

**Through the Lens of Networks:  
Health Promotion Policy Implementation for the Elderly  
at the Local Level in Thailand**

**By  
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This PhD thesis is dedicated to:

my first academic adviser, Associate Professor Dr. Bidhya Bowornwathana (1950 – 2013);

my first public policy lecturer, Assistant Professor Dr. Ora-orn Poocharoen; and

my first public policy educators – my parents, Winit and Revadee Srichamroen

In memory of Dr. Jenny Neale.



## Abstract

The Thai government has included health promotion in its national policies and strategies to directly address the health of the elderly. Multiple government organisations at various levels are involved in this health promotion policy and its related efforts. With an emphasis on ensuring that the elderly in the community benefit from national health promotion policies, and have access to health promotion services, the policies directed government organisations to work together as a network to implement the health promotion policy for the elderly at the local level. The Local Administrative Organisations (LAOs), decentralised government organisations, acted as the centre of the networks in each sub-district across the country. Networks play a role as an essential mechanism in the health promotion policy implementation for the elderly and in reaching out to the smallest unit of the community: individual older people. However, there are known gaps in the functioning of the decentralised governance arrangements and in coordination between organisations to implement the health promotion policy. Policy implementation can be improved to ensure that key goals and objectives are met.

The objective of this research was to analyse the ways in which the LAOs and other government organisations together implement the health promotion policy for the elderly at the local level in Thailand. Using a network perspective, the governance structure and governance characteristics, including relationships and the functioning of the policy implementation network, are identified and analysed. How the observed network characteristics affect network collaboration, policy outcomes, and actors' capacity in policy implementation are then explored.

Within an interpretivist perspective, the research employed multiple network analysis approaches and mixed methods data collection such as network mapping, non-participant observation, interviews, and questionnaire surveys, across two case study sites. A combination of thematic analysis and constant comparative methods were employed to analyse the data.

The networks in this study were found to have a hybrid governance form, being a combination of lead organisation-governed and shared governance. However, it is not possible to predict the likelihood of achieving good policy outcomes based on the form of network governance alone; other networks characteristics must also be studied. At the network level, influential factors indicative of policy outcomes were found to be the exchanges of political and cultural capitals between network actors, with the latter differentiating the policy outcomes across the two cases. To improve the network actors' capacity in policy implementation, learning and resource exchanges between actors were found to be important. Based on the study findings, an intervention to improve policy

outcomes should be encouraged through financial capital exchanges between network actors as this is when administrative authority is most dominant.

The research provides an empirical review to inform policymakers and practitioners that the most influential factors should be embedded during the funding process so that the policy implementation can better support health for the elderly and the aged society that Thailand is entering.

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## List of Acronyms

A.D.	Anno Domini (current era year in Christian Calendar)
ASEAN	Association of Southeast Asian Nations
B.E.	Buddhist Era
CCM	Constant Comparative Method
CG	Care Givers
CM	Care Managers
CSMBS	Civil Servant Medical Benefits Scheme
CUP	Contracting Units for Primary Care
EU	European Union
LAOs	Local Administrative Organisations
MOU	Memorandum of Understanding
NAO	Network Administrative Organization
NESDB	National Economic and Social Development Board
NHSO	National Health Security Office
NPM	New Public Management
NSO	National Statistical Office, Ministry of Information and Communication Technology
PAOs	Provincial Administrative Organisations
SHI	Social Health Insurance Scheme
TA	Thematic Analysis
TAOs	Tambol Administrative Organisations
WHO	World Health Organization





## Chapter 1: Introduction

### 1.1 Overview

Thailand is one of the many countries becoming an aged society (Office of the National Economic and Social Development Board, 2011). With the increasing numbers of older people and the declining number of younger people and fertility, the government must prepare to accommodate social and economic changes that occur from the rapid shifts of this demographic structure. It is predicted that countries experiencing an ageing society are likely to have increasing national expenditure on health care (Office of the National Economic and Social Development Board, 2011). Thailand already has higher health care expenditure as a result of the implementation of its three public health benefits programmes compared to before the health care reform: the Universal Health Coverage Scheme (UHC), the Civil Servant Medical Benefits Scheme (CSMBS), and the Social Health Insurance Scheme (SHI). In 2009, it was found that health care expenditure in Thailand for the previous 30 years was increasing with 75% of the cost spent on medication and treatment (Kanchanachitra et al., 2009). This finding suggested that the financial resources for health care in the country were spent on curative care rather than on encouraging the population to stay healthy. This will be a challenge for an ageing society and a future aged society (Kespichayawattana & Jitapunkul, 2008).

A shift of health care expenditure from curative care to health promotion is a common strategy employed by countries becoming an aged society, as it is a measure that can restrain health care expenditure and prevent chronic diseases in older ages (Fiscal Policy Research Institute Foundation, 2013; Ming & Chan, 2015). The United States National Research Council (1988) noted about health promotion that “this approach has promised for reducing the incidence and prevalence of the chronic and acute disease among both the general population and the elderly (sic).” (p. 108). However, as countries have different contextual health determinants and social and economic factors affecting the health of their population, national plans, strategies, and their evaluation vary based on these factors as well as their existing governance structure (Rütten, 2001). To address health promotion for the elderly in Thailand’s context, the networks approach has been employed as a mechanism for policy implementation. This network mechanism is led by a decentralised government organisation located in sub-districts around the country to reach the elderly in the community.

A decentralised governance structure and well-performing organisations within the structure can play essential roles in enabling autonomy in administration and flexibility of government organisations at the local level to provide primary care and health promotion services to people in their own community (Kang, Cho, & Jung, 2012; Health Systems Research Institute, 2010). In Thailand, this

responsibility involves collaboration with Local Administrative Organisations (LAOs), the key actor in the decentralised governance structure, and other organisations at both regional and provincial levels in their respective area. Being directed by the national policies and plans namely the 2<sup>nd</sup> National Plans on the Elderly (2002-2021), 1<sup>st</sup> Revision of 2009, Health Promotion Foundation Act, B.E. 2544 (2001), the Determining Plans and Process of Decentralization to Local Government Organization Act B.E. 2542 (1999), and the Elderly Person Act B.E. 2546 (2003), the LAO in each sub-district and other organisations working with them have been formed as networks to implement health promotion for the elderly. The policies also included the sub-district elderly clubs, representatives of the policy target in the networks. Accordingly, the networks are comprised of government organisations from decentralised and centralised governance structures and a non-public organisation. However, these networks operate without a clear guideline or formal structure, making their operation a black box of the policy implementation.

To explore the collaboration between organisations at the local level in implementing health promotion policy for the elderly in Thailand and to improve implementation, networks and governance network theoretical frameworks and a policy implementation study approach will be used in this research. They frame this study and an analysis of the interactions between organisations involved as policy implementation network actors. The analysis of the networks of policy implementation can explain the network governance structure, characteristics, and actors' capacity (Koliba, Meek, & Zia, 2011; Torfing, 2005; Wang, Chen, & Berman, 2016). The analysis of the network level form of governance explains the characteristics of the networks and how they function. The analysis of network relationships also explains the dynamics of ties within the network including power among network members and leadership. These analyses also identify the most influential factors affecting networks' operation and performance and the policy implementation at the actor level. Understanding of these aspects can help improve implementation strategies and network outcomes.

## 1.2 Statement of the Problem and Research Questions

Scholars have studied health promotion implementation from the perspective of decentralisation by looking into its progress following decentralisation reform which transferred management and authority to the local level (Chardchawarn, 2010; Leoprapi, 1998). Some have studied particularly health care decentralisation from the perspective of networks of health care facilities and process management and the provision of health care services (Health Systems Research Institute, 2010; Leethongdee, 2006). However, health promotion policy implementation led by a decentralised

government organisation and the process of the policy implementation as a network have not been focused on. Moreover, as the topic of health promotion for the elderly in Thailand has received growing attention, how the LAOs as a decentralised organisation implement this policy in collaboration with other centralised government organisations has not been widely explored.

This leads to the main research question of, *“How do the networks of health promotion policy implementation for the elderly at the local level in Thailand function?”* The sub-questions are:

1. *What are the characteristics of the networks, and their network-level form of governance?*
2. *Amongst the network characteristics and other factors found to be relevant, which are the most influential factors affecting policy implementation?*

This research applies network analysis, a case study method, and descriptive statistical analysis. As mixed methods research, it provides empirical evidence to answer the research questions about how the governance network for health promotion for the elderly functions. More importantly, it explains the extent of networks that were policy-directed to form, not voluntary or mandated networks, and the influential factors affecting policy implementation at the network level and actor level. Answers to these research questions will largely contribute to the field of network and network governance theories.

### 1.3 Outline of the thesis

Chapter 2 provides background to the research that highlights the ageing situation in Thailand, including the health of the elderly population, the current related policy, and the existing government measures to promote the health of the elderly. Chapter 3 reviews literature related to networks, network governance, and policy implementation. Chapter 4 provides the conceptual framework for this research based on the background, literature review, and research questions. Chapter 5 outlines the research methodology and analysis approaches. Chapters 6 and 7 analyse findings based on research sub-question one regarding network characteristics as well as form of governance and their relationships. They also respond to research sub-question two regarding the most influential factors in policy implementation at the network level. Chapter 8 analyses responses to research sub-question two about the most influential network characteristics affecting policy implementation at the actor level. Chapter 9 summarises findings in the previous three chapters and concludes the thesis with recommendations for policy and future research.



## Chapter 2: Research Background

### 2.1 An Ageing Population: Definition and Current Situation

An ageing population is a phenomenon in most countries where the proportion of older people increases significantly compared to the younger and working age population, creating an imbalance between the working age and non-working age groups (Tinker, 2002; United Nations, 2013). In 2015, the United Nations estimated that by 2030, the number of those aged 60 and older would increase from 901 million to 1.4 billion, making them 55.7% of all age groups globally. Within this same period, Asia will be the second fastest growing region to Latin America and the Caribbean in terms of the number of older people (United Nations, 2015b).

Population ageing is now developing at a faster pace in developing countries when compared with their developed counterparts. The United Nations (2015) presented this contrast from Kinsella and Gists' study from 1995. In it, they found that developed countries such as France and Sweden took 115 years and 85 years respectively for the proportion of their population aged 60 years or over to rise from 7% to 14%, while it only took 34 years for China and just 23 years for Thailand. This fast-pacing of ageing leads to social changes and policymakers need to address several critical issues to prepare for an older society.

#### 2.1.1 Ageing Situation in Thailand

Thailand is also experiencing the phenomenon of an expanding older population in its demographic structure. The following table shows the continuous growth of the older aged population in the country in over 20 years from 1994.

*Table 1: Number and Ratio of Older Persons in Thailand Reported in Survey Years*

<b>Year of Survey</b>	<b>Number of Older Persons</b>	<b>The ratio of the Older Persons per 100 Population</b>
1994	4,011,854	6.8
2002	5,969,030	9.4
2007	7,020,959	10.7
2011	8,266,304	12.2
2014	10,014,705	14.9
2017	11,312,447	16.7

*Source: National Statistical Office, Ministry of Digital Economy and Society (2017); Report on the 2017 Survey of the Older Persons in Thailand.*

From 1994 to 2014, the older population in Thailand increased more than twofold. This was also reflected in the calculation of the Index of Ageing (percentage ratio of persons aged older than 60 years old and persons younger than 15 years old) in a report by the Ministry of Social Development and Human Security (2014) to determine the country's population structure in terms of age (see Table 2). The report suggested that some regions in Thailand had already entered the 'Complete aged society' in 2013, and these regions will become the 'Super-aged society' as early as 2020. Nationwide, Thailand is projected to enter the 'Super-aged society' in less than twenty years from 2016, when the proportion of the population aged 60 and older reaches 28% of the total population (Foundation of Thai Gerontology Research and Development Institute, 2014). Table 2 and Figure 1 below show the categorisation of the Ageing Index and the comparison of ASEAN member countries with the addition of Japan, China, and South Korea based on the Ageing Index calculation.

Table 2: Ageing Index

Ageing Index Value	Population Structure
< 50	Young society
50 – 119.9	Aged society
120 – 199.9	Complete aged society
> 200	Super-aged society

Source: Ministry of Social Development and Human Security (2014). Aged Population in Thailand: Present and Future.

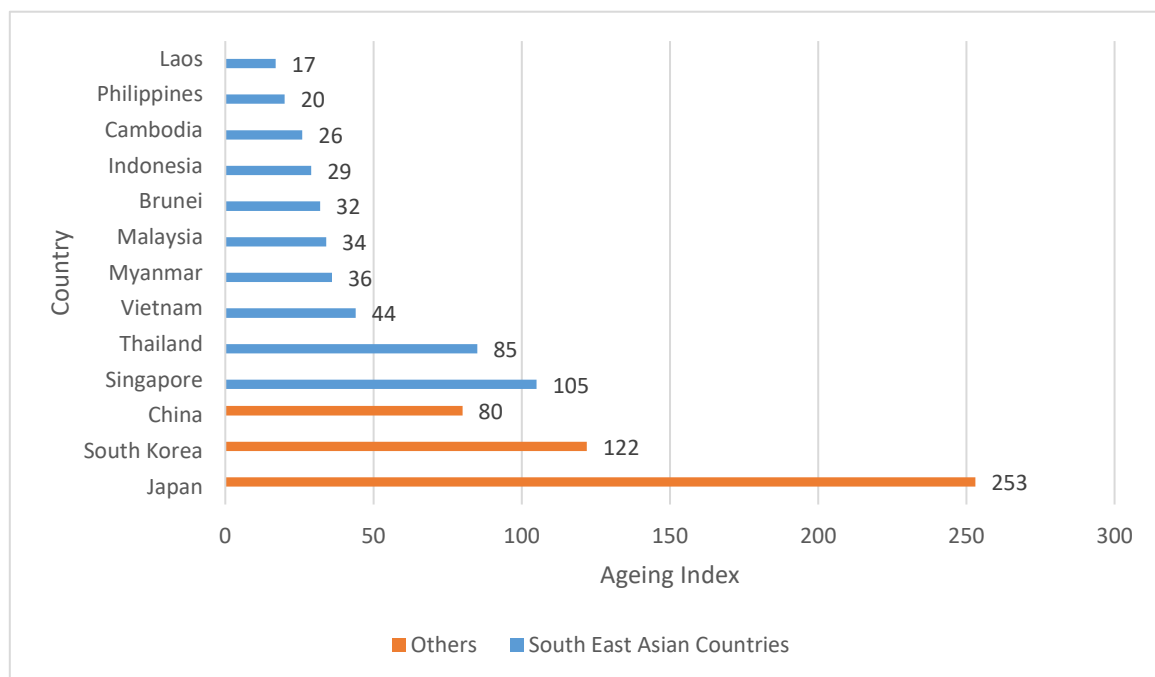


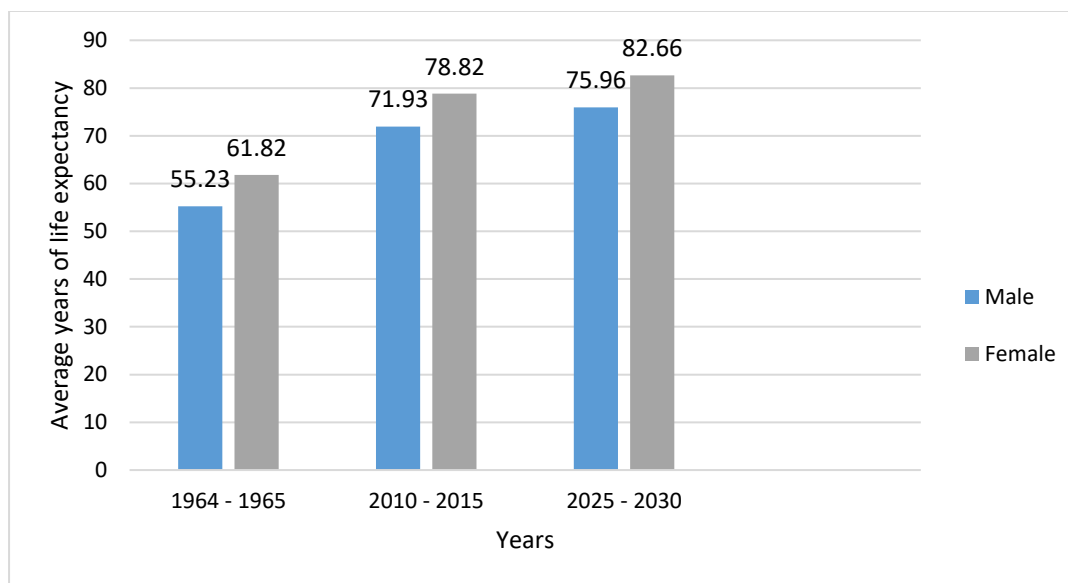
Figure 1: Ageing in ASEAN, Japan, China, and South Korea based on Ageing Index  
Source: Adapted from Prasartkul (2013). Ageing Situation: Trends and Impacts from Entering ASEAN. Copyright (2013) by Bureau of Health Promotion.

Figure 1 shows that based on the Ageing Index in 2013, Thailand was already an 'Aged society.' It only trailed behind Singapore among ASEAN member countries, and its Ageing Index has already surpassed China. The information indicates a significant demographic structural change for Thailand has already begun. This demographic structural change can be explained by the longer life expectancy of both the male and female population and the declining fertility rate in the country.



### Life expectancy

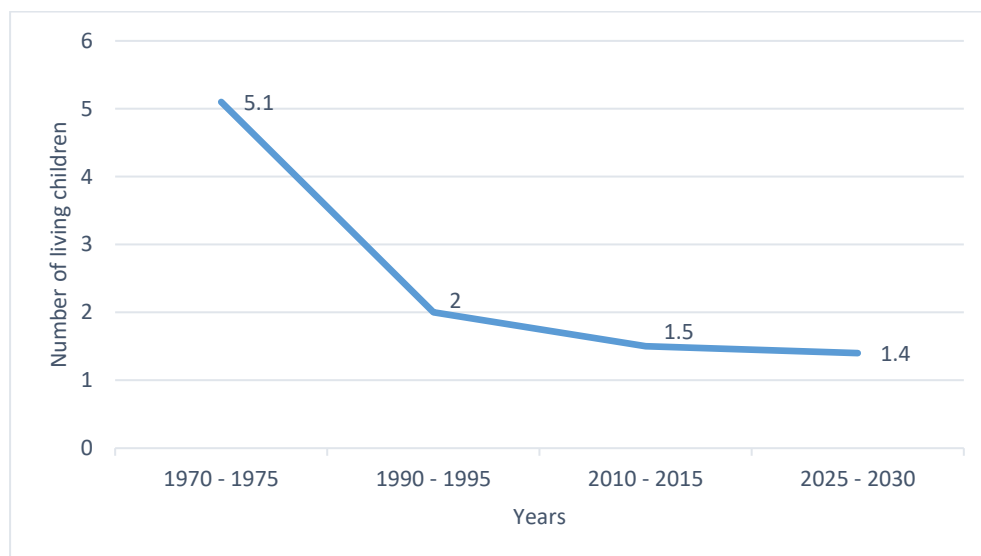
Life expectancy at birth in Thailand in 2015 compared to in the 1960s had increased by more than fifteen years, and it is likely to increase in the future. Thailand is projected to be in seventh place with the most substantial percentage point change in the proportion of older people projected for the years 2015 – 2030 (United Nations, 2015b). The following figure shows the increasing life expectancy of the male and female population in Thailand.



*Figure 2: Life Expectancy at Birth of Males and Females in Thailand and Future Projections*  
*Source: Ministry of Social Development and Human Security (2014). Older Thai populations: Present and Future.*

### Declining fertility

The fertility rate began to decline towards the end of the 1960s when life expectancy extended to over 70 years (Knodel & Chayovan, 2008). Researchers have studied the impact of an ageing population on Thai society, particularly on the younger generations. With the lower fertility rate resulting in decreasing potential support for older populations to depend on, the country will have far more elderly people than the number of working-age persons to support them. The decreasing fertility that began in the 1960s has also contributed to the decline in the number of living children of the elderly from 4.6 for those over 80 years old to just 2.1 for those aged 50-54 years old (Knodel, Prachuabmoh, & Chayovan, 2013). The following figure shows the declining fertility in Thailand.



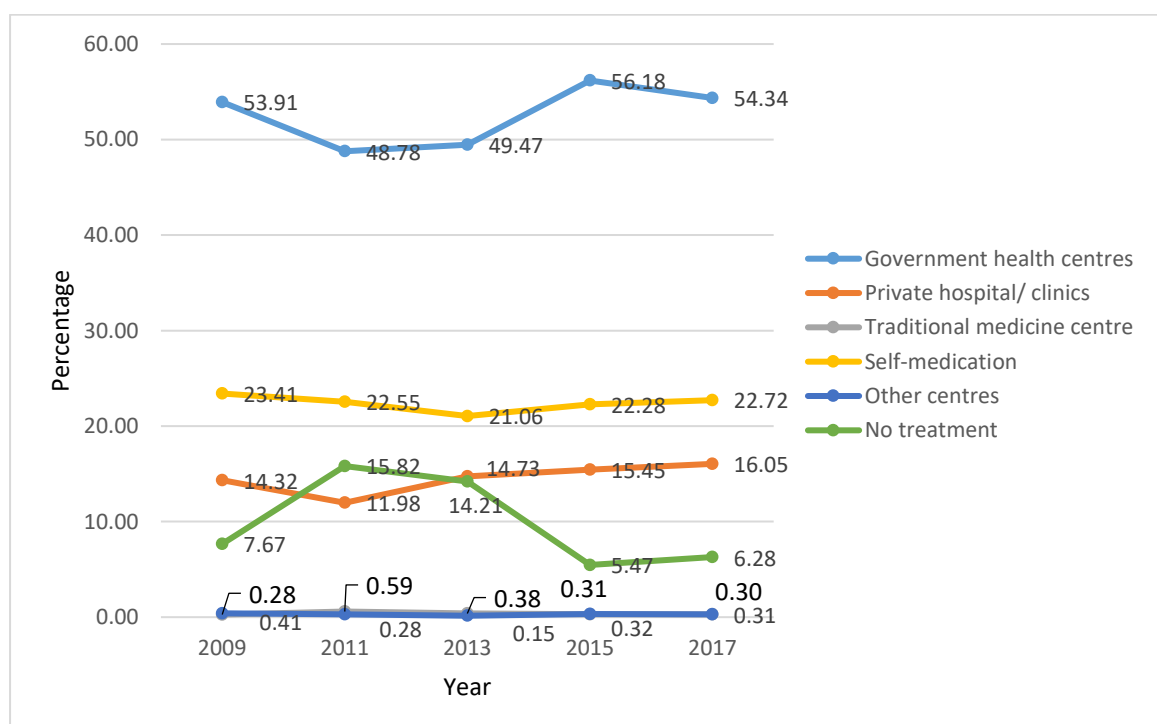
*Figure 3: Total Fertility (child per woman) in Thailand*  
*Source: United Nations (2015a); World Fertility Pattern 2015.*

This demographic structural change has an impact on the social welfare systems. Gietel-Basten et al. (2015) have noted that it will be challenging for the management of the pension programme and universal health care in the future if the current demographic trend continues. Moreover, this situation suggests that the older population may be perceived as a burden on the younger generations in the future (Knodel & Chayovan, 2008; Knodel, Teerawichitchainan, Prachuabmoh, & Pothisiri, 2015). This has already become challenging particularly for the elderly who live outside the municipal areas in Thailand as they tend to rely on a carer more than those living within the municipal areas (Osornprasop & Sondergaard, 2016).

## 2.1.2 Health and Health Care Utilisation of the Elderly in Thailand

The number of the elderly in Thailand reported experiencing health issues has risen every year since 2009 compared to other age groups (National Statistical Office, 2009, 2013, 2016, n.d.). The most significant percentage of people who felt ill or unwell for the month before the date of a national interview by the National Statistical Office from years 2009 – 2017 fell within the age group of 60 years old and over followed by the age group of 25-59 years old. It is noticeable that the number who felt ill in the oldest age group increased more than two times in comparison with the younger groups, despite the 30-year span of the younger group. It can be an indication that feeling ill or unwell is prevalent as age progresses implying that the population aged 25-59 and 60 and over groups combined are the largest groups that utilise health care services (National Statistical Office, 2009, 2013, 2016, n.d.).

Across all age groups, 91% - 92% of the Thai people receive their health care treatments and services from a health centre provided by medically trained doctors (including conventional medicines, traditional medicines, alternative medicines, and unknown) (National Statistical Office, 2009, 2013, 2016, n.d.). The following Figure 4 shows the percentage usage of at least one type of health centres for health care treatments and services by Thai people.



*Figure 4: Utilisation of Health Care Treatments and Services by Type of Health Centre*  
Source: The National Statistical Office (2009, 2011, 2013, 2015, & 2017); Survey on Health and Welfare.

Government health care centres are the primary sources of treatment for the Thai population of all ages; thus, it can be implied that the government resources in health care are the most utilised. (Osornprasop & Sondergaard, 2016). Among all age groups of the Thai population, the largest group who had visited the hospital for treatment within 12 months before the biennial national Survey on Health and Welfare was those aged 60 years and older. Hospital visits were generally due to chronic diseases which are more prevalent in older populations (National Statistical Office, 2013, 2016, n.d.). Moreover, the number of elderly utilising the in-patient care services increases continuously from the age of 60 before declining after 85 years old (Osornprasop & Sondergaard, 2016).

In addition, it was found that the majority of the elderly in Thailand live outside municipal areas (National Statistical Office, 2014). Many of the elderly living in rural areas have a chronic disease, are poor or bed-ridden, and have problems with mobility. They also have more difficulty in accessing health care facilities due to the unavailability of affordable transportation (Osornprasop & Sondergaard, 2016). This group of the elderly is the most vulnerable as they also have to depend heavily on the availability of a carer to assist or accompany them to travel to a health care facility (Osornprasop & Sondergaard, 2016). However, the number of elderly who have a carer in this group is fewer than those who live in the city or within municipal areas (Tamdee, Tamdee, Greiner, Boonchiang, Okamoto, & Isowa (2019). Ministry of Social Development and Human Security, 2014). It was also found that dependency of the elderly also caused economic burden to the family members who take care of them. This dependency of the majority of the elderly in Thailand will be more challenging in the future. It is not only because of the decreasing number of younger people due to declining fertility rates, but also because of the increasing tendency for adult children to move out of their aged parents' province. The rate of internal migration rose from 28% in 1995 to 39% in 2011 (Knodel et al., 2013). Thus, to minimise the social and economic impact of the demographic change on the younger generation, family members, carers, and the elderly's own well-being, the good health of the elderly population should be a national strategy goal (National Research Council, 1988).

Accordingly, the Thai government has addressed the situation with health care policy in national plans and strategies in an attempt to accommodate the needs of the older and ageing population and ensure the services reach the smallest unit of the society through the functions of government administrative systems (Knodel et al., 2015). The policy and programmes will be explained briefly in the following sections.

### 2.1.3 Government's Response and Policy Addressing Ageing Population

The evidence of a policy on ageing in Thailand is contained in Thailand's national plans and strategies, particularly in the National Economic and Social Development Plans. This has served as Thailand's development strategic document since 1961. The current plan is the Twelfth, covering the years 2017 – 2021 (Office of the National Economic and Social Development Board, n.d.). An ageing population and aged society are one of the central concerns of the Twelfth Plan.

Economically, the Plan supports business and skills training for jobs related to elderly care, tourism, and home care. Long-term care for the elderly is also incorporated in the service management of every sector. This Plan will continue to encourage elderly participation in the development of the community and business. According to the Plan, the elderly will have the opportunity to continue to develop, be able to work and earn income through elderly learning and capability building with collaborations across sectors (Office of the National Economic and Social Development Board, 2011). Other current core national policies address the significance of entering an aged society, the elderly and health of the elderly are such as:

1. The Second National Plan for the Elderly (2002): The Plan laid out the development plans on the topic of the ageing population and the elderly in the country for the years 2002 – 2021. It has been written under the guiding principle “the elderly are the valuable assets to the society” and was revised in 2009 (The National Committee on the Elderly, 2009, p. 1). The objectives of the plan focus on the well-being of the elderly, social awareness of quality ageing preparation, the involvement of social units and business sectors in the society regarding the elderly, and the formulations of policy and practice guidelines on the subject (The National Committee on the Elderly, 2009).
2. The Elderly Person Act B.E. 2546 (2003): The act established the National Commission on the Elderly in Thailand. The Commission has the Prime Minister as the Chairman with members from organisations within the Ministry of Social Development and Human Security, Ministry of Public Health, Thai Red Cross Society, National Economic and Social Development Board as well as representatives from private organisations. The Commission's duties include determining national policies and practice directions regarding the elderly and their development as well as administering the Older Persons' Fund assisting the low-income elderly population (Ministry of Social Development and Human Security, 2003).

To implement the national policies on the elderly at the local level, the Ministry of Social Development and Human Security together with the Ministry of Interior and Senior Citizen Council

of Thailand established in 2013 the Centers for the Quality of Life Development and Occupational Promotion for Older Persons (Knodel et al., 2015). The Centers are an example of a collaborative project between national government organisations to support the organisation of activities for the elderly at the local level, primarily by the LAOs. They promote jobs, health, social development and other aspects as well as supporting elderly care volunteers and the information management of the elderly population database. As of 2018, 1,279 Centers had already been established throughout the country within the management of the LAOs and this number will continue to grow (Department of Older Persons, 2018; Office of Promotion and Protection of Children, 2013; Ministry of Social Development and Human Security, n.d.).

However, despite the government's effort to improve the quality of life and health of the elderly in Thailand, only 7.2% of the elderly were satisfied with the public services including the health promotion services being provided according to the information in the Twelfth National Economic and Social Development Plan. Elderly support amenities are still to be installed or provided in public places (Office of the National Economic and Social Development Board, 2017).

#### 2.1.4 Health Care Services for the Elderly in Thailand

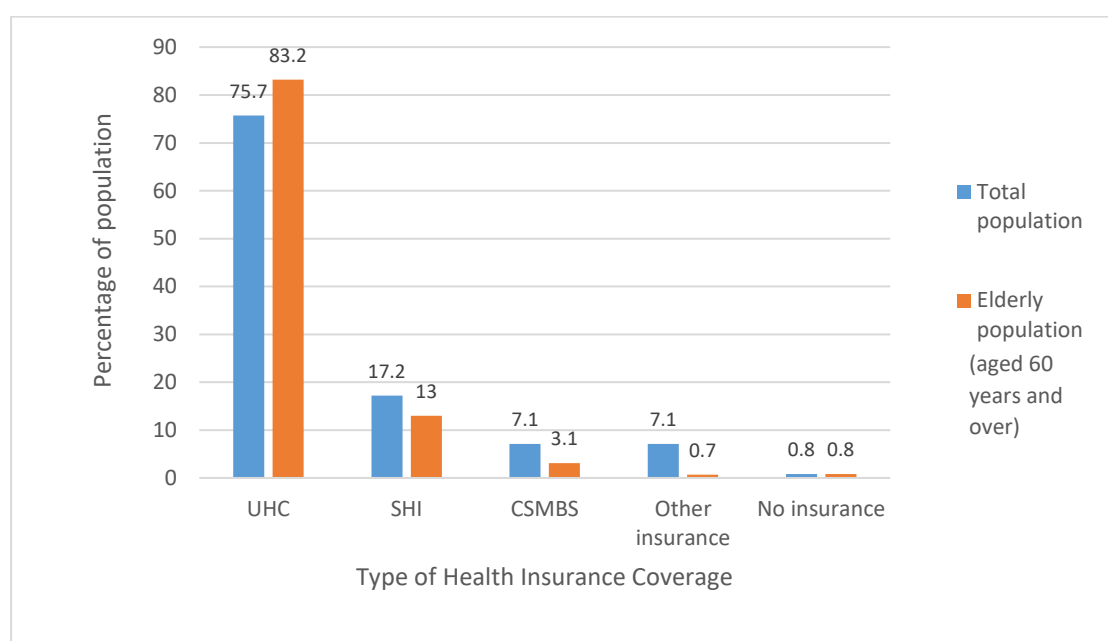
The Ministry of Health as the leading public health organisation in Thailand has been coordinating with other government agencies to strengthen public health care and health promotion initiatives established through public health care providers to all ages and income levels (Office of the National Economic and Social Development Board, 2011). Health promotion has become one of the core focuses as a part of the national human resources and population capability building strategies across all age groups (Office of the National Economic and Social Development Board, 2017). It is also a part of the benefit packages of all the public health insurance schemes in Thailand.

##### 2.1.4.1 Thailand Public Health Insurance Schemes and Their Cost

The primary public health insurance schemes available for the Thai people are:

1. Civil Servant Medical Benefits Scheme (CSMBS) for civil servants and their dependents and state enterprise employees
2. Social Health Insurance (SHI) for formal sector employees which the employee (private employees) and the employer co-contribute
3. Universal Health Coverage (UHC) for those who are not eligible or insured with the CSMBS and the SHI schemes (Jongudomsuk et al., 2015; National Statistical Office, 2016).

Overall, 99.2% of Thai citizens have health insurance coverage. Among those that are covered, 75.7% are under the UHC, 17.2% are under the SHI, and 7.1% are under the CSMBS. In addition, 7.1% also have a private insurance in addition to their public one. Only 0.8% of the total population do not have any health insurance (National Statistical Office, 2017). From the national data in 2017, 99.2% of the total elderly population in the country was found to be covered by health insurance (National Statistical Office, 2017). The following figure shows the total population and the elderly population and their health insurance coverage.



*Figure 5: Health Insurance Coverage of the Total Population and Elderly Population in Thailand*  
Source: The National Statistical Office (2017). Survey on Health and Welfare; The National Statistical Office (2017). Report on the 2017 Survey of the Older Persons in Thailand.

Almost all the Thai population and the elderly are covered by at least one public health insurance with the majority being covered by the Universal Health Coverage (Sakunphanit, 2015). Health prevention and health promotion are included in all health insurance schemes (see Appendix A1). However, since Thailand started to provide a universal health care scheme in 2002, the development of the programme rapidly increased the number of patients utilising public health care services due to the low cost and ease of access (Sakunphanit, 2015). The elderly population was found to be the largest group that received health promotion services (National Statistical Office, 2009, 2013, 2016, n.d.). This data reflects that, like the general health care utilisation, the population aged 60 years and older utilise and benefit from the government-funded insurance programmes and services more compared to other age groups.

By 2005, health care expenses per capita in Thailand had increased almost 1.6 times from 1995 as a result of the implementation of the three public health insurance schemes. Seventy-five per cent of the health care expense then was spent on medical services or treatments, only five per cent was spent on health prevention and promotion. It was suggested then that the country should invest more in health, especially in the prevention and promotion aspects (Kanchanachitra et al., 2009).

To manage the rising health care expenditure, the Ministry of Public Health modified the country's health care strategies in 2009 to be more assertive by engaging the local and community public organisations and the general population. The strategies reformed the responsibilities of local health centres, which are the closest to the people in the community, to be more targeted towards health promotion and prevention. However, a study on the health and the health care system for older persons in Thailand found that health centres, particularly at the primary care level, still spent financial efforts and resources on curative care rather than health promotion and illness prevention (Kespichayawattana & Jitapunkul, 2008). Therefore, in preparing health care in the ageing society, a shift of concentration from curative care to health promotion is suggested as a measure to control health care expenditure and prevent chronic diseases in older ages (Fiscal Policy Research Institute Foundation, 2013; Ming & Chan, 2015). Health promotion activities that are comprehensive, well-coordinated, and effective in cost provide solutions for illness prevention and alleviating health inequalities in society (Vathesatogkit, Lian, & Ritthiphakdee, 2012). Moreover, they will help with the reduction of health care expenditure for the government (Fiscal Policy Research Institute Foundation, 2013) and eventually enable the practical financial feasibility of universal health care (Coe & de Beyer, 2014).

## 2.2 Health Promotion

The previous section talked about changes in Thai society with the recent demographic trend in the country towards the population ageing and entering the aged society. Health promotion is viewed as an approach to ensure and protect the health of the elderly and to help save health care expense by both the individual and the government. In this section, I will first provide an overview of the international definition of health promotion, its adoption internationally, and health promotion in Thailand's context, including the elderly population. Later, I will introduce the decentralised governance structure and organisations that have been tasked with health promotion responsibilities in Thailand.



### 2.2.1 Defining Health Promotion

The World Health Organization (WHO) defines health as being the complete state of physical, mental, and social well-being. Health is influenced by factors beyond those within the health sector, such as social, economic, and political factors (Kumar & Preetha, 2012). Therefore, to achieve the highest possible standards of health, a holistic approach should be taken in addition to curative care, and be inclusive of all stakeholders (Kumar & Preetha, 2012). WHO defines health promotion as “the process of enabling people to increase control over, and to improve their health” (World Health Organization, n.d.-d), a holistic approach that includes empowerment and participation of individuals and communities (Kumar & Preetha, 2012). Health promotion can be summarised as an approach within the context of primary health care that applies health outcome improvement, prevention, and control techniques to address risk factors for people’s health and oral health, ultimately to improve their health and quality of life (World Health Organization, n.d.-b). It covers promoting health at every health care service level: primary, secondary, and tertiary (Caplan, 1961) and promoting health education and health-related learning (Tones & Tillford, 1994).

The definition of health promotion has developed since it was introduced by the WHO’s first International Conference on Health Promotion in the Ottawa Charter for Health Promotion in November 1986. The Ottawa Charter is regarded as leading a shift from prevention of diseases to capacity building for health or an empowering process for people to have a good quality of life (Kickbusch, 2003; Breslow, 1999). The Charter discussed the importance of engagement at the local level, and that “health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems,” and highlighted the significance of community empowerment and participation (World Health Organization, n.d.-d).

The definition of health promotion can also vary within the context of health professionals’ roles (Ferguson & Spence, 2012). Health promotion actions may also depend on factors such as the understanding of health promotion of those providing services (Ferguson & Spence, 2012), dynamics of the family and social interactions (Smith & Jones, 2016), and effective communication between those providing services and their patients (Richardson, 2002). The meaning and practice of health promotion in the international context may be different depending on the goals of the practice and the target population (Macdonald & Bunton, 2003).

### 2.2.2 Health Promotion Implementation at International Level

The Ottawa Charter has been an international guidance in health promotion since it was globally adopted in 1986 (Ireland National Health Promotion Office, 2011). The Charter suggested that the basic strategies of health promotion are to advocate, enable, and mediate (State Government of Victoria, n.d.). Based on these strategies, means of health promotion actions are:

- 1) Build Healthy Public Policy: Inclusion of health in policy agenda in all sectors and all levels through decision making and the awareness of policy makers.
- 2) Create Supportive Environments: Promotion of community and natural environment maintenance, and safe, stimulating, satisfying, and enjoyable living and working conditions.
- 3) Strengthen Community Actions: Empowerment of communities to take effective actions, make decision, plan and implement strategies for health improvement, and support of community resources and development, and participation.
- 4) Develop Personal Skills: Providing information, education for health, and enhancing life skills to promote health in order to support personal and social development.
- 5) Reorient Health Services: Collaboration of individuals, community groups, health professionals, health service institutions and governments in providing beyond clinical and curative services, and to focus the total needs of the individual, as a whole person, with social, political, economic and physical environment components.
- 6) Moving into the Future: Ensuring that the society one lives in creates conditions that allow the attainment of health by all its members (World Health Organization, n.d.-a).

However, as each individual, family, and community are different and vary by their social, cultural, and economic factors, health promotion strategies should be adapted based on local needs. Governments, bodies, or institutions involved as drivers of health promotion of individual countries and regions should consider these contexts for planning and implementing the strategies (State Government of Victoria, n.d.). At the international level, continents and regional intergovernmental organisations such as the EU and ASEAN have set up their own health promotion strategies and working groups to provide a broad guideline of health promotion implementation and evaluation for countries and member states. Rütten (2001) mentioned that developed and developing countries have different public policies in relation to health promotion based on their different challenges and structures. Therefore, contextual factors must be taken into consideration in health promotion policy making and evaluation (Rütten, 2001).

Health promotion strategies for countries have been guided further in Thailand by the Bangkok Charter for Health Promotion. In 2005, the Bangkok Charter for Health Promotion was established to expand the Ottawa Charter in identifying actions and commitments required in health promotion to address the determinants of health at the international level (World Health Organization, n.d.-b). With the Bangkok Charter, health promotion became considered as an agenda for global development. The Bangkok Charter highlighted that health promotion should be a core responsibility for a country's government at the national, regional, and local levels (World Health Organization, n.d.-b). Accordingly, national government planned health promotion policies and strategies based on contextual factors of their country. The following section provides examples of health promotion policies and strategies in different regions and countries.

#### *2.2.2.1 Regional Health Promotion Strategy as a Country's Guide*

As seen in the previous section, the Ottawa and Bangkok charters encouraged the development of regional and national health promotion policies and strategies. In this section, I contrast health promotion approaches in three regions, the EU, Africa, and South East Asia. The three examples are presented based on the different statuses of their economic development. The EU is comprised of member countries that are both developing and developed countries. Africa consists of many countries that are considered the poorest in the world. South East Asia consists of mostly developing countries (World Population Review, 2019). Each region sees different health determinants affecting their health promotion focuses and other contextual factors influencing their strategies and policy planning.

For EU member countries, health promotion was the first thematic priority of the European Union Health Programme in 2014—2020 (European Commission, 2014). By considering health promotion a part of an individual's health and well-being that is beyond health factors, European health promotion is based on the "health in all policies" principle (European Parliament, 2016). According to the EU Health Programme, funding strategies for the years 2014—2020 emphasise reducing risk factors and unhealthy habits, such as use of tobacco, alcohol, and drugs. It also focuses on prevention of HIV/AIDS, tuberculosis, and hepatitis, chronic diseases such as cancer, age-related and neurodegenerative diseases, as well as providing health information and establishing knowledge systems (European Commission, 2014). The strategies also mentioned funding for non-governmental organisations for health-promotion collaborations.

For Africa, health promotion strategies aim to reduce communicable and non-communicable diseases, violence and injuries, maternal and child health conditions, and new and re-emerging diseases (World Health Organization Regional Office for Africa, 2013). Communicable diseases in this

region are HIV/AIDs, diarrheal diseases, malaria, tuberculosis and childhood diseases. Non-communicable diseases most prevalent in the African region are malnutrition, oral diseases, sickle-cell disease, blindness, deafness, neurological conditions and mental disorders (World Health Organization Regional Office for Africa, 2013). While multi-sectoral effort is needed in this region, strengthening the leadership of the ministries of health of member states is a top priority in the health promotion strategies of this region. In addition to the strategies, the region focuses on building capacity for health promotion practice, developing good governance and health regulations and legislation, gathering evidence for practice, strengthening partnerships and networks, and advocating for sustainable health promotion financing options (World Health Organization Regional Office for Africa, 2013).

South East Asia has focused its health promotion effort on reducing communicable diseases such as HIV/AIDS, tuberculosis, and malaria, and non-communicable diseases such as diabetes, cancer, and heart diseases. South East Asia has also seen the rise of diseases influenced by natural events such as earthquakes and volcanic eruptions. Bird flu and SARS are additionally emerging health threats in the region, as well as re-emerging diseases such as dengue fever and malaria (World Health Organization Regional Office for South-East Asia, 2008). To guide countries' governments within the region, the strategies for health promotion according to the WHO Regional Office for South-East Asia include infrastructure for coordination and management, capacity building, regulation and legislation, partnerships and networks, evidence for health promotion, policy and advocacy and social mobilisation, financing health promotion, and management of change (World Health Organization Regional Office for South-East Asia, 2008). Unlike in Africa, where the strategy prioritises strengthening the leadership of individual countries' ministry of health, the WHO regional health promotion strategy in South East Asia suggests that the whole of government, not only the national ministry of health, must be involved as drivers of health promotion. Three core approaches suggested to plan national strategies in this region are:

- 1) Issue-based approach: Promote healthy practices addressing common major issues within the region, such as diet and nutrition, tobacco, physical activity, injury prevention, safe sex, patient safety and food safety.
- 2) Setting-based approach: Address health risk factors in places that individuals live, work, and play, such as community, workplace, and school.
- 3) Population-based approach: Plan health promotion strategies tailoring by groups of population, such as children, women, elderly, the poor, and others (World Health Organization Regional Office for South-East Asia, 2008).

These examples from the EU, Africa and South East Asia contrast health promotion policies and strategies across regions and show that the needs that drive regional health promotion strategies and plans are based on different health determinants and other contextual factors. At the national level within a region, countries' policies on health promotion present diversity in governance systems and structures that are either centralised or decentralised (Chronic Diseases and Healthy Ageing Across the Life Cycle, 2015). Despite the different health determinants in each region, a common theme is that health promotion policy and implementation efforts should be collaborative. The collaborations can be between sectors, levels of government, and organisations. In South East Asia in particular, the regional strategy stressed the roles of national governments in taking leadership in driving the health promotion policy and implementation efforts in their countries. Moreover, the suggestion of involvement of organisations other than the ministry of health has encouraged holistic efforts that enable the well-being of individuals according to health promotion principles. Accordingly, this regional strategy has been adopted by countries in the region including Thailand, where an ageing population and its ensuing impact on the society and economy has become the national priority to address.

#### *2.2.2.2 Health Promotion in Addressing the Ageing Society*

The concept of health promotion is applied to healthy ageing for older people internationally. Many countries, regardless of their economic development status, have started to take actions to address the health of the elderly population (Strümpel et al., 2008). Developed countries such as the United States and New Zealand each have launched national initiatives and programmes as collaborations between central government organisations. These central government organisations are such as ministries or federal agencies and implemented at the local level by states or cities, District Health Boards, and those providing primary health care with engagement from the community and individuals (Ministry of Health, 2016; National Research Council, 1988).

In developing countries, where prevention largely gears towards addressing disability and chronic diseases, programmes and policies in health promotion also help alleviate the impact of health care costs caused by the increasing number of the ageing population (Kaneda, 2006). Like their developed counterparts, health promotion policy and implementation in many developing countries also involve community and individual engagements. Health promotion for the elderly approaches in developing countries includes inter-sectoral collaborations, community-based management, and using local resources provided by the local government (World Health Organization, n.d.-c). These approaches have been a part of the health promotion for the elderly implementation by the government, such as the Active Ageing Framework in the Western Pacific Region and The Health

Care for the Elderly Programme in Myanmar (Han, 2012; World Health Organization, n.d.-c). At the regional level, ASEAN has launched related collaborative initiatives and frameworks addressing this emerging issue in the region, such as ASEAN Health Sector Initiatives on the Promotion of Healthy and Active Ageing, 2011-2015 (United Nations Economic and Social Commission for Asia and the Pacific, 2015). Strategic Framework for Social Welfare and Development (2011 – 2015) has also been established to set out initiatives for older people to improve their quality of life. Initiatives that have been implemented cover research projects on social pensions for older people coordinated by the Philippines, a conference addressing active and healthy ageing coordinated by Singapore and Vietnam, and community-based self-care training workshops organised by Vietnam. Each ASEAN member country may have its own programmes to address the growing aged population (HelpAge, n.d.).

With an ageing population in Thailand increasingly affecting the social and economic development of the country, health promotion has become a crucial strategy to offset the effects of the ageing population. The following section introduces health promotion in Thailand's context, its development, and national policies and strategies addressing the country's elderly health.

### 2.2.3 Health Promotion in Thailand Context

The definition of health promotion in Thailand follows that of the Ottawa Charter. Thailand's Health Promotion Foundation Act B.E. 2554 (A.D. 2001) defined health promotion as "any act which is aimed at the fostering of a person's physical, mental and social conditions by means of supporting personal behaviour, social conditions and environments conducive to physical strength, a firm mental condition, a long life and a good quality of life" ("Health Promotion Foundation Act, B.E. 2544 (2001)," 2001). In the past, the term "health promotion" in Thailand was understood as health promotion interventions provided by health professionals, but as a result of the Ottawa Charter on Health Promotion in 1986, its definition was extended to cover health promotion strategy (Chindadawattana & Pipatrojchanakamol, 2007). It is also discussed by Thai scholars that the principle of health promotion is to support the capacity of individuals and communities to be able to identify and analyse issues and plan for addressing barriers to the good health of individuals and the livelihood of the community (Faculty of Nursing, 2012). Moreover, similar to international studies on health promotion, it focuses on social and environmental changes that affect health and social equality, leading to collaboration across sectors and people's participation such as in health promotion activities for individuals and communities (Faculty of Nursing, 2012).

### *2.2.3.1 Health Promotion Development in Thailand*

Health promotion effort in Thailand began after the Second World War when the government's primary health services network was extended to the provincial, district, and sub-district levels (Achananuparp, 2005). Early health promotion strategy in the country focused on control and prevention of infectious diseases such as tuberculosis, malaria, plague, and cholera. It also extended to family planning, mother and child health, nutrition, and sanitation, which were critical health issues in Thailand. The health promotion tools used then were medical measures such as vaccinations, medical technologies, and sanitation. With the human resources and public health services networks at the core of the implementation, health promotion in Thailand was able to disperse into the sub-district level which provided a substantial foundation for early prevention and health promotion in the country (Achananuparp, 2005). The results of the early health promotion measures in Thailand were satisfying with the eliminations of bubonic plague, framboesia, elephantiasis, and smallpox. The country was also able to manage birth control, achieving the goal of population control at the desired growth rate.

However, early health promotion in Thailand lacked the participation of the community and other sectors. The collaborations were limited to using public schools as service centres for health services workers, midwives' training, and malaria volunteering corps establishment (Achananuparp, 2005).

Health promotion actions and services in the early period in Thailand were also limited due to the centralised authority. More than 600,000 health volunteers were in their roles as government appointees rather than being community representatives; thus, they were unable to assist in solving their own community's health issues. As a result, health promotion activities in the community in the early stages of the development were inefficient and not deemed sustainable (Achananuparp, 2005).

Later, the Health Promotion Foundation was established following the launch of the Health Promotion Foundation Act in 2001 as an autonomous government agency to support health promotion activities for individuals and organizations across sectors in the country. Its founding was regarded as a 'landmark for health promotion in Thailand' (Buasai, Kanchanachitra, & Siwaraksa, 2007, p. 250). The Health Promotion Foundation's revenue comes from two per cent of the country's surcharged sin tax or excise tax on tobacco and alcohol collected from the producers and importers. Among the Foundation's 15 core plans in support of health promotion in the country is a health promotion plan for vulnerable populations which includes the elderly as the main focus and healthy community strengthening plan which involves the LAOs (Thai Health Promotion Foundation, n.d.).

### *2.2.3.2 Implementing Health Promotion Policy for the Elderly in Thailand: A Network Approach*

Policy and implementation of health promotion in Thailand have played essential roles in driving the concept forward as it involves required actions from the macro policy level by the national government and activity implementation on local and micro levels by the local community and individuals (Chindadawattana & Pipatrojchanakamol, 2007). Accordingly, for national level policy formulation on health promotion, the related activities and strategies, as well as a body of organisations, were established to accomplish health promotion in Thailand. These elements ensure the continuity of performance and the participation of sectors in society. Organisations related to health promotion in Thailand have been established as networks to garner communities and individuals' participation as a consequence. The networks have expanded rapidly and proved to be an essential factor contributing to health promotion development in the country. They include the national level organisations whose responsibilities are mainly health promotion and health development such as the Ministry of Public Health which oversees the Village Health Volunteers, the Universal Health Care Scheme, and the health promotion programmes, and district hospitals, and local organizations such as community organisations, local administrative organizations, civil organisations, research institutes, and health promotion NGOs (Kumpalanon, Ayuwat, & Sanchaisuriya, 2012). The Ministry of Public Health is the leading health organisation in the country network, with the internal sub-organisations and external organisations such as the non-health sectors including the NGOs and civil organisations, local administrative units, and research institutes (Kumpalanon, Ayuwat, & Sanchaisuriya, 2012). The Health Promotion Foundation has also taken a role steering the health promotion campaigns and research by working with other national organisations, regional and local organisations as well as through its own regional and provincial offices (Health Promotion Foundation Act, B.E. 2544 (2001), 2001). The National Health Promotion Foundation Committee consists of members who are representatives of related national organisations whose missions are related to health promotion of citizens in the country and includes the Ministry of Interior and Ministry of Public Health (Health Promotion Foundation Act, B.E. 2544 (2001), 2001).

Moreover, in Thailand, the government applied a collaborative strategy to promote the health of the older population in the country according to the South East Asia regional health promotion strategy. The application is evident in national policies in the forms of acts, plans, and strategies such as the 2<sup>nd</sup> National Plans on the Elderly (2002-2021), 1<sup>st</sup> Revised of 2009, Health Promotion Foundation Act, B.E. 2544 (2001), the Determining Plans and Process of Decentralization to Local Government Organization Act B.E. 2542 (1999), and the Elderly Person Act B.E. 2546 (2003). These policies are



central to health promotion for the elderly population in the country and emphasis promoting quality of life of the elderly that requires inter-organisational efforts.

The regional offices of the related ministries within the country along with the LAOs take operational responsibilities for national plans and acts as provided in the following table.

*Table 3: National Policies and Actors Involved in Health Promotion for the Elderly in Thailand and Their Broad Scope of Work*

<b>National plans/ strategies/ acts related to elderly health promotion</b>	<b>Level of government authority</b>	<b>Organisations or offices involved (Focal Points)</b>	<b>The broad scope of work related to elderly health promotion</b>
The 2nd National Plan on the Elderly (2002 - 2021), 1st revised 2009	Central administration	<ul style="list-style-type: none"> <li>- Ministry of Public Health</li> <li>- Ministry of Interior</li> <li>- Thai Health Promotion Foundation</li> <li>- National Health Security Office</li> <li>- Public and private networks</li> <li>- Office of the Prime Minister</li> </ul>	<ul style="list-style-type: none"> <li>- Develop national plans and indices regarding the collaboration of health promotion for the elderly efforts across organisations and levels as well as determining the focal organisations of efforts and strategies (The National Committee on the Elderly, 2009)</li> <li>- Develop guidelines and regulations in collaborating and assisting local administrative organisations in their operations (Jongudomsuk et al., 2015; Prutipinyo, 2015)</li> </ul>
	Local administration	Local administrative organisations (sub-district administrative organisations and municipality offices)	<ul style="list-style-type: none"> <li>- Together with other entities, such as religious and private entities, to take part in provision of welfare for the elderly emphasising a community-based approach (Ministry of Social Development and Human Security, 2003)</li> <li>- Render health care and social services to elderly persons who can afford such services, provided such services shall</li> </ul>

National plans/ strategies/ acts related to elderly health promotion	Level of government authority	Organisations or offices involved (Focal Points)	The broad scope of work related to elderly health promotion
			<p>be certified and standardised with fair and reasonable cost (Ministry of Social Development and Human Security, 2003)</p> <p>- Encourage the establishment and running of elderly clubs and networks as well as support activities of the elderly networks (Ministry of Social Development and Human Security, 2003)</p>
	Central and regional administrations	<p>Central level</p> <p>- The Office of Promotion and Protection of the Elderly, the Office of Promotion and Protection of Children, Youth, the Elderly and Vulnerable Groups, Ministry of Social Development and Human Security</p>	<p>- Cooperate and coordinate with the centralised administration units, the regional administration units, and state enterprise, as well as the other organisations which enables the protection, promotion and support of the elderly under the Elderly Person Act and related laws (Ministry of Social Development and Human Security, 2003).</p>

National plans/ strategies/ acts related to elderly health promotion	Level of government authority	Organisations or offices involved (Focal Points)	The broad scope of work related to elderly health promotion
		<p>Regional level</p> <ul style="list-style-type: none"> <li>- Provincial Office of Ministry of Social Development and Human Security</li> </ul>	
Determining Plans and Process of Decentralization to Local Government Organization Act B.E. 2542 (1999)	Local administration	Local administrative organisations (sub-district administrative organisations and municipality offices)	<ul style="list-style-type: none"> <li>- Manage and deliver social welfare services and improve the quality of life of the elderly ("Determining Plans and Process of Decentralization to Local Government Organization Act B.E. 2542 (1999)," 1999)</li> <li>- Manage health care and disease prevention and control ("Determining Plans and Process of Decentralization to Local Government Organization Act B.E. 2542 (1999)," 1999)</li> </ul>

National plans/ strategies/ acts related to elderly health promotion	Level of government authority	Organisations or offices involved (Focal Points)	The broad scope of work related to elderly health promotion
Health Promotion Foundation Act B.E. 2544 (2001)	Central and regional administrations	<p>Central level</p> <ul style="list-style-type: none"> <li>- Health Promotion Foundation</li> </ul> <p>Regional level</p> <ul style="list-style-type: none"> <li>- Provincial offices of the Health Promotion Foundation</li> </ul>	<ul style="list-style-type: none"> <li>- Encourage and support health promotion of population at every age pursuant to the national health policy ("Health Promotion Foundation Act, B.E. 2544 (2001)," 2001)</li> <li>- Develop the capacity of communities and local actors on health promotion by working with communities, community-based or private organisations, organisations for public benefit, government agencies, state enterprises or other state agencies ("Health Promotion Foundation Act, B.E. 2544 (2001)," 2001)</li> <li>- Support health promotion campaigns through various activities in a manner which is conducive to people taking care of their health, make the best use of their free time and reduce their consumption of alcoholic beverages, tobacco, or other health-impairing substances ("Health Promotion Foundation Act, B.E. 2544 (2001)," 2001)</li> </ul>

National plans/ strategies/ acts related to elderly health promotion	Level of government authority	Organisations or offices involved (Focal Points)	The broad scope of work related to elderly health promotion
Elderly Person Act B.E.2546 (2003)	Central administration	Central level  - The Office of Promotion and Protection of the Elderly, the Office of Promotion and Protection of Children, Youth, the Elderly and Vulnerable Groups, Ministry of Social Development and Human Security	<ul style="list-style-type: none"> <li>- Set the primary policy and plan about the protection, promotion, and support of the status, roles and activities of the Elderly Person to commission and propose the matter to the National Commission on Elderly Person</li> <li>- Gather the information, studies, research and development about the protection, promotion and support of the Elderly Person</li> <li>- Act as a centre in the coordination, dissemination, and public relations work or activities concerning the Elderly Person</li> <li>- Create a system caring for local Elderly Persons</li> <li>- Cooperate and coordinate with the centralised administration unit, the regional administration unit, and state enterprise, as well as the other organisations which</li> </ul>

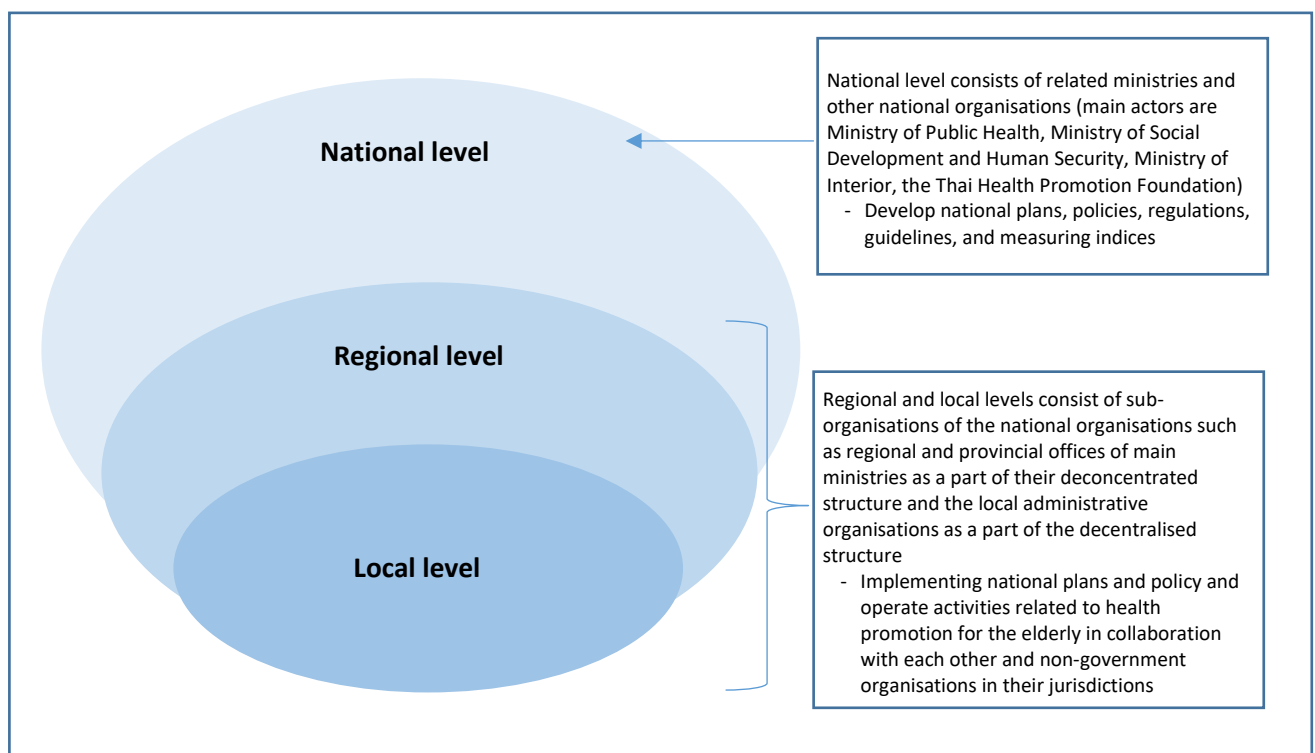
National plans/ strategies/ acts related to elderly health promotion	Level of government authority	Organisations or offices involved (Focal Points)	The broad scope of work related to elderly health promotion
			<p>are involved with the protection, promotion and support of Elderly Persons under this Act and related laws</p> <ul style="list-style-type: none"> <li>- Follow-up and assess the results of the performance of the key plans from relevant units and report to the Commission</li> <li>- Consider advising the Commission to have or to amend the laws on the protection, promotion and support of the status, roles and activities of the Elderly Person</li> <li>- Perform other activities as assigned by the Commission</li> </ul>
National Health Security Act B.E. 2545 (2002)	Central and local administrations	<p>Central level</p> <ul style="list-style-type: none"> <li>- National Health Security Office</li> </ul> <p>Local level</p>	<ul style="list-style-type: none"> <li>- National Health Security Office as a central government organisation managing health funds for Thai citizens and distribute funds to the public health care providers throughout the country.</li> <li>- Build health security through health promotion and disease prevention programmes for people in the</li> </ul>

National plans/ strategies/ acts related to elderly health promotion	Level of government authority	Organisations or offices involved (Focal Points)	The broad scope of work related to elderly health promotion
		<p>- Local Administrative Organisations</p> <p>Other related organisations at the local and regional level</p>	<p>community with budget from the National Health Security Funds and Local Health Funds, operate with LAOs in collaboration with related organisations, and manage programmes at the local level with assistance from the National Health Security office ("National Health Security Act B.E. 2545 (2002)," 2002)</p>



There is involvement of actors from different levels of government. While organisations at the national level play a key role in developing plans, guidelines, and policies related to the elderly health and health promotion, others at the lower levels are mandated by acts that outline their responsibilities and authorities that include promoting the elderly health and quality of life. They are also encouraged by national plans and strategies to work together in taking action. These multi-level roles reflect what Koliba et al. (2011) referred to as “mixed actors operation in a mixed social scale” (p.31).

Figure 6 illustrates different government levels and actors involved in the health promotion for the elderly in Thailand from the integration of national policies and plans.



*Figure 6: Government Levels and Actors Involved in the Health Promotion for the Elderly in Thailand*

Health promotion policy for the elderly in Thailand encourages the participation of individuals, community, and society. It also builds an appropriate environment in support of the elderly health which includes the psychological environment, assertive actions by the community in fostering activities for the elderly, and preventive health care such as screening and consultation (Department of Health, n.d.-b). Accordingly, efforts have been made in health promotion for the elderly in policy development and implementation on national and local levels. For example, the Health Promotion for the Elderly and Persons with Disabilities project work plan was developed in 2012 by the Department of Health and other organisations within the Ministry of Public Health. Activities within

the framework of the programmes are carried out by related government organisations outside of the Ministry of Public Health as well as the elderly clubs at the local sub-district level. Each province and each club collaborate, develop, and implement their own strategy within the framework of the plan (see examples in Appendix A2). In order to ensure that the elderly population has been reached and are able to access the health promotion services provided by the government, implementation responsibility has been incorporated into the existing decentralised government structure (Pittayarangsan et al., 2010).

This section illustrates how health promotion for the elderly in Thailand progresses from the national policies to implementation throughout the country. The implementation of the national policies is carried out by the government sub-organisations at different levels. The connection between policy and the actual implementation is not without a form. The core national policies suggested that the implementation of health promotion for the elderly requires cooperation and collaboration of organisation as a network at the local level. With the government organisations directed as a focal point in the national policies.

*“The present National Plan for the Elderly contains the new measures to underlie and comply with the change in social situation and the elderly problem conditions such as ...encouraging of long-term care, systematization and plans for assistance in case of disasters, provincial and local networks on administration and development of the elderly, etc., and specify the 1<sup>st</sup> and the 2<sup>nd</sup> focal points for implementing and determined strategies and measures as the key agencies in monitoring and operation under the National Plan for the elderly subsequently.”*  
(The National Committee on the Elderly, 2009, preface).

The 2<sup>nd</sup> National Plan for the Elderly (2002 – 2021) defines supportive networks as “relations between the elderly group, public entities and private entities that render community-based multipurpose service for the elderly.” (The National Committee on the Elderly, 2009, p.22). The multipurpose service for the elderly, according to the plan, includes enabling the elderly to have a good quality of life with feasibility for them to socialise, accessibility to public transport systems, public spaces that are usable, health and social services including long-term community-based care and home care (The National Committee on the Elderly, 2009). National policies and plans suggested that the LAOs is an important actor in providing the multipurpose service for the elderly in the community. The most recent national policy that suggest these crucial roles of this local government organisation is the National Primary Care Systems Act B.E. 2562 (2019) where it stresses the LAOs as the driver of collaboration of the primary health care systems and health promotion for general population including the elderly at the implementation level.

The next section will outline the decentralisation governance structure in Thailand where the LAOs posited, their roles as a local government organisation and in delivering health promotion services to the target population as a product of the national plans and policies.

### *2.2.3.3 Decentralisation and Its Roles in Health Promotion for the Elderly in Thailand*

Decentralised governance is the dispersal of substantial government structures into several tiers which provide services to the people living in subnational jurisdictions (Dillinger & Fay, 1999). Before the decentralisation reform in Thailand, which began in the late 1990s, the government administration in Thailand focused on deconcentrating hierarchical government and structures, and bureaucracy (Chardchawarn, 2010). Deconcentration transfers authority and responsibility from the central government to the lower levels of governments while maintaining the same hierarchical level of accountability where the power stays with the public officials, not the local people, representative democracy rather than participatory democracy. On the other hand, the decentralisation transfers political, fiscal, and administrative responsibilities to government organisations in the sub-national or local levels (Haque, 2010). Decentralisation reform was a trend for many developing countries in the 1980s (Haque, 2010).

Similarly, in Thailand, decentralisation was promoted in the 1997 Constitution to encourage transparency and responsive government through public participation and local representation (Chardchawarn, 2010). The subsequent Decentralization Act 1999 and the Decentralization Action Plan 2000 established local administrative organisations structure to accommodate the provincial economic and social development throughout the nation (Jongudomsuk et al., 2015; Unger & Mahakanjana, 2016; Leethongdee, 2006).

Accordingly, Thailand's government administrative structure is separated into three levels, which are central, provincial, and local (Berman, 2011). The provincial administrative level has organisations that operate in the same regions at the local level such as in provinces, districts, and sub-districts but they provide different type of services (Jongudomsuk et al., 2015). The autonomy and fiscal resources of the organisations within the provincial administrative structure are transferred from and funded by the central government. On the other hand, while the organisations within the local administrative structure are also partially funded by the central government, namely the Ministry of Interior and others based on their collaboration programmes, they are autonomous and more flexible as well as able to earn revenue from local taxes as well (Berman, 2011; Unger & Mahakanjana, 2016).

#### *2.2.3.4 Roles and Responsibilities of LAOs*

The Determining Plans and Process of Decentralization to Local Government Organization Act B.E. 2542 (1999) and the subsequent Operational Plans and Process of Decentralization to Local Government Organization of B.E. 2545 (2002) highlighted the transfer of functions that were previously the responsibility of the centralised organisations and agencies to the local administrative organisations. These responsibilities are categorised as “(1) basic infrastructure; (2) quality of life; (3) community development; (4) local commerce, investment, and tourism; (5) environmental preservation; and (6) local cultural preservation and local wisdom.” Therefore, the LAOs are government organisations at the local level responsible for the social and economic development of people in their jurisdiction, supervised, supported, and evaluated by the Department of Local Administration, Ministry of Interior. With their autonomy in administration and revenue earning, they are the only decentralised organisation in the network of health promotion policy implementation for the elderly. Accordingly, they are not a part of the hierarchical centralised structure like other network actors.

The aforementioned national policies indicated that the LAOs shall have the power to systematise the public services for the benefit of local communities. Listed under Chapter two, Determination of Powers and Duties in Public Services System, the Determining Plans and Process of Decentralization to Local Government Organization Act mandated that the LAOs are to:

- 1) Establish local self-development plan
- 2) Provide and maintain land route, water route and water drainage
- 3) Provide and control of market, wharf, pier and parking
- 4) Public utility and other constructions
- 5) Public assistance
- 6) Promote, train and carry on occupations
- 7) Commerce and investment support
- 8) Promote tourism
- 9) Provide education
- 10) Social welfare and develop the life quality of children, women, old people and disadvantaged people

- 11) Conserve local arts, custom, knowledge and good cultures
- 12) Improve the slum areas and arrange for housing
- 13) Provide and maintain recreational areas
- 14) Enhance athletic sports
- 15) Enhance democracy equality, rights and freedom of people
- 16) Enhance the participation of people in the development of local organizations
- 17) Keep clean and keep the city in perfect order
- 18) Waste management system including wastewater
- 19) Public health, family sanitation and health care
- 20) Provide and control the cemetery and cremation
- 21) Control of livestock farming
- 22) Provide and control of animal slaughter
- 23) Security measures, public order, sanitary, theatre and other public places
- 24) Provide, maintain and benefit taking from forestry, land, natural resources and environment
- 25) City plan
- 26) Transportation and traffic engineering
- 27) Preserve public places
- 28) Control of structures
- 29) Prevent and alleviate public dangers
- 30) The public order, promote and support the prevention and security measures of life and properties

31) Other activities for the benefit of local communities announced by the Committee of Decentralization to Local Government Organization<sup>1</sup> (The Determining Plans and Process of Decentralization to Local Government Organization Act B.E. 2542 (1999), 1999).

The responsibilities and authorities of the sub-district LAOs cover the aspects required for health promotion and the development of elderly well-being as defined by the WHO. The sub-district LAOs' revenue comes from local taxes such as land and house taxes, liquor and excise taxes, automobile tax and fee, gambling tax, animal slaughter tax and benefits from the slaughters, and business license fees and fines, among others. The LAOs are also entitled to gain revenue from 10-20% royalty fees should their area cover the areas where minerals and petroleum are collected (Determining Plans and Process of Decentralization to Local Government Organization Act B.E. 2542 (1999), 1999). In addition, the Determining Plans and Process of Decentralization to Local Government Organization Act B.E. 2542 (1999) also indicated that the sub-district LAOs gain their income from subsidised funds from the government, state agencies, state enterprises, loans from ministries and their sub-organisations, as well as from service fees, public utilities, and others.

As a result of the decentralisation reform, the responsibilities for primary health care and public health were transferred to be overseen by the LAOs, such as the municipalities, provincial administrative organisations, and the sub-district administrative organisations (Khunhan Sub-district Municipality, n.d.) as a part of their accountabilities (Krueathep, 2004).

Thus, the decentralised governance structure in Thailand enables the LAOs to implement health promotion policy by providing access to health promotion initiatives and services to people in their community (Health Systems Research Institute, 2010). The decentralised structure also allows more flexibility in collaboration (Berman, 2011; Unger & Mahakanjana, 2016).

Figure 7 shows the spheres of authority of government levels in Thailand.

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<sup>1</sup> The Committee is consisted of Prime Minister or Deputy Prime Minister delegated by the Prime Minister as the Chairman, Minister of Interior, Minister of Finance, Permanent Secretary of Interior, Permanent Secretary of Finance, Permanent Secretary of Education, Permanent of Public Health, Secretary - General of the Council of State, Secretary - General of the Civil Service Commission, Secretary - General of the National Economic and Social Development Board, Budget Director of the Bureau of The Budget and Director-General of the Department of Local Administration, twelve representatives of the LAOs, and Twelve qualified persons composed of experts in the field of State administration, local development, economics, local governance, political science and law.

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*Figure 7: Authority Relations of Government Levels in Thailand*

Note: Shaded boxes are organisations as part of the LAOs, the key local government units in this study

*Source: Adapted from Unger & Mahakanjana (2016). Decentralization in Thailand (p. 175).*

In this study, the shaded organisations in Figure 7 are the units of the study. The Transferring Responsibility Act of 2000 defined responsibilities of the sub-district municipalities and sub-district administration organisation as the same. Both organisations will be referred to as a local administrative organisation or LAO in this study to prevent confusion of the readers.

#### *2.2.3.5 LAOs and Their Roles in Health Care for the Elderly*

Since 1994, the LAOs in Thailand started to have increasing levels of autonomy from the central government as a result of the Sub District Council and Sub District Administrative Organization Act in providing health promotion and health care services supporting the local population (Pittayarangsan et al., 2010). Nowadays, LAOs also manage the Health Promotion Hospitals under their own administration. Citizens in the community are also more aware of health care through the LAO's preventive health initiatives and health promotion campaigns (Office of the National Economic and Social Development Board, 2011).

Decentralisation in Thailand (see timeline in Appendix A3) gradually transferred autonomy and established structures providing primary health care and services, including health promotion to the LAOs. Because the LAOs are close to their community, they are able to deliver primary health care and health promotion and develop community engagement in local health management more comprehensively (Tejativaddhana, 2014). Following the decentralisation reform in 1999, primary health care responsibilities and services in health promotion, health prevention, rehabilitation, and others were transferred to the sub-district and municipality administrative organisations or sub-district LAOs (Department of Local Administration, 2006). However, despite having responsibilities and autonomy to administer other organisations that provide primary care and health promotion services like the health promotion hospitals in their community following the health care decentralisation (Health Systems Research Institute, 2010), the LAOs originally had no personnel in health care related positions of their own (Office of the Public Sector Development Commission, 2008). As a result, they received technical support and training from the Ministry of Health and central personnel were transferred to the local level (Office of the Public Sector Development Commission, 2008).

In addition, the draft National Health Policy Committee Bill has been under consideration by the National Reform Steering Assembly since 2016. If it passes, the Bill will establish the National Health Policy Board, Area Health Board, and Provincial Health Promotion and Disease Prevention Board that will strengthen, integrate, and unify the mechanisms of health care and health promotion from the national level to the local level. The proposed bill also includes population ageing as a significant factor in justifying the establishment of the Committee and the Boards (National Legislative Assembly, 2016; National Reform Steering Assembly, 2016).



Figure 8 shows that the health service structure in Thailand is a system of coordination across sectors, ministries and levels of operating administrative governments. Some of the primary care units at sub-district level includes Sub-district Health Centres and health centres in villages which are under the administration of the LAOs, Ministry of Interior. Their complete transfers were subject to the readiness of the LAOs in their particular areas such as having sufficient revenue, human resources, population, operation expenses, quality of service, management experience, and development opportunities (Leethongdee, 2006).

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*Figure 8:Thailand Health Service Structure*

*Source: Adapted from Tejavivaddhana (2014). Capacity Building for District Health System Management Network to Achieve Health Promoting Districts (24DHS).*

The national strategy on the elderly health promotion and development is included in the Second National Plan for the Elderly (2002-2021) (The National Committee on the Elderly, 2009). In the strategy, the LAOs have the responsibility of developing programmes or activities to promote the health, disease prevention, and primary self-care of the elderly population in their jurisdiction. The Plan suggested planning and implementing of this strategy should include the Ministry of Public Health, Ministry of Interior (Local Administration Department (LAD))/LAOs, the Thai Health Promotion Foundation, and public and private networks (The National Committee on the Elderly, 2009). The health promotion of the elderly at the local level, has thus become a collaborative endeavour (Foundation of Thai Gerontology Research and Development Institute, 2015).

Nevertheless, not all health centres in the country have been completely transferred to the local government. Most local administrative organisations, although they do not have a health care facility under their administration, have been transferred the responsibilities and budget for managing primary health care including health promotion and rehabilitation (Korboon, 2008). Some health centres at the sub-district level have been upgraded to the Sub-district Health Promotion Hospitals under the management of the Chief District Health Office and the Community Hospital Director. Despite the complexity of the health care and administrative structure, the Sub-district Health Promotion Hospitals, the health centres, and the local administrative organisations provide primary health care and health promotion services in different forms to people in their catchment areas (Tejativaddhana, 2014). However, the development of decentralisation and functions of the organisations within the structure has had challenges.

With the decentralisation reform, local administrative organisations have been established with flexibility and autonomy to deliver health promotion and primary care services for people in their community (Pittayarangsan et al., 2010). The flexibility and autonomy enabled them to develop and propose their own programmes in support of the development of the quality of life of the elderly in their own community. The independent programmes and activities can involve other government, civil, and private organisations outside the decentralised structures in their district and province, and more importantly participation of the local population (Prutipinyo, 2015). LAOs under the decentralisation reform, particularly the sub-district level LAO offices, have direct contact with the elderly in the community as they work in partnership with the local elderly clubs (Department of Health, n.d.-b). "Health promotion for the Elderly in Thailand" highlighted key national policies and actors involved in the health promotion for the elderly in Thailand, which includes those in all government authority levels and their broad scope of work related to the topic. Operational functions and activities related to health and health promotion of the elderly of organisations under those mentioned in the national policies can be found in Appendix A4.

#### *2.2.3.6 Implementing Health Promotion Policy for the Elderly: Core Organisations*

National health promotion policies in Thailand have embraced implementation of the concept of collaboration as recommended in the South East Asian region's health promotion strategies. Collaboration is directed through the policies. It called for policy implementation by a network of organisations with different missions and operational functions with the aim to enhance the holism of health promotion according to the Ottawa Charter. The organisations operate at different levels in the governance system and to better understand their relationships, I have applied an institutional approach.

Peters (2016) suggested that the institutional approach focuses on the "organisations and institutions within the public sector that make and implement public policies" (p. 308). Furthermore, the patterns of governance of organisations can be explained based on the definition of new institutionalism (March & Olsen, 1984). According to March and Olsen's (1984) new institutionalism, political systems through which governance is provided need to be considered in order to see the patterns of governance and to understand the roles of organisations. Political systems may include the nature of governance, such as single or multi-level of governance, the horizontal or vertical fragmentation of governance, and institutions' capacity (March & Olsen, 1984). Institutions shape the behaviours of individuals that participate in the institutions with their values and symbols (Peters, 2016). These values and symbols are exemplified by the normative point of view as law or bureaucracy (March & Olsen, 1984). Peters (2016) further explained that this view of values and symbols "can also be used as a means of producing governance" (p. 310) of institutions and it is located in the sociological institutionalism school of thought.

The governance of the organisations involved in health promotion policy implementation for the elderly in Thailand could be aligned with what Bache, Bartle, and Flinders (2016) referred to as the early manifestation of multi-level governance. It involves government organisations in several tiers, from national, regional, to local levels. Their relationships have vertical interactions in decision-making and include horizontal interactions with non-governmental actors (Bache, Bartle, & Flinders, 2016). In the case of health promotion policy implementation for the elderly in Thailand, government organisations involved in the implementation at the local level are the "arm's-length bodies" doing the policy task-specific work of the central government (Pollitt & Talbot, 2004). Values and symbols directing the organisations and the individuals within are the national policies and plans relating to the health of the elderly. Altogether, their behaviour at the policy implementation level is policy or task specific and is more intersecting than at the national level. To understand the government organisations involved in health promotion policy implementation for the elderly in

Thailand from an institutional perspective, I present the following governance and authority characteristics of these organisations.

*Table 4: Characteristics of government organisations implementing the health promotion policy for the elderly at the local level in Thailand*

Features	Centralised government organisations	Decentralised government organisations
Actors	<ul style="list-style-type: none"> <li>- National organisations and sub-national organisations</li> <li>- Ministries and their sub-organisations</li> </ul>	LAOs
Governance and fragmentation	<ul style="list-style-type: none"> <li>- Ministries' officers dispatched to their sub-organisations and sub-national levels (regional, provincial, and district), durable governing structure</li> <li>- Vertically fragmented as hierarchical in decision-making and approvals</li> <li>- Horizontal interactions may include with non-governmental organisations</li> </ul>	<ul style="list-style-type: none"> <li>- Still under the supervision and control of the Ministry of Interior who has the authority to approve their annual budget plans and local regulations, dissolve local councils, and dismiss local councillors (Nagai, Funatsu, &amp; Kagoya, 1997).</li> <li>- Led by a director or a mayor directly elected by the residents for the management of the organisation</li> <li>- Horizontal interactions including with non-governmental organisations such as civil organisations in their local jurisdiction</li> </ul>
Responsibilities and authorities	<ul style="list-style-type: none"> <li>- Oversee national policies and macroeconomic development, infrastructure development, and</li> </ul>	<ul style="list-style-type: none"> <li>- Demonstrate both political and administrative decentralisation authorities. authority spreads out from the central political level to</li> </ul>

Features	Centralised government organisations	Decentralised government organisations
	<p>social development (Asian Development Bank, 1999)</p> <ul style="list-style-type: none"> <li>- Functions depend on the missions of parent organisations at the national level. These functions are outlined by laws and regulations such as national acts establishing the ministry or the parent national organisation.</li> <li>- Parent organisations supervise sub-organisations and evaluate their performance by benchmarking against national policy indicators.</li> </ul>	<p>another elected official, and this elected official plays the role of a manager or an administrator of the authority (Pollitt, 2005).</p> <ul style="list-style-type: none"> <li>- Formulate local policy and manage its own administration, human resource and financial resource.</li> <li>- Intersecting and task-specific, according to the national policies covering their scope of work in the development of the local community and well-being of the people in their jurisdiction (Organisation for Economic Co-operation and Development, 2018).</li> </ul>

In addition to the centralised and decentralised government organisations, non-governmental organisation such as the sub-district elderly club is another actor that plays an important role in the health promotion policy implementation for the elderly at the local level. It represents the policy target population in the implementation process. The elderly clubs adhere to the guidelines provided by the Department of Older Persons, Ministry of Social Development and Human Security (Senior Citizen Council of Thailand, n.d.).

## 2.3 Summary of the Background Chapter

An ageing population has become a global issue that international organisations and governments are managing in different ways. These include both developing better health care systems and economic structures. For Thailand, with an increasing number of the elderly due to the change in population structure is an essential factor influencing health promotion policy. To support and encourage good health for today's elderly and the ageing population, national health promotion guidelines, initiatives, and organisations have been established and incorporated within the primary health care system in the country. Decentralisation reform has enabled the government to provide health promotion and primary health care services to the population from the national level, such as policy, down to the community and individual levels as in the implementation of the policy and guidelines. The local administrative organisations as the government units closest to the community and individuals carry out this responsibility with some managing their own local primary health care facility.

It can be concluded that the challenging factors and different aspects which motivate and affect health promotion policy implementation for the elderly in Thailand by the LAOs are:

1. Increasing national health expenditure

National expenditure on all current public health care coverage schemes in Thailand has been increasing, particularly for the UHC that covers the majority of the Thai population. With the history of using the budget intended for health promotion and prevention for curative care, health promotion and prevention programmes may not have been effectively implemented by the organisations involved. The majority of the population utilising health care and health promotion services are the elderly; it is crucial that ways to improve health promotion policy implementation be explored. This is to enhance health promotion for the elderly in Thailand which should in turn help reduce future the national health expenditure, relieve the burden on the younger generation whom the elderly depend on, and develop innovative measures to improve the future policy for the elderly health and other groups of the population who can benefit from health promotion.

2. Collaboration and participation of key actors at the local level

Collaboration and participation play a supportive role for health promotion policy implementation in the decentralised governance structure (Achananuparp, 2005; Buasai et al., 2007; Health Systems Research Institute, 2010). The collaboration and participation

between key actors as a network at the local level help respond to health and mental health needs as well as the long-term care of the elderly population in particular (Prasartkul, 2013).

### 3. Community engagement

Thailand has a well-dispersed structure of primary care service providers from the central and national level down to the local and community level (Achananuparp, 2005). This structure also acts as a point of building community engagement which assists local health management (Tejativaddhana, 2014). However, it still needs individual and community empowerment to drive collaboration between and across sectors and effective behavioural change (Achananuparp, 2005).

### 4. Human resource management and capacity at the local level

After the transfer of responsibilities in health promotion from central government agencies to the LAOs, the LAOs still lacked a suitable human resources allocation strategy and systematic follow-up and evaluation (Achananuparp, 2005). A more recent study by Buasai et al. (2007) found that most of that weakness had been addressed with the assistance from the Thai Health Promotion Foundation in developing knowledge and technical capacity at the local level.

### 5. The slow progress of decentralisation and limitations due to regulations

There is slow progress in health care decentralisation, namely the transfer of the health centres which provide primary care and basic health promotion services from the central governance structure to the sub-districts administrative organisations and municipalities (Leethongdee, 2006). The pilot transfer started in 2007, with 22 transfers achieved in 2010 and 11 more between 2011 – 2012. However, the total number of health centres nationwide is 9,762 (Jongudomsuk & Srisasalux, 2012; Leethongdee, 2006). Moreover, while the flexible decentralised governance allows opportunities for the LAOs to collaborate with other local and regional government organisations in taking the role (Berman, 2011; Unger & Mahakanjana, 2016), the regulations for related projects and initiatives proposals and budgeting has yet to completely accommodate this responsibility (Foundation of Thai Gerontology Research and Development Institute, 2015).

These factors and subsequent challenges show that health promotion efforts implemented by the government at the local level involve more than a single organisation and need collaboration from different actors. Decentralisation and its corollaries for health care are key enablers for the Thai government to support the independence and sustainability of the local community. They also

enable the government to respond and assist health and other needs of the people in the community and throughout the country through the operations of LAOs as its local agent (Institute for Population and Social Research, 2014; Korboon, 2008). Moreover, the transfer of health care related responsibilities from the central government to the LAOs includes the transfer of whole health care networks of multiple health care management organisations and providers (Thai Health Report, 2014). However, the LAOs are not entirely separated from other government organisations in the deconcentrated structure, such as the Provincial and District Public Health Offices. Although the national acts and constitution have provided LAOs with independent decision making power and flexibility in managing their own operations, collecting their own revenue, and implementing programmes in the scope of central policies, the LAOs still need assistance from other organisations in terms of resources, expertise, funding, and facilities.

Functions and activities carried out by the network of actors mentioned in the national health promotion policy for the elderly at the local level can be summarised in the following aspects:

- Resource exchange such as knowledge and financial resource through training programmes and budget being provided for services from and to one another
- Coordinated actions such as planning of activities and programmes
- Information sharing such as the establishment of standards, guidelines, and shared policy implementation evaluation measurements and indices
- Capacity building such as educating one another and the policy targets

The development and the modification of responsibilities regarding health promotion by the LAOs were also found to be featured as one of the factors leading to improved basic infrastructure for health promotion (Achananuparp, 2005). As the health promotion policy implementation for the elderly involves other government units outside of the decentralised governance structure such as those regional offices of central ministries (Foundation of Thai Gerontology Research and Development Institute, 2014), my proposed research will look into the horizontal perspective of the collaboration as a network. These nodes or actors have the mutual goal of developing the quality of life of the elderly in Thailand based on the national policies and their organisation's mission. Their functions and activities collaborated at the local level exhibit the characteristics of network functions, according to Koliba et al. (2011). Not only have these organisations been directed to collaborate as a network unit in implementing the health promotion policy for the elderly at the local level, being a part of this policy and the government sector has led to the emergence of interaction patterns of a network (Klijn & Koppenjan, 2016). Furthermore, the collaboration of



organisations directed by the national policies to implement health promotion for the elderly presents the characteristic of multi-level governance. Their collaboration also presents the concept of new institutionalism, where the dominance of law and regulations, in this case as national policies, shape the behaviour and functioning of the individuals within and the organisations as a unit. However, while national policies refer to actors involved collectively as 'networks' at various levels, they do not elaborate on their relationship extent of the content of the networks, neither do they establish the network structure nor guide the management of the network. While their collaborations indicate network operational function characteristics, their relationships cannot be determined from the written national policies or their documented organisational functions. Thus, this research explores closely and in-depth how the LAOs implement the health promotion policy for the elderly with their networks of collaborating actors at the local level to achieve the common goal.

## Chapter 3: Literature Review

Earlier in this thesis, the statement of the problem and the background chapter explained about the ageing situation in Thailand, the health of the older population, the health care system in the country, and the ongoing national efforts to address these issues by the government through a health promotion approach. As summarised at the end of the background chapter, health promotion policy implementation for elderly networks in Thailand is loosely formed in terms of specifics and the characteristics of the inter-institutional networks involved in implementation: their governance, management, and functions are like a black box. My research questions focus on opening the box of policy implementation in these policy implementation networks. The research includes seeking an explanation of what factors may differentiate the performance of the policy implementation networks and identifying their unique characteristics. Therefore, in this chapter, I examine the public administration theory literature that might be helpful for conceptualising the multi-organisation networks and implementation of the health promotion policy.

This chapter includes the syntheses of relevant theories and gaps that emerged from the review of literature. The concept of networks is outlined first to provide an overarching idea of the term and its use to explain the collaboration of organisations in public administration and public policy research. Then, the integration of policy implementation and networks theory is reviewed with a view to the latter as a means for achieving a complex policy goal. Lastly, the characteristics of the internal workings and dynamics of networks that have been studied internationally will be elaborated upon to focus on the relations among networks' actors and how they affect policy implementation, and shape the purpose of what the networks have been established to do.

### 3.1 Networks

Networks have been referred to in the national policies as a unit of collaboration between related government organisations in health promotion policy implementation for the elderly at the local level in Thailand (The National Committee on the Elderly, 2009; Ministry of Social Development and Human Security, 2003). These organisations have different expertise and individual missions to tackle different social issues. These networks have been formed loosely without a formally established management structure, flow of authority, administration guidelines, or network-level functions, and have a lax guideline to draw on the different knowledge bases and expertise of network members to address health promotion practices for the elderly. To uncover and explain these networks, their characteristics should be determined as a way of facilitating knowledge and

connections of relationships between organisations. Network theory therefore presents as a useful conceptual framework to study this type of multi-organisational interaction (Klijn & Koppenjan, 2012). The following sections will discuss this further with an introduction to the network approach as a governance mechanism in which these actors operate on in the stage of policy implementation, the networks' own forms of governance, networks in health policy, and the characteristics of networks.

### 3.1.1 Networks as a Multi-Organisational Collaboration and a Mode of Governance in Policy Processes

This section discusses the concept of networks, their formation and structure, provides an explanation of networks as a mode of governance, and describes how the application of networks is different from the alternative governance approaches of hierarchies or markets in their benefits and disadvantages.

Organisations can be conceptualised as nodes whose relationship or lack of relationship with other organisations (nodes) can be considered as a network (Brass et al., 2004). A network relationship can also overlap with other types of relationship (see Appendix A5) such as in a complex public service delivery system, through dyads, coordination, collaboration, and co-production (Poocharoen & Ting, 2015). Organisations become a part of a network for different purposes, as Provan and Kenis (2008) found. Usually, the membership of networks is driven by the results or goals that individual organisations try to achieve but are limited by factors that make them unable to do so on their own. Similarly, organisations becoming a part of networks are those aiming to achieve collective goals, not just their own (Provan & Kenis, 2008). This relationship does not necessarily have to be a legalised or formal structure as it can be in the form of social establishment, agreements, or social contracts such as a service referral system in healthcare (Barringer & Harrison, 2000; Provan et al., 2007). However, legal contracts or legally binding documents for the relationship may exist for the network in addition to the social contracts (Provan et al., 2007).

Networks are described as “partnerships, collaborative agreements, and inter-organisational relationships” (Provan et al., 2007, p. 481), involving working across agencies. The term is also presented in studies which looked into organisations that work together and can be explained by resource dependence theory (Pfeffer & Salancik, 2003); that is, where the relationships between organisations are based on their interdependency of each other's resources (Hillman, Withers, & Collins, 2009). Common themes that surround the definition of *networks* include “social

interaction (of individuals acting on behalf of their organisations), relationships, connectedness, collaboration, collective action, trust, and cooperation” (Provan et al., 2007, p. 481).

Koliba et al. (2019) noted that collaboration and cooperation are used interchangeably to describe relationships between two or more actors whose power within the relationship stems from social norms of trust and reciprocity as that of a network. From actors’ networked relationships, a public policy is a product of a multi-organisational collaborative interaction affecting societal processes or driving changes in the society. It is “a set of decisions by governments and other political actors to influence, change, or frame a problem or issue that has been recognised as in the political realm by policy makers and/or the wider public.” (Hassel, 2015, p. 569). A public policy is considered “made and implemented in networks of interdependent actors” who interact to directly influence societal processes and do so by providing guidance mechanisms in connection with public policy processes (Kickert, Klijn, & Koppenjan, 1997, p. 2).

The concept of connecting public policies and strategic institutionalised actors or organisations involved is referred to as policy networks (Kickert et al., 1997). The structure of these networks may consist of actors from different sectors and organisations having specialised functions contributing to achieving policy purposes (McGuire, 2006). In a case where only actors strategically influence societal or policy processes, it is referred to as public management (Kickert et al., 1997). Kickert et al. (1997) elaborated that public management in this case might also be considered as network management, as it involves managing interactions of actors in the process. Therefore, it can be understood that the intertwined connections between public policies, organisations that develop and put them into action, and interactions between these organisations altogether are a steering mechanism to ensure the policy proceeds towards the policy desired outcome. This guidance mechanism is seen by Kickert et al. (1997) as ‘governance’. The same term is also used by Jessop (1997) for this process of coordination towards achieving common goals among social agencies within a network that consists of interdependent actors. This is also agreed in the study by Ansell and Gash (2008), who referred to multi-organisations or stakeholders coming together for decision-making based on a shared goal in policymaking and public management. Collaborative governance then is seen as a mode of governing. Although focusing on interactions of organisations in implementing public policy, Ansell and Gash’s definition of governance always involves non-state actors and public agencies whose process of collaboration and meetings are collective, while other scholars did not specify this requirement. For example, Hill and Lynn (2005) explained that in public management, governance usually refers to the management of an organisation and extends to overseeing other agencies which provide public services under contract. Thus, it can be understood that networks, as a mode of governance in public policy

processes, can be a collaboration of only public sector actors, or they can be a combination of actors from different sectors.

From the background chapter, national statistics and reports suggested that elderly health promotion in Thailand needs a multi-organisational collaboration. These organisations normally operate to achieve their own institutionalised goals separately. Yet, the national policies directed them towards collaboration with each other and the elderly that they work with. We can view their multi-organisational collaboration as a policy network in that their interactions connect their institutionalised context – such as their missions and functions – with the policies that they share a role in implementing, and through their resource exchanges, serve as a governing mechanism for the policies to proceed in the implementation process (Kickert et al., 1997). The interdependency between actors leads to their influence on public policy and social processes. The public actor-dominated networks show a property of collaborative governance. The key of collaborative governance, according to Ansell and Gash (2008), is the role of public agencies and government bodies at all levels in initiating and managing collaboration between actors to fulfil their purposes and comply with a policy.

In addition, networks as a significant form of governance require a different approach to management and controlling among organisations (Provan & Kenis, 2008). This form of relationship reduces uncertainties and improves competitive positions (Grabher & Powell, 2004). Networks was found to address the weakness of the traditional hierarchical or central government-steered public policy process that excluded knowledge and expertise of implementing actors, the target population, and other stakeholders in providing contextual information from the action level (Keast et al., 2004; Kickert et al., (1997). The network approach then emerged from the bottom-up, or market orientation advocates with multi-actor perspectives, with the rationale that the central government-steering model was disadvantaged as it lacked inputs from the implementing and local actors (Kickert et al., 1997). This disadvantage also presented in the case of Thailand prior to the decentralisation reform mentioned in the previous chapter. Thus, it can be understood that the central government applied the networks concept in the national policies for the implementation of health promotion policy for the elderly in Thailand at the local level because it shares the bottom-up perspective as decentralisation. The appointment of the LAOs, a decentralised government organisation, as the central network actor also reflects this idea. Furthermore, with interdependency between network actors to achieve their own organisation's goal and collective policy goal, networks and governance networks are appropriate theoretical frameworks for understanding how organisations work together in policy implementation and service delivery of health promotion for the elderly at the local level in Thailand.

The networks in this study have been formed within the primary centralised and hierarchical governance structure with actors who are sub-organisations of ministries. However, the networks are led locally by a decentralised organisation, the LAOs. This formation of networks and their place in the hierarchy is not uncommon. Kapucu and Wart (2006) suggested that networks can exist under bureaucratic settings where hierarchies are more solidified. This setting can offer benefits as well as limitations. In service delivery, networks are more mobilising and flexible (McGuire & Agranoff, 2014). However, while being more flexible in providing resources and exchanging information among the organisations, individuals, or agencies, enabling them to adapt and work efficiently and promptly, these benefits may be limited by bureaucratic regulations and hierarchical processes and restrictions (Kapucu & Wart, 2006).

Despite the formation purpose of the networks, their attributes such as actors, trust, and goal consensus are indicative of their internal form of governance. At network-level, this multi-organisational collaboration has a different form of governance which is used to describe the structural characteristic or the governance structure of the network and the likelihood of the outcome of policy they are involved (Provan & Kenis, 2008).

### 3.1.2 Forms of Network Governance

Network effectiveness may be due to its internal form of governance. This sub-section presents three forms of network governance and the variables affecting the performance outcomes of networks.

Provan and Kenis (2008) categorised forms of network based on how the networks are governed: by every organisation in the network, by a single or a few organisations, or externally. Features of these forms of network governance structures were used to predict the likelihood of network performance and policy effectiveness. The forms of the network that have been categorised by network scholars are:

- 1) Shared governance: Actors within the networks have equal interactions and share governance responsibilities. This form of the network depends on the commitment of internal network actors and is considered highly decentralised with a high level of trust (Poocharoen & Ting, 2015; Provan & Kenis, 2008). Activities and relationships of the networks and external actors are managed by internal actors (Provan & Kenis, 2008). Chaskin et al. (2001) found that this form of network is prevalent in health and human services as the conditions of the network form reinforces what they called 'community capacity' (p. 234).

- 2) **Lead organisation-governed network:** This form of network is opposite to the previous one as only one or a few actors within the networks lead the management and interactions, making it more centralised. The lead organisation-governed form can be found in both vertical and horizontal networks depending on the resource sufficiency of the actor that plays the lead organisation role, or the leader role can be mandated (Provan & Kenis, 2008). The lead organisation coordinates essential decisions and activities within the network as well as facilitates other network members to collectively achieve the network goals (Provan & Kenis, 2008).
- 3) **Network Administrative Organisation (NAO):** The NAO network form is also centralised. However, instead of having a member of the network as a lead organisation actor, an external entity is appointed or established to take the role either by the network actors or by a mandate (Provan & Kenis, 2008).

The form of network governance structure helps explain the relationship of the whole network at the network level (Provan & Kenis, 2008). The form of network governance is also a key factor to help predict the likelihood of network effectiveness or its performance in the future (Provan & Kenis, 2008). From the review of literature, the form of network governance can be determined from the following structural and relational contingencies of network centrality, density of trust, number of network participants, network goal consensus, and network-level competencies (Provan & Kenis, 2008).

Provan and Kenis (2008) also found that most network governance research in the past looked into the characteristics and functions of the network and their impact on network effectiveness. They concluded that the key predictors of the effectiveness of each form of network governance can be drawn from the network's key structural and relational contingencies. These are trust, number of participants in the network (indicating its size), level of network goal consensus, and the need for network level competencies. From their review of the literature, they found that while these are the key predictors of network governance form and can explain network variance, there can be other factors influencing network effectiveness or the achievement of policy goals. They suggested that future research could look at the possible evolution of network governance forms that may emerge from either a network that is mandated or forms by choice (Provan & Kenis, 2008).

Although the national policies suggested the formation of health promotion policy implementation networks at the local level in Thailand, they did not formally establish the networks' own form of governance. The analysis of their form of network governance can not only provide knowledge for understanding their governance relationship but can also help to predict the likelihood of the

policy outcomes implemented by these uniquely formed networks and reveal the influencing factors affecting them.

As the networks in this study are the mechanism of policy implementation, the next section will introduce this policy process and the review of literature in relation to networks operating in this process.

### 3.2 Policy Implementation and Networks in Policy Implementation

Policy implementation is a stage within the policy process and where the networks in this study operate. This section provides a discussion on policy implementation theory, its development, and networks as a method in implementing policy.

#### 3.2.1 Policy Implementation

Policy implementation is a stage in the policy process between the specification of policy outcome wanted and focuses on the actors and processes involved in achieving those ends (Howlett & Ramesh, 2003). This section provides a discussion on policy implementation theory, with a particular focus on networks as a means of achieving a policy outcome. In an early study, Montjoy and O'Toole (1979) proposed that policy implementation should be conceptualised as an organisational problem because an organisation was the unit that executed governmental programmes. Moreover, changes in patterns of internal activities usually occur first within an organisation after a policy is enacted and policy implementation can be a tool used to understand the management of an organisation, particularly a public one (Montjoy & O'Toole, 1979; O'Toole, 2000). Therefore, policy implementation in this section will be discussed from an organisational or intra-organisational perspective.

Van Meter and Van Horn (1975) determined that the phase in the policy process when the policy has been adopted, and funding for the policy has been committed is the beginning of policy implementation. Furthermore, the actions of the policy implementation are taken by actors or group of actors to achieve the policy goals (Van Meter & Van Horn, 1975).

*“[policy implementation] includes both one-time efforts to transform decisions into operational terms, as well as continuing efforts to achieve the large and small changes mandated by policy decisions.” (p. 447)*

Montjoy and O'Toole (1979) also defined policy implementation as when a decision has been made to carry out a policy. The definition of policy implementation has shifted back and forth over time.



Hill and Hupe (2009) viewed from a top-down directed process to being seen as more influence by bottom-up actors. Mazmanian and Sabatier (1983) viewed it as the carrying out of a basic policy decision. For this reason, policy implementation overall is considered to be the fulfilment of a policy where the decisions made and actions taken result in the desired policy effects (Montjoy & O'Toole, 1979). Therefore, provided with the definition of networks in Section 3.1, networks in this study may be called policy implementation networks as they are a group of organisation actors whose collaborative interaction is aimed at addressing a policy issue, in the process of policy implementation.

Koliba et al. (2019) found that multi-organisational networks have been described differently such as public sector networks (Agranoff, 2007); governance networks (Sørensen & Torfing, 2005; Klijn & Skelcher, 2007); and cross-sector collaborations (Bryson, Crosby, & Stone, 2006). Based on Koliba et al. (2011), a multi-organisational network “undertaking coordinated action and resource exchanges to achieve certain policy ends – be it problem framing, policy creation, or policy implementation” is described as a governance network (p.116). Thus, multi-organisational networks formed to implement a policy and achieve a common policy goal like the ones being studied in this thesis are considered governance networks. The following section explains the functions of governance networks, including the development of the governance network concept and their presence in policy implementation.

### 3.2.2 Governance Networks

Network theory has been applied in studies of relationships in multi-organisational networks, including in policy implementation (Hill & Hupe, 2002). From studies in the field of networks, a type of network with a feature of carrying out policy functions at the multi-organisational level and operational level is called a governance network (Koliba et al., 2011). This feature distinguishes governance networks from other types of networks and can address weaknesses or gaps that other governance concepts, such as the New Public Management (NPM) concept, may cause. In Thailand, the NPM paradigm was adopted as a concept for governance reform (Bowornwathana, 2000). In NPM, governance concentrates on the vertical or top-down control relationship between government organisations and external organisations. While the NPM reform concept is often associated with a shrunken bureaucracy, Sudhipongpracha and Wongpredee (2016) found that this is not the case in Thailand, where the influences of the traditional central government persist in making policy implementation at the local level central government-centric. On the other hand, scholars have found that the functions and operations of a governance network could address

complexities, interdependencies, and dynamics of public problem-solving and services delivery as a part of policy implementation, issues that the NPM could not address (Klijn & Koppenjan, 2012; Koliba et al., 2011). To exemplify how networks function in policy implementation in Thailand, an application of the governance network concept is beneficial in this study.

Klijn and Koppenjan (2016) defined governance networks as “more or less stable patterns of social relations between mutually dependent actors, which cluster around a policy problem, a policy program and/ or a set of resources and which emerge, are sustained and are charged through series of interactions” (p. 21). Klijn and Koppenjan (2016) also found that the term governance has been conceptualised in different ways. Across these conceptualisations, a common element of governance definitions is the focus on the process of governing and dealing with a complex issue to achieve the desired outcome. Moreover, this approach is a shift from one emphasising hierarchical position (Klijn & Koppenjan, 2016), like collaborative governance or a governance of a public affair that focuses only on policy issues and as an alternative to hierarchical governance (Ansell & Gash, 2008).

Governance in reference to governance networks concentrates on the particularly complex interaction process between actors or organisations working together (Klijn & Koppenjan, 2016). Klijn & Koppenjan (2016) concluded from a review of literature on the definition of governance that it should be understood as “governance within governance networks, or in other words: network governance” (p.8). Therefore, according to Klijn & Koppenjan (2016), governance network focuses on relationships between organisations or actors working together “and the process of handling complex problems, and processes of policy implementation and service delivery” (p. 8).

Governance covers “self-regulation of actors within a network; the ‘networking’ of these actors” (Klijn & Koppenjan, 2012, p. 594). The actors in the network may be public or private, can be across levels of government, and the interactions within the network are interdependent and horizontal (Klijn & Koppenjan, 2012). The history of governance network studies dates back at least 40 years originating within the study of ‘organisational science, political science, and public administration’ (Klijn & Koppenjan, 2012, p. 588). Traditionally governance on network as identified by Klijn (2009) has elements of public administration and focuses more on the complexity of network actors’ decision-making processes, outcomes and value conflicts. These aspects are embedded and may emerge in the policy initiatives and implementation networks.

The definition of “governance networks” has been expanded by Torfing (2005) and other scholars in relation to six aspects:

(1) Governance networks may consist of actors from different sectors such as public, private, and semi-public who rely on each other's resources and capacities but are autonomous in term of operational command (Marin & Mayntz, 1991). The relations among actors are horizontal, meaning they do not have hierarchical control over one another (Marin & Mayntz, 1991);

(2) The interactions between the governance network actors are negotiations which include bargaining over resource distribution within deliberation frameworks to facilitate learning and building of trust and mutual understanding (Scharpf, 1993);

(3) The governance network actors' negotiated interactions take place within an institutionalised framework which is regulated according to norms and other formal rules or standards but flexible due to the course of action (Torfing, 2005);

(4) The governance networks are independent and the interactions within them are not subject to a hierarchical chain of command or market law (Scharpf, 1993). However, the environment of a particular organisational actor in the governance network may be more influential than the others in terms of facilitating and constraining the network capacity for self-regulation so must be studied carefully (Torfing, 2005);

(5) Governance networks must contribute to the production of a public purpose such as values, plans, regulations with a frame of a specific policy area and the general public must be the beneficiary of this contribution (Marsh, 1998) and;

(6) Governance networks can be present in both policy formulation and policy implementation (Torfing, 2005).

Furthermore, in governance network research, Klijn and Koppenjan (2016) distinguished three traditions of research focusing on different types of governance networks. The first tradition, policy networks research, explores power in public policy making, particularly in decision-making. The second tradition, multi-organisational service delivery and policy implementation networks research, predominantly uses organisational and multi-organisational perspectives in viewing networks as a means for service delivery and policy implementation. It focuses particularly on resources interdependency between network actors. This second research tradition maintains that governance networks have a strong origin tied to organisational theory and resource dependencies among organisations, seen as the basis of the network's establishment (Rogers & Whetten, 1982, as cited in Klijn & Koppenjan, 2012). The third tradition, collaborative governance and intergovernmental relationships research, overlaps the second tradition on interdependency of policy implementation networks and focuses on collaboration in solving complex policy problems that involve actors in

vertical and horizontal levels (Klijn & Koppenjan, 2016). Thus, the mechanism of the multi-organisational coordination of networks and the subsequent reified outputs and outcomes that follow were the central focuses of this governance network theoretical tradition (Hjern & Porter, 1981). Although the three research traditions each have a distinct focus, it is common that researchers converge or combine elements from these different traditions (Klijn & Koppenjan 2016). This categorisation of network research traditions, however, does not include consideration of whether the formation of networks plays a role in aspects of network processes after collaboration between organisations has already begun.

Considering the definition of networks and the definition of governance networks, it can be concluded that governance networks are networks of more than two organisations that work together in carrying out a policy function, particularly policy implementation and service delivery. Thus, a study of a governance network investigates the process of interactions between these organisations in policy implementation to accomplish shared goals (Koliba et al., 2011; Klijn & Koppenjan, 2016; Klijn, 2009; McGuire, 2006). The following section reviews functions of governance networks to accomplish shared goals.

#### *3.2.2.1 Governance Network Functions*

In an earlier study of governance networks, O'Toole (1997) stated that organisations in a network function beyond regulated policy and formal connections. Keast et al. (2004) found that in terms of structures, a network has its own characteristics which include sharing a common mission among network actors, being interdependent with the relationship of members being based on trust, and network actions based on equal horizontal partnerships. Koliba, Meek, and Zia (2011) suggested that network-level characteristics can be explained by their structures and functions. The network-level structures referred to governance form of the network and the policy tools the network focuses on such as grants, social regulations, public information, or others and based on the network's place in the policy stream.

In their study about the convergence of theories in networks, collaboration, and co-production, Poocharoen and Ting (2015) found that the functions and values of a network are influenced by the characteristics of the actors as well as the structure and processes of the network itself. In addition, learning is another feature of a collaborative network's functioning (Newig, Günther, & Pahl-Wostl, 2010). The central actor in a network plays an important role in driving the coordination of network activities and identifying the local common values among actors in the community (Bazzoli, Harmata, & Chan, 1998). Koliba et al. (2011) suggested that functions of a network can coexist and they are:

- Operating functions - based on network-level operational goals. Network actors exhibit these interactions within the network:
  - Coordinating actions
  - Mobilising and exchanging resources
  - Diffusing and sharing information
  - Building capacity
  - Learning and transferring knowledge (Koliba et al., 2011)
- Policy stream functions – based on policy stream model, a network functions in a stage of policy cycle or development which include:
  - 1) Defining the problem
  - 2) Designing and planning policy
  - 3) Coordinating policy
  - 4) Implementing policy through regulation
  - 5) Implementing policy through service delivery
  - 6) Monitoring and evaluating policy
  - 7) Bringing political alignment of policy actors (Kingdon, 2003)
- Policy domain functions – a policy arena that a network functions within such as health, education, defence, transportation (Koliba et al., 2011).

It is common that a governance network undertakes more than one operating function and has more than one policy stream and policy domain (Koliba et al., 2019). While governance networks are different in functions depending on what the networks have been formed to accomplish, network functions and their extent remain a black box inviting exploration. To understand governance networks in policy implementation, where the networks in this thesis are located, the next section reviews literature in this setting.

### *3.2.2.2 Governance Networks in Policy Implementation*

Governance networks and their features have been viewed as an efficient response to managing policy and governance tasks that are complex (Torfing, 2005). The features that make them efficient include flexibility in responding to complex issues (Klijn & Koppenjan, 2000), specific knowledge of actors (Kooiman, 1993; Torfing, 2005), and establishment of consensus building (March & Olsen, 1995; Mayntz, 1993). Governance networks are suitable for policy implementation as they can reduce the risk of implementation resistance as the actors in the networks involved in the decision-making process have a shared sense of ownership and responsibility towards the policy and the issues. Accordingly, the policy implementation process is supported by network actors (Sørensen & Torfing, 2003). Wang et al. (2016) also stated that the implementation capacity of the network may

include the abilities of the network to foresee the implementation directions and resources. These abilities have been found to not only positively affect the capacity of the implementation but also its outcome. The specific knowledge of actors within the network is an advantage in the decision-making process. When the relevant knowledge of different actors is combined, it provides the foundation for feasible decision choices (Kooiman, 1993; Torfing, 2005). Moreover, the establishment of consensus building in a framework of governance networks in policy formation and implementation networks helps facilitate negotiations and conflict resolution (Mayntz, 1993).

Klijn (2009) argued that issue complexity, decision making, and negotiation are a traditional focus of governance networks. More recent studies on governance networks have emphasised investigating the increasing involvement of social groups and the general public due to the efforts of the public actors (Klijn, 2009). Involvement of public actors includes coordinating and managing social fragmentations in order to facilitate the achievement of public policy goals (Papadopoulos, 2000), encouraging interactive decision-making to facilitate public debates (Klijn & Koppenjan, 2000), and promoting policy sectors that support social development at the local level such as economic and education (Lowndes & Skelcher, 1998). As a result, the interest in studying the partnership in policymaking and implementation grew in the field of governance network research (Klijn & Teisman 2003; Hodge & Greve, 2005; Klijn, 2009; Sullivan & Skelcher, 2003). Despite the growing interest in governance networks in policymaking and implementation, Hill and Hupe (2014) suggested that an aspect on behavioural output variables to characterise the performance of policy implementers should be added to the current research in the field. This is to provide an understanding of variations in performance of the implementation, and to study the linkage of policy formation and street-level implementation (Hill & Hupe, 2014).

Scholars in policy implementation networks research found that the linkage between policy formation and implementation is vertical for the direction of administration power. This top-down linkage can either be the cause of communication problems or collaboration problems between the two levels (Hill & Hupe, 2009). While communication problems involve getting the right message across to all actors, collaboration problems involve the management of the bargaining process in decision-making between levels of actors (Hill & Hupe, 2014). However, this statement indicates that there are still research gaps to be explored further in the case of multi-level intergovernmental policy implementation networks, where bargaining relationships are limited by the policy or other restrictions. A research interest in response to providing an explanation for the research gaps has been placed in looking to explain factors affecting the behaviour of staff working at the implementation level (Hill & Hupe, 2014).

The discussions of governance networks in policy implementation research highlight the need to provide more understanding of collaborations at the implementation and government levels of actors. In relation to this thesis question, this led to a review of literature about the approaches used in studying governance networks in policy implementation, discussed in the following section.

### *3.2.2.3 Policy Implementation Study Approaches*

Policy implementation research was regarded as a study to understand the 'black box' operation and its outcome (Harachi et al., 1999). Interest in studying policy implementation appeared to have come from initiatives that failed to meet expectation in the 1960s and 1970s (O'Toole, 2000). In 1984, approaches to synthesising policy implementation such as top-down, bottom-up, large and small scale analysis started to be more prevalent with a variety of interests and models to explore aspects such as different research designs, implementation processes and products, and study frameworks (O'Toole, 2000). Scholars also called for multi-dimensional research as a core of public management and public policy study (Lynn, 1996). Towards the end of the 1990s, scholars questioned the decline of research in policy implementations (DeLeon, 1999; O'Toole, 2004). Some scholars speculated that it might be due to the existing theory that had not developed in recent years. O'Toole (2004) suggested that it could be improved by applying different approaches to extend the perspective beyond the traditional top-down and bottom-up approaches. He called for a third-generation policy implementation study approach, which is more context-dependent and general.

To explore beyond the traditional policy implementation study approach but to narrow down the scope of variables, multiple perspectives have been considered as indirect contributions to policy implementation research. Amongst them are analytical frameworks that especially address the multi-actors theme. The policy implementation research framework themes as categorised by O'Toole (2000) and the frameworks and approaches that have been developed by policy implementation research scholars include 1) institutional analysis; 2) governance; and 3) network and network management.

Network and network management was developed following the more complex structure and the network patterns that emerged from the relationship of the multiple actors involved (O'Toole, 2000). Network research, which includes network analysis approaches, has become prominent in the studies of policy implementation in the United States and internationally (O'Toole, 2000). Scholars have become more interested in the networked character of policy implementation and the studying of public programme management in the form of networks (Kickert, Klijn, & Koppenjan, 1997; Milward et al., 1996). Features that have been studied are the connection between the network characteristics and policy implementation performance (Klijn et al., 2016; Mischen & Jackson, 2008),

networks management and organisational performance (O'Toole & Meier, 1999), and networks for intergovernmental management (O'Toole, 2000). Tools that have been used for studying networks in policy implementation include 1) the network analysis approach – a micro-level tool to study the connections and interactions between organisations or actors involved in policy implementation such as participation and coordination in the implementation activities (Bazzoli et al., 1998; Hoeijmakers et al., 2007; Provan & Kenis, 2008); and 2) case method approach – a framework used to analyse network process, structure, and characteristics of actors that influence the network performance (Poocharoen & Ting, 2015). A study by Fernández et al. (2007) supported the focus on actors at the local level, as it found that policy implementation depends on local circumstances and local policy preferences. This specific concentration of policy implementation study using a micro-level tool such as a network analysis and case method approach corresponds to the governance networks in policy implementation research, where the processes and functions of implementing actors still need to be explored. The following section provides examples of these approaches being applied to studying networks in health policy implementation and their performance.

#### *3.2.2.4 Governance Networks in Health Policy Implementation and Performance*

Networks were found to be a mode of governance in health policy and implementation for different objectives, such as increasing efficiency (Barnett et al., 2009) and improving service delivery (Wiktorowicz et al., 2010). While other aspects of governance networks may vary across different government levels and settings, the significance of the central actors or central nodes emerged in a similar pattern especially how they influence coordination, engagement, motivating other actors and stakeholders in the network, and network performance (Hoeijmakers et al., 2007). This section provides examples of studies of governance networks in health policy implementation and discusses the common theme that emerges in relation to this thesis, which is the networks actors belonging to different government levels and across governance structures. An example is Wiktorowicz et al.'s (2010) study of governance networks in mental health policy implementation in Canada. The researchers found that the central actor of the networks played an important role in coordinating network activities, and this affected participation and relationship development between actors. Therefore, it can be understood that the central actors have more underlying roles than coordinating resource exchanges between actors.

Furthermore, the same study by Wiktorowicz et al. (2010) also found that for multi-organisational collaborations between different levels of governments and across governance structures to develop as a governance network, it requires what Provan and Kenis (2008) identified as network key structural and relational contingencies. These contingencies are: a moderate number of actors, goal



consensus, trust, and network-level competencies, and they are indicators of the form of network governance mentioned earlier in this chapter. In the study by Wiktorowicz et al. (2010), the form of network governance and collaborations between actors also vary based on the development of the studied areas (rural and urban), the network size (small and medium), and governance structure (centralised and decentralised). They found that a decentralised structure enabled mediation, flexibility, and informality, which benefited the coordination of the network. The small- and medium-sized urban networks are usually in a shared governance form with a high level of trust, whereas the large urban and rural networks are externally brokered and loosely connected (Wiktorowicz et al., 2010). However, in Wiktorowicz et al.'s study context, the networks are the recognised mode of governance, and the actors within the networks negotiated among themselves about their roles and services. Therefore, it is an example of networks in health policy that are formally structured by the national government with shared performance indicators, but the roles within the networks are left to be negotiated by the implementing actors. This study raised further questions about the governance form of a network, network characteristics, and network performance in a case where the networks are not formally structured, not originally recognised as a mode of governance, and where actors' roles depend on their individual organisational functions and not a negotiation.

In regard to the relationships of network actors, a study by Hoeijmakers et al. (2007) on the governance network of a health promotion policy development at the municipality level in the Netherlands showed that the local health promotion policies required a strong community involvement to promote health in all sectors. The study found that in a policy network, three relationships were the most relevant in the pre-policy processes stage. These were communication, involvement in public health action, and strategic collaboration with the municipalities as the central actor of the network. The importance of the central actors of a network also presented as a factor influencing the achievement of network policy implementation and service delivery.

The connectedness or linkage of the networks was found to depend on the presence of the central actors in a community-based health care service delivery network (Bazzoli et al., 1998). Network connectedness is dominated by the existence of the centrality established by the central actors. Leaders identified by each organisation in the network and stakeholders played roles in tracking and focusing on the core objectives, influencing policymakers or political agendas, and managing conflicts that may occur. These tasks were also found to be the roles of the central actor in the studied health service delivery network (Bazzoli et al., 1998). It was found that the network actors and organisations that play the role of central actors are influential in motivating collaboration in the

network even though they have little or no authority in control of resources such as budgeting or payment allocations involving other organisations in the network (Bazzoli et al., 1998).

In addition, in a more specific view of governance network in health-related policy in low and middle income countries, the focus in past studies was the analysis of the policy which sought to explain “what happened” but not “what explains what happened” (Gilson & Raphaely, 2008, p. 303). Thus, the past research under this topic contributed to explaining the analyses of policies more than proposing strategies for the development or improvement of the policies. Few were deemed to be useful inputs to an evaluation that would help improve policymaking and policy implementation. Moreover, while network analysis started to be the trend in policy studies, implementation theory has not been often applied in low and middle-income countries (Gilson & Raphaely, 2008).

Past studies on networks in health policy revealed a common theme of collaborations between organisations that are a part of different levels of government and under centralised and decentralised structures. To achieve the policy goals, emphasis had been placed on the implementation level, where relationships between actors have an influence on network performance and the central nodes play a crucial role by coordinating between network members. Gilson and Raphaely’s (2008) study added to the necessity of more research exploring governance networks in health policy in a low- and middle-income country, network characteristics, and their governance to improve policy implementation and policy outcome.

Knowledge of network attributes was useful for understanding policy implementation when governance networks were used as a tool or method in achieving the policy goal. To apply policy implementation study approaches and learn more about the policy implementation networks, their characteristics provided micro variables to concentrate on. The next sections provide literature reviews regarding network characteristics as a foundation for guiding the exploration of the networks being studied.

### 3.3 Characteristics of Networks

The networks in this thesis are a collaboration of organisations with loose ties that are bounded by the direction of national policies. Interactions between these network actors establish the characteristics of the networks. These attributes also affect network performance and provide an understanding of how the networks operate as a government instrument in policy implementation. Networks scholars identified essential network characteristics that affect network performance as ranging from network-level characteristics such as leadership and power, to micro characteristics

like network ties. These variables are interrelated and cultivated from interactions between network actors, and influence relations among them. Wasserman and Faust (1994) suggested that network actors' attributes and the pattern of relationships between them can be drawn from the extent of ties between actors and network-level characteristics mainly emerge from these ties. The following sections present literature review on essential network characteristics that provided as a guiding framework to configurate and understand network variables and governance.

### 3.3.1 Leadership within Networks

Earlier in this chapter on the discussion about networks as a mode of governance, a literature review showed that networks can be seen as a form of collaborative governance in which public and non-public actors participate, and where public actors of all levels have a role in regulating or initiating collaborations to address a policy issue (Emerson, Nabatchi, & Balogh, 2012; Ansell & Gash, 2008). In a collaborative process such as in a network, leadership is required for mediation and facilitation (Ansell & Gash, 2008). This section reviews relevant networks and the collaborative governance literature on leadership as an essential network characteristic.

Not only does the leadership of a network actor at the organisation level affect network functions and performance, the leadership of the staff within network actor organisations is also significant (McGuire & Agranoff, 2014; Agranoff & McGuire, 1999). The leadership in network settings requires navigating through joint activities between actors, such as planning strategies and financial arrangements, implementing projects, and developing multi-actor contracts (Agranoff & McGuire, 1999). Two-way communication and influence between actors are keys in a collaboration. This is why leadership roles in collaborative governance, including in networks, are facilitating this communication and support resource exchanges among network actors to drive them (Emerson, Nabatchi, & Balogh, 2012; Ansell & Gash, 2008). Emerson et al. (2012) suggested that leadership in collaborative governance refers to an identified leader whose roles include initiating collaborative efforts between actors, such as providing assistance in staffing, technology, and resourcing. An additional role of a leader in collaborative governance is empowering and representing other actors to create a balance of power among them (Ansell & Gash, 2008). These roles are crucial in collaborations and can be cultivated among the actors (Emerson et al., 2012). A leader in collaborative governance and networks may be those who have the roles of a sponsor, facilitator, representative of an organisation or constituency, among others (Emerson et al., 2012). Their roles as the leader include mediation and negotiation in case of a conflict or if consensus cannot be reached by the actors involved, and intervening to keep the agenda in shape, such as by maintaining ground rules (Ansell & Gash, 2008). It is also crucial in trust building between actors, facilitating

dialogue, and exploring mutual gains (Ansell & Gash, 2008). However, while some scholars agreed on the significance of leadership in collaborative governance and networks, they found that the roles of a leader can be assigned to more than one actor. This is because multiple skills of leaders are required in a collaboration, and successful collaborations were found to use multiple leaders who may be formally or informally assigned (Bradford, 1998; Lasker & Weiss, 2003). The importance of leadership can vary depending on the context of the collaboration. In a case where the incentive to collaborate is low, power and resources are unequally distributed. Also, where there was a prior conflict between the actors, leadership is more essential than in a case where these issues do not exist, or are less intensive (Ansell & Gash, 2008).

Literature regarding leadership in the phenomena of collaborative governance and networks showed that leadership is essential not only for bringing the actors together to achieve a collective goal, it also manages actors' relationships and resources, builds capacity through empowerment and creating dialogues, and solves conflicts. These roles support the operation of actors as individual organisations and as a collaborative unit to achieve collective goals. However, as roles and the importance of leadership can vary depending on the context of collaborations, factors influencing leadership should be identified so that they can be encouraged to improve the outcome of collaborations.

### 3.3.2 Power between Actors

The power of actors within a network can be subject to the characteristics of actors as individual organisations, such as the resources that they own, or it can be given externally by the institution that formed the network. Factors determining power within networks and collaborative governance are social power dynamics, political dynamics, and power relations within communities where the networks operate in or across levels of government (Koliba et al., 2011; Ansell & Gash, 2008). As networks are conceptualised as relationships or lack thereof between actors, social power dynamics analysis helps in understanding the power characteristics of the networks (Koliba et al., 2011). As an alternative to social power dynamics analysis, centralisation-decentralisation theories can also be used in studying the administrative flow of a network. These theories include the discussion of the roles of actors as central and peripheral actors, and are applicable for analysing a network that presents a hierarchical structure (Koliba et al., 2011).

Characteristics of power can also be determined from the political dynamics within the networks. Koliba et al. (2011) suggested that favours and persuasive powers are considered political capital, a resource exchanged between actors within the network. However, the source of political power is debated between scholars. Putnam (1993) suggested that it is built on an individual's action rather

than as an outcome of group interactions. On the other hand, Koliba et al. (2011), suggested that sources of political power could extend to coming from an individual, a team with effective leadership, or an entire organisation. Thus, there can be multiple sources of power within the network depending on the lens or theories used to analyse the dynamics. Social power may be institutionalised based on the position of the network actor in the governance stream and from interactions between actors. Political power can come from the influence of an individual, an organisation, or a group of organisations. Being able to identify the source of power and how power is distributed within the network can provide an insight into the decision-making process and resource distribution within the network.

Imbalanced power is a common issue between actors in a collaboration due to their unequal capacity, status, and resources (Ansell & Gash, 2008). Scholars found that in networks, actors who are the network central node hold more power as they usually have resources needed by the network and have administrative authority (Provan & Kenis, 2008). This also presents the interdependency between actors and the dependence that will especially grow on the central node, which has the needed resources or access to resources for others (Stevenson and Greenberg, 2000). To resolve the issue of imbalanced power, the significance of leadership becomes essential, as the leader should ensure that the less powerful actors, such as those with limited capacity, are still represented and empowered (Ansell & Gash, 2008). Emerson et al. (2012) suggested that the combined power of the actors affects the collective action of the collaboration. Thus, the characteristic of power within the network can also be indicative of the network outcome or performance. To analyse social and political power dynamics and administrative flow of a network, input variables can be drawn from ties between network actors (Koliba et al., 2011).

### 3.3.3 Ties between Actors

The autonomy of actors can be hierarchical, but the relationship, or the lack of relationship, across organisations and between network actors may be less formal and based on trust without any structured or legal obligations (Provan et al., 2007). Koliba et al. (2011) and McGuire (2006) provided a theoretical framework to analyse networks of collaborative public management. These networks have structures involving multiple nodes and linkages, collective actions, resource exchanges between nodes, and functions aligned with a specific national policy. The structures of a network are described as “nodes” presented in Figure 9, where they link based on their coordinated actions and exchange of resources.

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*Figure 9: Nodes and Ties of a Network*

*Source: Koliba, Meek, and Zia (2011). Governance networks in public administration and public policy (p. 44).*

Ties between actors within the network can be determined based on the existence of the following variables (Koliba et al., 2011):

- Resources exchanged: financial, natural, physical, human, social, political, cultural, and knowledge. These resources can be exchanged through formal or informal means.
- Formality and the coordination of ties: there is no standard frequency of coordination between actors. Inter-organisational network actors may have temporary coordination or regular coordination routines. The formality of the networks can be determined from interactions between actors such as actors that develop broad operational goals for their daily routine which has a formal tie. The formality and coordination of ties can be assessed separately and do not have to align.
- Strength of ties: links between two nodes or more within a network can be referred to as social ties. Strength of ties can be weak or strong and can be determined by, multiple variables such as duration and/ or frequency of contacts, emotional intensity and resources exchanged. For example, a weak tie has less frequent contacts and little emotional intensity. Axelrod (1984) mentioned that the durability of a relationship builds cooperation between parties.
- The flow of authority across ties: the direction of administrative power is the flow of authority based on the social power of the actors within the network.
  - Vertical ties suggest the social power of command and control where one actor has authority over the other. The network represents a hierarchical meta-organisational structure (Koliba et al, 2011). The command and control relationship in vertical ties can be explained by the principal-agent theory, which involves centralised and

decentralised governances. In this theory, power and authority appear in the hierarchy of top-down and bottom-up governance structures where organisations at the macro level or the state, as principal, have the authority and provides centralised direction to their agents or the society (Koliba et al., 2019). The interactions in this relationship include contractual agreements and bureaucratic reporting. The resource predominantly exchanged is the financial resource (Koliba et al., 2019). This indicates the vertical flow of authority and that the organisations at the top of the governance structure always hold the power over the sub-national or sub-organisations with financial resource exchange as the main activity.

- Diagonal ties suggest a concessive and compromise social power of actors who negotiate between each other. The network represents a mixed meta-organisational structure (Koliba et al., 2011).
- Horizontal ties suggest collaborative and cooperative social power. The actors share the authority and represent a collaborative meta-organisational structure (Koliba et al., 2011). Co-equal relationships implicate the horizontal ties wherein distributed power is developed from collaboration and cooperation on common projects or programmes (Koliba et al., 2019). Cooperative game theory, social capital theory, and community of practice research are central in the analysis of this type of relationship, when the trust of network actors is formed based on the perception that they can co-benefit from working together and exchanging resources (Koliba et al., 2019).
- A network that has no ties between actors suggests that it has competitive social power and actors have authority over each other. This represents a market meta-organisational structure (Koliba et al., 2011).
- Multiplex ties exist in a network where more than one type of resource is exchanged. It also exists in a network where there is more than one type of administrative or collaborative authority flow in addition to the resource being exchanged. The most prevalent resources being exchanged that forge multiplex ties are information and financial capitals (Koliba et al., 2019). Multiplex ties are found among network actors that have a formal hierarchical arrangement for exchanging financial capital and where information sharing occurs across governance levels of actors (Koliba et al., 2019).

- Accountability relationships: accountability is an obligation each actor within a network holds and has ties with each other and as a whole unit. This relationship can be determined based on the roles of actors within the network, which can be categorised as a democratic, market, or administrative and can also overlap.
  - Democratic frames such as elected representative accountability (elected officials or representatives), citizen accountability (citizen or interest groups), and legal accountability (court or judiciaries)
  - Market frame such as shareholder accountability (owners, shareholders), and consumerist accountability (consumers)
  - Administrative frames such as bureaucratic accountability (bureaucrats, supervisors, principals), professional accountability (professional associations), and collaborative accountability (collaborators, partners, and peers)

Accountability relationship of a network can be determined from the direction of accountability between the actors: to whom and from whom, and the analysis of the social power flow (see Flow of authority across ties) (Koliba et al., 2011). Ties mentioned in the literature can be configured based on the flow of authority and power, the resources exchanged, and the governance structure of the network actors. It is questionable whether more than one type of tie can exist in a single network, and if there are any other network characteristics that can define actors' authority and power relationships. Moreover, ties between actors may change over interactions, as there can be a variety of network activities in one programme or project. It can be seen that multiple network variables can be configured from the analysis of networks ties alone.

### 3.4 Limitations of Networks

While networks are mechanisms for solving policy issues, networks themselves can encounter process and action barriers and can be constrained by internal and external causes. Internal limitations of networks that are barriers to operation can come from the distribution of the strength of ties between network actors that might have existed before they became a part of the network, and unequal power structures within the network. External limitations can be the local power structure in the network's area of operation, and government structural changes affecting networks' processes (McGuire & Agranoff, 2011). Political, financial, and legal issues surrounding the policy and agenda that networks have been formed to address are also common barriers (McGuire & Agranoff, 2011).



Networks are usually adopted within another governance arrangement as a method of policy implementation. Eberhard et al. (2017) studied comparative water governance networks in Australia, the United States, and France, where the approach was adopted in a policy implementation process dominated by hierarchical governance. Their research questioned whether the network approach was practical to address such a complex issue as water policy conflicts. They found that limited power sharing and highly dynamic water governance were challenging in policy implementation. Reasons included that networks were not the only mode of governance at play. Governments have to manage, or metagovern these processes, and there could be tensions in processing between these modes – thus affecting their outcomes. Furthermore, although there was a network goal consensus between actors, the resourcing issue may not always be resolved. They also found that the constraints of centralised power and political legitimacy due to hierarchical governance still posed as obstacles for networks to effectively bridge hierarchical functions and create productive networked relationships. McGuire and Agranoff (2014) supported these findings, as they suggested that networks did not always replace the hierarchy, and an organisation's staff may be part of the structure of both the bureaucratic hierarchy and network.

Limitations of networks found by scholars are also likely to take place in the health promotion policy implementation networks in Thailand. This is because network actors, as an organisation, belong to both the hierarchical structure by virtue of their institutional establishment and are a part of the policy networks formed to solve specific policy issues. Network actors belong to these two modes of governance and structures simultaneously throughout policy implementation. A metagovernance analytical perspective to view such an arrangement is suggested by Eberhard et al. (2017) to unbox how actors, as parts of a metagovernance structure, frame problems, facilitate network engagement, and determine network performance. The scholars left questions for future studies to explore about governance networks in a different policy context and the power dynamics and political implications of such networks employed within hierarchical systems, which this thesis will contribute to.

### 3.5 Summary of Literature Review

The literature review discussed the relevant theories and approaches particularly relevant to the research questions and network characteristics. Networks are coordinating relationships (or lack thereof) of actors to achieve the networks or policy goals. Governance networks focus on the process of governing and dealing with a complex issue for actors that are mutually dependent

clustering around a policy programme and interacting. Policy implementation emphasises the efforts or actions of organisations and individuals directed to achieve policy goals. While existing research on networks and governance networks in public policy and public administration focused on the impact of the network functions on the outcome, it is crucial for researchers and practitioners to look beyond *what* contributes to practical results. The questions of *how* the governance networks and implementation variables function are also important to analyse in depth. Evidence from a review of literature in the field supports the need to expand research in that direction. This is where the perspective of a policy implementation study approach is applied and the integrated with the network and governance network theories to provide a more comprehensive analysis of the implementation process and actions.

The current state of governance networks in policy implementation research provides an opportunity for a study that applies governance network theory to analyse the network interactions, functions, and existing policy implementation variables more in-depth. This will combine the growing need for research in the field of health promotion for the elderly elaborated in the background section with the necessary addition of research in health policy analysis in low-income and developing countries with more explicit conceptual frameworks to fill the gaps in the existing related literature as follows:

1. Lack of empirical evidence on network functions: Research about network governance contingencies, characteristics, and factors influencing network effectiveness is still required (Provan & Kenis, 2008). In the more general perspective, empirical research is also required to explore in depth forms of the networks and their functions in practice and whether there are other forms of the network other than what have been found (Provan et al., 2007). Current empirical research that explores how network variables influence the functions of networks are still lacking, particularly in relation to how the networks function at the micro-level and as a network unit (Provan et al., 2007).
2. Abundant theory variables but inconclusive theory consensus: Existing literature on governance networks in health-related policy in low and middle-income countries is limited and provides sparse evidence to explain how the governance networks happened and how they function (Gilson & Raphaely, 2008). Thus, the existing literature has yet to yield strategies for policy improvement (Gilson & Raphaely, 2008). Moreover, O'Toole (2004) stated that while the variables found in policy implementation theory continue to increase, theoretical consensus is still open. Regarding relationships at network-level, scholars call for further analysis of the evolution of the governance structure form and factors that may

emerge contributing to the network outcome (Porvan & Kenis, 2008).

3. Scarce literature looking beyond the relationships within the network and network effectiveness: Studies of networks are limited to the linkage between the networks and their effectiveness (Provan & Kenis, 2008). There are still opportunities for future research to expand to other aspects of a network, such as their characteristics and how they function, and their impact on the policy implementation capacity (Wang et al., 2016).
4. Governance networks studies researched networks that have been recognised or formally structured as a mechanism of policy implementation or as a mode of governance to achieve policy goals (Barnett et al., 2009; Wiktorowicz et al., 2010). However, there are other types of networks such as those that form by choice, semi-mandated networks, informal networks, and others that may not have a formal governance structure or clear policy guidance. There can be networks that are not recognised as a formal policy implementation mechanism. The characteristics of networks that are not formally structured or recognised as a mode of governance and formal policy implementation mechanism need to be explored to reveal the factors that affect their performance and policy outcome. Among the questions left open in unexplored types of network is their ties or relational characteristics in cases where bargaining relationships are limited or non-existing.
5. Studies found that networks as an instrument of the government for policy implementation in traditional hierarchical governance is not an uncommon arrangement (Kapucu & Wart, 2006). Within this arrangement, the governance networks field can still benefit from a study that looks into the power dynamics and political dimensions implications of the networks in this particular arrangement, such as in a variety of policy contexts and the benefits of the networks in this structure (Eberhard et al., 2017).

Based on the literature review, the three core aspects needed to analyse and explore to address the found research gaps and to provide a further understanding of networks are forms of network governance, the interactions and administration power between different levels of network actors, and network characteristics. These three aspects have been found to benefit from the understanding of mandated and formally structured networks in the existing research. To understand the types of networks that are not identified as formally structured or mandated, I adapted Koliba et al.'s (2011) framework of network variables taxonomy to study the characteristics and ties of networks, and Provan and Kenis's (2008) framework of networks' key structural and relational contingencies to configure the form of network governance, power and leadership characteristics, among others, within the network. These frameworks have been applied to network

research to frame the analysis explaining factors that affect the relationships of actors within the network, their governance structures and characteristics, and network-level performance.

Networks in this research are directed by national policies to form loosely and are positioned to operate in centralised and hierarchical governance, while being led by a decentralised actor. This thesis offers contributions to the field of networks from the exploration of these uniquely formed networks by addressing the mentioned research gaps. Existing network variables provided by current frameworks would be applied as a guiding framework to explore these networks.

Furthermore, their emerging characteristics can be revealed given their unique formation and structure. The five areas of gaps in current research in the field of networks, governance networks, collaborative governance, and networks in policy implementation will also be discussed further in the discussion sections of findings chapters.

From the literature review, I developed a conceptual framework of this thesis based on the concepts and frameworks of networks, governance networks, and approaches to study networks in policy implementation, and applied it to study the health promotion policy implementation for the elderly in Thailand. I also defined the concept of these uniquely formed networks in this study. The definition of these networks and their operations in health promotion for the elderly in Thailand and the conceptual framework for this thesis are explained in the following chapter.



## Chapter 4: Conceptualisation of the Problem

This chapter presents the application of theoretical concepts and frameworks of networks, governance networks, and policy implementation from the Literature Review chapter in the context of health promotion policy implementation for the elderly at the local level in Thailand, which was introduced in the Background Chapter. The following sections outline the application of the theoretical concepts, the definition of the networks in this study, and the conceptual framework guiding the methodology and methods of this research.

### 4.1 Networks, Governance Networks, and Health Promotion Policy Implementation in Thailand

Looking back at the previous chapters, decentralisation has had an impact on health promotion policy implementation for the elderly at the local level in Thailand, particularly in relation to structural and collaboration factors from the governance network perspective. Structurally, the LAOs, as an organisation within the decentralised Thai governance structure, are appointed as the steering actor of health promotion policy implementation for the elderly and the improvement of older people's quality of life at the local level (Limskul, n.d.). In terms of collaboration, the operational and administrative flexibility to take action, and the independent decision-making authority enabled by decentralisation, allow the LAOs to work with other network actors by focusing on their mutual goals. However, the local networks that are led by the LAOs include network actors from other levels of government, such as sub-organisations of ministries, that are a part of centralised and hierarchical governance. The representation of actors as government organisations within both centralised and decentralised governance structures makes the networks metagovernment networks. It can also be said that the networks themselves are placed in this traditional governance structure as they operate under the regulations and funding of central ministries.

We argued in the Background Chapter that the scope of work of organisations involved in health promotion policy implementation for the elderly requires inter-organisational collaboration. This collaboration involves the multi-level organisational and intergovernmental policy implementation approach that includes different levels of government organisations and across governance structures. This network structure shows the multiplexity of ties between actors involving hierarchical relationships from resources exchange according to Hill and Hupe (2014) and Koliba et al. (2019).

Koliba et al. (2011) indicated that organisations' particular goals should be considered in terms of compatibility with others within the governance network and understood in terms of official and operational goals. Hall (1980) explained that the official goals of network actors are "constraining or guiding principles" from which rules, policies, procedures, and habits emerge (p. 68), while operational goals are the actors' actual actions that might not necessarily align with the official goals (Hall, 1980). Therefore, regarding organisations involved in health promotion policy implementation for the elderly at the local level in Thailand, their official goals are set by national policies and plans which then guide their operations. A governance network's operational functions, according to Koliba et al. (2011), and the relevant examples exhibited in national policies related to health promotion for the elderly in Thailand, can be seen in the following table.

*Table 5: Operational Functions of Governance Networks and Implications Exhibited by Organisations Involved in Health Promotion Policy for the Elderly in Thailand*

<b>Governance network operational functions (Koliba et al., 2011)</b>	<b>Implications in the health promotion policy implementation for the elderly in Thailand</b>
Coordinating actions - Regulated and written within a macro-level network context	<ul style="list-style-type: none"> <li>- National policies stated that the named central organisations and their sub-organisations whose missions involved the development of quality of life of the elderly work together and with LAOs to deliver the services to the people in all communities</li> </ul>
Mobilising and exchanging resources – Occurrence of resource exchange between actors within the network is a key function in governance network operation	<ul style="list-style-type: none"> <li>- The Decentralisations Act and the Transferring Responsibility Act served as a mandate for resource mobilising from the central organisations to the LAOs, particularly for human resources and facilities such as the local health centres and their staff.</li> <li>- Resources such as knowledge and financial resources are exchanged between organisations within the network: <ul style="list-style-type: none"> <li>o District Public Health Offices provide knowledge and assistance to the LAOs in developing programmes and activities from the Local Health Fund such as the Long-</li> </ul> </li> </ul>

Governance network operational functions (Koliba et al., 2011)	Implications in the health promotion policy implementation for the elderly in Thailand
	<p>term Care initiatives for the elderly in the community</p> <ul style="list-style-type: none"> <li>○ National Health Security Office provides the Local Health Fund for the LAOs to develop the health promotion programmes for the elderly at the local level</li> </ul> <p>With the resources from other organisations within the network as in these examples, the LAOs are able to implement health promotion policy and deliver the services for the elderly which also help other organisations achieve their individual goals and the network-wide goal of developing the quality of life of the elderly</p>
<p>Diffusing and sharing information – data is arranged for a better understanding of the whole network, information/ data is used to monitor and evaluate the performance of the network. The common goal is also considered shared information in governance networks</p>	<ul style="list-style-type: none"> <li>- The national target of the quality of life of the elderly is shared as a common goal for the network.</li> <li>- Population and other local data is used and shared on a project-based basis with each organisation within the network having a different level of information collected. The LAOs have the in-depth and most up-to-date information of the elderly in their community, for example.</li> </ul>
<p>Building capacity – facilitating other network members or other networks to be able to carry out operational or policy functions</p>	<ul style="list-style-type: none"> <li>- District Public Health Offices facilitate capacity building for the LAOs in health care service and network management</li> <li>- LAOs, together with other network actors, help build the capacity of the elderly clubs in the community in developing and implementing</li> </ul>



Governance network operational functions (Koliba et al., 2011)	Implications in the health promotion policy implementation for the elderly in Thailand
	programmes to promote the health of the club members, including educational programmes.
Learning and transferring knowledge – learning and knowledge promotion between network actors including facilitation of capacity building through technical exchange	- Joint training programmes between network actors provided by the actors such as a Long-Term-Care training programme provided by District Public Health Office to other organisations within the network

Governance network theory has been mentioned in studying policy that addresses complex issues, policy implementation that includes multi-level governmental organisations (Hill & Hupe, 2014), inter-organisational collaborations between different levels of governments and across governance structures (Wiktorowicz et al., 2010), and in health policy implementation performance (Barnett et al., 2009). It is also a theoretical tradition in policy initiative and implementation studies (Klijn, 2009). Therefore, I have chosen network theory, governance network theory, a policy implementation study approach framework, and a network analysis framework as guiding frameworks and analysis tools for this research.

Based on this conceptualisation, the framework of network-level characteristics applied to answer the research questions is based on the theoretical concepts of networks and characteristics of governance networks. It should be noted that one of the characteristics of the network is its governance structure, i.e. the features of how the network is governed. Throughout this research, the network governance structure will be referred to as *network governance*. The type of networks being studied is identified as *governance networks*. The following table shows the governance network variables that help to determine the extent of relationships between network actors and network-level characteristics.

*Table 6: Network-level Characteristics Variables*

This content is unavailable. Please consult the print version for access.

*Source: Adapted from Koliba et al. (2011); Governance Networks in Public Administration and Public Policy*

While these variables serve as a guiding framework for exploring network characteristics, the analyses of these variables may reveal other important variables and the identification of influencing factors that affect policy implementation and performance. These network characteristics were applied with other network concepts to help develop an in-depth understanding of the networks in this study. As introduced in the previous chapters, health promotion policy implementation for the elderly network at the local level in Thailand is not only embedded in the traditional centralised and hierarchical governance, they are also led by decentralised actors. These networks did not form voluntarily, nor were they legally mandated, but they were directed to form loosely by the national policies. I define this type of network in the following section.

## 4.2 A Policy-directed Network

Network scholars have defined the development of a network based on what establishes their collaborative relationships. For non-voluntary networks such as ones in this study, many terms have been used in the existing literature. Grafton, Abernethy, and Lillis (2011) referred to three hospitals whose collaborative relationships were formed by a central public funding authority as a mandated network. In their study, they used the term “assignment” when explaining that the hospitals were mandated to form collaborative relationships (Grafton, Abernethy, & Lillis, 2011, p. 243). The institute that assigned organisations to collaborate in Grafton et al.’s (2001) study was not actually part of the network and did not play a more engaged role vis-à-vis network members beyond giving orders. This type of development is prevalent in networks mandated by an external organisation or Network Administrative Organisation (NAO) and a lead organisation-governed network (Isett & Provan, 2005; Moynihan, 2009; Saz-Carranza, Salvador Iborra, & Albareda, 2016). For the latter case, the leading organisation is a single member of the network and has task-specific resources (Moynihan, 2009). Moreover, Kenis and Provan (2009) defined a mandated network as a network dictated by government policy. Organisations mandated to form as a network are obliged to do so (Saz-Carranza et al., 2016), and the mandated network also has clear command and control relationships (Moynihan, 2009).

The health promotion policy implementation network at the local level in Thailand is established by national policies with a written appointment of related ministries and government offices as “Focal Points” (The National Committee on the Elderly, 2009). However, there are multiple national policies, plans, and strategies established by multiple national government organisations that supported and advised the formation of the local network, including its actors. No clear command and control relationships of the local network were clearly stated in any of the policies, only the direction that these organisations shall form a collaborative network (see Table 3). Moreover, no set of rules or regulations have been established to particularly oblige organisations to participate in the network, in any specific way. Therefore, while national policies are the key developer of the network, it cannot be fully claimed, based on the existing literature, that the health promotion policy implementation for the elderly network at the local level in Thailand is a policy-mandated network.

In the stage of network development of networks in this study, the national government, which established policies that led to formation of the network, can be viewed as a network manager because its role is influential to network structuring. This included introducing actors, influencing resources, such as bringing in financial and expertise, and framing strategies (Klijn, Koppenjan, & Termeer, 1995). For framing strategies, Klijn et al. (1995) used the term “directing internalisation

process” (p. 449). The term “directed” is used in a study that explained policy implementation as “actions by public and private individuals or groups that are directed at the achievement of objectives set forth in policy decisions” (Paudel, 2009, p. 37). It is also “a process of a series of decisions and actions directed towards putting a prior authoritative decision into effect” (p. 38). As the term “directed” does not include the aspect of being obliged by the policy, it may be more appropriate to refer to the loosely mandated networks in this study as policy-directed networks rather than a mandated network. Therefore, I defined the networks in this study as *policy-directed networks*.

### 4.3 Conceptual Framework

In response to the research questions, the network and network management theme is appropriate for this research. This is due to the complexity of the decentralised governance structure, level of analysis at the local level, and the characteristics of the health promotion policy implementation for the elderly network in Thailand. The network and network management theme in the network theory assist in the analysis of the relations between actors within the network in implementing the policy. The network analysis approaches, and the case method approach are the primary tools used to study a particular network with the LAOs as the main actor. This research is an opportunity to explore various aspects of a policy-directed network, such as their characteristics, governance, and functions at the network level. Furthermore, it looks further at the actor level by identifying the most influential characteristics and factors affecting the policy implementation at actor level.

To address the gaps of existing literature mentioned in the Literature Review Chapter and provide new knowledge, this study will apply network and network governance theoretical concepts, and a policy implementation study approach to explore policy efforts, such as actions and network characteristics, and provide a practical aspect. Most importantly, it will study how these variables affect the functioning of the network at network-level. The relationship of actors who represent operational functions of a governance network interacting on a policy-directed collaboration is explored, which is a rare example of a policy implementation study. The findings will complement and strengthen networks and policy implementation theories and facilitate the development of the policy design and implementation.

In order to contribute to the existing literature on networks and policy implementation, the form of governance structure and characteristics that include relationship at network-level and network-actor level are examined. This is to provide additional knowledge on the outstanding characteristics of policy implementation of the whole network at the local level and influential factors on the

implementation capacity of network actors. In addition, based on the focus of governance network characteristics on how the network functions or how actors operate together as a network, the characteristics are explored further as to whether they influence actors' collaboration in the network and affect their implementation of the policy. Governance network characteristics can be determined from its ties between actors and network functions that include governance structure and operational functions (Agranoff, 2007; Koliba et al., 2011). Ties between actors at the network level include resources exchanged, the strength of ties, the formality of ties, administrative authority, and accountability (Koliba et al., 2011). As ties between network actors are unique, leading to the unique characteristics of the governance network (Koliba et al., 2011), the extent of policy-directed networks in this thesis offered understandings of other networks that are similarly formed and developed.

Thus, building from the research questions and the literature review, the conceptual framework for this study, variables of interest, and their effects on the policy implementation are illustrated in the following framework. This conceptual framework has helped to guide and shape the research methodology and methods explained in the next chapter.

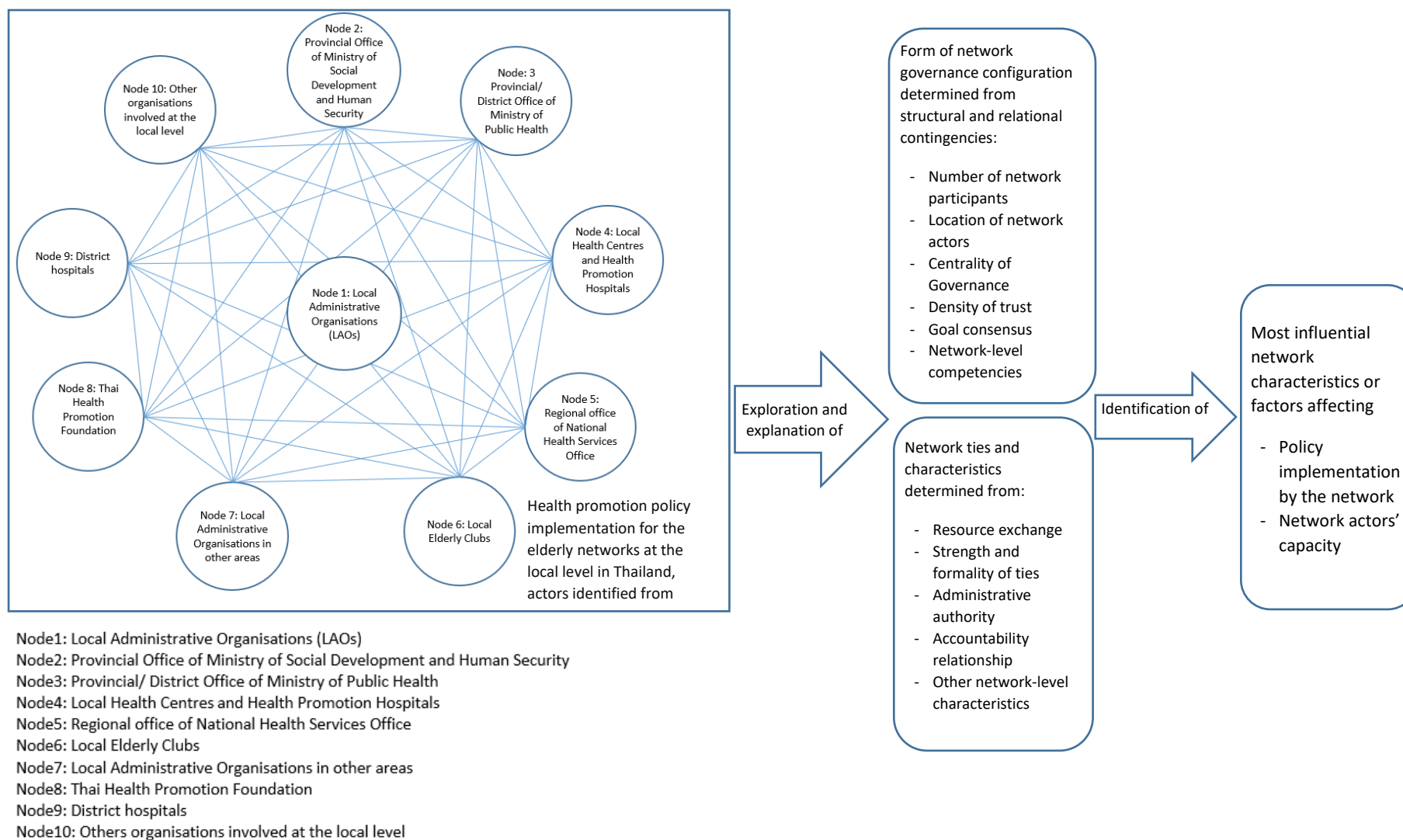


Figure 10: Conceptual Framework



## Chapter 5: Research Methodology and Methods

### 5.1 Introduction

Constructionism is the epistemological basis of this research. Crotty (1998) stated that for constructionism, meanings come from the interpretation of human beings as they engage with things in the world. That is, without human interpretation, things in the world do not hold their own meaning. As reflected in the literature review, the definition of a network, governance network, and policy implementation, as well as the structures of related theories and the government organisations, have all been developed and constructed either by theorists and researchers or by the national institutes. Consequently, this research explores two structures which can be claimed constructionist according to the primary definition of the paradigm; one theoretical and the other organisational. It will apply theories already established to understand and explain these structures and to analyse health promotion policy implementation for the elderly by the LAOs at the local level in Thailand.

Jacobs and Manzi (2000) suggested that in the view of constructionism epistemology in the social sciences, knowledge is defined mainly by researchers. This is a parallel argument to Crotty's (1998) that meanings are subject to interpretations of human beings. Jacobs and Manzi (2000) also found that constructionism was the epistemology in a study of organisational change, but the framework within this epistemology analysed the organisation as a network, not a hierarchy. The Foucauldian framework is an example presented in constructionist research that analysed power mechanisms in an organisation as a function of a "relational" network rather than a linear power exercise (Foucault, 1980). While organisations have been studied as a hierarchy, Foucauldian framework is an example of how constructionists define meanings based on experience and interpretation, which is different from the mainstream perspective. Foucault (1980) based his analysis on relational process and found that power was interdependent within complex network structures and organisation dynamics, and that power in an organisation depends on the social interpretation of those within. This suggested that although Foucault (1980) used discourse analysis to interpret power relationships, other methodologies such as survey research can be used as an analysis approach for interpretation in constructionist research. Furthermore, it can be said that constructionism has been used in policy implementation and networks research. An example is presented in Jacobs and Manzi's work (2000) in which scholars have researched housing policy initiatives. The research involved defining meanings and collaborations of multiple actors on the implementation level based on the constructionist epistemologies such as partnerships (Hastings, 1996), actors interactions across



sectors (Allen, 1997), and conflicts between actors in the implementation process (Jacobs, Kemeny, & Manzi, 1999).

Constructionism takes into consideration factors and environment that influence the studied topic and research participants. However, while the influence may be subject to the interpretation of a person or the researcher with their views and experience resulting in a personal conclusion, constructionists argued that interpretation could be validated by methods of enquiry such as a legitimate framework and specific research methods that accept subjective roles (Darlaston-Jones, 2007). Charmaz (2008) critiqued the idea that understanding of the abstract is a focus for the constructionist, marking the *what* and *how* research questions that emerged from the empirical phenomena. Moreover, the contextual emphasis of constructionism also garners the views of participants in addition to those of researchers, making the research analysis and presentation more integrated (Charmaz, 2008). Accordingly, with a constructionist epistemological basis to answer the research questions in this study, interpretivism is most relevant as the central theoretical perspective for the study. Interpretivists assert that humans' thoughts and behaviours are influenced by culture and social interactions (Crotty, 1998). Although one's interpretation of meaning is based on their personal experiences and views, those experience and views are shaped by the varying contexts in the situation, culture, society, and history (Cresswell, 2007). As a result, the inclusivity of an interpretivist perspective enables researchers to understand better the social reality involved in the studied subject and to be able to explain human behaviours, decisions, experience, and views of it (Crotty, 1998).

The following sections expand on the research methodology, methods, data collection, and approaches used in the data analysis that are based on the foundation of the aforementioned epistemology and research paradigm.

## 5.2 Methodology

Interpretivist researchers seek to provide credibility and trustworthiness for their research and employ a research approach that addresses these aspects of their study (Decrop, 1999). Under the constructionist epistemology, Scheurich (1996) suggested using a framework to assess the acceptability of the research that is based on validity and trustworthiness. Accordingly, I applied qualitative and quantitative methodologies and methods to provide these attributes. While qualitative research is interpretative, a quantitative method, such as a survey, is commonly used to assist in the interpretation of qualitative data (Gallivan, 1997). Gallivan (1997) also found that, on

the other hand, researchers could also use qualitative data to reinterpret and construct surveys. A common research approach that serves this purpose is triangulation. It is an approach widely used in positivist and post-positivist studies, although it has also been applied to and is relevant in other theoretical research perspectives, such as interpretivism (Gallivan, 1997; Decrop, 1999). Decrop (1999) suggested that triangulation is most relevant in the post-positivism, interpretivism and constructivism paradigms where researchers should mention explicitly how the data is triangulated. Triangulation corroborates different sources, methods, investigators, and theories to capture a theme or a perspective emerging from the data (Cresswell, 2013). In interpretivist mixed methods research, triangulation enhances the validity of interpretations (Decrop, 1999). Mixed methods research allow methodological pluralism in which researchers can analyse data with approaches that are both process-oriented and variance-oriented and located within different theoretical perspectives (Gallivan, 1997). Triangulation does not only employ data collection by two different methods, but also two different methods of analysis integrating both fieldwork and surveys (Jick, 1979). It also needs more than one set of data from qualitative and quantitative collection methods (Gallivan, 1997).

The concept of triangulation as explained in the previous paragraph had been built into the methods for this research. The research objective is to analyse health promotion policy implementation for the elderly in Thailand using governance networks and policy implementation theories as a framework of analysis. This objective requires interpretivist knowledge of both interactions among the implementation of network actors and an in-depth analysis of the organisation and policy implementation structures involved. Tuli (2011) concluded from a review of literature that an interpretivist perspective is a theoretical framework for most qualitative research. Interpretivist researchers tend not to generalise but study real-world situations on a specific matter to understand a particular phenomenon in depth (Tuli, 2011). The partnerships built between researchers using this paradigm and participants through a qualitative research methodology allow for deeper insights on a context as the methodology provides richness in the in-depth data and high validity (Tuli, 2011). Krauss (2005) stated that qualitative methodology is a powerful epistemological tool as its contextual rigour in data analysis allows researchers to maximise the potential for generating meaning making it an appropriate methodology to understand a particular phenomenon.

To understand the relationship and functions of policy implementation network in actual situations, qualitative methodologies, including a case study, are used to respond to the research questions. The relevant elements can be studied simultaneously with a combination of qualitative and quantitative methods (Creswell & Clark, 2011). As scholars found that the characteristics of a network are represented by their collaborating actions (Hoeijmakers et al., 2007; Klijn et al., 2016;

Poocharoen & Ting, 2015), both methodologies are used in this study to identify these network characteristics. By identifying network characteristics, the impact they have on implementation capacity will be determined (Wang et al., 2016).

The analysis of governance network characteristics is related to the research question, and research objectives determine the extent of network relationships and whether the characteristics or factors of the network have an impact on LAOs and other actors' implementation of the health promotion policy implementation for the elderly. In order to investigate network members' collaborative actions and interactions, Levy (2006) suggested that a quantitative methodology is more appropriate in studying the already known variables affecting the phenomenon or process. In this case, the network characteristic variables have already been identified by previous scholars, but in order to determine the extent of those variables and examine their impact on the network actors' implementation of the policy as well as relationship dynamics, a qualitative method proves useful. A qualitative method such as an interview and direct observation ensure the reliability of the study (Poocharoen & Ting, 2015). Therefore, this study adopts the triangulation approach for the purpose of strengthening the interpretation of relationships between actors within the network and capturing emerging factors affecting policy implementation. Triangulation approach was applied to data sources and methods, which will be discussed in the following sections.

### 5.3 Methods

Borgatti et al. (2002) found that prior to 2002 most networks were explored using a single methodology that was "either qualitative and secondary data or standardised questionnaires and structural network analysis" (p. 511). The more recent network studies provide evidence of employing either quantitative methods of inquiry such as a survey (Klijn et al., 2016; Klijn et al., 2015; Klijn & Koppenjan, 2016) and qualitative methods such as an interview and case study (Howes et al., 2014), and document analysis (Fünfgeld, 2015). While scholars have made progress in understanding what networks are, their structure, operation, and development through the single-method approach, using both methods of inquiry can yield insights into other aspects of the network and their actors such as network relationships and their development, founding conditions, and changing contexts particularly in a large-scale network (Provan, Fish, & Sydow, 2007). Moreover, the mixed approach assists scholars to extend their understanding of the function of networks, especially when using narrative interviews and participant observation (Provan, et al., 2007). The mixed-methods approach for this research explores the structure or form of social relations and the process of the interactions revealing the content of the network as network analysts recommended

(Edwards, 2010). In addition, while research can extract the general concepts of the network from a quantitative survey, the qualitative interview and direct observation complement efficiency and reliability for the analysis of this research (Poocharoen & Ting, 2013).

Provan et al. (2007) pointed out that studying of multi-actor networks by employing both methodologies are still inadequate, even though they could provide more useful understandings, especially about the form of the governance in the network. To address this inadequacy, this research employs the mixed-method approach for the inter-organisation policy implementation and governance network functions analysis. This approach provides a multi-aspect analysis of a network that a single-method may not inclusively cover or capture the emergence of.

### 5.3.1 Case Study

A case study is strongly associated with qualitative research (Ritchie & Lewis, 2003). It is a method widely used to study in-depth the interactions or conditions of a different scale of the social unit in a society which can range from a family to a community (Kothari, 2004). A case study is suitable when “a how or why question is being asked about a contemporary set of events, and over which a researcher has little or no control” (Yin, 2014, p. 14). In this research, LAOs and their roles in health promotion policy implementation for the elderly were studied. Collaborations in policy implementation are an interaction experienced by the LAOs and other network actors. Lastly, the functioning of the LAOs and their collaborating agencies are to achieve the policy implementation goal. Some of the events of collaboration and interactions are directed by policies and guidelines, which the researcher has no control over.

### 5.3.2 Sampling

Sampling is conducted for both qualitative and statistical purposes at different stages of this research. Non-probability or purposive sampling is suitable for qualitative research in the process of selecting populations for the study (Ritchie & Lewis, 2003). This sampling approach is used in three stages: 1) selecting individuals at the national policy and the top of decentralisation structure levels for in-depth interviews based on organisation and their roles in implementing the health promotion policy; 2) selecting the areas for data collection based on the areas’ representativeness of certain social characteristics such as their location in urban and rural areas, and recognition of their health promotion of the elderly programmes, this stage of sampling takes into consideration the feasibility of data collection in a limited timeframe; 3) selecting individuals working in the network at the local level for the in-depth interviews and questionnaire responses regarding policy implementation interactions, collaboration, and activities.

### 5.3.3 Survey

Survey research is used to determine the characteristics of the populations being studied, including the relationships between the data and the unknowns (Kothari, 2004). Creswell (2009) said that a survey “provides a quantitative or numeric description of trends, attitudes, or opinions, of a population by studying a sample of that population. From sample results, the researcher generalises or makes claims about the population” (p.145). In conducting the survey, the research variables or events are not manipulated by the researchers as what is being studied are the conditions or relationships that already exist or have happened (Kothari, 2004). In this research, surveys are used to explore the governance structure form of the network, the relationships established from the collaboration, and to determine the degree of governance characteristics represented by the interactions the LAOs and other actors have within the network of the health promotion policy for the elderly implementation. All the surveys disseminated were in Thai. The researcher gains indicative information from the surveys, which were conducted only at the provincial and local level with selected groups of the population according to the purposive sampling method.

## 5.4 Data Collection

Creswell and Plano Clark (2011) explained that the quantitative and qualitative strands of research could also be mixed during the data collection process. The connection between the two strands can be established by using the results of one to shape the other such as in selecting participants and developing data collection protocols or instruments (Creswell & Plano Clark, 2011). The data collection was separated into two phases, as outlined below.

### 5.4.1 Phase One: National Policy Level Data Collection

The macro level in this research is the national policy organisation. The data collection in this phase was conducted with individuals selected by purposive sampling. This phase of the data collection aimed to interview individuals in the national organisations whose responsibility involves health promotion for the elderly policy and implementation planning, and execution. The four key participants in this phase were:

- Deputy Director-General, Department of Local Administration, Ministry of Interior
- Director, Healthy Community Strengthening Section, Thai Health Promotion Foundation
- Director, Strategy and Planning Division, Department of Older Persons, Ministry of Human Development and Human Security

- Director and Deputy Director, Bureau of Elderly Health, Department of Health, Ministry of Public Health

The conversations were structured as open-ended interviews. The qualitative data collection method of open-ended interview provides much more in-depth data than closed-question quantitative survey data (Creswell & Clark, 2011). The interviews in this phase were based on the theories of networks, governance networks and policy implementation. The interview was to explore the expectations of the health promotion policy for the elderly implementation from the policy design level.

Due to the positions of the interview participants and their high volume of responsibilities, I anticipated that scheduling an appointment with them could take longer than expected, and rescheduling was possible. Moreover, as the request for the interview process in Thailand is paper-based and very bureaucratic because the request had to go through many levels of approval, it was best to start sending the requests while I was in the country for ease of contact. Unlike Phase Two, data collection at the local level where I could negotiate the interview dates, the first phase had to be strictly by appointment with fixed dates and time. Making appointments until finishing the interviews with the four participants took from December 2017 to January 2018. Some reschedulings were required. Scope of the interview questions, information about the research and the researcher as well as a verification letter from my supervisors were translated into Thai and sent with the interview request letters.

However, scheduling interviews with the participants in phase one was very cooperative. Despite rescheduling, I was able to gain direct contact with two of the participants' secretaries through referrals, hence, shortening the time for making appointments. Time spent on the interviews varied from one hour to almost two hours. Some participants such as the Deputy Director-General of Department of Local Administration, and the Director of the Strategy and Planning Division, Department of Older Persons prepared some documents that they thought might be useful regarding the interview topics. Three interviews were conducted during work hours, but the interview with the Deputy Director-General of the Department of Local Administration at the Ministry of Interior was in the evening after office hours. All interview participants gave their contact details and permission to contact their assistant should there be follow-up questions.

Three of the four interviews in phase one were directed to the research topics and scope of interview questions given to participants before the interview. One of the interviews was off topic. The participant prepared a presentation and content that did not directly address the topic and

scope of questions sent beforehand and insisted on finishing the presentation. However, I was able to ask some, but not all related questions at the end of the presentation.

Information from phase one gave me a perspective from the national policy planning and evaluation level. Moreover, the information from this phase helped shape and narrow the questions used to interview participants at the local level in the following phase. Data from this phase was not included in the analysis as participants and their organisations are not a part of the local policy implementation networks.

#### 5.4.2 Pilot Data Collection

After sending the interview requests for phase one data collection in December 2017, while waiting for the responses, I conducted pilot interviews and surveys at Rimping Sub-district Municipality Office. It is a LAO in Lamphun, a province located 27 kilometres south of Chiang Mai. The purpose of the pilot interviews and surveys were to validate whether the interview questions were sufficiently inclusive and to gain feedback from participants regarding their understanding of the survey questions. The pilot data collection helped determine more precise interview questions and provided more background information about the local level operation and policy implementation regarding the research topics. Moreover, the pilot interviews raised policy issues that I could then request further information about and explanation from the national policy-level interview participants. Two pilot interviews were conducted, and 25 surveys were collected at Rimping Sub-district Municipality Office in December 2017.

#### 5.4.3 Phase Two: Local Level Data Collection

The local level data collections consisted of both qualitative and quantitative methods. Two LAOs were selected for data collection using purposive sampling:

A LAO with evidence of outstanding programmes and collaborations with other organisations for the elderly or a “model LAO” was selected. Based on archival research, which involved online newspapers, national organisation journals and newsletters, and government organisation’s awards database, Donkaew Sub-district Administrative Organisation was selected as a case study. Donkaew Sub-district Administrative Organisation is a LAO located in Maerim District, Chiang Mai Province, Thailand. This LAO has long-standing records and national awards for outstanding programmes for the elderly in their community that involves working with other local organisations to deliver the elderly health promotion services (Health Systems Research Institute, 2012; Local Administration Development College, n.d.; ""Ro:hng-riian- phuu-suung-aa-yoo" na wat dta gam jaak choom chohn

["The elderly school" innovation from the community]," 2017; Thai Health Promotion Foundation, 2011).

Another LAO, Nampreaepattana Sub-district Municipality Office was selected as the second case study. It is another LAO in the same province but located in a different district with different and more disadvantaged geographic and demographic characteristics which will be explained further in the following section. Case study two was selected based on their implementation of similar health promotion programmes for the elderly such as the elderly school and community engagement activities for their elderly population. Considering its different characteristics, it provided a contrast of network perception, network governance, and policy implementation. This LAO followed the implementation model of Donkaew Sub-district Administrative Organisation and invented some of their own models. The differences in their management and resources were also considered as factors obstructing or delaying them in establishing successful policy implementation at the same level as the first selected LAO. For feasibility reason, the second case study LAO was also located in the same province as the first one. Thus, the regional offices of central government involved in both LAO's elderly programmes were the same (National Statistical Office, 2014).

After the case study LAOs were selected, the following data collection approaches were used.

#### *5.4.3.1 Interview and Network Mapping*

Open-ended interviews were conducted with individuals within the LAO offices whose responsibility involves the welfare of the elderly and activities within the health promotion policy for the elderly in the community. These interviews also included individuals in the management roles of the selected LAOs who are involved in decision making and planning for policy implementation in the community. This stage focused on the LAOs that are at the closest level to the community, which are the municipality and the sub-district administrative organisations. Participants interviewed included people such as the Deputy Director of the LAOs and other relevant employees identified by each office. The outputs from this interview process help in identifying relevant actors of the network in the policy implementation and identifying individuals in the policy implementation process who are most relevant to respond to the questionnaire. This interview also provided details on the extent of the relationships and interactions within the network.

In Phase Two, 21 key people who are directly involved in the coordination of policy implementation in the case studies were interviewed. Among them, eight participants were in Donkaew LAO's networks. Ten participants were in Namprae's networks. Three interview participants were a part of both case studies' networks. Interview participants included:



- LAO staff in various levels whose roles are related to health and welfare of the elderly population in the sub-districts
- Staff of local and regional levels organisations whose offices are located in the sub-districts
- Staff of regional organisations at district and provincial levels who are actors of the LAOs' networks
- Staff at other organisations and groups determined by the LAO as part of their network.

Network mapping and stakeholder mapping have been used in health promotion research, in data collection and the analysis processes, first to visualise connections between people and structures in the partnership and later to determine whether there are connections between them (Hoeijmakers et al., 2007; Lewis, 2005). Network mapping is also a tool to explore members' positions and connections within networks and to later analyse their capacity in the health policy development process (Hoeijmakers et al., 2007). In this study, high-level network mapping was used to identify relevant actors at the local level of the health promotion policy implementation for the elderly in the selected sub-districts. It was used to gain an overview of the broad network relationships such as the frequency of contact between network actors and programmes or activities that they collaborate with. In this study, network mapping is in the form of a table. Participants who were asked to complete a network mapping table were those interviewed. The network mapping table was originally pre-listed with regional and local organisations mentioned in the national policy as actors of the policy implementation network. Spaces were available for participants to list other organisations in their network that may not have been listed along with the frequency of as never, rarely, usually, and all the time. Although a similar question about frequency of contact is also on the survey questionnaire, it is inclusive at the whole-network level, but not between individual organisations as on the network mapping table. Of all 21 key interview participants, 15 people completed the network mapping table. The others were unable to complete due to time constraints or other duty commitments that came up on the day of the interview. Chapter 7 on Network Ties visually presents the results of the network mapping in the two case studies using the program R.

#### *5.4.3.2 Survey questionnaires*

Questionnaires for the survey are used to collect data by asking research participants (Denscombe, 2010) questions to identify the form of network governance structure and the extent of governance network characteristics represented by actors' interactions and the impact on the actors' implementation of the policy using a Likert Scale. The questionnaires consisted of open-ended and closed-ended questions which obtain two broad types of information, namely facts and opinions (Denscombe, 2010). Participants who responded to the questionnaire are the selected LAOs'

employees involved in the implementation of the health promotion policy. Open-ended questions that are not predetermined, categorised, or scaled (Creswell & Plano Clark, 2011) were also used to determine the extent of network characteristics and implementation activities for the target population. Closed-ended questions are commonly used to obtain data predetermined on response scales or categorised by the researcher (Creswell & Plano Clark, 2011) and are asked to acquire information on the network functions and characteristics. In Phase Two, 95 survey questionnaires were collected from all network actor organisations in the two case studies. To be qualified to participate in the survey, staff at organisations would have to have taken part in network activities as participants, coordinators, organisers, assistants, planners, funders, and evaluators. The contact person at each organisation, also an interview participant, assisted with the purposive sampling in selecting the group of staff at their organisation who were qualified as survey participants based on their roles and duties. However, the dissemination of the surveys was opportunistic. It based on who, amongst those qualified at the organisation, was available to complete the surveys between the time of survey dissemination and collection. Hard copies of surveys were handed out to participants who met the inclusion criteria and who were present at the organisations on the days they were handed out. All disseminated surveys were returned completed in an envelope provided for collection. The response rate of the survey was therefore 100%, although some people who might have been eligible to complete the survey may not have received it. Among 95 surveys completed and collected, 62 were from Donkaew, 29 were from Namprae, and four were from regional-level organisations that are a member of both networks.

#### *5.4.3.3 Non-participant observation*

Non-participant observation has been used in governance network research (Bevir & Richards, 2009) such as to study how health network members coordinate their activities (Sheaff et al., 2010). It was used in this study at the internal meetings of the selected LAOs to learn about their implementation planning, network activities planning, and interaction dynamics between actors. From the non-participant observation, the researcher is able to see the behaviour of policy network actors (Bevir & Richards, 2009) in the meetings such as collaboration behaviours, conflict and resolution decision making, and exploring further the extent of governance network characteristics represented by the interactions. This tool complements other research methods such as interviews, surveys, and documentary analysis (Liu & Maitlis, 2012). In this research, seven multi-organisation network activities were observed: they included meetings and network events participated in by actors within and outside of the networks. Minutes of the meetings were acquired in addition to my observations — the non-participant observation assisted in providing clarity of roles or assignments

for actors in the network. Aspects of network interactions and relationship dynamics from existing network literature were used to assist as a guide during observation (see Appendix C).

I observed the following four activities in Donkaew.

- 1) The Annual Vulnerable Population Groups (the elderly and disabled persons) Day in Donkaew Sub-district. Participants in this event and activities included the sub-district elderly club members, Donkaew Sub-District Administrative Organisation staff, Chief of Chiang Mai Province Office for Local Administration, Chief of Rimping District Office for Local Administration, representative from district hospital and a health education institute located in the Rimping district, staff from non-profit organisations that have worked with the LAO, and other representatives of organisations working with the population groups in Donkaew sub-district. The activities at the event were performances by the elderly and mentally challenged individuals in the community, lunch, prize drawing, elderly sports day, and recognition speeches. The venue of this event is a local temple's event hall.
- 2) The weekly elderly school: Donkaew Sub-District Administrative Organisation's Social Welfare Division leads the sub-district elderly school (Homsuk Elderly School) every Thursday. Activities at the school focused generally on health of the elderly but also include health promotion activities such as muscle exercise, recognition exercise, social gatherings, and discussions of events within the sub-district. The location of the weekly elderly school is at the local temple's event hall.
- 3) Donkaew Sub-District Administrative Organisation's network meeting: as mentioned previously, this meeting was to be conducted monthly. But with high volume of engagements of the executive and the workload of the LAO, Donkaew Sub-District Administrative Organisation led the network meeting in May 2018 after seven months. Participants of this meeting were representatives of organisations whose office located in Donkaew sub-district territory. Topics discussed include projects updates and follow-up, advertisements of events organised by meeting participants' organisations, and local population well-being related issues such as trash collections, and fresh market sanitization. The venue of this event was at Donkaew Sub-District Administrative Organisation's meeting hall
- 4) Model LAO presentation: Donkaew Sub-District Administrative Organisation's hosting 40 Deputy Directors of other sub-district local administration across Thailand as a part of

their development training. As a model LAO, Donkaew Sub-District Administrative Organisation had been requested to host and share their experiences about community management with other LAOs across the country. In this event, 40 Deputy Directors of other sub-district local administration across Thailand visited the Donkaew Sub-District Administrative Organisation to learn about their community development programmes and good governance culture. The venue of this event was at Donkaew Sub-District Administrative Organisation's meeting hall.

I observed the following three network activities in Namprae.

- 1) The monthly meeting of the elderly club of Namprae sub-district and its Sub-district Municipality Office: this activity participants were officers and staff from the Namprae Sub-district Municipality, the leader of the sub-district elderly club, 11 representatives from each village within the sub-district and other general members. The meeting agenda included an invitation to the dementia information session, inform of the elderly club account balance, dengue fever vaccination, rabies vaccination and prevention. The venue of this meeting was at a local temple.
- 2) Thainiyom Road Session: Thainiyom was a project initiated by Prime Minister Prayuth Chanocha during the time of this fieldwork. The project was assigned to Ministry of Interior and their sub-organisations including the LAOs to implement in their community throughout Thailand. It consisted of series of informative sessions where representatives of organisations within the district traveled to villages in sub-districts to inform the people about their rights, benefits, and social services that they are entitled to and can access. The sessions also included health promotion and prevention elements such as prevention of seasonal contagious diseases. However, very little of network interactions could be observed as each representative from organisations were there to give a talk, but not interact with each other regarding the topics discussed. The participants of this particular session that the researcher observed were officers and staff from Namprae Sub-district Municipality Office who led the session, a representative from the sub-district Health Promotion Hospital, an officer from the Chiang Mai military base, an officer from Hangdong District Agricultural Extension Office, and the villagers. Participating organisations vary from session to session but they were all led by the LAO. Lunch was provided for all participants. The session venue was a village multi-purpose pavilion.

- 3) Information session on dementia: this educational session was led by a registered nurse from Chiang Mai Neurological Hospital and supported by the Namprae Sub-district Municipality and the sub-district Health Promotion Hospital on the budget provided by Chiang Mai Social Development and Human Security Office. The nurse gave a presentation about dementia, how to observe the symptoms, what the elderly should do if they suspect they have dementia, and the treatment entails. Participants were a group of the elderly in the sub-district, staff coordinator of Namprae Sub-district Municipality Office, and the registered nurse who conducted the seminar. This event venue was the temporary Namprae Center for the Quality of Life Development and Occupational Promotion for Older Persons located in the area of the Namprae Sub-district Municipality Office.

#### 5.4.4 Case Study One – Don Kaew Sub-district Administrative Office, Donkaew Sub-district, Maerim District, Chiang Mai (Donkaew LAO)

Donkaew Sub-district is a 48.53 square kilometres area within Maerim District, north of Chiang Mai central District. The south and the east sides are adjacent to Chang Puek and Sanpeesua sub-districts within Muang Chiang Mai District (central district of the province) where it is more urban. The geography of Donkaew Sub-district is mountain plain. Residential areas form one-fourth of the entire land area. The majority of the land in the sub-district is owned by the government and used as the location for many government, military, and public organisations.

From the census data in 2017, of the 15,547 people in the sub-district, 2,034 are elderly that is 60 years and over, making up 13.08% of the total population (data from a presentation on 3 January 2018). Six hundred and twelve of the elderly are former government officers and on the government employee retirement pension and benefit packages. Among 7,685 households within the sub-district, 55% are households of workers for hire, 21% are commercial, 18% are government officers, two per cent are farmers, and four per cent are others. Donkaew Sub-district categorises the population's income in two categories. Those with income from agriculture and farming earn an average of 42,263 Baht per year, and those with income from outside the agricultural industry earn an average of 50,000 Baht per year (Donkaew Sub-district Administrative Office, 2017). The average household income of Thailand in the first half of 2017 was 26,973 Thai Baht (National Statistics Office, 2017).

Economically in 2016, Donkaew sub-district had its own revenue of 28,107,891 million Baht (Donkaew Sub-district Administrative Office, 2016) from local taxes and other fees collected from individuals and businesses (The Revenue Department, 2012) in 10 villages within the sub-district.

The central government organisations also funded the sub-district as cash and through development programmes for 38,289,817 million Baht (Donkaew Sub-district Administrative Office, 2016). The sub-district has revenue-generating initiatives such as recycling services and making fertiliser from garbage collected in the community. Donkaew LAO has won multiple awards for its overall management of the sub-district and programmes implemented within the area such as the 13<sup>th</sup> Local Administrative Organisations with Good Governance Awards 2016, and the Local Administrative Organisations with Good Management 2015.

Donkaew Sub-district has advantages from being geographically located close to the central city area and is the location of many government organisation offices and schools. A district hospital (formerly a provincial hospital), Nakhonping Hospital is also located in the area of Donkaew Sub-district. The advantages include residents being close to government offices and the hospital and many are employees of those offices or are employed in the nearby urban area. As a result, it is convenient for the residents to contact or travel to government offices and the city. Furthermore, the central government funds infrastructures that the sub-district benefits from such as roads. Moreover, it is easier for the Sub-district Administrative Organisation and other government organisations to work and collaborate as they do not have to travel long distances. These advantages will be discussed further in the data collection process and findings sections.

#### *5.4.4.1 The Elderly in Donkaew Sub-district Administrative Organisation's Policy*

Donkaew Sub-district's development follows Donkaew Sub-district Administration Organisation's executive development framework which has eight dimensions; 1) infrastructure; 2) economic; 3) water resources; 4) health; 5) education, religion, tradition, and culture; 6) society; 7) natural resources and environment; 8) government and good governance. Elderly care is one of the focuses on the health dimension of the sub-districts' development policy framework. The policy ensures that all the people in the sub-district have the right to and can access health services to which they are entitled. For the elderly in particular, the policy emphasises both physical and mental care that includes health promotion, and support for health conditions. The policy aims to develop the elderly in the community to be respectful and become role models for younger generations.

Under the health topic of the Sub-district Administrative Organisation's Policy, it states that populations are to be provided with health and dental care appropriate to their age groups, health promotion services such as physical check-ups and primary care. The policy also extends to supporting public health centres and health care providers within the sub-district and the development of their staff capacity. The health and quality of life of the elderly in Donkaew's sub-district are also included in the Sub-district Administrative Organisation's social policy. The policy

ensures that all the eligible elderly receive government welfare and other social assistance. Moreover, the Sub-district Administrative Organisation encourages the elderly within the sub-district to develop and participate in social groups to stimulate them to engage in activities that help retain their good physical and mental health. The social groups may include local cultural activities where the elderly can pass on their knowledge and traditional practices to the younger generations and ultimately help sustain their local culture. In addition, the social policy topic also includes home fix and maintenance services for the elderly and other vulnerable groups in the sub-district to ensure they stay in a good, secure, and safe environment.

Within the sub-district development policy, development strategies are developed to be the guidelines for implementation. For Donkaew's development strategies, elderly health is a part of the health development strategies emphasising the capacity for rehabilitation.

In 2018, 52 out of 5,200 Health Promotion Hospitals around the country have been transferred to be under the administration of their sub-district's LAO (Thai Health Promotion Foundation, 2018). Since Donkaew Health Promotion Hospital underwent this transition, it has been renamed as Donkaew Sub-district Community Hospital ("Service a family," 2012). However, it operates as a Health Promotion Hospital and is still referred to as the former name in many sources. To prevent confusion, this study refers to Donkaew Sub-district Community Hospital as Donkaew Health Promotion Hospital, its former name.

#### *5.4.4.2 General Observation during Fieldwork at Donkaew Sub-district*

Donkaew Sub-district Administrative Organisation has won multiple awards for its management of the sub-district, community environment, and support of programmes for groups of people in their community. This resulted in them being a Model Local Administrative Organisation that other local administrative organisations visit to learn from. Central government organisation such as the Department of Local Administration also featured Donkaew Sub-district Administrative Organisation as one of their training and development programmes' fieldwork visits. These training and development programmes are for officers holding the Deputy Director position in 7,852 Local Administrative Organisations at the sub-district level across Thailand (Department of Local Administration, n.d.).

As Donkaew Sub-district is located close to the central district and other government organisations, it attracts people who work in the city and with the appropriate talents who would like to work near the city to apply for positions at the Donkaew Sub-district Administrative Organisation. The Deputy Director of Donkaew Sub-district Administrative Organisation and the Director of the sub-districts Health Promotion Hospital both hold a PhD and mentioned that the sub-district does draw talent.

The Sub-district Administrative Director said that they have a very competitive recruitment process for temporary long-term employees with rounds of exams and ethical evaluation. The recruitment process usually attracted a pool of competitive and educated applicants. The location is also an advantage for providing health services. There are rotations of doctors from the district hospital (Nakornping Hospital) who take a shift at the Donkaew Health Promotion Hospital once a week. The hospital also has its own registered nurses and other health staff, such as nurse assistants. The sub-district Health Promotion Hospital also draws interest from retired doctors who live within the area and nearby to be part-time at the hospital in addition to the doctors from the District Hospital. Donkaew Sub-district Administrative Organisation supports the budget for hiring part-time doctors. Moreover, as the Nakornping Hospital, the district hospital is located in Donkaew Sub-district, employees of the hospital, including nurses and doctors, are the sub-district residents.

During the time of data collection in Donkaew Sub-district, primarily February – March 2018, the process progressed quickly in terms of the initial introduction, referrals, interview appointments, and survey collection. For example, I attended a community event and was referred to a person who was the contact person in the Donkaew Sub-district Administrative Organisation's elderly health promotion network. I was able to interview that person on the same day.

#### 5.4.5 Case Study Two – Nampraepattana Sub-district Municipality Office, Namprae Sub-district, Hangdong District, Chiang Mai (Namprae LAO)

Nampraepattana or shortened as Namprae Sub-district is an 80.55 square kilometre area located within Hangdong District in the south of the central district of Chiang Mai Province. Nampraepattana is not adjacent to the central district of Chiang Mai province and is 16 kilometres away from the centre. The geography of the sub-district is mountain plain with 50% a national conserved forest area (Nampraepattana Sub-district Municipality Office, 2019).

From the census in 2017, Nampraepattana Sub-district has a population of 6,904 in 11 villages. Among the population, 1,219 are the elderly aged 60 years and over, 17.7% of the total sub-district population (Department of Provincial Administration, 2017). The majority of the sub-district population are farmers or in agricultural industries such as growing rice or soybeans. The other group of the population are labourers for hire in more urban areas nearby.

According to the sub-district LAO's financial statements of 2017, Namprae Municipality Office had revenue collected from local taxes and fees collected from businesses and individuals of 39 million Baht. The central government organisations also funded the sub-district in cash and through development programmes for 16 million Baht.



There is a geographical contrast between the Donkaew Sub-district and Nampraepattana Sub-district in that the latter sub-district is located farther from Chiang Mai central district and urban area. Moreover, the transportation infrastructure in Namprae is not as developed as some parts of the four-lane road have been under construction for a few years. This delay is due to the complication of construction approvals by the communities and between central and local government organisations.

#### *5.4.5.1 The Elderly in Namprae Sub-district Municipality's Policy*

Namprae Sub-district Municipality's development policy covers eight topics; 1) infrastructure; 2) economic; 3) health; 4) society; 5) education, religion, and traditions; 6) environment and natural resources; 7) good governance; 8) other development plans (such as internal management and facilities development). For Namprae, elderly quality of life is emphasised in the social development topic. The Municipality focuses on developing the elderly network and ensures they receive government assistance and other social opportunities. Moreover, under the education, religion, traditions and cultures topic, the Municipality engages the elderly in participation of cultural activities to sustain their local traditions and cultures.

In the development strategies of Namprae Sub-district Municipality, the Health and Quality of Life Strategy includes two development strategy guidelines that directly address the elderly in the district. First, it supports education and life-long learning for the elderly by developing learning centres and independent learning programmes in the community. Second, it develops the quality of life of the elderly along with children, youth, women, and vulnerable individuals by gathering group data to develop appropriate programmes, develop appropriate infrastructure suitable for their conditions, and support their vocational education according to their capacity so that they are able to earn income and be independent.

#### *5.4.5.2 General Observation during Fieldwork at Namprae Sub-district*

Although Namprae Sub-district is not too far from the central district and urban areas in Chiang Mai province, infrastructures such as main roads are still under development for expansion and the irrigation system has not been improved. The main road separates the sub-district into two sides with one side opposite the mountains. The mountainside experiences drought and irrigation issues more than the other due to lack of water resources, especially underground.

Health Promotion Hospital of Namprae Sub-district is not under the administration of its Namprae Sub-district Municipality (its LAO), unlike Donkaew Health Promotion Hospital. Instead, it is directly under the administration of the Ministry of Public Health regional office – Hangdong District Health Office, thus considered a regional organisation. The hospital has doctors and dentists on rotation

from the district hospital (Hangdong Hospital) on weekly shifts. The hospital also has registered nurse of its own.

Namprae Sub-district Municipality works closely with the Thai Health Promotion Foundation in implementing health promotion for different groups of populations in their community. The Health Promotion Foundation introduced the “context-based” approach to the Namprae Sub-district Municipality and worked with the staff closely to plan and implement health-promotion related programmes within the community. Namprae Sub-district Municipality also participates and organises its own trips to visit other LAOs to learn more about programmes in their communities. The elderly school within Namprae Sub-district supported by the municipality office was also implemented after Donkaew Sub-district Administrative Organisation’s programme.

During the time of data collection in Namprae sub-district, some appointments were delayed or rescheduled, especially those with members of the elderly club. As most of the members are labour for hire or farmers and still work after 60 years of age, their schedule depends on their employment. Moreover, for the surveys, the municipality contact person voiced a concern that the level of education and knowledge capacity of people whose roles qualified them to respond to the survey because of their involvement in health promotion activities for the elderly might be limited. This concern was real, especially in the participants who were members of the elderly club and those who work and volunteer for the Namprae Health Promotion Hospital. For the elderly group, most members were unable to read, and those who are able to read were not able to comprehend the questions asked on the survey. The group of potential participants who work and volunteer for the sub-district hospital were not able to comprehend the questions asked on the survey. The latter group was a concern of the registered nurse who was the contact person at the hospital.

## 5.5 Data Analysis

As data collected for this research were both quantitative and qualitative, mixed-method data analyses are employed and vary with different types of analysis tools such as computer programmes and techniques used (Creswell & Plano Clark, 2011). For qualitative data analysis, the data may be coded and grouped into themes (Creswell & Clark, 2011). The unit of analysis in quantitative methods is numeric, and the units of analysis in qualitative methods are words and visual images (Denscombe, 2010) they can be analysed simultaneously (Creswell & Clark, 2011). The critical aspect of the analysis of this research is that the unit of analysis outcome is the network as a whole. The analysis of the form of governance structure allows the whole network to be analysed as a unit with input from individual actors (Provan & Kenis, 2008).

The qualitative data was analysed based on network analysis. Network analysis provides an insight into how the network functions and interacts by taking into consideration other factors such as structures, values, connections, and the relationship of members of the network (Hoeijmakers et al., 2007; Poocharoen & Ting, 2015). The following network analysis frameworks were used to determine the form of the governance structure of the network, governance network characteristics, and influential characteristic factors for actors' implementation of the policy.

#### 1) Forms of the network governance analysis

Provan and Kenis's (2008) key structural and relational contingencies of network governance forms categorised networks into three forms of a governance structure based on how the network is governed. They were used to determine the governance structure of the health promotion policy implementation for the elderly network at the local level. The following table shows the network key structural and relational contingencies of forms of the network and how they can be identified to determine governance structure.

*Table 7: Key Structural and Relational of Network and Indicators of Network Governance Forms*

<b>Key structural and relational contingencies</b>	<b>Indicators</b>
<b>Network centrality</b>	Number of actors leading the management and interaction of the network, roles, and their responsibilities
<b>Density of trust</b>	<ul style="list-style-type: none"> <li>- The commitment of internal network actors' interactions</li> <li>- Collaborating activities between actors</li> <li>- Trust and reciprocation of trust among network members across the network</li> </ul>
<b>Number of network participants</b>	<ul style="list-style-type: none"> <li>- Number of organisations participating as members of the network</li> <li>- The geographical location of the actors and their effect on network activity participation</li> </ul>
<b>Network goal consensus</b>	<ul style="list-style-type: none"> <li>- Agreement of actors on the network-level goals</li> <li>- Occurrence of conflicts</li> </ul>

<b>Key structural and relational contingencies</b>	<b>Indicators</b>
	- Conflict resolution mediator(s)
<b>Network-level competencies</b>	- Interdependency of network-task requirements - Skills and competencies of each network actor

The analysis of the indicators of these network aspects helps identify the network governance form of the health promotion policy implementation for the elderly of the case study networks. The possible forms of network governance that can be identified from the analysis are 1) shared governance; 2) lead organisation-governed; 3) network administrative organisation governance. The analysis of the network governance form can be used to predict the likelihood of network effectiveness and policy outcomes.

*Table 8: Key Predictors of Effectiveness of Network Governance Forms*

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*Source: Provan, K., & Kenis, P. (2007); Modes of Network Governance: Structure Management, and Effectiveness.*

## 2) Governance network characteristics analysis

This analysis based on relationships and network-level characteristics of the network.

Characteristics variables in the analysis were selected from network variable taxonomy by Koliba, Meek, and Zia (2011), see Table 6.

## 3) Identification of influential characteristics or factors affecting policy implementation by actors as individual organisations

Statistics are used as a tool to draw a conclusion in research and can also provide a summary of data for further analysis (Kothari, 2004). Descriptive statistics are used to determine the degree of perception of influential factors and other variables. SPSS was used with quantitative data to generate descriptive analysis. A commercial software programme NVivo was used to assist in the qualitative data analysis process such as information for the analyses of the form of network governance structure and network's characteristics and relationship. The analysis by NVivo enables the researcher to thematically code (Weiss, Hamann, Kinney, & Marsh, 2012), identify patterns of ideas and concepts (Bazely, 2007) and contrasts situations where the data demonstrates variations (Wyborn, 2015). The analysis strategies for these purposes using NVivo are the thematic analysis and constant comparative method. These analysis methods will be explained in the following sections.

Data from both case studies were not analysed separately for several reasons. The first reason applies to both qualitative and quantitative data analysis. It is because the study is based on the factor that the same national policies direct all the networks of this policy implementation. All the networks have the same core actors as directed and are provided with the same systems of funding and administrative structures. The purpose of the study is not to compare the funding and administrative structures that have been similarly established by national policies for the networks. Rather, it studied the management characteristics and relationships that the policies cannot control or pre-determine as they vary depending on each network's interaction dynamics. The second reason why data analysis between the two case studies is not separated is that quantitative survey data included the data from individuals who belong to the regional-level organisations that are actors in the networks of both case studies, separating the analysis by case study would duplicate the responses from these individuals. Third, the availability and capacity of participants who completed the survey between the two case studies are different based on their sub-district information. While the survey helped provide descriptive numerical data, this study relied on qualitative data in providing in-depth explanation and capturing emerging different findings between the two cases. Therefore, the survey data from the two case studies were analysed as the same set of data.

Yin (2014) suggested that, for case study analysis, the best preparation is to have a general analysis strategy as a guide to link the data with what the researcher wants to find out. The analysis can be a combination of analytical techniques the researcher develops (Yin, 2014). In this study, I employed two data analysis approaches; thematic analysis and the constant comparative method.

#### 5.5.1 Thematic Analysis (TA)

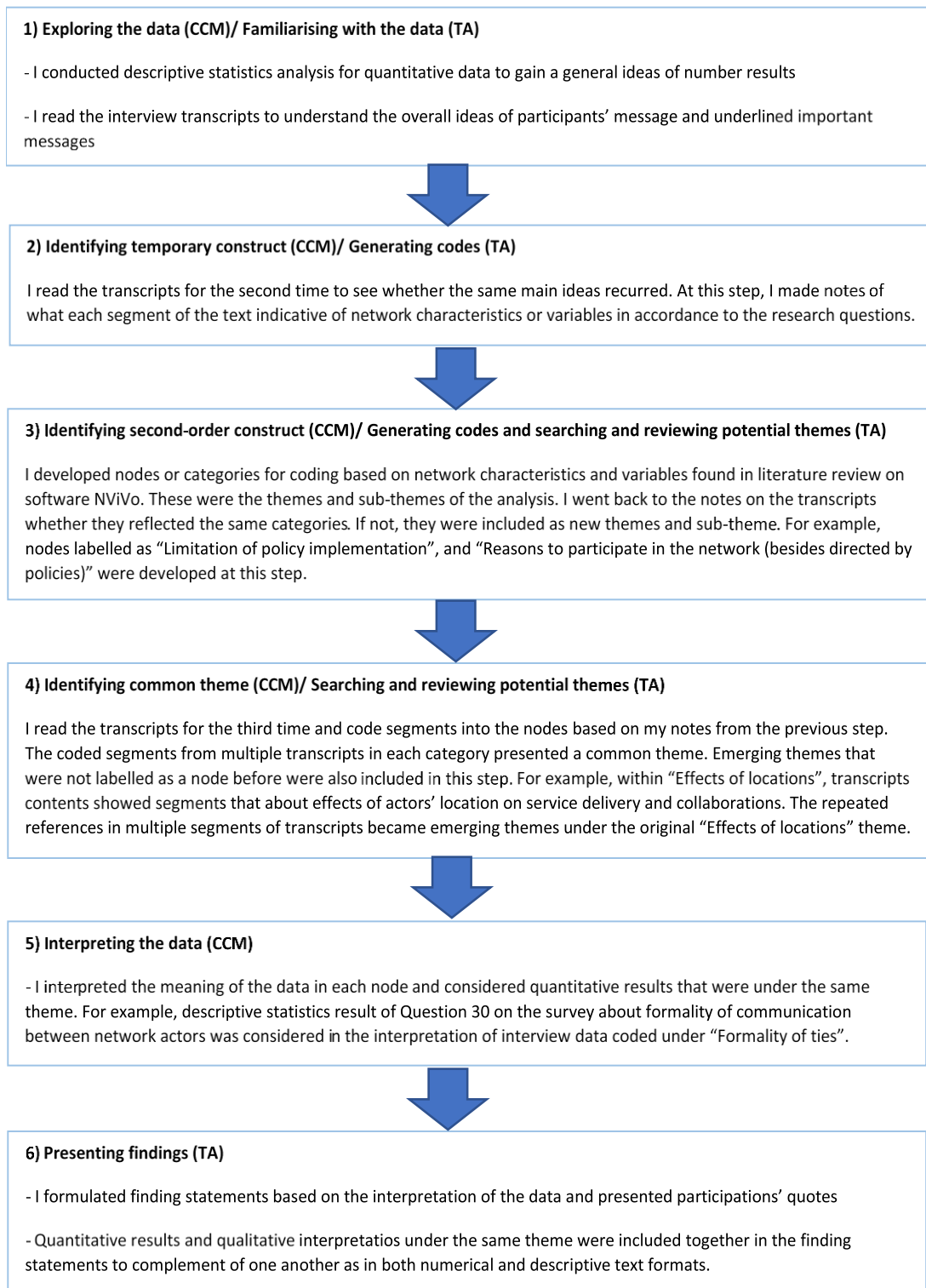
Thematic analysis was applied as an overarching approach for both qualitative and quantitative data as it is suitable for multi-methods study due to its ability to provide flexibility (Braun & Clarke, 2012). The quantitative data was analysed first and used to inform or supplement qualitative data. This data analysis approach was based on the application of thematic analysis on mixed-methods data conducted in sequence referred to as exploratory sequential in which quantitative data was used to inform qualitative inquiry (Guest, MacQueen, & Namey, 2012). The TA enables researchers to generate codes based on research questions and theories being applied. It also allows additional codes or emerging themes to be developed simultaneously. Both inductive and reductive thematic analyses were used based on the research questions and knowledge provided by existing literature on networks. The analysis of the form of network governance was inductive or theory-driven, based on the key network structural and relational contingencies of the three network governance forms conceptualised in network governance theory. The analysis of network ties is an exploration based on the relationship variables identified in network literature as a guide. However, the network ties variables were from existing network literature, the extent of each variable was open-ended, therefore deductive or data-driven interpreted freely by the researcher. The identification of the most influential network characteristics or factors and their effects on network actors implementation of the policy is deductive using the inputs from the identification of network governance forms and explanation of network ties variables.

#### 5.5.2 Constant Comparative Method (CCM)

The constant comparative method was employed in the analysis of interview transcripts. This method is to identify patterns in data by “comparing one segment of data with another to determine similarities and differences” (Merriam & Tisdell, 2016, p. 32). As I would like to explore the network characteristics and variables, this method would allow me to describe their extent and capture the main ideas of the content of the data. Thomas (2013) suggested steps in undertaking CCM are 1) exploring the data; 2) identifying temporary constructs; 3) identifying second-order construct; 4) identifying common themes and; 5) mapping and interpreting the data.

### 5.5.3 Combining TA and CCM

The application of both approaches was beneficial to my analysis. TA guided me based on the research questions and the theories behind, it also helped as a caution to focus on the essential elements research questions seek as answers. CCM enabled me to see patterns of the data by reading and re-reading while comparing the content in the transcripts and assured that they reflect a story even after interpretation. Many of the steps from thematic analysis and constant comparative method overlap. My application of both approaches is in Figure 11 where CCM indicates steps from constant comparative method and TA means steps from thematic analysis approach.

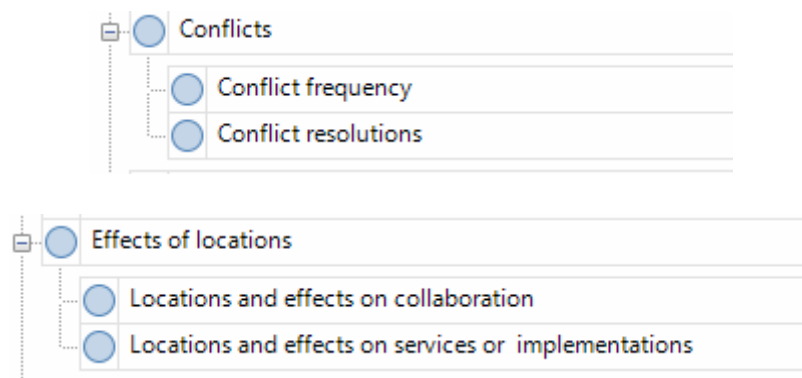


*Figure 11: Application of TA and CCM as Analysis Strategy  
Note: Adapted from Braun and Clarke (2012) and Thomas (2009).*



### 5.5.3 Generating Codes and Themes

Gläser, J., & Laudel (2013) mentioned that coding is a useful step in qualitative research before interpretation. Following the combination of TA and CCM as an analysis strategy, I used the In-vivo coding approach to code interview transcripts. In-vivo is a coding strategy that maintains the language of the interview participants (Leavy, 2017). Phrases, words, or sentences are coded based on research questions or what the research wants to learn from the data (Leavy, 2017). At phase two of this research, tags and labels for coding were developed following the variables of network characteristics and ties as theory-driven coding. They were assigned as parent nodes on NVivo for the first layer coding, started after the transcription of the interviews. As coding contributed to the analysis process to conceptualise the data collected (Clarke & Braun, 2013), second layer coding was conducted simultaneously to capture emerging themes under each parent node under the first layer. The emerging themes were coded as sub-nodes. Using the In-vivo approach, phrases and sentences from the transcripts were coded into nodes. This approach also helped in assuring consistency of coding as I could concurrently check for patterns or keywords from the data whether they represented the same essence within the themes on NVivo. Figure 12 shows the first layer coding of two parent nodes and the second layer of coding of emerging themes as sub-nodes.



*Figure 12: First Layer of Coding of Parent Nodes and Emerging Themes as Sub-nodes*

Conflicts and effects of locations were pre-coded as the parent nodes. Conflict frequency and Conflict resolutions, and Effects of location on collaboration and services or implementations are the emerging themes coded as sub-nodes as interview participants mentioned in the transcripts. For some variables, a third layer theme emerged as shown in Figure 13.

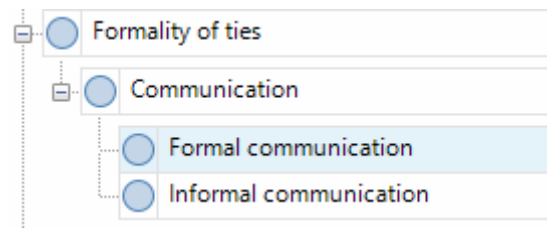


Figure 13: Emerging Themes under the Second Layer Sub-node

Formal and informal communication emerged in the third layer of coding. Only three layers or two levels of sub-nodes were generated in the coding process. As it was not the aim of this study to compare the two case studies and as the structure of both case studies have been similarly developed by the national policy, they were coded on the same platform.

Figure 14 presents the overall design of the theoretical framework and methodologies that set the frame for the research methods.

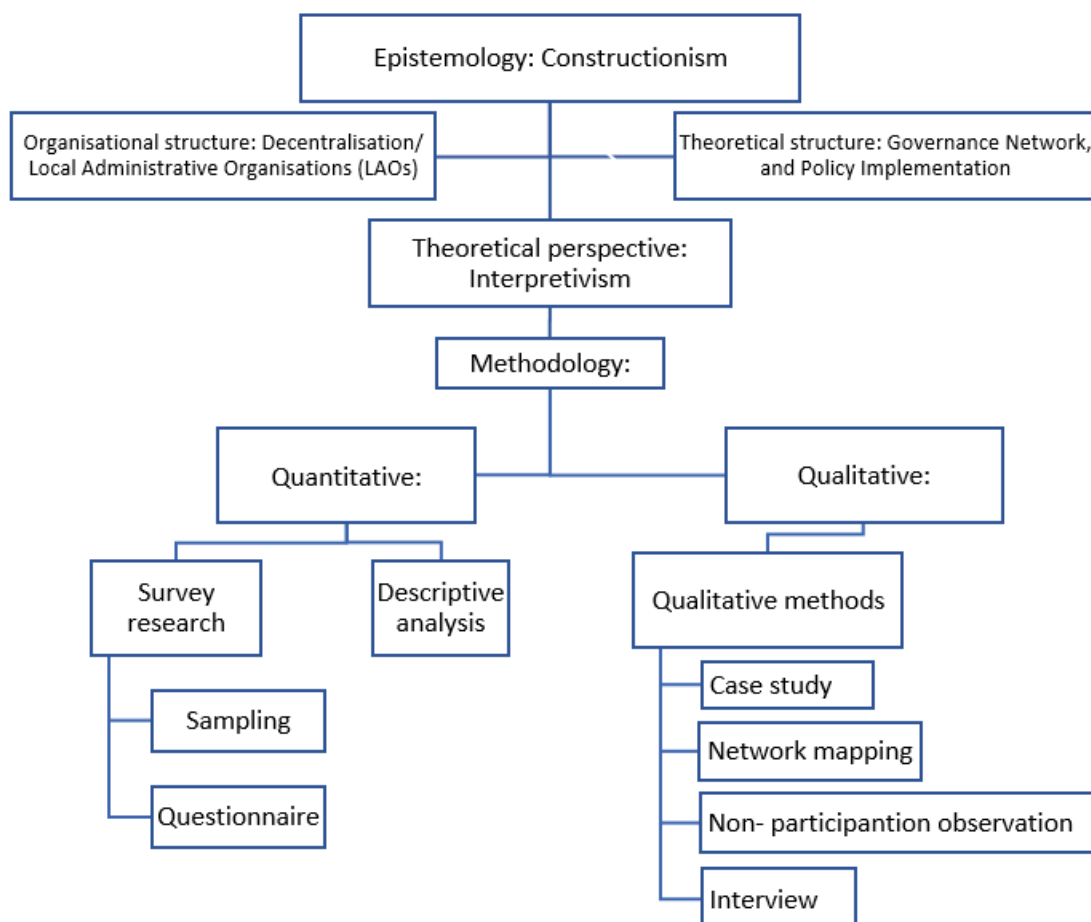


Figure 14: Research Methodology Integrated with the Theoretical Framework

## 5.6 Presenting the Findings

Findings are presented in three chapters, Six, Seven, and Eight, emphasising the issues set out in the research questions – the form of network governance, characteristics of ties and relationships of network actors, and influential network characteristics or factors affecting the policy implementation. Discussions of findings are included in the conclusion of each finding chapter. This is because each of the first three finding chapters is built on the one(s) prior. The arguments explained in a previous chapter are the foundation of explanation in the later chapters. Evans, Gruba, & Zobel (2014) suggested that not having a separate discussion chapter in a thesis is not uncommon, and it can be included as a section. This style of presentation combines the descriptiveness of the finding results and the interpretativeness of the discussion (Swales, & Feak, 2012). Chapter nine is an integrated summary. This final chapter also presents conclusions; what this research means for practice and how it can contribute to improving health promotion policy implementation and better achieving policy goals in the future.

## 5.7 Quality Assurance

These measures were taken to ensure the quality of the data:

1. The initial data collection tools were developed in English for ethics approval and were translated into Thai.
2. The data collected in Thai was translated to English by the researcher. The interview transcripts were translated from Thai to English by the researcher within 48 hours of the interview to ensure the richness and inclusiveness of the context at the time of data collection was captured.
3. Following phase one, national policy-level interviews, an analysis was conducted to identify the key provincial and local actors to be surveyed and interviewed and to help the research understand the framework of the local policy implementation.
4. Following the questionnaire surveys at the local level, an immediate analysis was undertaken to identify any emerging characteristics of information that should be included in the following in-depth interviews.

Credibility assures data collection and interpretation quality (Yin, 2015). Four focuses of credibility are trustworthiness, triangulation, validity, and rival thinking (Yin, 2015). Trustworthiness focuses on the explicit and methodically reporting of data collection approach including sampling process, site

selection, and the authenticity of the data source (Yin, 2015). The information ensuring the trustworthiness in this thesis was highlighted in the Data Collection section. Authenticity of the data source, namely the study participants about whether they were accurate representations, was assured by the purposive sampling based on the relevance of their roles to the topics being explored.

The data collection and interpretation in this research are based on the triangulation approach to assure the credibility of my findings. Triangulation is a sub choice of credibility assurance in qualitative research (Yin, 2015). Triangulation can be applied throughout the research among data sources, investigators, theory, or methods (Patton, 2002). My thesis employed the data sources and methods triangulation to ensure the quality of the qualitative data and interpretation. The thematic analysis of this study is drawn from triangulated data sources of voices of interview participants, their survey responses, and documents such as national policies, plans and reports. The triangulated data collection are interviews, survey questionnaires, and non-participant observation. Data from different sources and collection methods complemented each other in terms of providing the assuring alignment for interpretation.

Validity in qualitative research is indicative when the research presents proper data interpretation that reflects the real world of the subject being studied (Yin, 2015). The interpretation depends on researchers' understanding of the context-specific observation (Ellis, 2004). My understanding was developed from the theoretical framework. The data collection tools such as interview questions and survey questionnaires were based on the knowledge in existing literature regarding networks and policy implementation. A checklist for crucial aspects of actors' interactions based on this knowledge was also developed for non-participant observations.

Rival thinking was engaged throughout the research. The research questions are based on the assumption that the collaboration of groups of organisations within the case studies operate as a network as they have been formed and labelled as by the national policies. However, in practice, this cannot be confirmed until the analysis of the data is completed based on the application of the network theory. A possibility that these groups of organisations may not be claimed as a network in practice was kept open throughout the data collection process and analysis.

## 5.8 Ethics

The confidentiality of information from the interviews and the questionnaires was maintained throughout the research process. The consent form was reviewed and signed by interview

participants (see Appendix F). Brief background information about the research and their expected role was explained to all participants. For interview participants, the information was given verbally and in writing (see Appendix E). For the questionnaire and non-participant observations, the information sheet was given to participants in writing (see also Appendix E). Victoria University of Wellington's Human Ethics Committee (HEC) approval for the data collection was gained on 7 September 2017 (Approval Number 0000025130, see also Appendix B). The HEC approval also served as the basis for the request to collect data as required by public organisations in Thailand. Pictures taken during non-participant observations were approved verbally by the meeting participants prior to the meeting.

Confidentiality of interview participants whose quotes were presented in the findings were maintained by only stating their organisation governance level and indication of case studies.

## 5.9 Reflections on Methodology and Methods

Establishing the epistemology ground of this research as constructionism and the central theoretical perspective for the study as interpretivism was very helpful in designing the research methods, data collection planning, and managing data analysis. Timeline planning for the data collection in two phases worked very well. Although Phase One took two months to finalise while it involved only four interview participants, I was able to use the time in between to conduct a pilot data collection for Phase Two. The pilot helped me understand the network structure better and clarified the roles of local actors and staff involved at each network actor organisation. The feedback from participants in the pilot also helped in simplifying the language used in the final questionnaire surveys in the two case studies. The three-month period for Phase Two allowed me to conduct survey data entry and interview transcriptions simultaneously. This approach of simultaneous data collection, data entry, and interview transcription enabled me to understand the data better and the time frame allowed me to go back to the participants again if I had further questions. Most of the interview participants showed a great level of understanding of their roles, national policies, and the elderly population in their area. This was very advantageous for me as I gained the in-depth information for my research questions and the breadth of knowledge of the policy implementation and the local context. This advantage was important for inclusive data analysis and synthesis.

There were challenges in the data collection process. First, interview participants are not only involved in the health promotion policy for the elderly but many other policies that include all groups of the population. This allowed them limited time to participate in all data collection

activities. Some were able to only complete the interview and survey but not the network mapping table. However, the crucial information of identifying network actors and the frequency of contact were obtained from the interviews. The information was also supported by their full interviews which covered the information not available from network mapping. Second, the capacity of case study participants in delivering surveys was different. However, interviews with their representatives such as their supervisors or managers complemented the richness of data in addition to their survey. This difference in capacity was also included as an input for network characteristics analysis.



## Chapter 6: Governance of the Networks

This chapter addresses the first research question about the health promotion policy implementation for the elderly networks' characteristics. The characteristics included the form of network governance and functions. In the literature review section, three types of network governance form were introduced: 1) a shared governance network where all participants have an equal role and authority in network governance; 2) a lead organisation-governed network, with one member taking the role as the leader; and 3) a network governed by an organisation that is not a member or is an external organisation designated to govern the members. The governing organisation in the third case is called a unique network administrative organisation or NAO. This section first looks at the form of network governance of health promotion policy implementation for the elderly at the local level in Thailand. Elements and contingencies of networks and governance networks theories are used to explain what form of governance the case study networks operate within, what implications this has for policy implementation, and what could be predicted as the policy implementation outcome. As mentioned in the Literature Review chapter, these elements are characteristics of networks that emerge from actors' relationships and interactions such as network ties, leadership within the network, and power between network members. Furthermore, the key network structural and relational contingencies used are network participants, network centrality, density of trust, network goal consensus, and network level competencies. These are what Provan & Kenis (2008) refer to as "key predictors of effectiveness of network governance forms" (p. 237).

Diagrams are used to present characteristics and interactions of network actors found in the case studies in this chapter.

### 6.1 Number of Network Participants and Their Locations

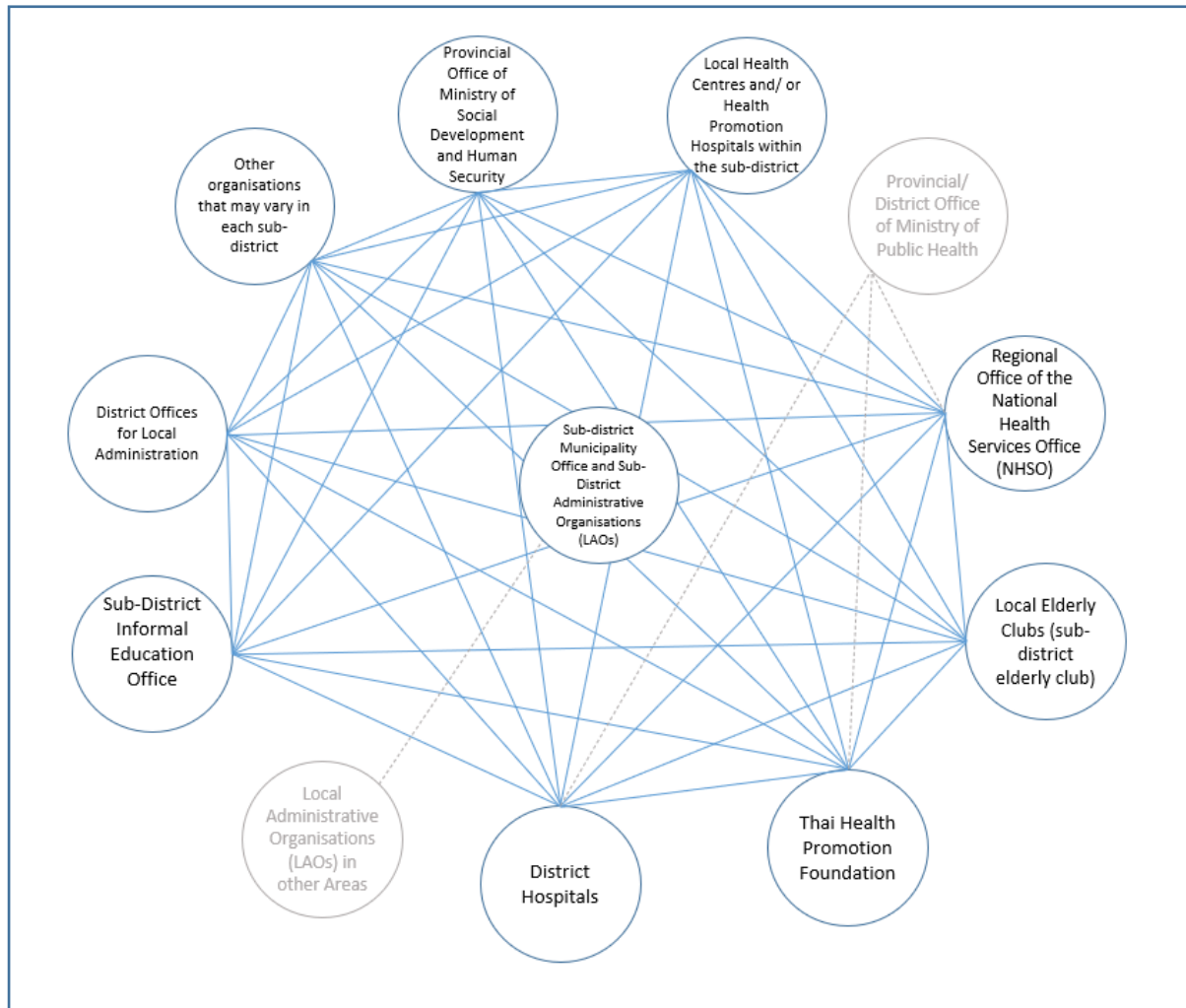
The number of network participants or network actors and their geographical location can play a role in predicting the likelihood of policy outcome (Provan & Kenis, 2008), especially when the form of network governance is determined by its characteristics. The following sections show findings on who the network members in the case studies are, their locations, and how these variables affect policy implementation.



### 6.1.1 Number of Network Participants

The number of network participants affects its form of governance (Provan & Kenis, 2008). For example, in a network with a large number of participants, shared governance might not be suitable. This is because having many actors with equal authority within a network may make it difficult for the whole network to control the direction of its actions and decision-making. Moreover, with a large number of network participants, actors may spend more time and effort in an attempt to coordinate than taking action on addressing the actual network issues or goals (Provan & Kenis, 2008).

Ten organisations were shown as core actors or nodes in the network diagram (Figure 10, p. 98) as part of the study's conceptual framework. These core actors are LAOs, sub-organisations of ministries mentioned in national policies and plans, and the local elderly clubs (Table 3, p. 38). However, it was expected that these potential network members might be different in each sub-district, due to the authority and flexibility of LAOs' operation in their own area. This proved to be the case. From the original core network actors listed from the national policies in Figure 10 (p. 98), Provincial and/ or District Office of Ministry of Public Health and LAOs in other areas were removed as they are not active and are therefore not determined to be core network actors by the local network actors in practice. They were replaced by District Offices for Local Administration and Sub-district Informal Education Office. Core network actors in practice of networks in the case studies are shown in the following figure.



*Figure 15: Core Network Actors Mapped from the Case Studies*

*Note: Adapted from Figure 10 (p. 98), inactive actors (grey nodes) in the local networks are removed from case studies.*

Interview participants from the LAOs and other organisations within the network all said that they seldom directly interact with the Provincial or District Public Health Office, the first organisation that was removed from the original lists of core actors. Most of their interactions, if they take place, are related to regulations consultation, internal supervision with their sub-organisations, performance measurement, and other management procedures that are centralised by the Ministry of Public Health. Thus, these two government organisations were excluded from networks in the case studies. Also, LAOs are not core actors of the networks outside their own sub-district. Interactions among LAOs in other areas regarding health promotion for the elderly are limited to informally consulting or discussing issues with each other. As interactions among LAOs in different areas mainly involve exchanging and sharing information, they have a predominant characteristic of a dyad, not a network (Provan & Kenis, 2008) and this research does not focus particularly on these interactions.

During Phase One of the data collection, I was introduced to the recent Thailand 20-Year National Strategy (2017-2036). A participant at the national policy level told me that there had been an integrated national strategy to prepare for the aged society Thailand is entering. The strategy was developed and signed as the Memorandum of Understanding (MOU) of Integration of Collaboration in Life-long Human Capital Development (Childhood and Elderly Age Groups) between four ministries in 2017, the Ministry of Social Development and Human Security, Ministry of Interior, Ministry of Public Health, and the Ministry of Education. The framework of the strategy aims to develop three aspects for the elderly, which are: 1) Social Participation; 2) Social Security and; 3) Strong Health. Specific responsibilities related to the elderly health promotion for each ministry and their sub-organisations are:

#### Ministry of Social Development and Human Security

- Support pilot areas in the integrated development of quality of life of the elderly
- Be role models for practice learning of the Center for the Quality of Life Development and Occupational Promotion for Older Persons
- Support organisations in public, private, and civil sectors to take important roles in driving the work for the elderly quality of life and occupational development
- Support the expansion of the elderly school to cover all areas where the Center for the Quality of Life Development and Occupational Promotion for Older Persons is located
- Develop elderly care systems in the community by focusing on community participation

#### Ministry of Interior

- Support and assist in building stability and security of families
- Support and develop aged-friendly communities/ cities
- Support and encourage wage guarantee
- Support and assist LAOs to establish the elderly service centre, an elderly school and the Center for the Quality of Life Development and Occupational Promotion for Older Persons within the LAOs' area

#### Ministry of Education

- Support and assist the quality of life development activities to keep the elderly socially engaged in the community in a variety of curriculums and forms

- Train elderly caregivers and family volunteers in collaboration with the Ministry of Public Health to care for the elderly who are dependent on the family and the community so that their family members who are of working age can continue to work
- Support building family relationships and activities that strengthen family relationships

#### Ministry of Public Health

- Encourage healthy behaviours
- Develop elderly health service systems and establish quality elderly clinics in hospitals with more than 120 beds
- Develop the Long-Term Care system for the elderly in the community and individual care plans
- Develop the capacity of human resources whose work is related to elderly care
- Support and develop elderly groups and elderly clubs, health promotion temples, and other religion centres

Regional organisations of the mentioned ministries were also core actors in both case studies. During Phase Two of data collection, interview participants mentioned the involvement of the Ministry of Education through its sub-organisation of the district and sub-district Informal Education Office. These organisations have helped the LAOs with the development of the curriculum for the elderly school, sharing knowledge and information, helping find trainers or instructors suitable for the elderly classes, and other activities. The collaboration between the Informal Education Office and other actors within the health promotion for the elderly network existed long before the recent announcement of the integrated strategies of the four ministries. I added the sub-district Informal Education Office as a member of the health promotion for the elderly policy implementation at the local level as a result. The second organisation that was added was the District Offices for Local Administration, as they work closely with the LAOs in supervising, aligning the LAO's work with the Ministry of Interior and ensuring alignment of performance by monitoring and evaluating their operations, providing support, and giving advice. The District Offices for Local Administration also participate in local activities organised by the LAOs within the district and sometimes help mediate conflicts. In summary, for the number of network participants, Donkaew has 11 members, and Namprae has 10 in total. Please see Appendix A7 and A8 for lists of names of network members in each case study networks, their type of organisation, and their level of governance.

According to Provan and Kenis (2008), a network that has more than six participants or members might face a challenge if the governance of the network is shared equally among them. The number of core network members in the two case studies are not significantly different. I found that the location of the sub-district, its geographic characteristics, and infrastructure such as roads were factors contributing to service delivery. Other factors may also be more influential to both service delivery and network collaboration.

### 6.1.2 Location of Network Members' Organisations

Another factor in determining a suitable form of the network governance and the number of network actors is the location of their organisations and whether they are clustered or spread out geographically (Provan & Kenis, 2008). Donkaew Sub-district has the advantage of having many government organisations located within or close to their area. These organisations include members that are mutually shared with Namprae and the mutual regional-level network actors such as the Chiang Mai Provincial Social Development and Human Security Office and the NHSO Regional Office that are located closer to Donkaew Sub-district. Moreover, the geographic characteristics of the two sub-district case studies are different as Namprae has more areas at the foot of a mountain. Namprae Sub-district is located far from other regional-level government organisations. Its district hospital, Hangdong Hospital, is about six kilometres away from the sub-district, whereas Donkaew Sub-district is less than one kilometre away from its district's Nakhonping Hospital. Interview participants from organisation network members in Donkaew area acknowledged this advantage.

The interview participants were asked whether the location of network members and the convenience of travelling between organisations have an impact on the collaboration of their network. The effects of location of network members can be categorised as affecting service delivery or policy implementation and coordination or interaction between network members.

#### 6.1.2.1 Effects of Location on Service Delivery and Implementation

The target population of the whole network is the elderly in the sub-district. Location of the organisation within the network unavoidably has effects on service delivery and implementation from the network member to the target population. The effects are magnified, especially when the network member co-delivering services are not at the local level because they are located further away from the target population as the following quotes illustrate.

*"Location is a big factor. Suppose we have to send a document or have an old person [who needs help] to see us, if they live in Maejam, Mae-aye, or somewhere far away, it could take them three hours. Some of the districts in Chiang Mai are farther away from*

*us than a nearby province. ...When people in those districts have to come to see us, it is really difficult for them. ...Mostly if they have social issues, their LAO or their LAO's network may take them to see us here. But if they need to come to see us for a personal issue, such as they need to take out a loan, to set up work, or start a business, they have to come on their own to see us for assistance by making that three or four-hour journey. A return trip would take all day.” (A regional officer/ Chiang Mai Province).*

One of the interview participants highlighted Namprae Sub-district's obstacles. She said that they affect how the target population can access services and participate in policy implementation.

*“Scattered location of organisations within the sub-district is a big obstacle. In Namprae, our road system is not simple. The old people who want to participate in the activities have to rely on their family or relatives. Namprae is a big sub-district. Houses are scattered as well with four-lane roads. On top of that, there is another main road, making it even more difficult. Old people find it challenging just to come to the activity venue. Those who come, live around the Municipality Office. There are two villages that can travel there the easiest. The old people in the other nine villages want to come too. Every time we visit their village, we hear about how difficult it is for them to travel. They do not want to go to the venue by themselves because there are often road accidents. ...If their relatives are not available, they cannot come. I feel bad for them, but I do not know what to do. (A staff member from a sub-district government level organisation/ Namprae).*

Both case study areas have multiple-lane roads and the sub-district residential areas are divided by the roads, making it hard for the old people to travel to activity venues or visit network organisations within the area. Only Donkaew LAO provides a pick-up and drop-off service for them. This service in Donkaew could be the result of the availability of budget as Donkaew LAO's income was higher than Namprae LAO's according to their budget reports published on their websites (Donkaew Sub-district Administrative Organisation, 2018; Nampraepattana Municipality Office, 2018).

#### *6.1.2.2 Effects of Locations on Network Coordination and Interaction*

Interview participants had different opinions on the effects of location on coordination or interactions amongst network members. An interview participant said that despite distant locations of some network members and inconvenient travel, they are not an obstacle to network collaboration.

*“For coordination, sending documents or things like that – there is no problem. Now we have emails, fax, and such. It is easier. If we have to go somewhere in Chiang Mai, we can just go. No travel issue in coordination or interaction. We also have LINE [a mobile phone instant messaging application] now, making it easy to send information or files. Sometimes we do not even have to see each other. When information is requested, it can be sent through LINE, that is it.” (A regional officer/ Chiang Mai Province).*

Technology plays a very helpful role in their coordination and communication when they work in collaboration with one another. In addition to the previous participant, a sub-district LAO staff in Donkaew and a sub-district Health Promotion Hospital staff in Namprae expressed similar views.

Interview participants also mentioned that besides communication technology, relationships among network members also play a part in connecting organisations within the network despite their locations.

*“We are fortunate that most of the network members are located close by to our sub-district. We can also fax documents or work with each other using the internet. That saves us from having to be physically there.” (A sub-district LAO staff/ Donkaew)*

*“Organisations within the sub-district are not very far apart. Coordination nowadays is also easy. It is just picking up the phone because we mostly know each other. Like we know the director of the [sub-district] school and the director of the Health Promotion Hospital. Sometimes they call us in and we just go see them. We also have numbers of others within the central province area and we know them. We can just call them to coordinate informally first. For the Chiang Mai Provincial Social Development and Human Security Office, we normally have to send a formal letter, we would call first too, and then we take the letter in later. It is manageable unless they are in the mountain, that will be a bit difficult.” (A sub-district LAO staff/ Namprae)*

However, other interview participants disagreed. Location is still a challenging factor for them despite the availability and helpfulness of communication technology for relationship building between network members. Like location and service delivery and policy implementation, interview participants who said location is a big challenge for them in coordinating with other network members and their work are mostly those working for an organisation not located within the sub-district.

*"Location is a challenge. I am responsible for 11 sub-districts. I have to take my own car. Sometimes, as a woman going to the field on my own could be unsafe. I have to find someone to accompany me. Sometimes I cannot even drive there because I do not know where the place I have to go to is. I do not know who is where. I have to work with people in the area. Someone influential in the area would be a key contact, and then I take it from there. Communication technology is helpful for building relationships, but I still have to visit the place in person. Travelling is still a challenge." (A district hospital staff/ Donkaew)*

*"Locations highly affect collaboration. In Chiang Mai alone, we have so many rural areas. Our office is responsible for eight northern provinces, some are on the mountain, very far, a small number of population and geographically dispersed. Throughout the eight provinces, there are over five million people. In some LAOs' areas, they are so far away that we have to travel all day, sometimes, we get there at nightfall, sometimes, we do not even get there yet at nightfall. ... Technology is tremendously helpful, but in many cases, we have to physically travel to the areas." (A regional officer/ Chiang Mai Province)*

Participants from network members who are regional-level organisations think the effects of locations on network collaborations, service delivery, and implementation are more challenging than their counterparts who are local-level organisations. This is due to the higher numbers of networks they are a part of. District government organisations such as district hospitals are responsible for all sub-district organisations within their territory. Provincial government organisations such as the regional office of a ministry and a provincial hospital are responsible for sub-districts in all districts within their province. Regional government organisations such as the Chiang Mai Regional Office of the NHSO are responsible for sub-districts in all districts of the eight provinces in the Northern region of Thailand.

For a network, the spread-out location of the members can disrupt collaborations, such as the inability to have frequent meetings (Provan & Kenis, 2008). In the case studies, while advancement and availability of technology have been mentioned as helpful for collaborations, geographical locations of network members still have a noticeable effect particularly for actors who belong to more than one network such as regional-level government organisations.

A participant who works for a regional-level organisation with multiple LAOs within one of the districts in the study indicated that whereas location may have an effect on service delivery for some LAOs, it is not a factor for some others. She mentioned that a few sub-districts that are located



farther away from the city centre than a case study area or considered as rural, perform better in delivering services. Their performance was measured by participation of the elderly, and number of activities in relation to health promotion for the elderly. This comment implied that the location of network members may affect service delivery, but the outcome or performance can vary in different sub-districts depending on other network factors.

## 6.2 Network Centrality of Governance

The number of actors leading the management and interaction of the network, roles, and their responsibilities indicates the degree of network centrality (Provan & Kenis, 2008). All the interview participants indicated that they believe the LAOs at the sub-district level together with the Health Promotion Hospital in their sub-district are the leaders of elderly health promotion. However, a different governance structure between the two case studies should be mentioned. Donkaew Sub-district Health Promotion Hospital is under the administration of the LAO, making them both belong under the decentralised structure of the Ministry of Interior. Namprae Sub-district Health Promotion Hospital is managed separately from the LAO and under the administration of the District Health Office (Hangdong District Health Office), Ministry of Public Health. This difference is shown in the following figures.

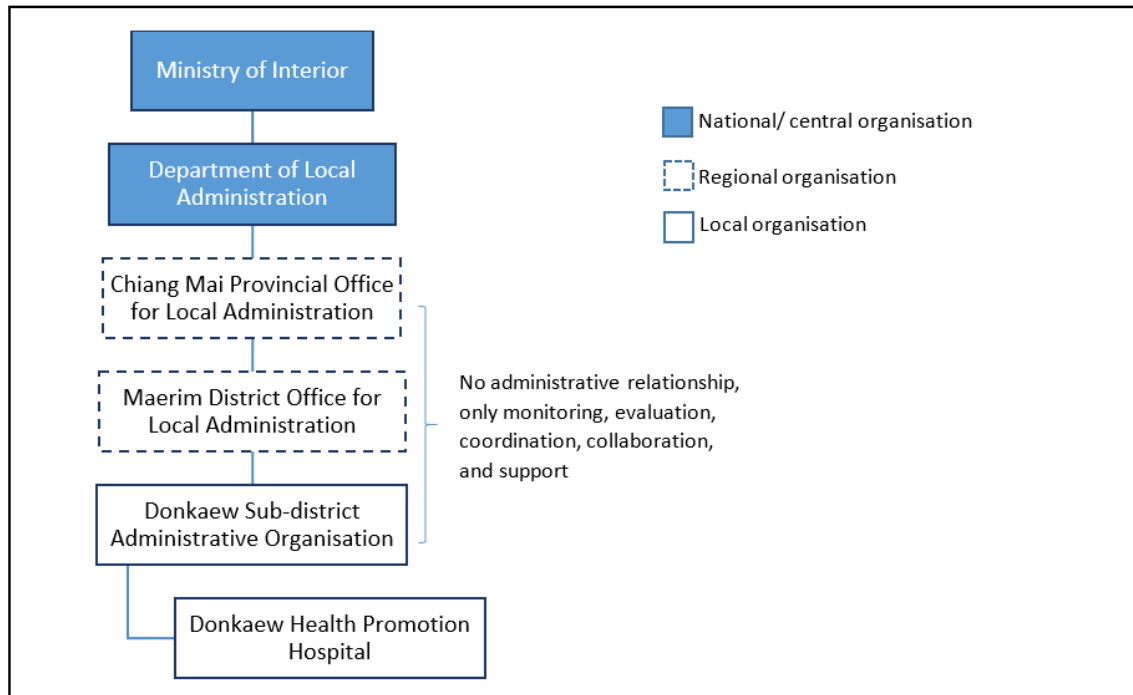


Figure 16: Donkaew Case Study: Sub-district LAOs, Health Promotion Hospital, and Administrative Parent Organisations

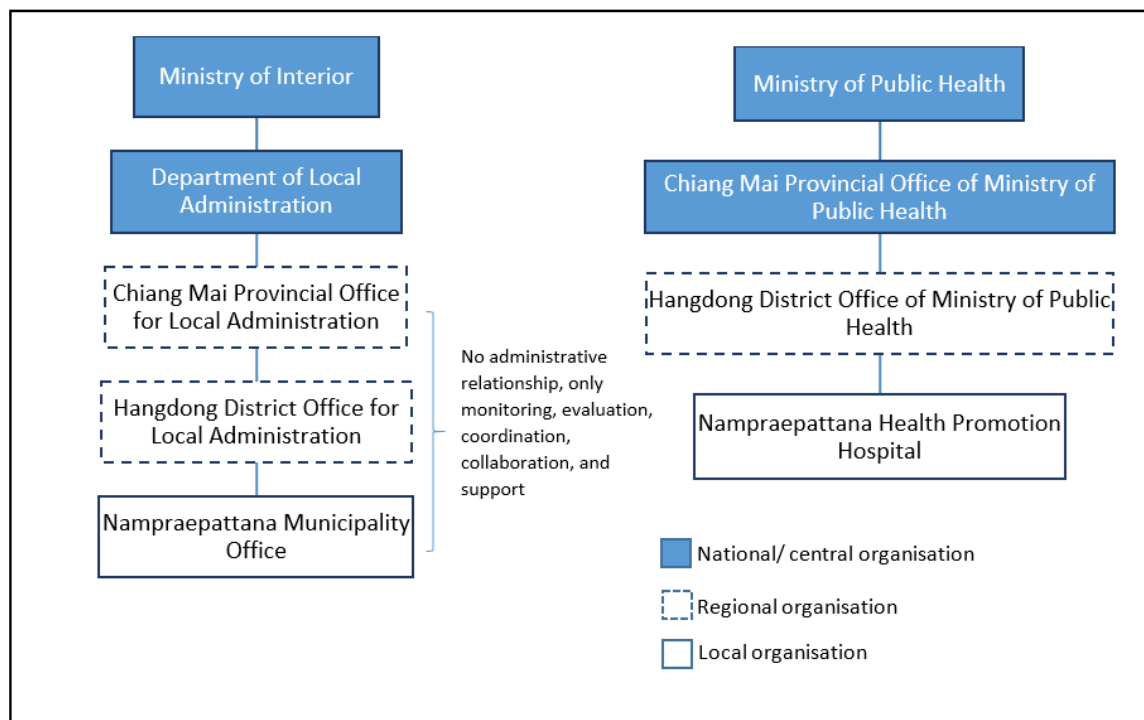


Figure 17: Namprae Case Study: Sub-district LAOs, Health Promotion Hospital, and Administrative Parent Organisations

In both sub-districts, “health promotion for the elderly” is included in the definition of the elderly population’s quality of life. Participants referred to elderly health promotion with an awareness that

it is a part of the quality of life development. Activities that are not directly related to health, such as occupational training or cultural activities are believed to indirectly affect older people's mental health and physical health. In both cases, the leadership of elderly health promotion implementation is shared between the LAO and the Health Promotion Hospital. Moreover, the LAOs and the sub-district Health Promotion Hospitals cannot achieve their organisational mission without one another.

In Donkaew Sub-district, the LAO has its own Health Division overseeing policies related to the health of the community members, although some of them overlap with the Social Welfare Division. Donkaew LAO's policies extend to cover the health promotion activities, and primary care treatments provided by the Sub-district Health Promotion Hospital. The community health volunteers registered with the Sub-district Health Promotion Hospital are also under the same management and health-related policy supervised by the LAO. The sub-district Health Promotion Hospital in Donkaew is perceived as another division within the LAO.

*"All policies are planned by Donkaew Sub-district Administrative Organisation. The Health Promotion Hospital plays a role as a division. For example, we have a goal of building a healthy sub-district. We focus on people by their age groups and vulnerabilities such as children 0-6 years old, pregnant women, etc. To achieve our goal, each division is distributed tasks in relation to their operational functions that cover one or more age groups– the Social Welfare Division, the Health Division, the Health Promotion Hospital, and the community." (A sub-district LAO staff/ Donkaew)*

Namprae LAO does not have its own Health Division but has an officer assigned to oversee work related to health and quality of life of all the people in the community. This officer may work directly with the people or together with staff at the sub-district Health Promotion Hospital. In Namprae Sub-district, the community health volunteers work directly with and are under the supervision of the Health Promotion Hospital staff. The sub-district LAO plays an important role supporting the Health Promotion Hospital in activities related to elderly health promotion that are not the hospital's day-to-day functions, such as diabetes and blood pressure screening, and cervical cancer screening. Such support includes assisting the Health Promotion Hospital in searching for and inviting speakers to come to educate or train the elderly on health promotion and prevention topics such as reducing risks of dementia or physical exercise.

In addition, in both sub-districts, the LAOs and the Health Promotion Hospitals work together in applying to the Sub-district Health Fund and the Long-term Care Fund for the elderly distributed by the NHSO. The purpose of the District Health Fund is to support activities related to health promotion, disease prevention, and primary care mainly implemented and provided by the Health

Promotion Hospitals throughout the country across all age groups. The purpose of the Long-term Care Fund directly addresses the elderly who are dependent and bed-ridden (NHSO, 2016). These funds can be distributed directly to Health Promotion Hospitals, the direct care providers. However, an interview participant whose responsibility is to manage the Long-term Care fund at the regional level mentioned that the national policy had been designed to involve the LAO so that they can also take part in caring for the health of the elderly in their community.

The sub-district LAOs in both areas work closely with their Health Promotion Hospitals. They also work directly with the elderly in the community through the sub-district Elderly Club. In Donkaew, a staff member in the sub-district LAO Health Division said that their elderly related policy comes from a bottom-up approach. They design a policy that responds to the needs of the elderly in their community. Voices from this group can be heard weekly at the Elderly School every Thursday.

The community health volunteers can also be a voice for the elderly who stay at home and those that are bed-ridden. Donkaew LAO also supports its sub-district Elderly Club by assisting them in writing grant proposals and contacting external organisations on their behalf.

Similarly, in Namprae, the Elderly Club President mentioned that the LAO's policy and projects related to the elderly health promotion and activities come from the voice of the elderly in the community. Through regular meetings between the members of sub-district Elderly Club and representatives of the elderly in each village within the sub-district, their needs and activities they are interested in are brought up to the LAO. Then, they get assistance with referrals, drafting grant proposals, or providing services or equipment they need for their activities from the LAO office.

In all the interviews, participants said they think the sub-district LAO is the centre of policy implementation in relation to the health promotion for the elderly. A minority of the interview participants said both the sub-district LAOs and the Health Promotion Hospitals are co-leaders in different related roles – the former provides direction and the latter provides health-specific services or services that require medical expertise and knowledge.

Overall, in the two case studies, the sub-district LAOs share similarities in key roles and responsibilities related to health promotion for the elderly, which are:

- 1) Designing local policy based on the needs and interests of the elderly in the community;
- 2) Assisting the elderly club in their sub-district in writing grant proposals;
- 3) Collaborating with other organisations to address the needs and interests of the elderly in their community, especially where they do not have expertise or resources

- 4) Acting as a point of contact and grant receivers for the Sub-district Health Fund and the Long-term Care Fund (Namprae Sub-district is not yet a participant in the national Long-term Care Fund) from the NHSO
- 5) Supporting the Health Promotion Hospital and the local Elderly Club in their operational functions
- 6) Coordinating with other organisation outside their sub-district for the Health Promotion Hospital, the Elderly Club, and the elderly population in their area.

The Sub-district Council and Sub-district Administrative Organisation Act suggested that the Sub-district Council and sub-district LAOs should provide health promotion and healthcare services supporting the local population (Pittayarangsan et al., 2010). Thus, they have been tacitly given the status as a central node in health promotion for the elderly in the network. However, the LAOs, especially at the sub-district level, do not have all the resources required to achieve the goal of promoting the health of the elderly holistically. They have to work with other organisations to acquire the resources needed to provide services and respond to the needs of the target population in their area. On the other hand, other organisations within the networks also have to achieve their individual missions in relation to health promotion of the elderly, and they would not be able to do so without interacting with the sub-district LAO and exchanging resources.

Thus, it can be said that in terms of interactions, the implementation of health promotion for the elderly in both case studies is centrally governed because the coordination mostly comes through and from the sub-district LAOs. However, at the network level, the LAOs do not have the governance authority over other actors within the network, with the exception of the Health Promotion Hospital that is under their administration like in Donkaew.

### 6.3 Density of Trust

Density in networks is the overall level of connectedness between network members developed from their ties that evolve over time (Provan et al, 2007). Density of connections is indicative of density of trust (Provan & Kenis, 2008). Density of trust means members in the network trust one another or they show reciprocation of trust. Reciprocation and distribution of trust are also necessary for understanding network interactions. Trust is also a part of network development (Provan et al., 2007). In regard to forms of network governance structure, trust among network members at the network level can be determined from reciprocation of trust among members based on each other's capacity, their commitment of interactions, and collaborating activities to achieve

what the network is committed to do (Provan & Kenis, 2008). Findings in these aspects are in the following sections.

### 6.3.1 Reciprocation of Trust among Network Members

Questions that explore the extent and density of trust in the network were included in the interviews. Interview participants were asked whether they believe in other organisations' capacity to implement activities and provide health promotion services for the elderly in the sub-district and why. They were also asked about activities that they do together and the level of commitment from other organisations within the network such as for meetings and activities organised both by their own organisations and others.

In the surveys, participants were asked whether they trust in the capacity of other organisations within the network to implement the health promotion policy for the elderly (Q23). Among the survey participants, 67% said they trust in the capacity of *all* members within the network, 18% trust *only some*, and 5% only trust in the capacity of *their own organisation*. This indicates that participants trust in the capacity of at least one organisation within the network and most of them trust in the capacity of all network members.

Interview participants' responses on trust in other's capacity can be divided into two categories. One group only mentioned the capacity of the organisations within the network, while the other also mentioned the capacity of the elderly population as a factor of the policy implementation. When asked about trust in other organisations' capacity, interview participants said that they trust them. Their trust is mainly based on other organisations' missions, official responsibilities mandated by national policies and acts, specializations, and specific knowledge and expertise that human resources in the organisations are supposed to have. For example, sub-district LAOs are trusted in their capacity for implementing health promotion policy for the elderly population and related services because they are, physically, the organisation closest to the community. As a consequence, they are knowledgeable about their population's needs and social and economic context of their community (Determining Plans and Process of Decentralization to Local Government Organization Act B.E. 2542 (1999), 1999). Moreover, interview participants who are not sub-district LAOs' employees also believe that the LAOs know best about the characteristics and needs of the elderly population in their community.

Organisations in the network are also trusted based on their functions. For example, the sub-district Health Promotion Hospitals are trusted to provide care, rehabilitation training, and disease prevention knowledge to the elderly population in the community. The Chiang Mai Social

Development and Human Security Office is trusted based on their services and expertise in elderly support programmes and consultation related to funding regulations.

*“I really trust in the capacity of other organisations because they own the responsibilities. Like for health screening for the elderly, the Health Promotion Hospital is specialised. I trust them a lot. Generally, it is like matching people with a job or matching an expert with a topic.” (A sub-district government officer/ Namprae).*

Among interview participants from different organisations within the two case study areas, the sub-district LAOs were mentioned most frequently as the most trusted organisation when it came to health promotion implementation for the elderly overall based on their organisation’s resources received, responsibilities, and perception of their capacity at the local level.

*“Sub-district LAOs are trustworthy. No hesitation. They have the budget for different social development aspects – from the Department of Local Administration, and other supporting organisations. NHSO and the Thai Health Promotion Foundation also support them in the budget for elderly activities such as dancing, exercising, health screening, and sports. Other organisations do not receive as much budget for this purpose as much as the sub-district LAOs or not as consistently. That is if speaking about my district in particular. Sub-district LAOs also have transferred human resources from those who have taken the exam and been placed with them, and some have social development officers of their own. They have people, so they take responsibility. They are also the closest to the people in their community; they can do it better than other organisations. But if I speak specifically about health, the sub-district Health Promotion Hospitals are more specialised, talking about caring for the elderly specifically. But overall, the sub-districts LAOs are the leading actor.” (A regional officer/ Donkaew).*

A participant who worked with multiple sub-districts mentioned an interesting point on trusting of capacity among organisations within the elderly health promotion implementation network. He said that when they collaborate with other organisations, including the sub-district LAOs, the project or funding contracts ensure the trust in the contracting organisation’s capacity to some level. For example, to be granted the funds, contracts usually require organisations to provide evidence that they are capable of achieving the goals of the projects being funded. This includes resource capacity in various aspects such as facility, skills and expertise of their staff, and sometimes, their past project success. Qualification requirements of their hired staff are also a verification ensuring that they have specific skills and knowledge capacity. Other criteria such as the type of their organisation as a government, non-profit, or health-related organisation also need to be met. Generally, their

organisations' official mission and responsibilities play a role in certifying that they have the capacity to carry out a project successfully.

Personal capacity and collaboration of individual staff or officers representing an organisation within the network also affect trust and collaboration.

*"Originally, we would believe in all other organisations, but sometimes after we work together, we run into issues. It might be about individual staff or officers who coordinate with us in particular, some of them might not be very committed. It is a factor [for working together]. Trust for other organisations also depends on their representatives. Sometimes particular organisations have direct responsibilities, but their representatives are not committed, are uninterested, or do not collaborate. It is hard to work together in that case". (A regional officer/ Chiang Mai Province).*

Trust in the capacity of other organisations within the network is based on their official missions and responsibilities. An approach to ensure the capacity of an individual from the network organisations in delivering services related to health promotion for the elderly is through referral and personal relationships. This approach applies specifically when the required collaboration involves technical expertise.

*"[W]hen we invite someone to help us design the activity, such as when we invite them to come to the elderly school or to the sub-district LAO, we have to ask around first. Not asking them directly but asking others around us to give feedback on how they are. We enquire and seek references from those around us, from people we know, from the organisations we know. If our friends or a senior recommends us someone, it is usually informal, and we can ask anything. Mostly, they meet our expectations." (A sub-district LAO staff/ Donkaew)*

*"So far I rely on people I know. Like, I have a friend who has a degree in gerontology, so anything about the elderly I coordinate directly with her. So, for the Municipality, when they want to invite someone for the elderly topic, I use my personal connection. If other organisations' work is related, I just phone them, like to coordinate with the village headmen or the district headman. It is more convenient, not complicated. So, speaking about knowledge and trust in capacity, I already know that people I contact will be able to help." (A sub-district Health Promotion Hospital staff/ Namprae)*

The capacity of the elderly population also plays a role in the policy implementation of the network actors.



*“Overall, I think we probably do not have to utilise a lot of our own capacity but to enhance the capacity of the elderly population. They are actually able to develop themselves and their groups on their own. ...It is better if they can come together as a group on their own and lead themselves. It will be powerful that way. We should have the capacity to push the elderly for initiatives, but it is up to the capacity of the elderly population in the community. ...The elderly now also have the better capacity, partly because of technology. Their union is clearer in purpose and more powerful, unlike in the past. Now those elderly who are the drivers of activities are former government officers or retired teachers. Knowledgeable and capable individuals drive the elderly work more than before. Each area emphasises elderly work more because they have drivers, mechanisms -- I mean those who have roles and power to do so. They can garner collaborations.” (A regional officer/ Chiang Mai Province)*

### 6.3.2 Commitment of Internal Network Actors’ Interactions

Among survey responses, 45% indicated that their organisation needs a commitment from others *all the time* to accomplish the implementation of health promotion policy for the elderly. Thirty-eight per cent said their organisation *usually* does (Q14). The form and the extent of commitment can be understood from the interviews. In the interviews, participants were asked if their organisations commit to collaborating and/ or participating with others in the network. *All* the interview participants said they try to. They ‘mostly’ receive a commitment from other organisations as well. Seventy – one per cent of survey participants said they *agreed* and 22% *completely agreed* that their organisation participates in the network due to the alignment of its own mission and the goal of the network (Q22).

In the analysis of social relations, commitment is a key factor of relationship performance (Rampersad, Quester, & Troshani, 2010). Kollock (1994) referred to commitment as the behavioural patterns of exchange within a network. He also found that commitment could mean moral obligations or feelings of attachment (1994). In this study, I found that commitment among internal network actors can be categorised as two types. The first one is a directed commitment through the national policies. It is suggested in broad terms by national policies such as the Second National Plan on the Elderly 2002 – 2021, and Elderly Person Act B.E. 2546 (2003 A.D.) where it is indicated that organisations should work together in policy activities related to health promotion for the elderly at the local level to achieve a common goal or expected outcomes.

*The present NPE [The 2<sup>nd</sup> National Plan on the Elderly] contains the new measures to underline and comply with the change in social situation and the elderly problem*

*conditions such as encouraging the saving disciplines [sic] in all ages, budgetary allocation to support activities for the elderly run by local administration organizations, encouraging of long-term care, systematization and plans for assistance in case of disasters, provincial and local networks on administration and development of the elderly, etc., and specify the 1st and the 2nd focal points for implementing the determined strategies and measures as the key agencies in monitoring the operation under NPE subsequently. (Second National Plan on the Elderly 2002 – 2021, preface)*

*“Section 10: The Bureau of Empowerment for Older Persons, the Office of Welfare Promotion, Protection and Empowerment of Vulnerable Groups, the Ministry of Social Development and Human Security, shall have authority to undertake the tasks involving protection, promotion and support of the elderly and responsibility for secretarial and technical tasks of the Committee and shall have the following authority and responsibility: ... (5) To cooperate and coordinate with the central authorities, the provincial authorities, the local authorities and the state enterprises as well as other organizations in facilitating the elderly to access the protection, promotion and support entitled to them under this Act and any other relevant laws.” (Elderly Person Act B.E. 2546 (2003 A.D.))*

I found that commitment to participate in network activities also depends on the official missions and responsibilities of the organisations. Activities that occur are monthly meetings between two or more actors within the network or co-organised health promotion activities for the elderly. The level of commitment of network actors is reflected in the following quotes.

*“If speaking of levels, I would say a good level of commitment is there, but not excellent yet, no. Because they are still an individual organisation, right? But... they help in the execution process, supporting, sometimes decision-making too, our network members. Some help in everything, like the district hospital, they are amazing. So, some of them are at an excellent level of commitment, especially if they have missions that are directly connected to us, like if we share common goals. These are excellent because they get the part that fulfils their own goals too. Like if their organisation’s programme goals are similar to ours, we collaborate excellently. Some organisations share our goals but indirectly, they help us all right. They do not turn us down, they do not cut us off. Quite good. Our request has never been rejected.” (A sub-district LAO staff/ Donkaew).*

*“Every time we organise something and inform other network members, they come. Every time. It also depends on their organisations’ responsibilities in the activities. If it*

*involves them, they come, every time.” (A sub-district Health Promotion Hospital staff/ Namprae)*

In the first type, commitments of actors within the case study networks are driven by common goals. Provan and Kenis (2008) found that other than wanting to achieve their individual organisation’s goals, the purpose of organisations coming together as members of the network is that they also would like to achieve the collective goals.

The second type is more of a voluntary nature. This applies to activities that are less formal such as social events or cultural activities organised mainly by one network actor. Participation or attendance is based on the availability of the actors’ representatives.

In the two case studies, interview participants were asked about the commitment of their own organisation and other organisations within the network. They mentioned that many commitments are ‘returning the favour’. For example, an event to showcase projects related to the elderly and vulnerable population was organised by Donkaew LAO during the period when these interviews were taking place. Donkaew LAO invited representatives from organisations within their networks to come and participate as guests. Although their participation was not required, most of them attended.

*“Generally, their enthusiasm [in participation] is okay, quite enthusiastic. I would not say all are in the A-plus level, but 70%-80% of them are. We rely on personal relationships. We have to be open-minded and be open to help out others. Like when we organise something, they attend or participate. When they organise something, we return the favour. We also have a local word for that, it is called ‘aow mue’ or ‘aow wan’. We collaborate.” (A regional officer/ Chiang Mai Province)*

*“I would like to say that other members always attend and participate in our activities. They all have their own organisational responsibilities, but if they are available when we hold an event or an activity, mostly they come. It is the same for us if they organise something and they invite us if we are available, or we can reschedule our own thing, we join them too” (A sub-district LAO staff/ Donkaew)*

Factors that may influence commitment and participation of members within the network are area-specific culture, geographical characteristics of the area, similar goals to achieve at an individual organisation level, and capacity of individual staff or officers directly involved.

*“Other organisations are usually committed to participate in our activities with the elderly, and they are very well attended. It might be because, in semi-urban areas, some*

*things are still very traditional – local participation and activities are usually well attended. Organisations that participate also do not find it hard to travel. Some areas are narrow, but their narrowness and size make them easy to get to, it is not that people have to go across the mountain or anything like that” (A district hospital staff/ Namprae)*

*“Speaking for myself, I am quite determined [to commit to network activities]. When I am invited to participate as a speaker or in a seminar related to the elderly, I prepare well each time. Aged society is one of the top nationally important issues. Other organisations are quite committed too. ...At the provincial level, other organisations also commit well. (A regional officer/ Chiang Mai Province)*

### 6.3.3 Collaborating Activities between Actors

From the survey, participants said the number of organisations they work with in the implementation of health promotion policy for the elderly within their sub-district ranges from one to ten organisations (Q2). Survey participants were asked to rank the top three activities they have done with others within their networks, which they think are most useful for collaboration (Q35). The data analysis revealed that training, including joint training, is seen as most useful. The second and third most useful activities are visiting other areas together to learn about their elderly work and knowledge and exchanging information among network members and learning from experience exchange.

Collaborating activities involve organisations across and between governance levels within the network. The activities are periodic, scheduled, or issue-based. Sometimes, activities involve all organisations at the same governance level. Sometimes, they involve organisations across governance levels. In the survey, participants were asked to list the top three activities they do with other organisations within the network and the top three organisations they interact with most frequently. A survey question that asked participants specifically what the projects are that they work on with other organisations under the topics related to health promotion for the elderly (Q34), participants said elderly school and elderly club activities, non-communicable disease prevention information sessions for dementia, oral care, back pain, and osteoarthritis, elderly exercise and health screenings. Survey participants were asked to rank the three organisations they have worked with most often (Q3). The results are 1) LAOs; 2) Health Promotion Hospitals, and 3) Chiang Mai Provincial Social Development and Human Security Office.

Among the survey participants, 57% said they *agreed* that their organisation interacts with every organisation within the network. Those who said they *completely agreed* with the statement

accounted for 33% (Q7). These results indicate that some activities do not involve all network actors. The minimum number of network actors that participate in an activity is two. Although the number may indicate the dyadic form of participation, the planning and process leading up to the activity usually comprised more than two actors as well as shared resources. In addition, nearly half of the survey participants responded that their organisation also worked with organisations outside the health promotion for the elderly policy implementation network (Q16). From the interviews, organisations that are not regular network members, or those outside the network, are often the non-profit organisations and hospitals that are under the governance of the Ministry of Public Health at the regional level (district or provincial hospitals outside their district). These collaborations, especially with the hospitals, come from personal connections of the staff members of organisations within the local network. From the survey, the top three activities or interactions related to health promotion for the elderly where they collaborate with other organisations, are 1) knowledge and information exchange among network members and learning from experience exchange; 2) organising elderly sports and recreation activities; 3) visiting other areas together to learn about their elderly work (Q35).

For the length of collaborations, 23% of survey participants said that the period of time that they have worked with an organisation within the health promotion policy implementation for the elderly was *less than two years* and *four to six years*. Among these, 21% said they have worked for *two to four years*. Those who have worked on the topic for *six to eight years* accounted for nine per cent, and 13% said *longer than eight years* (Q36). These results imply that most of the network actors do have some experience on the topic. Those with multiple years of experience working with other organisations within the network could be considered to have knowledge and expertise in collaborations concerning health promotion for the elderly.

Many of the activities mentioned in the survey were talked about in the interviews, and some actors were repeatedly mentioned, indicating the frequency of collaboration. From the interviews, collaborating activities between actors within the networks can be categorised in many ways. The following are specific collaborating activities between the network actors that I found to occur most often.

#### 6.3.3.1 Meetings

Meetings between network members either take place on a regular basis such as a monthly meeting or on an issue basis. The meetings may involve two or more network members at a time. From the interviews, I found that regional government organisations who manage and distribute funds from the central government to other organisations meet with the LAOs and other network members at

the local level. The meeting usually involves regulation consultation where the budget-distributing organisation may clarify regulations, explain processes of funding approval and criteria, and provide some level of training. The meeting takes place on both formal and informal platforms.

*"We have meetings with sub-district LAOs that participate in our projects such as those in our Centers for the Quality of Life Development and Occupational Promotion for Older Person projects. We would call them in, like currently in Chiang Mai we support 30 centres. We have activities that will help them build capacity or help them with other things... it depends on the case. Overall, the meetings are mostly about clarifying the regulations or the Ministry's related missions. We do not meet on a regular basis, it is case-based." (A regional officer/ Chiang Mai Province)*

*"For the Long-term Care Programme and its funding, we organised meetings as a platform for our network members to come to discuss as a starter. They are LAOs, health centres, etc. For health centres, we train their Care Managers (CM), and we provide funding for them to train Care Givers (CG). ...We select and invite LAOs who have potential to be trainers to train for other areas as well. So, on this platform at the regional level, we talk about the policy direction, process, sort of tune in with each other. ...If they have questions or concerns about the regulations and the programme, they can also ask us there. ...We plan on having a team of instructors to follow-up and assist the LAOs in the future, and we will be a facilitator from a distance, perhaps for documents, knowledge, funding, it depends. ...We organise the meeting every year to keep them up with the regulations and explain it to them. There is also a workshop after to make sure they understand what to do in their sub-district after they leave the meeting." (A regional officer/ Chiang Mai Province)*

The meetings between network members at the local level have different purposes such as to inform and update other organisations about existing or upcoming projects and to consult each other about the existing or emerging issues in the area. In Donkaew Sub-district, organisations that participate in the monthly meeting are not only sub-district or locally based but extend to regional level organisations and other sub-organisations of the central government agencies located within the sub-district border.

*"We usually have a monthly meeting with organisations within our network. This extends beyond sub-district level as it includes all organisations located in our area such as the Skills Development Centre, the nursing college, the village headmen, sub-district headman. The police are also in our network, they come to inform us about crimes in the*

*areas and how our village headmen can help, how we can monitor and such. ...We talk about everything in the monthly network meeting. ...Some organisations inform us about projects being worked on at their place. Suppose the Disease Control Centre would like to come in the area to work on disease control, the Health Promotion Hospital would send someone from their Community Medicine Division to help. If other organisations at the meeting think it can be connected to what they do, they will bring in their projects too.”*  
(A sub-district LAO staff/ Donkaew)

*“In the work related to the elderly populations, the Municipality Office [a LAO] takes major actions. They then coordinate with us, the Health Promotion Hospital. We have a meeting every month, the Municipality Officer issues an invitation and informs about which village in the sub-district we will be meeting for the month. For me, I deal with dental care and health screening [for the elderly].”* (A sub-district Health Promotion Hospital staff/ Namprae)

The active participation of network members at the network meeting, including the enthusiasm of the members to take roles and responsibilities related to the elderly health promotion, is also reflected in the survey results. Sixty – nine per cent of the participants *agreed* that strategic collaborative efforts are determined as each network member seeks or establishes their own roles in the initiative (Q39.2).

At Donkaew LAO, the regular meeting is usually held monthly. However, due to the royal cremation of King Bhumibol in Thailand in October 2017 and other commitments on the LAO’s agenda, they did not hold the regular network meeting from October 2017 – April 2018. During my non-participant observation at their meeting on 30 April 2018, I found that the participants included organisations that are not directly involved in elderly health but contribute indirectly to the topic. These organisations located in Donkaew Sub-district take part in building a safe and orderly environment for the community in Donkaew Sub-district and help build its economy and develop other social aspects. These organisations include the Land Development Office Region Six (a regional government organisation under Ministry of Agriculture and Cooperatives), Institute for Skills Development (a regional government organisation under Ministry of Labour), and the military base office. The public who are people living in the sub-district or outside was also allowed to observe the meeting.

I was informed in advance that the topics discussed in this regular meeting might not directly relate to elderly health as it depends on the priority issues that particular month when the meeting took place. The number of meeting participants was 40. Donkaew LAO took part as

the meeting facilitator and started by introducing the meeting agenda which included updating and informing organisations about news and progress of on-going programmes, and to discuss issues within the sub-district. Both Donkaew LAO and participants were able to initiate discussion. Based on the ability to raise an issue or initiate a discussion, the exercise of authority and power relations was very even among meeting participants. They referred to and discussed a national policy, “Thailand, Zero-waste Society”. The most exchanged resource in this meeting was information about resources available for organisations to share or utilise. The total time of the meeting was two hours, with discussion open to be taken up by relevant organisations after the meeting. Action planning did not take place during the meeting but rather information exchange and issue discussion.



*Figure 18: Donkaew LAO Meeting with Organisations Within their Network and Sub-district Area, Chiang Mai, Thailand. April 30, 2018.*

Meetings between organisations within the network vary in each of the case study areas. Donkaew LAO's monthly meeting with other organisations has a large number of participants due to the number of government offices located within their sub-district borders. However, some of these organisations do not have a direct mission related to health promotion for the elderly. The subjects related to the elderly health promotion may not necessarily come up regularly at the monthly meeting. Donkaew Sub-district has an elderly school attended by the elderly population in the sub-district every Thursday. At the elderly school, facilitated by Donkaew LAO staff members, the elderly participants learn and practice all aspects to improve and maintain good quality of life such as muscle exercises, calculation for brain exercises, handicraft work, meditation, disease prevention, group exercises, and other activities, depending on their interests as communicated to the Donkaew LAO. It is also a weekly platform that offers the opportunity for the elderly in the community and the sub-district LAO



to meet and discuss the well-being of the elderly population, upcoming local activities, exchange information, and voice the community's interests.

For Namprae, the sub-district LAO does not have a regular meeting with multiple organisations they work with at the same time like in Donkaew. Their elderly school does not take place regularly either. However, they meet with the sub-district elderly club representatives twice a month at a local temple. One meeting of the month is a discussion to update ongoing projects, activities, seasonal diseases prevention, or funding news and other matters under the topic of the quality of life of the elderly. The other meeting is the monthly elderly welfare allowance distribution for the elderly by the Ministry of Social Development and Human Security through the LAO office. Other activities for the elderly also take place on the monthly welfare distribution day, such as health information seminars, group workshop on handicraft products, and other activity planning.



*Figure 19: Namprae LAO Meeting with the Sub-district Elderly Club Committees and Interested Members, Chiang Mai, Thailand. April 27, 2018.*



*Figure 20: An Information Session on Reducing Risks of Dementia for the Elderly at Namprae LAO*  
*Note: Namprae LAO in collaboration with the Health Promotion Hospital, the Namprae Elderly Club, and Center for the Quality of Life Development and Occupational Promotion for Older Persons (with supporting budget from the Ministry of Social Development and Human Security): An Information Session on Reducing Risks of Dementia for the Elderly by an instructor from the Chiang Mai Neurological Hospital. Chiang Mai, Thailand. May 5, 2018.*

When not all network members at the sub-district level are able to attend an external-network meeting, a representative from an organisation within the network at the local level may transfer the knowledge and information learned or received at the meeting to the others.

*“I specialised in diabetes and blood pressures, so when there is a district-level meeting, they would invite me for my expertise. There is another lady from another sub-district that has been invited for the elderly work. I learn from her at the meeting. After the meeting, I come back and transfer what I learn to others in the area. Not everyone can attend the meeting at the district level because of the limited budget, but someone from the sub-district Health Promotion Hospital will always be there.” (A sub-district Health Promotion Hospital staff/ Namprae)*

Survey participants were asked about their meeting experience with other network members (Q39). Among participants, 73% agreed that the meeting facilitator is always identified at a network meeting (Q39.1). Moreover, 57% of the participants agreed that time and energy are spent on performing the activities rather than on planning (Q39.3). This could be observed from the meeting where actors involved in a topic or a programme agreed to come together for planning away from the network meeting, in a smaller group setting in order to save the whole-network meeting time. It can also be concluded from the interviews that this may be because a single activity or issue to work on may not involve all of the network members.

Thus, the planning of activities takes place outside the whole network meeting with network members who indicate at the meeting they would like to get involved or those with direct responsibilities. The participation in meetings at the two case studies can be explained in stages of a strategic alliance collaboration.

Gajda (2004) identified from literature about the development of strategic alliances that there are five collaboration principles. In Principle Five, she indicated that collaboration develops over four stages:

- 1) Assemble and Form –programme evaluators form an alliance and play the role of a facilitator. At this stage, the alliance vision and mission are communicated.
- 2) Storm and Order –each member establishes their own role for the activities or programmes being discussed.
- 3) Norm and Perform –the alliance has established their working norm, they spend time and energy taking action. At this stage, the facilitator may work with other members to gather data and information from the performance and feedback into the alliance feedback cycle.
- 4) Transform and Adjourn – members work together in the evaluation and assessment of findings to modify their strategies.

The meetings of the LAOs' network in the two case studies, especially in Donkaew, strongly represents a strategic alliance collaboration. The sub-district LAOs usually play the role of a facilitator, bring up new issues and follow-up with existing issues introduced in the previous meeting. This reflected the Assemble and Form stage of Principle Five. However, the LAO who played the role of the meeting facilitator was not the network evaluator. Network members are also assertive in aligning their own organisational mission and projects with the issues being brought up at the meeting. Survey responses also indicate that time and energy are spent on taking actions rather than planning at the meeting. This reflected both the Storm and Order and Norm and Perform stages. Moreover, the updates and follow-ups by the LAO from the previous meetings included in the agenda implied that this routine would be repeated in the next meeting suggesting the Norm and Perform stage again. It can be summarised from the network meeting I observed at Donkaew that a level of evaluation and assessments of network activities or programme outcomes occurred when the meeting members discussed the progress of the implementations or follow-up updates. Their interactions and commitments in issues' resolution and programme collaboration reflected the Transform and Adjourn stage. From the non-participant observation, the researcher is able to see the

behaviour of policy network actors (Bevir & Richards, 2009) in the meetings such as collaborative behaviours, conflict and resolution, decision making, and exploring further the extent of governance network characteristics represented by the interactions. The observation complements other research methods, such as interviews, surveys, and documentary analysis (Liu & Maitlis, 2012).

Evidence of a strategic alliance of a community network drawn from meetings observation and interviews was presented in Donkaew. The survey results presented similar findings of agreement. Responses from the Namprae case study area are similar, although not as strongly. Most of the survey participants indicated they *agreed* that the meeting facilitator has always been identified in multi-organisation meetings (75%) (Q39.1). Strategic collaborative efforts are determined as each member seeks or establishes their own roles in the initiative (62%) and time and energy are spent on performing the initiative rather than planning the implementation (48%). From the qualitative and quantitative data combined, it can be summarised that both case studies represent a strategic alliance based on their meeting interactions but vary depending on the extent of activities, network actors' commitment, and participation.

#### *6.3.3.2 Budget Support and Funding*

Every government organisation within the health promotion for the elderly networks at the local level operates on the budget allocated to them from the central government through their parent ministry. In addition to the allocated budget, service providers like public hospitals also gain revenue from their health services such as treatments and medications prescribed. The LAOs can also generate their own revenue through taxes, fee collection and commercial activities, as described in the Background Chapter. However, the allocated budget LAOs received from the Ministry of Interior, their parent ministry, is mostly for their functional operation, including salaries for employees. Revenue that they generate on their own might not be sufficient for carrying out social programmes that respond to the needs of different groups of population in their community. With the advantage of their office and staff being closest to the community and having the local resources and networks, other government organisations and offices of different ministries may ask the LAOs to carry out programmes for them by providing budgets or funds which are controlled through programme contracts or policy regulations. This way, while other government organisations achieve their missions through funding the LAOs to implement their programmes, the LAOs are also able to serve their communities with budget supports from other organisations. Overall, the benefits of budget support and funding between LAOs and other organisations falls upon people in the community who receive assistance or resources through the programmes being funded and implemented.

*“One of my responsibilities is budget support for the Long-term Care Programme. Health Promotion Hospitals and the Care Managers proposed their Care Plan and we assist them with budget received from the NHSO for the bed-bound cases.... We have the approval process and supervisory systems through the programme funding committee set up by the NHSO. ... We also receive budget support from the Thai Health Promotion Foundation for our health-learning institute where we assist other LAOs, as a successful case model, in the transfer of Health Promotion Hospitals to be under the LAO’s administration. ... We received a budget from the Chiang Mai Social Development and Human Security Office. This comes in monthly as the welfare support for the elderly in our community - 600, 700, 800 Baht per month depending on their age. They pay the money through the sub-district LAOs. Our Social Welfare Division distributes the money each month.” (A sub-district LAO staff/ Donkaew)*

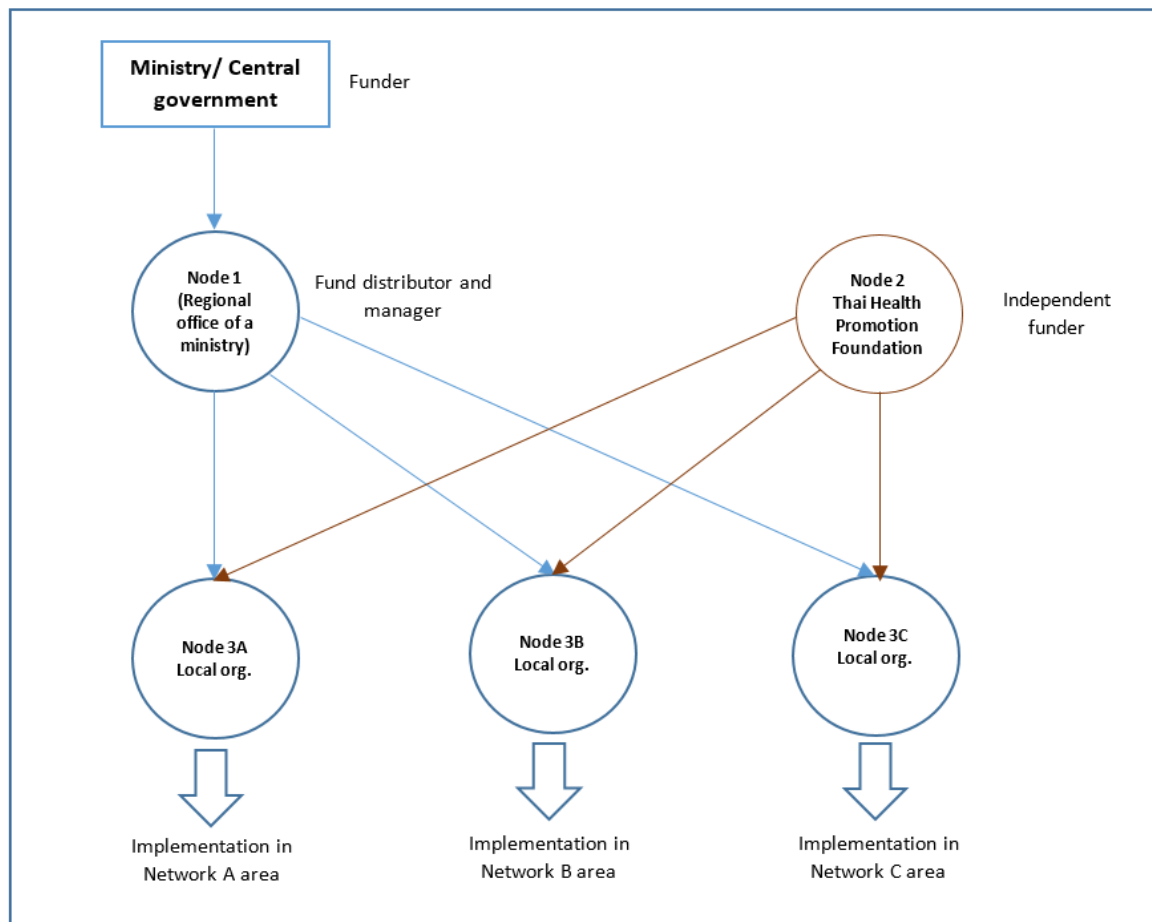
*“The Chiang Mai Social Development and Human Security Office collaborates with us in a lot of ways – speakers, budget, sometimes they help the poor in our sub-district. For example, some elderly patients are not able to take care of themselves. They are poor, very poor, so we have to send their case details to request welfare support from the Chiang Mai Social Development and Human Security Office. We are also helping each other more in our own community like in occupational support, income development, healthcare for the elderly, and help them [the elderly] sustain the society. We have started for 2-3 years now. The NHSO has the Long-term Care programme we are going to participate in. ...Now we have exercise machines, group exercise activities of the elderly, sometimes we use the NHSO budget support for these activities. ...We have submitted a proposal for funding of the repair and renovation of the Center for the Quality of Life Development and Occupational Promotion for Older Persons in our sub-district from the Chiang Mai Social Development and Human Security Office. They are reconsidering it and we expect to receive the budget support next year.” (A sub-district LAO staff/ Namprae)*

For Donkaew Sub-district, the implementation of activities about health promotion for the elderly does not always rely on budget support by the sub-district LAO or the regional government offices. Activities take place on a regular basis as the elderly club facilitated by the sub-district LAO has developed a self-funding approach. Moreover, the sub-district LAO ensures that the continuity of programmes and activities that benefit the well-being of the elderly population in the community are not interrupted by lack of external budget support.

*“We do not take budget as a core factor to implement programme or activities that benefit the elderly population in our community. The good thing about this is that we are quite self-sustainable. If we take the external budget as a core factor, we will always wait for the budget and once we use it up, everything stops. Like in other areas, they open the elderly school only when they get the budget. Once they use it up, the school goes on a break as they wait for the next round of funding. Homsuk Elderly School in our sub-district never has a break. Because the staff members and officers from the Donkaew LAO keep running it without waiting for the budget from other organisations. ...We utilise resources we have. For example, ...the elderly students bring their own lunch. ...The elderly students also have their own funding. They collect money among themselves at 20 Baht each time [they come to school]. ...Another fund comes from when a monk comes to teach Dhamma to the elderly group, the participants donate money. Usually, the monk does not take it, so the students keep it as the elderly club fund. ...This fund is also used to buy stationery for the elderly school – pens, notebooks or whenever they want to do something at school like when they wanted to make Kanom Tien (a traditional dessert for Chinese New Year), they used this fund to buy ingredients. (A sub-district LAO staff/ Donkaew)*

The facilitation and support of Donkaew Sub-district LAO enable continuity and ongoing activities related to the development of quality of life, including health promotion for the elderly in the community and their independence from external budget support. It implies that if a sub-district has sufficient resources and support from the LAO, the elderly club can fund their own activities and do not have to always rely on external budget support from organisations outside of the sub-district, particularly for their elderly school activities.

From the survey (Q 19), 40% of the participants said that their organisation manages most of the budget from the central government on health promotion policy for the elderly. When looking specifically by governance level of the participants’ organisations, 46% of participants from network actors at the local level, said their organisation *often* takes the role of managing most of the budget from the central government on the health promotion policy for the elderly. In comparison, when considering only regional-level actors, including district hospitals, 37% of participants said their organisation *always* takes the same roles while 26% said they *often* do so.



*Figure 21: Budget Support and Funding Interactions among Network Members*

A ministry or the central government is not regarded as a member of the local network because they do not interact directly with network members at the local level (see Figure 21). Node 1 represents the fund distributor and fund manager who are usually a regional office of a ministry or the sub-organisation of the funder. Node 2 in the figure is the Thai Health Promotion Foundation, who is also a national organisation, the same level as a ministry. However, the Thai Health Promotion Foundation does not have a regional office, so they distribute their funds directly to the fund receivers at the local level. Therefore, they are also a part of the local network as they do not only distribute funds to the organisations at the local level, but they also interact directly in network activities. Their interactions include providing funding consultation according to the regulations, transferring knowledge and expertise in implementation approaches, and other supports as requested by the selected local implementing organisations who received their fund.

Regional-level organisations (Node 1) such as the regional office of the NHSO and the provincial office of Ministry of Social Development and Human Security generally hold the dual roles of support and management of the central government fund. They distribute the funds to qualified local level organisations. They ensure that they distribute the fund in compliance with the regulations and

criteria set and that the funds are being used for their restricted purposes. Local level organisations also play both supporting and management roles for funds originally from the central government. In the supporting role, they allocate the funds received from the regional-level government organisations to the programme target groups. For example, the elderly Long-term Care Fund is allocated by the LAOs to sub-district programmes that are related to or aligned with the goals of the national Long-term Care programme developed by the Ministry of Public Health, the original funder. The District Health Fund is also allocated by the LAOs to sub-district programmes that are related to health quality improvement of vulnerable population groups within the sub-district, including the elderly. Funding for the Center for the Quality of Life Development and Occupational Promotion for Older Persons, originally from the Ministry of Social Development and Human Security distributed to the LAOs through the provincial ministry office, is allocated for the elderly population within the sub-district represented by the elderly club. The programmes implemented within the sub-district may be run by the LAOs themselves or by other network members at the local level, such as the Health Promotion Hospital, or the elderly club. In the budget management role, they also take actions similar to regional level organisations who distribute the fund to them for the same purpose, which is ensuring the compliance, and alignment of use of the funds with the goals and regulations set by the central government.

#### *6.3.3.3 Planning and Planning Support*

As none of the organisations within the health promotion for the elderly network has the resources and expertise required to accomplish their mission on their own, they require support from one another. Previously, I mentioned the findings that show that one of the collaborating activities between organisations within the network is the exchange of knowledge, expertise, and technical support, particularly for the delivery of services or implementation. Collaborating activities among network members can also be in the form of planning support. Organisations with speciality knowledge or technical expertise may assist others that have fewer resources in planning their activities.

*“In planning our activities, I have to coordinate with other organisations especially asking for their knowledge support like from the Health Promotion Hospital or Nakhonping Hospital. We would not want any errors in the implementation of the activities so after we have project ideas, we collaborate with organisations that are the experts. ...When we want to do a project, we process through the sub-district LAO, we talk to them first about planning the project. Their Social Welfare Division or the Health and Environment Division will guide us on how we should drive it forward.” (An elderly club member/ Donkaew)*



*“If talking about planning activities related to health promotion for the elderly in the sub-district, mostly it came from ‘returning the data and information’. We plan together with other organisations that have data and information on the population in every age group in our sub-district. We exchange (or return) the data with the management of the sub-district LAO, the community, we look at the data together and plan what we would like to do for that year. ...The data and information are about the situation of the aged population in our sub-district, their illness, their age group, and their condition. We use them to guide our policy and action planning. ...Mostly in the planning process, it is internal – the sub-district LAO, the community, the Health Promotion Hospital. ...Sometimes we use information collected by other organisations or we use their success as our examples. ...the Thai Health Promotion Foundation and the NHSO came in in the early stage of policy planning. They gave us directions or recommendations based on the information and data we have. This process though, did not involve the community, just them and the staff in scholar positions at the sub-district LAO.” (A sub-district LAO staff/ Donkaew)*

*“We participate in the sub-district LAO town hall meeting where they explore issues in the community, and we sit down together. Our plans are similar if they cover the same topics. Like, for the issues related to the elderly population, the process is from town hall, meetings, down to each village, we find out what they really want in the community. Inputs for our planning came from the people themselves. After we have a plan, we work with our organisations in planning days of activities, search for speakers, and get the materials that will be used in the activities.” (A sub-district level officer/ Namprae)*

*“Other organisations take part in our planning. ...The nursing college also knows about elderly care and about our elderly population because their instructors take the nursing students to home visits based on the lists from our Health Promotion Hospital. So they helped us in planning with their own expertise and information or data they collected in our community.” (A sub-district LAO staff/ Donkaew)*

From these examples, collaboration in planning support between organisations within the health promotion policy implementation for the elderly can be seen in the form of data or information and knowledge or expertise. Both forms of input come directly from the elderly population within the community. For example, data or information collected and used in the planning process comes from home visits, town hall meetings, and consultation between the elderly club members and government organisations. The input obtained from the policy target population and their

participation in the policy planning process is crucial to the effectiveness of policy implementation (Sabatier, 1986).

According to Provan and Kenis (2008), the integration of service provision or comprehensiveness of project planning depends on the flexibility and stability of the network. The flexibility of the network means organisations within the network can work together, exchange resources and expertise with one another without encountering obstacles from hierarchies, or that hierarchy alone could not help accomplish (Provan & Kenis, 2008; Kapuchu & Van Wart, 2006). Stability of the network means the ability of the network members to sustain a long-term relationship with at least some other network members (2008). The flexibility of the health promotion network for the elderly in both case studies regarding planning is exhibited through a willingness to assist other organisations within the network and the informality of assistance requests by just talking. The stability of the network can be taken for granted as it is directed by the national policies and plans that they work together. Thus, it can be summarised based on flexibility and stability that within both case studies, the networks' capacity to perform key function exists (Provan & Kenis, 2008).

It should be acknowledged that for planning and planning support in Donkaew sub-district, an obvious advantage in the process is more elderly-specialised organisations are located within their geographical areas, such as the district hospital and the nursing college.

#### 6.3.3.4 Monitoring

Within the health promotion for the elderly policy implementation network, there are one or more organisations that play monitoring roles for a programme or an activity implemented by the others. The monitoring role is usually associated with the official mission or responsibilities of the organisations playing the role as a fund allocator or distributor, a local supervisor, or a resources provider. The following quotes are examples of monitoring by a local supervisor.

*"...the Municipality Office [LAO] is the leading actor in monitoring work about the elderly. We are just a participant when they organise an event or an activity. Every month when we have a meeting, we will update them on what we are going to do for the month, but they are the one who monitors. We take leading actions about health, but the Municipality Office covers more broadly – the quality of life, occupation, health - through us, and other things. They organise a study trip, Elderly Teaches Grandchildren activities, they also monitor the related activities, everything." (A sub-district Health Promotion Hospital staff/ Namprae)*

*“...I also monitor and evaluate the LAOs in their management, council, budget, public services, and good governance. ...I support them in their operational functions, monitor, and evaluate them according to the national Local Performance Assessment (LPA) to make sure that what they do align with the national policies.” (A regional officer/ Namprae)*

The next quotes are examples of monitoring by a funding distributor, allocator, or a resource provider.

*“For the Long-term Care programme, we, the NHSO allocates the budget, health providers provide services, LAOs make sure activities and services on the budget reach dependent elderly in their community. For monitoring and evaluation, the Public Health Office looks at the health results, we look at how the budget gets used, but it is all related as we share the same information. We analyse and evaluate them together. ...We monitor all of the LAOs that receive a budget from us.” (A regional officer/ Chiang Mai Province)*

*“The use of the Sub-district Health Fund that NHSO allocates has to comply with the programme regulations. Sometimes when the fund gets distributed at the local level to the implementing groups, unintentional mistakes are made. So, we have advisers at the provincial level to monitor and assist health providers or other groups that receive the fund to use the money according to the regulations set.” (A regional officer/ Chiang Mai Province)*

These responses indicate that the monitoring roles can be taken by both organisations at the local level, and organisations at the regional level. Such roles are associated with the official mission or responsibilities of the organisations playing the role as a fund allocator, a local supervisor, or a resources provider. The monitoring organisations sometimes evaluate the implementers and activities being implemented based on the national policies, regulations, and guidelines. However, not every organisation within the network has a monitoring role. For example, the District Offices for Local Administration provide assistance, supervise, and advise sub-district LAOs within their district. They also monitor and evaluate their performance against criteria set by the Ministry of Interior. These are part of their responsibilities written in the Determining Plans and Process of Decentralization to Local Government Organization Act B.E. 2542 (1999), and the Ministerial Regulations on Structuring of the Department of Local Administration, Ministry of Interior B.E. 2551 (2008) which are not limited to elderly health promotion related performance. Therefore, monitoring among network members is not voluntary.

#### 6.3.3.5 Learning

Organisations within the network learn from each other. From the surveys, 73% of the participants *agreed* that they learn about new approaches and skills from participating in network activities (Q 37). Poocharoen and Ting (2015) found that in a network whose collaborative function is to solve a complex issue, learning is one of the significant elements as a function of the network itself. This is also reflected in the survey responses because what survey participants said they learned from each other are techniques in implementing activities, data management systems, or concepts in policy implementation. It is possible that the directions of learning are vertical – between organisations across different governance levels (national, regional, and local), and horizontal – between organisations at the same governance level. From the interviews, I found that learning in the health promotion policy implementation for the elderly network in the case studies takes place in both directions and, in some cases, learning in both directions take place in the same project. The interviews revealed that some organisations learn from their peers horizontally at the same governance level, and some learn from others at the same governance level as well as across different governance levels, as can be seen in the examples below.

The first quote comes from when Donkaew LAO, a local government organisation, learned from the Thai Health Promotion Foundation, a national organisation, about implementation approaches. Then, LAOs in other sub-districts learned from them. This reflects vertical learning between a local level organisation and a national organisation, followed by horizontal learning between local level organisations.

*“We have done very well in taking care of the elderly population in our community. The good results came from real actions. So LAOs in other areas want to learn from us or want to be a part of our network. The Thai Health Promotion Foundation played an important role as they selected us to be a model LAO on many topics. Other LAOs visit us to learn, even educational institutes like Chiang Mai University and Naresuan University came to visit us. Thai Health Promotion Foundation helped us transform into a training centre for other LAOs, the public can also walk in and learn from our practice. ...For the Health Division, in particular, we collaborate with other organisations in many ways. First, we learn from their data to develop our knowledge. Second, we exchange implementation approaches. Third, they may come to learn from our practice as I said. ...They usually approach us, sometimes the NHSO or the Thai Health Promotion Foundation recommended us to them. We won an award in elderly care innovation by using the CEC (Community Caregiver Center) approach in implementation, many visit us to learn about that.” (A sub-district LAO staff/ Donkaew).*

The second quote is from an interview participant whose organisation, a Health Promotion Hospital, is a local-level organisation that learned from Chiang Mai Provincial Social Development and Human Security, a regional-level organisation. The interview participant, along with staff members from the Municipality Office, then went to learn from another sub-district LAO. This is also an example of vertical and horizontal learning.

*“Namprae Municipality Office was a great centre of work about the elderly. Chiang Mai Social Development and Human Security Office is great too. When something comes up [a learning opportunity], they always inform the Municipality Office and us. We go together. ...We work closely, learn from each other, and learn together. Last time we went together to Nhongtong [another sub-district in the same district]. They are one of the national role models in Long-term Care programme implementation for the elderly. We went to learn about their practices, and we will adapt it to our community, this year we will start the Long-term Care programme in our sub-district.” (A sub-district Health Promotion Hospital staff/ Namprae)*

The following figure illustrates vertical and horizontal learning between network members who are organisations in a different governance structure. Vertical learning occurs when network members at the local level such as a LAO, Health Promotion Hospital, or a sub-district elderly club (Node 2) learn from organisations at a higher governance level such as the Thai Health Foundation (national) or Chiang Mai NHSO Office (Node 1). Horizontal learning, in this case, is when a local government organisation (Node 2) first learns from an organisation at a higher governance level, and other local organisations (Node 3 and Node 4) subsequently learn from them.

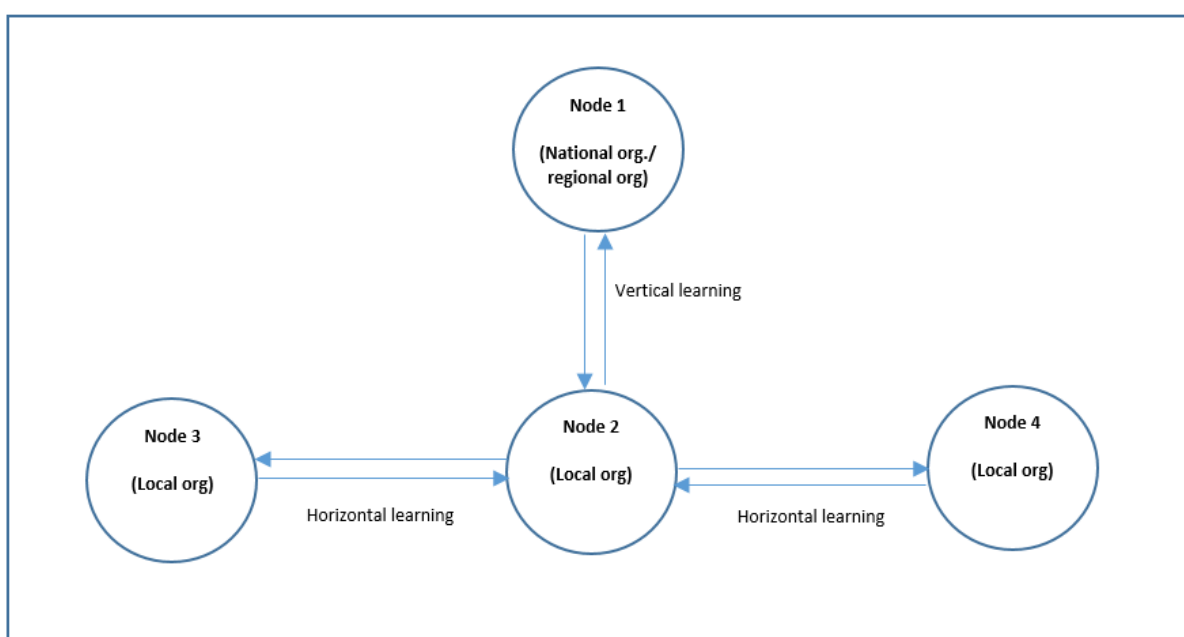


Figure 22: Vertical and Horizontal Learning

The following quote is an example of a case where only horizontal learning took place. It is when a network actor participated in activities with other actors from the same level of governance structure and learned from activities they did together.

*“We organise a monthly rotation meeting where we travel to different villages to hold a meeting to inform the elderly population in that village about activities we are organising and ask them which activities they would like to participate in. We have a range of activities for them to choose from like physical health, mental health and spiritual mind. For physical health, we coordinated with the Health Promotion Hospital, such as for fall prevention. For mental health and spiritual mind, we invited a monk from the community temple to teach us how to meditate. Sometimes there are recreational activities like traditional Thai dancing or other dancing. We invited a speaker from the Municipality Office to educate us about our rights, so the elderly know what they have to do, like for an election. Last year we also had a field trip with the elderly; there were over 100 elderly participants. We went to a temple and visited Koh-Kha Municipality Office [in Lampang Province] to learn about their activities for the elderly in their sub-district. Next year we might do the same activities together.” (A sub-district LAO staff/ Namprae)*

Reflecting the interview data, Figure 23 below shows learning between network members (nodes) when only horizontal learning takes place.

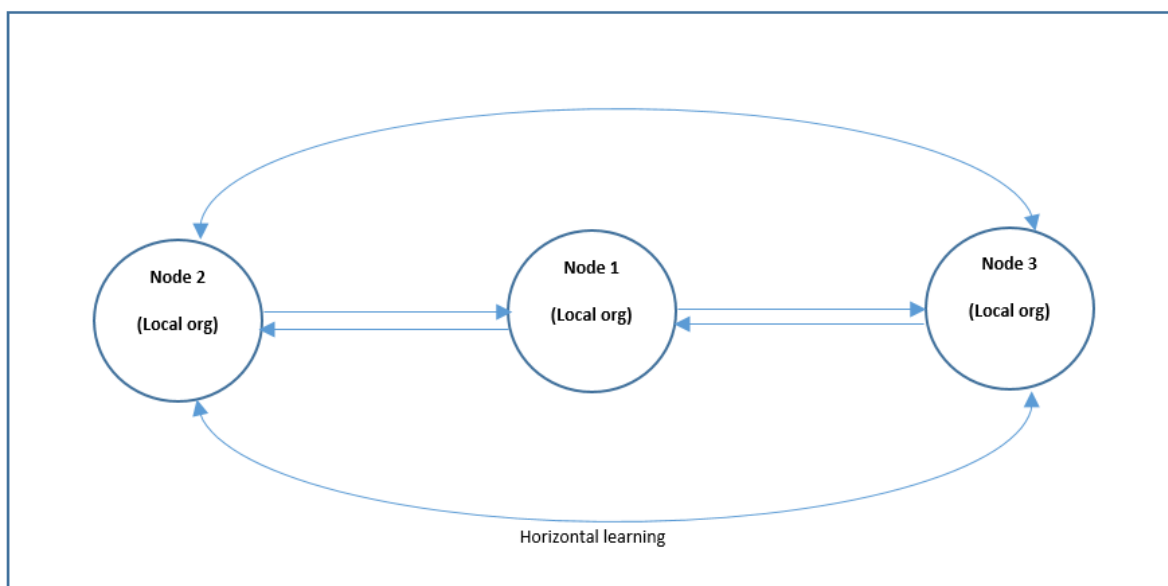


Figure 23: Horizontal Learning

As the interview data shows, organisations that provide learning to and receive learning from

one another in the horizontal only learning do not have to be a member of the same sub-district network.

While working together on complex issues, actors within the network learn about new ways of doing things, new knowledge, and practice techniques. The emergence of collective learning is a characteristic of a network (Newig, Günther, & Pahl-Wostl, 2010). This collective learning is reflected in the survey results where 62% of the participants agreed, and 20% completely agreed that they believe what they learn from participating in network activities is helpful for their organisation in achieving its role as a network member (Q 38).

#### 6.3.3.6 Training

Training is one of the interactive activities among the health promotion policy implementation for elderly network members. Among the survey participants, 51% indicated that individuals whose work relates to the elderly health promotion from organisations within the network *usually* participate in relevant training together and 26% of the participants indicated that they do that *all the time* (Q 46). This strongly suggests that participating in training is a common network activity that actors do together. From the interviews, I found that training can take place in two scenarios. The first is when one or more representatives of network actors may receive training from another actor within their local network. From the survey, 57% of the participants indicated that an organisation within the network *usually* provides training to the other network members. The second scenario is when one or more representatives of actors within the network receive training together. An example is when a sub-district LAO receives training from another actor within its own network along with representatives of local organisations from other areas.

In the first scenario, trainers are usually an organisation at a higher governance level. In the following quote, trainers are from a district level hospital, which is a regional organisation within the Ministry of Public Health. The trainees are Care Givers, volunteers who receive stipend from Donkaew LAO, which is a local-level government organisation. They are supervised by Donkaew Health Promotion Hospital and under the grant provided by the NHSO through the Donkaew LAO. We may call this scenario “exclusive internal – network training”.

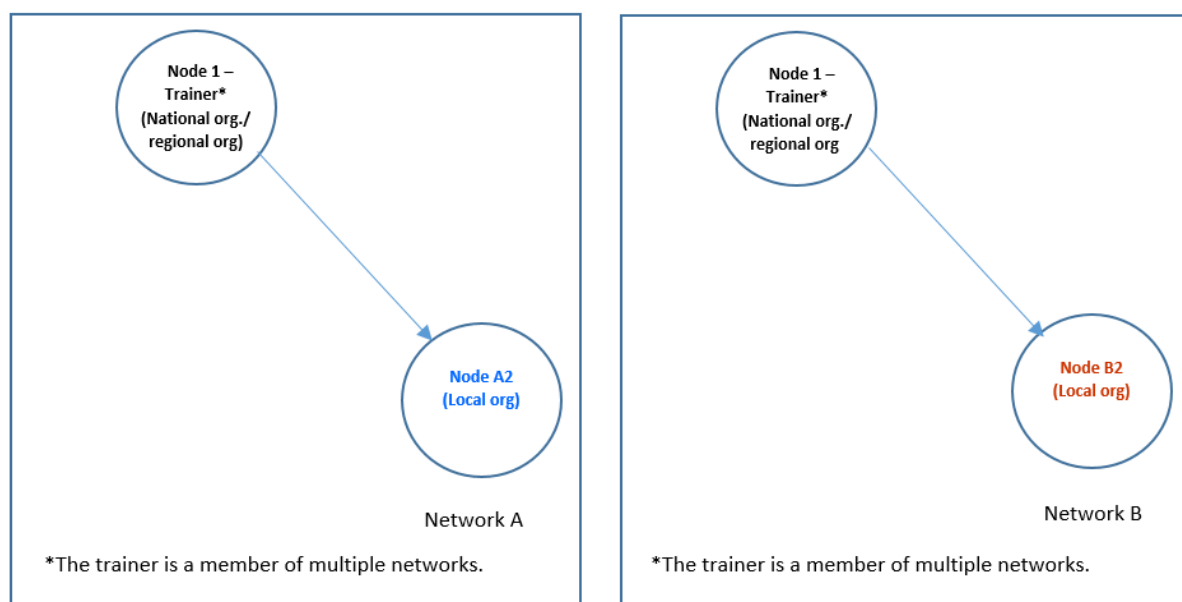
*“We have the (elderly) rehabilitation centre, open every Friday near where the Homsuk Elderly School is. Physiotherapists from Nakhonping Hospital come to train our Care Givers. There are the Care Givers group that train for 70 hours, and the other group that trains for 420 hours. Care Givers from both groups come to get training here. They get training in physiotherapy for the elderly. For example, if an older person feels unwell in a certain case – they train our CG on which part of her body, she should get physiotherapy*

*and how long she should get treatment. The Care Givers are under the supervision of the Health Promotion Hospital.” (A sub-district LAO staff/ Donkaew)*

In the following quote, a participant from a Hangdong District Hospital talked about when she trained Care Givers at the sub-district level, which resonates with similar training given by a different district hospital referred to in the previous quote.

*“We look at the home-bound and bed-bound elderly group on a case by case basis. Mostly we train the Care Givers to help them exercise or stretch the old persons’ muscles, use elastic bands to help them exercise, and emotionally support them during a home visit. Their mental health is important because sometimes their family members are not there, and no one takes care of the old persons, but they have the Care Givers.” (A district hospital staff/ Namprae)*

The first training scenario described by the interview participants can be illustrated by the following figure.



*Figure 24: Exclusive Internal – network Training*

In Figure 24, Node 1 is a regional or national government organisation. Consequently, it is a member of more than one network (Networks A and B) and it plays a role as a trainer for another network member who is an organisation at the local level (Node A2 and B2). It can be said that Node A2 of Network A and Node B2 of Network B, who are both organisations at the same governance level, also share the same trainer. However, they receive training separately as a part of their own internal network activities that exclude trainees from other networks. In

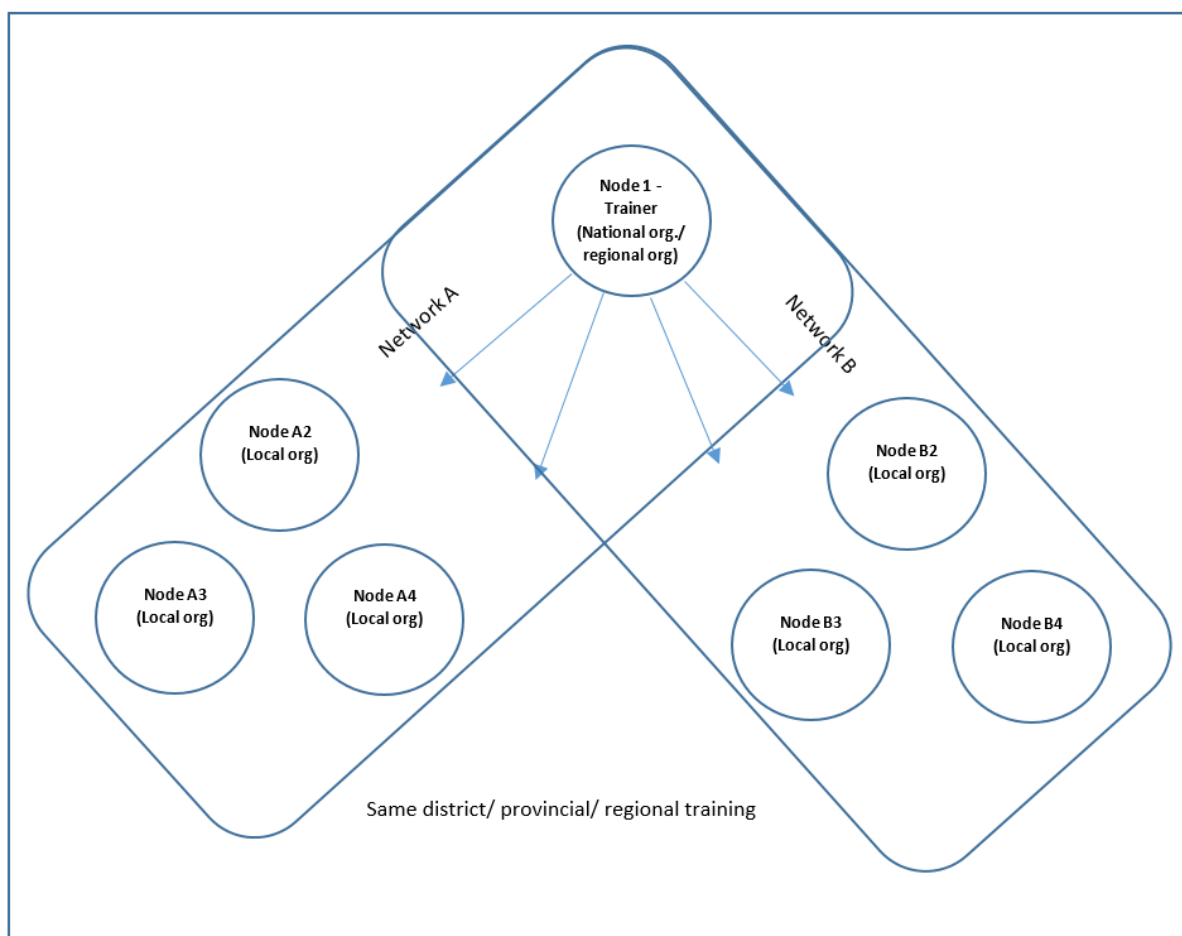


this scenario, the trainer is usually a district hospital, Chiang Mai NHSO Office, the Thai Health Promotion Foundation, or Chiang Mai Provincial Social Development and Human Security Office. Trainees are always an organisation at the local level, such as sub-district LAOs or a health promotion hospital. Training in this scenario is usually to train and transfer speciality or technical knowledge and skills and practices.

The second scenario is when one or more actors of a network in the same area receive training together from another actor along with representatives from different areas. I will call this scenario “multiple-networks training”.

*“There are also networks at the provincial and district levels and organisations at these levels coordinate with the LAOs in their areas either formally or informally. They invite the funding committees at the local level to participate in our training...We invite them [through the provincial and district level organisations] to our training for knowledge updates on our funding management [for the Sub-district Fund]. ... The committee consists of the LAOs and the civil groups.” (A regional officer/ Chiang Mai Province)*

In multiple-network training, the trainer is usually a regional, or a national organisation such as the Thai Health Promotion Foundation, Chiang Mai NHSO Office, a district hospital, or Chiang Mai Provincial Social Development and Human Security Office. The trainees are network members at the local governance level, such as sub-district LAOs and Health Promotion Hospitals. The trainer is a mutual member of more than one local network.



*Figure 25: Second Training Scenario: Multiple-network Training*

Nodes in Network A and B in Figure 25 represent members of networks from different sub-districts that participate together in the same training led by a mutual network member. In a multiple-network training, there could be members from sub-district networks within a single district or a single province to hundreds within many provinces, depending on the area of responsibility of the trainer. For example, a district hospital may organise training where participants are members of sub-district networks within their responsible district. Chiang Mai regional NHSO Office may organise training for LAOs and their sub-district health promotion hospital from all sub-districts within eight Northern provinces who are their responsibility. Thus, the participants in the training could represent up to more than 700 networks. Training in this scenario is usually to train local level organisations to acknowledge and familiarise themselves with national funding programmes and regulations, data and information collection methods, and systems used for the programmes. An interview participant of a regional level government organisation said that some training is training-of-the-trainers for a selected group of well-resourced LAOs, on building capacity and transferring knowledge of funding regulations and using online systems so that they can train other LAOs in nearby areas.

In both cases, training takes place on a regular basis, such as once or twice a year. They may take place with flexible arrangements between the trainer and trainee organisations. The training provided by the funding organisations about budget regulation and fund management may be organised less frequently than practice training provided for and received by organisations that are close to each other in physical distance. Learning and knowledge transferral through training is a characteristic that occurs in a governance network and is considered as technical exchange (Koliba, Meek, & Zia, 2011).

#### 6.3.3.7 Problem-solving

Actors within the network collaborate with one another in problem-solving. They may be involved in the early stage, such as in identifying and researching issues related to the health of the elderly, planning problem-solving strategies, or taking action to solve issues. The quote below is an example of actors working together in identifying issues that need to be addressed.

*“To plan a policy, we have to know of the issues first. [We find out about the issues] from the Village Health Volunteers or from the elderly population. ... Other organisations come in at the issue researching stage - what the issues are, and how we go about analysing the issues.” (A sub-district Health Promotion Hospital staff/ Donkaew)*

The elderly population and the community as the target population also take part in identifying problems. However, this process requires assistance from government organisations within the network. The benefit of the involvement of the target population is their participation and engagement at the actions stage.

*“We start from researching about the problems regarding the elderly health, similar to the planning process. We go out weekly, 48 times a year. We ask the older populations to list down what they would like to do. Sometimes if a conflict arises, we ask them to vote. The Health Promotion Hospital and the sub-district LAOs always take part. The LAOs come with us every time. The good thing about this whole process is that the target population prioritises their own issues and from this, we gain their cooperation when we take action.” (A district hospital staff/ Donkaew)*

*“We learn of issues about the fellow elderly, their health, and their needs in general from the monthly meeting of the village elderly committee. We then bring up the issues to the Namprae Municipality and they assist us or reach out to other organisations in our network on our behalf, especially in writing formal request letters, obtaining budget*

*support, or searching for speakers or trainers for us.” (An elderly club member/  
Namprae)*

Collaborating activities for problem-solving among network members are inclusive. It is notable that the elderly within the sub-district, takes part in identifying the issues, prioritising their concerns, or by just having their voice heard through the LAOs or other network actors working in their area. It can be summarised that even for problem-solving, where it requires the capacity of one or more organisations within the network, the identification and prioritisation of issues are mostly bottom-up, directly from the policy target population. The participation of the policy target population can make problem-solving more responsive to the local problems (Sabatier, 1986).

#### *6.3.3.8 Empowerment*

Network actors in Donkaew Sub-district, in particular, mentioned ‘empowerment’ often, especially in relation to government organisations empowering the elderly population. The following quote represents the first of two reasons to help relieve the burden of work for other government organisations within the network.

*“[Speaking about the Center for the Quality of Life Development and Occupational Promotion for Older Persons] When we work in the area, we do not work alone. We pull in our network members such as the LAOs and the social development officers. We try to make the elderly clubs own it, not the LAOs. Although the Social Development and Social Security Ministry owns the budget, we want the elderly to own it while we [the network] play supporting roles. They have to be capable on their own, this is my principle. If they understand what they are doing the programme for, they will be capable and will be able to keep up on their own. ...Things we do are pointing out reasons for the elderly projects, asking them to identify stakeholders and meeting together with the elderly groups, and discussing with the sub-district LAOs on their behalf. If the LAOs support the ideas, then they hold a town hall meeting in which we participate. Then we ask the larger group of the elderly in the community whether they agree and support the activities or projects. If they do, then we do the planning together. This process highly supports sustainability. We cannot leave everything to the sub-district LAOs because they have many responsibilities to cover, too many already. ...So, we have to empower the elderly group. At least they will have their own ideas of how to implement their own projects or activities with the guidance and support of other network actors, especially in their sub-district. It is more sustainable this way.” (A district hospital staff/ Donkaew)*

This quote illustrates how a network member does not only take into account the network's common goal and target population, but it also supports other members. Sustainability develops from this empowerment can benefit the target population by including their participation and responding directly to their needs and interests. It is also beneficial to other network members by relieving their overwhelming responsibilities while empowering the target population at the same time.

The same participant also talked about the second reason for empowerment, which is to build the capacity of the elderly group in the sub-district.

*"We might have to provide support in finding instructors for the elderly school and discussion facilitation. We also have to change the perspective of how the elderly group perceive the elderly school through empowerment. It should not be the same old concept that there is a school, teachers, students, but it could be us together, helping one another. Once they are reduced to being just students, their leadership will also drop. We have to empower them by building their capacity for thinking, initiating ideas, and stepping out of the belief that the sub-district LAO owns the school, rather they [the elderly] own the school. They should develop a plan and a curriculum together as they have done." (A district hospital staff/ Donkaew)*

There is no direct indication about the empowerment of the elderly population present in the Namprae case study area from the interviews. Agranoff and McGuire (2001), mentioned that network management employs techniques similar to organisation management such as group problem-solving, action planning, and process consultation. These techniques present as elements in collaborating activities between network actors in the Namprae case study area, although they were not mentioned explicitly that they are for the purpose of empowerment. However, the bottom-up approach of taking consideration of the elderly's project ideas and interests for programmes and activities within the sub-district suggests that empowerment of the elderly group exists in Namprae as well. Considering the elderly club as a representative of the elderly population in the sub-district as a network actor, empowerment, as a network collaborating activity, presents in both case studies. Ideas and interests brought up or proposed by the elderly club will eventually be supported and collaborated in by other actors, if funding is granted.

#### *6.3.3.9 Other Collaboration Activities*

There are other collaborating activities between network actors that participants mentioned in the interviews. These activities sometimes involved external-network organisations that are in a different governance level or organisations that do not regularly work with more than one actor

within the network. These activities occur less frequently. Examples of network actors and external-network organisations and their activities are:

- Vaccines supply approval and distribution: A district hospital coordinated with the District Health Office for vaccines to be distributed at the sub-district level, (Donkaew).
- Task distribution: The sub-district LAO collaborated with the District Office for Local Administration about reporting, receiving and acknowledging tasks and responsibilities assigned to them from the central government through the Governor and the District Chief (Ministry of Interior), (Namprae).

In terms of collaborating activities, at the organisational level, regional network actors interact with others at the local level most in information exchanging activities, especially context and area-based information. An interview participant, who is an officer at a regional government organisation, said that this is because his organisation does not have an office at the local level, but the information from the local level is required as an input to the elderly related programmes implemented and management of funding given to the sub-district LAOs. The interactions lead to a close relationship between actors in both levels of organisations, particularly the regional-level actors and the LAOs.

The density of interactions between network members in terms of reciprocation of trust, commitment, and collaborating activities found in the two case studies is very extensive, highly dependable, yet very supportive. These findings indicate high trust density and will be discussed further in the Conclusion and Discussion section of this chapter.

## 6.4 Network Goal Consensus

Network goal consensus is one of the factors that determine the form of network governance (Provan & Kenis, 2008). However, goal consensus in this regard is not only the agreement of the network actors on the goals they share but includes how the network decisions and activities are facilitated among the actors to achieve the common or network goals (2008). In this research, three factors that helped with the analysis of the extent of network goal consensus were 1) agreement of actors on the network-level goals; 2) occurrence of conflicts and; 3) conflict resolution mediator(s) (Provan & Kenis, 2008; Poocharoen & Ting, 2015).

### 6.4.1 Agreement of Actors on the Network-level Goals

The national policies in the forms of an Act and a national plan (see Table 3, p. 38) suggests that the ultimate overarching elderly health promotion goal is to ensure that the increasing elderly

population in the country has a good quality of life. With health promotion as a means to help them maintain good physical and mental health in their old age, related government organisations serve, provide, and implement programmes that stemmed from the policies for the target population or for their benefit according to their organisation's specific mission and functions. The subsequent health promotion for the elderly policy implementation networks formed by government organisations are goal-directed networks. Consequently, the network goals are systematically agreed upon by the network actors as their organisational mission and functions have been fundamentally established to respond to the goals. While the organisations within the network are "made" to agree to the network goals, it does not mean that all are capable of accomplishing the network-level goals with their own resources and capacity.

Despite their different organisational functions, direct relevance to the policy goal, level of authority in the implementation area, resources capabilities, and skills capacities, 76% of survey participants said all organisations involved in the health promotion policy implementation for the elderly at the local level make a decision together (Q24).

The agreement of actors on the network-level goals is reflected by their organisation's staff understanding of the health promotion policy implementation for the elderly goals. From the survey, 86% of the participants indicated they *agree* or *completely agree* that they understood the goals of the health promotion policy implementation for the elderly network at the local level (Q21). The understanding was observed in the interviews when participants talked about their collaborations with the other actors within the network. The reasons they are a part of the network are not only are their organisational mission and functional responsibilities enforced through membership of the network, but they are also aware of the existence of the common goal and that aligning theirs and other organisations' work benefits the elderly health and quality of life. This shared understanding is shown in the following quotes.

*"Our mission is not only to achieve our own goals, not just the ministry's goals. Goals are broad and extended to those of our province, all of us organisations in the province want to see the elderly's quality of life improve. It is called provincial strategy in the development of the quality of life of the older people. This is another factor we work on together in the area. ...It is not just spending the ministry's budget only on functional responsibilities of our organisation, we also think about and respond to the provincial goals." (A regional officer/ Chiang Mai Province).*

*"We work with other organisations because it is for the older people. Sometimes the work does not directly relate to my roles but I help out, I get to know others. ...We are*

*goal-oriented. It extends to all ages of population groups. We help each other.” (A district hospital staff/ Donkaew)*

It can also be summarised from the surveys that network actors have an agreement on the network-level goal by sharing the same understanding of the national policy goals that directed their network formation – a good quality of life for the elderly. From the interviews, this common understanding has also become, if it had not already been, an individual organisational goal of the actors within the network. This is advantageous to the target population as they benefit from the network actors’ collaborations and their non-competitive nature (Provan & Kenis, 2008). Organisations within the network have a common network-level goal with an aligning individual goal that can be achieved by functions of different organisations besides their own.

#### 6.4.2 Occurrence of Conflicts

Data from the survey showed that 60% of the participants thought conflicts between staff, officers, or employees within the network are not uncommon (Q42).

From data collected in the two case studies, specific conflicts regarding the actions of actors in collaborations were not mentioned. However, when asked about conflicts, interview participants said that conflicts that arose were around the need for the programme or activities of the target population and the funding or budget regulations that limited spending in response to the need. Sometimes budget spending regulations of funds received by the LAOs become a source of conflict. It is not an action, personal, or emotional conflict, but a conflict between the funding regulations and the needs to use the funds. The quote below exemplifies this conflict where the budget a LAO received was subject to the regulations set by the funder (NHSO) and the State Audit Office of the Kingdom of Thailand.

*“The NHSO does not let us claim expenses on traditional Thai medical treatment for the elderly in our care because they saw that the budget for this expense can be transferred from the existing traditional treatment fund overseen by the Provincial Public Health Office [not defined as a network actor in this study]. They wanted us to make a claim with that office instead. We informed them that by the time we receive the money from the Provincial Public Health Office, it would be too late for the patients, especially those that need rehabilitation or those with coronary artery disease. They need timely continuous traditional treatment. NHSO would not let us make a claim with them, so we used our own money for the timely purchase. We operate differently. They followed the*



*regulations, but we had our needs. The claim approval could have been more flexible based on the needs and context of the area.” (A sub-district LAO staff/ Donkaew)*

From the quote, the funding regulations and the inflexibility to include the claim in the existing funds of the NHSO caused a conflict between the needs of the community and the budget spending regulations. This situation happened in Donkaew Sub-district where the LAO has sufficient budget of their own to support the programme needed by the elderly in their area. It could be difficult for other sub-district LAOs that do not have sufficient financial reserves. Namprae LAO, on the other hand, does not have funding reserves to support the emerging need of the elderly population. In Namprae, this type of conflict also occurs, but when it does, the proposed programme or activity is put on hold. The following quotes are from an interview with a staff member of Namprae LAO and the head of its sub-district elderly club on this matter.

*“There are some conflicts with other [local] actors, but mostly they trust the municipality [LAO]. For example, when they proposed for funding, sometimes we had to tell them that we cannot approve it due to regulations, they understood. Mostly we talked it through this conflict. It was never problematic, we understood each other.” (A sub-district LAO staff/ Namprae)*

*“Most projects and activities related to health we request funding for are usually granted. Some are limited because the available funds do not match with the projects we would like to do. In that case, we have to wait until there is a fund that its regulations would approve our project. Sometimes we have to wait for a year or more.” (An elderly club member/ Namprae)*

The quotes on the issues between the regulations and needs of the community showed that they are a common conflict issue. However, the actions taken to resolve this specific conflict led by the LAOs may be different in each sub-district.

Besides the conflict of funding regulations and the needs of the target population, an interview participant from a regional-level organisation explained that the reason conflicts between network actors are very rare is because actors' functional responsibilities do not overlap. This is due to the different knowledge and expertise they possess, and their official duties assigned by the central government. Another reason mentioned by the same interview participants was that as network actors will have to continue working with one another, a good relationship and respect have to be maintained.

*“Conflicts are rare; there could be an irritation here and there, but we [the network] cannot be broken. We have to maintain the relationship because we need each other. Dispute-level of conflict to the point that someone has to leave has never happened. We respect each other. Also, on a personal level, no one has a conflict with any other. Each organisation has their own work and do their own work within their official responsibility boundary.” (A regional officer/ Chiang Mai Province).*

However, another interview participant from a regional-level organisation, a district hospital disagreed. She believed that by focusing on their own responsibility and accomplishing individual, organisational goals while working with others within a network can sometimes lead to conflicts.

*“Disagreements are common. Sometimes we would like to prioritise our work, but sometimes they [other actors] want to prioritise theirs as well.” (A district hospital staff/ Namprae)*

These results imply that when working together, conflicts can occur especially at the individual staff level. They also occur at the organisation level. Neither are specified to be at a significant level. On a rare occasion, when a conflict occurs, mediation or other conflict resolution approaches take place.

#### 6.4.3 Conflict Resolution Mediator(s)

Particularly for a goal-directed network, when conflicts are addressed as a part of the governance mechanism, it indicates the engagement of actors and their supportive actions (Provan & Kenis, 2008). When conflicts do occur, over three quarters of survey participants (76%) either *agreed* or *completely agreed* that they are always recognised and resolved respectfully (Q43). Recognition of conflict as a normal situation, particularly an interpersonal conflict, will rise as organisations that work together grow more integrated and personal involvement increases as a part of a collaboration (Gajda, 2004). From the interviews, conflict resolution can be categorised by using two approaches. The first approach is voting. The second approach is mediation through a discussion. Conflict mediator also varies by the approach taken to resolution.

##### 6.4.3.1 Voting to Resolve a Conflict

When asked about conflicts, most interview participants said that there have been none or are very rare. However, one interview participant whose organisation is at the regional-level and organises monthly meetings for LAOs of multiple sub-districts, and personally participates in activities related to health promotion for the elderly in multiple sub-districts said that disagreements are common.

*“There are no conflicts per se, but disagreements are common. Everyone has had a different experience. When they occur in a meeting, we raise our hand to vote – how many agree, how many disagree.” (A regional officer/ Donkaew)*

#### *6.4.3.2 Discussion to Resolve a Conflict*

A mild conflict about taking actions on an issue might occur between network actors. Another approach that actors used to resolve such conflict is through a discussion. This approach appears to work well when the actors are aware of their roles in activities such as a support provider or as a decision maker. An interview participant who is a district hospital staff member said that the sub-district LAOs and actors within the sub-district know their community best. They can decide what is best for their community and their community members. When working together, her organisation plays a role in proposing ideas and supporting the activity should the idea is approved by the sub-district LAO or other actors within the community. If they disagree, she has to respect their decision. Therefore, the conflict is minimised or avoided in a situation where it could occur.

*“I learned that the decision has to come from them [the LAO]. Our job is to sell ideas. Whether they support the idea or not is up to the community needs, not mine, not my organisation’s. Sometimes we do not have to say much, in a case when they know exactly what they want or how to do it. It is quite clear, especially when they have good leadership.” (A district hospital staff/ Donkaew)*

A disagreement that takes place due to different individual actors’ prioritisation is resolved by a discussion to negotiate, according to another interview participant drawing from her experience working for a regional-level organisation and participating in multi-organisation network meetings.

*“...[When a disagreement takes place] we discuss how we are going to resolve it. Like which way or whose approach we are taking to find a mediation that both of us are comfortable with to collaborate collectively. ...We do not normally vote. Usually, one of us would propose an idea after a disagreement; then the other would voice whether they agree or if they have another idea. Then we discuss the option.” (A district hospital staff/ Namprae)*

This mediation approach is also adopted as a means to resolve a disagreement that occurs between a LAO and other actors working with them. Usually, this type of disagreement is caused by a lack of understanding or knowledge of the local or sub-district specific context surrounding the target population. A LAO staff said an outside-of-sub-district organisation

might disagree on their topic prioritisation while working within and with the sub-district LAO, based on their general knowledge or experiences from elsewhere. A discussion to mediate the disagreement then takes place to create a mutual understanding of a situation in the community.

*“Suppose they [other network members] would like to talk about something at the session [at the elderly school], the subtopics could be A, B, C,... sometimes in a case where they are invited to instruct in our class or in a case where we are invited to go out, it has to be context-based. Sticking with the standard A, B, C.... outline is not always relevant. We negotiate to make the content more relatable. So, it is more like collectively finding a solution, as a negotiation. Not to the level of conflict resolution, probably not.”*  
(A sub-district LAO staff/ Donkaew)

The data suggests that conflicts in the form of disagreements are always resolved by voting or a discussion between actors to find a collective resolution. The interview participants mentioned no specific conflict resolution mediator, but it could be assumed that for a disagreement that occurs in a meeting, the actor hosting the meeting and playing a role as a facilitator is the mediator. This assumption is supported by the survey result that 83% of the participants said that when an issue arises in regard to the health promotion policy implementation for the elderly, an organisation plays a role as interactions’ facilitator such as arranging the meeting, inviting organisations, and facilitating the meeting discussions (Q5).

Moreover, among those participants that said there is *an organisation that plays the role of a conflict mediator*, 53% indicated that *a different actor takes turns at the role when an issue arises* (Q5). This strongly suggests that when conflicts occur within the network, they are usually mediated by a single actor, but that actor may not be the same one depending on where and in what circumstance the conflict takes place. Out of 29% of survey participants who said *one organisation always takes the role* as a mediator, the majority indicated *a LAO is that one organisation*. For a discussion to resolve a conflict, it also appears that there is no obvious appointed mediator. The actors involved would engage in a discussion to come to a mutually agreed solution without any organisation deciding for others. This conclusion is also supported by data from the survey results where 58% of participants *agree or completely agree* that no organisation makes a decision for others (Q25).

For network goal consensus, members of the two sub-district networks in the case studies strongly agree with the network-level goals. This agreement is primarily due to the national policies and plans that established common goals for them. The national policies and plans

also directed the organisations to form as a network to accomplish the common goals. Moreover, network actors' individual organisation mission is aligned with the national policies and plans, although by different levels of priority and involvement depending on their organisation's functions and responsibilities. The agreement of actors on the network-level goals, the mutual understanding of them, and the joint activities that reflect shared values and guide actions. This reflection is a network governance characteristic that Jones, Hesterley, and Borgatti (1997) referred to as "macroculture", an element that makes the network effective.

The two networks in the case studies strongly present the characteristic of network goal consensus as shared-governance networks where no single actor plays a dominant role in conflict mediation (Provan & Kenis, 2008; Poocharoen & Tong, 2013). Moreover, this observation is drawn from the data showing their shared understanding of network-level goals, a collective decision-making approach to reach network consensus, and approaches to conflict recognition and resolution. In terms of conflict resolution mediation, in particular, the dominant survey result indicated that more than one organisation, rather than the same actor takes the role of a conflict mediator. Based on this summary alone, both networks exhibit the characteristic of the shared-governance network. However, those that said there is one organisation that always takes the role of a mediator, indicated that the organisation is a LAO. This leads to an implication that while the majority of the data suggest that the networks are shared-governance based on conflict resolution characteristics, the minority data shows a lead organisation-governed characteristic. The variety of conflict resolution and mediators suggests that actors within the network have their own logic based on appropriateness in applying resolution and mediating approaches to reach a consensus.

## 6.5 Network-level Competencies

For the actors to become a member of a governance network, they must possess the capacity to contribute resources and competencies to others (Torfing, 2005). While the reasons for organisations joining a network can vary, either they participate voluntarily or are mandated, they seek to achieve a goal that they otherwise are not able to on their own (Provan & Kenis, 2008). This leads to the important question of whether the actors within the network possess the competencies required for the network to achieve its network-level goal, and if not, how they attain them (Provan & Kenis, 2008). Two critical issues related to network-level competencies according to Provan & Kenis (2008) that need to be considered in determining an effective form of governance network are "the nature of the task being performed by network members" and "external demands and needs being faced by the network" (p.240).

National policies directed organisations to be a member of the network based on their organisation's mission, functions, and responsibilities. A single organisation, despite its high level of expertise and knowledge, will not be able to provide a holistic health promotion outcome and ultimately yield a good quality of life for the elderly on their own. They need others to assist them in achieving their own organisation's goal. Thus, the network-level goal needs integration of competencies from multiple organisations. Due to the unique expertise, responsibilities, and resources each network actor has, the nature of tasks being performed by each actor varies accordingly. Therefore, actors within the network are interdependent due to the different capacity they are able to contribute to achieving the network-level goal collectively, a formation is suggested by the national policies. I found that network actors assist, support, and exchange resources with one another as a part of their collaborating activities. According to Provan & Kenis (2008), in a network where actors are interdependent like this, a high level of network-level coordinating skills can be expected because the interdependent actions need to be facilitated.

The interdependence of actors within the network are confirmed by the survey results where three quarters of the participants said that, at the local level, their organisation *usually* or *always* possesses expertise or knowledge related to the assigned tasks related to the health promotion policy implementation for the elderly (Q27). This clearly shows that actors within the network do have task-specific competencies and they believe that their contribution is based on those individual competencies. Furthermore, only 37% of survey participants *agree* that their organisation is the core provider and the only one that has sufficient resources for the related activities and programmes among others within the network (Q26). Nearly half of the survey participants said they *disagree or neither agree nor disagree* that their organisation is the core provider and the only one that has sufficient resources for activities and programmes related to health promotion for the elderly. These findings signify how interdependent actors within the network are, and the majority believing that they are not a core provider also suggests that there is no one dominant member contributing to network-level competencies.

External demands, as outlined by Provan & Kenis (2008), include buffering or handling a fluctuation in funding, changing of regulations, recruiting new members, and obtaining further funding. However, the networks in the case studies are unique as their formation and tasks are directed by national policies. Thus, they do not have to deal with many of these challenges. The policies protect them from challenges that may be caused by external demands, although they may pose as a limitation itself. For example, the central government (ministries) and a national organisation (the Thai Health Promotion Foundation) provide funding for actors within the network for elderly health promotion periodically, but they might not be sufficient for all the required activities. However,

actors do not have to compete with others with the same responsibilities to acquire funding, but they must meet the criteria for the available funds with their own individual skills and resources.

In the case of changes or updates in regulations involving funding or welfare delivery, actors, specifically those at the regional level, will be the ones working with others in the network to build mutual understanding. This external demand can be a challenge for a shared-governance network as centralised actions to pass on the information, and other activities are required to create a mutual understanding and subsequent implementations. Nevertheless, this is when the advantage of being a policy-directed or semi-mandated network prove to be an advantage. For example, regional-level organisations address the external demand for regulation change for the whole network as a lead organisation passes on the information and skills training required by the change.

In addition, although it is highly possible that for network-level competencies, the network will be lead organisation-governed, scholars mentioned possible limitations caused by this form of governance. These limitations include reluctance to make financial commitments to build the required skills and a lack of specific skills or competencies that could assist other members (Provan & Kenis, 2008). These limitations did not seem to be a challenge in the networks being studied in this research. The primary reason could be that national policies set them up as individual organisations and as a network. However, while none of the policy and strategy has set up an official structure or provided a fixed direction for how the network should operate, they prevented the pressure of external demands on the network actors by establishing the framework that formed the network and appointed roles for organisations as a network actor. The most apparent roles are funders and fund receivers who take actions as well as network centre in the policy implementation at the local level.

## 6.6 Conclusion and Discussion: A Hybrid Form of Network Governance

From the findings in this chapter, the following table shows the form of network governance and network key structural and relational contingencies drawn from national policies, along with the form of network governance from the case studies.

*Table 9: Summary of the Case Study Networks' Form of Network Governance*

<b>Network Structural and Relational Contingencies</b>	<b>In policy</b>	<b>In case studies</b>	<b>In existing literature</b>
Number of participants	<b>10 core actors</b>	<b>10 – 11 core actors</b>	<b>Shared governance: fewer than six, Lead organisation-governed: more than 10, flexible number)</b>
Centrality of governance	<b>LAOs as centre of the local policy implementation network</b>	<b>LAOs as centre of the network, highly centralised as a betweenness gatekeeper of the network</b>	<b>Shared governance: equally spread out, Lead organisation-governed: highly centralised</b>
Trust	<b>The density of trust cannot be determined</b>	<b>A high density of trust</b>	<b>Shared governance: high, Lead organisation-governed: low density, and highly centralised</b>
Goal consensus	<b>Exists as a given factor, level subject to actual practice</b>	<b>High</b>	<b>(Shared governance: high, Lead organisation-governed: moderately low)</b>
Need for network level competencies	<b>High, based on the direction to integrate organisations with different specialisations</b>	<b>High based on specialisations</b>	<b>(Shared governance: low, Lead organisation-governed: moderate)</b>
<b>Conclusion</b>	<b>Cannot be determined</b>	<b>A hybrid form – a combination of lead organisation-governed and shared governance</b>	



Based on Provan and Kenis's (2008) explanation of forms of network governance, it is concluded that the networks of health promotion policy implementation for the elderly at the local level in Thailand have a combination of lead organisation-governed and shared governance forms. This hybrid model reflects the management of network activities based on organic characteristics such as the number and location of actors and management characteristics of the networks. National policies (Table 3, p. 38) suggested the LAOs play a role as the centre of network governance. The local-level implementation networks in the case studies consist of 10 -11 actors. This number of network actors is suitable as a lead organisation-governed network which the national policies suggested and for the effective outcome (Provan & Kenis, 2008). However, there is no evidence that the policies intended to establish a lead organisation-governed network for this purpose. The lead organisation-governed form of network governance lessens the complexity of a network's meetings and decision making which was found to be the case in the case study networks' collaborating activities.

The studied networks showed that although they are highly centralised, network actors indicated they trust their central actor, the LAOs. They also highly trust other network members. This is a common characteristic usually found in the shared-governance network where there is a high density of trust distributed across the network (Provan & Kenis, 2008). Sources of trust between networks actors include numerous collaborating activities and commitment in doing these activities which allow actors to interact frequently both at a personal and organisational levels.

The collaborating activities between network actors and their participation showed a high level of commitment, which is key in networks (Poocharoen & Ting, 2013). Through these activities, actors developed new working approaches that they learned from others within the network, particularly in the Donkaew case study where learning is more extensive. This presented the networks collective learning characteristic. Also, as a result of having extensive collaborating activities, a high level of coordination between network actors took place which suggested a form of shared-governance network (Provan & Kenis, 2008; Poocharoen & Ting, 2013).

The coordination between network actors for things such as equipment and vehicle support, sharing from training, and empowering one another as well as the target population showed that actors are network goal-oriented and target population-focused. This encouraged actors, particularly those who work directly with the elderly population, to be more flexible in the activities and being supportive of each other in providing resources that the others lack. This is a supplement to achieving the collective networks' goal. However, it must be noted that the goal of the network itself also came from national policies. Thus, this could be the main reason that influences the whole network to agree to the network-level goal enabling goal consensus among network members. As a

result, they exemplified a shared-governance network based on the high level of network goal consensus and no dominant decision makers in building consensus. While it can be implied that network goal consensus of the case studies is a given factor provided by the national policies, the way any conflict is managed is determined by each network. From the findings, the conflict mediator and resolution facilitator are perceived to be either a single actor or multiple actors. This is indicative of a characteristic of either lead organisation-governed or shared governance forms of network respectively. Both networks also have their own similar approaches to conflict resolution. Approaches of conflict resolution and roles of facilitator and mediator were not suggested by any policy. This means that it is possible a conflict resolution approach of a lead organisation-governed network, where one actor takes a dominant role as a facilitator or mediator, still takes place even though the policy is not a factor.

Robins, Bates, and Pattison (2011) suggested that the stronger macroculture from the shared network goals and objectives, the less the conflicts among network actors, as no members would try to prioritise their own policy at the expense of others. Network goal consensus and conflict occurrence within the case studies are the manifestation of a strong macroculture. Although there have been disagreements caused by actors' desire to prioritise their work in a collaborative programme or an activity, their policies are joint, the network-level goal and the individual organisation's goals are still aligned, and disagreements are always resolved for the collective benefit. This may be the reason that the disagreement or conflict that emerges can be smoothly and peacefully mediated by a vote or a negotiating discussion.

In terms of network-level competencies, most of the organisations within the network do not consider themselves as a core provider. This indicated the shared-governance network form where no dominant actor plays a role as a core provider of the whole network. Moreover, although the LAOs play the role of the centre of the network in both case studies, they also do not consider themselves as the core provider of the network.

The policy implementation network at the local level was designed to be lead organisation-governed in term of network governance form where the LAOs were directed to be the central node of the network by the national policies. The findings of network's management and the ensuing trust and competencies from the collaborating activities at the implementation where actual practice takes place revealed that the networks within the case studies have a hybrid form of governance. This hybrid form is a combination of lead organisation-governed and shared governance forms. The LAOs sustain their position from the national policies as the centre of the network. Their key roles and responsibilities also have a high level of holding the 'betweenness centrality' of the network.

According to Provan, Fish, & Sydow (2007), an organisation with betweenness centrality serves as a gatekeeper of the network and connects between organisations that are not directly connected for the purpose under the same topics. Moreover, based on the variety and extent of collaborating activities within the network that mostly involved the LAOs, it implies a level of 'multiplexity' LAOs exhibit as a central actor.

Provan & Kenis (2008) suggested that in a case where trust and goal consensus decline as the network becomes bigger in terms of the number of actors and network-level competencies are highly desired, the shared-governance network form will not be as effective as other forms. However, this is not likely to be the transformation of the network governance form in the case studies. Although the national policies that established the networks in this study did not include the design of their network governance form, the policies unintentionally control the maintenance of the number of network actors, the high level of trust, and goal consensus. It is likely that the form of network governance in these networks will remain a hybrid. It is also possible that factors that construct the form of network governance may not be definitive for the prediction of policy outcome (Provan & Kenis, 2008). Therefore, the likelihood of achieving the policy outcome may not be conclusively predicted based on the form of network governance alone in this study. However, exploring other aspects of the networks will help shed light on what can be factors in predicting policy outcomes and provide policymakers with a better understanding of the networks at the local implementation level. The next chapter explores network ties and relationships developed from network interactions and the multiplexity of the LAOs, and it will also offer guidance in predicting the policy outcome.

## Chapter 7: Unboxing Networks Relationships

Characteristics of a network can explain the network relationships. This chapter addresses the first research sub-question about the extent of relationships between network actors as their characteristics, and operational functions. Based on social network analysis commonly applied to study network ties, formality and strength of ties between actors can be used to characterise their relationships (Koliba, Meek, & Zia, 2011). A network itself in a general definition by Brass et al. (2004) is “a set of nodes and the set of ties representing some relationship, or lack of relationship between the nodes” (p.795). To determine whether that relationship exists or not and to explain the extent of the relationship, Koliba et al. (2011) indicated that there are variables that should be looked into to analyse the relationship characteristics of a network. These variables include network resource exchange, the strength of ties, the formality of ties, administrative authority, and accountability relationship. In addition, administrative ties reflected as social ties between actors might be the most crucial among these variables in analysing the governance of the network (Koliba et al., 2011).

Results from data collected for this research describe the relationship characteristics and the extent of ties between actors within health promotion policy implementation networks for the elderly in the case studies. While their network formation is directed by national policies and plans, the relationship between actors within the networks certainly cannot be policy-constructed. Rather, the dynamics of the network relationship variables have been established and developed over time and depend on the extent of their variables. The following sections discuss these variables and the relationship characteristics of the networks being studied, emphasising the resources being exchanged within the networks and the ties established, maintained, and developed between network actors based on the resources exchanged.

### 7.1 Resources Exchange

From the case studies, resources exchange between actors within the health promotion policy implementation for the elderly networks covers a range of tangibles and intangibles. Tangible resources exchanged include personnel, equipment and vehicles, funding, and facilities. Intangible resources network actors exchange are knowledge and information, relationships, and values. Koliba et al. (2011) mentioned that stocks and flows of resources or capital are inputs fed into the system of exchange between network actors. These capital resources can be specifically grouped into eight types: financial, natural, physical, human, social, political, cultural, and intellectual or knowledge

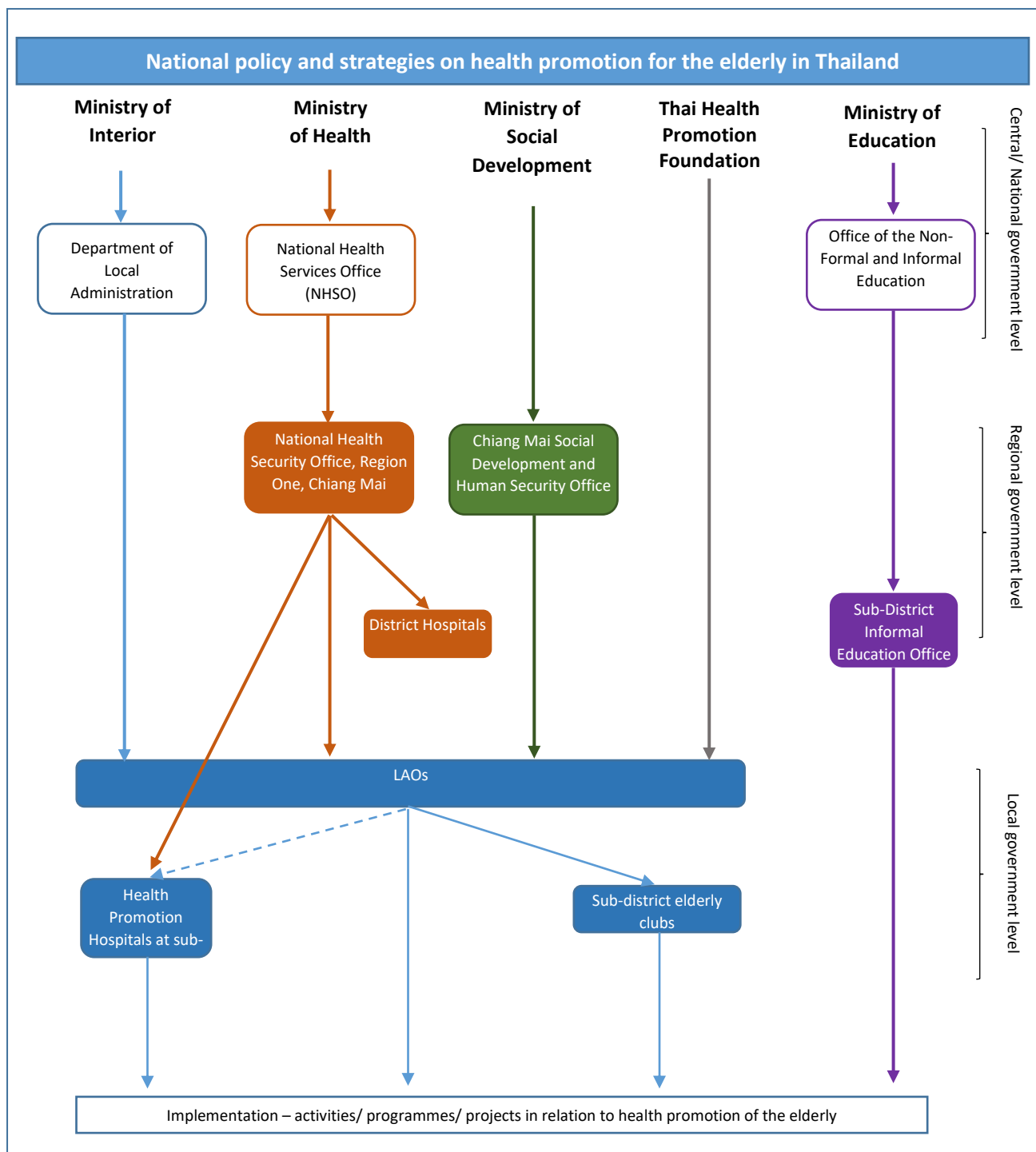
(Koliba et al., 2011). The description and types of capital resources summarised by Koliba et al. (2011) were used as a guideline to develop survey questions enquiring about the occurrence of resource exchanges between actors and their frequency. According to the survey participants, all types of resource capital were exchanged by their organisations within the network. The following sections are findings of resources that are exchanged most extensively and which are influential to the relationships of actors within the networks.

#### 7.1.1 Financial Capital

Among survey participants, 10% indicated that their organisation had exchanged financial capital that included cash, securities, loans, and funding with other organisations within the network *all the time*. The majority of 42% said they *usually* exchanged these resources, and 26% said they *rarely* exchanged (Q45.1). These results indicated that the extent of financial capital exchange between network actors varied.

Financial capital exchange takes place because the networks consist of regional-level organisations who are the distributors of central government funds while local-level organisations are the receivers and deliverers of programmes and services funded by that money. The LAOs use the funds to implement projects and activities either directly by themselves, collaboratively with other network members, or indirectly by distributing the funds to their sub-district elderly club according to their projects or activity proposals. Some of the regional-level organisations within the networks, such as the district hospitals, also receive funds from the regional NHSO office, as they are healthcare providers.

In an exchange of financial capital, actors who are service providers at the implementation level and received the allocated fund carry out national programmes or develop other projects and activities in response to the national policy goal with the elderly in the community. Figure 26 illustrates the exchange of financial capital and policy implementation from the central government to actors in the case study networks.



*Figure 26: Financial Capital Exchange between Organisations within the Case Study Networks*  
 Note: 1) Shaded boxes are network members in case study networks; others show the sources of budget or funding (supervising organisations); 2) Only members involved in financial capital exchange are included.

The Health Promotion Hospital at the sub-district level that is under the administration of a LAO such as in the case of Donkaew receives funding through and from the LAO. In a case where the hospital has not been transferred to the administration of a LAO as in the case of Nampree, their primary

funding comes from and through the Ministry of Public Health and their regional-level organisations (see Figure 26).

Most members in the health promotion policy implementation for the elderly networks in both case studies exchange financial capital (see Figure 26). The higher the organisation is in the hierarchical governance structure, the more responsibility the organisation has to allocate funding to other organisations. This responsibility includes ensuring that the fund receivers meet the criteria and implement programmes that adhere to the fund regulations. All organisations involved in the exchange of financial capital also manage the resources to some level. This conclusion is also reflected in the results where participants were asked about the frequency their organisation manages most of the budget from the central government on the health promotion policy for the elderly (Q19). Only six per cent said that their organisation *never* manages the budget from the central government.

Even though LAOs are a mechanism of decentralised governance with supposedly independent authority and management flexibility, they are restricted by regulations attached to the funding they receive as core budget from the central government through the ministries. Collaborations between network members also emerge after budget allocation is disbursed for each organisation. An interview participant explained that whereas her organisation worked in a sub-district on informal education and received a budget from the central government, after the budget allocation, she could see an opportunity to work with other organisations at the implementation level if their projects could be aligned.

*“In each quarter, the budget is allocated, and it is up to our [supervising] organisation which topics they would like us to educate the elderly population [with that budget]. ... we would know in advance that in this coming quarter we would work on health so we would coordinate with other organisations to see whether they have plans to work on a health topic in this area too. If they do, then we collaborate with them. We participate in their planning, so we know activity schedules. ...An example of co-planning is with the Health Promotion Hospital who is also in our network – suppose we have a plan to work with an elderly group, we go over to them and talk about our plans. Then, we incorporate our plans with the same group of the population together.” (A staff member from a sub-district government level organisation/ Donkaew).*

The quote above shows that the exchange of financial capital also plays a role in incorporating implementation planning and activities between organisations. This implies that direct resource

exchange can indirectly bring organisations to work together on projects that align and serve a common goal as well as the individual organisation's goal that needs to be accomplished. In addition, the organisations at the implementation level do not only carry out programmes and activities in response to the policy goals, but they also make sure that the programmes and activities respond to the needs of the policy target population to whom the financial capital are directed to.

*“Before we start a project regarding the elderly population, we would talk to the elderly group first as well as survey their interests and their needs. If their interests and needs match with the topics that our budget is allocated for, then we can do it.” (A sub-district level officer/ Donkaew)*

*“The NHSO already has the funds, right? So, if Care Givers [in the sub-district] want to do a project about elderly health, they can submit a proposal for funding from the existing funds available.” (A sub-district LAO staff/ Donkaew)*

Care Givers are trained community volunteers supported by the Long-term Care Fund provided by the NHSO in Donkaew sub-district. They work directly with the elderly population in the community. Their work includes home visiting and assisting with basic rehabilitation exercises for the elderly. Having seen their living environment and working directly with the elderly population, the Care Givers are knowledgeable about the needs of the elderly within the community and the surrounding context. Activities and programmes are planned according to financial capital, specific regulations, and goals. Organisations receiving the resources also ensure the money is used purposefully on initiatives that come from the voices of the target population.

Exchange of financial capital between network actors have structures to facilitate them as well as measures to evaluate the spending and accountability (Koliba et al., 2011; Wattanasupachoke, 2009). From the interviews at both the national level and the implementation level, I found that the structure to facilitate the financial capital exchange for the elderly health promotion exists within the broad responsibility of each organisation involved. However, the measurement and effectiveness of the measures are questionable. For example, the table below is a copy of the Second National Plan on the Elderly 2002 – 2021 strategies on elderly health promotion and development.



Table 10: A Modified Copy of Strategy 2 – Strategy on the Elderly Promotion and Development from the Second National Plan on the Elderly 2002 – 2021

No.	Measures	Focal Points	Index	Targets			
				2006 (5 years)	2011 (10 years)	2016 (15 years)	2021 (20 years)
<b>1</b>	<b>Measures on health promotion, prevention against disease and primary self-care</b>		<b>Proportions of the elderly population who have requisite behaviour for health</b>				
<b>1.1</b>	Organise health promotion activities* in a variety of formats suiting the elderly and their families.	1. Ministry of Public Health 2. Ministry of Interior (Local administration Department LAD)/Local Administration Organizations(LAOs)] 3. Bangkok Metropolitan Administration, Pattaya City Administration 4. Thai Health Promotion Foundation 5. National Health Security Office 6. Public and private networks 7. Office of the Prime Minister [(the Government Public Relations Department, the Mass Communication Organization of Thailand (MCOT)]	Proportions of the elderly population who have requisite behaviour for health	20%	30%	40%	50%

Note: Health promotion activities refer to general counselling involving the elderly health promotion, prevention against diseases, primary self-care and exercise.

Source: The National Committee on the Elderly. (2009); The 2nd national plan on the elderly (2002 - 2021), 1st revised of 2009.

From the example national plan in Table 3, the “proportions of the elderly population who have requisite behaviour for health” (The National Commission on the Elderly, 2009, p.15) is an indicator of national health promotion measures. However, it is clear that this indicator can only provide the output or the number of the elderly in percentage with the expected behaviours, but not the quality or how well their requisite behaviour translates to good health as a result of the national strategy

implementation. Other than the quantitative information, the current indicator does not reflect whether the health promotion measures can actually improve the health of the elderly. Therefore, whereas there is a well-structured financial capital exchange as is expected in a governance network, the effectiveness of the financial capital exchange cannot be evaluated, and conclusions drawn from the current indicator.

The transparency of funds and budget spending is audited by agents of regional offices of the national Comptroller General's Department and the State Audit Office of the Kingdom of Thailand (Disciplinary Finance and Monetary Office, n.d.; "The Comptroller General's Department, 2014). The annual budgeting report of LAOs in both case studies are also available to the public on their websites. However, online access to budgeting reports cannot be expected for all LAOs across the country as this depends on the individual LAO's capacity and resources.

In summary, whereas the financial capital exchange structure and accountability measures have been established, the cost-effectiveness of the exchange cannot be assessed based on the national policy indices. Each ministry and national organisation involved may also have a separate measurement for the outcome of the financial capital exchange and budget spending.

### 7.1.3 Human Capital

Human capital is important for an organisation's success (Wright, Dunford, & Snell, 2001). Hitt et al. (2001) literature review on the effects of human capital on an organisation's strategy and performance concluded that an organisation's actions are a result of human variables, particularly those of top managers (Thompson, 1967; Hambrick & Mason, 1984). Human capital affects the organisation's actions and is critical because people possess skills and knowledge that the organisation relies upon (Hitt et al., 2001). While human capital is a part of an organisation, the knowledge, skills, and technical expertise are assets of the individuals (Koliba et al., 2011). The organisation develops as the human capital gains qualifications and the ability to take actions against rapid changes it encounters (Gökalp, 2015).

In accomplishing the goal of health promotion for the elderly, organisations within the health promotion policy implementation for the elderly networks exchange human capital with one another. To explain this more precisely, the network members exchange skills, knowledge, and expertise their individual staff possess with other organisations. Based on the survey responses, 70% of the participants said that human capital (skills, individual expertise, and labour) are *usually* or *always* shared among network members (Q45.3).

Interview participants mentioned that human capital exchange and sharing between organisations within the network are indeed based on the skills, knowledge, and expertise that individuals possess.

*“Our network members – the nursing college and hospitals [located within the sub-district area], they have expertise in health and have experts who can support us like doctors, nurses, and physiotherapists. They have supported us. Their people physically come to help us out - the doctors come help at our Health Promotion Hospital, the physiotherapists help us at the rehabilitation centre. They are professionals and able to treat our people.” (A sub-district LAO staff/ Donkaew)*

The findings of Hambrick and Mason’s study (1984) on the association of human capital exchange, especially personnel in the position of managers and the results in organisation actions were also present in this research. An interview participant mentioned that human capital, particularly those in the executive or management positions, their vision and leadership at a LAO could be influential in steering the actions of the organisation.

*“Working on elderly topics is not just for one organisation. It takes the elderly population themselves, other people, and organisations. This collaboration concept has to be mutually understood by all in the network. For example, we [the LAO] work for the achievement of the NHSO funding goal like the Long-term Care Fund, and other funds, but our whole area benefits from them. We can work with anybody. We gain benefit in network management. Normally, common goals and shared directions are hard to establish within the network. If these can be accomplished, resources would just automatically follow – shared resources, human resources, knowledge, they would naturally happen. To make them happen, we have to have a common mindset. For us, this has been established at the management level.” (A sub-district LAO staff/ Donkaew)*

In addition, I also found that people have cultivated their individual assets such as knowledge and skills from their experience of working on the job for a period of time. These assets have become valuable for not only their own organisation but also others within the network. The quotes below are examples of how human capital exchange and sharing take place between organisations within the network and the value of the exchange.

*“For organisations we have MOU agreements with, we do research together. For example, the nursing college is knowledgeable about academic and health research. They have to do the academic work in the area, train, and organise knowledge*

*management sessions in the area as part of the collaboration agreement. Most of this is academic work that is beyond our capacity. If it is something we can do on our own, we will do it ourselves, but research and academic work are something we still lack experience of. We have to rely on researchers from other organisations to do research for us and help with our KM [knowledge management]. Lately, it has been like that.” (A sub-district Health Promotion Hospital staff/ Donkaew)*

*“... We learned from other organisations within the network. We see their problem solving, viewing of issues, and exchanging experiences. It makes us progress quicker, as opposed to starting from zero we get a head start [from seeing others]. We do not have to try it out on our own in something because we could learn from others’ experience and from their failures. If they had done something and failed, we would not attempt it. If they succeeded, we learned about it. We get to see different views from knowledge, experiences, and expertise.” (A sub-district Health Promotion Hospital staff/ Donkaew)*

The interviews reflected Davenport’s (1999) benefits of human capital exchange as “the maximizing of knowledge, skills, talents, and behaviours of workers” (p.89). Interview participants said that human capital exchange, particularly experiences and expertise of individuals from other organisations, enabled them to gain a broader vision that affects their way of working.

Organisations within the network do not have their own employed human capital to provide specialised health services nor holistic services related to the elderly quality of life. They have to rely on human capital, among others, from other network members. A clear example is the Health Promotion Hospitals within the two case studies. While they have nurses and other professionally trained health staff to provide primary care and health screenings, they still need to have specialists or experts in other topics from other organisations to assist in their operations.

*“We have assistance in technology, a staff member from the Donkaew LAO who is an IT expert, helps us with the technology issues, and GPS [Global Positioning System] work. With GPS, we know who is located where, when they are sick or need treatment, we use GPS systems to take us to them. We ask for collaboration from the LAO, their IT staff comes to support us.” (A sub-district Health Promotion Hospital/ Donkaew)*

Similarly, another interview participant who is a nurse at a district hospital provides her expertise to other organisations at the sub-district level.

*“We work with the LAOs in all sub-districts in our district. First, we help them with health screenings, all done with professional nurses for both physical health and mental health screenings. Then, we train community health volunteers. This year we let the [trained] volunteers take over the screenings and we looked at the results and categorised the elderly into groups [social-bound, home-bound, and bed-bound]. ...Later, we plan for home visits of those elderly who are bed-bound. After the home visits, we developed a care plan for them [each bed-bound elderly] and handed it over to the LAOs. ...There are three Care Managers in our district, I am one of them. We had our training first, then we trained Care Givers from the sub-districts according to the Department of Health’s curriculum. Once they complete the training, we distribute the cases [within their own sub-district]. (A regional officer/ Chiang Mai Province)*

Across all groups of participants whose length of working experience at their organisation vary between less than two years until more than ten years, most of the participants (61%) indicated that network actors *often* exchange human capital. The largest group (35%) who reported they *often* exchange human capital are those that have worked in their current position for two to five years. The second largest group (31%) that reported the same result are those who have worked in their current position for more than ten years (Q54 and Q45.3). This indicated that no matter how long a participant has been in their current position within their organisation, they perceived that human capital exchange has often occurred.

### 7.1.3 Social Capital

Putnam (1993) defined social capital as a trust building through social interactions. Social capital emerges from human capital, particularly learning. It is a foundation capacity for collaboration and trust (Weisband, 2009). The value of social capital in networks, according to Weisband (2009) is that it “propels network governance by deepening cultures of trust.” (p. 913). With trust, a strong social capital grows, and the stress of a centralised network’s bureaucratic control becomes more flexible. This is due to the establishment of bonds between network actors based on trust, shared understandings, and expectations (Weisband, 2009). Koliba et al. (2011) suggested that the root of social capital came from social exchange theory that explained the behaviours of individuals or organisations interacting with one another. These interactions lead to connections between them in which knowledge develops. In their book on Governance Networks in Public Administration and Public Policy, Koliba et al. (2011), provided examples of social resources capital defined as “social

ties forged through bonded, bridging, and linking ties; common norms forged as a result of social ties: trust and durability.” (p.87).

*“It [interacting with other organisations] positively affects our work in elderly health promotion. Not just on us, but the elderly population also learn together with the network. They benefit from their relationship with the network as an exchange. When we go out, we learn from our network, and we also gain contacts. We establish good relationships and exchange our visions. If we do not go out, and do not establish relationships with network members, the vision would be limited. We would not see others’ innovations and what they are doing. ...going out and being open to others to come in to learn from us give us development perspectives.” (A sub-district Health Promotion Hospital staff/ Donkaew)*

According to the interview participant above, social capital was developed as a by-product of learning interactions. Besides the social capital, they also developed a broader vision in new ways of working in the elderly health promotion practice. This benefit is similar to the benefits of the human capital exchange. The positive outcome of policy implementation also comes from trust between network members interacting with one another as an interview participant highlighted.

*“Benefits [of working together as a network] are shown as a strong network with collaboration and trust. Donkaew is very successful in almost everything because of their collective mindset and their volunteers. The community participation process is very important.” (A regional officer/ Donkaew)*

The following quote reflects the benefit of social capital in network governance found by Weisband (2009) in that it eases the bureaucratic control, particularly in a centralised environment.

*“Health promotion for the elderly population in practice at the local level also depends on individuals in the area. When a [regional] social development officer like me coordinates with those in the local area, a personal relationship is very important. If we have a good relationship with the local government staff, work is easy in terms of coordination and collaboration. It lowers formality in the process and increases the informality, which means it is easy to communicate with each other. This is good for fieldwork.” (A regional officer/ Chiang Mai Province)*

A LAO staff member also agreed that social capital developed in the form of bonding and personal relationships between staff within the network member organisations helped shortcut the bureaucratic processes.

*"I know people whom I have coordinated with personally through this job. ...A benefit is, it helps reduce the formal processes when we collaborate... Like maybe from five steps to three steps if we know each other well. For example, for an organisation that we have not worked with before, we will first have to send a formal request letter to give them information about what we are doing or trying to do. Then, we have to wait for them to call us back. Later, they have to let us know whether they will be available and coming or not. But if it is an organisation that we know quite well and are familiar with each other, we could just give them a call 'next Thursday, we will have this event, can you come?' and if they are available, we will send a letter later. They would just put it in their calendar. Everything is done in one call, and we will send a response form, and wait for it to come back, that is it." (A sub-district LAO staff/ Donkaew)*

According to the survey responses, 70% of survey participants said that social capital resource; as in trust, relationship durability, and social ties forged through bonded bridging and common norms; is *usually* exchanged or exchanged *all the* time among network members (Q45.4).

The social capital of the networks in this research has been developed from the human capital exchange among network members. To explore the overall relationship of network actors as a part of social capital, survey participants were asked about the positivity of relationships between their organisation's staff and others within the network, and 87% *agreed* or *completely agreed* that staff, officers, or employees of their organisations have positive personal relations with other organisations' in the network (Q. 41). To explore whether the length of individual staff's participation as part of the health promotion policy implementation for the elderly network has an impact on their opinion of the positive personal relationship with other actors' staff, I conducted a comparative analysis (Q36 and Q41). The analysis showed that 68% of participants whose longest time working with a network actor organisation varied between less than two years to more than eight years *agreed that* employees of their own organisations have positive personal relations with others within the network. The longest time the largest group that *agreed* (74%) employees of their own organisations have positive personal relations with others within the network is four to six years.

Hence, the social capital of the networks was associated with the length of time of an actor's participation in the network.

#### 7.1.4 Political Capital

Political capital, according to Koliba et al. (2011) “is accumulation and selective use of influence and power” (p.90). They provided examples of political capital as favours and persuasive powers. Putnam (1993) suggested that political capital is built on an individual’s action rather than as an outcome of group interaction. Koliba et al. (2011), however, suggested that sources of political power could extend to coming from an individual, a team with effective leadership, or an entire organisation.

Interview participants mentioned how the priority of the management of a sub-district LAO can affect the support for and direction of the whole network of health promotion policy implementation for the elderly at the local level. The quotes implied the instilment of a collective mindset could come from the connection between management leadership and political capital. Leadership in the LAOs, in particular, comes from what Koliba et al. (2011) called representational political capital. The deputy-director of a sub-district LAO in Thailand is a permanent position, but the highest level of management in the organisations is the director who is elected and thus is regarded as a political position. An elected director leads the management team, represents the community’s interests, and ensures that their social and economic needs are met. Survey participants were asked if a political capital exchange or sharing takes place within the network in the form of favours and persuasive power. Among the participants, 50% said it *usually* takes place or does so *all the time* and 31% said the exchange *rarely* takes place (Q45.5).

From both case studies, it appears that the director prioritises for the community based on the population’s needs and other social and economic factors. An interview participant below works with many sub-district LAOs. She believes that the elected director’s leadership is the most influential factor for the success of health promotion of the elderly in each sub-district, rather than any other factors.

*“Sub-districts that are outstanding in their elderly work are driven by their director and the strength of the community. There are many factors to drive policy implementation. In a modern community, there are people of many generations, if the director is unable to unify and empower people in the community, then nothing can be driven forward. I believe community leaders [sub-district LAO directors] are important. They have to use multiple empowerments to get people to participate and prioritise elderly issues. ...In some sub-districts, their director has strong leadership and a strong community. They often have the quality of life development activities, even though they are located far away, and with limited funding. It is really up to the leadership.” (A regional officer/ Namprae)*



While leadership from politically elected directors in both sub-districts represents the needs of the community, it is apparent that the prioritisation in each sub-district differs depending on other factors such as the social and economic development within the area. The following quote from a staff member in Namprae Sub-district shows that infrastructure development in their area has been given priority over elderly health promotion.

*“Infrastructure development takes so much budget – roads, electricity, water, and we also have many fixed monthly expenses. Primarily, we focus on the development of these infrastructures first because in our sub-district, they are still an issue. We did a community development plan with people in the community during town hall meetings, infrastructure is still needed.” (A sub-district LAO staff/ Namprae)*

Although the challenges of the aged society Thailand is entering are clearly evident in communities throughout the country, the previous quote suggested that for Namprae, infrastructure development is a priority. However, due to the central government’s national policies about health promotion and quality of life development for the elderly that come with funding to the local governments, it has become the LAO’s responsibility to cover implementation in this area.

*“Topics about the elderly are the crucial trend for the country and community development. Some communities do not drive these topics as much as they should, I think it will be too late if they do not adapt [to the demographic trend]. If they have not started by now, they are quite outdated.” (A sub-district Health Promotion Hospital staff/ Donkaew)*

A significant influence in Donkaew that makes it different from Namprae in prioritising the elderly health promotion is that the elected sub-district LAO director agrees with the quote above and supports the activities and programmes related to elderly. An interview participant from a regional organisation that works with multiple sub-districts in Mae-rim District including Donkaew views this priority as one of the political factors and that many LAO directors prioritise because it affects their votes in the election.

*“In my view, the elderly population is the target of the political votes because they are stable votes based on their nature. Nominee campaigning for an elderly issue is likely to get their votes. Just when we say we would like to work for the elderly, the sub-district LAOs would just volunteer to participate because it will help them reach their target*

*votes. They do their work well, though. Working-age population go out to work; they do not stay at home. Some are not even in their home area on the Election Day or do not even vote, but now Mae-rim is an aged society, almost completely, close to 20% of the population. So the elderly are the target of the votes and the LAOs.” (A district hospital staff/ Donkaew)*

The previous quote suggested that political capital is forged from interests exchange between the LAO Directors and the elderly population. This exchange is when the LAO Directors receive their votes from the elderly population, they represent and respond to the needs of the elderly population in return.

While it is common that leadership of an organisation highly influences the actions and direction of the organisation it manages, it was unexpected to find that leadership in one organisation can be influential in driving the actions of the whole network. It is even more unexpected, especially that this one influential organisation does not have sufficient capital and capacity to accomplish the network goal on its own or have any dominant resource. This finding, however, presented clearly only in Donkaew case study, where more than one organisation within the network mentioned the leadership influence of Donkaew LAO as a significant force that drives the work of the whole network forward. An interview participant who works with multiple LAOs at the sub-district level mentioned the influence of leadership in policy implementation.

*“[The LAO Directors] help with funding, sponsoring, and driving forward. Areas, where directors are supportive, are usually successful. Often, my problem is that the elderly in the community are not able to come to an activity or an event. We have to discuss solutions, so we invite the directors [of particular areas where the activity or the event takes place] because they hold the authority. I cannot bring the hospital vehicle [for pickups], that is for sure. We invited the directors to the discussion, they could authorise pick-up vehicles, like in Mae-sa and Donkaew Sub-districts they had the vehicles, issue solved.” (A district hospital staff/ Donkaew)*

*“From my experience, some sub-district LAOs are not successful [in elderly health promotion], perhaps because of their overwhelming responsibilities. Their management ideas and directions are also crucial. If they focus on traditional development, it all goes to infrastructures and building things, without talking to the elderly first. Like the decisions were made in the ministries and all thrown at the community. ...What distinguishes Donkaew from other sub-districts is the vision and leadership of their LAO*

*management, their responsibility and accountability. If the management gives directions, the rest will follow, not only for missions about the elderly but for every mission.” (A district hospital staff/ Donkaew)*

*“There are many contributing factors to the LAOs that are successful in programme implementation. Speaking about LAOs in our district, it depends on the vision of the management. Donkaew, for example, their leadership, human resources, social capital, as they call it, and the participation process of people in the community are crucial. Their people, not just the management, the whole structure is a driving mechanism. These are important. Sometimes, funding is not even required, some work does not need any budget.” (A regional officer/ Donkaew)*

This is an important emerging finding. The LAO Director is elected every four years. Therefore, the direction of social development priorities within the sub-district can be different depending on the elected official. With more than seven thousand sub-districts in Thailand, it is not possible that health promotion of the elderly will be every director’s priority but the qualitative findings suggest that a director’s priority focus has an effect on the direction of the sub-district LAOs and their network as a whole with regard to health promotion for the elderly and others.

However, the prioritisation depends on other social and economic factors of the sub-district as well. The two case studies in this research proved to be good examples of different prioritisation. Factors contributing to the different focus of the management in these case studies are the infrastructure and the economy of the community. Donkaew is a flat area, located close to an urban downtown area, and well developed with all necessary infrastructure including an underground bypass. On the other hand, Namprae is not only located farther from downtown, parts of its area are mountainous and still experiencing drought. Moreover, a major four-lane road that divides the sub-district in half has been under construction for more than six years. Therefore, for Namprae, infrastructure development is the priority as it is the foundation of other social and economic development. The leadership in prioritising projects within the sub-district follows the needs of the community. This also determines the direction and the level of enthusiasm, drive, and support for the health promotion for the elderly population in the sub-district.

Political capital has been exchanged between organisations within the two case study networks. However, it is not in the sense of giving something for a return, but rather in the sense of being an influence for the actions of actors within the networks, with the people in the community as a beneficiary. The sub-district LAO directors who hold the decision-making power of the policy

implementation within the sub-district do not only represent the interests of the people within their area but take into account other social and economic factors that affect the prioritisation of the policy implementation. It is more apparent in Donkaew where community participation has been mentioned often as a part of the policy implementation success. This indicates that the community has been empowered by the local government. At the same time, the management of the local government that makes the decision for them and empowers them is their own representative who they elected.

#### 7.1.5 Cultural Capital

Cultural capital has been referred to as shared norms and expectations among organisations within the network, and it plays an important role in binding organisations together as a network (Weisband, 2009). From a broader view that looks beyond the organisational level, Koliba et al. (2011) suggested consideration of how cultural capital of a single organisation within the network affects its roles and functions within the network as an expanding view. The expanding views include cultural values, habits, customs, and rituals. These aspects of cultural capital were included in the survey. Participants were asked whether cultural capital as in values and habits have been exchanged or shared within the network: 78% of them said they *usually* have or have been exchanged or shared within the network *all the time* (Q45.6). This aspect was explored further in the interviews as to what values and habits have become the cultural capital of the networks within the study.

The two case studies appeared to be distinctively different on cultural capital. In Donkaew Sub-district, not only did interview participants often mentioned the same terms and values when discussing the implementation of health promotion for the elderly policy within the community, participants who work for organisations outside the sub-district within the same network also mentioned the same things and exhibited the same values. Examples below show the values mentioned by interview participants when asked about different aspects of being a part of the health promotion policy implementation for the elderly network.

*“Factors? Probably the continuous learning. Being a half-full glass enables us to learn more new things. Sometimes we think to ourselves that this [what they are doing] is good enough, it is not necessary to interact with other organisations, but our management would remind us that we should be a half-full glass so that we can always be filled with new things, new knowledge.” (A sub-district LAO staff/ Donkaew)*

The next quote came from another participant when asked about the sufficiency of their own organisation’s resources for accomplishing the network goal.

*"At the moment, I think so, yes, we have enough resources. But we are a half-full glass, we are ready to continue to develop. Like for human resources, it is something that we focus on. ...Human capital development will always continue, right? We have to continue to develop. ...in knowledge, skills, capacity, and management." (A sub-district LAO staff/ Donkaew).*

The continuous development Donkaew LAO developed as a value is recognised by other organisations working within the same network.

*"I think they put all their effort in, I give them 10 [out of 10]. They are determined, they never say 'no', 'not now', or 'we are not ready'. Like the issue that we want to discuss this week, they jumped right in. It is the idea of opening up. We have to be open first. Whenever we think we already know things, we cannot be that open. They [Donkaew LAO], are always open." (A district hospital staff/ Donkaew)*

The organisation's value of being a 'half-full glass' means that they can always be filled with more knowledge and experience in the continuous learning aspect. The management of Donkaew LAO has instilled this value in their staff. Working in the network based on this value, Donkaew LAO network has transferred their values to other actors, making their organisation's culture a network culture that other actors acknowledged and recognised. Koliba et al. (2011) noted that cultural capital is transferrable between organisations within the network "as the embodiment of organisational values, norms, and customs." (p.91). In this study, it can be identified that the value established by the Donkaew LAO has been transferred to other network actors resulting in their active participation in the network and continuous self-development, a culture that was not observed in the Namprae case study.

In addition, another outstanding value that could be observed in the networks, especially in the Donkaew case study is the goal of a community-oriented value. Actors within the network are aware that the goal of the work they do is for the purpose of the community and target population. A quote below by a Donkaew Sub-district LAO staff reflected this value.

*"When other organisations reach out to me for help, such as to be their speaker in an elderly school class, I go. Sometimes I help with activity planning. When we organise something, we will invite others too, and they would respond and come. They would say that they do not want to miss our event because when we were very busy, we still supported them so that they would support us in return. Sometimes, their management would come too. This makes me feel that my contribution is not only for my work*

*personally but for the organisation, for the elderly people, and ultimately for the community. Other organisations returning to work with us again is our [our organisation's] success and for me as staff.” (A sub-district LAO staff/ Donkaew)*

While organisations in the Namprae Sub-district health promotion for the elderly policy implementation network are also collaborative, their self-development and community-oriented values have not been observed as much as in Donkaew Sub-district. While Namprae's quantitative goals such as numbers of elderly participants in the programmes, or whether health services and welfares access for the elderly within the sub-district can be met, the sense of shared values is not exhibited as obviously as in Donkaew. Though cultural capital is transferrable among network members (Koliba et al., 2011), political capital through the elected officials may be more influential in prioritisations and tackling of issues within the sub-district. In the case studies where the health promotion for the elderly is on the national agenda, the local priority could still be a different issue. In a sub-district where this conflict occurs like in Namprae, the implementation of the health promotion policy for the elderly still takes place but may engender less collaborative efforts and active participation than other top local prioritised issues. Cultural capital was not found to be as powerful as political capital in issue prioritisation, but it was found to be more powerful in network collaboration. The latter case may influence network performance or the policy implementation outcome.

A distinction between the two case studies is that in Namprae when the needs of the community are considered, responded to, and prioritised, there is a lack of active and assertive participation driven by a shared network value. The involvement of the community is rather minimal such as voicing their needs in the town-hall meeting and getting infrastructure development projects provided. An interview participant who represents the elderly population within the sub-district, indicated that if the elderly group initiated the idea of projects they would like to do or see happen in the community, funding could be a limitation, and the projects have to wait until appropriate funds that match with their needs come through. The approach of Namprae LAO can be seen as reactive, where the network only responds to the issues being brought up and waits for the budget that matches the policy target's needs.

On the other hand, the involvement of the community in Donkaew is more active as the elderly population helps design their own elderly school curriculum. Moreover, Donkaew LAO has developed a culture of continuous learning, self-sustainability and self-development where funding should not obstruct initiatives or activities that should be continuous. Measures that the Donkaew LAO take are related to their own organisational value of being community-focused and seeing the

benefits gained by the community and the target group gain as their own individual and organisation's success. It implies that Donkaew LAO takes a proactive approach by actively bridging the network's goal and policy target need and not letting limited resources such as budget be an obstacle in the policy implementation.

#### 7.1.6 Intellectual or Knowledge Capital

"Intellectual" and "knowledge" have been used interchangeably (Koliba et al., 2011). The definitions of knowledge capital given by scholars include capital in explicit and implicit forms. The explicit form of knowledge can be tangible such as files, library collections, or databases. The implicit forms of knowledge are experiences, creativity, and skills possessed by individuals (Nonaka & Takeuchi, 1995). Organisations within the network own and share information and knowledge as an input for the whole network are intellectual capital examples provided by Koliba et al. (2011).

Information and knowledge have been exchanged extensively between organisations within the health promotion policy implementation for the elderly network in both case studies. Survey participants were asked how often organisations within the network exchange or share intellectual capital in the form of information, knowledge, and ideas, 72% said that they *usually* do or do it *all the time* (Q 45.7). The data can be grouped into two categories, which are the information and data exchange, and knowledge expertise and technical experience exchange.

##### 7.1.6.1 Information and Data

Information and data exchange are part of the interactions for health promotion policy implementation between the elderly network members. Exchange occurs among organisations at the local level and across the governance structure levels, such as between the sub-district LAOs and the regional government organisations. Demographic and health data exchange is useful in programme budget planning and allocation, particularly for implementation of programmes funded by the central government through their regional government organisations for the sub-district LAOs.

Information and data collection about the elderly population in the sub-district can be undertaken by a district organisation. The information and data collected are usually exchanged or shared between organisations within the network. More than one organisation can individually, directly, and indirectly benefit from the information and data collection.

*“...Other organisations help us research about policy issues and analyse them. Mostly, we get help in identifying issues from the nursing college. Planning and budgeting are mostly conducted internally, but identification of issues and solutions are usually assisted by other network organisations. They give us advice and opinions based on what they see and experience while collecting data and information in our sub-district. They go right there in the field. They meet directly with the elderly, so they gain first-hand insights. We do not need to request the data and information because it is already in our MOU that every time they conduct fieldwork in our area, they have to share with us what they get. From this, they get something, and we get something from their activity. It is an agreement. (A sub-district Health Promotion Hospital staff/ Donkaew)*

Data and information exchange can also be for budget allocation and distribution planning. This usually occurs between the regional-level organisation who distributes the central government’s budget for national programmes implemented by the LAOs and their local network.

*“We send a formal enquiry to the LAOs in our responsible region about the number of the dependent elderly population who meet the criteria of the Long-term Care programme. The criteria and the form are sent, but what the LAOs have to do is not only getting us the requested number. They have to talk to the Care Managers, whether their own (for sub-districts that supervise the Health Promotion Hospital), or those under the Health Promotion Hospital (for sub-districts that these two organisations are separate). The LAOs may have to work with the District Public Health Office whom we also send a separate letter informing them about the survey and asking for collaboration of data sharing. After they work together, they get the data we need, then they send it to us. After that, we ‘clean’ the data by analysing whether it meets our criteria - are the elderly qualified, are they entitled to the programme benefits based on their ADL value (Activities of Daily Living), are they still alive on the day we check. ...Then, we ensure that both ends, the LAOs and we have the same updated data, if so, then, we transfer the LAOs the programme funds.” (A regional officer/ Chiang Mai Province)*

Information and data exchange is not a stand-alone process and may vary depending on each sub-district and how organisations within the network are structured. In Donkaew Sub-district, information and data obtained by either the Health Promotion Hospital or the sub-district LAO are automatically shared within the two offices and owned by the sub-district LAO. However,



in Namprae Sub-district, the sub-district LAO and Health Promotion Hospital are under a different parent organisation. Thus, the information and data have to be requested to be shared.

*“Demographic and health data on the elderly population in the sub-district such as age group and health condition (social-bound, home-bound, and bed-bound) are collected and kept by the Health Promotion Hospital. If we want the information or the data, we have to send a request letter.” (A sub-district LAO staff/ Namprae)*

Collaboration is crucial for sustainability in multi-organisation implemented programmes (Frey, Lohmeier, Lee, & Tollefson, 2006). Frey et al. (2006) showed levels of collaboration based on relationship characteristics of organisations working together that range in order from: 1) networking; 2) cooperation; 3) coordination; 4) coalition; and 5) collaboration. Regarding data and information exchange, providing and sharing information and resources between organisations are among relationship characteristics of cooperation and coordination, respectively. From the case studies, it can be summarised that LAOs in both areas exhibit a level of collaboration in the form of cooperation and coordination. This also coincides with the view of Koliba et al. (2011) that data and information as a part of intellectual resources are exchanged in collaborations exercised by network members.

#### *7.1.6.2 Knowledge, Expertise, and Technical Experience*

When it comes to working on health promotion for the elderly, all the organisations within the network have a common goal to improve the quality of life of the elderly population. As the common goal is very broad, it touches on one or more responsibilities of every organisation involved. Expectedly, many participants mentioned that their organisation alone could not accomplish this common goal by themselves, and they need assistance and support from others. This leads to their interactions. From the survey, 97% of the participants said that intellectual and knowledge resources are exchanged among organisations within the network (18%, 49%, and 30% said they are exchanged *rarely*, *usually*, and *all the time* respectively) (Q45.7). The examples below show the interactions between organisations that need assistance and those that provide assistance to them.

For technical expertise:

*“We reach out to organisations that have speciality expertise, mostly technical expertise. We have to rely on the network, sometimes we have to ask for their staff to come in and help. For example, we asked for a physiotherapist to come help at our rehabilitation*

*centre, help us analyse what kind of rehabilitation our elderly population needs individually, and how to assist them. We asked for the physiotherapist from Nakhonping Hospital [district hospital]. Sometimes we have to ask our community doctor to come with us for the elderly home visit rounds because we cannot tell whether the elderly we visit have depression or not. If they do, the doctor will be able to help us diagnose and then we will find a treatment approach, a project, or an activity that suits that individual the most.” (A sub-district LAO senior staff/ Donkaew)*

For knowledge:

*“For health promotion for the elderly, well, we cannot do everything right? The sub-district LAO has its Social Welfare Department that takes responsibility for this, ... the nursing college also helps us with knowledge on health promotion. The Chiang Mai Social Development and Human Security Office comes in with occupational and quality of life of the elderly supports. They are another supporting force.” (A sub-district Health Promotion Hospital staff/ Donkaew)*

For knowledge and expertise through referrals:

*“Mostly we work with sub-district LAOs. They are organisations that take responsibility for the elderly club in their sub-district. ...Mostly, the elderly club has an activity they do with the LAO in their sub-district once a month, we participate every time. We help them coordinate with other organisations like if they want to learn about oral health, we coordinate with the Dental Department at our hospital for them. If they want to know about rehabilitation or muscle ache, we coordinate with the Rehabilitation Department for them. If they want to know about medications, we coordinate with the Pharmaceutical Department, ask someone to be a speaker at their event.” (A district hospital staff/ Namprae)*

Many of the health promotion activities for the elderly in the case studies are from the bottom-up approach or come from the needs directly requested or enquired about by the elderly population in the community as the source of knowledge. These activities and the requests have been made possible through the collaborations of the organisations within the network, particularly the sub-district LAOs.

*“The curriculum of Homsuk Elderly School [Donkaew’s elderly school] came from us looking for someone from the network to develop it like the nursing college, Nakhonping Hospital, our Health Promotion Hospital, the village health volunteers, and other*

*volunteer groups. We brainstormed and came up with a three-year curriculum. But after a year, the elderly students told one of our staff whom they had a close relationship with that they did not want to graduate, they wanted to keep learning until they could not anymore. So, we developed a life-long learning curriculum for them.” (A sub-district LAO staff/ Donkaew)*

*“The projects we need support for come from the decision of the head of the elderly club in each village when we have a meeting together. Sometimes we visit other areas to see what they do for ideas, then we go back and discuss it. If there is something we are interested in doing, we tell the sub-district Municipality Office or the Health Promotion Hospital.” (An elderly club member/ Namprae)*

*“We encourage the community to apply their local wisdom. Stimulate them with questions like, “you already know about this, do you want to take action?”, we have a budget to support them. We also support them in developing a process, exchange of information, showing them innovation, and help them develop capacity. There was one time we showed them the graph of the growing older population in Thailand and asked what they thought would happen in the next 10 years, 20 years, and how they plan their retirement. Then they came up with projects to propose to us.” (A sub-district LAO staff/ Donkaew)*

LAOs in the case studies respond to the needs and requirements of the elderly population in the community with their capacity. If the LAOs do not possess the knowledge or expertise required, they help refer the elderly to other organisations or bring other organisations to the community.

With intellectual or knowledge capital shared and exchanged extensively between organisations within the network, this finding is opposite to that of a previous study by Rijke et al. (2013). Rijke et al. (2013) studied strategies of governance reforms and their effect on the management of water systems in three different Australian cities. They found that the strength of having a large knowledge base and access is seen in decentralised governance. This is due to the involvement of many actors across disciplines. This was also observed as a strength of the case studies networks. However, a weakness found by the mentioned scholars that knowledge sharing might be limited in decentralised governance was not the case in this research.

Decentralised governance in this research, represented by the LAOs, allowed informality and flexibility of capital exchange within the case studies’ networks and even more knowledge and

information sharing among the actors. The LAOs, the decentralised organisation, play the central role of coordinating and connecting organisations for intellectual or knowledge capital exchange for policy implementation at the local level. Thus, the decentralised governance enabled and facilitated knowledge and information sharing among the network actors rather than limiting them. However, in the case studies networks, member organisations are a combination of government organisations that are a part of both decentralised and centralised governance structures as well as the target population.

#### 7.1.7 Physical Capital

According to Koliba, et al. (2011), physical capital may include buildings, equipment, and other properties. There are different definitions of physical capital given by network scholars. Koliba, et al. (2011) mentioned that “physical capital clearly exists as an observable and measurable asset. The purpose and benefits of physical capital are found in how it is used to generate income” (p.86). However, the networks being studied are government networks that have not been formed for the purpose of generating income, but rather for implementing public policy and delivering public services. Agranoff and McGuire’s (2001) explanation of physical capital can be applied to this research. They suggested that similar to other resources such as human capital and social capital, physical capital “facilitate coordination and cooperation for mutual benefit” (Agranoff & McGuire, 2001, p. 302). Exchange of physical capital is presented in both case studies. Among the survey participants, 70% said organisations within the network *usually* exchange physical capital, which includes activity venues, facilities, buildings, office space, elderly exercise equipment, vehicles for service delivery, and property, or do so *all the time* (Q45.2).

From interviews and observations during the fieldwork, I found that physical capital exchange within the networks reflects Agranoff and McGuire’s (2001) explanation of the purpose of the exchange – it facilitates coordination and collaboration for the mutual benefit of network members.

##### 7.1.7.1 Building and Facility

###### - Donkaew Case Study

Donkaew sub-district LAO hosts monthly meetings with their network members at their large meeting room. Participation at this regular meeting does not only include the health promotion policy implementation network members but extends to other topics’ networks as well. Representatives of most, if not all, government organisations within their sub-district area participate in the meeting. The meeting room at the LAO office serves as a venue for the organisations to discuss and update on-going issues or work in progress and to exchange information. The meeting is also open to the public to observe and participate in.

Their building and facilities are also shared with some others in the network who work within the sub-district area and those whose offices are located nearby, such as the Health Promotion Hospital. The sub-district LAO shares parking spaces with the Donkaew Sub-district Health Promotion Hospital. The parking spaces are also available for public visitors and network members who come to the LAO office or the hospital. The Donkaew Sub-district Informal Education Office is in the building and on the land adjacent to and owned by the LAO although the organisation is under a different administration (regional-level organisation).



*Figure 27: The Main building of Donkaew LAO Office, Chiang Mai, Thailand. April 30, 2018*

Activities of the Donkaew Sub-district Elderly Club are held at the community hall located at the community temple and considered its property. However, the temple allows the use of the hall for public purposes. Although the temple is not included as a health promotion policy implementation network actor in this study, the LAO, the elderly club, and other network actors participate in activities organised at the temple's community hall.





*Figure 28: Vulnerable Population Groups (the elderly and disabled persons) Activities in Donkaew Sub-district, Chiang Mai, Thailand. February 22, 2018.*



*Figure 29: Elderly Sports Day Activities in Donkaew Sub-district, Chiang Mai, Thailand. February 22, 2018.*

Currently, the Donkaew Sub-district elderly club does not have its own office but they can use activity venues at the temple and the LAO office meeting room to hold club committee meetings, discuss issues, and meet with the LAO or the Health Promotion Hospital staff. During the fieldwork, the elderly club had proposed and been approved for a budget allocation to build a Center for the Quality of Life Development and Occupational Promotion for Older Persons through the Chiang Mai Social Development and Human Security Office, with the assistance of the LAO. Once completed, this office will be used as the club's office space, meeting, and activity venue. While waiting for their new office construction to be

completed, the elderly club will continue to use office space and venues owned by the LAO office.

- Namprae Case Study

Physical capital exchange also takes place in Namprae Sub-district. The exchange arrangements, particularly for buildings and facilities, are similar to Donkaew. Location of network members' offices in Namprae Sub-district are far apart, but they do share and exchange the use of their facilities and buildings, especially for public purposes. Namprae elderly club has its own Center for the Quality of Life Development and Occupational Promotion for Older Persons building funded by the central government through the Chiang Mai Social Development and Human Security Office. The Center is located within the Namprae Municipality Office area, and they share the same parking space. Sub-district activities in relation to the elderly such as an educational class, an information session, and welfare registration are held at the Center building. During the fieldwork I observed an information session on Dementia in Older Persons coordinated and organised by Namprae Sub-district Health Promotion Hospital and the LAO led by a speaker from Chiang Mai Neurological Hospital. The session was held at the Center building.



*Figure 30: Center for the Quality of Life Development and Occupational Promotion for Older Persons at Namprae, Chiang Mai, Thailand. May 8, 2018.*

With more limited space within the LAO vicinity, activities held at the LAO office facility in Namprae may be fewer than in Donkaew. However, they have other common and public spaces where network members meet and do activities together such as the community temple's multi-purpose hall, the sub-district school hall, and a multi-purpose pavilion in

villages within the sub-district. These buildings and facilities though are not considered as network members' physical capital but rather public spaces owned and shared by external-network organisations such as the temple, the school, and the villages. Namprae also has limited funding for facilities and buildings in their sub-district and the Health Promotion Hospital in particular. An interview participant from the area mentioned that a fundraiser is sometimes organised in the sub-district to gain more money in addition to the funds provided from other organisations to buy equipment and build infrastructure.

*"...We get funding for infrastructure, but it is not enough. We do fundraising and ask for donations from clubs in the area; private foundations donated us money too" (A sub-district Health Promotion Hospital staff/ Namprae)*

From the quote above, it can be concluded that financial capital exchange between network members also has an impact on physical capital.

#### *7.1.7.2 Vehicles and Equipment*

##### *- Donkaew Case Study*

As Donkaew Sub-district Health Promotion Hospital is under the financial and governance administration of the sub-district LAO, their emergency medical service van is also under this administration. However, the use of the van by the hospital is authorised and does not have to be formally requested or permitted by the LAO office first, due to the urgent nature of situations the vehicle serves. The Donkaew Health Promotion Hospital also owns a mobile health care service bus that visits villages within the sub-district and provides primary health screening. This service is a part of their regular elderly home-visit by the village health volunteers. The home visit project and the village volunteers are funded by the NHSO with collaborations between network members ("Elderly Care in Donkaew Sub-district", n.d.)



This content is unavailable. Please consult the print version for access.

*Figure 31: Donkaew Health Promotion Hospital's Mobile Healthcare Service Bus. From SMART Camp: SMART Network: SMART Community. Retrieved from [http://memberofhcs.com/newsfile/20160513165819\\_5.%20%E0%B8%9C%E0%B8%B9%E0%B9%89%E0%B8%AA%E0%B8%B9%E0%B8%87%E0%B8%AD%E0%B8%B2%E0%B8%A2%E0%B8%B8%E0%B8%A3%E0%B9%88%E0%B8%A7%E0%B8%A1%E0%B9%83%E0%B8%88%E0%B8%AA%E0%B8%A3%E0%B9%89%E0%B8%B2%E0%B8%87%E0%B8%AA%E0%B8%B8%E0%B8%82%20%E0%B8%95.%E0%B8%94%E0%B8%AD%E0%B8%99%E0%B9%81%E0%B8%81%E0%B9%89%E0%B8%A7.pdf](http://memberofhcs.com/newsfile/20160513165819_5.%20%E0%B8%9C%E0%B8%B9%E0%B9%89%E0%B8%AA%E0%B8%B9%E0%B8%87%E0%B8%AD%E0%B8%B2%E0%B8%A2%E0%B8%B8%E0%B8%A3%E0%B9%88%E0%B8%A7%E0%B8%A1%E0%B9%83%E0%B8%88%E0%B8%AA%E0%B8%A3%E0%B9%89%E0%B8%B2%E0%B8%87%E0%B8%AA%E0%B8%B8%E0%B8%82%20%E0%B8%95.%E0%B8%94%E0%B8%AD%E0%B8%99%E0%B9%81%E0%B8%81%E0%B9%89%E0%B8%A7.pdf).*

Donkaew LAO also provides vehicles to pick up and drop off members of the elderly club and participants of the weekly elderly school and other activities for the elderly group. The vehicle does not only serve the LAO, and the elderly club as other collaborating network actors can benefit from the vehicle use too. For example, if an activity is organised as a collaboration of more than one actor and will be participated in by the target group, the elderly participants can be picked up by the vehicle from the stop in their village. As a result, the elderly population can access and are able to participate in the activity while the organising actors accomplish their goal by being able to reach the target population with their implementation and service delivery.



Figure 32: Donkaew Pick-up and Drop-off Vehicle for the Elderly Participants of the Elderly School and Other activities, Chiang Mai, Thailand. February 19, 2018

In addition, for Donkaew LAO, Boromarajonani College of Nursing Chiang Mai and Rajanagarindra Institute of Child Development (RICD) are a part of their sub-district network, as the two organisations are located in their area and often collaborate in elderly health promotion projects. The nursing college and child development institute assist the LAO and the Health Promotion Hospital with their elderly health promotion projects providing equipment and materials such as walking sticks and inflatable rubber beds. This equipment is in exchange for reaching the target population in the sub-district through the LAO social welfare and health services as an interview participant pointed out.

*“The Institute of Child Development [Rajanagarindra Institute of Child Development – a regional organisation under the Ministry of Public Health located in Donkaew Sub-district] helps us with the equipment we need for the elderly health as well such as the prosthesis and orthotics. If we have older people that need walking sticks, they support us with the sticks. They also provide us with inflatable beds specifically for bed-bound disabled elderly, ones that they can prop up in a sitting position. For the older people that cannot take a shower standing, they also provide us with shower seats and commode chairs for them.” (A sub-district LAO staff/ Donkaew)*

- Namprae Case Study

The vehicles and equipment exchange and sharing also take place in Namprae but on a different scale. This may be due to a more limited budget of both the sub-district LAO and

the Health Promotion Hospital as well as the extension of their network. Namprae Sub-district Health Promotion Hospital does not have its own emergency services' van or a mobile health service bus. According to an interviewee at the hospital, although staff have their personal cars, sometimes Namprae LAO lends them vehicles for fieldwork within the sub-district area. Other organisations such as the Hangdong District Hospital also provide equipment such as crutches, wheelchairs, walking sticks, and other physical rehabilitation equipment. This equipment may be lent or given to the elderly within the area upon request from the Health Promotion Hospital. They may be offered by the district hospital after they have visited patients' homes in the community and saw the need. If the Hangdong District Hospital does not have the equipment, they will help coordinate with organisations within the district network for equipment loans.

Namprae does not have public pick-up and drop-off services for the elderly in the sub-district. This is challenging for the elderly group, especially those who are socially active. However, the people in the community and their relatives occasionally assist one another by taking their elderly family members to participate in the sub-district event organised for them.

The staff and trained volunteers of the Health Promotion Hospital in Namprae visit the elderly people's home as well despite not having the mobile healthcare service bus. They also travel to each village within the sub-district and provide screenings and follow-up, particularly with those registered with high blood pressure, diabetes, and the elderly who are categorised as home-bound and bed-bound.

Although service vehicles are not available in Namprae Sub-district, the elderly in the community, especially those with chronic non-communicable diseases, still have access to and are provided with the basic care necessary for their conditions. These health-services are free of charge and funded by other organisations within the network.

In summary, physical capital exchange occurs in both case studies. The exchange of physical capital in the form of venues, buildings, and facilities does not have a clear structure. It mostly occurs on the basis that whoever organises the activity or hosts the meeting takes charge on providing a venue and other facilities. Physical capital exchange in the form of vehicles varies by area. During my fieldwork in Namprae, the Center for the Quality of Life Development and Occupational Promotion for Older Persons organised an educational session on dementia for the elderly. The speaker and her team from the Chiang Mai Neurological Hospital used their own van to travel to Namprae Sub-district. There is inconclusive evidence as to whether the

structure and arrangement of all physical capital exchange are the same for every network. Nevertheless, the location of organisations involved, geographical environment, and other resources such as funding affect physical capital exchange in various degrees.

#### 7.1.8 Natural Capital

In the World Trade Report 2010, the World Trade Organisation (2010) indicated that the definition of natural capital could be wide ranging depending on people's intuitive ideas and common sense. For trade purposes, they defined it as "stocks of materials that exist in the natural environment that are both scarce and economically useful in production or consumption, either in their raw state or after a minimal amount of processing" (p. 46). Daly and Farley (2004, cited in Koliba et al., 2011) defined natural capital more specifically as "stocks or funds provided by nature (biotic or abiotic) that yield a valuable flow into the future of either natural capitals or natural services" (p.87). Natural resources can be categorised as spatial (land and space), material (living matters), and biological (non-living matters) (Daly and Farley, 2004, cited in Koliba et al., 2011). From the definition and categories, Koliba et al. (2011), provided examples of natural capital resources that network actors may exchange, which are watersheds, farmland, air, wildlife, and recreation areas.

In this research, material production is not a focus. The natural capital shared among the network actors is the territorial space categorised as land. The spaces are the sub-district, district, and provincial territories. Moreover, air, watersheds, and natural wells within the case study areas are natural capital as well. The management of the health promotion policy implementation for the elderly networks and related activities involve natural capital such as air and spatial land in the sense of naturally sharing the use and benefit of them rather than exchanging them.

#### 7.2 Ties of Network Actors

What makes organisations a network is a relationship between them or lack thereof. Ties between organisations within the network indicate their relationships (Brass et al., 2004). To define ties between actors, formality and strength of ties can be examined (Koliba et al., 2011). Koliba et al. (2011) suggested that the most critical ties to consider between actors within the networks are the administrative authority ties as they explain the social ties of the actors. The direction of how power is distributed within the network can be viewed as flows of administrative authorities. Characteristics of the power can indicate a direction, a vector of tie, dynamic authority, and the meta-organisational structure of the network (Koliba et al., 2011). The characteristics of ties are based on the frequency and the formality of coordination and interactions for resource exchange

between actors within the network (Koliba et al., 2011). This research examines the strength and the formality of ties between network actors to describe the characteristics of their ties that will help us understand the relationship of organisations within the health promotion policy implementation for the elderly network in the case studies. The findings reveal critical factors influencing the relationships of network actors and the network-level functioning of the policy implementation.

#### 7.2.1 Strength of Ties (strong to weak)

Strength of ties can be determined by multiple variables such as duration and, frequency of contacts, emotional intensity, and resources exchanged (Koliba et al., 2011; Provan et al., 2007). Koliba et al. (2011) suggested that the strength of ties could be drawn from the frequency of contacts between actors, the emotional intensity of the relationship, and elements from social capital the network develops such as durability of the relationship or contact. However, it should be noted that the emotional intensity is up to the subjective perception of the network actors (Koliba et al., 2011). The extent and depth of the relationship are drawn from qualitative data.

Findings from the network mapping completed by interview participants show the frequency of contact between themselves and other actors within the network as the network diagrams generated by the software programme R below.

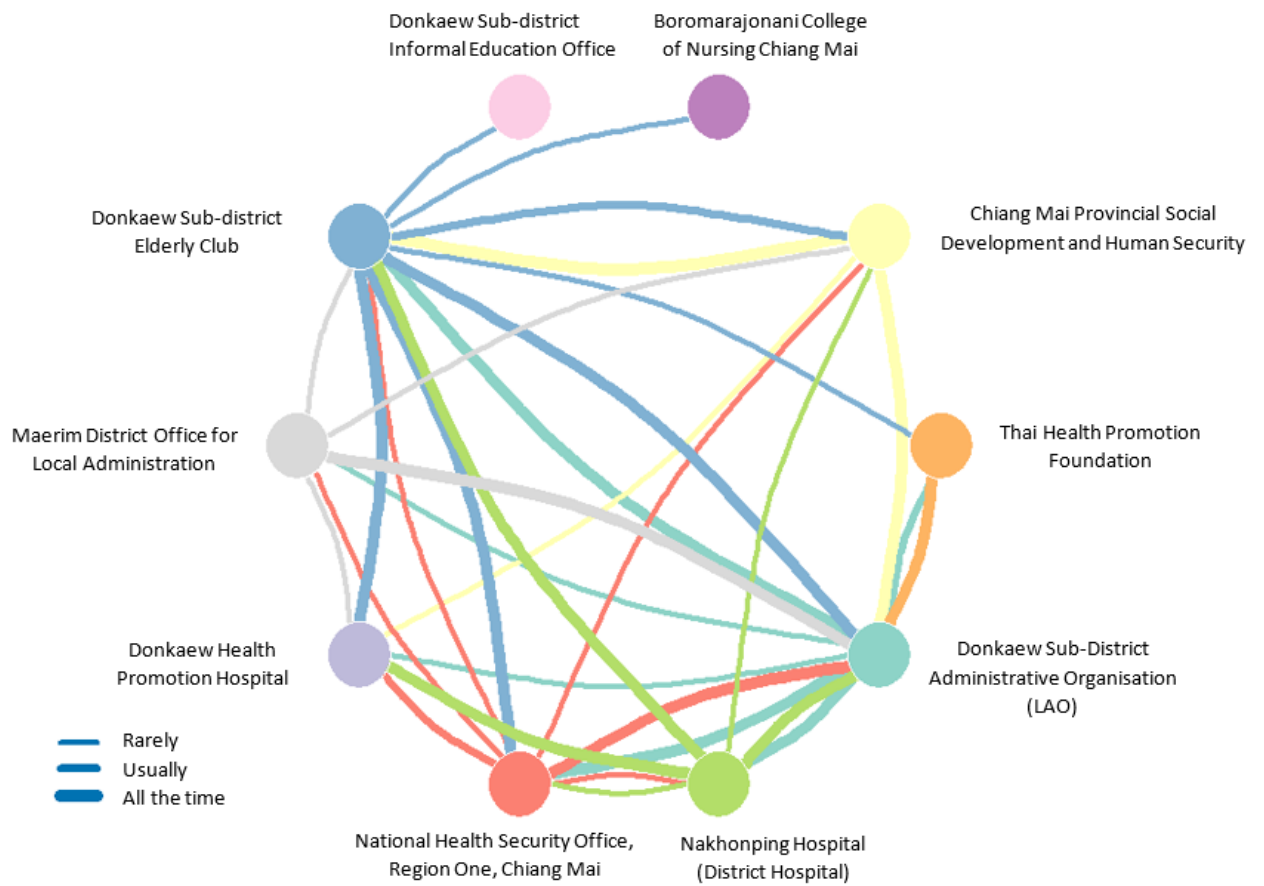
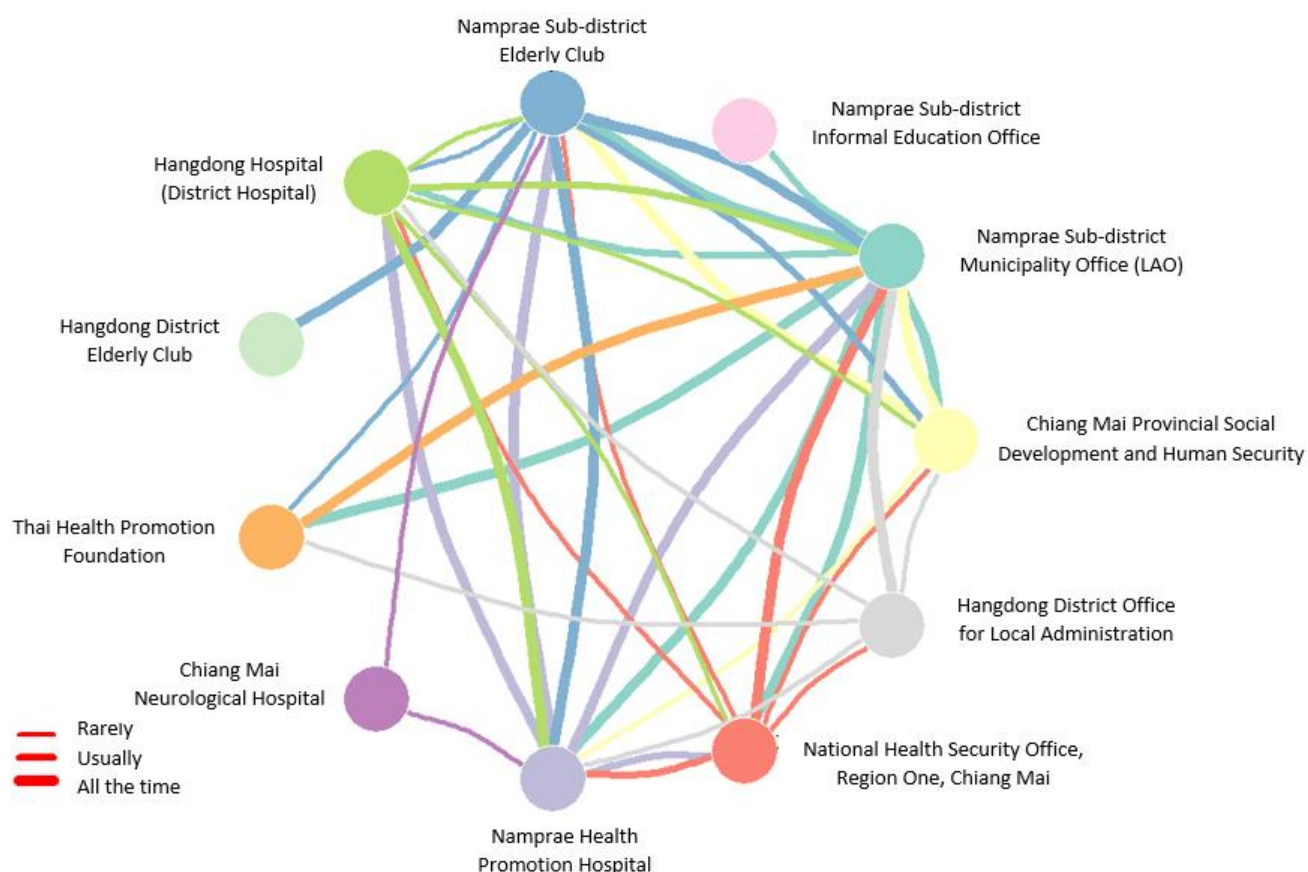


Figure 33: Frequency of Contacts between Actors in Donkaew Case Study Network<sup>2</sup>

<sup>2</sup> Different colors show different network actors. The thickness of links show the frequency of contacts between them and other actors.



*Figure 34: Frequency of Contacts between Actors in Namprae Case Study Network<sup>3</sup>*

The two diagrams in Figure 33 and Figure 34 are based on network mapping, undertaken during interviews with participants. The most frequent contacts represented by the thickest links are between the LAOs and their funding organisations, and those actors located within the sub-district areas. Not all interview participants completed the network mapping due to time constraint during the interview, hence some links are not represented in Figure 33 and Figure 34. However, the frequency and extent of contacts between actors were included in the survey and in interview questions.

From the survey, the durability of the relationship, or length of contact between network members, is acquired from the length an individual who belongs to a network actor organisation has been a part of the network. Among the survey participants, the minimum length an individual was a part of a network actor organisation was under two years and the maximum was more than eight years. The average length was four to six years (Q36). The length of an individual working with other organisations within the network can imply the length of their organisations' network membership

<sup>3</sup> Different colors show different network actors. The thickness of links show the frequency of contacts between them and other actors.

durability. From the survey responses, 86% of survey participants said they *agree* or *completely agree* that there are frequent communications between their organisation and others in the network (Q44). From these survey responses, it can be summarised that the average length of the durability of actors' participation within the network is four to six years, during which frequent contacts between the actors take place.

Moreover, social capital developed and exchanged can also explain the extent of network actors' strength of ties. Trust as a social capital was highlighted in the case studies, as 83% indicated that trust is one of the factors that encourage them to work with other organisations (Q49). Moreover, 100% of participants who responded to the survey said they trust in other network members' capacity in implementing the health promotion for the elderly policy (Q23). As a part of social capital, 52% of survey respondents also indicated that knowledge and expertise of other organisations encourage them to work together as a network (Q49). These findings imply that social capital is either developed after actors started working together as a network or had existed between organisations and drew them to work together. In either case, the strength of ties of actors within the network may grow stronger over time. This speculation was confirmed as accurate from the interviews when participants were asked about the relationship between their organisations and others within the network.

*"Personally, I rely on and trust the implementing of the health promotion of the elderly led by the sub-district LAO. Other organisations are supporters. Together, it is quite a strong team." (An elderly club member/ Donkaew)*

*"I trust in organisations within the network and their capacity to help us through their operations, and with their knowledge and expertise. Mostly a 100% when we ask for their help, it is because we trust that they can help us with their expertise." (A sub-district LAO staff/ Namprae)*

These quotes show that networks within the case studies have strong ties that are mainly based on trust and reliability of capacity. Interview participants also mentioned other factors contributing to the construction of strong ties, such as the bonding that emerged from collaborating and participating in activities together. The strong and friendly relationship helps keep actors within the network and sharing current information.

*"The level of trust is quite high. Mostly in the area, we really understand each other, everything we asked for, we are provided with. We have become a team, and it is important. If there was an activity and we were not there, they [the others] would ask*



*where we had gone and updated us with what we missed from the event. They kept us up to date with information. It is quite good in Namprae. The community and the people are good.” (A sub-district Health Promotion Hospital staff/ Namprae)*

In addition to trust formed that contributes to strong ties between networks members, relationships between the members at the local level also forged other benefits that help strengthen the ties as an interview participant said.

*“...I think what is more important are the relationships, connectedness, and strengthening of the friendship between organisations. When they reach out to us, we go. When we reach out to them, they come. Although location is a big factor, it is good when you are located close to others, but reliability and relationships are more important to build.” (A sub-district LAO staff/ Donkaew)*

A regional organisation staff member who works with multiple local networks also observed the strong ties of the network members that shows in network collaborations.

*“For organisations within the same network, they are all determined to achieve their goal. I would say 100% is possible. Even for programmes with a limited budget, if you asked whether they are happily collaborative, they all are.” (A regional officer/ Namprae)*

It can be concluded that the health promotion for the elderly policy implementation networks within the case studies have strong ties. The LAOs legitimately hold the highest administrative authority, the power that comes with their geographic territorial responsibility. Although a few organisations may possess resources or the expertise needed by others to implement the policy, protocols and regulations, national Acts still require that they work with other organisations to put the resources into practice. For example, LAOs will not be able to implement the policy on their own with only their budget and information at hand, even though they have the Health Promotion Hospital under their administration. Major funding organisations such as the NHSO and the Ministry of Social Development and Human Security will not be able to utilise their allocated budget for policy implementation at the local level without the knowledge of the community and target population from the LAOs or permission to work in their territory, to begin with. In cases like these, without working together, not only will the policies be unable to be put into action, their goal will never be achieved, and individual organisations will not be able to fulfil their own mission and responsibilities.

### 7.2.2 Formality of Ties (formal to informal)

The formality of ties can be determined based on frequency and depth of coordination between network actors and the formality of their coordination (Koliba et al., 2011). This is similar to Provan and Kenis (2008), who suggested that formality exhibited in regular meetings or unscheduled coordination between network members could indicate the level of formality in coordination among actors. In this study, data about the formality of coordination was collected from the survey, observations at both regular and case-based meetings, and interview responses.

Broad questions about formality in working with other organisations within the network were asked in the survey. In the responses, 57% of survey participants indicated that in terms of formality, they would describe working with the other organisations at the local level as *formal, limited only to those mentioned in the policies, and only through a formal communication channel* (Q30). For the same question, 17% indicated that they would describe the interactions of working with other organisations as *informal, based on trust and personal connections, and through various kinds of communication channels such as telephone calls* (Q30). However, when the survey participants were asked more specifically about formality in network management and coordination of network activities, 55% indicated that *they could be accomplished formally and informally such as in the regular meetings or unscheduled communications with a representative of other organisations* (Q11).

From the interviews, I found that the coordination and communication between actors in the network are both formal and informal. The formality of the coordination and communication presents mostly in the early stage of the relationship established between two or more actors. This may be due to the formation of the network, which is based on the direction of the national policies and strategies, rather than it forming voluntarily. Thus, the initial contacts between actors are usually formal and procedural, documents such as invitation letters or official memos are required as a reference or as evidence, especially in cases that involve funding.

#### 7.2.2.1 Forms of Formal and Informal Coordination and Communication

Interview participants in the following quotes explained forms of formal and informal coordination and communication between network members.

*“With other organisations, we are good at working as a network and quite experienced in working as a network on other topics too, for many years. Being a part of networks working on the elderly topic and others have enabled us to know many people. Most of the communication is informal because we already know each other, always ask each other questions. ...It partly depends on personal relationships, having worked with other people before makes coordination easy and informal. But there is formality too like*

*through meeting platforms and other formal invitations. But there is more informality if we are talking about the elderly work.” (A sub-district LAO staff/ Donkaew)*

*“Mostly informal contact like a phone call takes place first like when someone invites me to be an instructor [for an elderly and community health class]. If you ask me, I think informality makes things simpler.” (A district hospital staff/ Donkaew)*

*“There are both formal and informal coordination. The informal call would come first because we are quite familiar with one another. They would ask whether I am available at a specific time and date. After scheduling with me, they would send in a formal request to my organisation. Mostly between government organisations, a formal letter is required because when we do an activity together, it is during office hours, but we just have to schedule with each other first. In most cases, it is like this.” (A district hospital staff/ Namprae)*

*“Our communications are both formal and informal. The formal ones are such as official letters, informal ones are phones calls and LINE Groups [a mobile phone chatting application]. ...The NHSO also has a discussion web board like an online forum for fund receivers to consult about their questions and issues.” (A regional officer/ Chiang Mai Province)*

The previous quotes can be summarised as saying that coordination and communication between network actors are in both formal and informal forms. When asked about other informal coordination and communication, an interview participant at a regional government office mentioned that besides phone calls and chatting on a mobile phone application, they get together for a coffee or a meal as well.

*“We may get together for a coffee or a meal informally. Mostly for that, we have small meetings or just a small discussion to prepare and exchange information, ask for documents, and files before a big meeting.” (A regional officer/ Chiang Mai Province)*

From the quotes, formality in coordination and communication is usually in the form of official letters to request collaboration, participation, or support. Informal coordination and communication, however, have various forms such as a phone call, a chat on mobile phone messaging application, a web-based discussion forum, and an informal meeting or a small group discussion over a coffee or a meal.

#### 7.2.2.2 Purposes of Different Levels of Formality

One factor influencing informality is the familiarity of individuals responsible for the elderly topics having met or worked together before. On the other hand, in the case of a lack of familiarity with other organisations' staff, formal coordination or communication take place to 'probe' for the right person to coordinate with. This probing requires the authority and insight of the management at the organisation being reached out to. An interview participant provided an example in the following quote.

*"The first contact is usually formal. Other organisations may view it as a work assignment. Sometimes we do not know which officer [at other organisations] is responsible for the work that we have, so we must send an official letter first so that their boss or the management can assign the right person to take the responsibility of working with us. After we know the individual and they understand our work based on the official documents, then we can coordinate informally as sometimes we cannot fit all the details in texts on official letters at first." (A regional officer/ Chiang Mai Province)*

Moreover, formal coordination and communication after the initial contact may be to create a paper trail.

*"Mostly for formal communication, we issue official letters as and for evidence, also for confidence assurance, and to affirm clarity." (A regional officer/ Chiang Mai Province)*

The personal relationships between individual staff or officers reduce the formality in coordination and communication for network activities. After the initial contact and knowing an individual who works as a coordinator or a representative for the project at another organisation, the coordination and communication can become informal without any further formal procedures. It is apparent that in both case studies in this research where network members have worked together for some time with an average of between four to six years (Q36), the formality that takes place is procedural and for reference.

#### 7.2.2.3 Circumstances of Formality

The formality of ties between network actors was explored further to ascertain specific circumstances, other than the pre-existing familiarity between organisational staff. Interview participants provided information on the circumstances of formal and informal coordination and communication.

*“For formal coordination, mostly, it involves funding such as the Long-term Care Programme. They [the NHSO] wanted us to be the model and pilot community. This one came through formally. If the activity is in the seminar platform, academic discussion, knowledge exchange, something like this is a bit formal too. We get and issue official invitations for these.” (A sub-district LAO staff/ Donkaew)*

*“For meetings like planning meetings and regular or monthly meetings, we usually send out official invitations, we have been invited in the same way. If it is an urgent meeting, we just phone call.” (A regional officer/ Donkaew)*

*“Formal coordination and communications are such as following up with the annual budget, following up with committee establishment, or sending out a reminder for reports and the co-funding of the LAOs own funds, and sending an invitation for activities and training. Formal communications also include discussion memos such as responding to consultation about issues raised by the LAOs. As some issues are related to a big amount of funding, if we are unsure about the law, we would ask them [the LAOs] to send in a discussion memo. In a case that requires a consultation with a lawyer, we would issue an attached document to our central office [the NHSO], they have a legal department there with 20-40 officers. After we get the response from the central office, we then respond to the service unit with their suggestion or advice. Informal coordination like a phone call or Line messaging is used to follow up things as well.” (A regional officer/ Chiang Mai Province)*

*“If organisations already have an MOU with us, we can coordinate with them informally under the topic that we both are interested in such as for community training and fieldwork. We can give them a call. Other cases such as when we invite them for fieldwork and suggestions, or a meeting that is not in a meeting room setting or meeting environment, these can be informal too. If we would like to invite them to come in to offer opinions formally or ask for project collaborations, official letters are needed. (A sub-district Health Promotion Hospital staff/ Donkaew)*

*“When we invite a speaker or an instructor, we issue an official letter requesting collaboration. We make a call first though, and then official coordination comes after like calling a nurse whether she knows a physiotherapist. After she sends us a list of names, then we issue an official letter to the hospital the physiotherapist works at. Although we may personally know each other, there must be an official letter. General discussions mostly are not formal. Urgent cases are informal, like when an old person has to go to a*

*senior care home. We would informally get in touch with them about taking the elderly person in for a physical check-up and discussion.” (A sub-district LAO staff/ Namprae)*

From the previous quotes, formal coordination and communication in the form of an official letter or memo take place mostly when budgeting or funding are involved. Other cases are inviting network members to regular meetings, panel discussions, training, and consultations that need to be recorded and followed up with the involvement of expertise at a higher governance level.

The formality in regular meetings was also reflected in the regular network meeting in Donkaew, where the observation took place. The meeting was held in the formal setting of a meeting room where representatives of organisations within the network and organisations located within the sub-district area were seated in two rows of half circles. Official invitation letters were sent to organisations in advance, and all meeting participants had to introduce themselves at the beginning of the meeting. The meeting agenda was announced by the Deputy Director of the Donkaew Sub-district LAO and anyone who wanted to say something had to raise their hand, be invited by the Deputy Director to speak, and introduce themselves one more time before speaking.



*Figure 35: Donkaew Sub-district Administrative Organisation Meeting with Organisations within Their Network and Sub-district Area, Chiang Mai, Thailand. April 30, 2018*

Unofficial meetings, a get-together, or a discussion that does not take place in a formal meeting environment, however, do not require an official invitation or documentation. Informal coordination and communication can be expected in urgent situations when time is sensitive, and actions have to be taken immediately. Moreover, activities under the already established agreement between network actors do not require formal communications. In

addition, a routine operation, although carried out by a sub-district external actor, does not require anything formal, as a participant's example in the following quote indicates.

*"Something routine like a home visit that we regularly do every Tuesday and Thursday in the sub-districts does not require anything formal like an official letter. Sometimes we have to ask the sub-district LAOs, Health Promotion Hospitals, or the village health volunteers to come with us for a home visit like when their home needs a repair, or whether they have a supporting fund to help – things the LAO can help with. In the latter cases, we issue an official letter." (A district hospital staff/ Namprae)*

From the interview participant in Namprae case study, although the home visit within the sub-district LAO territory is carried out by a district hospital, an external sub-district organisation, the agreement of this action being implemented in the area has already been acknowledged. Thus, activities such as a routine visit do not require an official notice. A routine operation like the elderly home visits may be carried out by different organisations depending on the source of funding and the agreement between organisations within the area. For example, for Namprae Sub-district, Hangdong District Hospital nurses regularly visit the homes of the elderly as a part of their own work plan in collaboration with the sub-district LAO and elderly club. For Donkaew Sub-district, internal sub-district network actors such as the LAO, the Health Promotion Hospital, and the elderly club and their community health volunteers carry out home visits. They do so with funding from the national Thai Health Promotion Foundation as a part of the Development of Community Health Network to Livable Sub-districts in the Upper Northern Region (Thai Health Promotion Foundation, 2012, 2011). In other sub-districts outside of the case studies, network actors such as the local elderly club may receive funding for home visits from the NHSO under their Sub-district Health Fund through their sub-district LAO (Sub-district Health Fund, n.d.).

However, in case of a collaboration that is not a part of regular or routine activity or project with a network member based outside of the sub-district, a formal communication in the form of an official letter is required.

*"Inviting a speaker or an instructor [for an elderly class] requires an official letter, but we call to coordinate first every time. If the LAO would like us to be the instructor, they would just call. If it is within the sub-district, it is not formal, but if the organisations are outside of the sub-district, we issue the letter every time." (A sub-district Health Promotion Hospital staff/ Namprae)*

In summary, regarding the formality of ties, coordination and communication between network actors can be both formal and informal. The factors contributing to formality can be identified as the following.

- 1) Content of the contact – Most coordination that involves budget, funding, and laws are formal.
- 2) Urgency – Coordination and communication related to an urgent situation involving the immediate needs of the elderly are always informal.
- 3) An existing official relationship – Coordination and communication for collaborations based on established mutual agreements and mandating a policy that requires network members to work together on certain projects are mostly informal. Only the initiation needs to be formal with meeting and signing off the agreement.
- 4) The regularity of activity and collaboration – Activities and collaboration that occur periodically such as monthly or quarterly network meetings or grantee meetings usually require an official letter of invitation. Other than the general information about the date, time, and venue of the meeting, the official letter includes the topics that will be discussed and the list of participants attached. However, for routine operations related to the elderly, although they also occur periodically, they only require initial official notification and acknowledgement.
- 5) Personal relationships between network actors' staff – This is based on the average years of staff of organisations within the network, who have been working together with whom, and who are familiar with one another. Many of them have personal phone numbers of others. As they may have worked together even before their organisations formed as a network, most of the first coordination and communication among them regarding a collaboration or activities are informal.

### 7.2.3 Administrative Authority

Koliba et al. (2011) suggested that centralisation-decentralisation theories can be used in studying the administrative flow of a network as an alternative to social power dynamics analysis. The suggested theories according to the scholars include the discussion of the roles of actors as central and peripheral nodes applicable to analysing a network that presents a hierarchical structure such as the networks in the case studies. Administrative power and authority vectors of ties include vertical, horizontal, diagonal ties, and no ties that visualise the relationship of network actors (Koliba et al., 2011). In this research case studies, only the vertical ties and horizontal ties are found.



However, the administrative authority flow of networks in this study is complicated. This is due to the combination of different levels of governance of network actors (national, regional, and local), streams of governance structure that network actors belong to (centralised and decentralised), and sources of funding and the accompanying mechanisms of accountability and transparency monitoring, hierarchically through actors within different levels of governance and directly by the national actor funders.

Based on the network characteristics discussed previously in this study, the LAOs play the role of the central node in being the main actor that coordinates with others for the policy implementation within their sub-district and for the whole network to achieve its goal at the local level. The interactions between network actors in policy implementation are extensive. In combination with the previous chapter, I found that multiple factors such as high interdependency on capital, personal relationships between actors' staff members, and high level of trust reciprocated among actors help lessen bureaucratic pressure and the formality in coordination and communication, thus establishing strong network ties. In addition, whereas there is a debate among scholars about the different levels of influence between the durability of network actors' relationship and trust on network cooperation and collaboration (Koliba et al., 2011), networks within the case studies present the existence of both at a high level. These factors reflect the horizontal ties of collaboration and cooperation among network actors. However, activities and projects under policy implementation carried out by network actors rely on budget and funding from the central government. Thus, the authority of the funders over the use of fund controlled by the regulations and criteria are automatically attached to the process of funding and implementation of the policy using the funds. Therefore, the direction of administrative power and authority of the network is not entirely horizontal. The administrative power and authority of the central government are embedded in the hierarchical or downstream funding process which unavoidably shows vertical ties, although given to a central node which is a decentralised government unit.

All of the actors who hold status as funders or represent the central government at the regional level are organisations within the centralised governance stream, with the addition of the Thai Health Promotion Foundation. The Foundation funds the local networks directly with no regional representative. However, from the practice and the analysis of networks' implementation of the policy, it is apparent that government organisations work together across the governance stream extensively. Moreover, at the implementation stage, the combination of centralised and decentralised governance structures network actors belong to is not as much of an influential factor compared to whether the actor holds the status of a fund distributor.

To conduct an analysis of the network level administrative power flows, I, therefore, separate actors within the networks in two groups based on their funding status as it seems to be the most influential administrative authority factor. The first group are actors who are fund distributors for the implementation of the health promotion policy for the elderly at the local level. In the case studies, actors within this group are the Chiang Mai Social Development and Human Security Office, Chiang Mai NHSO Office, and the national Thai Health Promotion Foundation. The second group are the rest of the actors within the local network whose funding comes from the first group of actors on a periodical or project-based basis.

Based on the formality of ties previously discussed, the command and control characteristics of a vertical tie mostly present in the hierarchical structure (Koliba et al., 2011). In this study, this is also the characteristic of centralised governance structure in Thailand exhibited by government organisations within the stream. The vertical and horizontal authority power and vector directions continuously present as a network relationship dynamic between fund distributors and fund receivers. The presentation of these authority power and vector directions are unique and different from those between NGOs and their grantors. This is because although the central node of the network, the LAOs, are a decentralised organisation, they are still under the national government's supervision. Moreover, as long as they are sustained by the national funding through multiple central government's funds, they will always be under the command and control of the central government. The LAOs as a decentralised government agency have to adhere to the national policies, follow the administrative management mandated by the national Acts and guidelines which include the internal organisation management, and will never be a complete independent or autonomous actor. The restrictions of command and control apply to all actors within the network who are government organisations.

Koliba et al. (2011) indicated that there are four types of administrative power and authority drawn from social power characteristics of actors in governance networks:

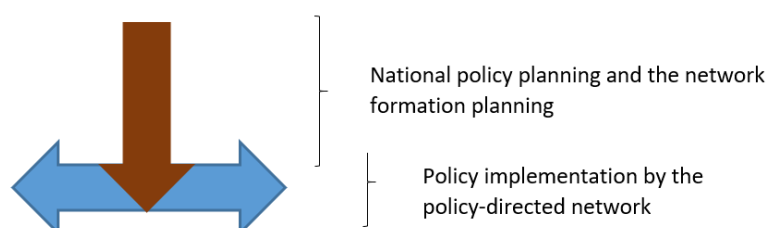
- 1) Command and control relationships between network actors indicate vertical ties such as in a bureaucratic structure where the dynamic of authority is top-down or one organisation has administrative authority over the other. This vector of ties usually presents in the hierarchical meta-organisational structure.
- 2) Collaborative and cooperative relationships indicate horizontal ties where trust and durability play a crucial part in the dynamics between actors that share the authority. This vector of ties usually presents in a mixed meta-organisational structure.

- 3) Concession and compromising relationships indicate diagonal ties based on negotiation and bargaining that usually present in a mixed meta-organisational structure.
- 4) Competitive relationships indicate no ties between network actors where they are rivals or compete in efficiency. In a market meta-organisational structure, usually no ties present.

Organisations within the case studies' networks present a mixed meta-organisational structure consisting of multiple organisations both a part of government structures (centralised and decentralised government organisations including public hospitals), an autonomous state agency (the Thai Health Promotion Foundation), and a civil group (sub-district elderly clubs). Considering this alone, the network could have diagonal ties of power direction. However, the characteristics of concession and bargaining relationship do not present at all at the practice level as all of the organisations within the network adhere to their own individual official responsibilities under their own parent organisation. Their formation as a local network is also directed by the national policies and plans, thus, not driven by a competition for administrative power. The concession and bargaining are not considered a factor because the network actors work together as a part of their directed responsibilities to achieve the national policy goal.

While the no-ties and diagonal direction of power ties can be eliminated as a characteristic of the network actors' administrative authority in the case studies, it cannot be concluded that the authority is only either vertical with command and control or horizontal with collaboration and cooperation. Both vertical and horizontal directions of administrative authority present throughout the policy implementation as a network of those within the case studies. However, I found that the vertical and horizontal direction of the administrative authority power within the network does not always occur simultaneously. It depends on when the direction is determined in the policy process. Network formation was directed at the national policy level. This leads to the budget being vertically allocated and distributed as a result. The vertical administrative authority streams through the monitoring and evaluation measures of policy implementation conducted by the funder organisations. The horizontal direction of administrative authority, on the other hand, dominates in the policy implementation at the local level where network actors rely on others' capital extensively and with more flexibility and informality. At this stage, however, the ties between network actors are not absolutely without the presence of vertical direction of administrative authority as it is attached to funds actors use to operate their own individual functions and to implement the policy. The interactions driven by the vertical ties also continuously occur to ensure the accountability and transparency of the actors' operation as an individual organisation and as a network.

The following figure shows the directions of administrative power driven by the financial capital exchange between the funder organisations and the implementing organisations. The financial capital exchange influences the command and control, and collaborative and cooperative social power relationships of actors. The vertical tie and horizontal tie of relationships between network actors begin at a different time and overlap in the policy implementation stage, particularly during service delivery and activity collaborations.



*Figure 36: Directions of Power*

It is important to note that at the implementation stage, status as a centralised or decentralised organisation within the governance structures does not affect the power distribution that emerged from interactions between network actors. This is because the funders who are positioned higher on the command and control vertical vector must rely on organisations downstream to carry out actions that will also help them achieve their organisation's goal. Thus, they too, are dependent on organisations they have administrative authority over. The funders' administrative power remains over the implementing organisations due to their responsibility to evaluate and monitor the use of their money. The influence of different governance structures disappears and is replaced by the funding status influence. Moreover, due to the funders' dependency on the fund receiver organisations who deliver services as a part of the implementation, the vertical tie blends with the horizontal tie where the interactions of all actors become more cooperative, collaborative, have high trust reciprocation and are very interdependent.

This finding adds to the existing literature that the direction of administrative authority may depend on the most influential resources shared among network actors (Koliba et al., 2011). In this study, the most influential resource that distinguishes the directions of the administrative authority is financial. Moreover, the networks in this study show that the flow of administrative authority across ties can be a combination of vertical and horizontal directions and have a different dynamic when determined at a different time such as at network stages and policy process or cycle.

#### 7.2.4 Accountability Relationship

Serious accountability challenges emerged from when the government system shifted to a governance system where multiple organisations working together closely has become a system with many centres. This is because the state, namely the central government, loses its traditional authority and is replaced by central actors (Koliba et al., 2011). This finding is similar in health promotion for the elderly in Thailand, where the LAOs play the roles of central actors in the policy implementation in local networks around the country. However, an interesting finding from the case studies differs from what Koliba et al. (2011) suggested which was the degrees of centrality within governance network depends on the contexts and are subject to network members' positionality. The difference is that based on the findings, actors who are in the funder position hold the most needed resource, which is the budget to implement the policy. However, network actors, including the funding actors, agreed that the LAOs are the most important actor in the policy implementation as the policy-directed network centre at the local level. From the survey, 60% of the participants indicated that LAOs *usually* lead discussions and topics related to elderly health promotion (Q48.1). Among the total participants, 72% indicated the LAOs *usually* initiate projects or activities to promote the health of the elderly within the community (Q48.2). Sixty per cent of the participants indicated that LAOs collaborate with other organisations in implementing a new programme or activity to promote the health of the elderly (Q48.3). Nevertheless, it cannot be said that LAOs possess "strength of the controlling entity" as Koliba et al. (2011, p. 245) suggested is possible in a governance network with strong ties. It is also clear that LAOs are not the single actor who has the controlling entity strength. This is because their control is limited by funding and budget spending regulations. The budget spending in particular restricts the use of the LAOs' own collected revenue as well. In summary, even as a centre of the policy implementation network, the LAOs do not hold the control and absolute accountability power of the entire network.

The accountability appears to be streamed vertically based on the control of the individual network actors' position in the hierarchical governance structure. The vertical stream is the direction of control of an organisation at a higher level within the same ministry. Horizontal accountability also exists but does not directly occur through the relationship between funders and fund receivers. Horizontal accountability is shared among network members across the governance structures. It also includes public and civil groups who can inquire about budget spending and service delivery reports, which are a part of the responsibility to make them accessible and transparent to the public. To explain the accountability relationship of the networks within the case studies, I applied the three Governance Network Accountability Framework by Koliba et al. (2011) in the analysis and found that

one of the frames dominates. The three accountability frameworks are Democratic Frame, Market Frame, and Administrative Frame.

#### *7.2.4.1 Democratic Frame*

Democratic Frame includes political accountability where the elected officials are responsible as the “democratic anchorage” of governance network (Koliba et al., 2011). The existence of this accountability is determined from whether the network’s activity actually benefits the citizen and whether the citizens have access to them (Sørensen & Torfing, 2005).

The representation of elected officials dominates as a key characteristic of accountability within this framework followed by citizen accountability, and legal accountability in the forms of “law, constitutional law, civil and criminal laws, and legislative mandates” (Koliba et al., 2011, p. 247; Romzek & Dubnick, 1987). All of these three accountabilities presented in the case studies but varied in degree depending on the unit being looked at.

At the whole network level, it can be said that the democratic accountability frame is presenting throughout the networks. Health promotion policy for the elderly was originally agreed upon and authorised by the relevant ministers. Ministers in Thailand are nominated by the elected Prime Minister. They are either already elected members of the House of Representatives or individuals nominated by the Prime Minister (“Constitution of the Kingdom of Thailand B.E. 2560 (2017).” 2017). This process represents the elected representative accountability. National Acts directed the responsibilities of each network member and their network formations came from the direction of national policies and plans. This represents their binding accountability. Finally, citizen participation in network activities and the outcomes of the network activities have an impact on them either individually or as a group. This represents citizen accountability.

At the individual network actor level, using the streams of governance structures as centralised and decentralised to look at network actors can be helpful. This level is where the degree of each democratic accountability characteristic varies. While all network members are virtually governed by elected officials, the LAOs, an organisation in the decentralised governance stream, represents the elected representative accountability the most. As their organisation leader, the director, is locally elected. Moreover, with the LAO’s office located in the sub-district, I found that citizen accountability also presents very strongly through participation encouraged by LAO staff. This is what Blair (2014) suggested that with the elected representative located in the community, there can be a strong presence of citizen accountability through participation, especially in the service delivery of the local governments. Other network actors also participate in various degrees depending on how much their functions serve the citizen. In addition, the LAOs is directly

responsible by ensuring health services have been provided to the people and the elderly in their community and that they have access to these services ("Determining Plans and Process of Decentralization to Local Government Organization Act B.E. 2542 (1999)," 1999). Other network actors also held accountable by different laws and acts, although, their services, if not as part of a network activity, would still require access to the population through the LAOs.

#### *7.2.4.2 Administrative Frame*

According to Koliba et al. (2011), the Administrative Frame is similar to the democratic frame in the sense that it can be viewed vertically and horizontally. The difference is that the vertical accountability relies on ties to a bureaucratic hierarchy, whereas horizontal accountability refers to the inter-organisational ties from collaborative arrangements. The Administrative Frame looks closely at the administrative mechanisms of a network in action in the form of relationships between actors. Three types of administrative accountabilities within this frame are bureaucratic accountability, professional accountability, and collaborative accountability.

Bureaucratic accountability highlights status relationships between subordinates and superiors based on bureaucratic hierarchical structures. This may present both within organisations and across the network (Koliba et al., 2011). An outstanding characteristic is a formality in "operating standards and procedures in place, along with stated rules and regulations." (Koliba et al., 2011, p.249). This characteristic presents very strongly in the case study networks as each organisation is hierarchically governed by superior organisations with vertical administrative power streaming down the organisations' structures. This applies to the LAOs even though they are a decentralised government organisation that should be flexible and has its own autonomy. Formal relationships also exist and control some interactions between network members such as budget spending, communication, and resource exchanges. This formality takes place due to the policy, regulations, acts, and laws that direct the formation of the network and control the functions and responsibilities of network actors and of the network as a whole.

The structures of professional accountability within the Administrative Frame "rely on the skills and expertise of professionals to inform sound judgements and discretion" (Romzek & Dubnick, 1987). This characteristic is strongly identified with resource exchange and the basis of trust between actors within the case study networks where they rely heavily on one another's expertise, knowledge, and sound judgements drawn from experience and familiarity with the elderly. Romzek and Dubnick (1987) suggested that professional accountability comes from the control of an organisation's human resources who are equipped with expertise and skills for their jobs. This accountability is ensured by the qualifications and ethics set by each organisation for individuals who

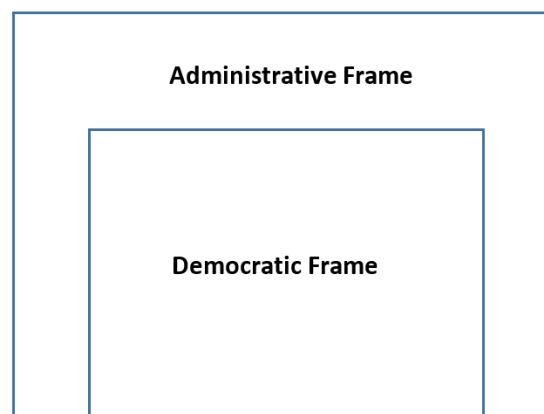
take up positions. From the case studies, the capacity of network actors and their human capital are guaranteed by their official organisation responsibilities and personnel qualifications. Their capacity expected to be exhibited in practice is also a source of trust. However, the level of trust between actors may vary depending on the actual ability exhibited during network interactions and activities.

#### *7.2.4.3 Market Frame*

The Market Frame can be understood as a private sector accountability structure that is most related to profit-making obligations and the checks-and-balances by the stakeholders of the business and the consumers. It might not be relevant to look at the networks in this research through this frame as there is no presence or purpose of profit-making obligations involved.

Therefore, the accountability of networks within the case studies represent administrative and democratic aspects.

The following figure illustrates that the Administrative Frame dominates other accountability characteristics.



*Figure 37: Accountability Frames of the Case Study Networks*

These accountability frames overlap in the analysis of accountability relationships among the studied health promotion network members, which Mashaw (2006) called a hybrid accountability regime. From the analyses and findings in the previous sections, all accountability frames can be applied to the case study networks with the Administrative Frame being the most pervasive.

The application of each framework, explicit standards and implicit norms drawn from the findings to exemplify the domination of the governance network accountability framework application on the case studies is included in Appendix A9.



## 7.3 Conclusion and Discussion: Characteristics of Network Relationships and Emerging Influential Factors

Findings in Chapter 6 (Governance of the Network) showed that LAOs, being positioned as a central actor of the network, also operate as the centre of management and coordination for the network. I found that the LAOs in both case studies possess limited resources as the centre of their respective network. All network actors are dependent on others' resources to achieve their individual organisation's goal and the whole network's goal. Relationships between network actors are influenced by resources exchanged between them and network ties are driven by this interdependency. With extensive collaborating activities including resources exchange, the ties of the network can be claimed as multiplex according to Provan, Fish, and Sydow's (2007) definition and principal-agent theory (Koliba et al., 2011). Financial, political, and cultural resources exchanged are the most influential to their network relationships and policy implementation. In addition, the flow of resources exchanged supports the coordination centrality of the LAOs and influences the whole-network's administrative and accountability relationships.

### 7.3.1 Financial Capital as an Influential Factor

Financial capital is highly influential in multiple aspects not only at network-level, but also at the actor-level. At the network-level, most of the financial capital comes from the national government, through its regional-level organisation network actors, the exchange limits local initiatives of the LAOs. Being a decentralised organisation, the LAOs should be autonomous and more flexible in decision-making (Berman, 2011; Unger & Mahakanjana, 2016). However, I found that financial capital exchange and its regulations lack flexibility and restrict the autonomy of the LAOs in decision making and consequent actions. The inflexibility of the LAOs to use the central government's funds, the LAO's largest financial capital provider (Office of the Decentralization to the Local Government Organization Committee, 2019), limits the LAOs in maximising their efforts in response to the need of the elderly populations who might request services or resources that do not match the funding regulations. Consequently, decentralised organisations are still centrally controlled by their main source of financial capital.

The hybrid governance network characteristics of the case studies are also highlighted by the financial capital exchange. The responsibilities of the LAOs in implementing the policy with the funds from the central government, delivering financial welfare for the elderly population in the sub-district, and supporting funds for projects proposed by the elderly club reflect their centrality in a network with the lead organisation-governed form at the local level. However, the vertically

streaming structure of financial capital exchange from the central government is accompanied by funding regulations and keeps the local network controlled by the central government as well. The LAOs are implicitly positioned under a hierarchical control as a result. The funding regulations are the source of vertical ties of administrative and accountability that take place throughout the policy process, including at the implementation stage. This bureaucratic hierarchy may limit organisations to work efficiently and in a timely manner (Kapucu & Wart, 2006), which was found to have occurred within Donkaew case study. The limitation usually occurs when the decision to use the funds is being made. The regional-level network actors hold more administrative authority and decision-making power at the stages before the policy is being implemented in activities, as they are virtually the source of financial capital distributing the funds within the network. This administrative authority is shared at the implementation stage as all the actors are equally interdependent in achieving the whole network-goal and their individual goal.

After financial capital comes into action at the local level, the characteristics of a shared-governance network further showed at this stage where coordination and communication between actors are both formal and informal based on personal relationships. This is the stage where hierarchy dissolves and the ties between network actors become horizontal as they are highly interdependent because resources dependency, more flexible due to informal communications, and highly trust each other's capacity based on expertise and experience. Activities and relationships of actors are still managed internally. This is due to their growing social capital (Weisband, 2009). These findings added to what has been found previously that the shared-governance network form is prevalent in health and human services (Chaskin et al., 2001). Furthermore, the shared culture of network actors established based on these relationships will eventually reinforce community capacity (Chaskin, 2001). Donkaew is a good example of having connection between community capacity reinforcement and shared-network culture. As the self-sustainable, continuous learning, and self-development shared culture initiated and transferred by the LAO to other actors, the actors reinforce the same culture to the elderly population and the community by supporting them to be independent and sustainable. Moreover, community capacity is also found to affect the positive outcome of a community-based health programme and helps sustain results beyond the programme period (Wisitcharoen, Boonchieng, Suwanprapisa, & Buddhirakkul, 2016).

### 7.3.2 Political and Cultural Capital as Influential Factors

There were two other influential resources exchanged within the two case studies that are distinctively different and may contribute to a different policy outcome. They are political and

cultural capital. Political capital sets the community priority issues and cultural capital is influential in establishing shared values between network members in implementing policy in response to those issues. The elected Directors of the LAOs who represent political capital in each sub-district are the leader of the LAO management team that can influence the cultural capital of the whole network. These two capitals were found to link with and have a high impact on the network-level capacity of the studied cases. In Donkaew, quality of life of the elderly population, including their health promotion is the sub-district top priority issue, in alignment with the national policy and development strategy.

Moreover, the cultural capital within Donkaew policy implementation network was shown to be a driving force for the policy implementation effort. The self-sustainability, continuous-learning, and self-development shared values established and transferred to other network actors by Donkaew LAO's management resulted in actors being supportive of one another and the network being proactive. This happened although other actors are not under the administrative management of the LAO. The same characteristics could not be concluded from Namprae where infrastructure development holds a higher position as a priority for the sub-district and no apparent shared network culture was observed.

Furthermore, even though political capital is influential in issuing prioritisation, it is not a defining factor limiting policy implementation performance. While Namprae prioritised infrastructure development, it was pointed out in the interview that more infrastructurally disadvantaged sub-districts performed better than Namprae in elderly-related topics based on the district-wide evaluation by Hangdong District Office for Local Administration. Nevertheless, actors in Namprae shared the satisfaction of their network performance. As a result, they are reactive – only implement activities assigned by the policy and let the availability of financial capital control their initiatives.

Political capital and cultural capital exchanged at the local network level are interconnected sequentially. First, LAO directors prioritise the issues to push based on the needs of the people that elected them. Second, they use their leadership to develop, or not develop the shared culture of their own organisation, and in some cases, as in Donkaew, make their organisation's shared culture a network culture. This sequence may cover other policy implementation networks beyond the health promotion policy for the elderly that the LAOs are a part of. This finding can be an opportunity for future study to explore whether this sequential influence takes place in other policy implementation driven by policy-directed networks. Comparing the two case studies it is highly likely that the policy implementation outcome depends on the shared network culture. This assumption is made based on that findings that what actors gained from being a part of the network is learning

about others' way of working, and their visions.

### 7.3.3 Network relationships

While resources such as financial, political, human, physical, and knowledge and intellectual capitals that have been exchanged between the actors may have existed and owned by actors prior to network formation, cultural and social capital have been developed as a result of the actors' interactions that took place subsequently. The various types of links between network actors such as joint projects, co-planning of activities, referrals, and shared and exchanged resources indicate multiplexity of the network (Provan, Fish, & Sydow, 2007). The relationships between network actors were defined based on these links. In this chapter, findings showed that the command and control relationships among network actors are driven by financial capital. The regional-level actors distributing and allocating funds hold the command and control power with funding regulations from the central government, who they are an agent for, as their tool. The command and control relationships are most dominant at the policy stages prior to and in the implementation stage, including directing actors to form as a network. The command and control relationships overlap with collaboration and cooperation relationships at the local policy implementation stage where all networks interact extensively to exchange resources. At this stage, the formality of ties and their circumstances are found to show more flexibility of activities and management within policy implementation, such as elderly home visits and interactions between actors. The level of flexibility and activities are found to vary depending on each network's social capital and management. These relationships overlapping at the implementation level without the presence of negotiation and bargaining between funding and implementing actors usually influenced by flows of financial capital (Koliba et al., 2011; Grafton, Abernethy, & Lillis, 2011). The mechanism of being the policy-directed network limits the latter relationships' dynamic as each actor has their own organisational responsibilities and expertise and their network formation is not a choice. Therefore, my findings imply that in a policy-directed network bargaining and negotiating relations may not exist or are not able to exist.

Koliba et al. (2011) mentioned that the network centrality of a member node could be indicative of the strength of ties of the network based on their power and authority. Using the centre-periphery metaphor of Shils (1975), the centrality of the node can be determined from their roles positioned at the hub of the whole network and their roles as a mediator between actors that can be deemed peripheral nodes. However, based on findings of the authoritative power of networks within the case studies, position and mediating roles are not applicable as indicators for actor centrality in this study. The LAOs have been given the central status and position as the centre of the health

promotion for the elderly policy implementation at the local level by the national policy. From Provan and Kenis's (2008) research mentioned in the Literature Review Chapter, actors with the roles as the centre of the network usually possess sufficient resources, power, and authority. However, the status of the LAOs as the network centre and their position as the leader of health promotion policy implementation at the local level in Thailand do not come with these things to achieve the network outcomes. Instead, in this case of policy-directed networks, the central actors who carry the main roles of coordination and hold the 'betweenness centrality' of the network, are not always dominant in resources, power, and authority. These findings contribute to the debate regarding the sources of power within networks. From the Literature Review Chapter, one group of scholars suggested that power within networks comes from an individual's actions, and the other suggested it can come from an individual's actions, an organisation, or a team with effective leadership. Findings in this chapter support the latter group of scholars, with the condition that strong shared network culture is developed at the implementation stage as one of the results of their ties.

Power imbalances between actors are due to unequal capacity, status and resources (Ansell and Gash, 2008). These inequalities can be resolved for the network by the resource-dominant actors empowering and representing the less powerful actors. Drawing from dynamics and administrative flow of the networks as suggested by Koliba et al. (2011), this power imbalance is found to become more equal at the implementation stage where policies and budgets are put into action, and collaboration and resources are exchanged extensively. However, the empowerment and representation are not only led by the most powerful actors, the LAOs, but all actors within the network doing them for one another as a result of shared network goals and culture. This is an interesting question for future research to elucidate further whether this can be observed only in a policy-directed network with similar characteristics, or if it is also possible to find in other types of networks. This can be a strength of a network whose formation is directed and ties between network members do not include a competitive relationship.

Furthermore, as Stevenson and Greenberg (2000) explained, the node or actor positioned at the centre while having access to resources, experiences a growing dependence on them from other actors within the network. These characteristics also do not apply to the LAOs that have been directed to be the central actor within the networks in this study. The definition of health promotion for the elderly in Thailand extends to the quality of life of the elderly that is community social and economic environment is highly influential. However, based on the extensive resource exchanges between the LAOs and other organisations within the network and the high resource and operational interdependency, especially between the LAOs and

health-specialised organisations, the central node characteristics of the LAOs are contradicting what Stevenson and Greenberg (2000) explained. Moreover, from the case studies, no single organisation can be claimed to hold the most authoritative power nor can achieve the network goal predominantly on their own based on the strength of ties. Thus, these indicators do not necessary apply to a policy-directed network.

Resource exchange relationships between network members also demonstrated characteristics of leadership within the networks. Findings in this chapter revealed a key variable that affects leadership in the studied networks. According to Emerson et al. (2012) and Ansell and Gash (2008), as referred to in the Literature Review Chapter, leadership roles in networks facilitate two-way communication and support resource exchanges among network actors. While two-way or network-wide communications within the networks are facilitated by actors holding different levels of leadership, a key variable that simplifies and enables network collaboration to be efficient and timely is the informality of the communications enabled by the closeness of their ties. Therefore, leadership roles in networks may include not only facilitating communication within the networks but also informalising them if possible. Informal communication is possible at the implementation level where power is equally distributed due to high interdependency and resource exchanges. Findings showed that leadership in case study networks is transferred easily, as network members are aware of their resource availability, empowerment, and judicial authority. This led to a conclusion that there can be multiple leaders depending on the context of the collaboration, as posited by Ansell and Gash (2008). Furthermore, drawing on the work of Bradford (1998) and Lasker and Weiss (2003), also cited in the Literature Review, the findings in this chapter indicate that network collaboration is likely to be successful as formal and informal leadership roles of actors depend on their multiple skills and capacity.

Collaborative accountability strongly presents in the case study networks based on the domination of administrative accountability relationship which Koliba et al. (2011) suggested takes place between network actors in horizontal relationships and at the interpersonal level. At the implementation level of the policy, interview participants within the network indicated that their interactions are collaborative partially due to trust, commitment, and their personal relationships. This presented extensively in the social capital exchange among network members. Lewis (2010) argued that network governance research did not usually engage social capital theory, which is close to the social network approach in considering resources exchanged between actors and their ties as an outcome. Network members' connectedness needs an empirical assessment of their ties to determine their like-mindedness and trust (Lewis, 2010). This thesis has applied social network

theory to the relationships between actors within case studies and found that their like-mindedness and trust came from their own organisation's goals in developing the elderly's quality of life and as a network from the shared network culture. Furthermore, the application of social network theory to the relationships between actors within case studies showed that trust seems to be the foundation of collaboration and cooperation among network actors and durability is less influential.

Trust shared and reciprocated among network actors builds on individual actors' organisation's responsibilities and expertise, knowledge, skills, and experiences their people possesses. This capacity came from the qualifications required for their positions. Durability may be less influential compared to trust based on the formation of the network, which was directed by the national policy and plans. This indicates that core network members will always be the same actors, regardless of the length of time they may have worked together previously. The durability of actors' participation in the network matters less than trust on the personal level between network actors' staff who work together. Quantitative data showed that participants mentioned they trust the others' capacity more frequently than the length of time they have worked together. Koliba et al. (2011) referred to past studies including Ouchi (1980) that based on the application of game and cooperative behaviour, the durability of relationship is more influential than trust among network actors. If the network is policy-directed and social network analysis has been applied to analyse the relationships of the actors, durability is not an influential factor. This is because actors would have to form as a network irrespective of each other's durability as an organisation, durability of their existing relationship, and joint experience. Moreover, their relationship is maintained, not only because of the prior established trust or durability but also because of the policy's directions and interdependency among them. Staff positions that include assigned responsibilities to coordinate and interact with others within the network help maintain the relationships within the network.

Furthermore, the application of network theory in my research showed other factors that lead to the durability of actors' relationship. The case studies networks' formation and cooperation are directed and controlled by the national policies and plans; their individual organisation's reputation is not as relevant as their expertise and organisation's responsibilities in relation to the policy topic. Trust built on the strong ties of network members and positive personal relationships between actors' staff lead to collaborative accountability, not their reputation or the existing durability. A part of the source of trust in my study is the policy itself where it assigned actors' individual organisation responsibilities and expertise as well as human capital qualifications. The durability of their relationships depends on their interdependency of resources and the direction of the policy and not the reputation of actors. In this setting, the trust built on the strong ties of network members leads to collaborative accountability rather than reputation or durability.

I conclude that accountability and network-level relationships within policy-directed networks are more appropriately analysed with the application of social theory that emphasises trust rather than game theory that sees durability and reputation as key elements. This also posed a further research question about whether it would be more appropriate otherwise to apply game theory if a policy-directed network is formed based on actors' reputation and the length of established relationships rather than actor's responsibilities, expertise, and resources. In addition, as I identified earlier the studied networks have been shown to be multiplex. However, the findings of the irrelevance of durability raised an issue with the existing literature that multiplexity of a network is an indicator of actors' strength of ties and durability (Provan, Fish, & Sydow, 2007). Therefore, it is not always necessary for the relationship of a network with multiplex ties to be identified by both the strength of ties and durability.

In my data analysis in this and the previous chapter, I have addressed the research questions that enquired into the form of network governance that included the characteristics of the network, and the network-level relationships. Also, factors influencing policy implementation at the network-level have been identified. In the next chapters, I will address how these network-level characteristics and relationships have an impact network actors in carrying out the policy implementation as individual organisations. I will also present how the findings connect to policy implementation in practice as well as recommendations based on these findings.





## Chapter 8: Factors Affecting the Policy Implementation at Actor Level

This chapter builds on the finding presented in Chapters 6 and 7 and addresses the second research question about which network-level characteristics or factors are most influential focusing on network actor level.

### 8.1 Influential Network-level Factors and Characteristics Affecting Actors'

#### Implementation of the Policy and Their Capacity

The second sub-question of this research requires identification of network-level factors or characteristics that are the most influential to the policy implementation at the actor level. The previous chapters highlighted that a high level of trust is an outstanding characteristic of networks within the study. The sources of trust arise from their network interactions and the assurance attached to the national policies, an actor's official responsibilities, and the qualifications of their staff as specified in their job descriptions. These also lead to an extensive social capital exchange between networks actors. Although trust is an outstanding characteristic of the networks, their collaboration will take place to some extent regardless, as all the network members are directed by national policy to work together to achieve a common goal. Therefore, it is possible that in other policy-directed networks where the level of trust is not as high, the social capital exchange may take place regardless, but the depth and extent of relationships may vary depending on other factors. For the studied networks, data emerged to explain not only factors or characteristics at the network level that are influential for the actors' participation in network collaborations but also their capacity development contributing to policy implementation.

#### 8.1.1 Influential Network-level Factors Affecting Actors' Participation in a Network

Besides the national policies that directed the organisations to form as a network, survey participants were asked what factors influenced them to work with other organisations within the network are (Q49). Most of the participants indicated that trust was one of the factors (75%). Other factors are familiarity and informality in communication (57%), expertise and knowledge of organisations within the network (49%), capacity of organisations within the network (48%), availability of resources within the network (42%), formality of communication (34%), decision making process within the network (30%), and number of network members (28%). Survey participants (2%) who indicated that other factors encouraged them to work with other

organisations within the network identified one of those factors as the participation of the elderly within the area.

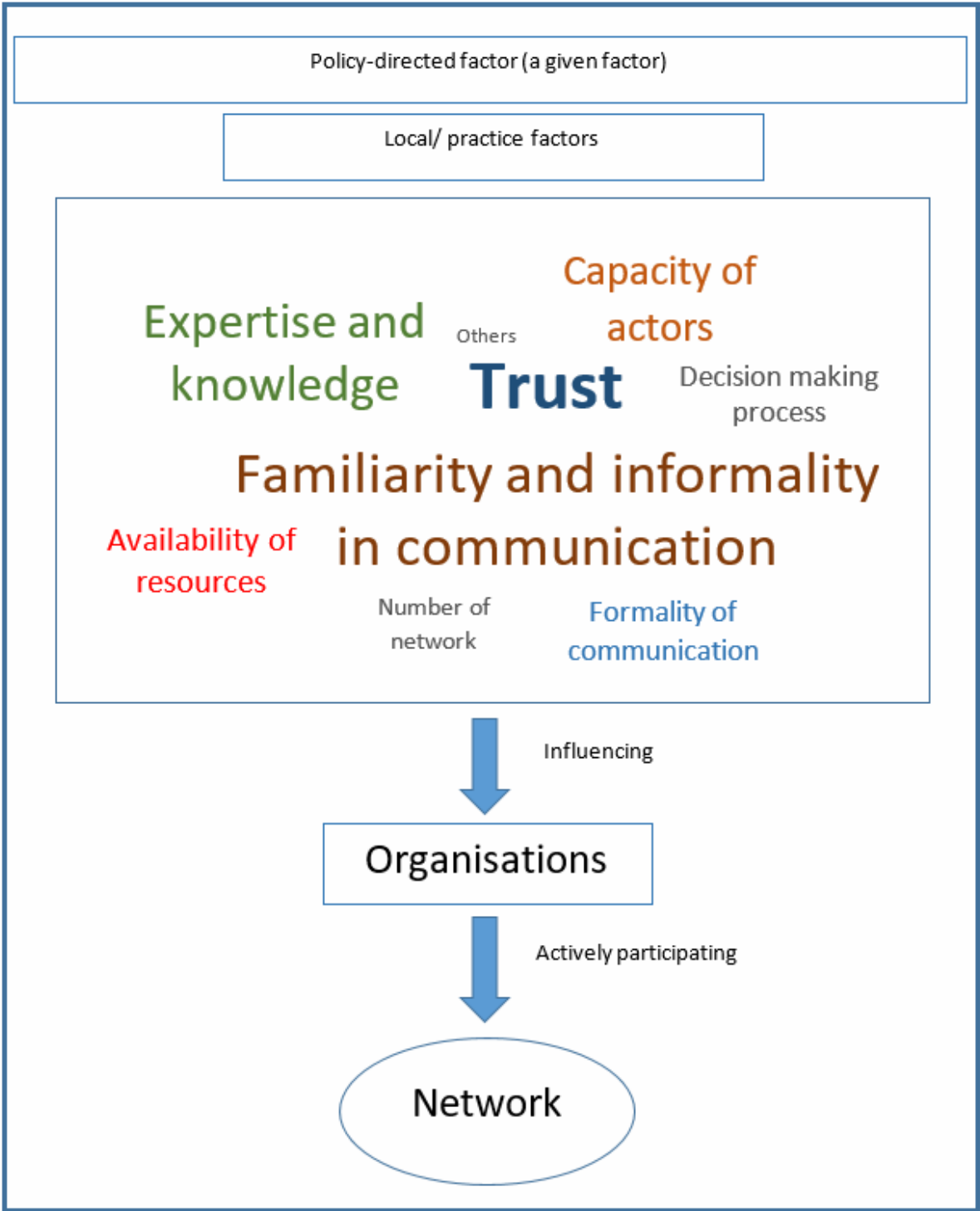


Figure 38: Factors Influencing Organisations to Actively Work with Others as a Network Based on Survey Responses  
Note: Size of words in the word cloud indicate frequency of use.

None of the survey participants referred to or acknowledged the policy or the fact that their organisation's participation in the network is policy-directed in the space provided for "other" choices. It is inferred that if there were no policy particularly directing them to work together on the health promotion of the elderly, they would still form as a network to deliver related services covered by their individual organisation's responsibilities. This inference was confirmed and elaborated by interview participants who stated that being a part of a network is an enticing factor itself as their organisation's goals align with others'. Moreover, in an organisation responsible for the regional level, their strategy covers the local level. Therefore, in order to achieve their own strategy outcomes, they have to collaborate with others at the local level as well.

*"Being a part of the network itself is a factor [to participate as a network actor]. Sometimes our [organisation's] goals do not only focus on achieving the central level mission, but there are also provincial plans. We present regionally at the provincial level. "How do we want to see the elderly in Chiang Mai with a good quality of life?", this question is another factor that we collaborate with others in the areas." (A regional officer/ Chiang Mai Province)*

The interview data also explains how each factor influences an organisation's participation in a network and other factors that were not mentioned in the surveys. For example, in intellectual or knowledge capital, interview participants indicated that other actors have knowledge and expertise that they do not, but they need them to work with the target population. The knowledge and expertise include health, medical training, information technology, and demography.

In respect of decision-making, an interview participant said that independent decision-making allowed by their management is a factor influencing them to work with other organisations using goal accomplishment as a driver, not budget.

*"The management, like the Director or the Deputy Director, uses integration and decentralisation in working within the sub-district. Our department is given the freedom to make a network decision. We can decide to work with any organisations with the aim of us achieving the goals or benefits. Sometimes, we do not have to use any budget." (A sub-district LAO staff/ Donkaew)*

Being a part of the community is also another factor that drives an organisation to participate in the network.

*"We participate as a part of a community. We are a part of the community." (A sub-district Health Promotion Hospital staff/ Namprae)*

An interview participant who works with multiple local networks in the upper northern region pointed out that political capital could be an influential factor in active participation and collaborations of organisations within the network.

*“The level of collaborations of network members is different. Some places put in all the effort, but some places already have too many things on their hands, we cannot blame them. We still have strong supports regardless of elderly health. If their local health organisations prioritise this, the network can be very strong.” (A regional officer/ Chiang Mai Province)*

Accordingly, while political capital could be an influential factor for active participation and collaborations of network actors, cultural capital can be seen as influential for network outcome as explained in the summary of the previous chapter. In addition, I found that an element of cultural capital, namely network value also affects network actors’ capacity, particularly in learning, and knowledge and skills development.

### 8.1.2 Influential Factors and Network-level Characteristics Affecting Actors’ Capacity Development

I was also interested in how network participation helps individual organisations develop their own capacity. Survey participants said that their organisations had gained numerous benefits from being a part of the network (see Appendix D), and these benefits help them develop their capacity.

Participants suggested that these benefits also encourage them to work with others. Survey participants were also asked to rate the top three capacity or resources their organisation has developed from being a part of the network. They were found to be skills, knowledge, and experience gained, followed by information exchange, and then budget or financial exchange. Their responses were coded and grouped into the nine categories of network capital (see Appendix A10).

Interview participants suggested that their organisation’s participation in network collaborating activities helped develop capacity in many different ways. Not only does it help their organisation to reach its individual goal, but it also makes them understand the target population better, which eventually contributes to being able to accomplish the network-level goal.

The following comment is from a district hospital staff member whose roles are working with sub-district LAOs and visiting homes of the elderly in multiple sub-districts. Her organisation is a part of the multi-organisations health promotion for the elderly networks in all sub-districts within the district, including one of the case studies.

*“Working with other organisations as a part of the network, we get to listen to the voices outside of the hospital. If we only stay in the hospital, we only see patients who come to us because they are sick or they need medical help. But when we go out with others, we see why they [the elderly] visit us often. We see the root cause such as their living conditions – very crowded or by themselves and no one takes care of them at all. If we only stay in the hospital, we would not get the picture – why are they so needy, why are they rude when they come to us. Seeing how they live makes us understand better why they are like that. Sometimes it is a pressure, so going out, seeing them, and talking to them make us understand. We also understand people’s view of the hospital better.” (A district hospital staff/ Namprae)*

The following quote is from a provincial hospital staff member who works with LAOs in Chiang Mai province about dementia in the elderly population.

*“I think it is an opportunity that I get to go out and work with others. I get to use my knowledge to educate them. Going out and working with others brings benefit to the people for sure. Their local instructor may have the knowledge but might not be as in-depth as I may be. Personally, I work in reducing risks in dementia and patients with dementia every day. The broad view might be different from the in-depth view.” (A regional officer/ Chiang Mai Province)*

Both quotes not only reflect capital exchange between network actors, but they also reflect a capacity that is gained or developed by being a part of the network as well. The first capacity is understanding the context of the target population. The second capacity is the ability to provide expertise for the collective benefit of the target population.

## 8.2 Conclusion and Discussion

The case studies can be described as multi-faceted policy function networks of health and social welfare policy. Based on the network functions and activities, trust was found to be an influential factor in the networks, relating to two sources. The first source is the official responsibility and expertise attached to each actor and their human capital. This source is given by the policy or act that established the actor as an organisation. The second source of trust is developed from a social capital exchange between network actors. Previous studies have also found the association between trust and network-level variables such as a perceived positive network outcome (Klijn, Edelenbos, & Steijn, 2012); network performance (Klijn et al., 2015); and network effectiveness (Isett, Mergel,

LeRoux, Mischen, & Rethemeyer, 2011). My research found that trust also contributes to simplifying collaboration through informality of communication and benefits in easing hierarchical processes. The impact of trust on network formation should be emphasised. Although the networks studied here were directed by national policies to form, research participants did not consider it as a factor that drew them to work together. Instead, based on trust and other factors found to be influential, organisations would participate in a network regardless of the policy's direction, if their individual organisations' missions align. Organisations also trust that others would be able to assist them in achieving their own organisation's goals and missions based on their resources and experience. Therefore, trust does not only have a significant impact on network-level variables, it also has a significant impact on the individual actor-level variables such as participation in a network as a network member and the formation of the network.

Organisations' participation in a network also contributes to their own individual capacity development. A review of interorganisational networks found that the network itself offers multiple benefits at the network level including learning and capacity building, sharing accountability, enabling innovation creation, and sharing risks (Popp, Milward, MacKean, Casebeer, & Linstorm, 2014). Further, I add the benefits of the network at actor level, focusing on actors' capacity development. In the two case study networks, interdependency between actors lead to extensive resource exchange. There was also an association between resources exchanged within the network, particularly the knowledge and information exchange and learning and network capacity building (Kenis & Provan, 2009). The extensive resources exchange, their relationships and interdependency at the network-level have an impact on individual actors' capacity development. According to Koliba et al. (2011), capacity building of individual actors takes place as an operational function of a governance network when actors facilitate other network actors to be able to carry out the network operational or policy functions. Actor-level capacity building of the studied networks takes place beyond improving the ability of the elderly clubs and elderly population in the community as mentioned by the national policies (see Appendix A4). It also includes capacity building in skills and capitals of each actor.

The benefits of participating in a network have been studied before. The network ties within the case study networks identify with the collaborative management ties elaborated on by Carlsson and Berkes (2005) that a government agency with jurisdiction over an area works together with other stakeholders based on their management functions and responsibilities. The co-management or collaborative ties between them can be both horizontal and vertical (Pinkerton, 1994). In my study, the LAOs are not only the network centre but are the organisation with the jurisdiction over the policy implementing areas. Carlsson and Sandström (2008) found that collaborative management

ties benefit the organisations within the network at actor level in cost reduction, risk sharing, and conflict resolutions. However, in their study, network actors extended beyond central and local governments, civil society and communities, to also include the private sector.

While other benefits of participating in a network found in past studies have also been found in my study, a cost reduction stood out. Donkaew LAO was able to reduce cost in their network activities, not as a result of being a part of the network, but from their own organisation's management culture in intra-organisation independent decision-making authority and a work culture of self-sustainability. This enabled Donkaew to conduct their network-related activities serving the elderly population in their sub-district without a budget constraint, a factor that obstructs continuity of activities and elderly's need in Namprae. It is also the organisation's culture that has been made the network culture. Benefits of network participation at the actor-level, particularly in cost reduction, may be subject to the individual organisation's culture.

My study showed that network members learned about Donkaew LAO's ways of working including their ability to reduce cost and sustain their elderly programmes, by participating in the same network. Moreover, this may ultimately have an effect on network-level cost reduction, depending on whether that individual organisation is in the position of being the network centre as in the case studies. This learning reflected findings mentioned in the Literature Review Chapter from Koliba et al. (2011) about network-level operating function - that actors exhibited knowledge transmission and capacity building among each other. In addition, findings in this chapter are persuasive and showed that the influence of cultural capital exchanges between network members is powerful. While it has been established in the existing network literature that collective learning is a network-level characteristic, findings presented in this chapter have added that learning also occurs at the actor level and it is a benefit gained as a result of the cultural capital exchange. In addition, one of the gaps found from the literature review was that strategies for policy improvements were still needed from network research. Aspects that can be considered in the process of network capacity building strategies were discussed in this chapter. How these findings can be put into practice to improve policy implementation will be discussed in the next chapter.





## Chapter 9: Integrated Summary of Findings, Policy Recommendations, and Conclusion

In this chapter, I first present an integrated summary of findings of the network characteristics in response to the research questions, later I will present the policy recommendations drawn from the finding and followed by the conclusion of the thesis.

### 9.1 Integrated Summary of Study Findings

The networks researched in this study implemented the health promotion policy for the elderly at the local level in Thailand as governance networks. National policies directed these networks be formed, with LAOs at the centre. The main research question is, *“How do the networks of health promotion policy implementation for the elderly at the local level in Thailand function?”*. The two sub-questions are:

1. *What are the characteristics of the networks, and their network-level form of governance?*
2. *Amongst the network characteristics and other factors found to be relevant, which are the most influential factors affecting policy implementation?*

Chapters 6, and 7 presented the findings from the research on the main question and addressed both sub-research questions, particularly at the network-level.

My findings are summarised in a table drawing on Koliba et al.’s (2011) governance network’s variables as a guideline (See Table 6, p. 94). Findings from my research in addition to the existing variables from the guideline are discussed in the extent column and in the following sections.

*Table 11: Integrated Summary of Network-level Characteristics of the Case Study Networks*

Characteristics	Variable	Variable descriptors of case study networks	Summary of extent found
<b>Network ties</b>	Resources exchanged	Financial	Extensive exchange of government funding and budget
		Human	Frequent sharing of workforce, skills, and capacity of human resource between actors
		Social	Positive relationship of staff representing network actors
		Political	Leadership of elected staff of the network central actor affects network efforts in implementation
		Cultural	Shared values in terms of way of working and mindset are significant to achieving network-level goal or beyond
		Knowledge	Extensive exchange and sharing of knowledge between network actors, especially in technical expertise
		Physical	Extensive sharing of building, vehicles, equipment
		Natural	Sharing of public land
	Strength of ties	Strong ties	Strong ties with friendly relationships between network actors based on frequency of contact, social capital exchange such as trust and reliability of others' capacity. Average length of contact between actors is between four to six years.
	Formality of ties	Formal and informal	Networks represented both formal and informal ties based on their communication. Formal communication in forms of official letters or invitations takes place for documentation and records keeping purposes and in the initial contacts. Informal

Characteristics	Variable	Variable descriptors of case study networks	Summary of extent found
			communication takes place for a discussion or activity follow-up purposes in the form of phone calls or mobile phone application chatting. Informal communication may be the initial contacts in a case when network actor staff know each other personally or have coordinated with one another before.
	Administrative authority	Vertical (command and control) and Horizontal (collaborative and cooperative)	Administrative authority is most dominant in financial capital exchange or funding process. Regional-level actors whose roles include fund allocation or distribution have administrative authority based on their control and command according funding regulation. Administrative authority flow is a combination of vertical and horizontal directions which overlap at the implementation level where funders and recipients collaborative relationship is based on their interdependency.
	Accountability relationship	Democratic and administrative accountabilities	Democratic accountability represented by elected leaders of the network's central actor - the LAO directors, and citizen or community participation in network activities. Administrative accountability is embedded in the bureaucratic hierarchical structures of all network actors, and their interdependency of resource exchange.
<b>Network-level characteristics</b>	Form of governance structure	Hybrid	A combination of lead organisation-governed and shared governance with LAOs the centre of network coordination as suggested by national policies
	Network configuration (based on cause for network formation)	Inter-governmental networks	Based on the cause of network formation, the networks primarily consisted of government organisations across levels (national, regional, and local).

Characteristics	Variable	Variable descriptors of case study networks	Summary of extent found
	Policy tools	Regulations, grant, contracts	The networks were directed to form in the post-enactment stage of national policies to implement health promotion policy for the elderly at the local level. The government tools focused in the implementation are funding and grant regulations, and programme contracts.
	Policy stream functions	Implementing policy through service delivery	The network provides and delivers health promotion services to the elderly at the local level. Actors within the network consist of those who directly deliver health promotion services to the target population and those who indirectly provide the services through funding and other support. Organisations that directly deliver services are those located within the sub-district and those with health-specific expertise who may or may not be located within the sub-district such as the district or provincial hospitals.
	Policy domain functions	Health and social welfare	National health promotion policies address health and disease prevention of the elderly both physically and mentally. The Health Promotion Foundation Act, B.E. 2544 (2001) defines health promotion for the elderly population as an aspect of the quality of life of the elderly, thus covering social welfare.
	Operating functions	Information sharing	Information sharing takes place across the network extensively. Information sharing covers a wide range such as transferring of knowledge, news, and project or problem-solving progress updates. Information sharing approaches are both informal and formal. Informal approaches are such as by telephone calls, mobile

Characteristics	Variable	Variable descriptors of case study networks	Summary of extent found
			phone messaging applications, and casual meeting. Formal approaches are such as organised training sessions and network meetings.
		Task and project coordination	Covering the multiplex ties from extensive network collaborating activities and resources exchange between all network actors with the LAOs as the centre of the network in the coordination of tasks and collaboration of projects taking place in the sub-district.
		Financial resource exchange	The financial resource is distributed and allocated based on the organisation's functions, responsibilities, and expertise of the network actors. Decisions on financial resource allocation are controlled by regulations established by the central government, mainly each ministry to whom the budget belongs. The administrative authority and accountability relationships accompany the vertical flow of financial resource.
		Reporting to and from	Occur both hierarchically and horizontally. Hierarchical reporting is driven by financial resource exchange and administrative authority of supervising organisation in the governance structures (sub-organisations report to supervising organisations). Horizontal reporting is driven by jurisdiction authority and project agreements such as MOUs.

Characteristics	Variable	Variable descriptors of case study networks	Summary of extent found
		Learning and transferring knowledge	<p>Developed from information sharing, individual professional experience or technical knowledge exchange, participation in network collaborating activities, and social and cultural resource exchanges.</p> <ul style="list-style-type: none"> <li>- Joint training programmes between network actors provided by the actors such as A Long-Term-Care training programme provided by District Public Health Office to other organisations within the network</li> </ul>
		Building capacity	Network actors build their organisational capacity through network activities participation and resource exchange, particularly learning and social capital exchange.
	Form of network governance	Hybrid form of governance	Networks shows a hybrid form of governance as a combination of shared governance and lead organisation-govern networks.
	Network configurations	Inter-governmental relations	Networks represent intergovernmental relations with a combination of hierarchical and collaborative arrangements and involve all level of government operations, namely national, regional, and local

*Note: This table is adapted from Koliba et al. (2011) and the final column relates to the findings of this research*

In addition, from Chapters 6 and 7, three key influential factors were identified for the network-level. The first one is financial capital, which connects with the administrative power flow of the network. The other two, cultural capital and political capital, have a high impact on the network activities and interactions that may contribute to network performance, and ultimately, the policy outcome.

Further, in Chapter 8, the research findings on the second research sub-question were presented and provided further insights into the main question regarding the most influential network-level factors characteristics affecting network actors' implementation of the policy. For network participation, the most influential non-policy factor is trust. The factors affecting individual actors' capacity development are the resources exchange between them, particularly skills, knowledge, and learning and gaining experience. Their capacity development and learning are influenced by cultural capital exchange which include network values, ways of working, and shared network culture. The last three factors are part of network-level operational functions.

From the three findings chapters, the table below highlights the summary of aspects of the network and network characteristics found to influence them.

*Table 12: Most Influential Factors Found from the Case Studies*

<b>Network aspect</b>	<b>Most influential factors</b>
<b>Coordination and interactions</b>	National policy (given factor), interdependency, goal consensus
<b>Service delivery and implementation</b>	Geographical locations of actors, available resources
<b>Implementation outcome and network performance</b>	Cultural capital and political capital
<b>Administrative power</b>	Financial capital
<b>Network participation</b>	National policy (given factor), and trust in other actors' capacity and resources
<b>Actors' capacity</b>	Learning and resources exchange influenced by cultural capital exchange



The national policies and national-level interviews confirmed that the existing national policies that formed the local level implementation network played a role partially as a framework guideline for operations. Moreover, national organisations do not participate or interfere in the network operations but rather regulate network actors who are within their ministry.

Thus, as previously discussed, the health promotion for the elderly policy implementation networks at the local level in Thailand developed their own characteristics and relationship structures after they had already formed as networks. The identification of their hybrid form of governance as a combination of the lead organisation-governed and shared governance networks cannot be used alone to predict the likelihood of the outcome and networks' performance. However, this identification is important in providing an understanding about network functions and network-level governance which shaped ties and relationships between actors. The analysis of the network relationships based on their ties and resource exchanges yielded a compelling conclusion that revealed the likelihood of the policy implementation outcomes. They were found to depend on political capital and the leadership of those in power of it - the LAO directors who steer the direction of the networks' effort in health promotion policy implementation for the elderly. The LAO directors hold the power of issue prioritisation in their sub-district and are the leader of the organisation playing a role of the network centre. The outcomes also depend on cultural capital - actors shared the same network values, ways of working, and perspectives which include continuous learning, self-sustainability and self-development. The extents of these latter characteristics are differentiating factors indicating networks' performance.

The findings demonstrated that the networks in this study are an effective policy implementation mechanism and achieve the policy goals as they have a microculture, an agreement on common goals, understanding, and joint activities reflecting shared values among them. Networks in this study can also have multiple leaders needed for network activities, provided that the LAOs are the centre of the network coordination. Networks' microculture and having multiple leaders are crucial elements reflecting the ability to achieve an effective and successful collaboration (Jones et al., 1997; Bradford, 1998; Lasker & Weiss, 2003). The LAOs also play the network leader roles most frequently. However, findings also revealed that networks may be limited in achieving their best performance due to the emphasis given to heavily quantitative national policy indicators. Their best performance is also limited by centralised regulations in funding distributed by centralised network actors

Furthermore, LAOs, as the centre of the local policy implementation networks, do not entirely have autonomy and are still under the restrictions of the central government regulations. A similar

restraint on organisational autonomy applies to other actors within the network. However, despite this finding, the LAOs and other organisations exhibit network characteristics based on their functions, collective characteristics, and relationships. Moreover, their network governance form can also be determined based on variables established by existing network studies. These variables help us to understand these networks that have been formed by the direction of national policies, and which are loosely mandated but still restricted. The restriction revealed at the network-level also implied that the limitations of decentralisation in Thailand still persisted, as the LAOs are not entirely autonomous and flexible. This limitation affects the whole network's ability to directly respond to the needs of the elderly population. The following section summarises policy recommendations drawn from my study.

## 9.2 Policy Recommendations

Although this study did not aim to systematically compare the two cases, the distinct findings in each are interesting and instructive. With supporting evidence that there is a connection between network relationship, shared network culture, and community capacity, it is reasonable to use these factors to explain why Donkaew's elderly health promotion projects are self-sustaining and achieve more success as evidenced by national awards. These findings should be taken into consideration for policy implementation improvement because currently national policy measuring indicators for elderly health as a result of policy implementation network collaboration do not reflect effectiveness. Individual actors' measures and indicators related to health promotion of the elderly emphasise outputs rather than the outcome of the policy implementation. For example, the national indicators for the performance of Department of Older Persons, Ministry of Social Development and Human Security only listed quantitative indicators under their "Effectiveness Evaluation". These indicators are "level of success of social development database", "percentage of networks using quality standards", "number of LAOs using knowledge about older persons in implementation and meeting policy targets" (Department of Older Persons, 2015, p. 1). The same national evaluation listed cost-effectiveness indicators for the financial capital of the networks as "funds requested and used" as in percentage (p. 1). The Ministry of Public Health's Integrated 10-Year Plan for Elderly Population Health Development 2014 – 2024 also have health promotion indicators that quantitatively measure implementation, such as "application of elderly health evaluation system, 1 network per system" and "percentage of sub-district promoting health of the elderly" (Department of Health, 2015, p.12). These indicators do not reflect the effectiveness of the policy implementation or the policy itself.

At the local level, Donkaew, despite being a LAO with outstanding performance, has listed the overall indicator related to health promotion of the elderly as “percentage of a healthy population in the sub-district” (Donkaew Sub-district Administrative Organisation, 2015, p. 49). It also has a specific indicator for the health of the elderly listed under the health development strategy as “10% of the elderly and disabled population received appropriate care” (p. 69). While the percentage of the healthy population can indicate the good health of the people in the community, the number of the population receiving appropriate care does not indicate the impact (or outcomes) of that care. Similarly, for Namprae, percentages of attendance and public satisfaction are used as a programme success indicator in their sub-district policy implementation plan (Namprae Sub-district Municipality Office, 2018). These quantitative indicators do not reflect the effectiveness of policy implementation at the local level either. The unclear national policy effectiveness measurement and indicators may exacerbate the misalignment between the direction of the national policies and the local priority influenced by the local network’s political capital. Moreover, as pointed out by national-level interview participants, each LAO has different levels of resource capacity, particularly human resources. The less advantaged LAO may lead the network to achieve only quantitatively measurable goals, which are not conducive to preparing their community for the aged society in the long-term.

Moreover, I identified the vectors of the administrative power of the mixed meta-organisation structure of policy-directed networks in the case studies. Their ties reflect administrative power as a combination of command and control (vertical vector) and collaboration and cooperation (horizontal vector) relationships which overlap at the local implementation level. To improve the policy implementation outcome of health promotion for the elderly at the local level in Thailand, the following recommendations should be considered, based on key findings in this research:

- 1) The two case studies showed that their elected LAO directors prioritised different sub-district development issues. Donkaew prioritised health promotion and quality of life of the elderly, in alignment with the national policies that formed its local policy implementation network. Namprae prioritised infrastructure development but still carried out health promotion services delivery and activities as a network as directed by the national policies. As political capital is influential in setting the priority issue for sub-district development, it is highly possible, based on the two case studies’ differences in this aspect, that there would be a variety of priority issues among 7,852 sub-districts throughout the country. These issues may not be in alignment with the focused issues of the national policies, which include health promotion of the elderly as in the two cases presented. The policy implementation outcome will be different as a result of the level of network effort driven by each LAOs’ elected leaders and their organisation as the network centre. Drath et al. (2008)

found that to achieve collective cooperation and collective work, leadership should emphasise direction, alignment, and commitment discussions focusing on expected outcome. Dialogues involving these aspects are believed to establish a common ground across different cultures and structural differences leading to the development of common practice (Drath et al., 2008). Wimbush (2011) supported the previous scholars with a suggestion of building a results-oriented culture to develop outcome-focused performance frameworks to align central and local governments' work. Therefore, an intervention to encourage or train LAO leaders to align local and national policy focuses should be promoted. In parallel, a common understanding on goal-oriented effectiveness among LAOs should be built to increase coordination between local and national priorities.

- 2) Cultural capital is developed after the network is formed and interacting. A network with a shared set of values such as promoting a self-sustainable and self-development culture showed a more successful outcome beyond meeting policy indicators that are currently quantitative. Local and national priority issues can be connected and go in parallel if the cultural value of self-development and self-sustainable are embedded in the policy process. Organisations that worked together as strategic partners on repeated collaborations developed a refined understanding of the other's cultures, including capabilities and other aspects (Zollo, Reuer, & Singh, 2002). Learning from interorganisational routines between organisations through cooperation and collaboration was found to enhance effectiveness and performance of shared objectives (Zollo, Reuer, & Singh, 2002). The influence of cultural values may be activated when the administrative authority from the financial capital exchange is dominant, as it is the driver of the command and control relationships of the whole network. Shared cultural capital may help bridge the misalignment gap influenced by the political capital in different areas across the country. The common understandings about the importance of establishing a clear connection between the different issues of social and economic development should also be engendered at the financial capital exchange stage. As such, national policymakers may use the authority through their regional-level sub-organisations, who are fund distributors and members of the local policy implementation network, to embed shared values for improvement of the policy outcomes as they hold the command and control power of in the funding process.

### 9.3 Contribution to gaps identified in the Literature

In the Literature Review Chapter, it was revealed that scholars have argued that empirical evidence on network functions is still needed, especially in the aspects of network governance contingencies,

characteristics, and factors influencing effectiveness. More research was also needed in exploring the influence of network variables on network functions and their linkage to the micro-level of the network or the actor level, particularly on their capacity in policy implementation. Empirical findings in Chapters 6 and 7 provided insight into network characteristics and functioning to address this gap from policy-directed networks. These are policy implementation networks without clear guidelines on how to function as a network, and that lack of a formal structure. Chapter 8 findings connected the network-level findings with the actor-level and revealed the most influential factors affecting actors' participation and capacity in policy implementation. Trust and informality in communication were found to be the most influential factors in actors' participation in the networks. These two factors also help to ease the hierarchical processes and barriers to policy implementation.

Furthermore, Chapters 6 and 7 also provided findings in regard to power dynamics and political factors affecting networks' operation within the context of health promotion policy implementation for the elderly in Thailand. The benefits of these networks' arrangements such as flexibility, extensiveness of resource exchanges, shared network culture, and collective learning and actors' capacity in policy implementation were also presented to address literature gaps through Chapters 6 – 8. I have also applied findings from network variable exploration into the policy recommendations in this chapter.

While this study was able to address some of the theoretical gaps in the field, it is not without limitations in the process and inquiries for future research to contribute further to the network and governance network theoretical frameworks. These challenges and recommendations for future research is outlined in the following section.

#### 9.4 Limitations and Recommendations for Future Research

There are a number of limitations in this research, particularly in relation to data collection. The first limitation is in sampling method of survey participants. To ensure that participants were the most appropriate source of information, purposive sampling was used. Survey participants were selected based on their participation in network activities. Some actors had a large number of staff who matched the sampling criteria but they were not available during the time between survey dissemination and collection, and those who were available did not have the familiarity and level of comprehension to answer the questions, or were unable to read. With limited time, I was not able to wait for those who both matched the criteria and were capable of completing the survey. Therefore, at some actors' locations, the number of surveys disseminated, completed, and collected was limited.

Another limitation is the absence of participant observation. I initially planned to observe at least two network meetings in each case study where contact persons at each LAO, the meeting organisers, suggested take place monthly. With the LAOs' other commitments and unexpected circumstances, monthly meetings did not take place as planned for several months. Although I was able to observe other network activities, not all network actors were present at once as was expected for the network-wide meetings. Future researchers should ensure with their networks if meetings are mandatory to take place or if there will be an alternative if the observation is absolutely necessary.

Opportunities for future research are for comparisons across the country or between groups of networks with different levels of performance. All networks under the same national policies in Thailand were formed with the same core network actors and were provided with the same funding systems and administrative structures. Despite the similarities, one case study network achieved beyond the national policy targets and was seen as a model network (winning awards), while the other only met the quantitative requirement. Given the two case studies in this research are among 7,852 networks around Thailand, future research could be conducted looking at networks with similar levels of policy implementation performance. This could include whether the extent of cultural and political capital is different among them. Findings from such research would be useful in directing efforts in areas that can help improve the policy outcome for the average-performing networks. The same comparison can be conducted in other regions as well.

In addition, this research studied policy-directed networks within the health and welfare policy domain. It will be an opportunity for future research to explore networks conceptualised as policy-directed in different policy domains. The exploration may include a comparison of network characteristics and factors affecting policy implementation and network actors' capacity between different policy domains. Also, network actors in this study are predominantly in the public sector based on the design of the policies that directed them to form. But as the concept of a governance network emerged from studies of collaboration of actors in different sectors, it would be an opportunity to look at a policy-directed network with actors across sectors. This would assist in providing inputs for policy implementation outcome improvement with interventions based on learning from different policy domains and with a diversity of actors' sectors.

## 9.5 Conclusion

Existing population age trends make it inevitable that Thailand will become an aged society. The importance of health promotion for older age groups is not only in reducing the country's health care expenditure, but also in mitigating the social and economic burden for the younger populations

and future generations. LAOs and other government organisations are directed by national policies to implement health promotion for the elderly at the local level. I wondered how they, being directed by the national policies, implement the policies. What were their network characteristics? What were the most influential characteristics among them affecting network actors' capacity and ultimately policy implementation? Especially with over 7,000 of the similarly directed networks throughout the country, could there be differentiating factors that contribute to networks having a more positive implementation outcome than the others?

These are the questions that led me to undertake this research. It has provided an understanding of the health promotion policy-directed networks' characteristics. It has revealed that the networks within the case studies have a hybrid network governance form, a combination of lead organisation-governed and shared governance in actual policy implementation. In this type of governance form, the policy implementation outcome cannot be predicted based on the characteristics of the hybrid form alone, but the in-depth analysis of other network factors, such as network ties and network-level functions, were more indicative. Cultural and political capital exchange, as elements of network ties, have been found to be the most influential factors in policy implementation. These factors also differentiate the policy implementation outcome between the networks. Shared cultural capital such as self-sustainability, self-development, and continuous learning values can help a network succeed beyond achieving the quantitative policy indicators, despite the different social and economic context of each sub-district. For political capital, the influence of this factor does not only depend on the prioritisation of policy implementation issue, but equally important is the ability of the elected LAO directors and their management team in connecting the local prioritised issue with the direction of national development policy.

In parallel, the capacity of individual actors should also be addressed to improve policy implementation. The most influential network factor affecting an individual actor's capacity development is learning and resources exchange. While resources exchange is the foundation of network relationships, learning between network actors, in particular, can be further encouraged by providing more learning platforms. The Donkaew network in this study has developed and participated in learning platforms online and offline, domestically and internationally. Similar models should be provided to organisations by their superior organisation or ministry so they can improve their capacity as an individual network actor, and together with other organisations as a network, in order to drive the national policies and local implementation in alignment.

This study has presented the influence of network variables that have a significant impact on policy implementation in policy-directed networks. It has contributed to addressing network literature gaps

by providing empirical evidence of influential variables that have an impact at both network level and at actor level. It has also provided an example and an explanation of how governance networks have developed and function in a middle-income country. This research is based on my interests in growing global social and economic concerns accompanying an aged society. I believe that the mediation of this complex issue and other issues can continue to benefit from studies using network theory.





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## Appendices

### Appendix A: Tables

#### Appendix A1: Key Public Health Services in Thailand

<b>Characteristics/ benefits</b>	<b>CSMBS (public employees)</b>	<b>Private Employees (employees of informal sector)</b>	<b>UHC (The rest of Thai citizen)</b>
<b>Scheme nature</b>	Fringe benefit	Compulsory	Social Welfare
<b>Health service utilisation</b>	At contracting unit of primary care (CUP) both public and private	At registered main contractor hospital (>100 beds), public or private	At any public hospital for outpatient services; or a private hospital, except accident and emergency. Only public hospitals for admission services
<b>Health services</b>	Ambulatory and inpatient care including accident and emergency and rehabilitation services, and preventive and health promotion services Note: prevention and health promotion for beneficiaries in all three schemes	Both ambulatory and inpatient care, including accident and emergency and rehabilitation services. No preventive services are provided, but NHSO manages prevention and health promotion for beneficiaries in all three schemes	Both ambulatory and inpatient care, including accident and emergency and rehabilitation services. No preventive services are provided, but NHSO manages prevention and health promotion for beneficiaries in all three schemes
<b>Renal replacement therapy (RRT)</b>	Covered and starts with peritoneal dialysis, the patient has to pay if choose haemodialysis	Covered; both haemodialysis and peritoneal dialysis, liable for co-payment if beyond the ceiling	Covered; both haemodialysis and peritoneal dialysis, patients are liable for co-payment if costs are beyond the ceiling
<b>Antiretroviral therapy for HIV/ AIDS</b>	Included	Included	Included

<b>Characteristics/ benefits</b>	<b>CSMBS (public employees)</b>	<b>Private Employees (employees of informal sector)</b>	<b>UHC (The rest of Thai citizen)</b>
<b>Organ transplantation</b>	Kidney and bone marrow covered for treatment of certain cancers	Kidney and bone marrow covered for cancer; corneal covered	No exclusion list
<b>Dental care</b>	Covered, both preventive and curative dental services	Reimburse no more than twice a year (max 300 Baht/treatment)	Covered, no limitation specified

*Source: Adapted from Sakunphanit, T. (2015); Universal Health Care Coverage through Pluralistic Approaches: Experience from Thailand. Copyright (2015) by International Labor Organization.*

## Appendix A2: Examples of Health Promotion Programmes or Initiatives and their Implementing Organisation in Thailand

Program/ Initiative	Implementing organisation/ type of organisation	Region	Details of Activities
Health Promotion Programmes for the Elderly and Persons with Disability Fiscal year 2012 (Khunhan Sub-district Municipality, n.d.)	Khunhan Sub-district Municipality, Srisaket Province (LAO)	North Eastern	The programme is to complement the limited welfare for the elderly provided by the central government. This program offers monthly activities including health education and physical and eyesight check-ups and screening services for the elderly in the community, recreation and meditation sessions, developing elderly care network at the village and community levels.
Elderly Capacity Building and Management Integration (Foundation for Older Persons' Development, 2015)	Kuangpao Sub-district Administrative Organization, Chomthong District, Chiang Mai (LAO and community)	Northern	The Sub-district Administrative Organization plays a key role in this program by registering the elderly group in the community as a foundation to be able to raise their own funding. The activities of the program include providing education, elderly care, capacity building for the elderly, skills support, community welfare, and information management. The elderly club in the area also sells their own products from the program. The program's work plan is integrated with the local agencies' work plans and offers learning opportunities for other elderly organisations in other areas to visit as a case-study trip location.



Program/ Initiative	Implementing organisation/ type of organisation	Region	Details of Activities
Elderly School for Health Model (Poonpermpan, 2016)	Ministry of Social Development and Human Security and the local elderly networks (central, regional, and community)	National	The elderly networks of each province may vary as to collaborating agencies but the key driver is the local administrative organizations with collaboration from the Province Office, temples, tertiary hospital, local elderly clubs, the provincial office of the Ministry of Public Health, and the District Office, and local administrative offices, community volunteers, and schools. The network established the elderly school using a temple as the site and centre to provide activities that benefit the elderly health such as knowledge exchange in health promotion and prevention, skills training, and study trips.
Thai Teyin Community Health Promotion Programme ("Thai thaeh yin" dtohn baaep phuu suung aayoo ruaam phalang saang sangkhohm sookkhaphaawa [Thai Teyin the elderly model of good health empowerment].", 2016)	Thai Teyin Community, Bangkok with support from the Thai Health Promotion Foundation (community)	Central	Thai Teyin community is one of the 20 nationwide communities selected to be the community elderly club capacity building model. Members of the community were former employees of the same company, Thai Teyin and members of the clubs are those who have retired. The programme is community driven by the elderly club with a series of projects such as nutrition training of the trainers, group exercise, herb farming, and elderly care volunteers.

Program/ Initiative	Implementing organisation/ type of organisation	Region	Details of Activities
Capacity Building and Health Promotion Activities for the Elderly (MRG Online, 2016)	Kohongse Sub-district Municipality Office, Had-Yai District, Songkla (LAO)	Southern	The sub-district municipality office, together with the elderly in the community, organised an event which featured activities to help build capacity and promote the health of the elderly. The activities in the event include an open platform for the elderly to exchange their experience and local wisdom knowledge, cooking competitions, and local exercise games.

### Appendix A3: Timeline of Health Care Decentralisation in Thailand and the Health Promotion

Year	Law/ legislation	Event highlights
<b>1997</b>	1997 Constitution, Section 284	- The mandate of decentralisation in Thailand
<b>1999</b>	The Decentralization Act 1999	- The transfer of public services and their associated budgets previously held by central ministries, including health and education to local administrative organisations, namely the Provincial Administration Organizations (PAOs), municipalities, and the Tambol (sub-districts) Administration Organizations (TAOs) (Jongudomsuk et al., 2015).
	The Decentralization Action Plan 1999	- The establishment of the District Health Systems (DHSs) (Bureau of Technical Advisors, n.d.-b)
<b>2001 - 2006</b>	The launches of Fund and Urban Community Funds, universal health coverage (UHC), and provincial integrated administration policies	- The transfer of personnel to the local administrative organisations and the launch of new national programmes slowed the progress of decentralisation - Establishment of a community health fund to be managed by the TAOs and municipalities (Jongudomsuk et al., 2015).
<b>2008</b>	The Second Decentralization Action Plan	- The transfer of health care centres, community public primary health care providers to the TAOs - Some health centres were upgraded to Health Promotion Hospitals
<b>2012</b>	The Third Decentralization Plan	- The transfer of networks of provincial health care providers in provinces with large populations to the Provincial Administrative Organizations (PAOs)
<b>2013</b>	The District Health Systems Policy	- Integration of health care management at the local level and engagement in the management of local health and health promotion among local organisations and the community
<b>Currently under review (2019)</b>	National Health Policy Committee Bill (draft under the review of National Legislative Assembly of Thailand)	- The establishment of the National Health Policy Board, the Area Health Board, and Provincial Health Promotion and Disease Prevention Board

#### Appendix A4: Functions and Activities Related to Elderly Health and Health Promotion of Organisations at the Local Level

Organisation	Parent organisation	Functions and activities related to health promotion and health of the elderly at the local level
Local administrative organisations (sub-district administrative organisations and municipality offices), under a decentralised governance structure	Ministry of Interior	<ul style="list-style-type: none"> <li>- Ensure safety and convenience of infrastructure and buildings within the community for the elderly</li> <li>- Manage health care services provided by local health care providers (local health centres and Health Promotion Hospitals) that have been transferred as a result of the decentralisation reform or by own organisations such as: <ul style="list-style-type: none"> <li>o Health treatment</li> <li>o Health promotion and disease prevention (including developing hygienic and safe local environment)</li> <li>o Rehabilitation</li> </ul> <p>This management is supervised, monitored, and assisted by the Ministry of Health and its regional offices (Institute for Population and Social Research, 2014).</p> </li> <li>- Manage the Long Term Care programmes for the elderly within Local Health Fund provided by the National Health Security Office with the assistance of officers from the District Public Health Office (HFocus, 2017b; National Health Security Office, n.d.-b)</li> </ul>

Organisation	Parent organisation	Functions and activities related to health promotion and health of the elderly at the local level
		<p>Support the establishment and operations of the local elderly club in the community (Limsakul, n.d.).</p> <ul style="list-style-type: none"> <li>- Provide primary care and health promotion advice for the elderly ("Aaw bpaaw thaaw gap gaan sohng seerm khoon na phaap chee wit khohn phi gaan lae phuu suung aa yoo [Local Administrative Organisations and the promotion of disabled persons and elderly's quality of life]," 2012; Institute for Population and Social Research, 2014)</li> <li>- Provide health promotion, disease prevention, and rehabilitation services to the elderly and other vulnerable groups of populations in the community</li> <li>- Promote participation of community members and other local organisations in health promotion and health security in the community ("National Health Security Act B.E. 2545 (2002)," 2002)</li> </ul>
	Ministry of Public Health	<ul style="list-style-type: none"> <li>- Provide special access for elderly patients</li> <li>- Establish elderly clinics within regional hospitals, general hospitals, district hospitals, and community health centres</li> <li>- Organise health promotion activities for the elderly</li> <li>- Develop a website for elderly health</li> </ul>

Organisation	Parent organisation	Functions and activities related to health promotion and health of the elderly at the local level
Provincial Social Development and Human Security Office	Ministry of Social Development and Human Security	<ul style="list-style-type: none"> <li>- Collect data on the elderly situation within the province (Office of Promotion and Protection of Children, 2013)</li> <li>- Support capacity building of the elderly with the participation of family, community, local administrative organisations, and other development partnerships</li> <li>- Educate families about living with the elderly and creating good relationships among different age groups</li> <li>- Support the elderly welfare including promoting jobs for the elderly to encourage their independence and integrity</li> <li>- Establish Quality of Life and Career Development for the Elderly Programme to be run by the elderly volunteer representatives to organise activities and health services. Encourage and support local administrative organisations to participate in elderly care and local wisdom exchange in the community as a part of the programme.</li> <li>- Encourage building the environment suitable for the elderly</li> </ul>
Provincial and District Public Health Office	Ministry of Public Health	Provincial Public Health Office <ul style="list-style-type: none"> <li>- Monitor health of the elderly in the province</li> <li>- Develop the capacity of the elderly clubs</li> </ul>

Organisation	Parent organisation	Functions and activities related to health promotion and health of the elderly at the local level
		<ul style="list-style-type: none"> <li>- Establish elderly clinics and express access for elderly patients at public hospitals (Ministry of Social Development and Human Security, 2014)</li> <li>- Taking actions according to the Long Term Care framework for the elderly (Nan Provincial Public Health Office, n.d.)</li> <li>- Operate with or support the operation of other related organisations (<i>The Government Gazette</i>, 2002)</li> </ul> <p>District Public Health Office</p> <ul style="list-style-type: none"> <li>- Provide health and rehabilitation services and coordinate patient referral and transfer according to the Ministry of Public Health and international standards</li> <li>- Provide health promotion and disease prevention services internally at health care centres and externally in the community</li> <li>- Manage health services network</li> <li>- Collaborate with local administrative organisations and other network partners in health management of population in the community (Panomsarakham Public Health Office, n.d.)</li> <li>- Assist the LAOs in developing programmes and activities from the Local Health Fund such as the Long Term Care initiatives for the</li> </ul>

Organisation	Parent organisation	Functions and activities related to health promotion and health of the elderly at the local level
		elderly in the community (HFocus, 2017b; National Health Security Office, n.d.-b)
Local Health Centres and Health Promotion Hospitals	Ministry of Public Health and Ministry of Interior (for those that have already been transferred to the LAOs)	<ul style="list-style-type: none"> <li>- Provide primary care services to people in the community such as in-house blood pressure check-up and nutrition advice</li> <li>- Visit the elderly's residence to ensure the appropriate environment for their health and safety, in some areas accompanied by the staff of their Sub-district Administrative Organisation ("Aaw bpaaw thaaw gap gaan sohng seerm khoon na phaap chee wit khohn phi gaan lae phuu suung aa yoo [Local Administrative Organisations and the promotion of disabled persons and elderly's quality of life]," 2012)</li> <li>- Provide health promotion, disease prevention, chronic disease control services to the elderly in the community</li> <li>- Educate the elderly in the community in health promotion and disease prevention</li> <li>- Build capacity of the elderly in the community together with a local network including regional government offices such as the LAOs, Provincial Social Development and Human Security Office, local elderly clubs, private sectors, etc. in providing to the elderly</li> </ul>



Organisation	Parent organisation	Functions and activities related to health promotion and health of the elderly at the local level
		activities including community exercise, elderly volunteer programme, and skills training programme
Regional Offices of the National Health Security Office	Ministry of Public Health	<ul style="list-style-type: none"> <li>- Provides LAOs with the “Local Health Fund” for assisting the health security and health promotion of key vulnerable groups of population in the community including the elderly (MGROnline, 2017; National Health Security Office, n.d.-d.; National Health Security Office, n.d.-e). The National Local Health Funds initiative is an integrated collaboration between the National Health Security Office, Ministry of Public Health, the Health Promotion Foundation, and other related organisations ("Saaw bpaaw saaw chaaw gam noht sit thi duu laae baeng haa gloom dtang dtaae nai khan yan phuu suung aa yoo [National Health Security Office categorised five groups of people receiving care rights ranging since before being born to the elderly]," 2017)</li> <li>- Manage the Long Term Care programme for the elderly with the LAOs and other related organisations such as those of Ministry of Social Development and Human Security, and Ministry of Public Health to provide care for the elderly who are bed-ridden and dependent in the community under the Quality of Life</li> </ul>

Organisation	Parent organisation	Functions and activities related to health promotion and health of the elderly at the local level
		<p>Development and Rehabilitation Centre (HFocus, 2017a; National Health Security Office, n.d.-d)</p> <ul style="list-style-type: none"> <li>- Support the participation of elderly networks as mentioned in the Elderly Person Act B.E. 2546 in the health security programme and encourage the collaboration between organisations in the network namely Department of Health, Ministry of Social Development and Human Security, and Ministry of Public Health who will extend this collaboration to the regional and local levels (National Health Security Office, n.d.-a)</li> </ul>
Local Elderly Clubs	Independent	<ul style="list-style-type: none"> <li>- Build the elderly capacity</li> <li>- Promote the health and mental health of the elderly</li> <li>- Establish a platform for the elderly to gather, build a relationship, and exchange knowledge and information</li> <li>- Assist and provide basic social welfare for members who experience hardship (Bangpla Sub-district Municipality Elderly Club, 2014)</li> </ul>
Other organisations at the local level such as temples, schools, etc.	Various	<ul style="list-style-type: none"> <li>- Provide a venue for the elderly health promotion activities upon request or collaboration with the LAOs or other regional or local organisations such as elderly classroom, skills training, knowledge exchange gathering (Department of Health, n.d.-a)</li> </ul>

## Appendix A5: Organisations Relationship Concepts and Description

Relationship	Description
Dyads	A simple and short-term relationship between organisations (Barringer & Harrison, 2000) mostly limited to a two-party organisation relationship rather than multi-organisation or a social system (Mitchell, 1969, cited in Provan, Fish, & Sydow, 2007)
Cooperation	In cooperation, organisations have a less formal relationship. They may share information and exchange resources without having mutual goals, and the relationship is not necessarily long-term (Thomson & Perry, 2006).
Coordination	Coordination can occur horizontally between organisations whose responsibilities relate to the same subject and are at the same level of governance. It can also occur vertically between different levels of governance (Hall, 1999)
Co-production	Co-production involves actors from across sectors, both organisations and individuals. In public service, these actors, such as clients and public providers use their practical skills and profit from the relevant benefits of their shared efforts (Poocharoen & Ting, 2015). Tangible incentives such as money, goods, or services are involved in the co-production between actors, but they are not necessarily absolute when the co-production design is of a public nature (Alford, 2002). However, the service design process and service delivery can be entirely separated and implemented by different actors while service users take an active role in both processes as a co-producer (Bovaird, 2005)
Collaboration	Collaboration or collaborative management emphasises the organisational level of co-labouring between sectors or actors to achieve common goals (Poocharoen & Ting, 2015). Agranoff and McGuire (2003) noted that “collaborative settings are not based in central authority and cannot be guided by a single organisational goal” (p.34). Actors in collaboration have a closer relationship than those in cooperation and coordination, and from this collaboration, a new

Relationship	Description
	<p>relationship structure emerges. Collaboration also “involved willingness of parties and stakeholders involved to enhance one another’s capacity for mutual benefit. The parties share risks, responsibilities and rewards, invest substantial time, share common turf, and have high level of trust” (Himmelman, 2001).</p>
Networks	<p>The network is considered a form of governance in policy-making and implementation (Klijn, 2009). Networks are described by McGuire (2006) as “a structure that involved multiple nodes-agencies and organisations with multiple linkages” (p.35). Actors within the network structure share a strong commitment to goals at multi-organisational levels; they also share resources and risks. Furthermore, they function based on a specific policy or policy area (McGuire, 2006). Networks are set up to deal with complex problems where collective learning can emerge from actors working together (Newig, Günther, &amp; Pahl-Wostl, 2010). The relationships of the actors in a network can be structurally vertical (hierarchical) and horizontal (collaborative). While the horizontal relationships exercise a check-and-balance system within the network, the vertical relationships can pose as an authority to maintain order within the network should a disagreement persist (Koliba et al., 2013). A study about networks includes an examination and analysis of network actors as node units and the relationship or ties between them (Provan, Fish, &amp; Sydow, 2007).</p>

Appendix A6: Operational Functions of Governance Networks and Implications Exhibited by Organisations Involved in Health Promotion Policy for the Elderly in Thailand

<b>Governance network operational functions (Koliba et al., 2011)</b>	<b>Implications in the health promotion policy implementation for the elderly in Thailand</b>
Coordinating actions - Regulated and written within a macro-level network context	<ul style="list-style-type: none"> <li>- National policies stated that the named central organisations and their sub-organisations whose missions involved the development of quality of life of the elderly work together and with LAOs to deliver the services to the people in all communities</li> </ul>
Mobilising and exchanging resources – Occurrence of resource exchange between actors within the network is a key function in governance network operation	<ul style="list-style-type: none"> <li>- The Decentralisations Act and the Transferring Responsibility Act served as a mandate for resource mobilising from the central organisations to the LAOs, particularly for human resources and facilities such as the local health centres and their staff.</li> <li>- Resources such as knowledge and financial resources are exchanged between organisations within the network: <ul style="list-style-type: none"> <li>o District Public Health Offices provide knowledge and assistance to the LAOs in developing programmes and activities from the Local Health Fund such as the Long-term Care initiatives for the elderly in the community</li> <li>o National Health Security Office provides the Local Health Fund for the LAOs to develop the health promotion programmes for the elderly at the local level</li> </ul> </li> </ul> <p>With the resources from other organisations within the network as in these examples, the LAOs are able to implement health promotion policy and deliver the services for the elderly</p>

Governance network operational functions (Koliba et al., 2011)	Implications in the health promotion policy implementation for the elderly in Thailand
	<p>which also help other organisations achieve their individual goals and the network-wide goal of developing the quality of life of the elderly</p>
<p>Diffusing and sharing information – data is arranged for a better understanding of the whole network, information/ data is used to monitor and evaluate the performance of the network. The common goal is also considered shared information in governance networks</p>	<ul style="list-style-type: none"> <li>- The national target of the quality of life of the elderly is shared as a common goal for the network.</li> <li>- Population and other local data is used and shared on a project-based basis with each organisation within the network having a different level of information collected. The LAOs have the in-depth and most up-to-date information of the elderly in their community, for example.</li> </ul>
<p>Building capacity – facilitating other network members or other networks to be able to carry out operational or policy functions</p>	<ul style="list-style-type: none"> <li>- District Public Health Offices facilitate capacity building for the LAOs in health care service and network management</li> <li>- LAOs, together with other network actors, help build the capacity of the elderly clubs in the community in developing and implementing programmes to promote the health of the club members, including educational programmes.</li> </ul>
<p>Learning and transferring knowledge – learning and knowledge promotion between network actors including facilitation of capacity building through technical exchange</p>	<ul style="list-style-type: none"> <li>- Joint training programmes between network actors provided by the actors such as a Long-Term-Care training programme provided by District Public Health Office to other organisations within the network</li> </ul>

## Appendix A7: Health Promotion for the Elderly Policy Implementation Network Members in Donkaew Case Study

<b>Network members (nodes)</b>	<b>Type of organisation</b>	<b>Level of governance – superior organisation/ parent ministry</b>
1. Donkaew Sub-district Administrative Organisation	Local Administrative Organisations (LAOs)	Local – Ministry of Interior
2. Chiang Mai Provincial Social Development and Human Security Office	Provincial Office of Ministry of Social Development and Human Security	Regional – Ministry of Social Development and Human Security
3. Donkaew Health Promotion Hospital	Local Health Centres and/ or Health Promotion Hospitals within the sub-district	Local – Donkaew Sub-district Administrative Organisation, Ministry of Interior
4. National Health Security Office, Region One, Chiang Mai	Regional Office of the National Health Services Office (NHSO)	Regional – Ministry of Public Health
5. Donkaew Sub-district Elderly Club	Local Elderly Clubs (sub-district elderly club)	Civil group
6. Thai Health Promotion Foundation	Thai Health Promotion Foundation	National (an autonomous state agency)
7. Nakhonping Hospital	District Hospitals	Regional – Ministry of Public Health
8. Donkaew Sub-district Informal Education Office	Sub-district Informal Education Office	Regional - Ministry of Education
9. Maerim District Office for Local Administration	District Offices for Local Administration	Regional – Ministry of Interior
10. Boromarajonani College of Nursing Chiang Mai	Other organisations that may vary in each sub-district	Regional – Ministry of Public Health

Network members (nodes)	Type of organisation	Level of governance – superior organisation/ parent ministry
11. Rajanagarindra Institute of Child Development (RICD)	Other organisations that may vary in each sub-district	Regional – Ministry of Public Health



Appendix A8: Health Promotion for the Elderly Policy Implementation Network Members in Namprae Case Study

<b>Name of organisation in Namprae (nodes)</b>	<b>Type of organisation</b>	<b>Level of governance – superior organisation/ parent ministry</b>
1. Namprae Sub-district Municipality	Local Administrative Organisations (LAOs)	Local – Ministry of Interior
2. Chiang Mai Provincial Social Development and Human Security Office	Provincial Office of Ministry of Social Development and Human Security	Regional – Ministry of Social Development and Human Security
3. Namprae Health Promotion Hospital	Local Health Centres and/ or Health Promotion Hospitals within the sub-district	Regional – Ministry of Public Health
4. National Health Security Office, Region One, Chiang Mai	Regional Office of the National Health Services Office (NHSO)	Regional – Ministry of Public Health
5. Namprae Sub-district Elderly Club	Local Elderly Clubs (sub-district elderly club)	Civil group
6. Thai Health Promotion Foundation	Thai Health Promotion Foundation	National (an autonomous state agency)
7. Hangdong Hospital	District Hospitals	Regional – Ministry of Public Health
8. Namprae Sub-district Informal Education Office	Sub-district Informal Education Office	Regional - Ministry of Education
9. Hangdong District Office for Local Administration	District Offices for Local Administration	Regional – Ministry of Interior
10. Chiang Mai Neurological Hospital	Other organisations that may vary in each sub-district	Regional – Ministry of Public Health

## Appendix A9: Accountability Relationship Analyses of the Networks in the Case Studies

Accountability Frame	Accountability Type	Explicit Standards	Implicit Norms	References and evidence of accountability sources in the study
Administrative	Bureaucratic	Performance measures, administrative procedures, organisational charts	Deference to positional authority, unity of command, a span of control	<ul style="list-style-type: none"> <li>- National Local Performance Assessment (LPA)</li> <li>- Participating ministries and organisations within the Integration of Collaboration in Life-long Human Capital Development (Childhood and Elderly Age Groups) Agreement</li> <li>- Funding regulations and procedures (Financial Capital)</li> <li>- Second National Plan on the Elderly 2002 – 2021, responsible organisations, and indicators of strategies</li> <li>- Organisation charts (available on all network actors' websites)</li> </ul>
	Professional	Codes of ethics, licensure, performance standards	Professional norms, expertise, competence	<ul style="list-style-type: none"> <li>- Establishment Acts of organisations</li> <li>- Constitution of the Kingdom of Thailand B.E.2560 (2017)</li> <li>- Acts and regulations outlining qualifications and responsibilities of the organisation's personnel such as the Local Personnel Administration Act B.E. 2542 (1999)</li> </ul>

Accountability Frame	Accountability Type	Explicit Standards	Implicit Norms	References and evidence of accountability sources in the study
	Collaborative	Written agreements, decision-making procedures, negotiation regimes	Trust, reciprocity, the durability of the relationship	<ul style="list-style-type: none"> <li>- Written agreements between organisations within the network</li> <li>- The high density of trust between network actors</li> <li>- The formality of communication and interaction between network actors</li> <li>- The average durability of the relationship between network actors is four to six years</li> <li>- Discussions for consensus and voting are used for negotiations and conflict resolutions</li> </ul>
Democratic	Elected officials	Laws, statutes, regulations:	Representation of collective interests, policy goals	<ul style="list-style-type: none"> <li>- At the national level, ministers of related ministries are appointed by elected officials.</li> <li>- At the local level, Director of LAOs, the central network node are elected, and they represented the community collective interests and are the political capital of the network</li> <li>- Acts and regulations direct or mandate the organisation's practices.</li> <li>- Policy goal such as stated in the Second National Plan on the Elderly 2002 – 2021 are shared as a network-level goal.</li> </ul>

Accountability Frame	Accountability Type	Explicit Standards	Implicit Norms	References and evidence of accountability sources in the study
	Citizen	Maximum feasible participation; sunshine laws, deliberative forums:	Deliberation, consensus; majority rule	<ul style="list-style-type: none"> <li>- Policy target population participate in network activities.</li> <li>- Local projects and activities come from the needs of the policy target and the community.</li> <li>- Town-hall meetings are organised to hear the opinions of the target population and the community about the policy topic</li> </ul>
	Legal	Laws, statues, contracts	Precedence, reasonableness, due process, substantive rights	<ul style="list-style-type: none"> <li>- Policy implementation and network activities are subject to the regulations from the source of funding. This includes the application, approval, expected outputs, monitoring and evaluations procedures.</li> </ul>

*Source: Adapted from Koliba, Meek, & Zia (2011); Governance Networks in Public Administration and Public Policy.*

Appendix A10: Capacity and Resources an Actor Developed from Being Part of Health Promotion Policy Implementation for the Elderly Network at the Local Level

<b>Capital</b>	<b>Capacity development benefits indicated by survey participants</b>
<b>Financial</b>	<ul style="list-style-type: none"> <li>- Budget for activities and projects</li> </ul>
<b>Physical</b>	<ul style="list-style-type: none"> <li>- Availability of facility</li> <li>- Better technology and equipment</li> </ul>
<b>Natural</b>	<ul style="list-style-type: none"> <li>- Environmental development for the elderly living</li> </ul>
<b>Human</b>	<ul style="list-style-type: none"> <li>- Coordinating skill development</li> <li>- Other skills development</li> <li>- Expertise</li> <li>- Labour</li> <li>- Work experience</li> <li>- Network management skill</li> <li>- Leadership skill</li> <li>- Availability of instructors or speakers for programmes and activities</li> </ul>
<b>Social</b>	<ul style="list-style-type: none"> <li>- Activity participation</li> <li>- Collaborations and supports for activities</li> </ul>
<b>Political</b>	<ul style="list-style-type: none"> <li>- Development of the elderly network</li> </ul>
<b>Cultural</b>	<ul style="list-style-type: none"> <li>- Cultural resources</li> </ul>
<b>Intellectual</b>	<ul style="list-style-type: none"> <li>- Learning about community participation principles</li> <li>- Area-based context knowledge</li> <li>- Development of systematic care for the elderly</li> <li>- Knowledge of needs and issues of the elderly population and the community</li> <li>- Learning from the community model team</li> </ul>
<b>Others</b>	<ul style="list-style-type: none"> <li>- Developed society and human security</li> <li>- Participation of people in the community</li> <li>- Participation of stakeholders</li> <li>- Transparency</li> <li>- Elderly school</li> </ul>

Capital	Capacity development benefits indicated by survey participants
	<ul style="list-style-type: none"> <li>- Continuity of activities</li> <li>- Improvement of work</li> <li>- Integration of work</li> <li>- Resources availability</li> <li>- Time saving and flexibility in the work process</li> <li>- Development of physical and mental health of the elderly</li> </ul>

## Appendix B: Ethics Approval



Phone 0-4-463 6028  
Email [judith.loveridge@vuw.ac.nz](mailto:judith.loveridge@vuw.ac.nz)

### MEMORANDUM

TO	Molly Womonmat Srichamroen
FROM	Dr Judith Loveridge, Convenor, Human Ethics Committee
DATE	7 September 2017
PAGES	1
SUBJECT	<b>Ethics Approval</b> <b>Number:</b> 0000025130 <b>Title:</b> Through the Lens of Governance Network: Health Promotion Policy Implementation for the Elderly in Thailand

Thank you for your application for ethical approval, which has now been considered by the Pipitea Human Ethics Subcommittee.

Your application has been approved from the above date and is valid until 31 December 2019. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Kind regards,

A handwritten signature in blue ink that reads 'J. A. Loveridge'.

Judith Loveridge

Convenor, Victoria University of Wellington Human Ethics Committee

## Appendix C: Non-participant Observation Guide

The following aspects were observed in the meeting. These aspects were drawn from network literatures describing network characteristics (Poocharoen & Ting, 2013; Sheaff et al., 2010; Bevir & Richards, 2009; Provan & Kenis, 2008; Provan, Fish, & Sydow, 2007)

1. Number of meeting participants and the number of organisations the participants represent
2. Organisation of the meeting facilitator
3. Objective and agenda of the meeting
4. Expected outcome of the meeting and meeting achievement
5. Decision making process
6. Discussion initiation and organisations leading discussion
7. Relevant plans or policy referred to
8. Roles of the central actor in the meeting
9. Conflicts and resolution mechanism
10. Consensus making
11. Number of time each an individual/ organisation representative speak in the meeting
12. Network task assignments
13. Formality of meeting process and interactions
14. Exchange of resources
15. Learning opportunity, knowledge and information sharing
16. Exercise of authority/ power relations
17. Mood of the meeting
18. Conclusion and meeting follow-ups
19. Length of the meeting
20. Time spent on planning and other discussions
21. Access to meeting minutes
22. Others



## Appendix D: Benefits of Being a Part of a Network for Network Actors in the Case Studies

- 1) Achieving their goals or tasks
- 2) Time-saving and better workflow
- 3) Exchanging of knowledge and discussion about the integration of work
- 4) Smoothness in coordination
- 5) Problem solving
- 6) Capacity building
- 7) Creating a sense of social-connectedness for the elderly
- 8) Organising activities
- 9) Building trust-worthiness of their own organisation
- 10) Effectiveness
- 11) Developing physical and/ or mental health of the elderly
- 12) Caring for the elderly in the community
- 13) Sustaining work continuity
- 14) Preparing for social issues emerging from future aged society
- 15) Building a collaborative network
- 16) Understanding of issues
- 17) Creating sustainability of activities
- 18) Building a relationship with one another
- 19) Creating motivation and work purpose
- 20) Establishing the elderly school
- 21) Responding to the needs of the elderly
- 22) Helping the elderly to become independent
- 23) Creating a sense of social-mindedness
- 24) Learning more about the elderly population

## Appendix E: Participant Information Sheets (interview, questionnaire, and non-participant observation)



School of Government Te Kura Kāwanatanga  
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### Interview Participant Information Sheet

[Date]

**Project title: Through the lens of network: health promotion policy implementation for the elderly in Thailand at the local level**

#### About this research:

This research is exploring the functioning of the health promotion policy implementation for the elderly in Thailand as a network of multi-organisations working together with the Local Administrative Organisations (LAOs). This research is looking to fill the gaps and add on to the knowledge about networks and policy implementation at the local level.

#### About the researcher:

Wimonmat Srichamroen is a doctoral student in Public Policy, in the School of Government at Victoria University of Wellington, New Zealand. The research has been approved by the Victoria University Ethics Committee with approval number 0000025130 and is under the supervisions of two academics.

#### Your participation in this research:

With your consent, you will be interviewed by me at a venue that suits you, and on a date and time of your convenience. The interview will be no longer than an hour depending on the discussion. Your interview will be audio-recorded with your permission to help in the analysis process. The information provided, along with other collected data will be used for my PhD thesis, academic journals articles, and for presentations at relevant academic conferences. A copy of my completed thesis will be deposited in the Victoria University of Wellington Library and will be available electronically in the institutional repository. After the completion and approval of the thesis, the research and finding discussion briefs will be made available upon your request.

Please note that your participation is voluntary, your name, position, and organisation will not be presented in the thesis and the subsequent publications. Although the interview is audio-recorded, you can ask the researcher to switch off the recorder at any time during the interview session and you are free to refuse to answer specific question. All the raw data will be kept confidential and all of the collected data will be destroyed two years after the end of my doctoral degree. Your interview will be transcribed and translated by the researcher.



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**Contact information:**

If you have any questions or would like to receive further information about the research, please contact me at the information below.

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### Questionnaire Participant Information Sheet

[Date]

**Project title: Through the lens of network: health promotion policy implementation for the elderly in Thailand by the local administrative organisations**

#### **About this research:**

This research is exploring the functioning of the health promotion policy implementation for the elderly in Thailand as a network of multi-organisations working together with the Local Administrative Organisations (LAOs). This research is looking to fill the gaps and add on to the knowledge about networks and policy implementation at the local level.

#### **About the researcher:**

Wimonmat Srichamroen is a doctoral student in Public Policy, in the School of Government at Victoria University of Wellington, New Zealand. The research has been approved by the Victoria University Ethics Committee with approval number 0000025130 and is under the supervisions of two academics.

#### **Your participation in this research:**

This questionnaire has been distributed to you by your supervisor with an envelope attached. I would appreciate it if you would fill out the questionnaire. When completed, please put it in the attached envelope and seal it, and put it in designated envelope which will later be collected by the researcher, me on \_\_\_\_ (date) \_\_\_\_\_. Participation in my research is voluntary and filling out the questionnaire is deemed to be giving consent to use the information. The information from the questionnaire will be used for my PhD thesis, academic journals, and for presentations at relevant academic conferences. A copy of my completed thesis will be deposited in the Victoria University of Wellington Library and will be available electronically in the institutional repository. After the completion and approval of the thesis, the research and finding discussion briefs will be available upon your request.

Please do not put your name anywhere on the questionnaire as this is anonymous. The data you provide will be analysed along with participants from other organisations. Please note that your participation is voluntary, your name, organisation, and other identifying information will not be presented individually in the thesis and the subsequent publications. Please answer all the questions if you can. All the raw data will be kept confidential and all of the collected data will be destroyed two years after the end of my doctoral degree. The collected completed questionnaire will be translated by the researcher.



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**Contact information:**

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### Non-participant Observation Information Sheet

[Date]

**Project title:** Through the lens of network: health promotion policy implementation for the elderly in Thailand at the local level

**About this research:**

This research is exploring the functioning of the health promotion policy implementation for the elderly in Thailand as a network of multi-organisations working together with the Local Administrative Organisations (LAOs). This research is looking to fill the gaps and add on to the knowledge about networks and policy implementation at the local level.

**About the researcher:**

Wimonmat Srichamroen is a doctoral student in Public Policy, in the School of Government at Victoria University of Wellington, New Zealand. The research has been approved by the Victoria University Ethics Committee with approval number 0000025130 and is under the supervisions of two academics.

**Your participation in this research:**

With your permission, your monthly district-level meeting will be observed by me, the researcher at your meeting facility. The non-participant observation will be throughout your meeting. I would like to take notes and obtain a copy of the meeting minute afterward. The observation will focus on the interactions between meeting participants. The data collected from the observation will add to the other collected data and will be used for my PhD thesis, academic journals, and for presentations at relevant academic conferences. A copy of my completed thesis will be deposited in the Victoria University of Wellington Library and will be available electronically in the institutional repository. After the completion and approval of the thesis, the research and finding discussion briefs will be made available upon your request.

Please note that your permission is voluntary, no names or identity of meeting participants will be noted or presented in the thesis and the subsequent publications. You can ask the researcher to leave the meeting at any time should you want to discuss sensitive or confidential matters. All the raw data will be kept confidential and all of the collected data will be destroyed two years after the end of my doctoral degree. Any notes from the meeting will be translated by the researcher.



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**Contact information:**

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## Appendix F: Participant Consent Forms (national policy level and local implementation level)

### Participant Consent Form (national policy level)

**Project title: Through the lens of network: health promotion policy implementation for the elderly in Thailand at the local level**

*Please sign the Consent Form to indicate that you have read and agree with the following statements:*

- I have read the information sheet for this study and understand the explanation given
- I have had the opportunity to ask questions and have had them answered to my satisfaction
- I understand that I have the right to ask further questions at any time
- I understand that I can withdraw myself (or any information I have provided) from this study within one month from the date of the interview and all information related to me will be destroyed.
- I understand that the data I provide will be kept secure at all times, and will be kept confidential to the researcher and the researcher's supervisors and it will be destroyed two years after the conclusion of the project.
- I understand the data will only be used for the researcher's PhD thesis, journal articles or conference presentations. Any further use will require my written consent.
- I understand that neither my name nor the name of my organisation will be used in the study, and the information that I provide will not be used in any way that will identify me.
- I understand that I will have an opportunity to provide feedback on the preliminary findings after all interviews have been undertaken

*Please check the following boxes where it applies to you:*

- ☐ I agree to the interview being audio-recorded.
- ☐ I would like a copy of the study findings summary.

Participant's Name : \_\_\_\_\_

Participant's Signature : \_\_\_\_\_

Date of Interview : \_\_\_\_\_



### Participant Consent Form (local implementation level)

**Project title: Through the lens of network: health promotion policy implementation for the elderly in Thailand at the local level**

*Please sign the Consent Form to indicate that you have read and agree with the following statements:*

- I have approved this interview/ I understand that my acceptance of this interview has been approved by the head of my organisation
- I have read the information sheet for this study and understand the explanation given
- I have had the opportunity to ask questions and have had them answered to my satisfaction
- I understand that I have the right to ask further questions at any time
- I understand that I can withdraw myself (or any information I have provided) from this study within one month from the date of the interview and all information related to me will be destroyed.
- I understand that the data I provide will be kept secure at all times, and will be kept confidential to the researcher and the researcher's supervisors and it will be destroyed two years after the conclusion of the project.
- I understand the data will only be used for the researcher's PhD thesis, journal articles or conference presentations. Any further use will require my written consent.
- I understand that neither my name nor the name of my organisation will be used in the study, and the information that I provide will not be used in any way that will identify me.
- I understand that I will have an opportunity to provide feedback on the preliminary findings after all interviews have been undertaken

*Please check the following boxes where it applies to you:*

- ☐ I agree to the interview being audio-recorded.
- ☐ I would like a copy of the study findings summary.

Participant's Name : \_\_\_\_\_

Participant's Signature : \_\_\_\_\_

Date of Interview : \_\_\_\_\_

### แบบตอบรับการเข้าร่วมการวิจัย

หัวข้อวิทยานิพนธ์: Through the lens of governance network: health promotion policy implementation for the elderly in Thailand by the local administrative organisations (การบริหารจัดการเครือข่ายในการนำนโยบายส่งเสริมสุขภาพสำหรับผู้สูงอายุไปปฏิบัติในประเทศไทย)

โปรดลงชื่อในแบบตอบรับเพื่อรับรองว่าท่านได้อ่านและทำความเข้าใจข้อตกลงต่อไปนี้แล้ว:

- ข้าพเจ้าได้อ่าน "ข้อมูลสำหรับผู้ให้สัมภาษณ์" สำหรับงานวิจัยนี้และเข้าใจรายละเอียดที่ได้ระบุไว้แล้ว
- ข้าพเจ้ามีโอกาสถามคำถามผู้วิจัย และได้รับคำตอบเพื่อทำความเข้าใจแล้ว
- ข้าพเจ้าเข้าใจว่าสามารถถามคำถามเกี่ยวกับงานวิจัยได้ตลอดเวลา (ถ้ามี)
- ข้าพเจ้าเข้าใจว่าข้าพเจ้าสามารถถอนตัวจากการสัมภาษณ์ หรือระงับการใช้ข้อมูลที่ข้าพเจ้าได้ให้ไปแล้วจากงานวิจัยนี้ภายในหนึ่งเดือนหลังจากวันที่สัมภาษณ์ และข้อมูลจากการสัมภาษณ์ รวมถึงข้อมูลอื่นๆ เกี่ยวกับข้าพเจ้าจะได้รับการทำลาย
- ข้าพเจ้าเข้าใจว่าข้อมูลจากข้าพเจ้าจะได้รับการเก็บรักษาด้วยความปลอดภัยและเป็นความลับระหว่างผู้วิจัยและอาจารย์ที่ปรึกษาเท่านั้น และข้อมูลดิบทั้งหมดจะถูกทำลายภายในระยะเวลาสองปีหลังจากผู้วิจัยจบการศึกษา
- ข้าพเจ้าเข้าใจว่าข้อมูลจากข้าพเจ้าจะถูกนำไปใช้เฉพาะในวิทยานิพนธ์ปริญญาเอกของผู้วิจัย บทความวิชาการ และการนำเสนอในการประชุมทางวิชาการโดยผู้วิจัยเท่านั้น การนำข้อมูลไปใช้นอกเหนือจากนี้ต้องได้รับการยินยอมจากข้าพเจ้าก่อน
- ข้าพเจ้าเข้าใจว่าชื่อของข้าพเจ้า ชื่อของหน่วยงานสังกัดของข้าพเจ้า และข้อมูลจากข้าพเจ้าจะไม่ถูกจะไม่ถูกใช้ในการระบุตัวตนของข้าพเจ้า
- ข้าพเจ้าเข้าใจว่าข้าพเจ้าจะมีโอกาสให้ความคิดเห็นเกี่ยวกับข้อค้นพบเบื้องต้นของงานวิจัยภายหลังจากที่การสัมภาษณ์ทั้งหมดสิ้นสุดลง



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กรุณาเลือกสิ่งที่ท่านเห็นด้วยต่อไปนี้:

- ☒ ข้าพเจ้าตกลงที่จะให้มีการบันทึกเสียงขณะสัมภาษณ์
- ☒ ข้าพเจ้าต้องการสำเนาของรายงานสรุปผลการศึกษาวิจัย

ลายเซ็นผู้ให้สัมภาษณ์

ชื่อผู้ให้สัมภาษณ์

วันที่ให้สัมภาษณ์

  
  
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## Appendix G: Questionnaire

### Through the lens of network: health promotion policy implementation for the elderly in Thailand

Thank you for agreeing to fill out this questionnaire about governance networks in health promotion policy implementation for the elderly. Please note that in this questionnaire, “network” refers to partnerships, collaborative agreements, and inter-organisational relationships involving working across organisations while carrying out health promotion policy implementation at inter-organisational and operational levels.

1. To begin with, please select a policy, a plan, or an Act regarding the health of the elderly that you are aware of or relates to your work (please select all that apply)
  - ☐ National Economic and Social Development Plan
  - ☐ The Second National Plan for Older Persons
  - ☐ The Older Persons Act
  - ☐ Other (please specify) \_\_\_\_\_
2. About how many organisations per one sub-district or municipality does your organisation work with in implementing health promotion policy for the elderly \_\_\_\_\_
3. Please indicate organisations that you have worked with in the topics related to health promotion for the elderly, please mark the most frequent 3 organisations  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. When an issue arises in regards to the health promotion policy implementation for the elderly, all organisations involved at the local level meet to discuss this
  - ☐ Never
  - ☐ Rarely
  - ☐ Usually
  - ☐ All the time
5. When an issue arises in regards to the health promotion policy implementation for the elderly, is there an organisation that plays a role as interactions facilitator such as arranging the meeting, inviting organisations, and facilitating the meeting discussions?
  - ☐ Yes, one organisation always takes the role, (please specify) \_\_\_\_\_
  - ☐ Yes, different organisations take the role as a facilitator
  - ☐ No, no organisation takes the role as the facilitator
  - ☐ Other (please specify) \_\_\_\_\_
6. I find that my organisation can accomplish the network-assigned task(s) related to the health promotion policy implementation for the elderly better with a facilitator
  - ☐ Completely disagree
  - ☐ Disagree

- ☐ Neither agree or disagree
  - ☐ Agree
  - ☐ Completely agree
7. My organisation interacts with every organisation in the health promotion for the elderly network
- ☐ Completely disagree
  - ☐ Disagree
  - ☐ Neither agree or disagree
  - ☐ Agree
  - ☐ Completely agree
8. My organisation takes charge as a centre of communication between organisations within the network of the elderly health promotion at the local level
- ☐ Never
  - ☐ Rarely
  - ☐ Usually
  - ☐ All the time
9. My organisation is formally appointed as the leader of the health promotion for the elderly network at the local level
- ☐ Yes
  - ☐ No, other organisation is (please specify the organisation) \_\_\_\_\_
10. There is no formal representative among organisations involved in the health promotion policy implementation for the elderly that my organisation work with
- ☐ Completely disagree
  - ☐ Disagree
  - ☐ Neither agree or disagree
  - ☐ Agree
  - ☐ Completely agree
11. The governance of the network can be accomplished both formally and informally such as in the regular meeting or unscheduled coordination between network members
- ☐ Completely disagree
  - ☐ Disagree
  - ☐ Neither agree or disagree
  - ☐ Agree
  - ☐ Completely agree
12. All network members take an active role in implementing activities
- ☐ Completely disagree
  - ☐ Disagree
  - ☐ Neither agree or disagree
  - ☐ Agree
  - ☐ Completely agree

13. The roles of each organisation in the collaborated programmes/ initiatives/ activities within the network are clearly identified
- ☐ Completely disagree
  - ☐ Disagree
  - ☐ Neither agree or disagree
  - ☐ Agree
  - ☐ Completely agree
14. My organisation needs involvement and commitment from other organisations in the network to accomplish our network goals
- ☐ Never
  - ☐ Rarely
  - ☐ Usually
  - ☐ All the time
15. My organisation takes part in managing the network relationships and operations
- ☐ Never
  - ☐ Rarely
  - ☐ Usually
  - ☐ All the time
16. My organisation coordinates with other agencies outside of the network in the matter of health promotion for the elderly
- ☐ Never
  - ☐ Rarely
  - ☐ Usually
  - ☐ All the time
17. My organisation manages direct contacts with the elderly
- ☐ Never
  - ☐ Rarely
  - ☐ Usually
  - ☐ All the time
18. My organisation provides all the administrative services and facilitates other network members in the policy implementation activities
- ☐ Never
  - ☐ Rarely
  - ☐ Usually
  - ☐ All the time
19. My organisation manages most of the budget from the central government on the health promotion policy for the elderly
- ☐ Never
  - ☐ Rarely
  - ☐ Usually
  - ☐ All the time

20. My organisation takes the role of aligning network activities and interactions with the health promotion policy for the elderly goal
- ☐ Yes
  - ☐ No, there is another organisation/ team set up to do this role (please specify)\_\_\_\_\_
21. I understand the goals of the health promotion policy implementation for the elderly network at the local level
- ☐ Completely disagree
  - ☐ Disagree
  - ☐ Neither agree or disagree
  - ☐ Agree
  - ☐ Completely agree
22. The participation of my organisation in the network is due to the alignment of its own mission and the goal of the network
- ☐ Completely disagree
  - ☐ Disagree
  - ☐ Neither agree or disagree
  - ☐ Agree
  - ☐ Completely agree
23. I trust in the capacity of members in the network to work on implementing the health promotion policy for the elderly
- ☐ Yes, all organisations in the network
  - ☐ Yes, some of the organisations
  - ☐ Yes, but only one organisation (my own or another)
  - ☐ No, I do not trust any
24. Despite their relevance to the policy implementation, authority, resource capabilities, or their size, all organisations involved in the health promotion policy implementation at the local level make a decision together
- ☐ Never
  - ☐ Rarely
  - ☐ Usually
  - ☐ All the time
25. No organisation makes a decision for other organisations, all organisations involved in the implementation of health promotion policy for the elderly make the decision together
- ☐ Completely disagree
  - ☐ Disagree
  - ☐ Neither agree or disagree
  - ☐ Agree
  - ☐ Completely agree

26. Among organisations involved in the implementation of health promotion policy for the elderly at the local level, we are the core provider as my organisation is the only one that has sufficient resources for the related activities and programmes
- ☐ Completely disagree
  - ☐ Disagree
  - ☐ Neither agree or disagree
  - ☐ Agree
  - ☐ Completely agree
27. At the local level, my organisation possesses the appropriate expertise or knowledge for assigned task(s)
- ☐ Never
  - ☐ Rarely
  - ☐ Usually
  - ☐ All the time
28. In regards to health promotion for the elderly, does your organisation have the autonomy to make decisions and operate on your own?
- ☐ Yes, we have the autonomy to make a decision and operate on our own (go to question 30)
  - ☐ No, we have to be authorised from other organisation (please specify)\_\_\_\_\_
29. Is the organisation who authorises you also involved in the health promotion policy for the elderly at the local level?
- ☐ Yes
  - ☐ No
30. In terms of formality, how would you describe working with other organisations involved in the health promotion policy for the elderly at the local level?
- ☐ It is formal, limited only to those mentioned in the policy, and only through formal communication channels
  - ☐ It is informal, based on trust and personal connections, and through various kinds of communication channels such as telephone calls or chat application
  - ☐ Other (please specify):\_\_\_\_\_
31. Which method is mostly used for decision making of the network? (select all that applies)
- ☐ Shared decision making
  - ☐ One or some organisations dominates the other (with or without authority)
  - ☐ All members have a vote
  - ☐ Other (please specify)\_\_\_\_\_
32. How often is a consensus reached?
- ☐ Never
  - ☐ Rarely
  - ☐ Usually
  - ☐ All the time



33. Do you need permission from your supervisor/ manager to discuss matters related to health promotion for the elderly with employees of another organisation within the network?
- ☐ Yes
- ☐ No
34. Please list “projects” that you have done with other organisations around health promotion for the elderly
- 
- 
- 
35. Please list three interactions (not the titles of projects) that you have with other organisations within the health promotion for the elderly network that you believe are most useful for your organisation's contribution to achieving the policy goal
- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
36. What is the longest time you have worked with an organisation within the health promotion policy implementation for the elderly network?
- ☐ Less than two years
- ☐ 2 to under 4 years
- ☐ 4 to under 6 years
- ☐ 6 to under 8 years
- ☐ Longer than 8 years
37. I learn about new approaches and skills from participating in network activities
- ☐ Completely disagree
- ☐ Disagree
- ☐ Neither agree or disagree
- ☐ Agree
- ☐ Completely agree
38. I believe what I learn from participating in network activities is helpful for my organisation in achieving its role as a network member
- ☐ Completely disagree
- ☐ Disagree
- ☐ Neither agree or disagree
- ☐ Agree
- ☐ Completely agree

39. In a meeting with other organisations in the network....

	Completely disagree	Disagree	Neither agree or disagree	Agree	Completely agree
39.1 a meeting facilitator is always identified					
39.2 strategic collaborative efforts are determined as each member seeks or establishes their own roles in the initiative					
39.3 time and energy are spent on performing the initiative rather than planning the implementation					

40. Working together with other organisations within the network enables me to see the direction and project the availability of network resources in the policy implementation

- ☐ Completely disagree
- ☐ Disagree
- ☐ Neither agree or disagree
- ☐ Agree
- ☐ Completely agree

41. Staff/ officers/ employees of my organisation have positive personal relations with other organisations' in the network

- ☐ Completely disagree
- ☐ Disagree
- ☐ Neither agree or disagree
- ☐ Agree
- ☐ Completely agree

42. Conflicts between staff/ officers/ employees within the network are not uncommon

- ☐ Completely disagree
- ☐ Disagree
- ☐ Neither agree or disagree
- ☐ Agree
- ☐ Completely agree

43. Conflicts between staff/ officers/ employees within the network are recognized and resolved

- ☐ Never
- ☐ Rarely
- ☐ Usually
- ☐ All the time

44. There are frequent communications between my organisation and others in the network

- ☐ Completely disagree
- ☐ Disagree
- ☐ Neither agree or disagree
- ☐ Agree
- ☐ Completely agree

45. The following resources are shared between network member organisations in a meeting or in a policy implementation activity

	Never	Rarely	Usually	All the time
45.1 Financial resource (cash, security, loan)				
45.2 Physical resources (activity venues, facility, buildings, office space, equipment, property)				
45.3 Human resources (skills individual expertise, labour)				
45.4 Social resources (trust, durability, social ties forged through bonded bridging and common norms)				
45.5 Political resources (favours; persuasive powers)				
45.6 Cultural resources (values, habits)				
45.7 Intellectual/ knowledge resources (information, knowledge, ideas)				

46. Individuals whose work is related to the elderly health promotion from organisations within the network participate in relevant training together

- ☐ Never
- ☐ Rarely
- ☐ Usually
- ☐ All the time

47. An organisation within the network provide training to the others

- ☐ Never
- ☐ Rarely
- ☐ Usually
- ☐ All the time

48. Please indicate your opinion about the roles of LAOs (such as TAO or municipality office) in the following aspects

	Never	Rarely	Usually	All the time
48.1 Play the steering role such as leading a discussion on health promotion for the elderly				
48.2 Initiate a new programme or activity to promote the health of the elderly in the community				
48.3 Collaborate with other organisations in implementing a new programme or activity to promote the health of the elderly				

49. From the following choices, what are the factors that encourage your working with other organisations within the network (select all that apply)

- ☐ Trust
- ☐ Informality of communication
- ☐ Formality of communication
- ☐ Expertise or knowledge of other organisation
- ☐ Number of network members
- ☐ Availability of resources within the network
- ☐ Capacity of network members
- ☐ Decision-making process
- ☐ Others (please specify) \_\_\_\_\_

50. How do the factors you have identified help you and your organisation in working on health promotion for the elderly with other organisations in the network?

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51. Please list

51.1 The three existing organisational capacities or resources of your organisation developed from being a part of the network

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51.2 three bottom capacities/ resources that needs improvement

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Finally, some questions about you and your organisation:

52 Please indicate your organisation type:

- ☐ Local Administrative Organisation (LAO)
- ☐ Regional-provincial agency of a ministry (including district hospitals)
- ☐ Regional (multiple provinces) office or agency of a ministry
- ☐ Others (please specify)\_\_\_\_\_

53 Please identify the category of your role at your organisation: (please select all that apply)

- ☐ Management or executive
- ☐ Planning and evaluation
- ☐ Operation
- ☐ Administration
- ☐ Other (please specify)\_\_\_\_\_

54 How long have you been working in the current position?

- ☐ Less than 2 years
- ☐ 2 – 5 years
- ☐ 6 – 10 years
- ☐ More than 10 years

55 Please indicate your highest qualification level:

- ☐ Certificate of Secondary Education
- ☐ Certificate in Vocational Education
- ☐ Diploma in Vocational/ Technical Education
- ☐ Bachelor Degree
- ☐ Master Degree
- ☐ Doctoral Degree
- ☐ Other (please specify)\_\_\_\_\_

56 Please indicate in which age group you fit:

- ☐ 20 – 29 years old
- ☐ 30 – 39 years old
- ☐ 40 – 49 years old
- ☐ 50+ years old

57 Please indicate your gender:

- ☐ Female
- ☐ Male
- ☐ Other

Please add any other comments about your experience working in the health promotion policy implementation for the elderly network

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Thank you for taking the time to fill this questionnaire. Please put the completed questionnaire in the attached envelope and seal it. Please put the sealed enveloped in the provided bags

## Appendix H: Interview Schedules (national policy level and local implementation level)

### Policy planning and evaluation officers at the national level

1. In what aspect is your ministry/ organisation involved with the health promotion policy for the elderly in Thailand?
2. Can you please tell me a little bit about yourself, your role and your involvement in health promotion policy?
3. Has the policy been designed to encourage the local agencies to work together as a network in implementation? To what extent is the collaboration or the coordination mandated or flexible?
4. What are the key responsibilities of the provincial or local office of your ministry/ organisation in regards to the implementation of the health promotion policy for the elderly?
  - a. Does the provincial or local office of your ministry/ organisation have sufficient resources to respond to the mentioned responsibilities?
5. Do these responsibilities x, y, z you mentioned involve working with other government offices outside your ministry/ organisation?
  - a. What are the extent of their interactions?
  - b. What are the roles of the provincial or local office of your ministry/ organisation in the interactions?
  - c. Are the interactions are mandated or suggested by the policy?
6. At the national policy making level, what are seen as the three most influential factors or characteristics of the multi-organisation working together as a network in the policy implementation at the local level?
  - a. How do x, y, z factors/ characteristics influent the interactions between organisations in the network?
7. Do the interactions between organisations in the network have an impact on an organisation's capacity in implementing this policy?
  - a. If so, how do they affect the organisation's contribution to policy implementation?
  - b. If not, what may be the reason that the interactions do not affect the contribution of the organisation's contribution to the policy implementation
8. How do the LAOs take part in the network as a member?
9. How do the LAOs take part as the centre at the local level?
10. What are the challenges for in the policy implementation stage of the health promotion policy for the elderly in Thailand?
11. What are the opportunities or advantages for organisations working together at the local level as a network to implement the health promotion policy for the elderly in Thailand?
12. To improve the process of the policy implementation, what can the organisation involved at the local level do?
13. Do you have any further comments on the process of the policy implementation outcome so far?
14. Thank you.

**LAOs employees and regional-level government officers working with the LAOs, and representatives of the local elderly clubs**

1. Can you please tell me a little bit about yourself, your role and your involvement in health promotion policy?
2. In what aspect is your office involved in the policy implementation of the health promotion for the elderly?
3. Does your office have a division or a person assigned to take responsibility for implementing the health promotion policy for the elderly?
4. Does this division or person interact with an external government office/ agency in implementing the policy in your community (or province)?
5. To what extent does the division or person interact with an external government office/ agency in implementing the policy in your community?
6. Who are the main actor in collaborating activities between organisations involved in the policy implementation?
7. How does your organisation design the implementation plan for the policy?
8. How are other organisations involved in the policy implementation planning and process and decision making?
9. Are there a formal structure of authority or functions of the organisations working with yours on the implementation of the policy?
10. Does your organisation have the resources needed to implement the policy on your own?
  - a. If yes, what are the roles of other organisations in the policy implementation?
  - b. If not, how do you distribute tasks or responsibility with other organisations involved in the policy implementation?
11. Under what circumstances does your organisation interact with others for the purpose of implementing the policy?
12. How often do these circumstances take place?
13. Are the interactions you mentioned in the previous answers mandated by the national policy to take place?
14. What are the three most influential factors;
  - a. for your organisation individually to working with others in implementing the policy?
  - b. for your organisation and others as a network to implementing the policy as a network or as a team?
15. How do factors mentioned impact the policy implementation?
16. How do the interactions between your organisation and others affect the capacity of your organisation in taking part or contributing in the policy implementation?
17. Do you have any further comments on the process of the policy implementation outcome so far?
18. Thank you.