

MANAGEMENT, COLLABORATION AND NEW PUBLIC GOVERNANCE: A CASE STUDY OF A PUBLIC HOSPITAL IN THAILAND

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Abstract

This study is a typical case study research which explores some factors underpinning multi-level governance in the Thai public health system and examines some variables comprising New Public Governance of public hospital administration. Various qualitative data were investigated, mainly from overseeing officials, former and present executives, and current personnel in Ban-phaeo Hospital (Public Organization) (BHPO), the country's only private-style managed public general hospital. Using the methods of chronologies, explanation building and pattern matching, empirical analyses were conducted. It found that governance in Thai public health-care service delivery had never been totally separated from outside power. This research identifies and elaborates the co-existing governances based on market efficiency and based on stakeholder collaboration in Thai public health administration. Moreover, the unique context of various stakeholders actively participating in managing BHPO empirically supports the proposition that public value management can be applicable and pragmatic for public administration. Therefore, a public general hospital can deliver health services efficiently with sufficient resources and effectively for medical performance when stakeholders are empowered to collaborate in the administration. The results plus the theoretical and practical implications are discussed, and public value management as a paradigm is verified with some refinements. Three activities at organizational level and three social arrangements at policy level are suggested for future practices. Finally, a reform of the Thai public health system governing the administration of public health-care services is urged, with a re-configuration of power arrangements for enhancing stakeholder collaboration.

Keywords: new public governance; public value management; stakeholder empowerment; collaborative network; public general hospital; Thai public health system.

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Introduction

Theoretical argument

The research is an attempt at lending support to public value management as a pragmatic governance (Wallmeier et. al., 2019). Moore (1995, pp. 21–25; 2013, pp. 7–10) suggested that public organizations recognize and respond to external factors in an environment instead of mainly fulfilling political demands (Moor, 1995, pp. 70–72). Public agencies must strategize their operations into concrete outcomes based on public value so that opportunities can be captured, and threats can be handled accordingly (2013, p. 207–208). Public value streamlines public organizations for the utilization of resources as well as the realization of public interests. Together with a strategic management approach (Boyne & Walker, 2010; Mintzberg, 1983, pp. 260–261; Porter, 1998, pp. 36–38), public value asserts accountability and transparency on public management (Stoker, 2006; Moore, 2013, p. 207–208).

In terms of public governance, various scholars (including Siddiki et. al., 2015; Purdy, 2012; Le Galès, 2011; Peters (b), 2011; Milward & Proven, 2000) contend that multiple stakeholders participate in determining how public resources may be used to fit their benefits. However, Handley and Howell-Morony (2010), and Heinrich and Lynn (2000, pp. 89–100) regard bureaucratic discretion as a way to centralize and facilitate how public resources may be utilized. Fortunately, both sides are quite agreeable on what should comprise public governance. In public governance, there are some types of social co-ordination following webs of shared rules so that certain purposes can be accountable (Peters (a), 2011, pp. 65–73).

Further, Wallmeier et. al. (2019, pp. 488–495) argued that public value management as governance required greater involvement of community stakeholders so that society can achieve efficient, effective and accountable outcomes. Wallmeier et. al. (2019) offered theoretical propositions to refine the relationship between public officials (the governing) and citizens (the governed) with an analytical framework comprising manageability, economization and democratic accountability. Therefore, New Public Governance (NPG) refers to social co-ordination following webs of shared rules so that public value can be accomplished. Public hospital governance consists of multiple power actors at various levels of policy making and implementation of health-care service deliveries. It is particularly complicated in Thailand.

Context of case study

Public health-care policy and management in Thailand has been centralized by bureaucrats for more than a hundred years since the Ministry of Public Health was first established. There were attempts to decentralize public administration of health-care services from elected representatives. In 1999, the Plan and Process of Decentralization of Public Services to Local Administrative Organization Act, B.E. 2542 (Government of the Kingdom of Thailand, 1999), was enacted into law, but did not

come into effect until ten years later. However, the actual implementation of such a plan regarding public health-care decentralization was belated and ineffective. The study of Jongudomsak and Srisasalux (2012, pp. 351–354) found that the transfer of respective personnel and assets had been completed to only 96 percent at the end of 2011 due to a lack of co-ordination between the ministry and local administrative organizations. In addition, the delay caused duplicated investment in health-care infrastructure. At the same time, Chardchawarn (2010, pp. 15–19) further affirmed that local elected officials and citizens had insufficient powers to mobilize the process. As a result, local people could not initiate any policies and accelerate the implementation of the policies, particularly regarding government resources. Finally, the Universal Health-Care Coverage (UHC) (a.k.a. Baht 30 for all diseases) policy which, since 2002, has separated purchasing function from service provision from all hospitals, centralizes financial resources for all fundamental health-care treatments to the National Health Security Office. Consequently, this limits the fees charged to individual patients. Many public hospitals, particularly in upcountry and rural areas, have operating costs which are higher than their income. Hence, almost all local public hospitals encounter insufficient resources to maintain and to develop medical personnel (Tejativaddhana et al., 2013, pp. 18–34; Taytiwat et al., 2011, pp. 48–52).

Market failures in public health-care services have worsened the situation. High returns in the health service in Bangkok and its vicinity attract more investment from public and private hospitals than upcountry. The investments in health care are mainly in technology for diagnosis and treatment of complicated diseases (tertiary care), instead of primary and secondary care in upcountry areas where higher needs are eminent. Larger public hospitals (i.e. general hospitals with 300 beds and above) in Bangkok, its vicinity and a few larger cities are allocated more funding for tertiary care, medical and support personnel, and technology. As a result, more than 70 percent of medical personnel have been stationed in public hospitals in Bangkok and central regional provinces since 1999. However, the medical personnel in public hospitals had decreased steadily from 1971 to 2009, while those in private hospitals had increased substantially (Office of Policy and Strategic Planning, Ministry of Public Health, 2011, pp. 303–326).

Together with a centralized power structure in bureaucratic institutes, the Thai market-driven health system is embedded with inequality in public policy implementation. Therefore, the governance of the administration of public general hospitals must be thoroughly examined as to whether it can ensure an efficient deployment of a large quantity and high value of public resources and, at the same time, an effective implementation of public health-care policy for all citizens. Therefore, this research aims to answer the questions: (1) How do various stakeholders collaborate in the administration of a general public hospital?; and (2) How does the independently administered general public hospital operate in responsive as well as accountable ways?

The governance of public general hospitals with a medical service capability at secondary (level 2.3) to tertiary care level (Excellent Center) and an in-patient capacity of over 300 beds is significant in order to ensure equally distributed and standardized health-care services for developing countries. Public hospitals of this size require a large amount of continuous investment in advanced technology and medi-

cal expertise and, hence, an extensive influence of political and economic powers. Ban-Phaeo Hospital (Public Organization) (BHPO) is typical in that the endured community involvement in the administration of the hospital provides a unique social setting of new public governance in a centralized public health context in Thailand.

Through the Public Organization Act, B.E. 2542 (1999) and the Establishment of Ban-Phaeo Hospital (Public Organization) Administrative Order, B.E. 2543 (2000), Ban-Phaeo Hospital (Public Organization) was founded. Under the contract for a rescue fund from Asian Development Bank during the financial crisis in 1996–1997, the Thai Government committed to privatizing either a hospital or a university. Back then, Ban-Phaeo Hospital was small in property and resources and therefore had the best chance of success with privatization among many other hospitals (Informants, May and October 2015).

Literature Review: Performance, Power and Governance

Managing medical performance

Medical performance is not only measured with codes of practice and clinical standards, but also with the operating results from efficient service delivery (Burau & Vranbaek, 2008, pp. 352–354; Lee, 2010, pp. 50–58). From an organization theory perspective, Gourdin and Schepers (2009, pp. 319–324) asserted that organizations and professionals sought to find ways to improve better results by developing certain procedures from information and knowledge. The organization needs to integrate knowledge into management and operations. Moreover, public organizations primarily rely on public resources for their establishment and existence; therefore, public hospitals must create public value.

Burau and Vranbaek (2008, pp. 352–354) emphasized that performance measurement based on professional self-regulation constrained the results of medical practices. In this sense, the expert-based power limits the performance based on market mechanisms which furnish cost-effective results. Kaplan and Porter (2011, pp. 47–54), Lee (2010, pp. 50–58), and Nordgren (2008, pp. 518–521) asserted the same emphasis on maintaining the performance of health-care services delivery with the market-driven mechanism rather than medical standards and regulations.

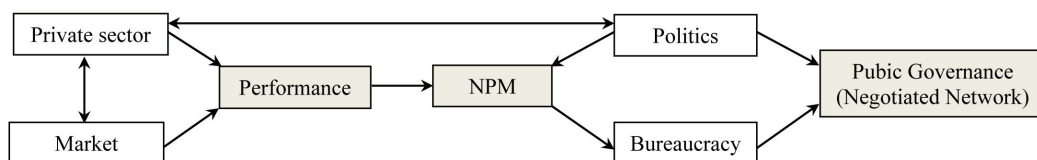
On the other hand, a power context can be affected by external influences which always trigger culture and leadership in organizations (Shein, 2010, p. 18). Shein (2010, p. 91) argued that organizational culture reflected an adaptive relationship of its members to the external environment. In the long run, the internal integration of groups will stabilize the balance of power within and on the outside. When power negotiation continues through learning and information flow, a network-based form of governance can ascertain that all power actors are more adaptive together and hence more flexible (Burau & Vranbaek, 2008, p. 351).

Because the social arrangements for medical performance governance require the result-oriented measurement of service delivery which is financially and managerially subsidized by government, the governance of the medical performance must re-configure the power relationship in favor of the public instead of the private sectors, and similarly for state jurisdiction over the medical profession (Burau & Vranbaek, 2008, pp. 359–364). Further, Burau and Vranbaek contended that

both health-care professionals and public bureaucrats need independent interactions. The professionals require a high standard of expertise while the government must ensure the provision of high quality health-care services for all.

In many countries where New Public Management (NPM) is a dominant approach in the implementation of public policies, the performance of public agencies is measured mainly on efficiency and utilization of resources regardless of who is carrying out the work. The public resources for public projects and operations may be re-allocated to private counterparts. The performance of contracting-out and privatization can be assessed by economically definite deliverables without public accountability. Such managerial approaches hollow out all capabilities and so long-term public value is displaced from the public sector (Bryson et. al. 2014, pp. 451–453; Savoie, 2010, pp. 16–18; Walker et al., 2011, pp. 708–710, 714–715). Moreover, in Lindblom's view (2001, pp. 214–215), the market force was efficient and triggered the balance of power in public organizations away from personal interest and more towards wider interests outside. He contended that market efficiency pressed toward horizontal collaboration rather than hierarchical bureaucracy (2001, pp. 195–197). For these reasons, public hospital governance extends beyond the structural relationship between physicians and patients, and between doctors and executives, to a more complex relationship beyond the organization. The figure below illustrates NPM as a power arrangement in which public hospitals are managed.

Figure 1: Theoretical framework of Market-driven Governance in Public Hospital Administration



Knowledge of health-care organizations is conceptualized under a bureaucratic perspective in organizations that focus mainly on administrative efficiency, such as in Preker, Liu, Velenyi and Baris (2007, pp. 1–5) and Morris, Devlin and Parkin (2007, pp. 17–20). With more influence of NPM, public hospitals are observed to achieve market-oriented results. In such a context, the private sector plays more of a role in coordinating, supplying, and contracting with respective public agencies in order to comply with political mandates. With this framework, NPM attempts to take advantage of the external environment but the management prerogative is derived mainly from the power of government and public bureaucracy. As a result, public governance is an economic and political arrangement of the network of negotiated counterparts.

New Public Governance of public hospitals

The medical performance in public hospitals can be affected by many factors and power actors simultaneously. On a public policy level, Morris et al. (2007, pp. 123–127, 147) observed that the market mechanism could mislead health-care

policy making and implementation. In the health-care market, where hospitals do compete freely without efficiency, according to Pareto rules (*ibid.*) the government must intervene. Because health-care service providers decide and invest but the patients cannot choose freely, health-care services require considerable investments so that they can economically operate. Therefore, service organizations purposely influence the market in one way or another (market power). Nonetheless, patients need medical treatment for their illnesses at affordable prices. At the same time, citizens who are not sick can also benefit by default (externalities). Unlike electricity, the production of health-care services is not equally distributed in society. Instead, a hospital can be the sole beneficiary from health-care externalities.

Porter and Teisberg (2006, pp. 312–342) further pointed out that the government must encourage competition for a holistic result of health-care service deliveries among all stakeholders: oversee agencies/bodies, service providers and/or co-producers and service recipients. Actually, medical performance is a result of multi-dimensional governance at all levels in the public health system. Factors from internal and external power actors, whether formal or informal, can be interdependent and exert influence on medical performance (Heinrich & Lynn, 2000, p. 14). Those dimensions comprise of external environment, clientele circumstances, operational or technological process, organizational structure, and a role in managing operational output or outcome of public policy implementation (*ibid.*, pp. 14–17). Moreover, Talbot (2010, pp. 618–623) indicated that health-care service co-producers also have an impact on medical performance.

In this regard, (Mintzberg, 1983, pp. 260–269) contended that organizations can negotiate and even control external circumstances in three advantageous ways: (1) fully understanding stakeholders, (2) strategically influencing them, and (3) forming a strategic alliance with them. An organization must attempt to align with complex and changing environments so as to co-opt for surviving and to keep its purpose of existence intact. Organizational structure and relationship can constrain strategic formulation which defines resources dependencies. To alter such dependencies, organizations can formulate a strategy that re-arranges a structure of alignment with an external changing environment for successful strategy execution (Hrebiniak, 2013, pp. 313–318).

From a network perspective, the power actors in the network find and distribute benefits to all parties in accordance with the organization's strategy; otherwise, the allocation of resources will be appropriated only for a few people with the most power in the network and, hence, they can access the most resources. Purday (2012, pp. 409–411) found that various stakeholders could collaborate in public projects without formal power structures. Still, their mutually agreed policy led to well-acceptable actions. This corresponds to what Donahue and Zeckhauser (2011, pp. 72–77), and Jones (2012, pp. 417–418) proposed in that stakeholders must take part in strategy formulation, implantation, and inspection mechanisms in all public works. In addition, Veronesi and Keasey (2012) asserted that the effectiveness of hospital oversight committees can also be assessed beyond the analysis of the formal structure, individual qualifications, and designated obligations. In Post-NPM, the focus shifts to the collective behavior rather than that of indi-

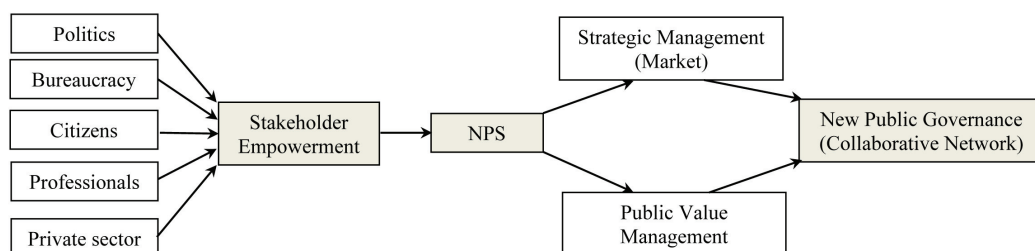
viduals. According to Veronesi and Keasey (2012, pp. 272–274), governance in the form of a semi-private committee allows directors to combine their leadership for an effective oversight of the hospital administration, thanks to interpersonal dynamics and interdependent processes among people.

Therefore, the true public benefits from the efficient execution of public policy do not only derive from actions of the state but they also depend on governance that recognizes the interests of both internal and external stakeholders. Public organizations should, therefore, be an accountable bureaucracy to all those stakeholders (Bidya Bowornwathana, 2013, pp. 137–139; Hood, 1991, pp. 17–20; Peters, 1996, pp. 99–104; Rhodes, 1996, pp. 652–657; Wilson, 1989, pp. 375–378); otherwise, public interests will be jeopardized.

In this regard, Lynn (quoted in Osborne, 2010, pp. 119–123) discovered that the pattern of traditional governance was replaced with the arrangements of networks decentralized in civil institutions. Lynn proposed a new public governance concept (NPG), which can be divided into two approaches: the first one in which a network kept connected to a bureaucratic system and the second concept that is held in just a particular type of network. However, Osborne (as referred to in Osborne, 2010, pp. 8–10), which supports the first NPG concept, explains that NPG must be considered as a theoretical and practical paradigm of public service delivery. NPG acknowledges plural societies that consist of multiple actors who rely on one another in the delivery of public services.

In conclusion, Osborne (2010, p. 9) suggested that NPG comprised concepts from the perspective of open natural systems, which focuses on external environment and institutionalized societies in the implementation of public policy. The allocation of resources is resulted from linkages between various organizations and actors. For this purpose, the relationships of Public Service Organizations (PSOs) are networked with ongoing negotiations and inherent accountability to all stakeholders. Further, Wachhaus (2012, pp. 33–34, 42) proposed that a network within public governance can completely replace the bureaucratic system. He proposed that individual control in the network must be reduced in order not to trigger a new formation of rigid power structure. Therefore, the success of network collaboration is achieved through the development of an information sharing system and the independent communications enhance living as social entities, a form that can replace all types of hierarchy. The second figure depicts the configuration of variables underlying NPG in public hospital administration.

Figure 2: Theoretical Framework of Stakeholder-derived Governance in Public Hospital Administration



The concept of power, as in McKee et al. (2008, pp. 24–38), points out the involvement of stakeholders in policy implementation with more emphasis upon public accountability. Public hospitals are aligned strategically to various stakeholders who exert their formal and informal powers in certain collaborative ways within the network. With NPG, New Public Service (NPS) (Denhardt & Denhardt, 2007, pp. 70–71; 2015, pp. 6–11) replaces NPM to ensure the public value can be delivered and sustained.

Research methodology

Research design

This research is a typical case study of Ban-Phaeo Hospital (Public Organization) (BHPO). The data were collected mainly from two groups of stakeholders who influence the administration of public general hospitals and their existence (embedded units of analysis), i.e. external and internal stakeholders, with nine and eleven interviewed informants, respectively. Firstly, the external group comprised oversight officials of relevant public-health departments and agencies for policy implementation in public general hospitals. This included administrators and officials in the Ministry of Public Health, in Bangkok Metropolitan Administration, and in three other public general hospitals, one medical college professor, and one authorized medical equipment importer. This group revealed political, economic, and societal contexts affecting the scope of public-health policies, their implementation, and outcomes. And secondly, the internal stakeholders comprised an administrative board member, a former administrator, present administrators, medical and nursing professionals, and technicians in Ban-Phaeo Hospital (Public Organization). Each person has designated power and uses it to control or create influence over the administrative reality in the hospital. Both the external and internal actors are empowered by legitimacy, expertise and information obtained. The interviews were conducted between March 2015 and April 2018 with authorized permissions. Access to these public officials gave way to relevant documentation, records, and experiences. Some official sources of online and public information were thoroughly adopted for preliminary information and gathering supportive evidence.

This study considers the period of public health-care events/actions over more than 15 years since the National Administrative Act, 2534 BE (1991) (Government of the Kingdom of Thailand, 1991, pp. 1–4) was promulgated in the Government Gazette (Book 108, Section 156) and later revised through eight amendments until the current 8th version, BE 2553 (2010), which affected changes in many structural and functional dimensions. Because of the development in various periods (Creswell, 2013, p. 99; McNabb, 2008, p. 274) of the organization of public and semi-state organizations in terms of administrative arrangement and legitimate power, it is important to study and understand the consequences in later circumstances and organizational aspects of the past onto present events/actions. Therefore, the study went back ten years before said law was enacted, including a significant change in health-care systems in 2002 when the National Health-Security Act (Universal Health-Care Coverage) came into effect.

This case study research proposes that an arrangement of New Public Governance is practical for effective, efficient and accountable performance in health-care service delivery in Thailand (a critical and typical case sampling) (Auefback & Silver-

stein, 2013, pp. 96–100). Although BHPO is the one and only public general hospital with governance from shared power among various stakeholders, its governance arrangement and performance management can be carefully explored for future reform of the public health-care system in Thailand. Some relevant interviewees, other than BHPO, were purposely approached to contrast administrative and organizational circumstances affecting different criteria of performance measurement which was derived from bureaucratic governance (Auefback & Silverstein, 2013, pp. 62, 96–97).

Data collection

The main method of collecting data was by in-depth interviews. Each interview begins with building rapport with individual informants (Ngamphisat Sangsangu, 2008, pp. 59–61), who were formally approached and made proper appointments. Each interview took 1–3 hours. When some open-ended questions had been answered thoroughly and the data had led to theoretical saturation, the interview ended for that person. (Auefback & Silverstein, 2013, pp. 19–23). Other methods and sources of data collection included focus-interviews within and outside BHPO, official documentation, archival records (i.e. minutes of meeting, purchasing files, etc.), and non-participant observation (amongst its uses, it provides informal linkage to various aspects within the organization).

The initial set of questions for the in-depth interviews were: (1) How do government policies affect the strategy and the scope of medical/nursing/diagnosis works of the hospital?; (2) What factors or who else is involved in planning for investment/technology/services for the hospital?; (3) How do specific local/community circumstances influence the strategy and operations of the hospital?; (4) Who/How are the medical performance determined and evaluated?; (5) How do relationships with the community/with affiliated public hospitals/with the ministry/local politicians/within your working unit affect the hospital administration?; and (6) Who and what process do scrutiny personnel/procurement/HR/medical/nursing works in the hospital? Note that the exact wording and numbers in each interview depended on the roles of and the previous answers from that interviewee.

The initial intents for the focused interviews were set as: (1) Enquire about specific cases in the work-unit and across the organization; (2) Enquire as to whether different professional staff confirm/contrast with others for critical stories or a set of data (e.g. physician vs. nurse, nurse vs. diagnostic chief, administer vs. physician, oversight vs. administer, and vice versa); (3) Enquire about important missing pieces of information (e.g. story, experience, order, decision, etc.) until the complete picture can be drawn; and (4) Enquire about more rival claims/results/impact of particular public policies and/or strategic management.

The above questions had to be supported by at least two pieces of information, whether interview or document or other. The answers are narrated (and translated from Thai language) in story-telling and explanatory manners in English rather than quoting exact verbal translations.

Data analysis

In order to get an explanation of specific characteristics of the situation (themes) in the case study with all levels of organizations and relevant factors in ex-

ternal environment, some particular patterns (causal mechanisms) must be created to describe the social context that occurs in real life (Creswell, 2013, p. 99; Yin, 2009, pp. 136–140). They eventually lead to linking and interpretation of both quantitative and qualitative data to confirm contextualized comparison. (George & Bennett, 2005, pp. 19–21; Yin, 2009, pp. 42–43, 130–135). In this study, methods of analyzing data include chronologies of events, pattern matching within the organization and as compared to other organizations, and explanation building from causal linkages.

Ethical considerations

This study considers the ethics in interacting with key informants in accordance with international standards regarding qualitative research from data collection to the presentation of the research results. (Nisa Chuto, 2008, pp. 260–271; Miles et.al., 2013, pp. 1892–1894; Yin, 2016, pp. 41–47).

Findings and analysis

Public hospital governance in Thailand

The Ministry of Public Health centralizes policy implementation as regulator, provider, and purchaser of health-care services in the kingdom. Firstly, as regulator, the ministry mobilizes and controls various agencies through the Office of Permanent Secretary at the top of the bureaucratic pyramid. The functional departments under the Office include Medical Development, Research and Development, Health Service Support, Directive Enterprises, Public Organizations, Strategic and Planning, and Regional Hospital Administration. The latter two agencies comprise 80 percent of the 2019 fiscal budget of the ministry (Office of Budget of the Parliament, 2017, p. 13). In particular, the Regional Hospital Administration monitors the policy implementation through 12 regional bureaus which supervises all respective hospitals in 76 provinces with the thirteenth bureau as a liaison to Bangkok hospitals. In this sense, the Ministry acts as provider of public health-care services. And finally, as purchaser, the National Health Security Office (NHSO), a directive enterprise under the Ministry of Public Health, expends most medical treatment costs in hospitals, the amount of some 80 percent of the fiscal budget of the health-care system.

Apart from public hospitals under the Ministry of Public Health's Office of Permanent Secretary, there are several other hospitals and medical colleges under other ministries and agencies, for example: 65 hospitals under the Ministry of Defense, 8 under the Ministry of Higher-education, Science, Research and Innovation, 2 under the Ministry of Justice, 1 under the Ministry of Finance, 2 under the Office of the Prime Minister, 10 under the Bangkok Metropolitan Administration, 5 under the Red Cross Society of Thailand, 8 under local provincial administrations and one independent public organization (i.e. Ban-Phaeo Hospital (Public Organization)). Moreover, there are nine government agencies under another five ministries and one independent Office of Auditor General involved for three main authorizations for financial resources, co-purchasing health-care coverage, and professional and service quality development to all public hospitals in Thailand.

It can be observed that public hospital governance in Thailand is obviously complicated with hierarchical multi-faceted institutions of the national public health sys-

tem. Central government agencies, from the Office of the Prime Ministry to various ministries to semi-autonomous agencies (i.e. NHSO and Healthcare Accreditation Institute (HA)), play some jurisdictional roles in public hospitals so that the standard deliveries can be monitored and ensured. But on the other hand, BMA and other local administrative bodies enact their authorities to allocate health-care services more effectively for their respective constituents in response to local needs. Nonetheless, there is another governance co-existing in the system, BHPO, where the local communities can engage in various aspects of the administration of the hospital.

Stakeholders and the administration of BHPO

Ban-Phaeo Hospital (Public Organization) (BHPO) was established as a health-care station for a small municipality of Ban-Phaeo (now an administrative district under Samutsakorn Province, 70 km south-west from Bangkok) in 1965. The original land of about 7,000 square-meters was donated from various plots of lands. The station had been funded and developed into a small hospital of a few beds in 1987. (Informant: October 2015; Ban-Phaeo Hospital (Public Organization), 2013, pp. 10–12).

In 2013, BHPO had more than 90 medical doctors and 30 general physicians for 1,900 out-patients daily (Ban-Phaeo Hospital (Public Organization), 2013, p. 24) with a capacity of 300 beds for overnight treatments. For the service level of similar district hospitals, there are no more than 40 resident doctors under standard headcounts (Butthasi et. al., 2001, p. 30). Moreover, BHPO's medical doctors and certified nurses are highly satisfied with their professional development and more flexible remuneration schemes than other public hospitals (informants: May and October, 2015). BHPO invested, improved, and maximized usage of advanced equipment for better quality service delivery (four informants: April, May and October 2015).

Since its establishment, the operations of BHPO have always involved neighboring communities; giving water purifiers, helping the search for the best cardiogram, etc. During 1991–1995 with helping hands (literally) and the efforts of local farmers, merchants, public officials in other agencies stationed in the area, Buddhist monks, local Rotary clubs and all personnel to promote the hospital services and to recruit more registered patients, BHPO emerged even stronger socially, financially and organizationally (informants: May and October 2015). From then on, the small amounts and value of donations become larger and much more from patients, including those not staying in the Ban-Phaeo District (three informants: May and October 2015). So, it is common to see the Director, doctors, nurses, etc. joining some community and personal events, even until today! An informant said (May 2015), "Some patrons ask our participation in important events, like a funeral in Bangkok, weddings in neighborhoods, Buddhist ordination. Anybody who has no more work will normally go. A Supervisor can be more available. The Director always joins unless he may be engaged in surgery. When tired, he asks deputies or assistants to go. It is our habit. We have never ignored the community".

On the other hand, community involvement in operating decisions has come with no personal trade-off but with common bonds from the past and on-going relationships, one generation to another (informants: May and October 2015). Another informant shared his feelings towards BHPO (May 2015), "We help Ban-Phaeo Hospital because one day it can help one of our family members". The en-

agement became legitimate when the law gave the community three seats on the Administrative Board. Together 10 members of the Administrative Board are officially approved by the Cabinet of Government every 4-year term.

Other advantages from the administrative autonomy are the continuous tenures of leadership of the hospital Director and so the uninterrupted development of health-care delivery. Most directors of public general hospitals, especially stationed in large cities, would be appointed in only the last few years of public service, while waiting for retirement (informants: April and December 2015). But at BHPO since it was re-established in 2000 until the present (2020), there are only two Directors on duties. It was also observed that BHPO had only had three Directors since 1995; the uninterrupted leadership and administration of BHPO strengthens working culture within organization and social bond to the community. Information (May 2015) from a Board Member and two nurses who had served under the two Directors since 1995 confirmed the effectiveness of administration from the strong relationship within the hospital and with local patients.

In 1990, the Social Security system in Thailand became effective for all employees in the country. For a small hospital, it was another new source of large income derived from patients registered through social security. So until 2015, BHPO had grown steadily. In 2002, there was a reform in Thai public-health administration with the Universal Health-Care Coverage scheme (Baht 30 for all diseases). As a small hospital on the outskirts of Bangkok, then BHPO had to be quick to capture these opportunities (three informants: May 2015) and to survive these intervened changes.

Performance and public value management

BHPO tries not to be dependent on only one major source of resources like other public hospitals. The hospital income has been boosted from operations and donations, the growth during ten years between 2014 and 2004 of five times and three times, respectively, with an asset increase of almost four times. In 2014, BHPO received approximately Baht 1,147 million from operations, 225.2 million from the Government, 49.8 million from donations and 58 million from interest and other incomes with assets amounting to 800.7 million (Ban-Phaeo Hospital (Public Organization), 2014, pp. 45–46). The figures increased from 2004 to 213.5 million, 101 million, 17 million and 6.5 million, respectively, with assets of 228 million (Ban-Phaeo Hospital (Public Organization), 2004, pp. 28–29). The operating performance is clearly leveled up because of the improved efficiency and the motivation of the personnel.

Because the succeeding two Directors worked closely with the Administrative Board, all committed old and new personnel have continued developing BHPO further (as the figures previously shown) in various aspects of public value management. (Six informants: April and May 2015). The following three aspects provide some notable examples.

- Health-care operations: (1) Utilization of medical technologies for more accurate diagnosis and treatment regardless of how severe the conditions of the patients are. They try not to have any equipment idle for long. (2) Encouragement of small surgeries, i.e. eye and cataract. (3) Contract-out some high investment and long-queuing services, e.g. complicated blood tests. (4) Bulk purchase of medical supplies. And (5) Mobile outpatient units to other cities and Bangkok. It is aimed

- at both marketing and training efforts. To get more patients who are civil servants working through the country, this can be a new stable source of operating income thanks to public allowances given to very public officials. In addition, the mobile unit provides more low-risk cases for doctors to practice.
- Human Resource Management: (1) Over-time hires of both resident doctors and current nurses, and part-time doctors so that BHPO can serve 24 hours a day. This scheme also retains qualified doctors and nurses. (2) Scholarship for recruiting new nurses. BHPO have a grant scholarship for high-school and advanced vocational school girls for a bachelor's degree in nursing science at colleges. This ensures a sufficient number of specialized nurses for the growth of BHPO. And (3) Training and development conducted between senior doctors and nurses for all junior staff. These are effective for dual purposes of cultural development and career advancement for professional personnel. Observed from the setting, there were young doctors and nurses (below 40) taking up managerial posts at BHPO.
 - Scrutiny and public accountability: (1) Separation of powers in the organization between user and purchaser of assets and equipment. Doctors will use equipment and required specifications while the Executive Committee search for suppliers, negotiate terms, and make purchase decisions. However, Thai public agencies have begun and transformed to adopt electronic procurement systems since 2005. (2) The Internal Audit Process consists of the Office of Internal Control, reporting to the Administrative Board, and the Audit Special Committee, appointed by the Administrative Board. The Office routinely examines accounting practices and financial discrepancies with the result reported only to the Administrative Board. If any fraud is uncovered, the Board will appoint an Audit Special Committee to gather facts and to propose the findings to the Board for final discretion. Apart from financial issues, the Audit Special Committee can be assigned to scrutinize other misconduct of the Director and other Executives. And (3) Constrained executive power of the Director. The position may have an autonomous power in administering all the affairs of the hospital, but it is always checked and balanced by various stakeholders in the Administrative Board.

Conclusion and Discussion

Conclusion

The findings support the proposition that public general hospitals can pursue efficient as well as effective performance from governance empowering various stakeholders to independently manage their health-care service. This ensures access to and use of the resources necessary to operate appropriately for changing circumstances. The prime focus on performance as in New Public Management (NPM) hollows out internal capabilities of public organizations and weakens all public scrutiny mechanisms. But in this case study, the administration of a public general hospital can result in prominent performance with important resources. So, it is crucial to limit the influences of the power of the bureaucratic system and to reform the health-care governance to be more inclusive for sustaining resources and accountability. New Public Governance (NPG) requires horizontal relationships and shared information with ac-

countable coordination of capability within the organization and with outside stakeholders. Therefore, the research questions are addressed accordingly as:

(1) Stakeholder empowerment and collaboration

Various stakeholders participate in public policy implementation and performance evaluation for ensuring that the outcomes are in line with their needs in health-care services: higher quality, wider scope of treatments, more accurate testing, and liable nursing cares. Communities have felt BHPO as their 'owned' hospital. The bond between them and the BHPO is typical. The long history of the hospital clarifies the context of BHPO which eventually leads to the configuration of stakeholders participating in overseeing the Administrative Board. With challenges encountered by the hospital several times, the organizational culture of commitment and the public mind has been developed and carried on to succeeding personnel. This public mind, then, links their feelings and working lives to their neighbors. BHPO always has informal and formal connections to local patients living nearby who have been involved in almost all aspects of planning and operating. Therefore, the outcomes of the administration of BHPO have mainly responded to the well-recognized needs of the community. Even when the BHPO grows to serve bigger areas, the sense of social belonging has not vanished from all these stakeholders. Instead, they are even more engaged officially and naturally.

(2) Strategic management and public value management

From this research, the administrators determine strategies for public-health policy implementation in a way that responds to the public as well as sustains the organization. Efficient outcomes alone are not the only requirements in health-care service operations. The patients must get effective diagnosis and treatment to cure them from illness. Speed of treatment, shorter queues and affordable prices must come with precise diagnosis, enthusiastic nursing care, accurate treatment, and medical skills. The administrators of BHPO can balance professional expertise with managerial pragmatism. In addition, they work well with highly skilled personnel, highly demanding clients, and highly bureaucratic officials in order that the organization can exist beyond their tenures without interruptions. These stakeholders are actually the prominent strategic circumstances to account for. With the mixture of stakeholders, the public value can be recognized and put forward for strategy and execution. The administrators of BHPO are able to collaborate with various stakeholders, to agree upon common interests, and ultimately to improve the medical performance. The managerial efficiency from maximized utilization of physical and human resources is then a strong foundation of the extended scope of medical specialization and in countrywide markets. The formation and execution of the strategy of the hospital are a constructive obligation of the administrators and their "team" inside and outside the organization.

Discussion

NPM focuses on creating results and aims at reducing the size of the resources allocation and so hollowing out capabilities from the public sector. The evidence points to the National Health Security Office (NHSO) being authorized as a sole purchaser of health-care service for the sake of efficiency. And together with the centralized and multifaceted institutions in the Thai public health system, only

large public general hospitals can operate and serve properly, as opposed to local and small hospitals upcountry where needs are not any less (Bureau & Vranbaek, 2008, pp. 352–354). People in remote areas have to put more effort into getting to well-equipped hospitals. For these reasons, NPM must be applied with a critical caution not only for external stakeholders providing flexible resources, but also their pressures aligning people in public organization strategically (Mintzberg, 1983, pp. 260–261; Pfeffer & Salancik, 2003, pp. 20–21; Schein, 2010, pp. 18, 91).

In terms of performance, the administration of a public organization that obtains resources with full support and collaboration from contributors of necessary resources shall be strategically adaptive to any health-care situations and re-create extensive service delivery as long as those resources may allow. In more critical issues of governance, it is found that governance in Thai public health-care administration could never be separated from power outside. Instead, collaboration with stakeholders' power can strengthen the delivery of health-care services with sufficient resources in response to ever more complicated diseases for the growing population.

This research confirms that NPG as a collaborative network attached to existing bureaucracies (Kooiman, 2010, pp. 57–61; Osborne, 2010, pp. 7–12; Rhodes, 1996, pp. 652–667) can be more appropriate for governance of public general hospitals. The collaborative NPG maintains power over necessary resources as well as exerts public accountability of the utilization of those resources within the public organization. Through this approach, public administrators can engage all stakeholders to ensure public value. The public value concept acknowledges that necessary resources are crucial to public management and belong to the citizens who have the ultimate power (Bashir, 2012, pp. 90–94; Raven, 2008, pp. 1–4; Selznik, 2011, pp. 53–57) to allocate, control and monitor the use of their resources. Consequently, the performance of public organizations can be derived primarily from the creation of value to benefit the owner of the resources, not for any political value, and not solely for economic value.

Theoretical implication

As a result of this research, a paradigm of public value management as contended by Wallmeier et. al. (2019) can be verified for further refinement as:

(1) Manageability enhanced with Economization: the strategies for public-health policy implementation can be determined in ways that respond to the public (effective) as well as sustain the organization (efficient). The public value in managing health-care service will be created from collaborative actors to overcome the short-term marketized impacts.

(2) Economization enhanced with Democratic Accountability: various stakeholders actively participate in public policy implementation and performance evaluation. There is no longer a dominant power-over relationship in managing the public value of health-care service delivery. Public value mindset in a public organization must be cultivated to endure horizontal connections with all stakeholders.

(3) Manageability enhanced with Democratic Accountability: various stakeholders involved in managing public value in health-care policy implementation. Public value pragmatism must be implanted entirely on strategic planning and execution processes in health-care organizations so that the opportunities of mutual

interdependence of resources and innovative practices of medical expertise can be founded and internalized.

With public value management as a paradigm, Public Administration can be ensured as a unique discipline and a science of effective, efficient and accountable governance for the society we live in.

In addition, the research shows that public management without public service accountability (see Osborne, 2010, pp. 119–123; Denhardt & Denhardt, 2007, pp. 71–74; 2015, pp. 6–11) cannot result in operational effectiveness. Public management aimed at creating public values can replace those errors in the NPM concept and helps to fulfil the practical principles for the ideal of the New Public Service (NPS) concept by asserting participative and accountable governance (Denhardt & Denhardt, 2015, pp. 6–11). The concept of public value (Bozeman, 2007, pp. 215–219; Bryson et al., pp. 451–452; Moore, 1995, pp. 21–25; 2013, pp. 7–10) clarifies the policy implementation in the NPG concept (Klijn, 2008, pp. 510–511; Osborne, 2010, pp. 8–10; Wachhaus, 2012, pp. 33–42) for being accountable to all stakeholders (Bidya Bowornwathana, 2006, pp. 667–669; Hood, 1991, pp. 17–33; Peters, 1996, pp. 99–104; Rhodes, 1996, pp. 652–667; Wilson, 1989, pp. 375–378).

Implication for practices

At an organizational level where public administration is restrained by bureaucratic power, a public service organization must retain its professional authority and capability with efficient and flexible service operations. It is essentially practical to adopt private-style management and market-focused operations in public health-care deliveries. With continuously improved skills of personnel and capabilities of an organization, the activities to scale up the number of clients are then required for sustainable growth in serving more. Along the way to gradual growth, collaborations from various partners are needed. To collaborate, however, needs cultivating public minds among officials in the organization. And more importantly, it must begin with a leader who can engage subordinates and all stakeholders (partners) and who can be tenured for quite an uninterrupted period.

At public policy level, the acquisition of resources must be realized by sharing power between public general hospitals and the owners of resources, without political and procedural interferences to the administration. As such, a scrutiny mechanism participated by the owners of resources must be imposed. At least three social arrangements must be ensured: (1) independent control over key resources to the public organization, (2) channels of active participation from communities, and (3) lateral network configuration from the colligative actions from various stakeholders.

The future reform of the public health system requires a civil society where its citizens are empowered actively to collaborate and to scrutinize the administration of their general hospitals. The success of the Thai Universal Health-care Coverage and the achievement of controlling the COVID-19 pandemic situation in Thailand must not be misrepresented in order to understand that a medical state where power is granted to medical professionals can continue forever. Unless the majority of people can afford health-care services at the right time and of an equal quality, the configuration of the power arrangement of Thai public health system governing the administration of public health-care services must be reformed now.

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