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INVITED ARTICLE

District Health System Management Learning: A big leap forward to people-centred District Health System in Thailand

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Abstract

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Reinforcement of District Health System workforce capabilities has been boosted from 2007 onwards through a "Context Based Learning" approach and evolved through actions and reflections of three main sets of experiences: i) Primary Care Practice Learning started in 2007; ii) Family Practice Learning started in 2012; and iii) District Health Management Learning (DHML) started in 2014.

DHML aims to facilitate effective networking for people-centred District Health System through the process of Participatory Interactive Learning through Actions (PILA). A Learning Team (LT) is set up in each participating district to learn from one local health driven project expected to improve on DHS development and quality of life of the people. The LT is usually made of 2-3 members from the hospital, 2-3 from the district health office and health centres, 2-3 from non-health, especially, people sector. For project implementation, the learning team interacts with several actors within the DHS and also beyond its limits: the "operational network". Systematic links are established between LTs and supportive actors building in this way a large "learning network": a local Preceptor (P) who directly supports the LT in the field; a Learning and Coordination Centre (LCC) in charge of facilitating regular exchange among 4-5 LTs within the same learning network; Academic Institutions (AI), some agents of which participate systematically in all learning process (assigned AI), others participating only when specific expertise is needed in relation to academic menus (AI on demand); and Sources of Learning (SL) for learning from site visits and relevant experts. Core competencies (self-control, vision and goals, planning, leading for change, working in team, and using management tools) and shadow competencies (values, relationships, communication, and power management) are expected to increase and to be accepted as necessary competencies for management of DHS.

Developmental evaluation, focusing on theory-driven, and realist evaluation, had been carried out systematically by the promoters since the beginning of the implementation (from June 2014 to August 2016), with the periodic and systematic participation of an international guest expert, and supported by data collection of a Thai academic team. The methods for collecting data were participatory observation of the DHML processes and reflections (at district, provincial, regional, and national levels), visits of several DHML local projects and interviews of key persons related to DHML and a questionnaire survey. From 2014 to 2015, 227 LTs, 216 Ps, 44 LCCs, 52 AIs, and several SLs in different regions of the country have participated in the process as DHML pioneers (from 2015 to 2016, had gradually been increasing). The definition of core and shadow competencies of management of DHS was well accepted by all participants; significant improvement of self-control (for better listening) and working in team among the core competencies, and of all four competencies among the shadow competencies was qualitatively expressed through stories telling, narratives writing, and systematic interviews. Learning networks (AIs-LCCs-Ps-SLs) to support the current and subsequent batches of LTs were successfully established. Matrix teams/links/networks in the districts were significantly facilitated and supported through the implementation of the DHML projects with a clear direction toward person- and people-centred care.

DHML fits into a sustainable comprehensive and continuous grounded capacity building which is now functioning in most districts in Thailand and still evolving. Several teams and facilitating conditions are being set up in order to work better together: functional relationship, continuously learn together: learning relationship, strengthen the organisation together: managerial relationship, for sustainable development of people-centred district health systems.

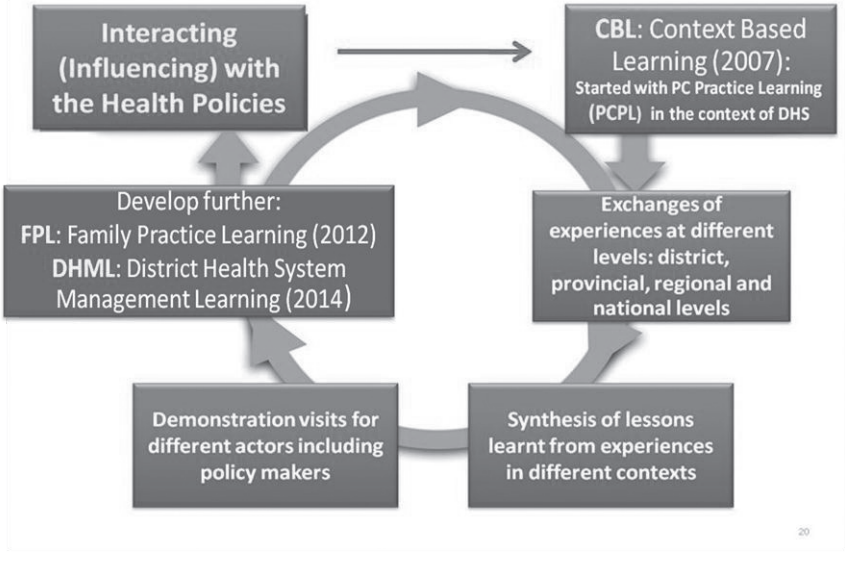
Keywords: Context Based Learning, District Health System Management Learning, District Health System, People-Centred Care.

Introduction

Moving from hospital- toward people-centred district health systems has benefited in Thailand from dramatic reinforcement of infrastructure and staffing in the periphery (community hospitals, health centres), and simultaneously from progressive physicians' concern for primary care. The universal health coverage scheme launched in the 2000s encouraged interaction between levels of care: primary care started to be financed through "contracting units for primary care" made of proximity units linked with at least one physician usually active in a hospital. Reinforcement of District Health System (DHS) workforce capabilities has been boosted from 2007 onwards through a *"Context Based Learning (CBL)"* approach[1], the main features of which are starting from activities in the working context and effective interaction within, and between, all levels of local health and social care system (district, sub-district, village, and family)[2-3]. CBL aims at being "participative interactive learning through action (PILA)[4]": learning by doing specific actions in one's own context, exchanging experiences of actions in different contexts, sharing common values and principles in order to learn from and for further actions.

In 2007, CBL was first introduced by focusing at existing health centre staff, *Primary Care Practice Learning* (PCPL), as a complementary strategy to formal training in order to improve on their skills in such a way they could effectively contribute in quality care provision within their integrated health care system[5]. *Family practice learning* (FPL) was consequently organized in 2012 to provide family doctors with skills related to quality patient-centered care and simultaneously skills to support the district health system[6-7]. *District Health System Management Learning* (DHML) was eventually set up in 2014. Evolution of CBL could be summarized as in Figure 1.

Figure 1 The processes of spiralling up through actions and reflections of evolution of CBL



DHML does not target the managers of the health system, only, but all staff involved in district health system development. It is a move to reinforce partnership between the district key stakeholders and actors, and their capabilities to work together for improving on district health system management and strengthening, and consequently health and wellness of the target populations.

DHML: Design and Implementation

DHML concerns any staff involved in reinforcing health system organization and aims to facilitate effective networking for people-centred District Health System through the process of Participatory Interactive Learning through Actions (PILA). In particular, it intends to train the district health system managers and management actors through their supports to one district health project. They should have comprehensive vision and principles of health district management, as well as common goals and complementary missions, in order to fully cooperate and integrate their own specific interventions, and resources, in the whole district development process: they are expected to work and learn together, as well as to develop together the health system. DHML participants can learn *from* the project through project implementation especially on better understanding their local health system and developing relationships for effective networking for people-centred district health system. They can also learn about new concepts, methods, and tools for a more effective of the project implementation. It is advised that selected project for learning should focus on a specific but complex issue, and involve different levels, i.e. village, health centre, hospital, in the district, and from different sectors, especially, people sector.

A manual of DHML was developed to be a guideline for implementation[8]. To start DHML, a core team was established and promoters coached the processes and a process of developmental evaluation in health system research[9-10] was also started.

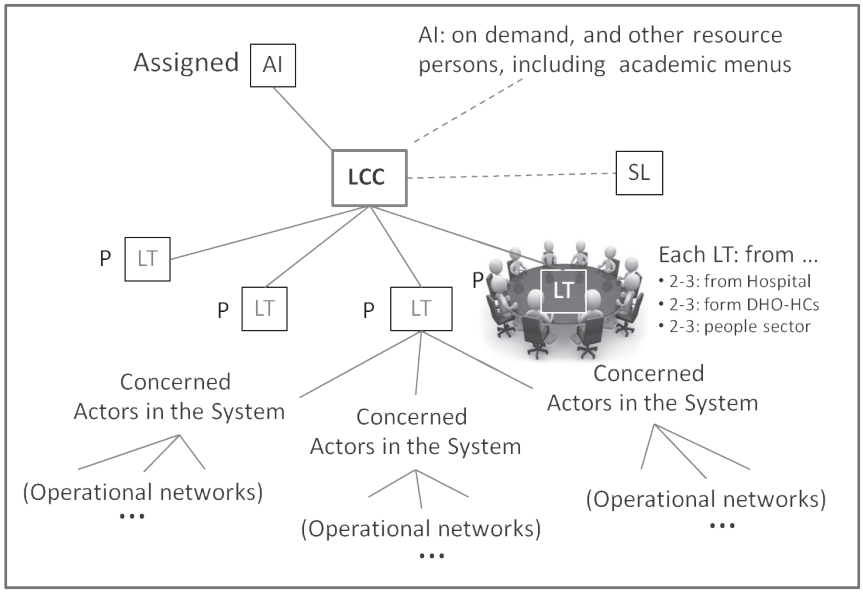
There are six core competencies to be acquired: self-control, vision and goals, planning, leading for change, working in team, using management tools. There are also four "shadow" competencies, which should be "like one's shadow" related to values and norms, relationships, communication and power management. Objectives go beyond the reinforcement of knowledge and know how, DHML aims at the transformation of the being of individuals, appropriate ego to harmonize with others, as well as to strengthen teams and system as a whole. These core and shadow competencies have basically been developed from common competencies for all health care managers, complexities and possibilities of district health system management, and a review of the literature.[11-13].

A *Learning Team* (LT) is set up in each participating district to learn from one local health driven project expected to improve on DHS development and quality of life of the people. The LT is usually made of 2-3 members from the hospital, 2-3 from the district health office and health centres, 2-3 from not-health and people sector, all are involved in the district project. For project implementation, the learning team interacts with several actors within the DHS and also beyond its limits: the *"Operational Networks"*.

Systematic links are established between LTs and supportive actors building in this way a large

"Learning Network" (Figure 2). The learning teams are accompanied by a local *"Preceptor"* (P) who provides coaching and technical support in the field. Each district learning team clusters with other teams (there are 4-5 district learning teams in each cluster); they attend during one year at least five "two-day" workshops in order to exchange on their district project development and learning process. *Academic Institutions* (AI) provide additional support. Some academics participate systematically in all learning process (assigned AI): they participate in the workshops, provide specific inputs when it is necessary, validate the learning process and also learn themselves from the field (they need to feed their teaching at the university). Others are mobilized only when specific expertise is needed in relation to eleven academic menus (AI on demand). For each cluster, an organization plays the role of *Learning and Coordinating Center"* (LCC). There is no standard profile for the LCC: it may be a community hospital, a teaching institution, a provincial health office ... depending on their potentials and willingness. Within the cluster, each learning team's district is considered as a learning site for the others. Additionally, districts and experts outstanding for a specific issue are identified as *"Source for Learning"* (SL) and used on demand, only. They are proposed to any learning district team, or cluster, for study field visits. It is not foreseen to have "demonstration districts", since all districts are continuously developing and learning. Districts are complex adaptive systems.

Figure 2 A learning network for Participatory Interactive Learning through Actions in DHML



AI: Academic Institution (academic experts)

LT: Learning Team (being systematically supported for 1 yrs)

SL: Sources of Learning

LCC: Learning and Coordinating Centre

P: Preceptor (Coach or Supervisor)

Four main learning situations are defined: i) continuous work of learning team members with concerned actors and operational networks; ii) meetings among learning team members; iii) meetings of learning team members and their preceptor; and iv) workshops attended by LTs and their supportive actors under the same network of LCC. The first situation is considered to be the most important since DHML intends to transform not only the learning team, but also their managers and the district health system as a whole,

In order to increase the capacities, learning material, as supportive information in relation to district health system, is offered in a set of eleven "menus"[14-15]. Participants are expected to select and mobilize the learning material they need: structuring papers, PowerPoint presentations, scientific papers, textbooks, videos, list of resources persons to be mobilized for conferences. They must decide on their own, they are empowered. They may however be supported to that effect by their P, LCC and AI.

The menus for DHML are the following: vision (principles) and goals; situation analysis; health problems, including risk factors and determinants of health; health care organization; health system management; health planning and management cycle; management of human resources and appropriate use of technologies; community participation and intersectoral collaboration; health management information system; financial management; and evaluation.

Evaluation of DHML

Developmental evaluation, focusing on theory-driven and realist evaluation[10,16,17], had been carried out systematically by the promoters since at the beginning of the implementation, from June 2014 to August 2016, with a periodical and systematic participation of an international guest expert[18-19], and the support of data collection by a Thai academic team[20]. Methods of data collection for developmental evaluation included:

- Systematic and participatory observations and reflections (at district, provincial, regional, and national levels) including visits of several DHML local projects for continuously context specific adaptation of the DHML process by the promoters in almost all clusters (each cluster having LCC as a focal point) of DHML pioneers.
    - o The team of Thai academics and the international guest expert have periodically and systematically participated in the process.
- Semi-structured interviews (purposive sampling) by the team of Thai academics in collaboration with the international guest expert
    - o Individual interviews included: executives of Ministry of Public Health, National Heath Security Office, and Academic Institutions (altogether 8 interviewees);
    - o Focus group interviews: academicians from Academic Institutions who participated to DHML process (12 academicians from different AIs); Committees of Learning and Coordinating Centres (40 persons from different LCCs); and Preceptors (10 Ps)

- A questionnaire survey was carried out by the team of the Thai academics in order to understand experiences of Learning Teams (180 respondents from different LTs).

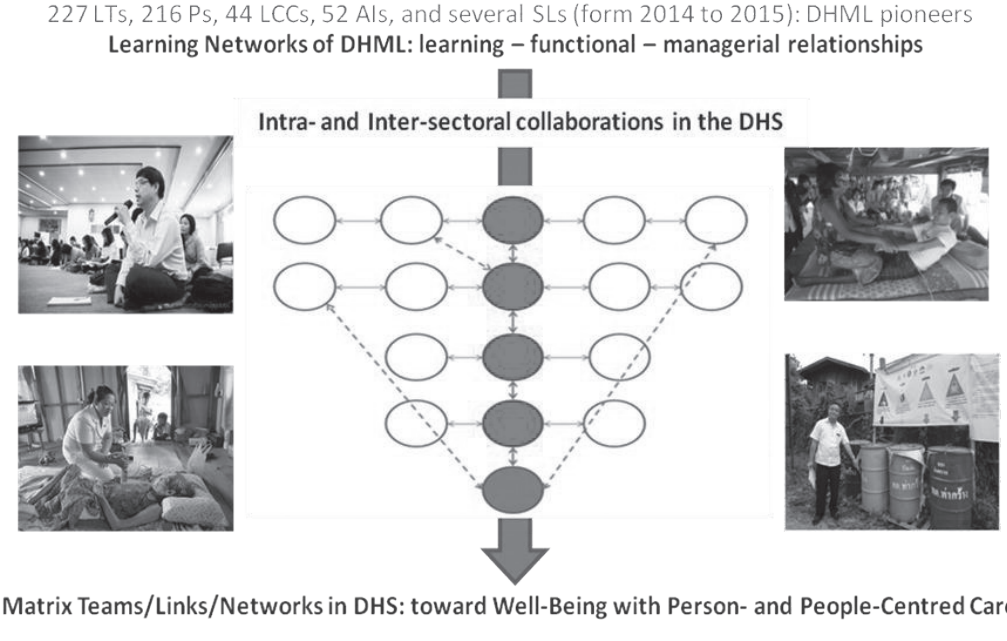
All findings were presented and discussed in several meetings. Lessons were sorted according to a framework of analysis which focuses on five issues: DHML learning process through the common district project implementation, the development of the supportive learning networks, the acquisition of new competencies, the improvement of health districts responsiveness and the teaching transformation in related academics institutions.

The scenario has been effectively implemented as expected. Learning networks have been set up according to the guidelines: From 2014 to 2015, 227 LTs, 216 Ps, 44 LCCs, 52 AIs, and several SLs in different regions of the country have participated in the process as DHML pioneers. From 2015 to 2016, the networks have gradually been increasing.

There was high diversity in the concrete situations. However, some common projects such as home-based long-term care, comprehensive interventions on non-communicable diseases, community psychiatry, and health promotion focusing on social determinants of health were commonly selected as projects for learning.

DHML processes could significantly stimulate developmental networks in the districts both intra- and inter-sectoral collaborations with a clear direction toward person- and people-centred care. (Figure 3). Matrix teams/links/networks in the districts were significantly facilitated and supported through the DHML project implementation.

Figure 3 Overall direction of implementation of the projects in DHML



Altogether, it was found that DHML was feasible and delivering some valuable concrete results. Syntheses of experiences of implementation of the projects are being done and categorized as parts and for further development of academic menus and sorts for learning.

Network development was impressive, both within the districts and beyond their borders. Each net-working has been growing up around each LT. Learning networks (AIs-LCCs-Ps-SLs) to support the current and subsequent batches of LTs were successfully established. Districts exchange their experiences, and the link between academic institutions is reinforced.

The definition of core and shadow competencies of management of DHS was well accepted by all participants; significant improvement of self-control (individual's change) and working in team among the core competencies, and of all four competencies among the shadow competencies was qualitatively expressed through stories telling, narratives writing, and systematic interviews. There was not much focus on technical capacities: it is first making better use of their already existing tacit knowledge, then if necessary mobilizing explicit knowledge from external experts.

Individual's change (changing the self: self-control, open-mindedness, listening capacities …) in order to synchronize and harmonize with others had significantly been focused in DHML and considered as a significant part of DHML in relation to transformative learning[21].

Many academics faced difficulties to play their expected role in the framework of DHML: teaching much less, but supporting the learning process. Learners mainly learned from their practice in the framework of DHML and could exchange their experiences and challenges during several meetings: at the workshops of LCCs, and also at regional and national levels. Consequently, formal workshops were organized to prepare the AIs.

Little use was made of possible AIs on demands. Transformation of AIs was eventually significantly observed in terms of interaction with field actors in specific DHS contexts, as well as of their teaching methods in their institutions.

During the field visits, some resources persons expressed their concern about DHML sustainability, continuity. All participants claimed that they enjoy the DHML process and didn't want to stop. On participants' demand, additional workshops have already been organized for a better wrapping up of the one-year DHML process. Some LTs claimed that they may continue to meet on their own without any financial support. There has been recruitment of new learning teams (a second batch) and new districts. Financial resources were therefore mobilized. Some former participants may try to attend as guest workshops organized for the new learning teams. Some first batch LTs play now the role of LCCs, making profit of their experiences.

Discussion

CBL (including PCPL and FPL as part of its evolution) was initially introduced focusing mainly on health care services, especially targeting existing health care professions. It was considered as a complementary strategy to their formal training, aiming at improving on their skills in such a way they might effectively contribute in quality care provision within

their integrated health care system. Consequently, DHML, a new sustainable dynamic in DHS management, putting the operational staff and community first, bringing all actors related to health together, being supported by those in charge of health management within the district. CBL progressively became a comprehensive concept, evolving through three main sets of experiences (PCPL, FPL, and DHML), a "working-learning-developing" life style of DHS.

It must be stated that CBL didn't start from scratch, but aimed at filing the gap between the existing dynamic and the expected DHS situation. Each situation should be considered as specific to each context of the DHS. Standardized introduction of CBL could have disempowered and frustrated the staff, destroying the already existing.

Although DHML was a new intervention, based on a working hypothesis related to both feasibility and results, it has been immediately initiated at large scale, because of contextual features. However, implementing DHML on a large scale has created another momentum, which has influenced a lot, feelings and ideas, as well as commitment of all actors. Ownership of DHML, at least as concerns the general principles, is shared. It is a bottom-up approach. DHML became a booster of the synergy between evolution of CBL and movements of DHS strengthening as a whole: DHML extensive experience was able to influence policy makers and reinforce advocacy for the district health system.

As capacity building, DHML fits into a sustainable comprehensive and continuous grounded capacity building system which is now functioning in most districts in Thailand and still evolving.

As organisation development, several teams and facilitating conditions are being set up, for examples District Health Board, Family Care Team, Primary Care Custer, etc., in synergistic way with evolution of DHML and CBL in order to work better together (functional relationship), continuously learn together (learning relationship), strengthen the organisation together (managerial relationship), for ultimately making the system responsive to people's needs and demands for development of People-Centred District Health System as a whole.

As networking, especially for learning teams, not only their knowledge should be shared, their dynamic should be expanded: horizontally (to actors at the same level), vertically (to actors at other levels of the system), and diagonally in order to focus on quality of life and well-being of every individual person in the system.

Conclusion and Prospects

DHML fits into a sustainable comprehensive and continuous grounded capacity building which is now functioning in most districts in Thailand and still evolving. Several teams and facilitating conditions are being set up in order to work better together (functional relationship), continuously learn together (learning relationship), strengthen the organisation together (managerial relationship), for sustainable development of people-centred district health systems.

Moving from hospital-focused health care toward people-centred District Health System has benefited in the framework of DHML from systemic interaction among actors from different sectors: the health sector, other non-health sectors, and especially people sector. DHML dynamic is expected to last and extend, and

contribute to a sustainable development of people-centred District Health System, which is going along with the global strategy on people-centred and integrated services of the World Health Organization[22]. The strategy was recently approved by the World Health Assembly[23].

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