Factors Influencing Physicians' Resignation from the Thai Public Health System: A Cross-Sectional Study

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Abstract

Background: Physician attrition from the public health sector has emerged as a pressing issue in Thailand, with significant implications for healthcare delivery and workforce sustainability.

Objective: To explore the key factors contributing to physicians' resignation from the Thai public health system and to examine physicians' perceptions of factors that may support retention.

Materials and Methods: A cross-sectional survey was conducted in 2025 among 50 physicians who previously worked in the public health sector and are currently employed in private hospitals or other organizations. Data were collected using a structured questionnaire assessing demographics, workload, stress, career stability, and opinions on systemic problems. Descriptive statistics and the Stuart-Maxwell test was used for analysis.

Results: Most respondents were male (54%), aged 25-44 years (48%) and had >10 years of experience (66%). During public service, 40% reported working >60 hours/week, compared to 12% after resignation ($p<0.001$). The leading causes of resignation were inadequate income (62%), unsupportive management (46%), occupational stress (40%), and excessive working hours (38%). In contrast, job security (86%), welfare benefits (70%), and career advancement (64%) were key factors retaining physicians in the system. Physicians emphasized that improved welfare, adequate remuneration, supportive workplace environments, and transparent governance would prolong their service in the public sector.

Conclusion: Heavy workload, insufficient income, and organizational stressors were the most significant drivers of physician resignation. Policy reforms ensuring fair compensation, workload regulation, and adequate staffing are urgently required to mitigate brain drain and sustain Thailand's public healthcare workforce.

Keywords: Physician resignation; Burnout; Public health system; Workload; Thailand

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Physicians constitute a core workforce within the public health system, playing a critical role in ensuring access to high-quality medical care. In recent years, however, physician shortages have intensified globally and in Thailand, raising concerns regarding workforce sustainability and health system performance. The migration of physicians from the public sector to private practice or other non-governmental roles, often described as "brain drain", has become a structural challenge that disproportionately affects rural and underserved populations[1].

The World Health Organization has projected a substantial global shortfall of health professionals by 2030, driven by population ageing, increasing burdens of non-communicable diseases, and emerging health threats[1]. These pressures are particularly evident in middle-income countries, where public health systems

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What is already known about this topic?

Physicians often leave public health systems due to heavy workloads, burnout, and low pay. Most research examines resignation intent, with little data on those who have left or on changes in their working conditions before and after leaving.

What does this study add?

Physicians resign not only due to low income, but primarily because of workload, organizational issues, and broader economic factors. Significant reduction in working hours after resignation suggests that excessive workload is a major driver. Job security and welfare help retain doctors but cannot counter poor work environments.

must balance expanding service demands with limited human resources.

Thailand has increased physician production over the past two decades to meet the growing healthcare needs of the population, especially following the introduction of universal health coverage and the ageing population. Several programs, such as the One Tambon One Digital (OTOD) and Mega projects, were developed to support this goal. Although the overall physician-to-population ratio has improved, challenges related to physician distribution and retention remain, particularly in the public health sector. Physicians continue to be concentrated in urban and economically developed areas, while rural and underserved regions still face physician shortages and more limited access to healthcare services[2,3].

Previous studies have also shown persistent urban-rural disparities in physician distribution, with workload, income, and career advancement opportunities influencing workforce movement[4]. Targeted policies such as the Collaborative Project to Increase Production of Rural Doctors (CPIRD) have improved short-term rural retention compared with normal track doctors; however, long-term follow-up studies found that turnover increased over time in both groups after the period of compulsory service[5].

Despite these retention policies, workforce movement from the public to private sector continues to increase. Although Thailand's public healthcare system is still the main provider of healthcare services across the country, the private healthcare sector has grown rapidly, especially in Bangkok and other large cities. About 71% of private hospitals are located in Bangkok, showing that private healthcare resources are heavily concentrated in urban areas[3]. Private hospitals often attract physicians by offering higher income, better working conditions, and more flexible schedules[6]. As a result, many physicians move from the public sector to private hospitals, leading to concerns about physician shortages and unequal distribution of healthcare workers, especially in public and rural healthcare systems[6,7]. Provinces with stronger economic growth tend to have higher physician density, whereas rural and lower-income provinces continue to face physician shortages and heavier outpatient workloads[2,8].

These conditions may contribute to increased workload intensity and burnout among physicians working in public hospitals outside major urban centers. Recent evidence suggests that physician resignation is increasingly associated with working conditions and mental well-being rather than financial factors alone. International studies have consistently reported higher levels of burnout among physicians compared with the general population, commonly related to long working hours, administrative burden, and poor work-life balance[9,10]. Studies from Thailand have reported similar findings, with excessive working hours and work overload associated with burnout, reduced quality of work life, and lower job satisfaction[11-13].

Beyond workload-related factors, organizational management, job security, welfare systems, and institutional culture have also been shown to influence physicians' decisions to remain in or leave public service[14]. However, most existing research in Thailand has focused on physicians' intention to resign rather than physicians who have already left the public health system. In addition, studies directly comparing physicians' working conditions before and after resignation remain limited, especially in the post-COVID-19 period.

This study aimed to examine factors related to resignation from Thailand's public health sector, with a focus on workload, working hours, work-related stress, burnout-related experiences, and welfare benefits. By studying physicians who had already left public service and comparing their working conditions before and after resignation in 2025, this study may provide useful evidence to support physician retention and the long-term sustainability of Thailand's public healthcare system.

Materials and Methods

This study is a cross-sectional survey was conducted among physicians who had previously worked in the Thai public health sector and were currently employed in the private sector or other non-governmental organizations.

Data were collected in 2025 using a self-administered questionnaire developed by the research team. The questionnaire was designed to represent information on physicians' demographic characteristics, professional backgrounds, and work experiences within the public health sector, as well as their current employment conditions following resignation.

The instrument assessed multiple domains, including experiences during public-sector employment, weekly working hours before and after resignation, and factors associated with the decision to leave government service. In addition, the questionnaire explored factors influencing overall work performance, perceived determinants of physician retention in the public health system, and conditions considered supportive of longer-term employment

within the public sector.

Statistical Analysis

Descriptive statistics (frequency, percentage) were used to summarize data. Weekly working hours were collected as ordinal categorical variables (20-40, 41-50, 51-60, and >60 hours/week). Because working hours before and after resignation represented paired categorical data with more than two categories, the Stuart-Maxwell test was used to assess marginal homogeneity between the two paired distributions.

Ethical Approval

This study was approved by the Bangkok Hospital Headquarters Institutional Review Board (IRB Certificate of Approval No. COA. 2024-06).

Results

A total of 50 physicians participated in the study. The demographic and professional characteristics of respondents are presented in Table 1. The majority were male (54%), aged 25-44 years (48%), and had more than 10 years of professional experience (66%). Most respondents were full-time physicians (92%) and were working in hospital-based settings (92%). Internal medicine (24%) and surgical specialties (12%) were the most common fields of practice.

Workload Before and After Resignation

Working hours differed substantially between public sector service and current employment. During public service, 40% of physicians reported working more than 60 hours per week, and 24% worked 51-60 hours. After resignation, these proportions declined to 11.8% each. In contrast, physicians working 20-40 hours weekly increased from 12% during public service to 40% at present. The Stuart-Maxwell test demonstrated a significant shift in the distribution of weekly working hours after resignation compared with during public service ($p<0.001$) (Figure 1, Table 2).

There was a significant difference between current weekly working hours and working hours during public service (Stuart-Maxwell test, $p<0.001$). Physicians who previously worked more than 60 hours per week during public service were more likely to continue working long hours at present, with 45% currently working 41-50 hours per week and 25% still working more than 60 hours per week. In contrast, most physicians who previously worked 20-40 hours per week remained in the same working-hour group at present (83.3%).

Overall, 19 physicians had similar working hours compared with their public service period, 29 physicians reported working fewer hours, and 2 physicians reported working longer hours than before. These findings suggest that working-hour patterns were

Table 1. Demographic and professional characteristics of physicians (n=50)

Characteristic	n (%)
Sex	
Male	27 (54.0)
Female	23 (46.0)
Age group	
<25 years	1 (2.0)
25-44 years	24 (48.0)
45-59 years	14 (28.0)
≥60 years	11 (22.0)
Years of experience	
≤5 years	8 (16.0)
6-10 years	9 (18.0)
>10 years	33 (66.0)
Employment type	
Full-time	43 (86.0)
Part-time	7 (14.0)
Work setting	
Hospital-based	46 (92.0)
Others/unspecified	4 (8.0)
Specialties	
Internal Medicine	12 (24.0)
Surgery	6 (12.0)
Family/Preventive Medicine	5 (10.0)
Pediatrics	3 (6.0)
Psychiatry	2 (4.0)
Obstetrics & Gynecology	2 (4.0)
Emergency Medicine	2 (4.0)
Anesthesiology	2 (4.0)
Rehabilitation	2 (4.0)
Others	14 (28.0)

Eleven physicians were aged ≥60 years, reflecting inclusion of senior physicians who had previously worked in the public health sector and later transitioned to private or non-governmental employment. Their inclusion provided perspectives across different career stages and years of professional experience.

Table 2. Comparison of weekly working hours before and after resignation (n=50)

Current weekly hours	During public service				p-value
	20-40 hours (n=6)	41-50 hours (n=12)	51-60 hours (n=12)	>60 hours (n=20)	
20-40 hours	5 (83.3)	5 (41.7)	6 (50.0)	3 (15.0)	<0.001
41-50 hours	1 (16.7)	6 (50.0)	3 (25.0)	9 (45.0)	
51-60 hours	0 (0.0)	0 (0.0)	3 (25.0)	3 (15.0)	
>60 hours	0 (0.0)	1 (8.3)	0 (0.0)	5 (25.0)	

Stuart-Maxwell test of marginal homogeneity: $p<0.001$

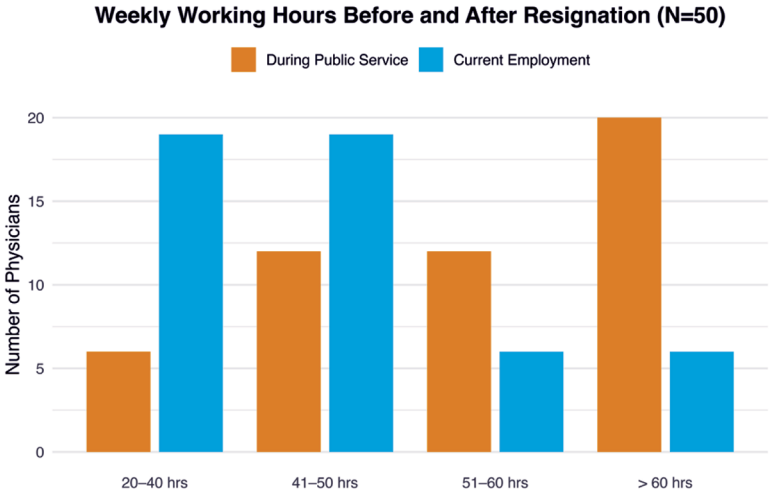

Figure 1. Weekly working hours before and after resignation.

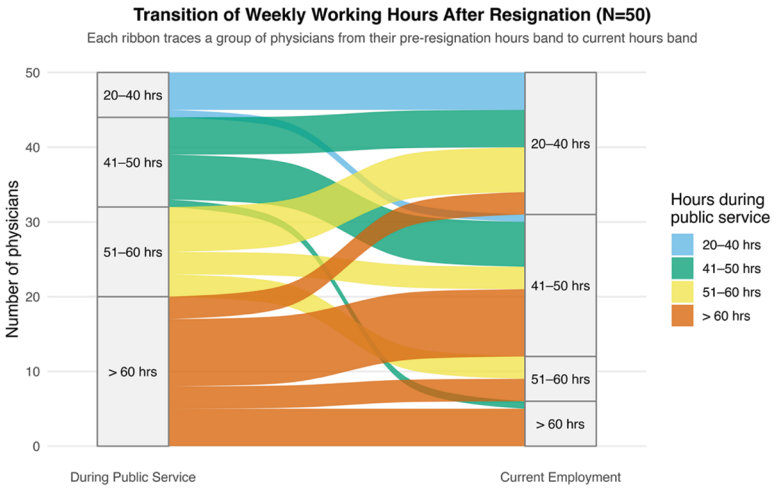

Figure 2. Transition of weekly working hours after resignation.

generally stable, although most physicians tended to reduce their workload over time (Figure 2, Table 2).

Reasons for Resignation

The leading causes of resignation are summarized in Figure 3. Inadequate income (62%) was the most frequently reported factor, followed by unsupportive management (46%), occupational stress (40%), and long working hours (38%). Other relevant factors included lack of flexibility (34%), shortage of staff and equipment (28%), and organizational politics (28%). While harassment and gender-related issues were rarely cited, the presence of such responses reflects potential underlying organizational challenges.

These results suggest that while financial inadequacy was the primary motivator, non-financial issues such as stress, organizational climate, and workload also played critical roles in physicians' decisions to resign.

Retention Factors

Despite these challenges, several factors were reported as reasons for staying in the public sector before resignation. Job security (86%), welfare benefits (70%), and opportunities for career advancement (64%) were the most common reasons (Figure 4). Interestingly, although income was the main reason for resignation, only 12% reported income as a reason to stay in the public sector. This suggests that the factors influencing physicians to leave may differ from the factors encouraging them to remain.

These findings suggest that although inadequate

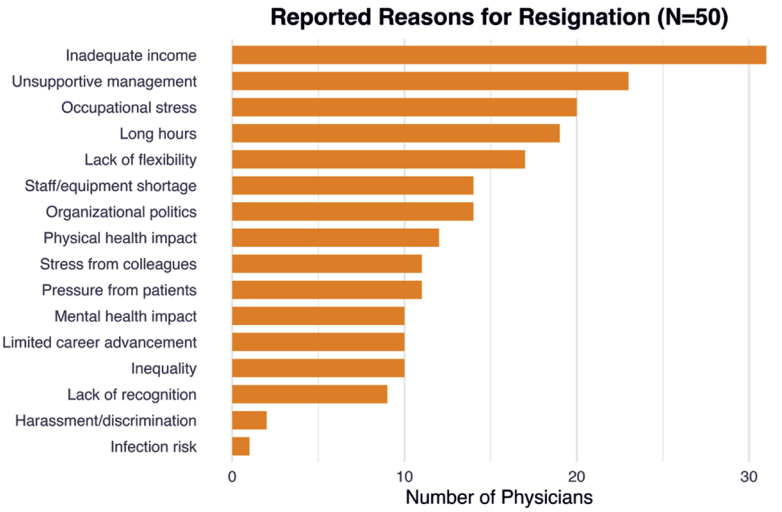

Figure 3. Reasons for resignation.

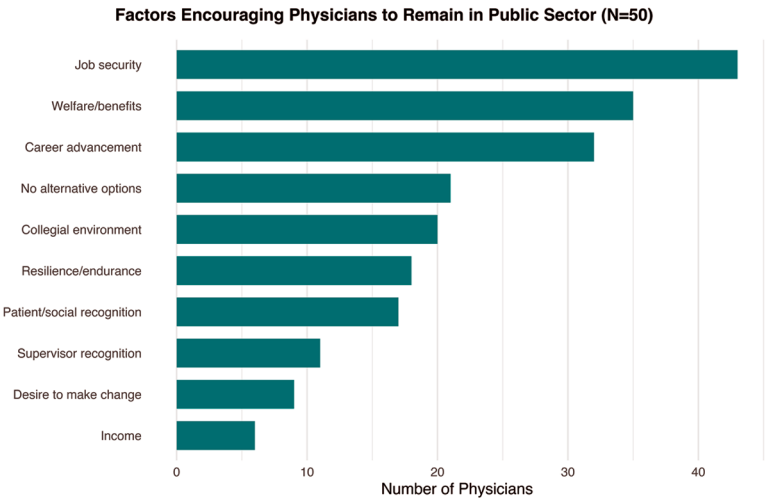

Figure 4. Factors encouraging physicians to remain in the public sector.

income contributed to resignation, job security and welfare benefits remained important reasons for staying in the public sector.

Physician Perspectives on Systemic Problems

Qualitative analysis of open-ended responses revealed five recurring themes:

1. Excessive workload and long shifts (29 responses): including 24-36 hours shifts and inadequate rest.

2. Inadequate compensation (26 responses): misaligned with workload and risks.

3. Resource shortages (18 responses): lack of staff and equipment.

4. Organizational politics and favoritism (15 responses): issues of unfair promotion and patronage.

5. Patient-related pressures (17 responses): high patient expectations and inappropriate use of services.

Narrative: Physicians highlighted systemic inefficiencies that not only affect their well-being but also compromise patient care. The overlap between financial, organizational, and patient factors suggests multifaceted roots to workforce attrition.

Discussion

This study examined factors associated with physicians' resignation from Thailand's public health sector using data from physicians who had prior public service experience and were currently employed outside government. The key findings were: 1) a

significant reduction in weekly working hours after resignation; 2) "inadequate income" as the most frequently reported reason for resignation, alongside prominent non-financial drivers such as occupational stress, long working hours, and limited flexibility, and 3) job security and welfare benefits as the strongest factors encouraging physicians to remain in the public sector prior to resignation, reflecting a clear push-pull dynamic.

Workload, Working Hours, and Occupational Stress

A central message of this study is the magnitude of workload change after leaving public service. The proportion of physicians working >60 hours per week decreased markedly, while those working 20-40 hours increased substantially, with statistical evidence indicating a significant reduction in working hours. International literature consistently links prolonged working hours and high administrative burden to burnout[15], psychological distress, and impaired work-life balance among physicians[9,16,17]. Evidence from Thailand also suggests a concerning burden of burnout and poor quality of work life among physicians, particularly when extended duty hours and after-hours shifts are common[18]. Together, these findings reinforce the need to address duty-hour intensity and workload distribution as key targets for retention.

Income Inadequacy as a "Primary push factor", but not a "Retention anchor"

"Inadequate income" was the most frequently cited reason for resignation, yet income was rarely identified as a factor encouraging physicians to remain in public service. This discrepancy suggests that physicians may tolerate relatively lower income when other working conditions—such as manageable workload, supportive leadership, and clear career development pathways—are acceptable. However, income appears to become a decisive push factor when combined with excessive workload and chronic occupational stress.

Previous studies on physician migration have consistently emphasized financial incentives as a major driver of brain drain[19]. Nevertheless, systematic evidence indicates that financial rewards alone are insufficient to ensure retention, as non-financial factors—including career development opportunities, organizational support, and adequate infrastructure—play equally important roles in motivating health workers to remain in public service[20]. However, emerging evidence indicates that income interacts closely with working conditions, professional autonomy, and organizational environment in shaping physicians' decisions to remain in or leave public service. Conceptual frameworks of health worker motivation highlight how income and other structural and organizational determinants—such as leadership, reporting structures, and institutional culture—jointly influence retention[21]. Qualitative studies further suggest that adverse workplace environments, including conflict, lack of recognition, and poor interpersonal support, contribute to burnout and intentions to leave[22]. Systematic evidence on physician attrition also underscores the importance of combining financial and non-financial factors, with professional development opportunities, supportive management, and organizational context playing key roles in retention decisions[14].

Organizational and System-Level Determinants

Non-financial organizational factors including limited work flexibility, shortages of staff and equipment, organizational politics, and unsupportive management were commonly reported in this study. These findings suggest that physicians' decisions to resign are strongly influenced by the overall working environment, particularly staffing adequacy and organizational culture. Resource shortages may generate a reinforcing cycle in which inadequate staffing increases workload and occupational stress, thereby contributing to burnout and subsequent resignation, which in turn further exacerbates workforce shortages.

Moreover, organizational politics and weak managerial support may erode trust and perceived fairness within institutions, undermining professional commitment and long-term retention. Beyond financial considerations, job stress arising from excessive workload, administrative burden, and limited resources has been consistently linked to increased resignation among physicians, particularly in rural and resource-constrained settings[23].

Another important factor is the increasing demand for healthcare services under Thailand's universal health coverage system. Over the past two decades, Thailand has achieved broad healthcare access and high use of outpatient services, leading to larger patient volumes in public hospitals. Although universal health coverage has improved access to healthcare, it has also increased the workload of physicians, especially in busy public hospitals. Physicians may face pressure not only from large numbers of patients, but also from growing expectations for faster access to care, continuity of treatment, and better service quality. These challenges may contribute to work-related

stress, emotional exhaustion, and lower job satisfaction among physicians in the public health sector.

Although concerns about long working hours among physicians have existed in Thailand for many years, putting effective limits on working hours remains difficult within the public healthcare system. This is partly due to not enough physicians, high patient demand, and unequal physician distribution across regions. Existing policies and professional recommendations to reduce excessive working hours may be difficult to apply consistently across all hospitals, especially in resource limited settings. Therefore, efforts to reduce physician workload should be combined with broader strategies such as increasing workforce capacity, improving staff distribution, and strengthening organizational support to ensure long-term sustainability.

Policy Implications

Collectively, the findings imply that physician retention strategies should move beyond a single-domain approach (e.g., compensation alone). Instead, retention likely requires integrated interventions addressing 1) workload and duty hours, 2) compensation structures that reflect work intensity and risk, and 3) organizational governance that promotes fairness, flexibility, and supportive leadership. Policies that increase physician production or rely on mandatory service may improve short-term staffing but may be insufficient for sustained retention if structural working conditions remain unchanged[20,24].

Policy Recommendations

1. Align compensation with workload intensity and clinical risk: Compensation structures should better reflect duty-hour intensity, responsibility, and occupational risk, particularly for on-call and emergency shifts. Revisions to overtime (OT) and performance-based payment schemes should emphasize transparency and perceived fairness, ensuring that additional workload is compensated consistently and predictably.

2. Establish clear duty-hour and rest standards: A national or organizational policy should define maximum weekly working hours and safe limits for continuous duty periods, including mandatory protected rest after extended shifts. Operational enforcement mechanisms (e.g., rostering systems, monitoring and accountability) are essential to ensure that duty-hour standards translate into practice rather than remain aspirational.

3. Increase and optimize supporting workforce and resources: Retention policies should include expansion of non-physician support staff (e.g., nurses, administrative staff, technicians) to reduce non-clinical burdens on physicians. Ensuring adequate equipment and operational resources may reduce inefficiencies and prevent the workload amplification that fuels resignation.

4. Strengthen mentoring systems and transparent career pathways: Formal mentoring programs should be implemented, particularly for early-career physicians, to provide professional support and mitigate stress during high-demand periods. Career advancement pathways should be transparent and competency-based, with equitable access to training and promotion opportunities to reduce perceptions of favoritism and organizational politics.

Strength

This study provides insights from physicians who had already resigned from public service—an important perspective that is less frequently captured in Thai workforce research, which often focuses on intention to quit among currently employed physicians.

Limitation

Several limitations should be noted. The modest sample size may limit generalizability and precluded stable specialty-specific analyses, particularly given the wide variety of medical specialties and practice settings represented. As workload characteristics may differ across specialties and settings, the findings should therefore be interpreted as reflecting overall physician experiences rather than specialty-specific patterns. The cross-sectional design does not allow causal inference, and self-reported measures may be subject to recall and reporting bias. In addition, burnout was not assessed using a validated scale; thus, findings related to stress and burnout should be interpreted as perceived work-related impacts rather than diagnostic prevalence. Future research should incorporate validated instruments, broader sampling strategies, and adequately powered specialty-specific analyses.

Conclusion

This study demonstrates that physicians' resignation from Thailand's public health sector is driven by a multifactorial interaction between workload, organizational conditions, and economic factors rather than by income alone. Although inadequate income was the most frequently cited reason for resignation, the substantial reduction in working hours after leaving public service highlights

excessive workload and prolonged duty hours as core structural contributors. Financial dissatisfaction appears to function primarily as a push factor when combined with chronic occupational stress, limited flexibility, and unsustainable work-life balance.

At the same time, job security and welfare benefits remain important anchors for retention, indicating a clear push-pull dynamic within the public health system. However, these incentives are insufficient to counterbalance adverse working environments characterized by staffing shortages, weak managerial support, and limited career development opportunities. The findings suggest that policies emphasizing physician production or mandatory service may improve short-term staffing but are unlikely to ensure long-term retention without parallel reforms addressing workload regulation, compensation aligned with work intensity, and organizational governance. An integrated, system-level approach is therefore essential to sustain the public health physician workforce in Thailand.

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Authors Contributions

AL: Conceptualization, investigation (literature search and selection), writing-original draft, and final approval. PK: Investigation (literature screening), writing-review & editing, and final approval. PW: Data curation, project administration, and final approval; TW: Investigation (literature review support), writing-review & editing. WC: Data curation, formal analysis, visualization. ST: Investigation (data collection), methodology (data collection planning), project administration. KS: Investigation (literature screening), writing-review & editing, corresponding author, and final approval. All authors approved the final manuscript.

Clinical Trial Registration

A clinical trial registration number is not required for this article because it does not report a clinical trial.

Conflicts of Interest

The authors declare no conflict of interest.

Data Availability Statement

Due to privacy and ethics, human participant data cannot be shared publicly. De-identified data can be requested from the corresponding author with institutional review board approval.

Ethics Approval and Consent to Participate

This study was approved by the Bangkok Hospital Headquarters Institutional Review Board (BHQ-IRB 2023-09-31; COA No. 2024-06, Renewal: COA No. 2025-15). Informed consent was obtained electronically from all participants. Participants were informed that completion of the online questionnaire implied their consent to participate in the study.

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Use of Artificial Intelligence

Artificial intelligence (AI) tools, specifically GPT-5.6 (OpenAI), were used to assist with language editing and improving the clarity of the manuscript. The authors reviewed and edited all AI-assisted content and take full responsibility for the accuracy and integrity of the manuscript.

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