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Organizational Learning Elements of a Private Primary Care Unit: A Case Study of a Private Hospital in Bangkok

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Abstract
This qualitative research seeks to investigate organizational learning (OL) at a Thai private primary care unit (PCU), located in Bangkok, and selected for its outstanding performance with the local community. In-depth interviews were conducted with twenty individuals from that hospital with various level of responsibilities and with seven community leaders and health volunteers, all of them key stakeholders. Data was also collected from relevant documentation. The data collected was analyzed using a thematic analysis based on three elements: (i) strategic leadership as related to transformational and transactional leadership, and knowledge creation and application; (ii) communication in terms of etiquette/manners and common language; and (iii) stakeholder relationships in terms of long-term relationship goals. A conceptual OL framework was used to present the relations among these elements. It was found that these three key elements were essential for effective OL of the PCU toward sustainable working relations with the local community. This study can benefit the human resources management, especially but not exclusively in healthcare units, and promote community development.

Keywords: Communication, Organizational Learning, Primary Care Unit, Stakeholder Relationships.

1. Introduction

Public health in Thailand was developed to support the health security of citizens. Initially, it consisted of four schemes: a public welfare scheme, a social security scheme, a voluntary health insurance scheme, and a public health welfare scheme for the poor and disadvantaged carrying a low-income card (NaRanong & NaRanong, 2006; World Health Organization, 2017). The voluntary health insurance scheme and the public health welfare scheme for low-income people were subsequently replaced by the *30-baht* scheme which covered all citizens, including the 'leftover' (Tangcharoensathien & Suphanchaimat, 2012). In addition, the National Health Security Office (NHSO) was established to administrate the 30-baht scheme, which later was changed to the Universal Coverage Scheme (UCS) (Tangcharoensathien & Suphanchaimat, 2012). In the following years, because of crowd service unit problems the NHSO decided to increase service units by allowing private hospitals to assist in the UCS (Ministry of Public Health, 2018; World Health Organization, 2017). This provided an opportunity for private hospitals to operate as primary care units (PCU) while still permitted to maintain the privacy of internal management as the NHSO gave them independence in term of financial or internal systems.

However, the right to self-manage private service units as well as paid per capita medical expenses paused serious challenges and required some learning on the part of private hospitals (Sorakraikitikul & Soontornwiwattana, 2019). Compared to their previous situation, private PCUs were now facing challenges at three stages: at the start of the contract with the NHSO, in the middle of it, and after it expired. When private hospitals contracted with the government, the switch to the public health scheme initially resulted in a lack of income since Thai citizens were not necessarily paying for the full medical services. While many private hospitals had decided to join the UCS to survive as private PCUs, becoming a private PCU thus meant changing from middle-high income to low-income stakeholders as, as part of serving the community, newcomers had to accept policies from secondary care units and the NHSO (Yangkratok, 2002). They needed to learn to build new relationships with stakeholders. To this end, the NHSO and secondary care units issued healthcare policies to encourage private PCUs to take care of the community under the concept 'the healthier people at family level, the fewer medical expenses' (Jittasano & Parinyasutinun, 2017; Yangkratok, 2002).

As a result, private PCUs learned to manage the cost of medical care and engage in community outreach as dictated by the NHSO policies. Half-way through the contracts, PCUs were subject to an annual quality assessment, called Private Primary Care Accreditation (PPCA), with the promise of increase paid per capita until the end of the contract should the assessment warrant it. All private PCUs adapted to this dynamic environment. After the contracts expired, they continued to operate as private hospitals and strove to survive amid the pandemic. How they managed to survive remains somewhat of a mystery. It can, however, be surmised that they developed organizational learning (OL), especially when still operating under PCU contracts with the NHSO as part of the UCS. Less clear though was what had become of their organization goals. Focusing on one such PCU, namely, Nan-ah hospital, located in the Klongsan district, Bangkok, Thailand, this qualitative research study aims to explore the learning elements which have supported private PCUs throughout the pandemic and beyond. Specifically, it seeks to answer the following research questions:

- What elements of learning supported private PCUs in their response to the changes in the Thai health care system as described above?
- What were private PCUs' goals in response to those changes?

Before addressing these queries, a few words on landmark developments at Nan-ah hospital in the last few years are in order as they will help to understand its trajectory to organizational learning. It is well known that challenges energize knowledge creation and learning. Private PCUs are no exception; Nan-ah hospital in particular, which faced challenges at the three stages of its contractual obligations as noted above. When contracts were awarded, private PCUs, including Nan-ah hospital, were forced to do some critical learning for their survival and make adjustment in regard of requests, information exchange, and relationship building through community feedback. Private PCUs were also confronted with other challenges after they familiarized themselves with local communities as half-way through their contracts, more NHSO and secondary care unit policies emerged to control service quality and accelerate proactive care. When the contracts ended, Nan-ah hospital, as was also the case with other private PCUs, found itself under the necessity to re-adjust as a private hospital to continue business. The key point here is that as new challenges piled up, OL likely developed (Sorakraikitikul & Soontornwiwattana, 2019).

As one of the private PCUs forced to cope with all these challenges, Nan-Ah hospital engaged in OL by dint of circumstances as its relations with the surrounding community attest. Indeed, after contracting with NHSO, Nan-ah hospital approached the community for relationship building. Although a private PCU, Nan-ah hospital soon became part of the community and in the following years became a leader in establishing the Warm Community

Clinic Association to collaborate with other PCUs. (Soontornwiwattana and Sorakraikitikul (2018) determined that the hospital resorted to engaging with stakeholders to learn and keep developing. They also found that job rotation was applied in order for employees to acquire knowledge from other professionals and external part-time employees. In 2017, as a testimony to its collaboration with communities, the hospital received the best award as a smoking care clinic. Moreover, after the contract with the NHSO expired, as part of its efforts re-adjusting to a new environment, Nan-ah hospital became famous on social media as the COVID-19 cheapest checkpoint. The outstanding performance of Nan-ah hospital among private PCUs in Bangkok strongly suggests that the hospital developed OL. It is important to note though that the organizational learning elements developed in Thai organizations likely differ from the Western concept due to the specific Thai context. This makes the conceptualization results in this study beneficial for Thai organization's learning and development. Moreover, this study could be a model for further organizational studies in other industries.

2. Literature Review

- *Organizational Learning*

Organizational Learning (OL) became popular when Argyris and Schon (1978) introduced single-loop and double-loop learning (Basten & Haamann ,2018). Single-loop learning is concerned with the action's result, and double-loop learning describes the improvement by revisiting assumptions (Argyris and Schon, 1978; Dixon, 1992). Huber (1991) and Dixon (1992) suggested approaches according to which organizations acquire knowledge, interpret it from distributors to receivers, and lastly store it as organizational knowledge. OL was born. The consensus among Western OL studies was a 'shared understanding and a common language,' which was essential in knowledge sharing and transfer. This focus, however, was altered in 1995, when OL studies occurred in the Asian context. This is when Nonaka and Takeuchi (1995) suggested that another vital element should be incorporated, the 'interpersonal relationship', a concept embedded in the study of Japanese organizations under the Socialization, Externalization, Combination, and Internalization (SECI) model. The model was later further developed and comprehensively articulated as organizational knowledge creation theory (Nonaka, Krogh, & Voelpel, 2006).

The theory principally described knowledge transfer and knowledge creation through daily work and interaction. The principle was refined in 1998, when Nonaka and Konno (1998) published *the four characteristics of Ba* in which they argued that most of the four learning processes occur through interactions. It was determined that relationships between individuals played a crucial role in the learning process. Meanwhile, in the western context, the focal point turned to leadership, which encouraged learning in an organization (Senge, 1990, 1996). The emphasis was on the importance of new leadership styles to initiate OL and on the attribute of problem confrontation, which, it was argued, led to the most outstanding results (Senge, 1996). The rationale was that bureaucratic culture is an obstacle to the learning of an organization and that people who can lead in different ways are needed in leading positions (Senge, 1996). A change in bureaucratic culture was encouraged so that new leadership skills for OL would emerge. As suggested by Vera and Crossan (2004), the top executive team, especially the CEO and top management, should be the change initiators.

- *Organizational Learning in the Asian Context*

It is important to note first that Western perspectives on OL, however, are not capable of being easily transported to Asian contexts – a Southeast Asian context in particular – where a bureaucratic culture remains strong. Since research was initially essentially based on Western perspectives, it is questionable whether the type of leadership styles and authority best suited for OL in Western firms apply to an Asian context (Senge, 1996). For a successful transfer of

OL practices to Asian contexts, many supportive elements need to be added, starting with relationships as suggested by Nonaka and Takeuchi (1995) as we just saw above. Other elements that should be reinforced or introduced include empowerment (Watkins & Marsick, 1993), system thinking, and a strong leadership (Senge, 1996). While, as noted above, a change of leadership style was encouraged in the Western context and realistically achievable, this is not the case in an Asian context, where hierarchical structures predominate and are more difficult to displace.

- Thai Organizational Learning Research

As can be expected from the above discussion, research on Thai OL shows that OL as applicable in a Western context is likely to be ineffective in Thai organizations, where, as in most of Asia today, a bureaucratic culture remains well entrenched. This unless new elements are added as we just saw. There have been extensive OL studies in Thailand (Yangkratok, 2002; Chaowanasiriyatham, 2015; Meehanpong et al., 2019). One of the problems is that research has been essentially based on Western perspectives, which raises the issue of whether leaders' authority and styles apply to the Asian context (Senge, 1996). The main concerns with these studies, however, is their inadequacy to clarify practices and the pressing need for some elements to be strengthened under an Asian bureaucratic culture as found in Thailand. For one thing, questionnaires were developed from a western context to measure learning (Chaowanasiriyatham, 2015). For instance, research conducted at Singburi hospital indicated that the behavior of the head nurse did not affect the performance of the PCU as a learning organization (Meehanpong et al., 2019). Yet, as Vera and Crossan (2004) have argued, it is the role of top management to change the bureaucratic culture as it has the authority it takes to do so. In some ways, the result was not a surprise, but the change of attitude needed for OL to take roots should have been more strongly emphasized.

In another Thai quantitative research study that sought to measure OL in a Thai government agency, Bangkok Urban Development, known for being highly bureaucratic, it was found that the items in the close-ended questionnaire were applied to fit the organization and therefore were unlikely to signal any need for change (Chaowanasiriyatham, 2015). Closed-ended questions such as, for example: 'You adapt your work to the organization's vision;' 'You adapt yourself to the current situation;' and 'You admit the corporate culture,' reflected the lack of decision-making power of employees and confirmed the status quo rather than challenge existing practices through either different closed-ended questions and/or open-ended ones. As these examples show, the questions asked run contrary to the definition of shared vision and system thinking among teams and simply reflects the predominant bureaucratic working culture in governmental agencies. In short, they were meant to reinforce the existing bureaucratic culture rather than investigate possible barriers to a strong OL performance (Chaowanasiriyatham, 2015).

A subsequent paper by the same author on the same agency and related to the 2015 study criticized the learning problems that arose from the top management and the interpersonal relationships (Chaowanasiriyatham, 2017). In keeping with Nonaka's (1995, 2006) perspectives, the discussion exposed the importance of relationship among stakeholders, unlike prior research that essentially concluded that the problems stemmed from hierarchical authority (Chaowanasiriyatham, 2015). The 2017 study suggested that reducing the role of leaders roles might be a serious problem in bureaucratic culture oriented organization (Chaowanasiriyatham, 2017).

3. Methodology

Since as prescribed by Gill (2014), in this qualitative research, an individual, an organization, and/or a private PCU could be selected for collecting information, data was collected from

participants cognizant of the challenges paused by a UCS under contract. Moreover, this study could not only collect experiences but also documentation (Creswell, 2003). The qualified organization in this research must have survived, responded, and learned from the challenges arising from changes in the Thai public health system, national policy adjustments, and the termination of contracts during the pandemic. As mentioned in the introduction, a former private PCU in the Klongsan district in Bangkok, Nan-Ah hospital, was selected based on its solid track record responding to challenges. The various distinctions it received in acknowledgment reflect the organization's flexibility and continuous attention to learning, all which strongly related to OL. It can therefore be surmised that OL developed in response to all the challenges the hospital faced and contributed to shaping its identity.

The triangulation method used for validation requires that data be collected from multiple sources (Heale & Forbes, 2013). Sources were thus collected from employees and influential people in the community (community leaders and health volunteers) and relevant documentation. In-depth interviews were deemed appropriate to acquire rich information about participants' experiences. Twenty interviewees were from the hospital: three executives, one chief of primary care service, three public health coordinators, a physician, five healthcare officers, two pharmacists, and five registered nurses (see Table 1 in Appendix). Other interviewees included seven community leaders and village health volunteers (VHV), who were the influencers and at the center of community information. Due to the health service rights, the names of the community people were blinded. In addition to conducting interviews with all the participants described above, the researchers were able to review the hospital's five-year annual reports relevant to stakeholders (the PPCA) as well as project reports with secondary care units. Collecting and analyzing data from hospital employees, community people, and the relevant documentation increased the reliability of the data as in-depth interviews were used to cross-examine the relevance of other data. All the data was analyzed using thematic analysis (Joffe & Yardley, 2004) to identify frequency and patterns, and was extensively described.

4. Results and Discussion

Data collected from the interviews indicated that OL was at the core of the hospital's mode of operation and that three key elements were relied upon in this Thai PCU to ensure continuous learning: strategic leadership, communication, and stakeholder relationship.

- *Strategic Leadership*

The various types of leadership that exist are well documented in the relevant literature. OL, however, requires uniqueness (Senge, 1996). In this study, the results indicate that the strategic leadership is based on transformational/transactional leadership. According to Vudy, era and Crossan (2004), transformational leadership initiates organizational changes and establishes the foundation of the organization system, including a culture of trust in individuals. Transactional leadership, on the other hand, extended to reward and promote existing knowledge systems and maintain continuous collaborative learning (Vera & Crossan, 2004). The hospital's top-level executives have embraced transformational leadership and the flexibility, feedback learning, and policy changing which characterize it.

The following comment from one of the executives reflects the flexibility of transformational leadership when it comes to finding new solutions: "We had to continuously adjust according to the situation and learn by doing, whether possible or not. If it were not successful, it was considered a lesson learned. Then we have to change and learn again and again." As corroborated by interviews with two healthcare administrative officers, the executives encourage them to try new tasks and seek skill development. As one of the officers, who was satisfied with the new skills, stated: "I was encouraged to try something new and then

followed the results for improvement. For instance, I visited the community and learned to talk to community leaders with the team. If I can practice new skills, it would be advantageous for helping others as well." In addition, the chief of primary care service, an executive level position, was quite clear about what a transformational behavior meant when he added that "Everyone has to be flexible and learn from doing new tasks. For instance, health care officers will be assigned for months in the dentist's office to help and learn. Then, they will be rotated to another department. This promotes skill development. If they are skilled, we can replace the positions and solve the problem of lacking a skilled workforce." Referring to the job rotation, another hospital's top executive said, that job rotation had been used since the hospital was founded as part of promoting exchange knowledge. According to him, "when employees move around different services, they develop a strong understanding of the nature of other services and communication with patients." These comments on the job rotation are in line with previous findings (Soontornwiwattana & Sorakarikitikul, 2018). Because of workforce shortages, employees learned new skills and there is a continuous flow of feedback.

As to transactional leadership and the use of acquired skills, especially communication skills, executives at Nan-Ah hospital encourage employees to communicate with key stakeholders efficiently, which requires a strategy of communicator selection. At every meeting with stakeholders, the hospital leaders select a communicator who fits the target audience, based on his/her knowledge and skills. As a top executive stated: "For example, at quality assurance meetings, employee with strong academic references is chosen so that he/she can communicate with the same academic language level and tone. This provides for a more efficient exchange of information." As explained by this executive, a brief from that communicator follows and anything that requires adjusting is dealt with immediately if possible. If not, no pressure is applied. It is clear from the above that both transformational and transactional leadership styles are used at the hospital. This is in keeping with Vera and Crossan's (2004) study which concluded that transactional behaviors encouraged the organization's members to use their skills while transformational leaders support feedback learning and changes. Moreover, the process of selecting a communicator to impart information and share procedures resembles the feed-forward suggested by Crossan, Lane, and White (1999).

- ***Communication***

Nan-Ah hospital values communication and to that end selects communicators to exchange information with target stakeholders as we just saw. Public health coordinators, who have been assigned as communicators, confirmed that communication was the key for information exchange and stakeholder relationships. This was corroborated by the interviews of community leaders, and village health volunteers (VHV), who acted as communication representatives of the communities. Their interviews confirmed that good communication can build trust in medical services and make people feel that they are not left behind. Moreover, they also confirmed that attention was paid to two key elements of communication: etiquette/manners and common language. In their interviews, public health officers stressed that the hospital had strict unwritten regulations in regard of manners and that everyone was expected to speak and behave well with every patient with no exception. As one public health officers explained, "It reminded me when I started the job. I was told to give it a try and talk to patients. If I did not talk properly, I would be actively trained as part of the on-the-job training. Everyone would be trained about manners as this is regarded as one the most important aspects of our daily work." Etiquette also dictates that while one should be frank with patients, no one should be brutally frank and 'shock' patients. As to the second key element, common language, it refers to the need to use lay terms as opposed to highly technical terms which people outside a small circle of experts would not understand.

This is especially important for shared understanding among specific stakeholder groups. As the chief of primary care service pointed out; "When we had to visit the community, we selected team members who could understand and use common language since we have to communicate with local people in the communities." This may mean also understanding some medical terminology but as this interviewee added, when this is the case "We have to understand the differences between the professions of medical staff and patients. We must not to the extent possible use medical terms or formal words to community people." For employees used to the medical jargon, using lay terms may not be easy. One executive admitted having difficulty communicating with VHVs. This why, when visiting the community, health care officers were specifically selected to communicate directly with the patients and the community people using terms the latter could understand.

Not only the surrounding communities, but the hospital also selected communicators who could match the competencies of other stakeholder groups (the NHSO, secondary care units, annual quality accreditation examiners, suppliers, and the Ministry of Public Health). As described by one of the top executives, "Communication with the NHSO and other primary care units will be assigned to the Chief of Primary care services, who knows about medical technology and terminology and has good relations with other hospitals." According to this executive, as expected, this generally provided for a smooth resolution of the issues at stake due to the strong relationship and the use of the same language. As to communication with surrounding communities, "it will be assigned to health care officers because they know each other from daily presence on the site. Communicating with the annual quality accreditation examiners and the Ministry of Public Health will be done by the Quality Assurance Coordinator, who understands the managerial terminology and official documents." Contacts with suppliers were handled by this top executive who is well versed with issues of quality and cost.

The following excerpt of an interview with one of the employees aptly captures the importance of using a common language: "If we could not speak their language, we would not know anything new. How much do we talk to them is how much we learn from them. We could listen to the reflection and reaction. It will be a warning if they do not speak out because it means they do not care about us anymore." In summary, the use of proper etiquette/manners and common language was instrumental in collecting knowledge from and sharing it with stakeholders. This is why, as the results show, Nan-ah hospital selected individuals who were equipped to communicate with stakeholders effectively so that information could be disseminated to build relationships. Consistent with Herremans, Nazari, and Mahmoudian's (2015) findings in a similar study, the hospital accelerated practices promoting stakeholder relationships by identifying stakeholders, collecting feedback, extending the practice to stakeholder groups, and utilizing information for learning. In short, communication as practiced at Nan-ah hospital was critical to expanding stakeholder relationships.

- Stakeholder Relationships

The satisfaction of stakeholders is paramount to the success of an organization in a hypercompetitive environment as is also the case with communication and strategic leadership (Davies & Davies, 2006). The quality of knowledge sharing also largely depends on the nature of relationships (Herremans et al., 2015). In addition to strategic leadership and communication, the key to continuous learning is a long-term relationship with stakeholders. As repeatedly stressed in interviews, a healthy relationship feeds itself on robust feedback. Several executives recited the founder's principle ('Relationship feud brings no end. Be kind to all,') as the leitmotif of the organization, which has been passed down for three generations. As noted by one hospital health care officer "We never argue with patients. Even if there is a misunderstanding, do not blame the patient. That was a rule of thumb." Failure to maintain a relationship with a patient or behave properly, it was explained would result in a dismissal. As explained by the

Chief of primary care, who was the leader of the Warm Community Clinic Association mentioned in the introduction, establishing and maintaining positive long-term relationships with all stakeholders avoids the risk of negative words of mouth, which in today's world of social media could spread like a wildfire. Stakeholder relationships also thrive on knowledge sharing and solid listening skills. As stated by executives and health care officers who have long worked in the community, "When someone tells us something, we do not argue at first, but listen […] No need to argue as the complaint was a reward for development." This was corroborated by a community leader: "When we recommend something, the hospital is never defensive. They listen and get involved in community activities;" and by a top executive, "Actually, we do not want compliments. We want to know more about what they want us to improve." It is clear from the above that executives and employees eagerly receive feedback and that stakeholder relationships are meant for stakeholders to share as much information as possible. In short, the organization sees relationships and relationship building with all stakeholders as one of its primary goals.

It is worth noting that aside from the relationships with the community, the hospital also seeks to build relationships and promote knowledge sharing with other private PCUs in Bangkok. As one executive explained, "We were the leader in establishing the Warm Community Clinic Association. We wanted private PCUs in Bangkok to cooperate. After setting it up, we took the role of an ordinary member and were not involved in management." There is evidence that the Association played a key role in negotiating health masks during the initial shortage and providing proactive COVID testing services until its role declined in 2020 after the termination of the NHSO contract. Nan-ah hospital's stakeholder relationship building efforts have turned it into a center for private PCUs. According to the Chief of primary care services, "Even after the contract ended, we asked for information or cooperation," which its prior good relationship made possible. In summary, stakeholder relationships boosted the exchange of information, which continued after the contract with the NHSO expired since according to one executive, the hospital "Did not take advantage of anyone. Despite allegations of corruption, the community felt doubtful and showed empathy for the hardship caused by the legal investigation process." Clearly, one of the byproducts of strong stakeholder relationship building was trust as noted by that same executive.

5. Conclusion

This qualitative research was conducted at a Thai private PCU located in Bangkok with the purpose of exploring OL in regard of this PCU's efforts to develop long-term relationships with the local community, something which, until the hospital contracted with the NHSO had not been necessary for the PCU to do. OL at this PCU is based on three supportive elements, strategic leadership, communication, and stakeholder relationship, which are meant to serve the primary goal of establishing long-term relationships. It was found that strategic leadership helps to develop employees, select capable communicators, and then give the feed-forward for strategies and policies. Selected communicators spoke a common language with etiquette/manners and could share information. The distribution and receiving process associated with knowledge sharing built long-term relationships, which in turn called for more sharing. Lastly, feedback was provided to community leaders for initiating changes and developing further strategies. The OL process at the hospital is in line with knowledge acquisition as communicators share and give feedback.

Moreover, knowledge interpretation and distribution occur when communicating in the same language (i.e. generally, in lay terms) to provide mutual understanding with stakeholders (Herremans et al., 2015). Leadership is essential (Meehanpong et al., 2019). Findings at Nan-Ah hospital are consistent with the conclusions of Vera and Crossan's (2004) study as well as

that of Mjaku (2020) in that the CEOs and the top executives were determined to promote OL implementation. Although, as we saw earlier, in these studies, strategic leadership was unspecific and open to various perspectives, in this study it is associated with both transformational and transactional leadership and was a turning point as it is in in any bureaucratic cultures. While previous Thai organizational research suggested overthrowing the bureaucratic culture and limiting authority, for the most part these suggestions have remained wishful thinking since any change depends entirely on leaders (Chaowanasiriyatham, 2015; Cheung, 2005; Meehanpong et al., 2019). In that sense, Nan-Ah hospital is an odd given its ability to generate shared understanding and long-term relationships. relationships.

- *Limitations and Future Research*

This study took place at a private hospital in Bangkok. Further research on similar OL issues should be therefore conducted in another context, such as a different province and possibly a different industry although the same industry in another province would also be relevant and enlightening. Moreover, further research in the Asian context should focus primarily on relationships as the goal and strategy for knowledge sharing. Since Nan-Ah hospital set a milestone in successfully developing the three elements (strategic leadership, communication, and stakeholder relationship), evaluating these three elements should be at the core of these studies. Such studies would benefit the human resources management and human resources development fields in Asia, especially but not exclusively in healthcare units, and promote community development.

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Table 1: Nan-ah hospital's participants

Name of organization/community	Position	Number of informants
Nan-Ah hospital	Executives	3
	Chief of Primary care service	1
	Public health coordinators	3
	Physician	1
	Health care officers	5
	Pharmacists	2
	Registered nurses	5

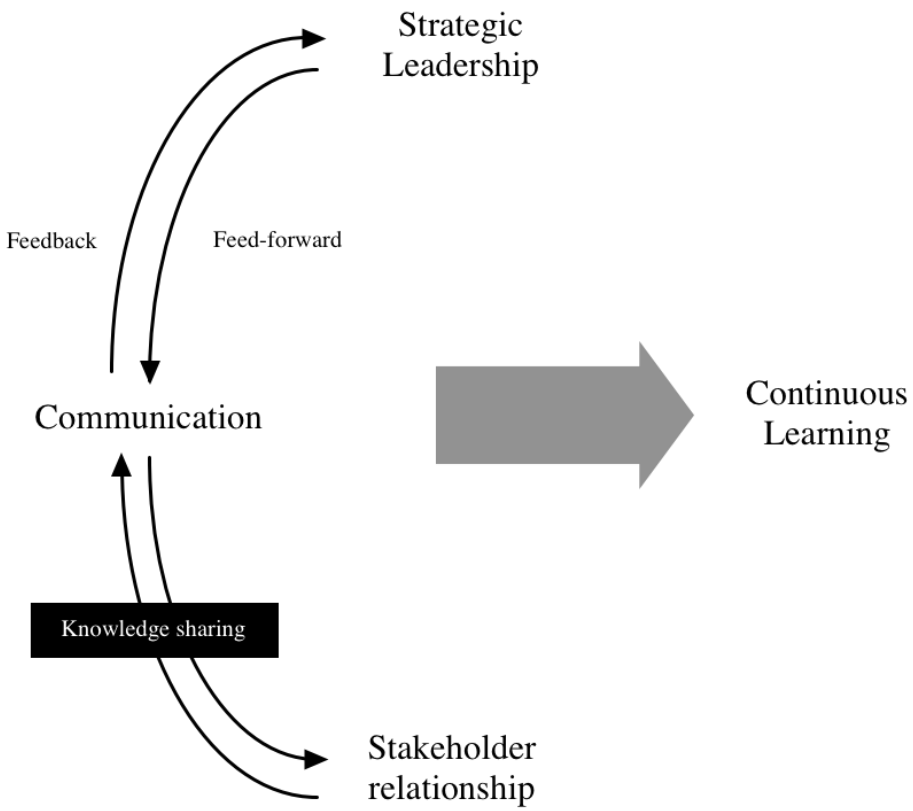

Figure 1: The OL process of Thai private PCU.