Multi-dimensionality of Local Public Health Capacity: The Case of Local Public Health Management in Northeastern Thailand

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ABSTRACT

Thailand has been experimenting with decentralized governance since the late 1990s. However, the decentralization reform process has been ploddingly slow. Thai local authorities show different levels of management capacity, especially in the public health. Drawing on extensive research on community development and decentralization, this paper distinguishes among three dimensions of local public health capacity: local organizational capacity, local fiscal capacity, and community capacity. Although the public health functions are not fully devolved to local jurisdictions, several local governments in northeast Thailand have been actively involved in health-related matters. Statistical analysis, in-depth interviews, and focus group are used to compare these "good practice" localities with their neighboring communities. The research findings help identify capacity-building measures that must be in place to empower local governments in the developing countries.

Keywords: Decentralization, Public Health, Local Government Capacity, Community Capacity

Introduction

As universal health coverage has become a common goal shared by countries of all income levels, widespread concerns mount over the effectiveness and sustainability of public health systems in many transitional economies, especially with regard to their accountability and responsiveness to citizens (Chernichovsky & Hanson 2009). In light of these concerns, countries around the world have adopted a variety of policy initiatives ensure that their government resources are mobilized to advance the quality of public health services.

Among these initiatives, devolving public health functions to a local level has been touted by public health scholars and practitioners as a policy instrument to improve efficiency, equity, and quality of health services (Bergman 1998; Bossert 1998). Enhancing local government's public health role also corresponds with the contemporary public health literature. By virtue of their proximity to citizens, local government officials empowered by the devolved functions and decision-making discretion can tailor public health services to heterogeneous citizen preferences (Bossert & Beauvais 2002; Hutchinson & LaFond 2004; Milne & Milne 2010). No longer confined to medical sciences, contemporary public health has become a multidisciplinary field with emphasis on proactive health policies and programs (Ashton 1992). This proactive approach emphasizes health education and healthy lifestyle promotion, rather than healthcare and ill-health treatment. Citizens and their communities are encouraged to work together to promote healthy lifestyle, rather than relying on external organizations and experts for medical treatment (Elder 2001; Laverack 2006; Gilchrist 2007).

In the 1990s, the centralized administrative systems in many countries proved themselves incapable of dealing with the exigencies of modern society and globalizing economy. Political and administrative decentralization has captured the post-Cold War *Zeitgeist* that favors democracy and citizen participation. A large number of developed and

developing countries initiated large-scale reforms that featured the transfer of essential administrative responsibilities to local authorities. In Southeast Asia, Thailand ratified the 1997 constitution that dedicated an entire clause to the principle of local self-government. However, as was the case in all developing countries, translation of the constitutional principles into practice was problematic. Incentives to expedite the decentralization reform were miniscule since the interior ministry that was put in charge of implementing the decentralization reform was the very one that would be most negatively affected by the reform. As a result, the decentralization reform progress is ploddingly slow; everything concerning the country's administrative and territorial structures remains largely centralized (Sudhipongpracha 2013).

This persistent administrative centralization is evident in the central government's retention of the public health functions (Taearak 2010a). Since the national decentralization reform officially began, 10 out of 34 disease prevention and health promotion functions have been devolved to the local level. Also, only 0.40% of all primary healthcare facilities in the country have been completely transferred to the local jurisdictions. In Thailand's rural and impoverished areas, these primary healthcare facilities serve several important roles, ranging from preventing and treating common illnesses and injuries to promoting healthy lifestyle through health education programs. However, the public at large and mass media often cast doubts over local government capacity, naming corruption and declining health service quality as the potentially negative effects of decentralization (Srisuchart, Tangtipongsakhul, & Arunruangsawasdi 2013).

Nevertheless, the term "capacity" remains elusive, especially in the public health sector (LaFond, Brown, & Macintyre 2002). Apart from an ability to improve the quality and efficiency of public health services, it is important that local government organizations can

maintain these improvements in the long run, independent of external intervention (Brown, LaFond, & Macintyre 2001). Yet, even though a common approach among development planners and public health reformers is to build local capacity, the public health literature offers limited discussion of how to measure capacity and what capacity-building programs are designed to improve (Peters & Chao 1998; Brown et al. 2001; Nunn 2007). Therefore, this paper adds to the extant public health literature by examining various aspects of local government capacity in managing public health services in Northeast Thailand. Even with the budget constraint and narrow scope of functional authority, several northeastern local administrative organizations have managed to develop local health programs that won a number of awards from academic institutions and international donor agencies in recognition of their active involvement in public health services (Sudhipongpracha 2013). Comparing these local governments with their neighboring communities that are less actively involved in health matters, this paper helps enrich an understanding of what dimensions of local capacity need to be developed, as Thailand is moving forward with its decentralization reform efforts.

Local Government Capacity in Public Health Management: A Literature Review

Adequate local capacity for public service management is vital to the success and pace of decentralization reform. Not only can local management capacity be used to determine what administrative functions should be devolved to local government authorities, the concept—if appropriately defined and researched—can provide the central government and donor agencies with guidance on how to prepare local governments of varying capacity levels for public service responsibilities (LaFond 1995). A review of existing literature on public health and local government reveals three crucial dimensions of local public health capacity: (1) organizational capacity, (2) fiscal capacity, and (3) community capacity (Gillies 1998; Homsy & Warner 2011). The three dimensions complement each other and are necessary to

ensure the quality of decentralized public health services (Gillies 1998).This section is devoted to a discussion of the theoretical and empirical works on these two facets of local capacity

In general terms, capacity denotes the ability of a person or an organization to "carry out stated objectives" (Brown et al. 2001,5). The main objective of public health decentralization is to improve the efficiency and equity of services (WHO 2010). In this context, efficiency is defined as allocative efficiency whereby local jurisdictions are expected to be responsive to local needs and can be held accountable by citizens in a transparent manner than high levels of government (Jha et al. 1998). Equity means "the absence of systematic and potentially remediable differences in one or more aspects of health across population groups defined socially, geographicall, or demographically" (Macinko & Starfield 2002, 2). Both efficiency and equity are difficult to achieve, even for the national government agencies. However, as decentralization proceeds in many countries, local authorities are expected to deliver public services that are both efficient and equitable. Local organizational capacity needs to be harnessed to realize the objective of decentralization (WHO 2010).

Local Organizational Capacity

Research works on public health decentralization in Thailand identify several componets of local organizational capacity. The first component is technical expertise defined by the presence of professional public managers in local government organizations (Homsy & Warner 2011). However, this definition of technical expertise does not fit the Thai local government context. In the United States and Canada, professional associations and tertiary education institutions actively offer a variety of activities to enhance the degree of professionalism among local officials (Svara 2009). On the contrary, public professionalization efforts in the developing countries suffer from overemphasis on technical

skills without inculcating in government officials the public service ethics and democratic values.

Additionally, in many formerly centralized states, such as Thailand, local government personnel system continues to operate under the shadow of draconian national bureaucratic regulations. Unlike in the Western hemisphere where citizens are allowed to vote in a referendum to choose the form of local government, the mayor-council form of government was bequeathed to all local administrative organizations in Thailand –regardless of their population size and legal status. In this mayor-council system, popularly elected mayors sit atop the administrative hierarchy of municipal government and hold ultimate political authority over policy formulation and implementation (Sudhipongpracha 2011). The success and sustainability of public health decentralization programs in Thailand hinges upon these high-echelon elected officials' understanding and knowledge of public health management (Techaatik & Nakham 2009; Taearak 2010a).

Nonetheless, the mayors' technical knowledge alone does not suffice to guarantee local government efficiency and effectiveness in handling complex public health issues (Uphaypkin, Intaralawan, & Iamngam 2004). Certain health-related functions, such as inoculation, medical diagnosis, and many types of curative care, require advanced medicinal knowledge and resources that extend beyond local government capacity. As local officials are inevitably at the front line of the government's pandemic responses, the local leaders must orchestrate collaborative relationships with higher levels of government to mobilize all available resources and personnel to contain pandemic outbreaks. Even in the absence of a pandemic, public health issues by their nature transcend geographic and jurisdictional boundaries. Today's local leaders cannot afford to stand comfortably aloof from their

adjacent communities in formulating and executing public health programs (Srisasalux, Vichathai, & Kaewvichian 2009; Van den Dool, Van Hulst, & Schaap 2010).

Apart from the local leaders' technical expertise and collaborative mindset, an effective local public health system also requires a department-level municipal government office specifically designed for public health management (Wongthanavasu & Sudhipongpracha 2013). Since not all municipalities in Thailand have municipal health department, the local authorities with a well-established health agency are better off than those without in safeguarding their local health programs against a sudden change in political leadership (Taearak 2010a; 2010b). Moreover, the presence of a municipal health department strengthens the resilience and continuity of municipal health services by ensuring funding and staffing adequacy (Leethongdee 2011).

Local Fiscal Capacity

Fiscal capacity refers to a measure of a local jurisdiction's ability to finance public services (Hyman 2014). Indeed, sufficient fiscal resources enable local governments to undertake tasks of public service provision and make headway on decentralization (Kurata & Ikemoto 2012). In their analysis of local fiscal disparity in Georgia, Boex and Martinez-Vazquez (2007) provide a menu of several local fiscal capacity measures, including poverty level and average per capita personal income. On the contrary, due to the American local governments' heavy reliance on property tax revenues, assessed property valuation per capita is a commonly used measure of local fiscal capacity in the United States (Yilmaz et al. 2006).

However, the assessed property values do not serve as a basis for municipal taxation in Thailand (Krueathep 2007). Devas (2008) suggests that in countries where property tax is not the main local revenue source, gross regional domestic product (GRDP) or regional income per capita can be used as a proxy for local fiscal capacity. Yet, the use of GRDP and

regional income per capita can be equally problematic, as the provincial economic data may not proffer an accurate reflection of each local community's tax base (Patamasiriwat 2012).

Local governments' own-source revenue still remains a vital indicator of local fiscal capacity (Boex & Martinez-Vasquez 2007). Yet, this indicator has to take into account other local characteristics (Wongthanavasu & Sudhipongpracha 2013). As Wongpredee and Sudhipongpracha (2014) note, each jurisdiction's population size must be taken into consideration to expose its true revenue collection effort and capacity. Then, based on the two scholars' concept, local own-source revenue must be analyzed as local own-source revenue per capita. In addition to the local authority's revenue collection effort, other public finance scholars emphasize local discretion in making budget choices. To measure this local budget discretion, each local government's own-source revenue must be expressed as the percentage of total revenues (Weiss 2007).

In the decentralized public health context, an indicator commonly used in assessing local fiscal capacity in Thailand is the local authority's budget commitment to health-related activities (e.g., Techaatik & Nakham 2009; Tosanguan, Pitayarangsarit, & Sumalee 2010; Wongkongkhathep 2011; Wungrath 2011). To measure this expenditure aspect of fiscal capacity, the amount of funds allocated by municipal government for local health programs is calculated as the percentage of each municipality's total annual expenditure. The rationale behind the use of this indicator is that even though a municipality is fully capable of collecting its own-source revenue, it may not make substantial contributions towards development of efficient and equitable public health services (Sudhipongpracha 2013).

Community Capacity

The development literature abounds with definitions of community capacity. From the decentralization perspective, community capacity denotes active involvement of citizens,

local authorities, civic groups, and private entities in community planning and decision making (Glickman & Servon 1997; Van Assche & Dierickx 2007; Andrews et al. 2008). Other definitions related to local economic development emphasize the existence of resources and problem-solving skills among individual community members prior to program implementation (Poister & Streib 2005; Walzer & Sudhipongpracha 2012). For public health scholars and practitioners, capacity has become coterminous with the empowerment concept since the 1980s when the 'New Public Health movement' reached its zenith (Jones 2001). Inspired by this movement, capacity is defined as the community members' ability to 'work together to increase control over events that determine their lives and health' (Laverack 2006, 113). Based on this definition, other experts suggest that community capacity encompasses individual and community assets that are conducive to participatory governance (Kretzmann & McKnight, 1993; Jackson et al., 1997; Laverack & Wallerstein, 2001).

Based on these diverse strains of literature, community capacity in this study refers to the synergistic interaction of human and social capital which can be mobilized to disentangle collective problems and improve the general public welfare within a given community (Checkoway 1995; Laverack 2006). Specifically, this definition requires a thorough analysis of the informal interaction among individual community members and organizations, as well as organized efforts by community leaders and local government institutions (Chaskin & Garg 1997).

In past empirical works on Thailand's public health system, several indicators were employed to measure community capacity. In his analysis of Thai local governments' preparedness for devolution, Wattana (2004) stresses the importance of formal and informal cooperative ventures between civic groups and public agencies within a given community. Two years after subdistrict administrative organizations (SAOs) were formally established in

Thailand, Prasitiratasindhu and Chuwonglersa (1997) conducted a performance assessment of the SAOs in Khon Kaen province and found that an important indicator of an SAO's administrative capacity is its ability to work with ordinary residents to address complex public issues.

In sum, this literature review showcases the multi-dimensionality of local public health capacity—defined in this research as the local jurisdictions' assets and abilities to achieve the decentralization reform objectives. In this section, the capacity concept is disaggregated into *organizational*, *fiscal*, and *community* dimensions. Amid Thailand's ongoing political and administrative reform process, local government units are at the frontline of public service provision, particularly in the preventive and promotional aspects of public health. Thus, an understanding of the local public health capacity is central to the reform efforts that seek to downsize the national government and empower local communities.

Research Methods

Research Design and Case Selection

A comparative case study is used to examine the level of public health management capacity in four local jurisdictions in Thailand's northeastern region. Comparative case studies can strengthen the theory-practice linkage that is vital to many disciplines, such as public administration (Leland & Thurmaier 2010). However, in compliance with the public health research protocol (Vallgarda & Koch 2008), the four communities' actual names are omitted and replaced with tropical fruit name (Table 1).

In this research, two local jurisdictions in which the local governments have taken an active role in health-related matters despite their limited authority are referred to as the 'good

practice' localities. Since the decentralization reform officially began in 1997, Durian city in Udornthani province has garnered many 'good governance' and 'excellence in public service' awards organized by government agencies and academic institutions in Thailand and abroad. In the same province, Mongosteen city boasts a similarly impressive record of awards from government and educational institutions, such as the 'good governance and public management' awards from the Department of Local Administration between 2006 and 2008. Additionally, for the past several years, both Durian and Mongosteen cities have consistently been honored by Thailand's Office of the Royal Development Projects as model communities for sustainable development and quality-of-life enhancement.

The good practice localities are compared against two jurisdictions with the inactive local governments (i.e., a comparison group) from a neighboring province—Nongbua Lumphy. Residents in both provinces hold the same party affiliation (i.e., Pheu Thai Party) and share common ethnic and linguistic characteristics. Despite a wide range of population density among the chosen jurisdictions in this study, past research works on American urban politics (e.g., Lyons, Lowery, DeHoog 1992) and Thai politics (e.g., Albritton & Bureekul 2002; Thananithichot, 2012) point out that population density does not have as much influence on citizens' political awareness as previously believed. In fact, the degree of political efficacy is not markedly different between Thai citizens in the densely populated urban areas and those in the sparsely populated rural areas (Thananithichot, 2012).

Variables of Interest

In this study, the primary variable of interest is the local jurisdictions' public health management capacity which consists of three distinct dimensions as previously identified and conceptualized in the literature review section. Drawn from past empirical and theoretical

works in diverse fields, operational definitions for each dimension of local public health capacity appear in Table 2.

Table 1. Comparative case study research design.

	Name of Locality	Province	Area (km^2)	Population (2012)	Population Density (per km^2)
Good Practice Group Active Local Government	Durian	Udornthani	47.70	138,136	2,895
	Rambutan	Udornthani	59	13,520	229
Comparison Group Inactive Local Government	Coconut	Nongbua Lumphu	39.50	51,338	1,299
	Palm	Nongbua Lumphu	81	5,560	68

Data Collection

Data collection methods employed in this research include document research, in-depth interviews, and focus group discussions (Table 2). Documents, such as local government budgets, annual performance reports, and local development plans, are analyzed to reveal each jurisdiction's fiscal capacity and certain aspects of organizational capacity. From November 2012 and January 2013, local government officials, including the mayors, municipal administrators, and city health personnel, were interviewed to obtain information on their organizational capacity and political leadership. The research team also conducted focus group discussions with community leaders and members from each of the four jurisdictions to gauge their understanding and attitudes towards public health, interpersonal relations, as well as their relationships with government agencies.

Table 2. Variables of interest, operational definitions, and data collection methods

Dimension of Local Public Health Capacity	Operational Definition	Past Research Works	Data Collection Method	Key Informant	Total Number of Key Informants
Local Organizational Capacity	▪ The mayors' understanding and attitudes towards public health	Uphaypkin, Intaralawan, & Iamngam (2004); Techaatik & Nakham (2009); Taearak (2010a); Wongthanavasu & Sudhipongpracha (2013)	In-depth interview	Local officials from each community (Mayor, Municipal administrator, Health department director)	12
	▪ Existence of a public health agency within the local government structure	Taearak (2010a, 2010b); Leethongdee (2011); Wongthanavasu & Sudhipongpracha (2013)	Document research	-	-
	▪ Percentage of municipal public health personnel in each local government	Taearak (2010a, 2010b); Leethongdee (2011); Wongthanavasu & Sudhipongpracha (2013)	Document research	-	-
Local Fiscal Capacity	▪ Local own-source revenue per capita	Boex & Martinez-Vasquez (2007); Wongthanavasu & Sudhipongpracha (2013); Wongpredee & Sudhipongpracha (2014)	Document research	-	-
	▪ Local own-source revenue as a percentage of total revenues	Weiss (2007)	Document research	-	-
	▪ Amount of local government budget allocations for health-related activities	Techaatik & Nakham (2009); Tosanguan, Pitayarangsarit, & Sumalee (2010); Wongkongkhathep (2011); Wungrath (2011)	Document research	-	-

Table 2 (Continued)

Dimension of Local Public Health Capacity	Operational Definition	Sample Research Works	Data Collection Method	Key Informant	Total Number of Key Informants
Community Capacity	▪ Level of participation in community health activities, such as physical exercise groups in a community	Wattana (2004)	Focus Group Interview	8-10 people per community	35
	▪ Local residents' attitudes towards participation in a community's health promotion activities and health management board meetings	Checkoway (1995); Prasitiratasindhu and Chuwonglersa (1997); Chaskin & Garg (1997); Laverack 2006).	Focus Group Interview	8-10 people per community	35

Research Findings

Despite a constitutional mandate, the decentralization reform initiatives in Thailand have been slowly put into action. The national government control on public service functions, particularly public health, remains intact. Also, the general public continues to cast doubts over the quality and efficiency of local public service. Thus, a crucial question for the next steps of decentralization reform in Thailand is how to strengthen local government capacity before devolving substantial administrative responsibilities to a local level. This section presents an in-depth analysis of the local jurisdictions in Northeast Thailand that have managed to offer public health services despite their budget and administrative constraints. To accurately explain each of the three aspects of 'local public health capacity,' the two 'good practice' localities are compared against the neighboring communities that have similar ethnic, linguistic, and political attributes.

Local Organizational Capacity

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

Based on the findings from in-depth interviews, mayors from the four jurisdictions show markedly different levels of public health knowledge. Municipal administrators and health department directors in this study were asked to assess their mayors' understanding and attitudes towards public health. On a scale of one to ten with ten being the most positive, the Rambutan (10 points) and Durian mayors (8 points) possess more public health knowledge than the Coconut (6.5 points) and Palm mayors (5 points). As the Rambutan City health department director opined, 'in meetings or during press conferences, the mayor speaks so eloquently and with sufficient depth of knowledge about public health'. When asked why his city administration has invested so much in public health, the Durian mayor responded:

> I strongly believe that health means the overall quality of life. A healthy person is a happy person. That is why my city administration has concentrated a lot of efforts and resources in health matters because I want Starfish city to be a happy community.

The Rambutan mayor made a similar statement during an interview, emphasizing that good health, including physical and mental health, is essential to sustainable community development.

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

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

On the other hand, the Coconut and Palm municipalities did not demonstrate as much commitment to public health as the 'good practice' localities. Despite the presence of a municipal public health department, there is a limited range of public health services in Coconut city. A lack of locally run health centers drives the Coconut city residents to travel

to other areas for healthcare services. Also, unlike the size of municipal public health workforce in Durian city, only 15% of the Coconut municipal government personnel are public health officials. The state of public health services in Palm city is equally problematic. Palm residents must rely on the central and regional agencies for health services because their municipality does not have an agency specifically assigned for health administration. Neither does it have public health personnel on its municipal government payroll.

Local Fiscal Capacity

Apart from organizational capacity, local authorities require adequate resources to finance their public health operations. Drawn upon the past literature, three aspects of local fiscal capacity include local revenue collected per capita, local revenue as a percentage of total revenues, and local budget allocations for health-related programs. The first two aspects help evaluate local governments' effort to ensure financial self-reliance and sustainability, whereas the amount of funding allocations for local health services illustrates the local governments' commitment to public health.

However, the two 'good practice' localities, especially the Rambutan city, appeared to have difficulty with revenue mobilization. Starting in 2009, the Rambutan city government experienced a sharp decline in own-source revenue per capita (Figure 1). This declining pattern stood in sharp contrast to a consistent and growing revenue stream in Palm city which is also a sparsely populated rural community. On the other hand, the densely populated areas—Durian and Coconut cities—did not significantly differ from each other in their per capita own-source revenue between 2008 and 2012. Only in 2009 did the Coconut city government's own-source revenue per capita clearly exceed the amount of revenue collected by the Durian city government.

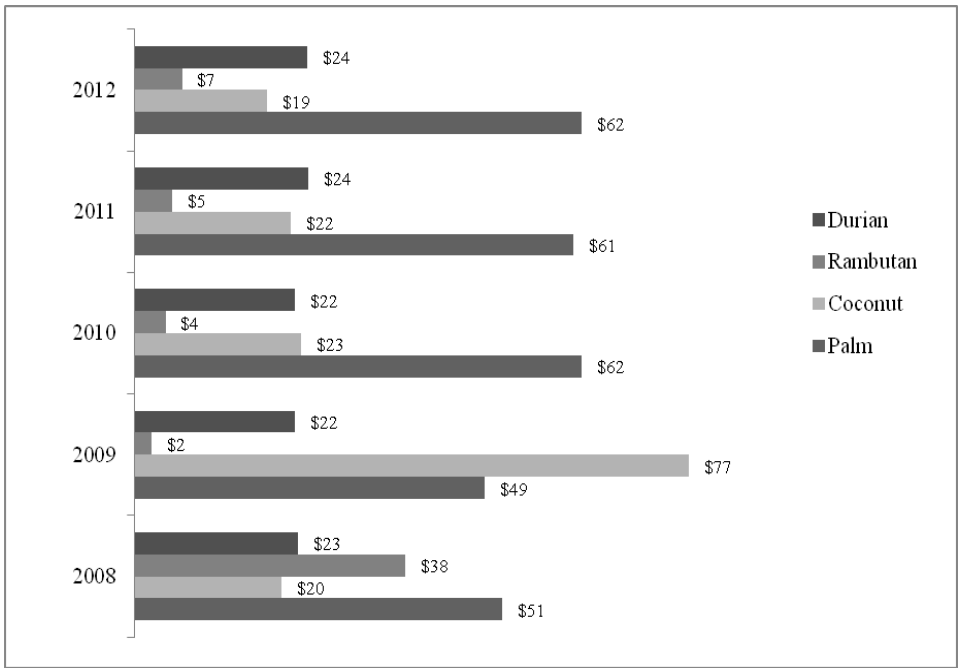

Figure 1. Per capita own-source revenue collected between 2008 and 2012 by the four jurisdictions in this study

The above analysis suggests that the localities with active local government involvement in public health might not be as financially self-reliant and sustainable as the comparison communities. Rambutan city in particular experienced a serious problem with revenue collection. When each jurisdiction's own-source revenue is calculated as a percentage of its total revenue, this study finds that own-source revenue did not make substantial contributions to the Rambutan city's coffer between 2008 and 2012 (Figure 2).

Apart from Rambutan city, one of the comparison communities—Coconut City—faced an even worse revenue situation. Since 2008, a dramatic decrease in own-source revenue has pressured the Coconut city government to depend on other financing sources, such as the national government grant. Nonetheless, contrary to past empirical works on fiscal decentralization, another comparison city—the Palm city government which has been inactive in community health management—enjoyed the strongest fiscal autonomy from

2008 to 2012. During the five-year period, Palm city's financial self-reliance was even higher than that of Durian city—a 'good practice' locality from a heavily populous urban area.

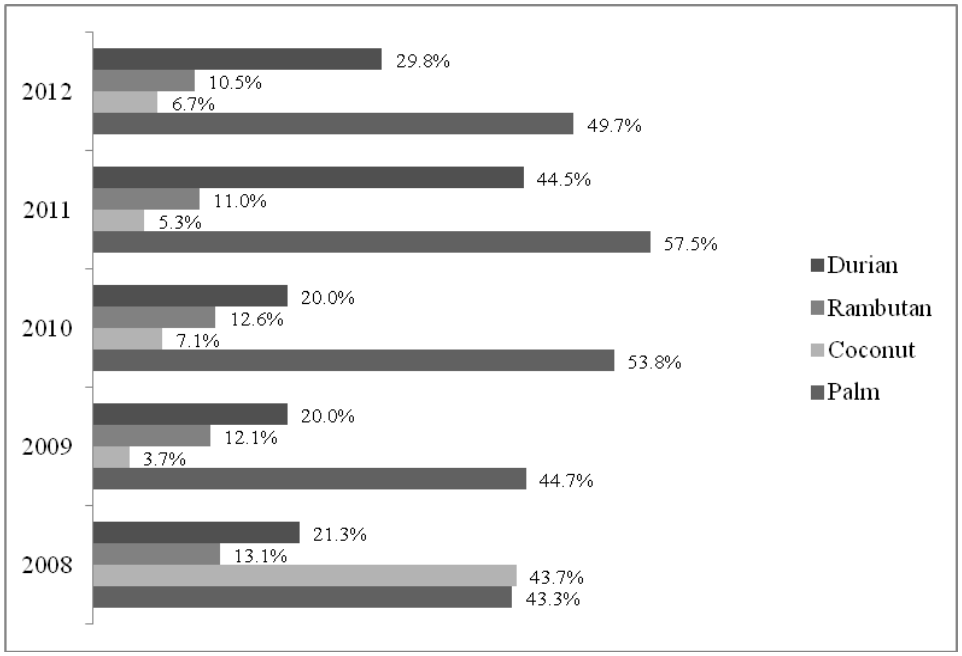

Figure 2. Own-source revenue as a percentage of total revenue collected by the four jurisdictions in this study between 2008 and 2012

Despite much empirical and theoretical support, own-source revenue data alone do not accurately depict the fiscal dimension of local public health capacity. Since decentralization began, local revenue collection has always been an important challenge facing many Thai local authorities regardless of their organizational structure, population size, and local economic conditions (Wongpredee & Sudhipongpracha 2014). Besides, there is no guarantee that a local government with high fiscal autonomy would earmark substantial funds for public health services. Thus, apart from local own-source revenue stream, it is necessary to consider how much each of the four jurisdictions spent on public health programs.

Between 2008 and 2012, the Durian and Rambutan city governments allocated more resources to public health programs than the Coconut and Palm city authorities (Figure 3). As

previously discussed, Rambutan city had the smallest amount of per capita own-source revenue, compared to the other three cities. Yet, calculated as a percentage of each year's overall budget, the amount of resources that the Rambutan city government dedicated to public health was larger than in other localities. Equally well-known for its municipal health programs, the Durian city government also set aside a substantial portion of its annual budget for public health—second only to the Rambutan city government.

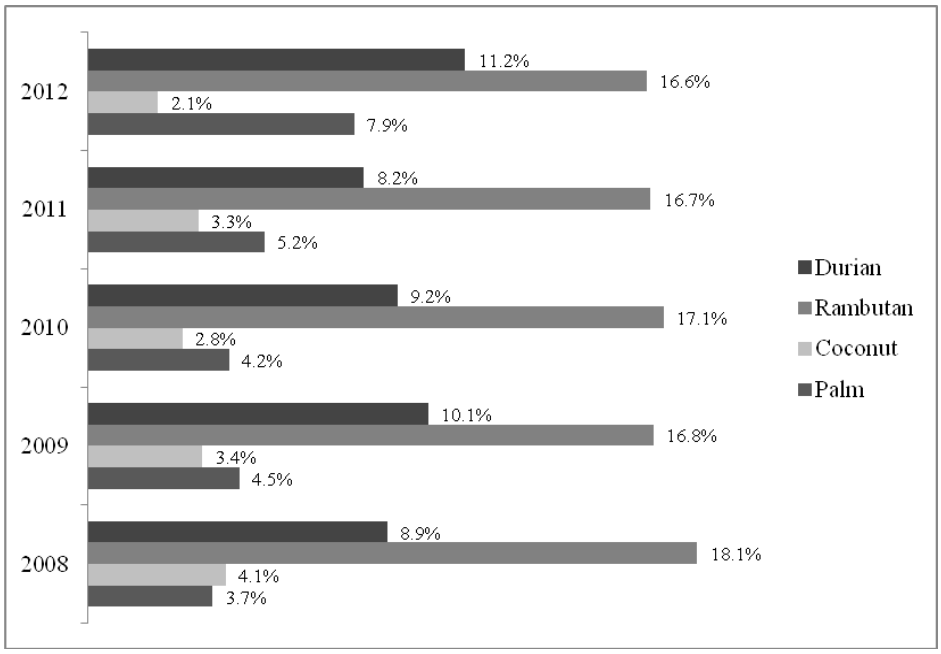

Figure 3. Local Budget Allocations for Public Health Programs as a percentage of Total Budget Allocations (2008-2012).

Community Capacity

In this study, community capacity is defined as the formal and informal relationships among individual community members, local government agencies, and civil society groups. These formal and informal networks within a given community serve as an important catalyst for community development and decentralization reform. Based on past research works about

decentralized governance in Thailand, the success of public health decentralization hinges on a solid working relationship between local government authorities and their citizens.

The Durian city residents have a tendency to form a variety of physical wellness groups (Table 3). Despite the absence of formal management hierarchy, the Durian wellness groups continue to expand their membership and have succeeded in soliciting financial and/or in-kind assistance from the Durian city government. Similarly, residents in the Rambutan community are inclined to get into physical wellness groups sponsored by the city health department. Not only do the informal physical wellness groups help to promote healthy lifestyle habits in both communities, they also demonstrate a high degree of social capital among the city dwellers.

Table 3. Number and type of informal physical wellness groups

	Community	**Number and Type of informal physical wellness groups in each community**	
		No.	**Type**
Good Practice Group Active Local Government	Durian	35	Aerobic dance, Chinese martial arts, yoga, bicycling, soccer, sepak takraw (Southeast Asian traditional sport), basketball, badminton
	Rambutan	10	Aerobic dance, bicycling, soccer, sepak takraw
Comparison Group Inactive Local Government	Coconut	2	Aerobic dance, soccer
	Palm	-	-

In addition to the informal wellness groups, citizens in the Durian and Rambutan cities are also involved in local government affairs. In a focus group interview, all Durian city residents (100%) stressed the importance of attending the community health board meetings. According to a senior citizen, a large number of Durian citizens willingly serve on each precinct's health management board and actively engage in making important decisions.

However, the Rambutan city residents showed a lesser degree of enthusiasm about getting involved in their city government's decision-making process. During the focus group interview, four out of nine residents (44.44%) reported that they do not actively participate in the local government affairs because they must tend to their cattle and rice paddies. However, almost every Rambutan resident in the interview (88.89%) stated that they monitor the mayor's policy initiatives, program implementation, and budget allocation on an *ad hoc* basis. They also contended that the Rambutan community has not seen any political conflicts for many years. One of the Rambutan youth leaders stated:

> Most people here are farmers and don't have the luxury of time to get regularly involved in local government affairs. But, they do check how local officials work from time to time. Fortunately, we in Abalone never run into conflict. Our disagreements can always be solved through informal interpersonal dialogues.

In contrast with the 'good practice' localities, levels of interpersonal relations and social activism are comparatively low in the Coconut and Palm communities. These two comparison communities have no dynamic social groups or popular involvement in local government affairs. During a focus group interview with the Coconut residents, a village health volunteer argued that the absence of social activism and citizen engagement in the city is caused by the citizens' inadequate education:

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

While interpersonal dialogues were instrumental in resolving community conflicts in the Rambutan city, the Coconut residents did not show much interest in collective actions. During a focus group interview, seven out of eight Coconut community members (87.50%) voiced their opinion that conflicts over the city government budget occur on a regular basis. Although these conflicts never become violent, the Coconut city residents, particularly the youth leaders and village heads, clearly demonstrated their displeasure against one another, especially when they were asked to comment on disease prevention activities.

Discussion and Conclusion

The constitutionally sanctioned decentralization reform in Thailand has prompted the national government agencies to devolve administrative functions to a local level. Today, the national government still exercises considerable influence over essential public services. The general public also cast doubts over local government capacity, as well as the merits of decentralization. However, because local governance provides an essential foundation for liberal democracy, capacity-building measures for the local government authorities and their constituent communities are an indispensable next step for the administrative reform efforts designed to enhance democracy and public service quality.

Yet, despite its appeal for community development efforts, the capacity concept suffers from elusive operational definitions. Granted, certain public health functions (e.g., health promotion and disease prevention) should be devolved to the level of government closest to the citizens. What aspect of local government capacity must be nurtured becomes an important question for the countries that are pursuing health decentralization. Drawn upon diverse scholarly works on decentralization, public health, and community development, the conceptual framework in this paper identifies three aspects of local public health capacity: organizational capacity, fiscal capacity, and community capacity. Four jurisdictions in

Thailand's northeastern region are compared to examine these three dimensions of local government capacity.

Two of these four communities—the Durian and Rambutan cities—have won a number of awards for good governance, service quality, and active citizen engagement. Regardless of the budget and administrative constraints, the cities governments in these 'good practice' localities have managed to put together a set of public health programs that improve both the quality of life and democratic governance. Based on the research findings, the 'good practice' city governments demonstrate strong institutional and fiscal commitment to health services. Their well-informed political leaders have a firm grasp and positive attitudes towards public health. An organizational structure and personnel designated for public health programs are readily available. Importantly, the strength of informal ties among the Durian and Rambutan residents has given rise to a number of physical wellness clubs and lively participatory politics.

The Coconut and Palm communities are different from the 'good practice' localities in terms of their organizational and fiscal capacities. Their mayors expressed less enthusiasm about assuming more public health responsibilities. Also, apart from the inadequacy (and even the absence) of a department-level health office and health personnel, the residents in the two comparisons demonstrate weak social ties and interpersonal communication.

However, as shown in Table 5, the fiscal dimension of local government capacity cannot effectively distinguish among the 'good practice' and comparison communities. Particularly problematic are the indicators that calculate the amount of local own-source revenue both on a per capita basis and as a percentage of total local government revenue. However, this problem is understandable. Similar to local governments in other countries, the local administrative organizations in Thailand are at the bottom of the fiscal food chain. A

confluence of factors, including the local taxation structure determined by the national government, has a strong impact on the city governments' financial health and is beyond their control.

Thus, based on this study, government reformers in Thailand and elsewhere must reconsider the use of fiscal indicators in their decentralization reform initiatives. Instead of pressuring the local authorities to collect more taxes, an intergovernmental grant system can be designed to provide an incentive for local governments to take up a more active role in local health management. For instance, a general-purpose grant can provide a substantial amount of financial resources for a local government organization to spend on personnel and basic health services. Furthermore, the research findings from this study can inform government reformers and community development practitioners in other countries as well. The quality of political leadership, organizational commitment, and strong interpersonal ties among local residents are three key attributes of the 'good practice' localities. These political, organizational, and social assets at the local level must be nurtured, particularly for countries with a long tradition of centralized public administration.

As Thailand and other developing nations are moving forward with their decentralization reforms, more in-depth research is necessary for an understanding of local capacity in managing other public service areas, such as education and environmental preservation. Besides, what is missing from this study is a longitudinal analysis of the socio-political dynamics in each 'good practice' locality. Information on how the local leaders and ordinary citizens have been working together to strengthen their community capacity can furnish even more policy recommendations for Thailand's ongoing local government reform.

Table 5. Summary of Local Public Health Capacity Indicators

Dimension	Indicator	'Good Practice' Locality		Comparison Locality	
		Durian	***Rambutan***	***Coconut***	***Palm***
Organizational	▪ The mayors' understanding and attitudes towards public health (On a 1-10 scale)	8	10	6.5	5
	▪ Existence of a public health agency within the local government structure	✓	✓	✗	✗
	▪ Percentage of municipal public health personnel in each local government	25%	13%	15%	0%
Fiscal	▪ Local own-source revenue per capita (5-year average)	$23	$11	$32	$57
	▪ Local own-source revenue as a percentage of total revenues (5-year average)	27.1%	11.9%	13.3%	49.8%
	▪ Amount of local government budget allocations for health-related activities (5-year average)	9.5%	17.1%	3.1%	5.1%
Community	▪ Level of participation in community health activities, such as physical exercise groups in a community	High	Medium	Low	Low
	▪ Local residents' attitudes towards participation in a community's health promotion activities and health management board meetings	Positive	Positive	Negative	Negative

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