns about availability and distribution of health care workers, the government has implemented a range of strategies over the years, including increasing "production" (the number of students graduated), local recruitment and training, compulsory rural service, revising curricula to include rural health issues, offering financial incentives to priority groups for rural postings, financial incentives for public sector health professionals who do not concurrently undertake private practice, accelerated promotion for rural-based staff, and recognizing professional achievement. The specific impacts of these programs have proved difficult to evaluate since they were introduced and adjusted at different intervals to respond to perceived needs.

3. Impacts of Public Sector Reform on HRH: Key Issues

Health sector HRH issues are complex in every country. To delimit our exploration of impacts specific to public sector reform and present findings in a manageable manner, we borrow from an analytical framework for civil service human resource management that has been developed by the World Bank.[12] This framework posits and is built around six core objectives for human resource management: (1) to attract and retain the required human capital; (2) a fiscally sustainable wage bill; (3) depoliticized, meritocratic civil service management; (4) performance-focusing civil service management; (5) ethical behavior by civil servants; and (6) effective working relationships with other cadres. Given our focus specifically on public sector impacts (rather than HRH issues more generally), the first two areas are of direct relevance. While the other areas are undoubtedly worthy of exploration, they fall outside of the scope of our work.

Breaking this down further, the issues that emerged in our exploration centered around three fundamental questions. First, what constitutes an appropriate HRH staffing complement for Thailand overall? Second, what specific kinds of recruitment and retention challenges (including compensation) have been posed by recent public sector reforms? Third, to what extent is affordability of concern, overall and for individual facilities?

These questions are complex, with boundaries that are at times blurred. This section presents an overview of the issues, summary of main stakeholder perspectives, references existing evidence base, and notes outstanding questions.

3.1 Appropriate Staffing Complement

Differing views on suitability of staffing: The question of what constitutes an appropriate staffing complement going forward depends very much on strategic considerations such as the future role of the MOPH-run system versus other types of service providers, the manner in which health services are conceived and delivered, and the evolution of population health needs. These factors are highly pertinent but outside of our scope. More narrowly, the fundamental question

[12] The Human Resource Management Actionable Governance Indicators questionnaire (HRM AGI). An overview of the questionnaire and more information on actionable governance indicators are available at www.agidata.org

that emerged in our exploration was whether the *current* staffing complement is suitable (not too small, not too large, with appropriate composition and distribution) and how it is influenced by public sector reforms – a point on which stakeholder views diverged.

In management assessments of staffing adequacy (whether facility-specific or overall), the first point of reference tends to be the staffing data and needs projections prepared by MOPH's Bureau of Policy and Strategy, which are referred to informally as the GIS[13]. However, in our discussions there was uncertainty as to whether this framework integrates sufficient information on all available resources, including Temporary Employees working in MOPH facilities (who comprise about 30% of MOPH employment and whose representation is thought to have increased under the rightsizing policy), as well as professionals working outside the MOPH system in other government, private or NGO facilities.

Nevertheless, MOPH stakeholders cite GIS data as substantiating the need to recruit and retain more staff in order to meet ratio-based staffing targets and, as elaborated further in the next section, believe that offering sought-after Civil Service status to professionals who do not automatically receive it upon entry (unlike doctors, who do) would be an important recruitment and retention tool. In contrast, stakeholders outside of MOPH spoke of the need for a comprehensive perspective that more systematically integrates all resources available within and outside MOPH – in data and projections systems as well as in the day-to-day delivery of care. They also suggested that rather than focusing predominantly on seeking more resources to meet GIS targets, developing alternative ways of doing business could help alleviate shortages by making more efficient use of existing resources.

These varied perspectives point to the following areas for further consideration (1) opportunities to refine the GIS projections systems in order to yield more nuanced information; (2) the scope for achieving efficiency gains via modified work practices; and (3) as with the discussion of recruitment and retention issues (below), the role, pros and cons of permanent versus flexible employment arrangements and differentiated compensation for individuals who perform similar work.

3.2 Recruitment and Retention

To what extent have public sector reforms – UC and rightsizing – affected MOPH's ability to recruit and retain staff where needed, distinct from the many other factors that influence job-seekers' preferences for a particular job or location? According to existing analyses, the universal health coverage policy – a landmark health sector reform for Thailand that allows almost all Thai citizens to benefit from public health insurance schemes -- has increased utilization rates over the past decade, with the increased demand falling largely on MOPH-run facilities since they serve the bulk of the population. Concurrently, rightsizing policy has continued to restrain the numbers of Civil Service and Government Employee posts that OCSC authorizes on an annual basis. That said, OCSC notes that, in recognition of health sector staffing needs, MOPH generally receives its "retired" civil service posts back from the nationally managed pool and thus maintains a stable number of civil service posts. This contrasts with other ministries, which may see their allotment reduced.

Multiple employment contracts with varying compensation: In the face of rightsizing restrictions on CS and GE posts, MOPH facilities have responded by hiring nurses and other staff

[13] See annex 4 for further information on the projections system.

on contract as Temporary Employees, where previously they might have been offered CS status. There also appears to be internal re-allocation by MOPH of available CS designations across professions and locations. For example, when a civil service nurse retires, the CS designation is not automatically transferred to another nurse in the same facility, but is passed up to MOPH management who may allocate the CS designation to a newly hired medical doctor[14] or a nurse in a different facility. We were not able to obtain details of procedures and criteria for such reallocation, and interviews suggested that even stakeholders such as the Nurse's Council or affected facilities may not be privy to this information.

The specific employment status awarded to professional staff (Civil Servant, Government Employee, or Temporary Employee) is relevant not only for financing reasons[15] but because, as noted earlier, the terms of employment and compensation packages differ. Thus with the exception of those who automatically receive civil service status (notably medical doctors), the differentiated terms that apply to the various employment categories (of which Temporary Employee and Government Employee are most relevant for professionals) mean that within MOPH, staff with the same job description may receive substantially different compensation[16]. Furthermore, it appears common for Temporary Employees to have their contracts renewed and work for years in the same facility, making them temporary in name only. Such multi-track arrangements are not uncommon in other countries or sectors but, to the extent that they may be unconstructive, they are worth examining.[17]

Specifically, Civil Servants receive the Civil Service Medical Benefits Scheme (CSMBS) package (which covers family members) and pensions as well as de facto lifetime employment, while Government Employees and Temporary Employees are eligible only for more restricted health and pension benefits through the Social Security Scheme (SSS). Government Employees and Temporary Employees are also on limited-term contracts that must be renewed periodically. Although pay of Government Employees and Temporary Employees may be adjusted somewhat to account for the absence of these benefits, it seems, from worker's expressed preferences for Civil Service status (see below and annex), that this does not redress the balance.[18]

Local initiatives are changing delivery of care: While the debate over Civil Service slots continues, a number of initiatives underway within the MOPH system are changing the nature of health work, recruitment of staff and prospective medical and nursing students, and as a result are

[14] Current policy is that all medical doctors automatically receive civil service status upon entry.

[15] Temporary Employees are financed fully from facility budgets, whereas salaries of Civil Servants, Government Employees and Permanent Employees are largely financed from MOPH-managed funds. See annex 5.

[16] Compensation is understood here to include not only monetary remuneration but also in-kind benefits such as insurance and pension. MOPH 2002 regulations governing employment of temporary and hourly employees explicitly state that for similar job content, the "job title and description shall be identical to that of a civil servant."

[17] On a related note, although compensation of Temporary Employees is regulated by MOPH, compliance difficulties and staff complaints in past years prompted the Ministry to call for improved adherence to guidelines. The extent to which this remains an issue was not clear from our interviews; for example, some Temporary Employees claimed not to receive regular annual increase (as Civil Servants do) or expressed other frustrations while other sources suggested that annual raises are a regular feature.

[18] Specifically, Government Employees are to receive a payment of 10% of base salary in lieu of pension, 5% for other benefits, and also a 5% contribution to social security. The MOPH regulations governing Temporary Employee pay that we reviewed were expressed in Baht terms without reference to the civil service scale, making it difficult to determine differentials during this initial exploration.

shifting service utilization patterns in hospitals and improving the health of beneficiaries. The advocates of these initiatives believe that they will result in changed patterns (and levels) of HRH needs in future. Of particular interest is the community nursing program being implemented in villages and hospitals in Khon Kaen province (annex 7). These continue to be the subject of substantial effort and appear to hold a considerable degree of promise.

Looking beyond recent public sector reform impacts, it appears that remuneration in the University System may outstrip that offered by MOPH. Furthermore, as in other countries, there is a widespread perception that compensation for full-time, private sector positions significantly exceeds that paid for similar positions in the public sector and that this is one (though perhaps not the only) factor that draws professionals (especially medical doctors) to leave the public system. In addition to differentials within and across employers, the question of the overall adequacy of compensation levels, by profession and over the course of a career, is worth examining.

Stakeholder perspectives vary: Stakeholders held varied views on how to respond to hiring restraints, and related recruitment and retention concerns. Table 5 below summarizes the main viewpoints expressed in the course of our interviews.

Table 5: Summary of Stakeholder Views as Expressed in Interviews

Senior MOPH Officials and Facility Directors

- UC has increased service demands and thus staffing needs; there are shortages of professionals (relative to ratio-based projections)
- Civil Service status is a first-best solution to attract and retain needed staff, and could be awarded in a targeted manner for greatest effect
- Alternative solutions might include offering contract workers significantly higher wages or CSMBS-like benefits funded by facilities.
- Local recruitment of nursing and medical students, and community-based nursing programs can positively influence staffing needs, care-seeking behavior, and population health
- Pay differentials – notably with private hospitals – drain staff (especially doctors) from public facilities

Professionals in MOPH Facilities

- Civil Service status is sought after because of medical benefits for family, job security, prestige
- Job satisfaction, proximity to family, and family preferences are also factors in career decisions
- Private sector is an option in some locations but some perceive it as high-stress, demanding or unstable
- Staff outside of the medical and nursing professions want increased recognition

OCSC and OPDC

- Government-wide restraints on numbers of civil service posts will continue
- In recognition of health sector's importance, MOPH generally retains the same number of Civil Service posts each year (while other sectors may face reductions)
- The way forward for the health sector lies in changing how business is done
- Work is underway to design career progressions and pay structures specially suited for health professions

Expert observers

- Evolving health needs may be best met by a flexible workforce and skill mix in future
- Partnering with private providers or adopting insights from private sector practices could reduce need for government to employ health workers
- Integrated perspective that encompasses MOPH plus other government, private, or NGO resources is needed

MOPH managers generally believed that offering CS status to new hires would be important in resolving recruitment and retention problems and thus that OCSC should award more CS slots to MOPH. Some expressed a more nuanced version of this view, that the CS designation should be awarded to certain categories of staff in specific locations (e.g. remote areas rather than urban ones) where evidence indicates that recruitment and retention are particularly challenging and CS status would help alleviate the difficulties. Some MOPH managers also suggested that an alternative solution might be markedly increasing remuneration of TEs to compensate for reduced benefits, or pooling resources to fund civil service-type benefits (i.e. enhanced health insurance and pensions) for these staff.

Civil Service status is highly prized: Health care workers in MOPH facilities[19] generally expressed a desire to obtain civil service status (over Temporary Employee or Government Employee status), citing three main reasons: (1) stable, ongoing employment (2) the desire to provide parents and other family members with coverage under CSMBS and (3) prestige associated with being a civil servant. Parents' preferences were particularly important; a number of interviewees noted that they had entered the profession to comply with their parents' wishes, despite themselves preferring a different career. At the same time, other factors such as the nature of the workplace, job satisfaction and proximity to family were also considerations, and the relative importance of civil service status varied across respondents. While some indicated that they might go elsewhere in future if they did not eventually receive civil service status in their current posts, others would not move simply to get a civil service-designated job because they were happy in their current workplace and location. Mixed views emerged of the appeal of private sector posts. While some individuals were open to working at private hospitals at some point in their careers, others saw jobs in private facilities as less appealing due to perceptions of lower job security and a more stressful, fast-paced work environment.

Ongoing commitment to rightsizing policy: Stakeholders outside MOPH (officials affiliated with OPDC and OCSC, and academicians) did not see the MOPH's requests for increased numbers of civil service posts as sufficiently convincing, and OCSC gave no indication that restrictions on establishment numbers would be relaxed in the near future. It was noted that concerns regarding recruitment and retention of medical doctors would in any case be unaffected, since these professionals already receive civil service status. Some emphasized the need for MOPH to develop alternative modalities for delivering services and utilizing human resources, which might require among other things more flexible employment arrangements to better adapt to evolving health priorities and skills needs over time. This would also include exploring opportunities to shift some services to the private sector or drawing lessons from private facility models. Other suggestions for revising delivery of care included outsourcing not only basic services but also some aspects of professional care (e.g. home nursing visits) to private providers.

At the same time, specialists within OCSC recognize that the health sector may require different treatment than "white collar" office jobs, for example to provide adequate career and salary progression to individuals who remain in clinical positions rather than moving to managerial posts. Indeed, work is underway to design and agree a revised regime that would reportedly include changes to starting salary, differentiating locality pay by location and incorporating local

[19] Most of those interviewed were nurses (in hospitals as well as community nursing programs) or nursing students, with some other professions (e.g. nutritionist, physiotherapist, medical doctor) included. Medical doctors are guaranteed civil service status upon hiring and thus were not asked about their preferences.

cost of living (in contrast to the current remote area allowance that differs only by profession), and adding further flexibility to the pay scale. This was expected to move rapidly and possibly come to fruition as soon as the next fiscal year.

An incomplete evidence base: As described above, there are divergent views on the extent to which making available increased numbers of civil service posts is a desirable strategy overall, or can address recruitment and retention concerns. This leads to the question of what evidence is available about the impact of rightsizing restraints on CS and GE posts. For example, other things being equal, are there fewer applicants for non-civil service openings, or is the lack of CS or GE designation driving staff to resign in order to seek more secure or better-remunerated employment elsewhere?[20] How important a factor is compensation in such decisions, and what are compensation differentials between public and private sector positions? Due to the exploratory nature of this work, we were not able to conduct a comprehensive and in-depth review of all related literature, and recognize that there may be other existing pieces of evidence beyond what are discussed here. However, in the course of interviews, HRH experts remarked that there is a lack of data on the impact of public sector reform on HRH, making the assessment a highly challenging task.

The following evidence was available in our interviews and document review. Experts affiliated with the Nurses' Council analyze turnover rates for nurses via exit interviews and report that for nurses under 30, the main reason for turnover is a desire to change jobs (19% of respondents) while lack of civil service status accounts for only 7.4% of turnover in this group. [21] In contrast, some stakeholders suggested that other data – such as the percentage of nursing graduates who choose to join MOPH facilities rather than private or other facilities, by region – indicate that civil service status is an important draw for the public sector, since provinces that offer easier access to CS status for nurses are better able to recruit recent graduates. These data were not available during our mission, however, and given the multitude of other influences in play – including local economic conditions, labor market characteristics, and personal or family preferences – it is not clear that a causal link can be made without further research. Anecdotally, some managers and health professionals interviewed by the team indicated a general belief that there would be greater numbers of applicants for advertised vacancies if the post offered civil service status rather than contract employment.[22] Analyses of reasons underlying medical doctors' resignations referred to a small-scale study conducted a few years prior.[23]

Regarding compensation, we were not able to obtain robust, current analyses of compensation differentials, whether within the public sector or across public, private and NGO employers.[24] Nonetheless, the existence of compensation differentials between public sector and private sector, and even within the public sector is widely accepted to be the case. A study from the late 1990s

[20] This dynamic would affect new hires who are nurses and other professionals who do not automatically receive CS status (i.e. not medical doctors).

[21] However, these data do not indicate the proportion of CS or TE designation of nurses who joined the exit interview.

[22] However, this does not mean that increasing the number of CS designations available to the health sector would immediately affect recruitment. While some hospitals may allow free competition for a newly available CS slot, others tend to bestow CS status on either the longest-serving TE personnel, or to give priority to those who graduated from MOPH nursing colleges.

[23] The study is a 2005 graduate dissertation that issued approximately 1000 questionnaires and had a response rate of 33%.

[24] For example, a recent study referenced public-private pay differentials from a 1999 paper.

reportedly found dramatic pay differentials between the private and public sector, most notably for medical doctors and dentists but also for pharmacists and nurses. Such dynamics are commonly described in other countries. Within Thailand's public sector, the University system reportedly offers a premium of 40-70% relative to MOPH CS salaries for those who are hired as "University Employees".[25] On the other hand, University Employees (like GE in the OCSC system), receive health and pension benefits from the SSS rather than the more generous and highly sought-after CSMBS to which Ordinary Civil Servants are entitled. Because earnings comparisons are subject to numerous biases, and a sound analysis of compensation requires considering not only monetary compensation but also in-kind benefits and non-pecuniary factors (such as workload and job security), in Thailand as elsewhere there is a need for additional nuanced analysis.

Systematic data such as numbers of applicants for advertised openings and turnover rates (by contract status), were not available during our visit. Nor is it evident that such data alone would be sufficient to draw a causal link between reform-related constraints and HR dynamics. The multitude of factors that affect professionals' decisions to pursue or resign from a position suggest that rigorous qualitative analysis of health care workers' motivations would be beneficial.

To sum up, while the small-scale studies and intuitive assessments noted here are valuable in their own right, they are not sufficient to support objective conclusions as to the role of public sector reform measures nor national-level policy deliberation of such sensitive and timely matters. This is particularly true as the health "landscape" evolves over time in response to Universal Coverage and other factors.[26]

3.3 Affordability

Affordability issues require greater attention: Affordability is an important, although far from the only, consideration underlying public sector employment policy. Concerns about wage bill expenditures, insurance costs and pensions liabilities are certainly among the factors underlying national employment restraints on civil service and government employee posts. Yet the affordability of proposed personnel measures -- whether hiring additional civil servants, raising wages of Temporary Employees to compensate for foregone pension and CSMBS benefits, or offering equivalent benefits - was rarely if ever mentioned explicitly by stakeholders.

At the level of individual facilities, those serving smaller populations receive correspondingly smaller funding from UC system, though this is somewhat mitigated by the Provincial Health Office's discretion to reallocate some funds across facilities in the province. Nevertheless, a number of interviewees suggested that such facilities – especially primary care facilities (known as Contracting Units for Primary Care, or CUPs) with a population under 20,000 -- had inadequate resources, which affected their ability to hire staff on Temporary Employee contracts. There was also mention of such smaller facilities incurring debts to purchase medical supplies.

The question of the current "weight" of personnel costs on facility budgets - including the extent to which it is affordable or crowds out other necessary expenditures -- remains in need of systematic analysis. Likewise, evaluation of overall fiscal impacts for the government budget

[25] Each university has a certain degree of flexibility to determine the premium for university employees.

[26] Among the reverberations of UC and the popularity of private insurance are expanded career options for health professionals who may, for example, work as administrators for insurance companies.

(and thus the feasibility) of measures that stakeholders suggested as means of mitigating recruitment and retention pressures, is yet to be done.

4. The Way Forward

Thailand's health human resources issues are influenced by many factors, including high-level decisions about health policy and, more broadly, the shape of the public sector as well as the manner in which such decisions are implemented. Furthermore, HRH dynamics vary with dimensions such as profession, geographic location, the nature of local labor markets, and the stage of an individual's career. In sum, the situation is complex, and not all issues can be addressed by HR-specific interventions.

The aim of this exploratory work is not to make policy recommendations but rather to suggest practical opportunities for moving forward. In this regard, two salient points emerged: first, stakeholders hold differing views about the nature of HR pressures/problems that flow from recent public sector reforms (as well as more generally) and appropriate solutions and (2) the evidence base for analyzing these issues in a systematic manner is incomplete.

The latter fact is recognized in Thailand's strategic plan for HRH, which includes among its strategies to "generate and manage knowledge and link evidence-based information to HRH policy development, strategic plan, implementation, monitoring and evaluation." The plan also recognizes a need to update and expand the analytical base, and "build the capacity of domestic researchers, administrators and concerned bodies."[27]

The text of this report has centered around three questions: What constitutes an appropriate HR complement; what are the recruitment and retention challenges; and what affordability issues arise from the present situation and proposed solutions. This section proposes analytical work that would contribute to disentangling the complex set of issues and dynamics at hand, divided broadly into diagnostic versus policy-focused work. To ensure that existing knowledge is taken into consideration and limit duplication of efforts, the proposed work would best be undertaken in close partnership with health sector experts in Thailand, with international support as appropriate (see "Approach" section below), with a stock-taking exercise at an early stage to incorporate any existing analysis on these issues. While our exploration of HRH issues was done through the specific lens of public sector reform impacts, much of the analytical work that is suggested below could, if appropriately designed, be used to shed light on the dynamics underlying Thailand's broader HRH concerns as well.

4.1 Diagnostic Work

1. Review of statistical and projections frameworks

MOPH data and projections tools may exclude certain HRH thereby presenting an incomplete picture of available resources and needs (a situation that is not uncommon in other countries). If that is indeed the case, to the extent that contract (TE) and private sector employment are expanding over time, the accuracy of these projections may be suffering. While a comprehensive information system has long been proposed, this is a resource-intensive undertaking and appears to be some way off.

[27] *The Strategic Plan for the Decade of National Human Resources for Health Development in Thailand (2007-2016)*. The National Human Resources for Health Strategic Plan Committee, Bangkok, 2007.

To fill the gap, a review would assess the current coverage of principal databases and projections tools, as well as identify practical opportunities for near-term improvements, whether by integrating data holdings from other organizations, undertaking new data-gathering efforts, or other methods.

2. *Actionable monitoring indicators*

While recruitment and retention are major issues, commonly used HRH indicators (e.g. ratios of doctors per 1,000 population) are too aggregated and slow-moving to pinpoint trouble spots, suggest responses, or track progress in a timely fashion.

In response to similar diagnostic challenges internationally, recent years have seen growing interest by public sector reform advocates in the use of "actionable indicators" that are narrowly-focused enough to provide specific evidence over short time frames and thus enable policy-makers to better target responses. Such indicators have been described as the "missing middle", in between measures of inputs and outputs on one end, and highly aggregated outcome measures on the other.[28] Specific to human resource management, an existing World Bank diagnostic tool (the Human Resource Management Actionable Governance Indicators questionnaire) includes indicators that could be adapted to Thailand.

Development of monitoring indicators for Thailand's HRH would entail working with partners to select indicators of interest (e.g. retention rates, turnover rates, vacancy rates, number of qualified applicants per advertised job opening, wage bill as percent of facility expenditures); agree a consistent methodology and the dimensions to be covered; design an implementation strategy; and field-test and generate baseline indicators. [29]

3. Probing staff perspectives: surveys and qualitative research

As a complement to the above records-based indicators, surveys of staff would gather systematic empirical evidence about the factors driving turnover, from the individual worker's perspective, as well as gathering related information (e.g. suggestions of or assessments of retention tools). Information might be gathered through a short, standardized questionnaire for departing staff or exit interviews (used on an ongoing basis.)

Going a step further, qualitative research via focus group discussions and in-depth interviews would be a source of more nuanced information about the staff motivations, factors driving turnover, potential incentives that would attract or retain staff in remote or hard-to-fill positions, as well as ways to re-think service delivery.[30]

---

[28] *Human Resource Management Actionable Governance Indicators Instrument Development*, PowerPoint presentation by Gary J. Reid, Lead Public Sector Management Specialist, The World Bank. January 6, 2009. For more information on actionable indicators, see http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPUBLICSECTORANDGOVERNANCE/0,,contentMDK:21530146~menuPK:286310~pagePK:148956~piPK:216618~theSitePK:286305,00.html

[29] Dimensions would include type of position, employment status of jobholder or position, stage of career, reasons for vacancy or turnover, facility type and urban/rural setting. The implementation strategy would consider effective use of pilots, a "sentinel surveillance" system in selected facilities, and broader-based data gathering.

[30] Similar work conducted in Lao PDR in 2009 yielded valuable insights into these issues.

4.2 Policy-focused analysis

4. *Modes of service delivery*

As suggested by some stakeholders, there appears to be room to undertake functional analysis of the current workings of MOPH services, and the scope and specific opportunities for modifying modes of service delivery (e.g. revising professional roles, contracting out, partnerships, lessons from private facilities' work practices).[31] This is a complex task that would include estimating impacts on staff numbers, skills needs, and costs over time.

One input to such deliberations might be an analysis of current staff utilization patterns that would probe the current allocation of staff time, with a view to identifying opportunities for more effective distribution of tasks (for example, shifting administrative tasks along the professional hierarchy to allow clinicians more time with patients.) Two possible tools are (1) a questionnaire that asks staff to self-report the tasks and time spent in a given period. This would be relatively quick and inexpensive, though subject to reporting error; and (2) an observational study in which a team of expert observers records tasks and time spent by staff over a given period. While more resource-intensive, this could also probe more technical questions such as whether clinical tasks are in practice assigned to the best level of professional.

5. *Evaluation of ongoing initiatives*

Initiatives such as Khon Kaen's community nursing program hold valuable insights for Thailand's health sector as well as other countries, whose uptake would be facilitated by robust evaluation and dissemination. Subject to interest by project directors, a review of evaluation methods would ensure an effective methodology for assessing impacts on staffing, service utilization, health outcomes and cost.

6. *Analyzing compensation*

Although pay issues generally figure prominently among HRH concerns, comprehensive analysis of the total compensation package available to different categories of staff across employment spheres appears to be lacking. This makes it difficult to evaluate the extent to which compensation differentials may play a role in personnel dynamics.

Going beyond our focus on public sector reform impacts, additional compensation-related issues mentioned were: (1) Health workers in other arms of the public sector (notably the University system, which is regulated separately from the "ordinary" civil servants who are under OCSC) reportedly earn higher wages than in the MOPH system, with resulting inequities in salaries for similar jobs within the public sector; and (2) private sector posts particularly for medical doctors are better-remunerated than in MOPH system. While these reported differentials are not a result of UC or rightsizing, any analysis of compensation would do well to include all relevant concerns so as to best feed in to policy deliberations.

A pay comparator analysis would address these earnings issues in detail (by position, employment sphere and contract type) and also probe opportunities for secondary employment and non-pecuniary benefits and factors such as work environment, job security and overall adequacy of compensation levels by profession. It could also probe issues around dual practice by professionals who work concurrently in public and private spheres. In order to yield robust findings, this work would require substantial effort and access to information. In particular, employers' consent to provide access to detailed compensation information (in exchange for a

[31] Functional and HR analyses that cover such issues have been conducted in other countries, for example Azerbaijan, Bosnia & Herzegovina, and Kyrgyzstan.

strict guarantee of confidentiality) would be critically important.

7. Modeling interventions and costs

Despite the fact that affordability is a fundamental issue for individual facilities as well as the health sector more generally, costing of HRH interventions tends to receive insufficient attention in many countries.[32] This seems to hold true in Thailand as well. Yet early-stage fiscal modeling of proposals is an important check on overall feasibility as well as the cost of specific design features.

Modeling might usefully be done for the measures mentioned in the course of our interviews, as well as interventions to be identified in future analytical work. These include design of a dedicated salary scale for health professionals; differentiated locality pay; increased salaries for Temporary Employees; pooling of facility resources to provide civil service style benefits to Temporary Employees; and matching salary scales offered by the University system.

4.3 Suggested Approach for Future Analytical Work

We suggest that any future analytical work would benefit from incorporating the following features.

First, an effective mode for undertaking the above work would rely upon ***close partnership between government and non-governmental health experts in Thailand, with targeted support by international bodies***. A number of entities in Thailand are already undertaking their own initiatives and have expressed a clear interest in collaborating with international organizations. Such partnership would combine international analytical and policy perspectives with the considerable expertise and in-depth national knowledge of Thai partners. It would also build upon existing knowledge and limit duplication of efforts by making effective use of the existing information base (much of which is held by diverse entities and available in Thai language only).

Equally important would be the adoption of an ***integrated perspective on HRH*** that encompasses all organizational and employment categories. Thus while existing information tends to be fragmented according to institutional or administrative boundaries, a comprehensive analytical approach would have within its sights not only MOPH's permanent employees but also health workers employed in other spheres, and take into account all funding sources, employment categories and professions. While this expanded perspective poses challenges, it would provide a more comprehensive picture of Thailand's HRH, thereby improving the evidence base for policy-making.

A third feature would be the use of ***a variety of analytical tools***, including one-off or periodic studies as well as ongoing monitoring mechanisms that gather empirical evidence to support and inform policy. The latter might include pilots, a "sentinel surveillance" system that collects information from selected facilities, or more comprehensive information gathering.

[32] A WHO presentation at the November 2009 conference in Vietnam described cost as "a neglected policy element" even though countries generally have limited financial resources, and cost considerations are important factors in persuading policymakers as well as conducting robust evaluations.

5. Conclusion

Human resources are at the heart of health sector and, in Thailand as elsewhere, questions about how best to utilize personnel form a rich and complex agenda. Ongoing nation-wide public sector reforms in Thailand – Universal Health Coverage and rightsizing restraints on certain categories of publicly funded employment – are among an array of factors affecting health sector human resources. However, the differing perspectives of stakeholders and recognized shortage of systematic evidence suggest that a robust assessment of impacts requires further systematic analysis in a number of areas. Adopting an approach that encompasses to the extent possible the full spectrum of health sector workers, employers, and HR issues will help facilitate a comprehensive response to HR concerns.

Annex 1 Overview of Public Sector Reforms affecting Human Resources in Health[33]

(Extract from terms of reference)

Introduction

Recent years have seen the introduction of a range of important cross-government reforms, including civil service, decentralization, and autonomization reforms. Although these reforms are implemented across government units, some of them have peculiar implications for the health sector.

Rightsizing Civil Service Reforms. Although the inefficiency and ineffectiveness of the Thai civil service had been noted by the public for a long time, efforts to reform the civil service only began in earnest in 1997, with the Civil Service Reform Master Plan 1997-2001. One of the key elements of the master plan is to right-size the civil service work force and/or to increase the capacity of the work force. During the first 3-4 years of the plan, efforts were made to reduce the number of government officials, largely by not replacing retired civil servants with new staff during those years.[34] Additionally, there are initiatives to hire new staff as government contract employees, and to turn some government units into autonomous public organizations (APO) – a form of government-owned, autonomous, non-profit organization. By early 2000s, efforts to reduce the number of government officials discontinued, and the government has pursued the policy to freeze (not increase and not decrease) the number of government officials since then.[35]

The purpose of the government's policy not to decrease or increase the number of government officials is to make the Thai civil service lean and more efficient. Although these efforts may work well with several ministries, the policy unfortunately has adverse effects on the health sector. The period that the government decided to freeze the number of government officials coincided with the introduction of universal health coverage – a landmark health sector reform for Thailand, which allows almost all Thai citizens to benefit from public health insurance schemes. The Universal Health Coverage (UC) scheme alone provides health insurance for about 75% of the Thai population. This is in addition to the two other public health insurance schemes that existed before – Social Security Scheme (SSS) and Civil Service Medical Benefits Scheme (CSMBS).

Most contracting health facilities under the UC scheme are government/public health facilities. The utilization rate of these facilities has increased significantly since 2001, leading to higher service pressures, and the need for more health personnel. Nevertheless, per the rightsizing civil service reform, the majority of new health-related positions (with the exception of doctors)[36] at public health facilities in recent years cannot be hired as government officials (civil servants), but as government's contracted employees. Unlike government officials, the contracted employees do not have job security, clear career path, and is not entitled to CSMBS and government pension.[37]

---

[33] The World Bank would like to thank Dr. Suwit Wibulpolprasert, Dr. Somsak Chunharas, Dr. Supan Srithamma, Professor Supachai Yavaprabhas, Dr. Jaruayporn Srisasalux, and civil workforce team at the Office of Civil Service Commission for providing valuable inputs to this TOR.

[34] Minutes of the meeting of Civil Service Reform Committee on 16 February 1998 (2/2541), chaired by Deputy Prime Minister Pichai Ratakul, and vice-chaired by Mr. Apisit Vejjacheeva, Minister to the Prime Minister's Office. Cabinet Resolution on 28 April 1998 on Civil Service System Reform.

[35] Cabinet Resolution on 27 June 2006 on Rightsizing Civil Workforce Strategy 2006-2008.

[36] This civil service reform does not affect doctors due to a combination of (i) lack of doctors in rural areas, and (ii) powerful lobbying from doctors' group.

[37] Government contracted employees are entitled to social security scheme benefits, which are significantly lower than benefits for civil servants.

The rightsizing civil workforce policy has started to show negative impacts on health workers at provincial level, particularly in terms of recruitment, work morale, and retention. For example, nationally, 21% of new nurse graduates decide not to work for MOPH. In some parts of northern Thailand, 60-70% of new nurse graduates decide not to work for MOPH. However, in southernmost region, where new nurses get civil service status, only 7% of new graduates from that region decide not to work for MOPH (despite problems of insurgency in this region). A field visit to district hospitals in Ubon Ratchathani province indicates that morales of health staff with the "contract" status are negatively affected; "contract" status is often seen as "second-class". Without job security and benefits that come with civil service status and with low salary, there are fears that many health staff may not be motivated to work in government facilities in the long term. They may work in government facilities for one or two years, and, after gaining some experience, leave for private sector, which provide significantly higher salary - resulting in internal brain-drain. In summary, with the current "contract" benefits and salary, it is very difficult to get motivated, high-caliber health workforce to work for the public sector in the long term. The rapid development of a medical services export industry and the growth of private health sector due to growing domestic demand from the Thai middle class only worsens the problem.

Decentralization reforms. Decentralization reforms were initiated at the turn of the century in response to the 1997 Constitution of Thailand. Drafted in a period marked by the popularity of "grass-root democracy" and "participatory" approach, the 1997 Constitution aims to promote the decentralization of powers to localities and development of local economies, public utilities, public facilities as well as information infrastructure in the localities thoroughly and equally throughout the country. The main purpose of the reforms is to enable localities to achieve self-reliance and self-determination of local affairs.[38]

Along the line of the 1997 Constitution, the Thai Parliament passed in 1999 a piece of legislation – Plans and Process for Decentralization to Local Administrative Organizations Act – calling for Thailand's government's ministries, including the Ministry of Public Health (MOPH) to develop action plans for the decentralization of functions, resources and staff to elected Local Administrative Organizations (LAOs) by 2010. The decentralization reform not only leads to the transfer of at least 25% of government's revenues to local governments, but also a gradual devolution of health centers (HCs) to local authorities. As of December 2009, 28 HCs out of over 9,000 HCs in Thailand have been devolved to Tambon Administrative Organization (TAO) and municipalities.[39]

Autonomization reforms. The 1997 economic crisis launched reform ideas for public institutions and policies in social sectors supported by the ADB social sector reform loan. Autonomization of public hospitals was part of the social reform package. The 1999 Act of Autonomous Public Organizations (APO) provided an enabling environment for reform. The main objective of the reform was better responsiveness of health care providers to local communities and to allow more flexibility in management instead of rigid central bureaucratic and financial controls.

Ban Phaeo Hospital in Samut Sakorn province was selected as a pilot governmental unit providing medical and public health services to undergo the reform. Ban Phaeo Hospital was a 200-bed MOPH district hospital in 1999 at the time the decision was made to convert it into an

[38] Section 78, the Constitution of the Kingdom of Thailand of 1997.

[39] Tambon is a local government unit in Thailand. Below district and province, Tambon forms the third administrative subdivision level. A Tambon consists of around 5-15 villages. A typical Tambon has a population of 5,000-10,000.

APO – a form of government-owned, autonomous, non-profit organization. It is now a 300-bed hospital offering services at primary and secondary level, with some tertiary level services. It is seeking to upgrade its status to that of a general hospital. The Ban Phaeo APO hospital has been highly successful in increasing the outputs, range of services, and turnover of the hospital, as has been documented in a series of before-after evaluation studies.[40]

However, Ban Phaeo Hospital is the only APO hospital to date. Further roll-out was stalled because of the lack of support from MOPH leadership (the hospital autonomization initiative was originally advocated by the Office of the Prime Minister, not MOPH), political concerns about "privatization," implementation difficulties in particular about changing the way public finances were managed, and resistance by civil servants whose employment conditions were to change. More recently, the Commission on Public Sector Development and the Cabinet have halted any further creation of APOs. This decision was taken in response to cases in which some of the many non-health-sector APOs established in the 2002-2005 period have performed poorly and run into financial difficulty. Boards of these APOs outside the health sector in some instances have been criticized for awarding themselves high remuneration, relative to the duties performed.[41] The government's policy and future direction on hospital autonomization remains unclear.

[40] Loraine Hawkins, Jaruayporn Srisasalux, and Sutayut Osornprasop, "Devolution of health centers and hospital autonomy in Thailand: A Rapid Assessment", Report from HSRI and World Bank, April 2009.
[41] Ibid.

Annex 2 Civilian Government Workforce and Employment Categories

Data published by the Office of the Civil Service Commission (OCSC) cover five major types of civilian government staff.[42] The following descriptions of each category are based on discussion with OCSC staff and other officials.

1. *Government Officials*: In the central and provincial administration, these are divided into: ordinary civil servants (including many health sector positions), royal household civil officials, teachers and education personnel, university officials, legislative body officials, police officials, public prosecutors, judges, and autonomous organization officials. Ordinary civil servants (often called simply civil servants) are regulated by the 2008 Civil Service Act, which specifies the institutional framework and terms of employment (including recruitment, transfers, discipline, monetary compensation and benefits). Ordinary civil servants participate in the Civil Service Medical Benefits Scheme (CSMBS) and the government pension scheme. Numbers of civil service posts are capped at the central level via process in which OCSC plays an important role. In local administration, there are 4 sub-categories of government officials: Bangkok Metropolitan Administration officials, provincial administrative organization officials, sub-district (Tambon) administrative officials and municipal officials.

2. *Permanent Employees:* Largely blue-collar service positions such as janitors, cooks, gardeners and security guards. There are plans to phase out this category and outsource these services instead. Existing staff will be allowed to serve out their careers.

3. *Temporary Employee and Local Temporary Employee:* Hired on short-term contracts that must be renewed periodically.[43] These may include lower-ranking jobs as well as professional positions. In the health sector, some hospitals hire nurses and other health care workers as temporary employees, with salary costs funded fully from hospital revenues rather than the central budget.[44] Temporary employees are not entitled to the CSMBS or government pension, and there is no centrally set cap on numbers of posts. Temporary employees are entitled to Social Security Scheme's membership and benefits.

4. *Government Employees:* Includes job functions similar to the civil service. Individuals are hired on limited term contracts (e.g. four years). This category is not entitled to CSMBS or government pension, but can enroll in the Social Security Scheme (a combination of pension, health insurance and other benefits that is considered less attractive than CSMBS). Personnel costs are funded from the central budget, and numbers of posts are subject to a centrally set cap. This category reportedly offers little career mobility; individuals remain in the same type of position into which they are hired.

[42] For each fiscal year, the OCSC issues two English-language reports on government employment: *Civilian Workforce in Thailand* and *Ordinary Civil Servants in Thailand*, available at www.ocsc.go.th. The most recent available year is 2008.

[43] MOPH regulations for Temporary Employees also regulate the employment terms and conditions of "hourly-based workers", including health care professionals.

[44] Interview with Dr. Sriphan Srithamma, 16 February 2010. Unlike MOPH, other ministries may use central budget to finance personnel costs of temporary employees.

Annex 3 Selected Provisions of the 2008 Civil Service Act[45]

Thailand's 2008 Civil Service Act stipulates the roles of the Civil Service Commission (CSC) and Office of the Civil Service Commission (OCSC), and framework principles governing the civil service workforce. It thus applies to civil servants working within the Ministry of Public Health system, and to the Ministry's management of its civil service workforce, though not directly to other categories of employees (temporary employees, government employees, and permanent employees).

Provisions relevant to the issues discussed in this note include the following.

Article 8: The powers and duties of the CSC include making proposals to and advising the Council of Ministers on human resources policy and strategy related to remuneration; approving the "manpower framework" of government agencies; developing policies and rules regarding scholarships.

Article 13: The OCSC reports directly to the Prime Minister. Its duties include monitoring and evaluating human resource management and manpower planning.

Articles 14-20: There is a tiered structure of Civil Service Sub-Commissions (CSSC) that serve as human resource management (HRM) bodies at different levels of government, including within each ministry, department, and province. CSC regulations determine the structure and authority of these CSSCs.

The ministry-level CSSC's powers and duties include formulating policies for HR management of the ministry's staff, consistent with CSC policy; staffing distribution among its constituent agencies; disciplinary proceedings; and other functions assigned by the CSC. The CSSC is chaired by the relevant minister, with the permanent-secretary as vice chair and includes not more than 8 other members plus an OCSC representative.

A similar arrangement is in place at department level, with the director-general (DG) chairing, a deputy director general designated by the DG serving as vice chair, and no more than 9 other members. The powers and duties are analogous to those of the ministry-level CSSC.

The provincial governor chairs the province-level CSSC, with a designated deputy governor as vice chair and no more than 9 other members. The duties listed for the provincial CSSC include formulating guidelines for HRM, disciplinary proceedings, and other duties assigned by the ministry, department, or the CSC, but do not explicitly include staffing distribution.

Articles 37-38 and 41: CSC regulates salaries and allowances, including supplementary allowances (for posts abroad, in specific areas, in certain classes or posts otherwise requiring special treatment), with approval by the Ministry of Finance. "Temporary subsistence allowances" are set by Council of Ministers. There is a general reference to civil service benefits and pensions, which are governed by separate laws.

Article 50 assigns the CSC responsibility for regulating salary scales and "position allowances", which are not counted towards pension entitlements. The Council of Ministers approves "adjustments" to salary and allowances, while changes of not more than 10% can be approved via royal decree.

[45] Unofficial English language translation

Articles 45-46: The grading system is composed of 4 categories, each divided into 2 or more levels, with salary and allowances regulated by an annex to the act. Allowances are excluded from calculation of pension benefits. The grading structure is:

- Executive (primary and higher level)
- Managerial (primary and higher level)
- Knowledge worker (practitioner, professional, senior professional, expert and advisory)
- General (operational, experienced, senior, and highly skilled).

Articles 47 and 48 assign each ministry's CSSC authority to determine the number of civil service positions in specific bodies, as well as the category and level of those positions. This is to be done in accordance with CSC procedures and guidelines for classifying positions (and assigning job titles) to ensure consistency.

Articles 52-71 govern recruitment, hiring, appointments and transfers. Recruitment is generally by competitive examinations (with CSC regulating the process) although ministries, departments and "supervising officials" may make exceptions.

Article 57 stipulates in detail which officials have authority to instate and appoint candidates to each of the categories / levels. For the bulk of positions within ministries, this authority is as follows:

- Permanent secretary: executive (primary level), managerial (higher level) and knowledge worker (expert level) positions.
- Director general, with approval by the permanent secretary: managerial (primary level), knowledge worker (senior professional level) and general (highly skilled) positions
- Director general: knowledge worker (practitioner, professional)
- Minister: managerial, knowledge (practitioner, professional, senior professional and expert) and general positions in the office of the minister

Civil servants in the executive category are to be rotated after 4 years, although exceptions can be made. CSC regulations govern relocation, transfer and cross-appointments.

Annex 4 Allocation of Posts and Staff

Under Thailand's "zero growth" public employment policy, the overall number of approved civil service posts nation-wide, and their allocation across sectors, is centrally-managed via a Public Workforce Determination Committee chaired by the Deputy Prime Minister (with membership including the OCSC, OPDC, Bureau of Budget, and Ministry of Finance). There is also a series of Sub-commissions on Workforce Determination.[46] The overall number of "Government Employee" posts is also regulated at the national level by a separate committee process.

When individual civil servants retire, their posts revert to a national-level pool and may be reallocated (returned to the same Ministry, transferred to another Ministry, or cancelled completely) depending upon perceived needs. The Ministry of Public Health generally has its retired posts returned to it; as a result, from 2005-2008, the number of approved civil service posts in the Ministry remained stable at between 179,000 and 180,000.[47]

For the health sector, the Ministry of Public Health in Bangkok decides the allocation of civil service posts across provinces according to its priorities. For example, the southern provinces that are grappling with civil unrest are understood to have priority for allocation of civil service posts. The office of the Permanent Secretary plays an influential role in human resources decisions, since 89% of the Ministry's civil service staff (151,061 out of 169,044 persons in 2008) is administratively mapped to it.[48] Previously, converting authorized posts across professional categories (e.g. from medical doctor to nurse) required OCSC input, but with the passage of the 2008 Civil Service Act, sectors may make such decisions themselves.

While province-level practices may differ, the Provincial Health Office (PHO) appears to play a prominent role in allocation of civil service posts. For example, in Mae Hong Son province, a "retired" civil service post that is returned via the national-level process does not automatically remain with the original facility; the PHO may instead allocate it to a different location.

MOPH and PHOs are also involved in the filling of job openings for civil service as well as temporary employee categories. Graduating medical doctors (who are required to serve in the public system for three years and automatically receive civil service status upon hiring) are matched with vacancies via a national-level process that takes place each spring.[49] Individuals are asked to specify their preferred location; given the general preference for large urban settings over remote or rural facilities, some vacancies have no applicants while others have several. In such cases, individuals are matched to jobs via a centrally run lottery. PHO approval is formally required for medical doctors who wish to move to other positions in the MOPH system once they have fulfilled their three year commitment, though one Chief Provincial Medical Officer described this as a formality given the perceived risk that a doctor might resign from the MOPH system if approval is not granted.

---

[46] There are 19 sub-commissions on workforce determination, with representatives of OCSC and each Ministry except Ministry of Defense, attached to each Ministry. These sub-commissions are not under the committee chaired by Deputy PM, but follow the policy made by the committee.)

[47] Data from OCSC's annual publication "Ordinary Civil Servants in Thailand".

[48] The difference between official posts and actual staff reportedly reflects factors such as posts that are temporarily vacant while waiting to be filled by new hires, and posts that are left vacant so that a filled position can be moved up in grade without exceeding limits on the wage bill budget.

[49] A national-level process allocated graduates across arms of the public sector, including MOPH, Ministry of Defense, Police etc.

In contrast, nursing graduates do not automatically receive civil service status when hired into the MOPH system, and are not subject to a legal service requirement. However, the process of admission to study in MOPH nursing colleges (under a "quota" of slots that is administered by the PHO) and the practice of awarding publicly-funded scholarships for study results in what interviewees described as a "social contract" to work within MOPH facilities for some time after graduation. Additional factors that attract new graduates to the public system are the prospect of eventually receiving civil service status, and the fact that private hospitals prefer to hire nurses with at least 1-2 years experience rather than new graduates. Civil service status is seen as appealing not only for the perceived job stability, but also because it entitles employees as well as their families (including parents, whose wishes carry considerable weight in young people's career decisions) to the Civil Service Medical Benefits Scheme.

Songkhla province provides an example of a province-level process for allocating new graduates to posts:[50]

> In February, the PHO informs hospitals about the number of scholarship graduates expected for that year (nurses, medical doctors, dentists, etc), and checks on any changes in distribution of current staff. The Provincial Chief Medical Officer then chairs a meeting attended by all heads of hospitals and district health officers to decide how many graduates from each profession will be allocated to each facility. The committee considers factors such as the GIS projections[51], population, workload, and number of patients. Additional, lower-priority considerations include the financial status of the hospital as well as its level (primary, secondary or tertiary). All new graduates are then called to attend the next meeting to be matched with facilities.
>
> Even if a facility is hiring a temporary employee nurse - a category that, formally at least, may be hired at the facility's discretion since there are no national-level hiring restrictions and salary costs are funded from facility-managed revenues - as long as they plan to hire a new graduate the request goes through this process since PHO is in charge of matching graduates to posts. However, in the case of applicants from a non-MOPH facility (e.g. a private hospital) the hospital can hire directly, without PHO approval.
>
> If a Temporary Employee nurse resigns from one facility in the MOPH system, s/he must wait for one year before joining another one, even if the resignation is due to reasons such as family relocation, and even if the previous employer is supportive. This is reportedly done to avoid excessive turnover among staff.

In Songkhla as well as Mae Hong Son provinces, interviewees spoke of a "family" approach to managing allocation of staff, in order to minimize difficulties faced by individual facilities. The

[50] In contrast to the process described here, recruitment of staff other than medical doctors, dentists, nurses and other scholarship graduates appears to be more fully in the hands of facilities.

[51] Interviewees used "GIS" as shorthand to refer to target staffing projections that are prepared by staff in the Personnel Planning Unit of the Bureau of Policy and Strategy (under MOPH). According to Bureau staff, projections are prepared using four methods (population ratios, health need, demand need, and service targets) and generate detailed descriptive reports (available on the Bureau's Thai-language website) including the extent to which locations exceed or fall short of these targets, and distribution maps from a geographic information system. Data cover only the MOPH system (not other public providers such as those under the Bangkok Metropolitan Authority) and reportedly exclude temporary employees and possibly the "government employee" category as well.

PHOs also have authority to adjust the allocation of UC funds to any given facility by up to 10%, which supports this approach.

Annex 5 Compensation of Health Care Workers in the MOPH System

Responsibility for the compensation of civil servants rests with the Civil Service Commission (with approval by the Bureau of Budget/ Ministry of Finance), with the OCSC managing the mechanics of the compensation system for civil servants as well as government employees.[52] A Ministry of Public Health regulation governs compensation of temporary employees within the MOPH system.[53] Government Employee salaries are regulated in a manner similar to civil servants, but with additional payments added in lieu of CSMBS, and an employer contribution toward pension coverage. Government Employees receive health and pension benefits through the social security scheme. Health workers in public sector entities that fall under different employment regimes – such as hospitals within the University system – are covered by the corresponding compensation system.

A new civil service pay system that moves away from fixed grades in favor of more flexible bands has recently been designed and is in its first years of implementation. OCSC is also considering the feasibility of introducing a dedicated salary scale for health care workers.

Allowances include a position allowance that is paid to individuals at or above grade C7 or its equivalent in the new system; a living maintenance allowance paid to civil servants, permanent employees and government employees who earn less than 11,700 baht, up to a maximum of 1,500 baht; a remote area allowance (paid to medical doctors, dentists, pharmacists, nurses and some other professional staff at highly differentiated rates), and a non-private practice allowance for some professionals.[54] Staff also earn overtime and some may also receive additional remuneration for particular aspects of their work[55]

Pension, insurance and in-kind benefits

Civil Servants are enrolled in the Civil Service Medical Benefits Scheme (CSMBS) that provides coverage to the individual as well as his/her family (including parents), and the government pension system. Government Employees do not receive CSMBS but can enroll in a Social Security Scheme (SSS) that combines health, pension and other benefits. Hospitals may also offer accommodation in hospital-owned housing, and commonly organize social activities for staff (group trips, exercise, social events)

Financing of personnel costs

For civil servants, government employees and permanent employees, base salary, position allowance, and living maintenance allowance are paid from MOPH central budget, while the non-private practice allowance, remote areas allowance, and overtime are paid from the facility's own budget. Compensation of temporary employees is funded fully from the facility's budget.

[52] The 2008 Civil Service Act establishes the CSC's responsibility for the civil service compensation framework.

[53] Ministerial Regulation on Criteria, Methods, and Conditions to Use Hospital Own Revenue to Pay for Salary of Temporary Employees under the Ministry, 2002.

[54] Sample payroll data obtained in February 2010 show a remote areas allowance of 50,000 baht/month for doctors and dentists, 14,000 for pharmacists, and 3,000-4,500 for registered nurses, with smaller amounts paid to some other jobs; and a non-private practice allowance of 10,000 baht/month for doctors and dentists and 5,000 baht for pharmacists.

[55] For example, nurses are said to receive additional payments for caring for high-risk patients or patients enrolled in the SSS.

Earnings in practice

Table 1 (below) presents examples of earnings for selected positions in a district hospital. These data are indicative only and, due to a number of limitations, should not be used to draw broad conclusions regarding the relative earnings of different employment categories nor professional groups.[56] For example, average earnings for each job includes individuals with varied lengths of service and levels of educational attainment; it is likely that civil service nurses have more experience and credentials than temporary employee nurses, who are more likely to be relatively recent hires. Despite these caveats, the table presents a sketch of how earnings regulations translate into practice, and illustrates the type of analysis that might be integrated into future work.

Table 1: Monthly Earnings by Position in a District Hospital (2010)

			As % of total (may not sum to 100% due to rounding)			
Job Title, employment category and number of records	**Average total earnings, gross (Baht per month)**	**USD equivalent**	**Base salary**	**Position and living maintenance allowances**	**Non-private practice and remote area allowances**	**Overtime**
Medical Doctor, CS (2)	103,655	$3,141	21%	5%	58%	16%
Dentist, CS (2)	74,865	$2,269	20%	-	80%	-
Pharmacist, CS (2)	37,555	$1,138	38%	5%	51%	6%
Registered Nurse, CS (30)	27,076	$820	64%	4%	14%	17%
Registered Nurse, TE (2)	19,892	$603	50%	-	15%	35%
Technical Nurse, CS (2)	25,750	$780	78%	-	4%	19%
Public Health Specialist, CS (2)	27,345	$829	91%	-	9%	-
Medical Science Officer, CS (2)	26,630	$807	85%	-	4%	12%
Dental Officer, CS (3)	17,297	$524	95%	-	5%	-
Pharmaceuticals Officer, CS (2)	15,530	$471	82%	-	6%	12%
Administrative Officer, CS (3)	12,893	$391	84%	10%	6%	-
Patient Assistant, PE (7)	13,909	$421	88%	3%	-	9%
Patient Assistant, TE (16)	8,183	$248	79%	-	-	21%
Driver, PE (2)	16,895	$512	87%	-	-	13%
Kitchen Assistant, TE (3)	7,981	$242	74%	-	-	26%
Janitor, TE (5)	7,521	$228	76%	-	-	24%

Source: Hospital payroll data, World Bank calculations
Notes: CS indicates civil servants, TE temporary employees, and PE permanent employees.

[56] To preserve anonymity, the table presents averages only. Positions with fewer than two jobholders per employment category were excluded, as were incomplete or inconsistent records. In some cases, a record was incomplete because the individual works at and receives part of his/her earnings from this facility but receives MOPH-funded earnings from a different facility's payroll. Average earnings for doctors are biased upward due to inclusion of the hospital director's post, which receives a substantial position allowance. The hospital's payroll also includes some staff that work at an affiliated health center.

Annex 6 Nursing Education and Personnel Issues[57]

Nursing training

Around 50% of nursing graduates are educated in MOPH-run nursing colleges, while the other half graduate from public and private universities.

For several decades, all nursing students at MOPH nursing colleges received scholarships (covering tuition and part of dormitory costs) to study nursing in exchange for a commitment to work at MOPH hospitals (assigned at the start of studies) after graduation. Each province received its own quota of spots at MOPH nursing colleges.

Due to national policy restricting the number of civil service posts, MOPH scholarships for nursing students at MOPH colleges were discontinued in 2002. In that year, first-year nursing students at MOPH colleges needed to pay for their own tuition fees, and did not sign contracts to work with MOPH following graduation. However, those who had already received MOPH scholarships prior to 1999 (second to fourth year students in 1999) continued to receive scholarship till graduation.

Previous to 2002, all nursing students graduating from MOPH nursing colleges got civil service status upon joining an MOPH facility. Starting in 2002, civil service status was no longer awarded automatically; in 2005, no nurses graduating from MOPH colleges got civil service positions and were instead hired as temporary employees.

From 2002-2005, hiring policy was in flux. Many medical, dentistry, and pharmacy graduates were first hired as government employees upon graduation. Later, controversy arose about awarding doctors government employee status; one of the concerns was that these doctors would soon assume hospital director posts and would face problems commanding hospital staff who are CS. MOPH began to award civil service status to all doctors and dentists (using posts allocated to the ministry from the national pool of retired civil service positions); this also involved redistributing civil service posts across professional boundaries, i.e. the retirement of a nurse would return a civil service post to the pool that, when OCSC allocated it to MOPH, might be assigned to a medical doctor's position.

The approach to setting targets for nursing graduates has evolved over time. For example, in 1999, based on assessment that the total number of existing nurses (some 120,000) was adequate and the target for graduates was reduced. However, this did not take into account other factors such as the professional level (registered nurse versus technical nurse), age profile and retirement projections, which affected the abilities of the existing workforce and thus the need for new graduates.

Professional designations

In addition to registered nurses (a four year course of study), there is a lower-tier "practical nurse" designation that assists patients with basic care under the supervision of registered nurses (and cannot conduct work independently e.g. in health centers or communities since they are not

[57] Based on an interview with Dr. Krisada Sawaengdee, Deputy President of the Nursing Council.

licensed to provide certain types of care). Small numbers of practical nurses have been trained by a few university hospitals in the past; as of 2007 MOPH nursing colleges also train practical nurses. Minimum requirements for entry to the one-year program are a grade 9 education, though many high school graduates also apply; many applicants are former nurse's aides (a lower category of staff who do not work directly with patients). Practical nurses are hired as temporary employees and do not receive civil service status.

Previously, a Technical Nurse designation was also offered, to respond to a need for more nursing staff. The course of study was two years, after which graduates could work for four years (with civil service status) and then complete an additional two years of study to become registered nurses. However, the technical nurse designation was abolished.

Recruitment and retention considerations

Exit interviews are reportedly conducted with all nurses who leave the MOPH system. For nurses under the age of 30, main reasons for departure are wanting to change jobs (19%) and not receiving civil service status (7.4%). For nurses 30 years and older, the main reason was a reluctance to work shifts (65%).

The perceived importance of factors such as civil service status and compensation is influenced by a number of factors. The security offered by civil service status may be particularly important to nurses in remote or rural areas but less so in locations where there is competition with the private sector. In urban areas, financial compensation and workload are more important than CS positions. An illustration is the case of Banpong Hospital in a semi-urban setting in Ratchaburi province. Faced with five civil service openings, the hospital asked fourth year nursing students (who had previously done internships at the hospital) to apply, with the promise of immediate civil service status. However, the students reportedly thought the workload at the hospital was excessive and instead applied to Ban Paeo autonomous hospital in a nearby province, which offers salaries that are 20% higher than Ban Pong. Similarly, some nurses may choose to remain in a Temporary Employee job because it is close to family, rather than pursue a Civil Service job elsewhere.

Annex 7 Community Nursing and Other Initiatives

Community nursing initiative in Khon Kaen Province

Leaders of Nampong and Ubonrat district hospitals and Khon Kaen Regional Hospital are implementing a community nursing program that aims to have nurses worked directly in communities, helping community members not only with standard health care concerns but also engaging in health promotion activities and improving the quality of life and livelihoods via practices such as crop diversification and sustainable agriculture. This program recognizes that not everyone needs to go to a hospital for care, and that community-based health care and health promotion practices can alleviate crowding and over-utilization of hospitals that impair their effectiveness. The program's champions hope to provide access to a community nurse to all villages in three participating districts within the three years. They are engaging health center staff and sub-district administrations (Tambon) in this effort.

The program's principles differ from standard approaches in several ways. The program does not see to recruit the "best and the brightest" but rather individuals who can learn, are diligent, and are good community members. Since villagers know who fits this profile, they are involved in selecting students. Before candidates are accepted for studies, they spend time volunteering to ensure a good fit. During their studies, students meet regularly with program organizers to ensure that they stay on course and do not lose their community focus. The program aims to provide salary, incentives and career progression that is equivalent to that offered in the regular system. An important motivating factor for trainees and active staff is the respect of the communities that they serve. Program leaders noted that their hospitals see fewer patients from villages that are served by community nurses, since their health concerns are dealt with locally. They believed that in the medium-term, the program would lead to a reduced need for health personnel.

Collaborative Project to Increase Production of Rural Doctors (CPIRD)[58]

The CPIRD was launched in 1995, with Khon Kaen hospital and the Faculty of Medicine at Khon Kaen University serving as the first site. The project aims to increase opportunities for rural students to study medicine and in turn, to improve the distribution of doctors in rural areas, since participants work for three years in their hometowns after graduation. Thirteen medical schools participated in CPIRD, with 34 sites around Thailand and an estimated 900 graduates per year.

"3,000 Nurse Program" for Southern Provinces

As part of a "Southern Peace Policy", the government that took office after the 2006 coup d'etat launched a special campaign to recruit and train 3,000 nurses in the southern provinces that are affected by civil unrest. To avoid a possible loss of momentum, intake was concentrated into one year, with more relaxed admissions criteria. Applicants may have lower grade point averages and more diverse academic background than those in the regular admissions stream. Since the program is new and participants are still in the midst of their studies, its impact is difficult to evaluate. However, according to staff of Boromarajonani Nursing College in Songhkla province, the program met with great interest, driven in part by the prospect of attractive employment close to home, and the prestige and benefits of obtaining civil service status. At this early stage, instructors noted that differences in cultural, academic and linguistic backgrounds were challenges that needed to be overcome.

[58] Based on information from the Khon Kaen Hospital Medical Education Center.

Annex 8
Human Resource Management in Health Facilities under Local Administration Authority

In response to a decentralization drive launched after the adoption of the 1997 constitution, a small number of health centers have been transferred from the authority of the Ministry of Public Health to sub-districts (Tambon) and municipalities; hospitals have not been part of this process. As of the end of 2009, there were 28 such "devolved" health centers, out of over 9,000 health centers nation-wide. In addition, local governments exercise authority over facilities that they established or acquired (e.g. from private sector) that have never been part of the MOPH system.

This summary of personnel management within such facilities is based upon information in recent analyses by the World Bank and the Health Systems Research Institute.[59]

- Ministry of Interior sets national-level personnel policies for LAOs, with its province-level units developing supporting regulations. Ministry of Interior is responsible for enforcement of HR regulations, and disciplinary, grievance and dispute processes.

- LAO takes over MOPH responsibilities for employment and management of staff, namely hiring, promotion, rewards and discipline. Some LAO decisions, such as creating new permanent posts, require approval of the province-level administration.

- LAO employees are perceived to have tenure protection (difficult to dismiss) whereas contractors hired by the LAO can be terminated more easily

- LAOs have discretion regarding the degree of human resources authority they delegate to health centers.

- MOPH funds for salaries and benefits of "Government Officers" are transferred to the Ministry of Interior, which provides them to health centres as an earmarked grant. For staff who were previously in the MOPH system and transferred to facility employment, this mechanism will continue until they retire. These staff also retain their civil service pension and medical benefits scheme (CSMBS)

- New hires of the health centre are paid from LAO general revenues, and are not eligible for a civil service pension of CSMBS

- Staff who work for the health centre are eligible for annual bonus from the LAO, subject to regulations of Ministry of Interior's provincial administration (under the authority of the Provincial governor, who is appointed by the government). These bonuses can reportedly be as much as five times a worker's monthly salary.

- MOPH retains control over funds for staff training

[59] *Devolution of Health Centres and Hospital Autonomy in Thailand: A Rapid Assessment*. Health Systems Research Institute and World Bank (Lorraine Hawkins, Jaruayporn Srisasalux, Sutayut Osornprasop). Draft report. April 2009; and *Getting Committed Health Workers to the Underserved Areas: A Case Study of Health Decentralization Reform in Thailand*. Sutayut Osornprasop, World Bank. Unpublished paper, April 2009.

Annex 9 Health Care Worker Profiles and Perspectives

The following profiles are based upon individual interviews, small group discussions (in Thai, with 3-6 participants) and two panel interviews (English/Thai) held with health care professionals at district and provincial hospitals who were invited by hospital management to meet with the World Bank mission.[60]

Srisangwan Provincial Hospital in Mae Hong Son province, northern region

The city is in a mountainous region near the Burmese border. The area is considered remote because, although it is a short flight from Chiang Mai, by car the trip takes 5-6 hours on winding mountain roads.

Hospital director

After finishing high school in Bangkok and then graduating from medical school, he came to Mae Hong Son by choice (not via the lottery). He worked for 2 years and then spent 3 years training at a hospital in Chiang Mai. After that he returned to this hospital. He has been director of this hospital for 17 years, and is a specialist in obstetrics/gynecology.

Nurse 1

She is originally from Mae Hong Son and graduated from nursing college in the MOPH network with a certificate (at the time, bachelor's degrees were not offered). She has been head of the pediatric unit since 1980, has civil service status and will be retiring in 1-2 years. She joined this hospital after graduation and a few years later spent 4 months at a hospital in Bangkok to study pediatrics. She subsequently earned a bachelor's degree from a university via distance learning, and later earned a Master's in Public Administration through weekend study at a university in Chiang Mai. She is in charge of 12 nurses and 3 nurse's aides.

Nurse 2

She is from this district, and graduated in 2009 from a 4-year nursing program at Lampang Nursing College (under the 'quota' of spots managed by the Provincial Health Office). During high school, she spent 10 days interning at the hospital; she was rated well on the internship and also scored well on the entrance exam for nursing school. She was accepted to study under the "quota" administered by the PHO, and also received a scholarship from the PHO in her final year. She was hired as a Temporary Employee and currently works in the operating room. In future would like to do a 4-month specialist course in Bangkok. The hospital pays to send 1 nurse per year, and to be considered she needs 2-3 years experience. She plans to stay here and is confident that she will get Civil Service status one day.

Nurse 3

She is from this district and graduated in 2009 from Lampang Nursing College, which she attended under the quota for this province. She did not receive any government scholarships and is not formally obligated to work here, but feels a sense of duty to do so. She was hired on a Temporary Employee contract and works in the obstetrics department. After gaining more experience at this hospital she plans to specialize. She would not relocate just to get a civil service position, but in future when she has a family, she will move where her family is.

Nurse 4

[60] Interviewers were Pattara Leelahavarong and Roongnapa Khampang of the Health Intervention Assessment Program (HITAP, within Ministry of Public Health), Sutayut Osornprasop and Jana Orac.

She is from this area and graduate from a nearby nursing college in 2009. She plans to keep working for the next 3-4 years and then go back to school, maybe for a master's degree. Civil service status has good sides like CSMBS and more annual leave, but being a Temporary Employee also has positives – she can freely move anywhere.

Medical Doctor
She is from Chiang Rai province in the north, and graduated from medical school in Bangkok. She voluntarily chose to come to Mae Hong Son province for personal and professional reasons, rather than being assigned through the lottery. In the first round of the lottery, there were not enough people to fill positions here, so she got her choice. After working for some time she went to Chiang Mai to become an ear, nose and throat specialist and then returned in June 2008. She expects to be here for 2-3 more years and then to move closer to Chiang Rai or Chiang Mai. She wants to work in the public system rather than in the private sector. Clients in the public system are easier to deal with whereas in private hospitals they can be more demanding, though she has no personal experience working in a private hospital and doesn't know how the work is organized. The nurses here are good, and she would be happy to stay longer if, for example, she received subsidized plane tickets so that she could visit her family, since transportation is an issue here. If she were staying here longer, she would open a private clinic.

Khun Yuam District Hospital, Mae Hong Son Province
The hospital is in a mountainous rural area about 65 km away from Mae Hong Son city (a 90 minute drive on winding roads).

Hospital Director
He is from Bangkok and graduated from a well-known university there. He voluntarily chose to come to this area (rather than being assigned via the lottery), which he had visited on vacation previously. He worked at the provincial hospital for 1 year, and then spent 2 years at another hospital. In 2003 he was asked to become director of this hospital. He enjoys practicing medicine and treating people and is not interested in non-clinical posts such as being a Provincial Health Officer. The staff are nice and good to work with, the area is pleasant, with no pollution. He would like to stay, though he might move in a few years so that his young children can attend better quality schools. Local schools lack teaching staff, especially for certain subjects.

Head nurse
She graduated from a Lampang Nursing College (4 year program) in 1990. Her first job was at Lampang Hospital. She trained as a specialist in primary health care for 4 months at Chiang Mai University, to improve her knowledge so that she could open a private clinic. She expects to move to Chiang Mai at some point in the near future because of her children, one of whom is studying there now. Her younger child is in school in the area, and the quality of schools is not as good as in urban areas. If she didn't have to consider these family issues, she would be happy to stay here due to better quality of life and easier work conditions.

Nurse's Aide
She is from this province and has been working at this hospital for 7 months as a Temporary Employee. She works as a nurse's assistant in the delivery room and operating room. After high school, she completed a six-month course at Ramborreerak school and then worked at Ramborreerak hospital. She resigned from that hospital 2 years ago because her family moved. She saw a job opening advertised on this hospital's bulletin board and applied; there were eight applicants. She had an interview and took a practical test, coming in second place. Since she did not get the job, she went to work with her husband, who sells food nearby. A year later, the

hospital called and offered her a job as a nurse's assistant in the operating room. Her family was very pleased; she loves to work at the hospital, and is also able to spend time with her family. Even though she does not have civil service status, this is a dignified job and quite secure. She plans to work here for a long time, to build a house in the area and spend the rest of her life here. She is also interested in taking a course at the open university, for her own interest. Her family can get treated at the hospital without charge.

Nampong District Hospital, Khon Kaen province

Nurses with Temporary Employee status
All interviewees are from this district. Two were accepted to nursing school under the PHO quota. Two others received a scholarship from the TAO and then worked there for a year. The TAO promised that they would get CS status but they were hired as TEs because there were no CS positions available. The Nampong hospital director invited them to work at the hospital with the prospect that they would get CS status more quickly than at the TAO. Civil service status seems to be important to these interviewees. One said that if there were a CS position in another province, she would resign to go there and move back to Nampong afterwards. None of them want to work in a private hospital because they believe that they will only be hired for a few years and then let go because of the higher salary. Working in a public hospital, especially in a community hospital, would be good for their family and they like working with people in the community. All of the nurses plan to study further to get a specialist diploma so they can gain more knowledge and practical work. They also believed that it would be a better career path.

Four Civil Service nurses
Three of the four have worked in this hospital for 24, 9, and 12 years. The hospital provides accommodation for staff who are not from this district, subsidized meals, a bicycle for each community nurse, uniform, and also pays overtime for community nurses. They work here because most are from this area and they enjoy working with the community. They are able to made decisions themselves, independently of doctors, to design and plan their work and serve the community. Finally, community members appreciate them, which is satisfying. They believe that there is no difference in financial incentives for generalist nurses versus specialist nurses.

Khon Kaen Regional Hospital (KKH), Khon Kaen Province
The city's population is about 140,000, with a population of 1.7 million in the province.

Nurse
He graduated in 2006 with a B.A. in nursing from an MOPH nursing college, under the quota administered by the Provincial Health Office. The PHO assigned him to this hospital, which hired him as a Temporary Employee. When he joined, there were already 30-40 other nurses on Temporary Employee contracts here. Initially, he did not mind being a Temporary Employee since he got a higher starting salary than civil service nurses (14,000 baht versus 9,000). However, in 4 years his salary has only increased once, by 400 baht, whereas his friends who have civil service or government employee status get an annual increase. Earlier this year, 4 civil service nurse positions were advertised at this hospital, and over 90 nurses with Temporary Employee status applied. He had been told some time ago that he would have priority for any civil service openings, but this year MOPH issued an order canceling the priority of "quota" students. The 4 positions went to nurses who had graduated from Khon Kaen University and had more work experience than him. Now he is discouraged. He does not want to move to a district

hospital, although the chances of getting a CS post might be better there. He prefers to live in a city, and would like to move to another provincial hospital that offers better overtime

Two Nutritionists (one Temporary Employee, one Civil Servant)
The civil service nutritionist holds BA and MPH degrees. She worked as a Temporary Employee at a different hospital for 2 years and then joined this one, where she has worked for 9 years as a civil servant. Her main issue is that nutritionists are not recognized as a profession and does not get the respect that other health professionals (e.g. nurses) do. This also has financial implications: nurses get a 3,500 baht/month professional allowance, but she doesn't get a professional allowance. The fact that nutritionists are not recognized as a profession is the most de-motivating factor in her work. The Temporary Employee nutritionist has the same views about wanting professional recognition for nutritionists and feeling discouraged by its absence. She also is concerned that there are few CS positions for nutritionists. Neither of them intends to leave KKH any time soon

Three third-year nursing students from Khon Kaen Nursing college
One interviewee was admitted via the usual entrance system while two others entered as community nurses. They study in the same program and same classes. The 2 community nurses applied to the program via their school, which received an announcement from the hospital stating that students with a grade point average over 2.5 could apply for a scholarship to train as community nurses. About 50 students applied and 2 were selected. Prior to the selection process, all students interned at the hospital as nurse's assistants, and their performance was a factor in selection for the scholarship; they also needed to take national-level tests (the Anet and Onet). Students were selected from every district.

They are interested in working at a community hospital because they grew up in this district and want to work for their own people. Their families are proud that they are working in the community. They would like to be CS because it is secure, and their parents would have CSMBS benefits. Some remarked that the term "Temporary Employee" does not sound good and doesn't make them feel secure. Comparing TE and CS, they felt that a CS is higher status although they studied the same subjects and do the same level of practice work. If they work more than 10 years but cannot get CS status, some of them will find other options to get CS status.

They don't want to work in private hospitals because it is not secure. They don't need the higher salary, just enough money to live and community nurse positions provide that. Working in a private hospital is stressful because of the workload. They also don't believe that a private hospital would keep them permanently. Local people accept someone who works in a public hospital more than someone who works in a private hospital. Because they grew up in a rural area, working there suits them. They can look after their family, and they like the close-knit relationships of rural people. It is easier to work with people you know than with strangers. The cost of living is also higher in the city since you have to buy everything while in a rural area you can grow it.

Nurse, Temporary Employee status, Intensive Care Unit
She is from this province. After high school, she took an entrance exam and decided to study nursing, expecting to join a public hospital as a civil servant; she only learned that civil service status was restricted after she had started her studies. After graduation in 2008, she joined Khon Kaen Hospital as a Temporary Employee, along with 40+ other new nurses graduating from universities (not MOPH colleges) who joined in the same intake. To supplement her earnings, she also works as a part-time nurse at a private hospital. She said the starting salary of nurses in private hospitals is 16,000 baht/month plus an experience allowance (500 baht for 1 year, and an

additional 500 baht per year up to a maximum of 2,500 for 5 years and over), overtime and other payments. She would like to get CS status, mainly because of the job security. However, if a district hospital offered her a CS position right away, she would not accept because she does not want to live outside an urban area not to spend time commuting from the city. She is interested in Government Employee status since this seems to offer more job security. CS and GE nurses get a bonus of 1,600 baht per year but TE nurses do not. Her hopes for getting a CS position are low: there is a lot of competition, and other TE nurses at KKH have more seniority. She may go work at a private hospital in future. She likes working at KKH because of the family spirit among nurses, and the patients are not demanding. The downside of working at a private hospital is that patients are very demanding, resulting in a higher workload. Her TE contract is renewed every year, following the annual performance assessment. Nearly all TE nurses pass the assessment and their contracts are renewed.

Government Employee and Civil Service nurses
Both Government Employee nurses had been Temporary Employees before obtaining GE positions in 2007 and 2008. The GE benefits were not different from TE e.g. with respect to SSS and health benefits. On the other hand, the CS nurses thought that GEs had more job security since the employment contract is for 4 years, whereas TE contracts are for 1 year. If the government provides more CS positions, GEs will have first priority on the waiting list. CS nurses also said that short course specialist training is available to both CS and GE nurses and they receive equal consideration in selection; however, master degree programs have been limited for GEs due to government rules. Benefits include accommodation or rent subsidy (approx 1,400 baht/month) in case there are not enough hospital-owned housing; uniform; a fund to help staff families and life insurance.

Regarding what would help retain staff in the hospital, the most important factor for the GEs is obtaining CS status. They feel there is inequitable treatment of staff who do the same work but are CS, TE and GE. The opportunity to study for a specialization or a master's degree is also an important benefit, because Khon Kaen is a training center.

The hospital has multiple strategies to attract new graduates: advertising in nursing colleges and university faculties, posting announcements on the website, or sending information to nursing colleges. Since 2009 they have provided ?scholarship? top-up funds (30,000 baht/year) to attract graduate nurses and compete with the university hospital and private hospitals. However, the number of nurses who apply has been less than needed. GE nurses were surprised that, although the shortage of nurses is a well-known problem, government policy has not provided more CS posts for them. Some have resigned from the hospital because they could not wait to get CS status.

Natawee District Hospital, Songhkla Province, southern region
The hospital is about 60 kilometers away from the province's main city of Hat Yai, and serves a population of about 95,000.

Physiotherapist
She is from this area and has worked at this hospital for just over 1 year with the status of Government Employee. She moved back to the area after 4 years working at a private hospital in Bangkok because her father and rest of her family wanted her closer to home. She is the first physiotherapist to be hired by this hospital and is in charge of establishing the physiotherapy services, in contrast to Bangkok where she worked in a unit that was already up and running. She hopes to get civil service status in future.

Medical Technician
She is from this province and graduated from a university in southern Thailand. She has worked in this hospital for 2 ½ years, with Temporary Employee status. Immediately after graduating, she working in a non-profit hospital (operated by a private foundation) for 6 months, but she found the work environment too rushed and not pleasant, with too much pressure. There is not much difference between her income at the non-profit hospital versus here. She learned of the vacancy from a salesman who visited her previous workplace, and called the laboratory technician here to learn more and meet face to face. There were no other applicants for the job. She also had a job offer (with Government Employee status) from a facility in the north of the province, about 120 km away, but chose to accept the Temporary Employee post which is only 20 km from her home.

Nurse 1
She is from a town 7 km away, and has been working at this facility for 10 months with Temporary Employee status. She chose this hospital because they needed a lot of nurses, and it is a border hospital with priority to get civil service posts.[61] She would not move to another workplace simply to get civil service status because she likes this hospital. Under Provincial Health Office rules, if she is awarded Civil Service or Government Employee status she will be required to work here 4 years before being allowed to consider other workplaces. She doesn't want to work in the private sector because her family wants her to serve the greater good. She learned of this vacancy after graduating, when she went to the PHO for orientation.

Nurse 2
She is from Hat Yai, and graduated from Songhkla Nursing College. She has been working here as a Temporary Employee for 11 months. PHO did not promise that she would get Civil Service status, but she knows that provinces in the south of Thailand have priority for receiving Civil Service posts. She received a government scholarship to study nursing, but there is no punishment if she chooses not to work for the Ministry of Public Health system afterwards. There are posts in Hat Yai General Hospital, but she's not interested at present. She didn't consider private hospitals because she thinks the government system is better; she might consider working for a private facility when she is older.

Nurse 3
She is from a town about 40 km away from this facility, and graduated 3 years ago. Her first job was working at Hat Yai hospital, where she stayed for 1 month only. Then the PHO suggested that she work for a community hospital and she chose this one. She was hired as a Temporary Employee but received civil service status after only 6 months on the job; some of her friends from her graduating class who work elsewhere are still on Temporary Employee contracts. She has another friend here who received Civil Service status a bit sooner than she did, but she had been working here longer.

Nurse 4
He is from a town 70 km from this facility and graduated from Songkla Nursing College 2 years ago. After graduation he had two offers, one to teach at the College and another to work here. He wanted to accept the teaching position but his family wanted him to work as a nurse. He came here because it has priority for Civil Service status; if he were a teacher it would take longer. He did not have a PHO scholarship, but studied under the "quota" from the Medical Services

[61] In preparation for expanding the facility, this hospital recently hired 12 new nurses; the nurses interviewed were from this intake.

Department of MOPH. He wouldn't want to work in Bangkok because it is too busy and rushed. His contract says that he may get Civil Service status "depending upon procedure" but it does not explain what that procedure is.

When asked why Civil Service status was such an important factor in their consideration, the interviewees at this hospital gave the following answers:

- Civil service status offers job security, and the family is proud to have a member serving in the civil service (Nurse 4)
- She wants to have the CSMBS for her parents' sake. She wanted to do further studies, but her mother wanted to get CSMBS so she started working instead. (Nurse 3)
- CSMBS for her parents. (Nurse 2)
- CSMBS for her parents, and job security (Nurse 1)
- Security. Her family is proud to have a civil servant, and believes that they are treated with more respect that "ordinary" people. CSMBS is also a consideration.
- CSMBS is a major benefit. She was covered by the SSS in the past but then she changed jobs and she hasn't yet renewed her coverage. (Physiotherapist)

None mentioned the pension benefit, but as they are all in their early to mid-twenties, other hospital officials agreed that they are too young to be thinking about retirement.

Baromaratchachonanee Nursing College, Muang District, Songhkla Province

Three nursing students

All three received scholarships under the Southern Peace Policy program for increasing the nurse workforce in the south by 3,000 nurses. One previously worked at a Tambon Administrative Office in an administrative position with civil service status. Three factors motivated her to resign and study nursing: she had always dreamed of being a nurse; under the scholarship program she can study tuition-free and become a civil servant nurse after graduating; and her old job didn't correspond with her Bachelor degree in Public Health (Environmental Health). She plans to work in her hometown for a long time.

The two others graduated from high school and passed the central admission examination. They didn't receive scholarships, however, until some other scholarship students quit the program and their scholarships transferred to new students. They are eligible for the program due to being from the targeted areas of Satul Province and Songkla Province. One said that he plans to work in his hometown until he completes the duration of the scholarship contract (at least 4 years), and then earn a Master's Degree to become a Nurse lecturer. The other plans to work at a hospital for 10 years and then undertake further studies.

The students said that if they have civil service status, they will work in a public hospital. Otherwise, a private hospital will be better. When they compared working in urban and rural areas, all preferred a rural setting because it's more peaceful, easier work, less competition, suitable for them, and near their family.

They agreed with this government policy of recruiting local residents to become nurses as a means of alleviating the South's problem. If local people work and live in their area either at a hospital or a health center, people will trust them and the Thai government. Even though some students have problems in studying such as responsibilities for their children and family, or difficulty understanding the course and Thai language, other classmates often help then understand the lectures, especially the South Nurse College students because of their orientation.

Annex 10 Documents reviewed

1. Thailand's Health Workforce: A Review of Challenges and Experience. Nonglak Pagalya and Thinakorn Noree, International Health Policy Program, Ministry of Public Health. August 2008.
2. Devolution of Health Centers and Hospital Autonomy in Thailand: A Rapid Assessment. HSRI and World Bank (L. Hawkins, J. Srisasalux, S. Osornprasop). April 2009.
3. Getting Committed Health Workers to the Underserved Areas: A Case Study of Health Decentralization Reform in Thailand. Sutayut Osornprasop, World Bank. November 2009.
4. Universal Coverage in the Land of Smiles: Lessons from Thailand's 30 Baht Health Reforms. David Hughes and Songkramchai Leethongdee. Health Affairs, vol. 26, no. 4. July/August 2007
5. HRH Research and Development. HRD Office, International Health Policy Program (IHPP), Ministry of Public Health. PowerPoint presentation 25 January 2010.
6. Review of the Thai Health Care System and Knowledge Gaps for Health System Research. IHPP & Thai National Health Foundation. PowerPoint presentation 10 July 2009.
7. Abundant for the few, shortage for the majority: The inequitable distribution for doctors in Thailand. Thinakorn Noree, Harin Chockchaichan, Veerasak Mongkolporn. International Health Policy Program (IHPP), Ministry of Public Health. August 2005.
8. Administrative systems in public and private hospital: Financial and business opportunities for the autonomous hospitals. Pannarunothai, S (1999). Health Systems Research Institute.
9. Administrative Reforms: Country Profiles of Five Asian Countries. United National Public Administration Network, 1997.
10. Factors affecting physician turnover from public hospitals in Thailand. Preuksananond, K., Pornpatanakul, W., Ratanakuha, L. et al. Dissertation, National Institute of Development Administration, Graduate School of Public Administration. 2003.
11. The Strategic Plan for the Decade of National Human Resources for Health Development in Thailand (2007-2016). The National Human Resources for Health Strategic Plan Committee. 2007.
12. Civil Service Act 2008 (English translation)
13. Ordinary Civil Servants in Thailand 2008. Office of the Civil Service Commission. (Reports for 2004 – 2007 also on file). Civilian Workforce in Thailand 2008. Office of the Civil Service Commission. (Reports for 2004-2007 also on file).

Annex 11 Meetings and Interviews

The following is a list of persons met during February and March 2010. At each health facility, staff were interviewed to develop health care worker profiles presented in this report; their names are not listed here in order to preserve anonymity.

Bangkok

Health Intervention and Technology Assessment Program (HITAP), MOPH

1. Dr. Yot Teerawattanano, Program Leader
2. Dr. Sripen Tantivess, Head of International Relations Division
3. Ms. Pattara Lellahavarong, Researcher
4. Ms. Roongnapa Khampang, Research Assistant

5. Dr. Suwit Wibulpolprasert, Senior Advisor, MOPH
6. Dr. Suphan Srithamma, Inspector-General (Region 12) and Director of Center for Peace in Healthcare, MOPH
7. Ms. Nichakorn Sirikanokvilai, Head of Workforce Planning Unit, Bureau of Policy and Strategy, MOPH
8. Ms. Rossukon Kangvallert, former Head of Workforce Planning Unit, Bureau of Policy and Strategy, MOPH
9. Ms. Khunying Dhipavadee Meksawan, Secretary General (retired) of OCSC, 1997-2002
10. Mr. Wisoot Prasitsiriwong, Advisor on Civil Service System, OCSC
11. Mr. Notigorn Kanchanachitra, Deputy Secretary General, OCSC
12. Mr. Avoot Wannvong, Deputy Secretary General, OPDC
13. Mr. Chawalit Tuantong, Director of Public Sector Development Unit (Health), OPDC
14. Dr. Supachai Yavaprabhas, Professor, Faculty of Political Science, Chulalongkorn University
15. Prof. Emeritus Wijit Srisupan, President, Nursing Council of Thailand
16. Dr. Krisada Sawaengdee, Deputy President, Nurse Council (also affiliated with IHPP)

Praboromarajchanok Institute for Health Workforce Development, MOPH

17. Dr. Somkuan Hanpatchaiyakul, Director
18. Ms. Songsri Kittiraktrakul, Deputy Director
19. Dr. Jureerat Kitsomporn
20. Ms. Fuengfa Norapanlop, Education Development Unit
21. Dr. Sarika Methanawin, Human Resources Specialist
22. Dr. Supatra Thammawong, Research Unit

Mae Hong Son Province

1. Dr. Suwat Kittidilokkul, Chief Medical Officer, Mae Hong Son PHO
2. Dr. Adung Sriratanaban, Director, Srisangwan Hospital
3. Mrs. Niramol Potikanit, R.N. and Head Nurse of Children's Unit, Srisangwan Hospital
4. Mrs. Supin Srijan, HRD Officer, Srisangwan Hospital
5. Dr. Waranyu Jamnongprasartporn, Director, Khun Yuam District Hospital
6. Mr. Siwaboot Khamsom, Public Health Specialist, Head of Health Security Unit;
7. Ms. Rossukon Panasantisuk, Finance Officer
8. Ms. Yuparet Nillaong, Administrative Officer
9. Ms. Nilubon Lakam, HRD Officer

10. Mr. Montol Suvannabut, Chief of Tor Pae Health Center (Tambon Mae Ngao, Khun Yuam District)

Khon Kaen Province

1. Dr. Wichai Assawapak, Director, Nampong District Hospital
2. Village heads, health volunteers and residents from Ban Kok Soong village
3. Dr. Apisit Thamrongwarangkul, Director, Ubonrat District Hospital
4. Ms. Nipa Taiso, head surgical nurse, Ubonrat District Hospital, and community nurse, Ban Kok Soon village

Khon Kaen Regional Hospital

5. Dr. Witaya Chadbunchachai, Senior Deputy Director & Director of Trauma and Critical Care Center
6. Dr. Somsak Pratipanawat, Director of Human Resources Development Center
7. Ms. Apa Patanaporn
8. Mr. Ronnayuth Chadpudsa, Secretary to Khon Kaen Hospital Director
9. Ms. Suwanit Pochan, Director of Nursing Department, KKH
10. Ms. Pantaporn Konjaiboon, General Administrative Officer, Human Resource Development Center, KKH
11. Ms. Pannipa Tongnarong, Boromarajonani Nursing College, Khon Kaen
12. Ms. Ancharee, Head of Quality Department

Songhkla Province

1. Dr. Supat Hasuwanakit, Director, Jana Hospital
2. Mrs. Hasuwannakit, Pharmacist, Namom Hospital

Boromrajonani Nursing College, Songkhla

3. Ms. Suwalee Chookiat, Lecturer, Community Health Unit
4. Ms. Bussakorn Komolpamorn, Lecturer, General Education Unit
5. Dr. Wantana Tinkarn, Lecturer

Provincial Health Office

6. Dr. Sunpong Ritthiruksa, Deputy Chief Provincial Medical Officer

Natavee Hospital

7. Dr. Suwat Wiriyapongsukit, Director, Natavee Hospital
8. Dr. Krongmal Kaewsanit, Head of Dental Department
9. Ms. Wannee Jenraksukhum, Head of Nursing Department