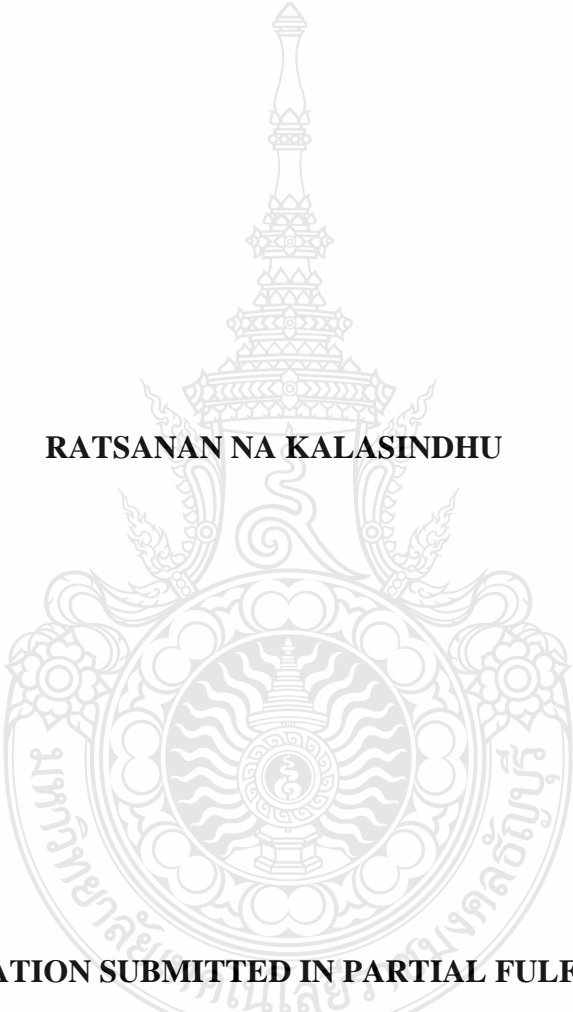


**MEDIATING EFFECT OF TECHNOLOGY ACCEPTANCE AND
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TRANSFORMATIONAL LEADERSHIP, CHARISMATICS LEADERSHIP,
AND SERVICE QUALITY IN PRIMARY HEALTHCARE PROVISION UNITS**

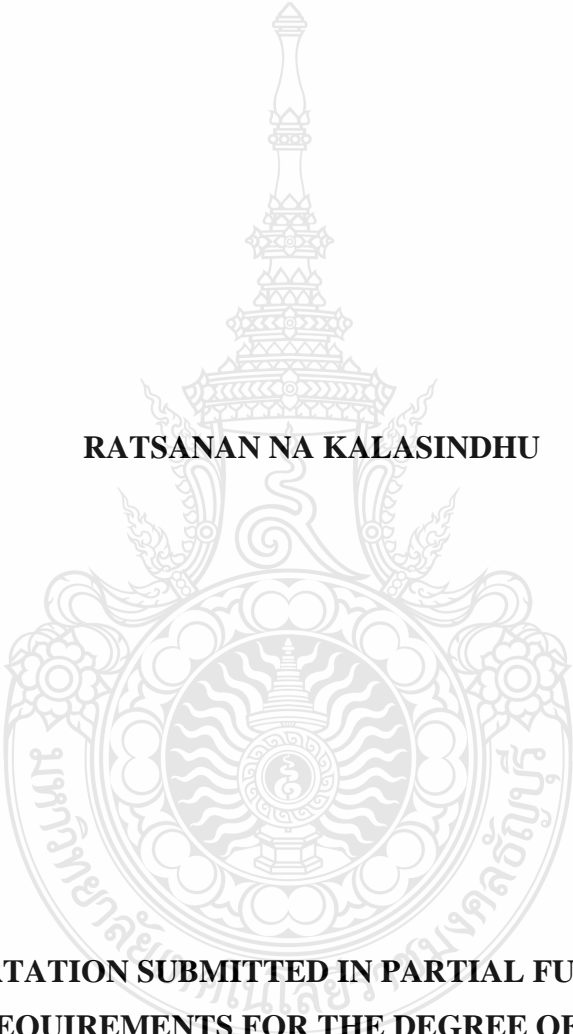
RATSANAN NA KALASINDHU



**A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT
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PHILOSOPHY PROGRAM IN BUSINESS ADMINISTRATION
FACULTY OF BUSINESS ADMINISTRATION
RAJAMANGALA UNIVERSITY OF TECHNOLOGY THANYABURI
ACADEMIC YEAR 2022
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Dissertation Title Mediating Effects of Self-Efficacy and Technology Acceptance on the Relationships between Transformational Leadership and Charismatic Leadership with Service Quality in Primary Care Units

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หัวข้อคุณสมบัติ	อิทธิพลส่งผ่านของการยอมรับความสามารถแห่งตนและการยอมรับเทคโนโลยีในความสัมพันธ์ระหว่างภาวะผู้นำการเปลี่ยนแปลงและภาวะผู้นำแบบบารมีกับคุณภาพการบริการในหน่วยบริการปฐมภูมิ
ชื่อ-นามสกุล	นายรสนันต์ ณ กาฬสินธุ์
สาขาวิชา	บริหารธุรกิจ
อาจารย์ที่ปรึกษาหลัก	รองศาสตราจารย์ชนงกรณ์ กุณทลบุตร, D.B.A.
ปีการศึกษา	2565

บทคัดย่อ

หน่วยบริการปฐมภูมิเป็นหน่วยงานของรัฐที่มีความสำคัญต่อประชากรส่วนใหญ่ของประเทศไทย หน่วยบริการปฐมภูมิได้ทำการขยายการให้บริการเพื่อรองรับประชากรส่วนใหญ่ในพื้นที่ชนบทของประเทศไทยหลายแห่ง ในบริบทของการจัดการองค์กรเพื่อคุณภาพการบริการที่ดีขึ้น รูปแบบความเป็นผู้นำเป็นหนึ่งในปัจจัยสำคัญในการพิจารณา แต่มีงานวิจัยน้อยมากที่มุ่งเน้นศึกษาความสัมพันธ์ของรูปแบบภาวะผู้นำการเปลี่ยนแปลงร่วมกับภาวะผู้นำแบบบารมีในหน่วยบริการปฐมภูมิที่ตั้งอยู่ทั่วประเทศ ดังนั้น งานวิจัยนี้จึงมีวัตถุประสงค์เพื่อศึกษาอิทธิพลส่งผ่านของการยอมรับความสามารถแห่งตนและการยอมรับเทคโนโลยีในความสัมพันธ์ระหว่างภาวะผู้นำการเปลี่ยนแปลงและภาวะผู้นำแบบบารมีกับคุณภาพการบริการในหน่วยบริการปฐมภูมิ

การวิจัยนี้ใช้วิธีวิจัยเชิงปริมาณ กลุ่มตัวอย่างที่ใช้ในการศึกษารวม 1,278 คน จากบุคคล 3 กลุ่มๆ ละ 426 คน ประกอบด้วยพยาบาลวิชาชีพ เจ้าหน้าที่สาธารณสุข และผู้รับบริการ ในหน่วยบริการปฐมภูมิครอบคลุมพื้นที่ทั่วทุกภาคของประเทศไทย (ภาคเหนือ 23.94%, ภาคตะวันออกเฉียงเหนือ 26.77%, ภาคกลาง 29.58%, ภาคใต้ 19.71%) โดยใช้วิธีการสุ่มตัวอย่างแบบหลายขั้นตอน เพื่อตั้งค่าโครงสร้างแบบลำดับขั้นของแต่ละกลุ่ม จากนั้นจึงทำการสุ่มตัวอย่างแบบง่าย เครื่องมือที่ใช้ในการเก็บรวบรวมข้อมูลคือแบบสอบถามซึ่งพัฒนาจากฐานทฤษฎีและผ่านการทดสอบจนบรรลุความต้องการตามกระบวนการที่เหมาะสม สถิติที่ใช้ในการวิเคราะห์ข้อมูลคือแบบจำลองสมการเชิงโครงสร้าง

ผลการศึกษา พบว่า การยอมรับความสามารถแห่งตนและการยอมรับเทคโนโลยีเป็นตัวแปรคั่นกลางที่มีอิทธิพลส่งผ่านในความสัมพันธ์ระหว่างภาวะผู้นำการเปลี่ยนแปลงและภาวะผู้นำแบบบารมีที่ส่งผลต่อคุณภาพการบริการในหน่วยบริการปฐมภูมิอย่างมีนัยสำคัญทางสถิติที่ระดับ .05 ส่วนกรณีที่มีการยอมรับเทคโนโลยีเป็นตัวแปรคั่นกลางเพียงตัวเดียวที่มีอิทธิพลส่งผ่านระหว่างภาวะผู้นำทั้งสองประเภทต่อคุณภาพการบริการนั้น พบว่า การยอมรับเทคโนโลยีไม่มีอิทธิพลส่งผ่านความสัมพันธ์ระหว่าง

ภาวะผู้นำการเปลี่ยนแปลงและภาวะผู้นำแบบบารมีต่อคุณภาพการบริการในหน่วยบริการปฐมภูมิอย่าง มีนัยสำคัญทางสถิติที่ระดับ .05 ทั้งนี้เนื่องจากผู้ป่วยซึ่งเป็นผู้ใช้บริการในหน่วยบริการปฐมภูมิไม่ได้เป็น ผู้ใช้เทคโนโลยีโดยตรง ดังนั้น การยอมรับเทคโนโลยีจึงไม่เป็นตัวแปรคั่นกลางที่มีนัยสำคัญทางสถิติใน ความสัมพันธ์นี้ การศึกษานี้เป็นการทดสอบเชิงทฤษฎีเพื่อสนับสนุนการสร้างแบบจำลองแนวคิดเชิง เปรียบเทียบบทบาทของการเป็นตัวกลางในบริบทหน่วยการบริการปฐมภูมิในประเทศไทย

คำสำคัญ: ภาวะผู้นำการเปลี่ยนแปลง ภาวะผู้นำแบบบารมี การยอมรับเทคโนโลยี การยอมรับ ความสามารถแห่งตน หน่วยบริการปฐมภูมิ



Dissertation Title	Mediating Effects of Self-Efficacy and Technology Acceptance on the Relationships between Transformational Leadership and Charismatic Leadership with Service Quality in Primary Care Units
Name-Surname	Mr. Ratsanan Na Kalasindhu
Program	Business Administration
Dissertation Advisor	Associate Professor Chanongkorn Kuntonbutr, D.B.A.
Academic Year	2022

ABSTRACT

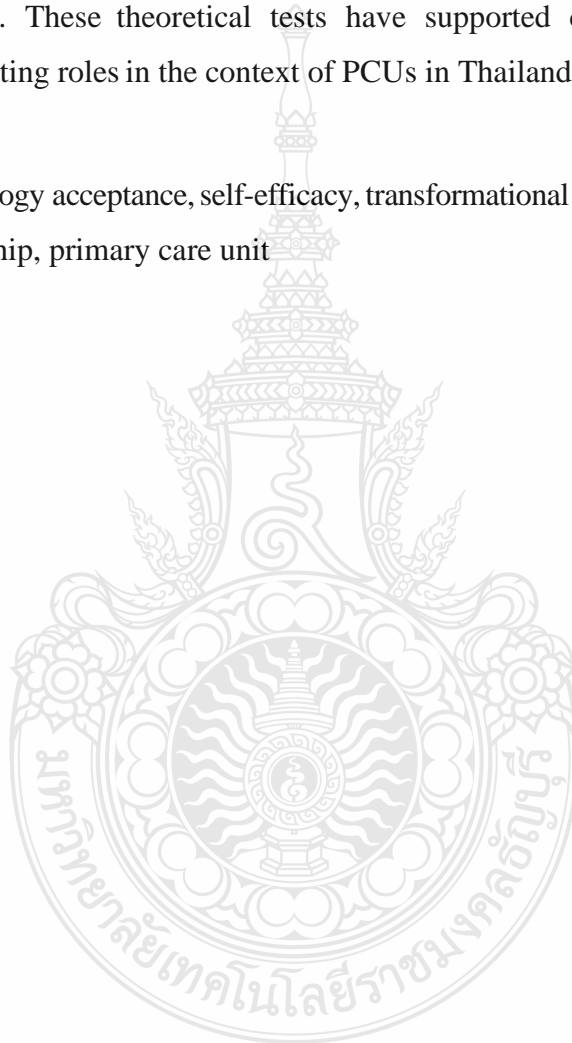
Primary care units (PCUs) are government agencies that are collectively crucial to most of the population in Thailand. These units have been extended from the state health services system to serve the majority of the population located in many rural areas. In the context of organizational management for better service quality, leadership style is one of the important factors to consider. But few studies have focused on the relation of leadership styles as transformational leadership in combination with charismatic leadership in PCUs located across the country. Therefore, this research aimed to examine the mediating effects of self-efficacy and technology acceptance on the relationship between transformational leadership and charismatic leadership with service quality in the PCUs.

This research used a quantitative research method. The sample group used in the study consisted of 1,278 persons, being 3 groups. Each group consisted of 426 persons from professional nurses, health workers and service recipients in PCUs covering all regions of Thailand (North region 23.94%, Northeast region 26.77%, Central region 29.58%, Southern region 19.71%). The multistage sampling method was used to set up the hierarchical structure of each group. Then, simple random sampling was applied. The instrument used for data collection was a questionnaire, which was developed based on theory and tested results until the appropriate process requirements are met. Statistical analysis of the data was performed using a structural equation model.

The research results revealed that both technology acceptance and self-efficacy had mediating roles in the relationships between transformational leadership and

charismatic leadership with service quality in PCUs at a statistically significant level of .05. But the relationship that has the effect of being a mediating role for technology acceptance which is the only mediating variable in the relationship between the two types of leaders on the quality of service demonstrated no statistically significant at a level of .05. This is because patients who used the service are not the direct users of technology, so technology acceptance demonstrates no statistical significance as a mediator between these relationships. These theoretical tests have supported comparative conceptual modelling in mediating roles in the context of PCUs in Thailand.

Keywords: technology acceptance, self-efficacy, transformational leadership, charismatic leadership, primary care unit



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Truly thanks to all population is 1,278 persons consisting of the Public Health Technical Officer, Nurses 639 persons, patient or customer 639 persons. The primary healthcare units are situated in the specified geographical group covering an area in Thailand, who are cooperated in filling out the questionnaire for this research

Innumerable thanks to Rajamangala University of Technology for providing me the opportunity to study and supporting till the end of the course.

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Ratsanan Na Kalasindhu

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CHAPTER 1

INTRODUCTION

1.1 Background and Statement of the Problem

In the information system revolution era, available technology digital does employ currently. These digital technologies create disruptive innovation in virtual healthcare clinics through telemedicine consultations which reduce the physical crowding of the patients in the hospitals and clinics. In addition, it helps the detection and diagnosis of disease and other related problems and symptoms. It can help in the proper isolation of the infected patient, thereby reducing the spread of disease. In the current scenario, advanced information technologies provide enhancement and better solutions in the medical field, like proper medical record-keeping, sampling, integration of devices, and causes of diseases. In the primary health care units (PCUs) area, this information-based service opens up new healthcare opportunities as it moves towards the best way of an information system to adapt world-class results. It enables the improvement of treatment systems in the hospital. Medical officers can now be better trained for disease detection and well-guided for future action. Technology digital's proper usage can help resolve different medical challenges like speed, cost, volatility uncertainty, and complexity. These constraints have been disappearing, able to be customized to monitor calorific intake and treatment like asthma, diabetes, and arthritis. This technology digitally controlled health management system can improve the overall performance of healthcare during the day.

Thailand has made remarkable progress in strengthening its primary health care units (PCUs) system. The facing challenges include inadequate education and qualifications with the health services information systems. Its workforce, characteristic of leadership, fragmented health information technology systems, a lack of digital data on everyday clinical practice. Furthermore, incentives that do not encourage self-efficacy and excellent performance, insurance policies hamper healthcare delivery efficiency with new information technology (IT) system devices, insufficient service quality measurement to improve healthcare service quality. The tremendous Digital transformation emerging in 2017-2026 is critical for Thailand to develop a system to raise

healthcare services and a concrete implementation strategy. Digital transformation strategy is an enormous change in society and afterward exhibits a consistent emerging pattern of activities in all sectors. Thus, the health care services system desires to adapt effectively by taking complete and creative advantage of Acceptance and Use of Technology to develop infrastructure, innovation, data capability, human capital, and other resources, with an awareness of these constructive ways and development opportunities. Simultaneously, the framework for driving digital technology to develop the national health systems, including paradigm shift, reformed digital technology implementation via all sectors. Moreover, it provides the public with the well-being possible benefits and steadiness satisfaction in Thailand's health care service, representing the contribution of services quality of the people's universal health care (UCH). The equalization of the standard of human rights can access connected health care services with the digital technology domain to utilize the public benefit and consistency in health care service. The development roadmap dose the path of the service of primary health care in Thailand. Under the national health care plan, “The National Committee of Primary Health Care” and “Office of the Primary Health Care Committee” were formed to serve primary health care’s mission. Firstly, the primary health care units (PCUs) context with four principles of 1) equitable distribution of health care, 2) community participation, 3) use of appropriate technology and 4) multisectoral approach became the main context for primary health care units (PCUs) development in Thailand. Universal Health care (UHC) reveals that public expenditure on health steadily increased from 56% in 2000 to 86% in 2011, while out-of-budgetary spending decreased from 27.2% to 12.4% of total health costs (Jongudomsuk et al., 2015). How can the Thai healthcare system employ similar efforts to improve the delivery of healthcare information (Administrative data, Clinical data), which spend 40% of their work hours on data management and reports? Health information technology (IT) has capitalized on delivery care solutions to serve the needs of patients (McLees, Nawaz, Thomas, & Young, 2015). According to Walumbwa, Avolio, and Zhu (2008), proposed health Information Technology (IT) adoption existed to perform health care spending and adequate health care quality.

The Acceptance and Use of Technology digital linkages solution has all health care services systems and functions of Administrative and, Clinical works. The need to

achieve comprehensive health care, success in reducing public health management costs, seamless and secure sharing of healthcare data, and the relevant law for controlled data exchange between applications. Thus, the Thai health care officers require modern management and leadership to induce subordinates, competencies responsive to emerging health services information systems to the creative advantage of Acceptance and Use of Technology are challenges to applied staff members management. Therefore, one of the creative advantages of Acceptance and Use of Technology connected to front line health the public providers with the possible benefits was the primary health care units (PCUs). Since the primary health care units (PCUs) have evolved through many innovations, health did activities such as community organization, community self-financing, management, restructuring the health system, and multisector coordinators. Thus, the primary health care unit explores various incentive strategies to implement Acceptance and Use of Technology, comprehensive of their personnel to develop a system to improve the quality of health care services and a robust best practical approach.

1.2 Significance of the Study

The problem statement dictates that studying the Primary healthcare workforce. Thailand has trivial evidence to support the Acceptance and Use of Technology digital linkages solution has all health care services systems and functions of Administrative and, Clinical works and the application of information technology (IT) is fragmented. IT systems for clinical care are often unavailable; they are not interoperable when available. IT systems for public health services are widespread, but they do not integrate with clinical practice. The resulting lack of linked digital data impedes the implementation of decision support and the timely generation of evidence from everyday primary healthcare practice.

The challenges for primary health care in Thailand require a strategy. The Healthy Thailand plan highlights primary health care's vital role and is committed to strengthening the primary healthcare system. The digital linkage, all health care services systems and functions of the currently. Which need for achievement has comprehensive include efficient health care, success in reducing cost in public health management, seamless and secure sharing on healthcare data, the relevant law for controlled exchange

of data between applications. Public Health Technical Officers and Nurses require modern management. Leadership to induce allied health competencies responsive to emerging regarding Internet use. High self-efficacy is positively associated with willingness to choose and participate in computer-based activities, expectations of the success of computer use, perseverance when faced with computer use difficulties, and computer-based performance (Eachus & Cassidy, 2006). It is crucial to the health care services of the Primary health care units (PCUs). Research and literature support the importance of high self-efficacy to the overall performance, productivity (Quinones, 1995). Although research and literature are abundant in self-efficacy in various professions and industries, less research or literature could identify in the direct healthcare profession.

Expectation from a knowledge gap between leadership styles (both transformational and charismatic leadership) and service quality through self-efficacy and Acceptance and Use of Technology digital linkages solution in quality and Primary Health Care units (PCUs) of Thailand because no research studies in the past. Furthermore, the study has proposed to emphasize fulfilling the theory's growth. Also, phenomenal knowledge is the demeanour pathway provision to primary health care services in the era 4.0 policy context. Similarly, Digital-health care record implementation and use of information technology sharing have led healthcare providers to examine the effectiveness of the information technology (Vest, Issel, & Lee, 2014). Meanwhile, McGeorge et al. (2015) revealed the insufficiency of information and advanced cost. These are related to the up-to-date health information system, which has interruptive the potential scale of the Acceptance and Use of Technology digital linkages solution has all health care services systems and functions of Administrative and, Clinical works. Treatment record implementation.

These are effort fact-finding to combine these concepts to examine the significant progress of disseminating new paradigm shift and recommendations as follow:

Firstly, the research result shall gather more understanding and propose emerging data on the mediating roles of technology acceptance and self-efficacy in the relationships among transformational leadership and service quality. The technology acceptance linkages solution has all health care services systems and functions of

administrative and, clinical works, on a provision of primary health care services in the public health in era 4.0 Thailand policy a digital economy.

Second, conclusion fact-finding emerging a conceptual model analysis shall examine the mediating roles of technology acceptance and self-efficacy in the relationships between charismatic leadership and service quality.

Finally, emphasizing the research contributes to recommendations regarding developing a system to improve healthcare quality. A concrete practice study consistently adapts effectively by taking complete and creative advantage of quality service via self-efficacy and technology acceptance—same standard linkage.

1.3 Purpose of the Study

The crucial point of the research assessment is to investigate the pathways of transformational leadership, charismatic leadership, self-efficacy, and act influence affecting service quality mediated via self-efficacy and the Acceptance and Use of Technology digital linkages. The solution has all health care systems and functions of administrative and clinical work, providing primary health care services in the era of 4.0 Thailand policy, a digital economy, which is taking the role in the position of responsibility for both health managers and leaders working at primary healthcare units (PCUs) in the era of 4.0 policy, a digital economy. So, this process mentioned above on process finding the answer to do the particular has a research instrument conducted equivalently across the population of the research methodology approach of the model.

1.4 Research Question and Hypothesis

1.4.1 Research Question

To fulfil the research objectives, investigation and seeks, which particularly examine the following research question:

Research question 1. To what extent do technology acceptance and self-efficacy mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit context?

Research question 2. To what extent do technology acceptance and self-efficacy mediate the relationship between charismatic leadership and service quality in Thailand's primary healthcare unit context?

1.4.2 Hypothesis

Predictions shall be testable to determine and adequate for possible relationship the research purpose between among the exogenous, endogenous, and mediate variables of a conceptual model this present research:

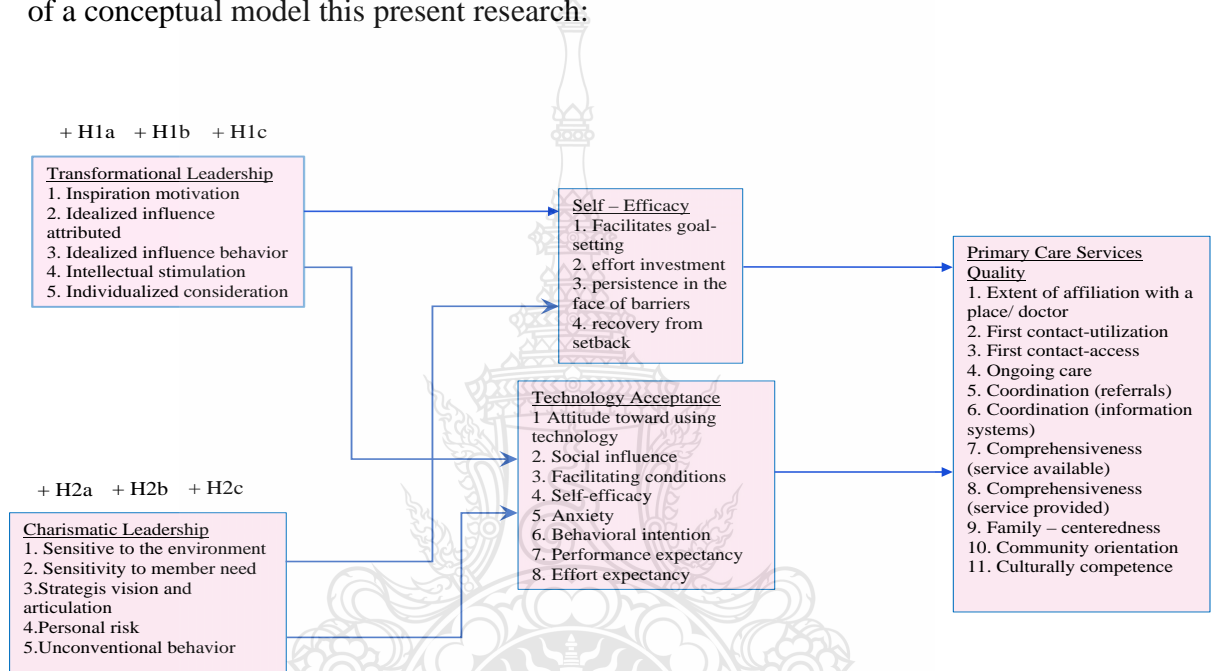


Figure 1.1 The theoretical model

Hypothesis-related constructs, research findings, and a previous literature analysis validated the significance of high self-efficacy to overall performance and productivity in computer software training (Gist, Schwoerer, & Rosen, 1989) The lack of evidence on self-efficacy and technology adoption behaviors suggests an urgent need to investigate the validity of this notion in this demographic. Leaders that exhibit transformational leadership actions boost the self-efficacy views of their followers. In addition, Bandura (1982) self-efficacy determinants provide a framework for comprehending the link between charismatic leadership and group efficacy. All of the consequences of the components were analysed to determine the extent of the conceptual model.

To answer Research Question 1, consider the following supporting hypotheses: Previous study identified the relevant assumptions and proved the existence of supporting evidence. The conceptual framework for study emphasizes the mediating roles of Technology adoption and Self-efficacy in the relationships between Transformational Leadership and Service Quality.

Individuals' self-efficacy beliefs are enhanced by leaders engaging in transformational leadership behaviors (Avolio & Bass, 2004). The positive relationship between transformational leadership and self-efficacy is empirically supported (Nielsen, Yarker, Randall, & Munir, 2009; Shamir, House, & Arthur, 1993; Walumbwa et al., 2008). Shamir et al. (1993) suggest that transformational leaders enhance self-efficacy. Similarly, regarding the concern about Internet use, high self-efficacy is positively associated with (a) willingness to choose and participate in computer-based activities, (b) expectations of the success of computer use, (c) perseverance when faced with computer use difficulties, and (d) computer-based performance (Eachus & Cassidy, 2006). Therefore, self-efficacy levels of nurses are a prominent issue of consideration for successfully developing and sustaining educational programs (Majid et al., 2011). In the surrounding healthcare service, staff members help patients access care by coordinating services, evaluating outcomes, and identifying social and environmental barriers to self-efficacy and self-management (Powers et al., 2017). The provider's ability to identify resources, track patient progress, and report outcomes is all in need. The providers in clinics practice with language congruency, cultural knowledge, and a philosophy of responsibility for patients' welfare, and social change, reflected in improved self-management and better patient outcomes. These expected as communication, participation, and social support were associated with performance improvement in self-efficacy behaviours. Self-efficacy is an essential element in the success of individuals in a variety of different settings. The proposed quantitative study assessed the applicability of the technology acceptance variable to explain primary healthcare leaderships' behavioural intentions to use digital health technology to meet their information needs and identify improvements in end-user usability.

The e-health system can improve safety and reduce patients' papers of the statement, and record-keeping can exist electronically, allowing health professionals to

concentrate on their duties. In particular, an electronic prescription (e-prescription) system allows them were eliminating errors from illegible handwriting. Whereas situation, social media in Thailand can define as “Social interaction through the use of applications on available tools, many of which are the Internet-based” (Jantavongso, 2013). These applications are available has online in the country, such as LINE, Facebook, Twitter, Instagram, and YouTube. Social media networks platform seminal relationships and create social networks. Therefore, the digital applications changed the approach patients, and health professionals communicate and how they have socialized. Hence, social media have become a vital component of the Primary Healthcare Units (PCUs) providers. As mentioned earlier, the number of 1,001 public hospitals and Primary Healthcare Units, 10,068 PCUs in the country have implemented some levels of Electronic Medical Records (EMRs) and Electronic Health Records (EHRs) on the works process (Kijsanayotin, Kasitipradith, & Pannarunothai, 2010). Consequently, this study to ensure Primary Healthcare acceptance of technology provision is an ongoing management challenge (Schwarz & Chin, 2007). That has an extent that Technology Acceptance adoption and diffusion research (Venkatesh, Morris, Davis, & Davis, 2003). In the literature associated with acceptance of new technology, Venkatesh et al. (2003) developed a unified model that brings together alternative views on user and innovation acceptance – The unified theory of acceptance and use of technology (UTAUT). Ward (2013) commented that the Unified Theory of Acceptance and Use of Technology (UTAUT) study live conducted in a public hospital. Settings, but mainly with administrative rather than clinical staff, the investigation rated perceived usefulness as significantly more important than perceived ease of use. The developed hypotheses concerning the effects of technology acceptance and self-efficacy mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit context.

Hence, the above theorizing and empirical evidence lead to the following hypothesis research regarding the extent to which technology acceptance and self-efficacy mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit. There were first dimensions of the hypothesis set that were distinguished: the set of aspects are descriptive; the theoretical test to determine

Hypothesis (H1a, H1b, H1c), to answer the research question RQ1 as follows, and Figure 1-2 and 1-3:

H1a: the positive effect to which self-efficacy mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit.

H1b: the positive effect to which technology acceptance mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit.

H1c: the positive effect to which technology acceptance and self-efficacy mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit.

To answer Research Question 2, consider the following supporting hypotheses: previous research mentioned the related assumptions and demonstrated such evidence as existing. The conceptual research framework focuses on the mediating roles of technology acceptance and self-efficacy in the relationships between charismatic leadership and service quality.

Bandura (1982) determinants of self-efficacy offer an approach to understanding the relationship between charismatic leadership and group potency. Bandura (1986) views expression of confidence as essential to convincing people that they possess the capabilities to master given tasks. By providing followers with clear visions of the future, high expectations for followers' performance, and displaying confidence in followers' ability (House, 1977). Charismatic leaders may be able to convince followers that they are capable of mastering given tasks, thereby enhancing followers' self-efficacy beliefs and subsequent performance. Therefore, charismatic leadership may be one source of verbal persuasion that influences individuals' self-efficacy beliefs. Charismatic leadership was a perceptual phenomenon. Charismatic leaders are adequate to the extent that they can communicate a vision of success to their followers (Conger & Kanungo, 1987).

A specific work performance done by individuals must be well-defined via the organizational leaders. According to certain charismatic features, leaders behave in admirable ways that cause users to identify with the leader to reach this matter. They may also result in an attitude of faith and respect between leaders and system users (Judge & Piccolo, 2004). The studies of Awamleh and Gardner (1999) looked only at attributions

of charisma as the outcome variable. Moreover, the single study to have looked at the effects of content (vision of quality and vision implementation) and delivery on follower outcomes (ratings of charisma, self-set goals, self-efficacy, task satisfaction, congruence of beliefs and values, and task performance) failed to effectively manipulate delivery (Shelley A Kirkpatrick & Locke, 1996). Neufeld, Dong, and Higgins (2007) also conducted a quantitative field study that integrated the Unified Theory of Acceptance and Use of Technology (UTAUT) with charismatic leadership theory to understand project champions' influence on user acceptance and use of large-scale IT projects in the manufacturing industry in Canada. The study examined only the charismatic, transformational leadership style as a determinant of large-scale global IT project implementation success. Hypotheses were formulated regarding the effect of these four variables on service quality. The above theorising and empirical evidence lead to the following research hypothesis regarding the mediating role of self-efficacy in the relationship between technology acceptance, charismatic leadership, and service quality. There were dimensions of the hypothesis set related to defining aspects. The theoretical is tested to determine Hypothesis 2 (H2a, H2b, H2c) to answer the research question RQ2 as follows, and Figures 1-4 and 1-5:

H2a: the positive effect to which self-efficacy mediate the relationship between charismatic leadership and service quality in Thailand's primary healthcare unit.

H2b: the positive effect to which technology acceptance mediate the relationship between charismatic leadership and service quality in Thailand's primary healthcare unit.

H2c: the positive effect to which technology acceptance and self-efficacy mediate the relationship between charismatic leadership and service quality in Thailand's primary healthcare unit.

1.5 Research Framework

The conclusion and collected postulated of previous research have to gather constructs in the conceptual model that could be applied to examine characteristics proposed from transformational leadership; charismatic leadership was an assumed to influence affecting service quality through both self-efficacy and technology acceptance. These are breakthroughs affecting service quality as a result. Therefore, according to the

conceptual model established by mediate variables, the following theoretical model was set up as displayed in figure 1-1. Meanwhile, Figures 1-2,1-3,1-4, and 1-5 illustrate the hypothesis of both the mediated effects. The relationships among variables were composite as exogenous constructs (transformational leadership, charismatic leadership, self-efficacy, technology acceptance) and endogenous (services quality).

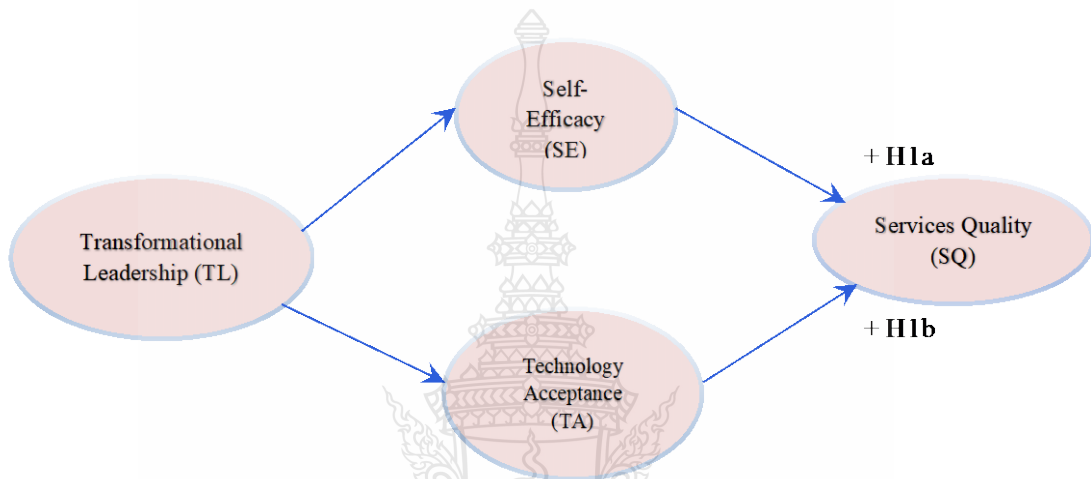


Figure 1.2 An illustration of the hypothesis (H1a, H1b): The conceptual research framework focuses on the mediating roles of technology acceptance and self-efficacy in the relationships between transformational leadership and service quality.

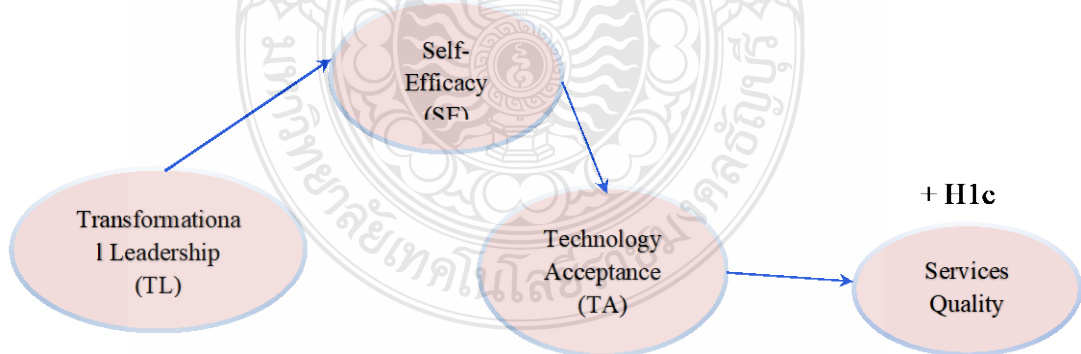


Figure 1.3 An illustration of the hypothesis (H1c): The conceptual research framework focuses on the mediating roles through Technology acceptance and Self-efficacy in the relationships between Transformational Leadership and Service Quality.

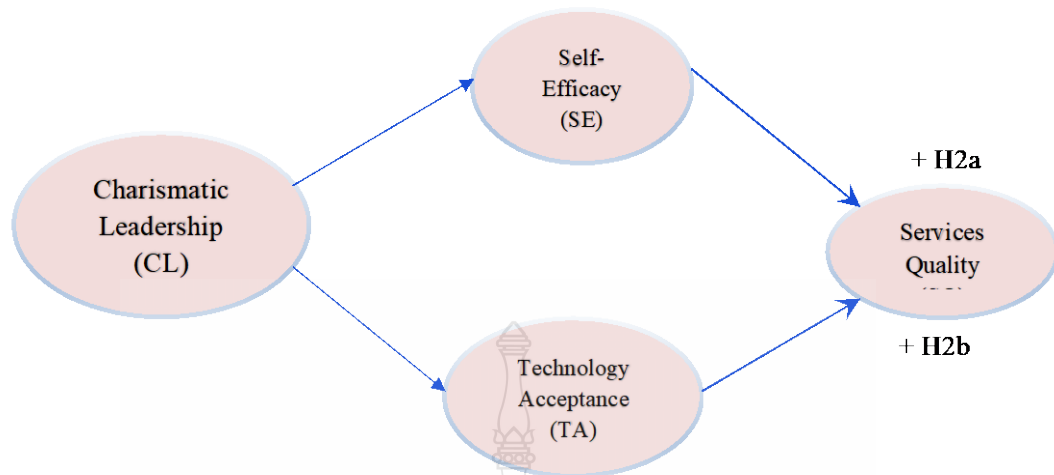


Figure 1.4 An illustration of the hypothesis (H2a, H2b): The conceptual research framework focuses on the mediating roles of Technology acceptance and Self-efficacy in the relationships between Charismatic Leadership and Service Quality.

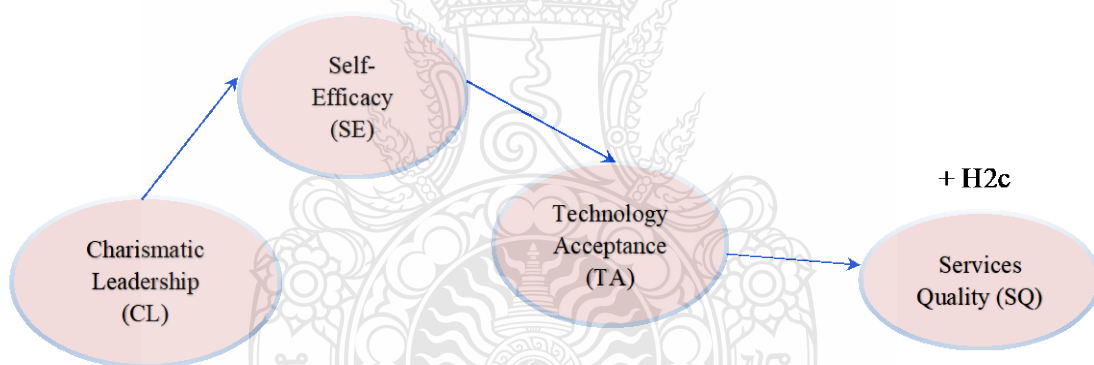


Figure 1.5 An illustration of the hypothesis (H2c): The conceptual research framework focuses on the mediating roles through Technology acceptance and Self-efficacy in the relationships between Charismatic Leadership and Service Quality.

1.6 Limitation of the Study

The investigation was limited, considering that the population conforming had a differential culture. Since the accuracy of the representative depends on the satisfaction and the honesty of participating in data collection. Only healthcare managers and leader officers have worked in primary healthcare services units of the public health across the Thailand area. The volunteer was asked to participate in the respondent questionnaire of

collected data. The questionnaire was written solely in Thai and translated back from the original English language. This mention limited study validity and reliability to ensure the robustness of research instruments. While a delimitation was geographic, the layout selected to conduct collected data was across the country, covering four regions of Thailand. Furthermore, among constructs were the only measurement with an evaluation instrument following the procedure listed in the research methodology as displayed in chapter 3.

1.7 Scope of the Study

The scope of the dissertation was limited to a proposed framework and finding to extend the body of knowledge regarding the association relationships among transformational leadership, charismatic leadership, self-efficacy, technology acceptance, and service quality. Therefore, service quality is services that were delivered progress via the extent of the subset. As the extent of affiliation with a place or doctor; first, contact-utilisation, first contact-access, ongoing care, coordination (referrals), coordination (information systems), comprehensiveness (service available), comprehensiveness (service provided), family-centeredness, community orientation, culturally competence, Insurance questions, and these are therefore of scope than the broader in field of Primary Healthcare Units quality. For a reason, broader in these areas have stood analysed. However, this study could be suitable for a services model applied to Primary Healthcare Units in public health in the era 4.0 policy Digital Economic context.

1.8 Definition of Terms

The essential terms are defined as follows in turn:

Healthcare quality is consistent with the degree of delivery to provide an increased outcome of quality in populations consistent with current professional knowledge (Lohr, 1990).

Health services is that identify effects on health, both physical and mental, that focus on preventing disease processes, promoting wellness, and rehabilitative and palliative healthcare, the statement by the Institute of Medicine (IOM) 1998.

Quality is defined “AS conformance to requirements; it is precisely measurable; error is unrequired to fulfil the laws of nature.”(Crosby, 1979).

Quality improvement. “The organized creation of beneficial change; improving performance to unprecedented levels” (Juran, 1992)

1.9 Organization of the Study

The organized outline from chapter one has been alignment body lists and describes the current state of era 4.0 policy in Thailand's Digital Economic context. Postulating implementation from the present state to the future is a mechanism for developing the national health system. Thus, the following items describe the problem of improving the service quality. Last, describing the association of the relationships among variables has distinctive significance and limitations in this research.

Chapter two conducts a literature survey on the five theoretical and primary healthcare service contexts. Researchers utilised in-depth study and synthesis of each concept and confirmed the relationships between exogenous, endogenous, and mediating variables. Finally, a table summarising the pertinent information was prepared to demonstrate how the conceptual model's several components fit together.

Chapter three provides setting quantitative research methodology that describes the research methodology used to cross-sectional. The research instrument discussed utilized the instruments, validated the reliability, and applied the structural equation modelling (SEM) to analyse and evaluate the survey data.

Chapter four describes the results of the analysis from chapter three. Besides, provide a graphical table, depiction of a conceptual framework, and exhibit research result as a descriptive statistical, reliable, and scale statistic of the constructs, structure equation modelling process, and hypothesis testing.

Chapter five is a definitive conclusion with the result of the investigation and discusses the use of the proposal to develop a framework. Finally, it presented implications for practice and theoretical suggestions for future research in this emerging field.

CHARTER 2

REVIEW OF THE LITERATURE

2.1 Introduction

This content review of the literature mentioned that the theoretical model consisted of an extensive literature review, presenting a collection of the feature of effecting that among each the constructs served to conceptual frameworks in the dissertation design to the proposed solutions. The concentration was on the definitions of terms and the theories of the mediating roles of Technology Acceptance and Self-Efficacy in the relationships among Transformational Leadership, Charismatic Leadership and Service Quality in Primary Healthcare provision.

The theoretical background to a comprehensive discussion of the subject matter provided on insights into the existing literature related to the effect of Transformational Leadership, Charismatics Leadership, on Services Quality. The study model provided the mechanism factors via self-efficacy, Technology Acceptance is the mediate factor that displays remarkable the mechanism that reinforces the conceptual framework are aim activity.

Practical leadership by healthcare professionals is vital in modern Primary healthcare units (PCUs) settings. The principles factor underpinning this is the drive to the Services Quality provision on a background of ever-increasing healthcare demands and the need for increased efficiency and productivity. There are many reasons why Services Quality improvement programs fail, however, the low self-efficacy of medical staff and their resistance to change to be negatively associated with (a) unwillingness to choose and participate in computer-based activities, (b) Hopeless of the success of computer use (c) Scarcely perseverance when faced with computer use difficulties, and (d) lack of computer-based performance. More engaged and willing to provide direct care when it needed amongst the most critical factors. Public Health Technical Officer and Nurses, who were acting leadership roles, need to overcome these barriers and adopt a style of leadership that is inclusive and meets the needs of patients.

Before deeply in theories and related literature. A brief leadership in healthcare has always been leaders inspiring future generations of Public Health Technical Officer

and Nurses, and academics. These leaders invariably viewed as highly charismatic but potentially also arrogant and unchallengeable in their decision-making processes. This leadership form is challenging to justify in modern healthcare settings where organizations comprise complex interactions between many patients and colleagues with multiple roles to fulfil.

Ultimately, a collective leadership approach, the new leadership approaches (including charismatic/transformational leadership), has emphasized the vision of the leaders, and they are inspirational. The charisma that cultivated loyalty and emotional attachment in the followers since the early 1980s, Bryman (1992) is most likely to create and sustain Services Quality. Thus, the review of the literature has served to examine the theory a more thorough understanding of how to achieve Services Quality excellence will likely be beneficial when analysing the study participants' responses and answering the research questions.

2.2 Primary Care

Modern primary care has lived executed integrated with enhanced access to health services, better health outcomes, and decreased hospitalization and emergency department services (Kane, Keckhafer, Flood, Bershinsky, & Siadaty, 2003). Previously decade, primary care concentrated on personal health care services and continuity of care. The curative of the past, "disease model" in several countries face changing rapidly. These are merging health, ageing, population growth, a rising burden of chronic, non-communicable diseases and multimorbidity, and technological advances are driving primary care transformation. These situations, demographic and epidemiological shifts require the primary care to provide on prevention proactive strategies to achievement quality of life and encourage that targets individuals and groups that are most affected by the structural determinants of primary health care, and these effectively required linking with public health (England, 2014).

Proactive primary care feature means that radical changes need to live created to the current service model, which includes integrating the backbone of public health functions and interventions into primary care services of any effective health system that aims for better population health. In many settings, proactively implementing primary

care officers has moved beyond individual-level work to the multi-assess and tackle structural determinants of disease at the local population level, housing, transport, and fruit and vegetables availability. Moreover, it holds extensive information about the local community's health profile, and professionals often develop a deep understanding of local social issues that drive illness. Thus, these analysing the leading causes of ill health at the practice population level, primary care can generate unique public health insights.

2.2.1 Definition of Primary Health Care Units (PCUs)

A concluded reference from “The 1978 International Conference on Primary Health Care”, defined as; “Essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community”. Through total participation cost, the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. Besides, it should be entirely dose integrated into the health service system of the country. The community's primary economic-political mechanism is accessible to people at household and office as well as possible.” Another definition of primary care, Barbara Starfield mention the need to reach to a health model that provides “the first level of contact with the health system to promote health, prevent illness, care for common illnesses, and manage on-going health problems” (Starfield, Shi, & Macinko, 2005).

2.2.2 Primary Health Care Units (PCUs) in Thailand

In the past four decade, Thailand of central issues of the “Charter for Health Development” in the 4th National Economic and Social Development Plan (NESDP, 1977 - 1981) and the National Primary Health Care Committee. Subsequently, Office of the Primary Health Care Committee, a division level within the Office of the Permanent Secretary, “Ministry of Public Health”, (Bureau of Policy And Strategy Office Of The Permanent ... (n.d.). Retrieved from <http://www.oalib.com/references/13543692>). They formed to carry out the primary health care mission, under the national health care plan, within the 4th - 10th NESDP (1978 - 2003). the Primary health care projects have then been processed to develop, generating its networks covering the whole country.

Due to socio-economic has changes and the government’s policy to reform the Thai bureaucratic system. One of the parts, the “Primary Health Care Divisions”, was set

up to replace the “Office of Primary Health Care Committee,” as ceased after the declaration of “Health for All” in 2000. A clear mission with holistic administration has existed conducted. The concept, “Health is People’s Right and Duty,” and the motto, “Take Health Promoting as first, Get Health Repairing Later,” place the strategy for implementation, primary health care. Played the role as a solid basis for the national health system, contributing to every village of the country. Reinforce of Village health volunteers of more than 1.04 million and multi-level of village health volunteer networks, have to “take-in-charge” their responsibility, to strengthen the health care system. They are creating people aware of themselves in health care as individuals, families, and communities.

The Sub-district (Tambon) as a service by Village Health Volunteers live in the community is the basement of the health service hierarchy in Thailand. The order consists of Health Centres, Community Primary Care Units. The District Health response to the challenges to the health system and the government's policy initiatives have been extensive and multi-dimensional and reflect extensively, of front-line comprehensive health providers 9,775 places of Primary health care service units across. In the workplace, they establish 3-5 officers for working to service patients included nurses, health workers, and public health professionals, without doctors in - charge. Furthermore, they are provided service patients to 11.8 million people on average per month or approximate 64.45 percentage of other healthcare services in Thailand. Moreover, in operations, Village Health Communicators (VHCs) and Village Health Volunteers (VHVs) responsibilities; To each village with an average size of 100 households, 10 VHCs and 1 VHV were assigned to “take-in charge” for their function (1 VHC for every 8 - 15 families and 1 VHV for 100 families). Each VHV also deserved themselves as a leader for the other VHCs. Since VHCs and VHVs played a role in the contribution of Primary health care toward target villages through community-based administration. Enough numbers of VHCs and VHVs with acceptable performance were crucial for getting primary health care's success during the decade.

Principle of Primary Health Care role, formulated to Implement in Thailand as follows: 1) Community Participation (C.I.), the people must share their collaborative activities through health care service, appoint themselves as owners of community’s

problems and village projects, and share their activities to solve the issues as well. 2) Appropriate Technology (A.T.) seeking conventional techniques or methods to be used and applied in primary health care works should be simple, suitable, and appropriate according to resources and people potential. 3) Basic Health Service (B.H.S.), the primary health care works in every village, must be approached to link with an available governmental health service system and set up an effective referral system. Finally, 4) Intersectoral Collaboration (I.C.) the primary health care are works must be carried out following extensive collaboration with authorities and officials from the Ministries of Public Health, Interiors, Education, and Agriculture and Cooperatives, and other governmental and private sectors.

2.2.3 Trend and Direction of Primary Health Care Units (PCUs)

Primary Health Care Division, as its authority to respond for primary health care of the country, on behalf of primary health care authority, leaders and personnel, related authorities and staff, who devoted themselves to support primary health care works, to be strengthened, sustainable, and progressed up the beyond future.

Primary health care service context had been changed according to the socio-economic situation, as shown its significant change in present time. In a further period up to the present, its development requires multi-sectoral collaboration, and VHV's responsibility has changed to be "Village Health Manager" and "Leader to Change Health Behaviour." It would purpose that the primary health care context would be changed again as affected by the Ministry of Public Health, responding which is in line with Thailand 4.0 policy and the digital economy. Digital-Health Strategy, emerging in 2017-2026, is one crucial step for Thailand to develop a system to raise the quality of healthcare services and a concrete implementation strategy. Digital Economy transformation strategy is an enormous change in society and afterwards exhibit a consistent emerging pattern of activities in all sectors. However, the primary health care service is always outstanding as the solid basis for the health system of the country, should be desired to adapt effectively by taking complete and creative advantage of digital technology in order to develop infrastructure, innovation, data capability, human capital, and other resources, with an understanding of these destructive way and development opportunities. Whereas the Ministry of Public Health serves as a framework for driving digital technology is a

mechanism for developing the national health systems, including paradigm shift, reforming of digital technology implementation via all sectors. Moreover, to provide the public with the wellbeing possible benefits and steadiness satisfaction in Thailand health care service. The equalization on the standard of human rights can access connected health care services with digital technology domain to utilize the public benefit and consistency in health care service setting.

2.3 Contextual Variable and Control Variable

Provided the controls variables apply to measure the influence of socio-demographic and variables related to tasks on five constructs variables included in the conceptual framework model. These control variables were age, marital status, education level, work experiences, current position, and type of task (Administrative works, Clinical works).

2.4 Leadership in Primary Health Care Units (PCUs)

Leadership is one of the active factors crucial in the modern healthcare setting to improve the service quality of provision on the nature rule of ever-increasing healthcare demands and the need for increased efficiency and productivity. Therefore, the effective leadership style by healthcare professionals and clinicians who assume leadership roles has adopted a style of leadership that is inclusive and meets the needs of healthcare professionals is transformational leadership and charismatic leadership behaviour style. Also defined in many different ways (Bass, 1990), but for this research, is the use of power, influence, and responsibility for the organization's success (Boyatzis, Smith, & Blaize, 2006). As mentioned above, it can be further refined by the theories of transformational, charismatic leadership.

2.4.1 Transformational Leadership

One of the definitions and theories of transformational leadership states that who will follow a leader who inspires them through vision, passion, and enthusiasm to the organization's common goal. These are about change, nature of change behaviour in the leadership, followership, an organization based on a mutually agreed-upon vision set by the leader and acted upon by the leader and followers (Brown & Posner, 2001). The

collected transformational leadership literature reviews from 1978 to the present, as examples in the emphasis on leaders who create change in deep structures, essential processes, or overall culture. A leader's mechanisms may be a compelling vision, brilliant technical insight, and charismatic quality. These are the material progress gathering from both academic and empirical, including Burns, House, Bass, and Conger.

In the last four decades of research, one theory on leadership has been developed extensively to show how it improves numerous in different kinds of organizations and individuals: the original piece began a model of transformational leadership theory by a political scientist (Burns & Leadership, 1978). Consequently, Bass (1985) took the initial theoretical of Burns (1978) as a foundation of a built a construct of transformational leadership theory. Transformational leadership has liked being capable of accomplishing something great by their ability to create a clear vision for others to follow. While, on the other hand, the transactional leaders were those who got the assigned task completed but did little more than meet the minimum expectations. To confirm the validity of this theory was vetted out and reviewed from several different perspectives (Bass, 1985).

Besides, these descriptive are characteristics of Transformational Leadership as organizational status change, new values, and vision towards the future that transcends the status quo create on trust, motivation, and commitment replaces self-interest with team spirit purposes, moral values, and ethics.

The initially theorized that seven components make up a transformational leadership, but after developing increased empirical study and consensus thought, agreed with others that the charismatic and inspirational pieces were closely aligned to draw the distinction, so the theory settled on six basic constructs that make up a transformational leader (Avolio, Bass, & Jung, 1999). Afterwards, those six constructs were again revised and increased to the seven outlined based on further study and reflection (Avolio & Bass, 2004; Bass & Riggio, 2006).

The first characteristic of transformational leadership is Idealized influence, which Bass & Riggio (2006) has summary as allowing the leaders to connect, be trusted, and be held in esteem with followers. Besides, the leader is perceived as fair and ethical. Therefore, they motivate followership to try to be like leadership. The leader looks as

being able to get the followership to endeavour for a common goal, based not only on words of leader say but inclusive what the leadership does as well.

Second, one of the common characteristics of transformational leadership is that the leader with inspirational motivation communicates with others in a clear vision of where they are headed (Bass & Riggio, 2006). For support, organizational strategy, this future state is intended to excite those around the leader to achieve the goals set and generate energy that will bring a team together (Atwater & Bass, 1994). Note, the closely aligned in the literature as Idealized influence and inspirational motivation have been merged in some locations to be called charismatic or inspirational leadership (Bass & Avolio, 1993). However, they are still considered separate constructs between an Idealized influence and an inspirational motivation (Bass & Riggio, 2006). Hence, they were measured in the Multifactor Leadership Questionnaire (Avolio & Bass, 2004).

The third, the following common characteristic of the transformational leadership factor is intellectual stimulation, in which the leadership employs this skill to spur followers to think in new and creative ways by challenging hypotheses, asking questions, and encouraging individual thought. The followers are challenged to always look for different approaches, and some failure, while they support trying something innovation, is considered a learning experience and an opportunity to try something else (Bass & Riggio, 2006).

Last, the four common characteristics of transformational leadership factors are Individualized consideration (Bass & Riggio, 2006). This factor of leadership theories was looking at employees as a cog in the overall organizational machinery (Fiedler & House, 1988).

Thailand Primary health care units (PCUs) have added further dimensions to healthcare leadership or healthcare manager, suggesting quantity domains of exceptional leadership capabilities. Moreover, another viewpoint, management and leadership, are understood as the capacity to guide the health institutions and mobilize stakeholders, organizations, and social groups.

2.4.2 The Charismatic Leadership

The charismatic leader has a character that is admired as supernatural by followers. This image of charismatic personality continues; charismatic leaders are

thought to be creative, trustworthy, respectful of others, self-sacrificing, risk-taking, and effective at communication (Sashkin, 1988). The revealed evidence strengthened during 1996 to current interest among researchers of charismatic leadership as Fuller, Patterson, Hester, & Stringer. Consequently, positive relationships between charismatic leadership and desirable outcome criteria have more interested in increased research in charismatic leadership in recent years. More one observes of the researchers has mentioned that charismatic leadership is due to its close relationship with Transformational Leadership theory (Hunt, 1991). Charismatic authority, in distinction, is understood to reside in the unique attributes or abilities of the charismatic leader. The social crisis was often seen as a necessary ingredient to the rise of charismatic leadership (Bass, 1990; Bryman, 1992; Hunt, 1991). While one of the most important contributions of leadership is articulating an inspiring vision (Awamleh & Gardner, 1999; Domm, 2001; Kouzes & Posner, 2002; Nanus, 1985). The Vision, an idealized, ambitious goal (Conger & Kanungo, 1998). It helps motivate followers by providing clarity and meaning to a follower's task. When followers perceive their job as meaningful, they will work hard to accomplish it. Nevertheless, one of the greatest mistakes leaders makes to not articulate a useful and inspiring vision (Kotter, 1996). Whereas Charismatic Vision is the power of vision is well documented in the overlapping areas of visionary transformational, and charismatic leadership (Conger, 1999; Conger & Kanungo, 1998). These areas also share a belief that some leaders have a special gift of effectively articulating a vision. These leaders have often been labelled charismatic, and their gift labelled charisma (Awamleh & Gardner, 1999; Conger & Kanungo, 1998; Den Hartog & Verbarg, 1997; Kouzes & Posner, 2002; Sashkin, 1988).

Notable, Charismatic leaders differ from other leaders in their ability to inspire followers with vision largely because of what their charismatic vision does. Correctly, able to description the charismatic vision as: (1), creates a supernatural and hero-like image of the leader, (2), heightens the inadequacy of the status quo, (3), promotes an attractive future vision that motivates followers to act, (4), develops collective identity, and (5), builds trust and self-esteem of followers by expressing a concern for and belief in followers (Conger & Kanungo, 1998). The charismatic vision is a critical reason charismatic leader has great influence and are observed to have charisma, an

extraordinary appearance, and presence attributed to charismatic leaders by their followers. Besides, charisma is commonly perceived as a non-verbal quality of exceptional leaders, and indicate, animated people are more likely to be perceived as charismatic (Kouzes & Posner, 2002). Which, other research suggests that people who are more energetic and physically expressive are perceived as more charismatic (Goleman, Boyatzis, & McKee, 2002). Consequently, some leading leadership theorists conclude that charisma best defined as “nonverbal expressiveness” (Cherulnik, Donley, Wiewel, & Miller, 2001; Kouzes & Posner, 2002). Moreover, the potential of characteristic, charisma is strongly related to speech (Fiol, Harris, & House, 1999). In Western society, especially, charisma is often associated with powerful speech (Bryman, 1992). Similarly, other research suggests that Den Hartog and Verburg (1997) found that charismatic rhetoric is a strong motivational aspect of top business leaders. Therefore, any useful definition of charisma must at least include verbal expressiveness.

2.5 Self - Efficacy

An evolution fundamental principle of Self-Efficacy, The social cognitive theory (self-efficacy) as an underlying behavioural conceptual framework advances that a predictor of individual behaviour and that enactive attainment and persuasion are two sources of self-efficacy (Bandura, 1986). That past, Bandura's (1986) social cognitive theory assigns a central role to the self-regulatory mechanisms which motivate behaviour. These mechanisms, self-efficacy is believed to transmit the influence from the environment and the individual's observations of the outcomes of past responses to subsequent behaviours. The fundamental theoretical model proposed by Locke, Cartledge, and Knerr (1970) explains how the various types of variables specified in formulations of goal-setting theory interact much in common with social cognitive theory's self-regulatory process. Dose, this cognition gives rise to an emotional reaction that drives goal setting and action. Besides, these did reveal, which proposed by Bandura's (1986) self-regulatory mechanism suggests that individuals use feedback about their previous work outcomes (existents) to formulate self-efficacy beliefs (cognition) and, depending upon their standards of performance (goals), decide how much effort to expend on a task in the future. Regrading, Self-efficacy involves “one's capabilities to

organize and execute the sources of action required to manage prospective situations” (Bandura, 1986).

Hence, the utilization of different coping strategies is affected by situational and individual variables, another variable significantly. Impacting the probability of completing a coping behaviour is individual self-efficacy. Therefore, self-efficacy is an individual’s belief in their ability to achieve or perform a task within a specific domain. In addition to the perceived ability to control environmental situations, lead to self-efficacy plays an integral role in regulating the effect (Bandura, 1997). Therefore, crucial four factors influence the development of self-efficacy: mastery experiences (balance of successes and failures in tasks), vicarious experiences (watching others similar to oneself perform and succeed in various behaviours), social persuasion (verbal persuasion about one’s capabilities), and positive mood enhancement and stress reduction (increasing efficacy at reducing stressors in life-changing situations). Self-efficacy and belief in one’s agency to control or influence their environment have been linked to well-being (Lent, 2004; Thompson, Kaslow, Short, & Wyckoff, 2002). While the definition of Self-efficacy on health as a component or construct of several health behaviours and health education theories that address individuals’ personal beliefs. They can perform a specific behaviour or action, or that they can overcome temptations, barriers, or negative behaviours created by others in their environment (Steffen, McKibbin, Zeiss, Gallagher-Thompson, & Bandura, 2002). The second construct of their study involved self-regulatory behaviours as the participants could be the failure to set goals or the inability to act on these goals. The last construct of their research dealt with outcome expectancies, as outcome expectancies are the expected results of physical activity. Furthers the concepts proposed by Bandura that self-efficacy beliefs can predict outcomes. Research determined a significant relationship between the three constructs and self-efficacy.

Self-Efficacy Among Health Professionals

Caregivers randomly assigned to a treatment group and a control group were exposed to a usual care setting and educated on adjusting their environment to simplify caregiver workloads and reduce stress. Social relationships enhance self-worth, self-esteem, and a sense of well-being when individuals feel valued by significant others (Miller et al., 2001). Including these researchers, Gitlin, Corcoran, Winter, Boyce, and

Hauck (2001) studied the effects of a home environmental intervention on self-efficacy and upset in caregivers and the daily function of dementia patients at sample numbers (N=171).

Among Health Professionals, it is distinctive's that individuals are more likely to engage and put forth more effort and persistence in activities. They have higher feelings of efficacy and are less likely to engage in those activities, for which they have fewer feelings of efficacy (Lenz & Shortridge-Baggett, 2002).

Similarly, Tang and Chen (2002) examined the health promotion behaviours of Chinese family caregivers for stroke patients. Regression analysis revealed the variable of caregiver's health status as the only positive predictor of caregiver self-efficacy. Satisfaction with social support was the strongest predictor of caregiver health promotion behaviour.

Besides, a study by Coon, Thompson, Steffen, Sorocco, and Gallagher-Thompson (2003), using skills training interventions for female caregivers of relatives with dementia from several samples 169. Those in anger and depression management groups showed significant reductions in levels of being anger Depression decreased significantly, while self-efficacy increased.

Regarding the concern about Internet use, high self-efficacy is positively associated with (a) willingness to choose and participate in computer-based activities, (b) expectations of the success of computer use, (c) perseverance when faced with computer use difficulties, and (d) computer-based performance (Eachus & Cassidy, 2006).

Nurses who have higher levels of self-efficacy appear to be more engaged and willing to provide direct care when needed (Fisher, 2006; Majid et al., 2011). Self-efficacy levels of nurses are a prominent issue of consideration for successfully developing and sustaining educational programs (Majid et al., 2011).

Evidence from researchers (Salanova, Lorente, Chambel, & Martínez, 2011) postulated that self-efficacy is the critical factor that influences nurses' extra-role performance through work engagement. Further argued that research has consistently demonstrated that nurses with high self-efficacy tend to view work problems as challenges that can solve through continued activity and effort—using self-efficacy in practice. Nurses could achieve a higher level of job satisfaction and work engagement. In

turn, they can have direct consequences for patients' status and quality of care. Based on the assessment, self-efficacy has systemic implications for the behaviour and action of nurses in a variety of clinical venues.

In the surrounding health care service, staff members help patients access care by coordinating services, evaluating outcomes, and identifying social and environmental barriers for self-efficacy and self-management (Powers et al., 2017). Whereas the provider's ability to identify resources, track patient progress and report outcomes all in need. The providers in clinics practice with language congruency, cultural knowledge, and philosophy of responsibility for patients' welfare, social change, reflected in improved self-management and better patients' outcomes. These expected as communication, participation, and social support were associated with performance improvement on self-efficacy behaviours. Self-efficacy is an essential element in the success of individuals in various settings.

2.6 Technology Acceptance

Currently, the Thai Primary Healthcare Units (PCUs) service has digitized its work processes. The e-health system can improve safety and reduce patients' papers of the statement, and record-keeping can be done electronically, allowing health professionals to concentrate on their duties. In particular, an electronic prescription (e-prescription) system allows them were eliminating errors from illegible handwriting. Whereas situation, Social Media in Thailand can define as "Social interaction through the use of applications on available tools, many of which are the Internet-based"(Jantavongso, 2013). These applications are available has online in the country, such as LINE, Facebook, Twitter, Instagram, and YouTube. Social media networks platform seminal relationships and create social networks. Therefore, the digital applications changed the approach patients and health professionals communicate and the ways they have socialized. Hence, social media have become a vital component of one of the Primary Healthcare Units (PCUs) providers in Thailand. As mentioned earlier, the number of 1,001 public hospitals and Primary Healthcare Units, 10,068 PCUs in the country have implemented some levels of Electronic medical records (EMRs)and Electronic health records (EHRs) on the works process (Kijsanayotin et al., 2010).

Besides, adaptive supporting change is critical for information processing systems; agility must extend into a digital ecosystem. These mentions lead to the design and represent digital systems, systems architecture Systems engineering needs to become a way of specifying reusable, reconfigurable, and scalable components that can be used and evolved into a digital ecosystem. It has referred to as evolution engineering (Bar-Yam, 2006). The information architecture must be resolved multiple representations and viewpoints of things both known and unknown and be able to adjust the evidence of understanding. However, digital ecosystems are known; they must be allowed to evolve and emerge. Supporting a digital ecosystem's self-organizing, interactive environment of a digital ecosystem will require agility members within the ecosystem - functions, interfaces, and data.

The technology acceptance systems in the Primary Health Care units (PCUs) services.

Midwives and other frontline health workers use smartphone medical applications, some relying on integrated sensors and accessories, to conduct the same tests of basic vitals and a host of point-of-care diagnostics. In the Primary Health Care units (PCUs) in Thailand, the smartphone postnatal care aimed to fill the gap in postnatal care for women and children in this region by enabling the visit to take place in patient homes, outside of the clinic, using an affordable, easy-to-use device, and without a highly trained medical professional. While the smartphone postnatal care visit represents a lower-tech variation on smartphone physical, they both embody a similar imagination of technological convergence across strikingly different contexts. The “smartphone physical” offers a typical example of a new Digital - health data instrument category that challenges institutions of the Primary Health Care units (PCUs) in Thailand and raises questions about the shape of data-intensive transformations in health.

Technology Acceptance can address inequities in Primary Healthcare Units (PCUs) systems and services in Thailand. Its applications across a wide range of Thailand areas such as ICT use ICT are as follows; 1) store, process, and transmit patient information. 2) manage the clinical, administrative, and financial information generated in health services facilities, 3) improve quality of patient care and patient safety, provide mechanisms for diagnostics and treatment between health professionals separated by

distance, 4) build capacity by offering health sciences training and continuing education courses online to students and health professionals, 5) provide innovative approaches for health care using rapid growing mobile devices, 6) make highly complex biomedical research achievable (Organization, eHealth, & eHealth, 2006).

Technology acceptance of Health interoperability in Thailand

The proposed quantitative study assessed the applicability of the technology acceptance variable to explain primary healthcare leaderships' behavioural intentions to use digital health technology to meet their information needs and to identify improvements in end-user usability. To harmonize the literature associated with acceptance of new technology, Venkatesh et al. (2003) developed a unified model that brings together alternative views on user and innovation acceptance – The unified theory of acceptance and use of technology (UTAUT).

According to Shultz and Hand (2015), the concept of usability was an essential but somewhat loosely defined aspect of consumer science, engineering, architecture, and technology, derived from the term “user-friendly.” The concept was generally used to describe systems and technology on digital health that are self-explanatory to untrained users (Shultz & Hand, 2015). Theoretical framework focuses on the influence of self-efficacy and facilitating conditions context on firms or organizations technology adoption. (Lee, Ramayah, & Zakaria, 2012). The users' assessment of the effort involved in technology use was directly related to their ability to use the relevant technology's functional elements. Lacka and Chong (2016) explained that the digital health user's effort in technology use was directly related to the user's ability to use relevant technology's functional elements, usability. Since digital health technology is applied, a better term would be technology usability. The former suggests that digital health technology use users' perception of new technology—usability use users' ability to use modern technology (its functional elements). Thus, the perception of effort involved in digital health technology is used to attain desired goals (Lacka & Chong, 2016).

The key variables are perceived usefulness (PU), perceived ease of use (PEOU), behavioural intention (BI), self-efficacy (SE), facilitating conditions (FC), influence perceived behavioural control (PBC), and actual use (AU) (Fathema, Shannon, & Ross, 2015; Iqbal et al., 2013). According to Turel, Serenko, and Giles (2011), PU was a

behavioural intention based on user experience with the system and was a predictor of behavioural intention. On the other hand, PEOU has a direct effect on behavioural intention: for instance, a user with limited experience may have higher intention to adopt the system because less effort is required (Johnson, Zheng, & Padman, 2014). Facilitating conditions refers to resources such as the Electronic Health Records, related hardware, software, and usability in expediting privacy-protection behaviours compatible with existing hardware and software in public healthcare (Iqbal et al., 2013). Behavioural intention is a behaviour control belief and links with the personal belief that the organization and technical infrastructure support the system's adoption (Turel et al., 2011). Perceived behavioural control refers to the perceptions of internal and external constraints on behaviour that has been widely assumed to predict an individual's behaviour in various disciplines (Iqbal et al., 2013).

According to Litwin (2011), contingency theory can explain when or under what organizational conditions employee involvement should be used to boost performance.. In additional, Patwardhan, Pandey, and Dhume (2014) added perceived usefulness (PU) and perceived ease of use (PEOU) as the two critical determinants. Patwardhan et al. (2014) defined behavioural intention (BI) as a person's relative strength of intention to perform a behaviour. Sackett (2014) added that this approach is equipped to respond with isolatable and presentable resolutions if medical emergencies occur. This standardization effort depends on the process used to engage proper support resources when patients are in a critical state. Buenestado et al. (2013) added that perceived usefulness (PU) indicates to what degree a person believes the information system will assist them in their job performance, while PEU demonstrates to what extent a person feels the proposed method is challenging to use. Ward (2013) commented that the Unified Theory of Acceptance and Use of Technology (UTAUT) study was conducted in public hospital settings. But mainly with administrative rather than clinical staff, and that the survey rated perceived usefulness (PU) as being significantly more important than perceived ease of use (PEOU). Therefore, the alternative measures solutions to service quality of primary healthcare unit incidents arising from primary healthcare leaderships' judgment.

2.7 Services Quality

The evidence wrote that accurate and precise diagnostic results result from the quality of service; a variety of models, such as Information technology adoption and expectation-confirmation, have been proposed to understand why users utilize and eventually adopt the technology. Information technology adoption focused on perceived usefulness and ease of use leads to technology adoption; these perceptions are related to user expectations about new technology. Quality is one's ability to achieve innate excellence (Schneider & White, 2004). Service quality is an organization's ability to meet customers' needs, wants, and expectations (Albrecht & Zemke, 2002; Edvardsson, Thomasson, & Ovretveit, 1994; Martin, 2003). The quality of service is the individual perceptions of the customer. Perceptions have formed over time, with customers basing their opinion on the experience, the service process, and delivery (Albrecht & Zemke, 2002; Zeithaml, Parasuraman, Berry, & Berry, 1990). The customer is the only person that can judge service quality (Zeithaml et al., 1990). Other quality indicators are often quantified to measure service excellence. However, it may limit service quality in areas that cannot be objectively measured, such as customer satisfaction. An objective measure may be best for measuring the technical component of service, whereas user-based judgments are best for measuring the quality-of-service delivery. Services should aim to meet customer requirements while preventing non-quality characteristics such as wasted time, delays, unsafe conditions, inessential service (Rosander, 1991).

2.7.1 Service Quality in Healthcare

Quality in healthcare systems can focus on many aspects of the system. The technical aspects of care, relationships between practitioner and patient, and the amenities provided are essential factors in a quality consideration (Andaleeb, 2001). Service quality in healthcare has been defined as the "provision of appropriate and technically sound care that produces the desired effect" (McAlexander, Kaldenberg, & Koenig, 1994). Moreover, more definition has come to include the delivery of the service and how it relates to customer needs and expectations (Self & Sherer, 1996). Measuring quality in healthcare has several benefits. Healthcare providers also benefit from examining the quality. Improving service quality may also impact the benefit, as patient and user satisfaction are directly related to service quality. Additionally, satisfying patients can

save money by reducing the number of resources spent on resolving customer complaints (Pakdil & Harwood, 2005).

2.7.2 Service Quality of Primary Healthcare Units (PCUs)

The generally related to customers' attitude based on their experience about service, as Zeithaml, Bitner, and Gremler (2003) described service quality as an agent who can impact guest satisfaction and thus can be of great help in realization for organizational goal. As further regarding in Primary Healthcare Units (PCUs) context, The World Health Organization (WHO) proposed a global goal to achieve primary care for individuals in all six domains established in the Institute of Medicine (IOM) Alma-Ata Declaration (1978). These six domains are first contact, longitudinal, comprehensiveness, coordination, person or family-centred, and community orientation. These six domains were agreed upon internationally and have proven useful to identify the breadth of primary care services in monitoring primary care quality since implementation (Forrest & Starfield, 1998; Franks & Fiscella, 1998; Organization, 2008; Starfield, 1998).

Primary Healthcare Units (PCUs) are distinguished from secondary care and tertiary care by duration, frequency, and intensity. Secondary care is typically short-term and involves sporadic consultation from specialists that offer expert opinions, surgically advice, and other advanced medical interventions. Tertiary care is the most sophisticated level of care and is required for extreme and specific conditions. Further, tertiary care is also institution-based, highly specialized, and technology-driven. Nevertheless, The Primary Healthcare Units (PCUs) are defined as health services that have been rendered by providers who act as principal consultants for patients within the healthcare system (Thomas-MacLean, Tarlier, Ackroyd-Stolarz, Fortin, & Stewart, 2014). While the Primary Healthcare Units (PCUs) providers are pharmacists, physician assistants, nurse practitioners, nurses (a common practice in the UK), a clinical officer (a common practice in parts of Africa), or traditional medicine professional (a somewhat standard practice in parts of Asia), traditionally, primary care has been crucial for ambulatory care services. Patients may or may not be referred for secondary or tertiary care, depending on the nature of the health condition.

2.7.3 Characteristics of Primary Healthcare Service Quality

Three elements from the WHO definition are particularly noteworthy to understand primary care: (1) point of entry, (2) coordination of care, and (3) essential care, which is as descriptive as follows.

Point of Entry

Primary Healthcare Units (PCUs) is the point of entry (i.e., first contact) for patients into the health care system. Healthcare delivery is organized around Primary Healthcare Units (PCUs) (Starfield, 1998). The first contact is closely associated with the gatekeeper role for the primary care practitioner (PCP). Gatekeeping implies that patients do not visit specialists and do not need admitting to a hospital without being referred by the primary care practitioner (PCP). Primary Healthcare Units (PCUs) should have located near a patient's home and workplace. Actual primary care is community-based in that it represents convenience and is easily accessible. These services must be widely available to urban, suburban, and rural communities for basic, routine, and inexpensive primary care services. Appropriate technology must also be incorporated into the delivery of primary care to avoid costly referrals to secondary and tertiary healthcare.

Coordination of Care

Primary Healthcare Units (PCUs) function is the coordination to deliver health care services between patients and various delivery components within the healthcare system. In addition to providing essential services, primary care professionals must serve as advisors, advocates, and system gatekeepers for patients. As coordinators, providers will refer patients to specialized sources for care, offer advice for various diagnoses and therapies, discuss treatment options, and provide continuing care for chronic conditions. Coordination of patient healthcare needs will ensure continuity and comprehensive coverage. Primary care goals can be achieved when patients and providers have formed a close, mutually beneficial relationship in time. The ideal system for healthcare delivery is based on Primary Healthcare Units (PCUs) but is also closely interlinked to adequate and specialized services. Regular and coordinated care requires certain secondary and tertiary services have to integrate with Primary Healthcare Units (PCUs), appropriate interaction, and consultation among physicians.

Essential Care

Primary Healthcare Units (PCUs) are crucial to healthcare. The goal of the healthcare delivery system is the optimization of population health, not just for those patients who have the means to access health services but for the entire population. Achieving this goal requires minimizing disparities across population subgroups to ensure equal access. Universal access to primary care services is better performed under a national healthcare program because healthcare financing is a crucial element that determines access to healthcare services. The lack of universal access to primary care services for countless millions is a pressing concern in Thailand.

2.7.4 The integrate of the Primary Healthcare Units (PCUs) of Service Quality

Balancing health needs, services, technology, and primary care is defined as provisions to integrate and access healthcare services from clinicians that address huge personal healthcare needs, develop a long-term partnership with patients, and practice within family and community (Starfield, 1998). Nevertheless, there are summarizes primary care characteristics service as:

First, Integrated care intends to encompass the provisioning of comprehensive, coordinated, and continuous services for a seamless care process. The integration combines events and information about events occurring in different settings and levels of care over time. The second following characteristic is functional, to services, comprehensive care addresses any health problem at any given stage of patient life cycles. The third characteristic is practical, to provide a combination of health services and information to ensure coordinated care and meet patient needs. Including the connection between services and including community resources. While, the fourth characteristic of continuous care refers to care over time by a single individual or team of healthcare professionals (known as clinician continuity) and capable and timely communication for health information, such as events, risks, advice, and patient preference (record continuity). Furthermore, fifth to provide accessible care is the ease at which a patient initiates interaction for a health problem with a clinician (e.g., by phone or at a medical facility), including efforts to eliminate barriers such as geography, administrative hurdles, financing, culture, and language among others. Moreover, the sixth characteristic

functional to provide Healthcare services are an array of functions performed by healthcare professionals to promote, maintain, or restore patient health. It includes all settings for care, such as hospitals, nursing homes, physician offices, intermediate care facilities, schools. The seventh characteristic functional regarding the role of Clinicians are individuals with the recognized scientific knowledge base, background, and authority to direct the delivery of health services to patients. The eighth characteristic functional as accountability, applies to primary care clinicians and the systems. These clinicians and policies are responsible to patients and communities to address the majority of personal health needs within a sustained partnership with the patient and for (1) quality of care, (2) patient satisfaction, (3) efficient use of resources, and (4) ethical behaviour. Consequently, a ninth of characteristics functional the majority of healthcare needs refer to essential primary care services that patients typically need to maintain health. Individual healthcare needs include physical, mental, emotional, and social problems that affect the normal functions of individual patients. Following the process, the sustained partnership refers to the relationship between patients and clinicians with mutual expectations over time. This relationship was based on developing mutual trust, respect, and responsibility. Therefore, in the eleventh function, a patient is defined as an individual who has interacted with clinicians. Because of actual or perceived illnesses, for health promotion, or prevention. The Lastly characteristic functional, the context of family and community, is an understanding of patient living conditions, family dynamics, and cultural background. Community is defined as the population served by the clinician. Additionally, community refers to geopolitical boundaries (city or region), members of specific health plans, or neighbours who share values, experiences, language, religion, culture, or ethnicity.

2.7.5 Services Quality Assessment for Primary Healthcare Units

Primary Health Care units were formed to serve primary health care's mission dimensions of quality generic and specific services that mainly established to serve people in a rural area, like a village or Tampon level, comprising of the prevention of the disease, health promotion, health treatment, and health rehabilitation. It needs deep collaboration from community and local people for planning, processing, and evaluating and the support from governmental health care authorities to provide knowledge, health

information, training activities, referral system, and necessary instruments. These instruments would initiate the beginning of community development by strengthening the community to solve their problems and managing their health care projects in collaboration with other sectors in the community as follows. Firstly, the primary health care units (PCUs) "Generic Dimensions" with four principles of 1) equitable distribution of health care, 2) community participation, 3) use of appropriate technology, and 4) multisectoral approach became the main context for primary health care units (PCUs) development in Thailand. Secondly, "Specific Dimensions" conclude an idea to formulate the Primary health care units (PCUs) developmental, comprising 1) committee, referred to villager's representatives 2) fund, referred to money resource as administered by community's committee, and 3) workforce, referred to villagers that would be able to handle PCUs mission in their village. In addition to the workforce, village health communicators (VHCs) and village health volunteers (VHVs), the typical model of community health workers in Thailand.

It proposed that service quality of care incorporates the structure, process, and outcomes. There were two distinguished dimensions of quality: *generic dimensions and specific dimensions*. Both of these are particular to primary care. *Generic Dimensions* (Campbell, Roland, & Buetow, 2000) that apply to all healthcare services are as follows: (1) accessibility of services, (2) clinical effectiveness, (3) interpersonal effectiveness.

Whereas *specific dimensions* for typical attributes of a primary care system include:

- (1) comprehensiveness having a broad range of curative and preventive services,
- (2) continuity of care having longitudinal care, and interpersonal continuity
- (3) coordination with other professionals and levels of care.

2.8 Related Constructs with the Hypothesis

This research is crucial to the Primary Healthcare Unit (PCUs) context. Thus, the previous research and literature review had supported the importance of high self-efficacy to the overall performance and productivity in computer software training (Gist et al., 1989). Although research and literature are abundant on self-efficacy in various

professions and industries, no investigation or literature could identify in the direct Technology Acceptance. Additionally, no analysis or literature could identify that calls for a study of this nature. The literature on self-efficacy in Thai primary healthcare (PCUs) is insufficient to suggest specific trends. Although researchers have made valuable contributions in describing and predicting self-efficacy in the practitioner's health care manager and leader, additional research is necessary to assess this concept in the healthcare manager and leader officer. The mere absence of data on self-efficacy and health-related behaviours demonstrates a compelling need to research this concept. The lack of research that replicates previous studies or utilizes consistent measures further leaves questions regarding the validity of the construct in this population.

2.8.1 The Mediating Roles of Technology Acceptance and Self-efficacy in the Relationships Among Transformational Leadership and Service Quality

First, focusing on cognition, which is central to this process in self-efficacy (SE), is the confidence in one's ability to execute the behaviours required to achieve the desired services quality (SQ) levels. The concepts of persuasion and enactive attainment as determinants of self-efficacy and behaviour (Bandura, 1986). These guided the selection of the Transformational and Charismatic leadership styles and task feedback as two potential antecedents of self-efficacy and improvement in performance services quality on a primary care services quality task.

Individuals' self-efficacy beliefs are enhanced by leaders engaging in transformational leadership behaviours (Avolio & Bass, 2004). The positive relationship between transformational leadership and self-efficacy has been empirically supported (Nielsen et al., 2009; Shamir et al., 1993; Walumbwa et al., 2008). The concepts of transformational leadership and self-efficacy ideas were examined closely. The transformational leadership theory of Bass suggests that five significant components of transformational leadership, idealized influence (attributes and behaviours), inspirational motivation, intellectual stimulation, and individualized consideration, are the factors that have their followers perform extraordinarily. In their effort to explain the effects of transformational leadership on the followers. Shamir et al. (1993) suggest that transformational leaders enhance self-efficacy and influence self-efficacy.

The develops hypotheses concerning the role of self-efficacy (SE) and Technology acceptance (TA) in mediating the relationship between Transformational Leadership (TL) and Services quality (SQ). The statement Bandura (1986) social cognitive theory assigns a central role to the self-regulatory mechanisms which motivate behaviour. Self-efficacy is believed to transmit the influence from the environment and the individual's observations of the outcomes of past responses to subsequent actions.

From the perspective of technology acceptance theory, information technologies are not entirely accepted when managers ignore factors such as the willingness and improved skills to applier technology acceptance of their employees and when an unsupportive atmosphere has been created (Hasan, 2003). However, leadership provides followers with self-efficacy (Kim & Beehr, 2017). In addition, senior management support (Hon, Bloom, & Crant, 2014). Which led to has been linked to performance and effort expectancies from the technology (Venkatesh et al., 2003). Similarly, these leaders can contribute to their followers' by changing their minds to become more open to technology acceptance, and as a result, by making them understand knowledge tools better (Kuo & Lee, 2011). Thus, propose a theoretical model that assumes that when followers perceive more supported by leadership behaviours, they intend to use them more because, based on the UTAUT, their performance expectation increases, and they find it more accessible, which enhances their knowledge creation, sharing, and application. It extends the UTAUT model and discusses its variables with serial mediation effects.

Hence, the above theorizing and empirical evidence lead to hypotheses research regarding the mediating role of self-efficacy and technology acceptance in the relationship between transformational leadership and service quality. The first dimensions of the related hypothesis set are distinguished: first set aspects are tested to determine hypothesis (H1a, H1b, H1c) and to answer the research question 1 (RQ1).

2.8.2. The Mediating Roles of Technology Acceptance and Self-efficacy in the Relationships Among Charismatic Leadership and Service Quality

The second hypothesis set, past further support for these antecedents, was found in the service quality management literature, which states that leadership style and task feedback obtained through employee involvement in the inspection of their work are

crucial determinants of continuous implementation (Deming & Edwards, 1982; Juran, 2003). The replication and modification from Shamir et al. (1993) have extended (House, 1977) earlier theory of charismatic leadership by explaining the mechanism whereby Charismatic leadership behaviours affect follower behaviours and attitudes. Specifically, charismatic leaders affect followers' emotions and self-esteem. Thus, they conclude that charismatic leaders increase followers' perceptions of self-efficacy by enhancing the followers' self-esteem and self-worth. Moreover, they imply that by trying, followers become not only part of a movement that is important and worthy but also powerful and effective (House & Shamir, 1993).

Likewise, past evidence concludes that charismatic leadership leads to self-efficacy (SE). Since the followers of charismatic leaders that influence subordinates' self-assurance and perceptions of self-worth, charismatic leaders also affect subordinates' self-perceptions of their ability to contribute to the mission of the unit (Smith, 1982). Qualitative comments from the participant's Followers of charismatic leaders report the higher intrinsic value of the goal, more heightened interest in the task, less role ambiguity, and more self-assurance than the followers of structuring and considerate leaders. Further, the experiment, Shelley Ann Kirkpatrick (1993) found that followers' quality self-efficacy beliefs mediated the relationship between vision manipulation and follower performance quality. As discussed above, self-efficacy cognitive can also be enhanced via verbal persuasion (Bandura, 1986). Is the support, according to an identity behaviour of charismatic leaders, is the ability to express confidence in followers' capability to meet performance expectations. Charismatic leadership, therefore, enhances followers' self-efficacy.

Existing theoretical research on the methods by which charismatic leaders influence their followers' performance reveals that charismatic leaders may have a favourable effect on the self-efficacy of their followers. This effect is anticipated to result from the charismatic leader's trust in the followers' capacity to satisfy demanding performance standards. Although there is no empirical support for this association, empirical data has been given indicating that self-efficacy mediates the relationship between the visionary part of charismatic leadership and the quality of follower performance. Thus, the preceding theoretical and empirical evidence indicates the need

for more research into the role of self-efficacy and technology acceptability as mediators in the relationship between charismatic leadership and service quality. These descriptive hypotheses are examined to establish whether hypothesis (H2a, H2b, H2c) is true, thereby contributing to the solution of RQ2.

Table 2.1 Summary of related research linking constructs of model

Author(s)	Variable related or Construct linkage	Purpose
Deming and Edwards (1982); Juran (2003)	The service quality (SQ) is related to leadership	Provides top-level managers with the specific, field-tested methods they need to successfully lead their companies on the quest for superior quality.
Shamir et al. (1993); House and Shamir (1993)	The charismatic leadership (CL) is related to transformational leadership (TL) demonstrates	Which these effects achieved; a self-concept based motivational theory to explain the process by which charismatic leader behaviours cause profound transformational.
Avolio and Bass (2004); Nielsen and Munir (2009); Nielsen et al. (2009); Shamir et al. (1993); Walumbwa et al. (2008)	The transformational leadership (TL) is related to self-efficacy (SE) The mediating effects of team and self-efficacy (SE) on the relationship between transformational leadership (TL)	The positive relationship between transformational leadership and self-efficacy has empirically supported "The mediating effects of team and self-efficacy on the relationship between transformational leadership, and job satisfaction and psychological well-being in healthcare professionals: A cross-sectional questionnaire survey."
Bass (1998); Shamir et al. (1993)		The effects of transformational leadership on the followers, That transformational leaders enhance the self-efficacy

Table 2.1 Summary of related research linking constructs of model (Cont.)

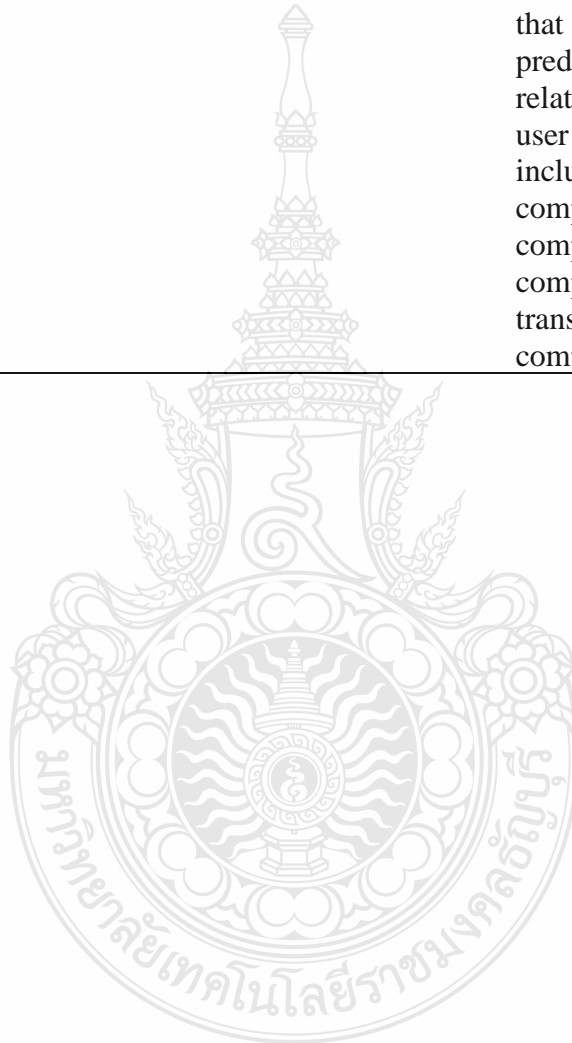
Author(s)	Variable related or Construct linkage	Purpose
Waldman et al. (1998)	The transformational leadership (TL) is related to Service Quality (SQ)	“Transformational leadership behaviours relevant to quality improvement efforts and managerial commitment were defined as an ongoing, yet flexible process”
Kouzes and Posner (2007)	The transformational leadership (TL) is related to Service Quality (SQ)	The model of transformational leaders provided followers the necessary support of the leader to motivate and engage individuals in quality processes.
Smith (1982)	charismatic leadership (CL) is related to self-efficacy (SE)	The impact of charismatic and non-charismatic leaders on follower self-esteem and affect.
Shelley Ann Kirkpatrick (1993)	quality self-efficacy (SE) beliefs mediated the relationship between charismatic leadership (CL) and follower performance quality (SQ).	charismatic and non-charismatic leaders on follower self-esteem and affect. that followers' quality self-efficacy beliefs mediated the relationship between vision manipulation and follower performance quality.
Bandura (1986)	Charismatic leadership (CL) is related to followers' self-efficacy (SE)	A social cognitive theory, charismatic leaders, is the ability to express confidence in followers' capability to meet performance expectations. Charismatic leadership, therefore, any enhance followers' self-efficacy.

Table 2.1 Summary of related research linking constructs of model (Cont.)

Author(s)	Variable related or Construct linkage	Purpose
McLees et al. (2015)	Technology acceptance (TA) is related to service quality (SQ)	Health information technology (IT) has capitalized on applications that improve the efficiency of healthcare operations and care delivery and has fostered greater innovation and collaborative care solutions to serve the needs of patients.
Abebe et al. (2013); Zhang, Yu, and Shen (2012)	Technology acceptance (TA) is related to service quality (SQ)	The telemedicine has extended the application of technology beyond retrieving patient data and supporting medical services and communication between patients and medical entities
Avancha, Baxi, and Kotz (2012); Shah, Murtaza, and Opara (2014)	Technology acceptance (TA) is related to service quality (SQ)	stated that quality, efficiency, and reduced costs are the results of using IT to improve health care.
Mishra, Anderson, Angst, and Agarwal (2012); Anthony and Campos-Castillo (2015)	Technology acceptance (TA) is related to service quality (SQ)	Electronic health records are expected to play a key role in improving the quality of US health care.

Table 2.1 Summary of related research linking constructs of model (Cont.)

Author(s)	Variable related or Construct linkage	Purpose
Howard (2014)	Technology acceptance (TA) is related to Self-Efficacy (SE)	it emphasized that efficient use of computers is a prerequisite for information literacy that computer self-efficacy predicts or moderate relationships between end-user and computer and includes variables such as computer phobia, computer anxiety, computer-based training transfers, and several other computer-related attitudes.



CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

This chapter contains a thorough research methodology on the mediating variables of technology acceptance and self-efficacy in the relationships between transformational leadership, charismatic leadership, and service quality in primary healthcare unit provision. It is typically undertaken in settings involving the leadership of information technology. The body of knowledge was applied to the provision of primary healthcare.

3.2 Research Design

The quantitative method used for these execution analyses shows how well leadership styles (including charismatic/transformational leadership), self-efficacy, and technology acceptance have been used to predict the dependent variable, service quality.

3.2.1 Population and Sampling

The criteria of service provision type, the total of the primary healthcare units is during service currently. They have allocated three classes from the total number of 9,775 places covering the country. As such, as the first type is a small size (S) that provides primary healthcare services and has a comprehensive scope, the population amounting to less than 3,000 persons per unit, placing the number of available services at 3,285 units, widespread in four regions of the country. Medium-sized (M) units provide primary healthcare services to more than 3,000 to 8,000 people per unit and are available on 5,403 units. The last type is a large size (L) that provides primary healthcare service covering the crowded population that amounts to more than 8,001 people per unit. There are 1,087 units broadly available across Thailand.

The numbers population is 1,278 persons consisting of the Public Health Technical Officer, Nurses 639 persons, and had separate data collected only services quality variable part from patient or customer 639 persons. The primary healthcare units are situated in the specified geographical group covering an area in Thailand.

Selecting a stratified multistage sampling process is an efficient sampling method. That combines stratified sampling and multistage sampling techniques. The way is based on grouping units into subpopulations called strata and then using a hierarchical structure of each layer's groups. In contrast, a simple random sample, the most straightforward sampling scheme, selects units from the population in one step. All groups in the people have an equal chance of selection, and the collections are independent. Of course, as with all sampling schemes, choosing the sample is still to make inferences about the population (Jain & Hausman, 2014).

Researchers consider the sample collected data location as the primary healthcare units situated in the specified geographical group covering an area in Thailand. The research goal is to assess the direct influencing effect on patients. They have received the primary health care unit services on service quality of the public health technical officer, nurses, transformational leadership, and charismatic Leadership style through a questionnaire. Researchers can form their sample group comprising 426 places, and the primary healthcare units consist of 3 types small (S), medium (M), and large (L) in the survey research. Classified the four-region, each region has selected mixed size type (S, M, L) 426 places are representatives per area, like the northern, the northeast, the central, and the southern. Multistage sampling is selected to use in studies. There are four stages to the implementation of sampling techniques in the following manner:

Firstly, choose the sample number of regions: the northern, the northeast, the central, and the southern, using quota sampling.

Secondly, choose the primary healthcare units established in the provinces. The province within each region uses the simple random sampling method. The northern has a number the established in 17 provinces; the northeast has the established in 19 provinces; the central area has the established in 21 provinces; and lastly, the southern has the established in 14 provinces. These are representatives of the province's layer.

Thirdly, choose the primary healthcare units to consist of 3 types are small (S), medium (M), and large (L) of the province within each region in the survey collected data. Classified the two places, each type has selected mixed size type (S, M, L). Numbers of the Primary Healthcare Units, 426 places are representatives per area from each district using the systematic sampling or quota sampling method.

It combines stratified sampling and multistage sampling techniques. Sampling is selecting a sufficient number of elements from the population. Understanding its properties or characteristics allows a study to generalize such features or attributes to population elements. To examine the effects of constructs relationships between transformation, charismatic leadership, self-efficacy, and technology acceptance, on service quality in the context of the primary healthcare units in the country.

3.2.2 Collected Data

At each place, healthcare managers and administrative employees who provided services in the Primary Healthcare Units (PCUs) were requested to complete a self-reported questionnaire on a 5-point Likert scale. The average score of respondents in a primary healthcare unit was used to account for the attitudes of members of the organization. The average score of all respondents in primary healthcare units was used to represent the attitudes of members of the organization using a quota sampling method. The research employs quota sampling to deliver reasonably accurate responses and represent different organizational positions. Hence, the respondents of each primary healthcare unit (PCU) comprised one public health technical officer, one nurse member, and one patient or customer. Simple random out of 98 of 426 PCUs selected for instrument pre-testing, the remaining population for data collection was equivalent to 328 places, with the number of respondents at 1,278. Using the Primary Healthcare Units (PCUs) as the unit of analysis, the average result score of all respondents in each PCU represents the individual organization.

Regarding the sample size, J. Hair, Black, Babin, Anderson, and Tatham (2010) suggested considerations and then obtained an adequate sample size number of 1,278 for the variables examined. Also, as a common rule, to have at least five times as many observations as the number of factors variables to be analysed, and the more acceptable sample size would have a 10:1 ratio. Thus, the quantity of population for the collected data is as follows in table 3-1:

Table 3.1 The population of collected data

Regions	Province	Numbers of the Primary Healthcare Units (PCUs)			Count of Data (N)	Percentage of Data %
		S	M	L		
Northern	Kamphaeng Phet	2	2	2	18	1.4%
	Chiang Rai	2	2	2	18	1.4%
	Chiang Mai	2	2	2	18	1.4%
	Tak	2	2	2	18	1.4%
	Nakhon Sawan	2	2	2	18	1.4%
	Nan	2	2	2	18	1.4%
	Phi chit	2	2	2	18	1.4%
	Phitsanulok	2	2	2	18	1.4%
	Phetchabun	2	2	2	18	1.4%
	Phrae	2	2	2	18	1.4%
	Mae Hong Son	2	2	2	18	1.4%
	Lampang	2	2	2	18	1.4%
	Lamphun	2	2	2	18	1.4%
	Sukhothai	2	2	2	18	1.4%
	Uttaradit	2	2	2	18	1.4%
	Uthai Thani	2	2	2	18	1.4%
Phayao	2	2	2	18	1.4%	
	Total	34	34	34	306	23.94 %
Northeast	Kalasin	2	2	2	18	1.4%
	Khon Kaen	2	2	2	18	1.4%
	Chaiyaphum	2	2	2	18	1.4%
	Yasothon	2	2	2	18	1.4%
	Nakhon Phanom	2	2	2	18	1.4%
	Nakhon Ratchasima	2	2	2	18	1.4%
	Buri Ram	2	2	2	18	1.4%

Table 3.1 The population of collected data (Cont.)

Regions	Province	Numbers of the Primary Healthcare Units (PCUs)			Count of Data (N)	Percentage of Data %
		S	M	L		
	Maha Sarakham	2	2	2	18	1.4%
	Roi Et	2	2	2	18	1.4%
	Loei	2	2	2	18	1.4%
	Si Sa Ket	2	2	2	18	1.4%
	Sakon Nakhon	2	2	2	18	1.4%
	Surin	2	2	2	18	1.4%
	Nong Khai	2	2	2	18	1.4%
	Udon Thani	2	2	2	18	1.4%
	Ubon Ratchathani	2	2	2	18	1.4%
	Mukdahan	2	2	2	18	1.4%
	Amnat Charoen	2	2	2	18	1.4%
	Nong Bua Lam Phu	2	2	2	18	1.4%
	Total	38	38	38	342	26.77%
Central	Samut Prakan	2	2	2	18	1.4%
	Nonthaburi	2	2	2	18	1.4%
	Patum Thani	2	2	2	18	1.4%
	Ayutthaya	2	2	2	18	1.4%
	Ang Thong	2	2	2	18	1.4%
	Lopburi	2	2	2	18	1.4%
	Singburi	2	2	2	18	1.4%
	Chainat	2	2	2	18	1.4%
	Saraburi	2	2	2	18	1.4%
	Chachoengsao	2	2	2	18	1.4%
	Prachinburi	2	2	2	18	1.4%
	Nakhon Nayok	2	2	2	18	1.4%

Table 3.1 The population of collected data (Cont.)

Regions	Province	Numbers of the Primary Healthcare Units (PCUs)			Count of Data (N)	Percentage of Data %
		S	M	L		
	Maha Sarakham	2	2	2	18	1.4%
	Roi Et	2	2	2	18	1.4%
	Loei	2	2	2	18	1.4%
	Si Sa Ket	2	2	2	18	1.4%
	Sakon Nakhon	2	2	2	18	1.4%
	Surin	2	2	2	18	1.4%
	Nong Khai	2	2	2	18	1.4%
	Udon Thani	2	2	2	18	1.4%
	Ubon Ratchathani	2	2	2	18	1.4%
	Mukdahan	2	2	2	18	1.4%
	Amnat Charoen	2	2	2	18	1.4%
	Nong Bua Lam Phu	2	2	2	18	1.4%
	Sa Kaeo	2	2	2	18	1.4%
	Ratchaburi	2	2	2	18	1.4%
	Kanchanaburi	2	2	2	18	1.4%
	Suphanburi	2	2	2	18	1.4%
	Nakorn Pathom	2	2	2	18	1.4%
	Samut Sakhon	2	2	2	18	1.4%
	Samut Songkhram	2	2	2	18	1.4%
	Phetchaburi	2	2	2	18	1.4%
	Prachuap Khiri Khan	2	2	2	18	1.4%
	Total	42	42	42	378	29.58%
Southern	Krabi	2	2	2	18	1.4%
	Chumphon	2	2	2	18	1.4%

Table 3.1 The population of collected data (Cont.)

Regions	Province	Numbers of the Primary Healthcare Units (PCUs)			Count of Data (N)	Percentage of Data %
		S	M	L		
	Trang	2	2	2	18	1.4%
	Nakhon Si Thammarat	2	2	2	18	1.4%
	Narathiwat	2	2	2	18	1.4%
	Pattani	2	2	2	18	1.4%
	Phangnga	2	2	2	18	1.4%
	Phuket	2	2	2	18	1.4%
	Yala	2	2	2	18	1.4%
	Ranong	2	2	2	18	1.4%
	Songkhla	2	2	2	18	1.4%
	Satun	2	2	2	18	1.4%
	Surat Thani	2	2	2	18	1.4%
	Total	28	28	28	252	19.71%

Another critical step is gathering data from the public health Technical Officer, Nurses who worked in the PCUs. Also, including the patient who has to visit treatment at PCUs. The survey instrument has been developed and revised. From ninety-eight completed questionnaires formed a data set during the pilot-testing process. Then one month before starting the data collection process, all respondents in the PCUs received a letter describing the purpose of the study and the directions for filling in a survey. Participating organizations provided addresses for the prospective participants to communicate directly. An informed consent letter was emailed to each participant as an introduction to the survey instrument, and it highlighted confidentiality and risks faced by respondents in the conflict of the current study. An electronic copy of the survey responses from the respondents has retained for a minimum period of 1 year, and then it was destroyed. Confidentiality has been maintained by heightening confidentiality, all respondents coded during the analysis, and participants' anonymity. Respondents were to

return the completed survey within a couple of weeks, while a follow-up email was sent to those who had not yet completed the survey—a cut-off date of 30 days from the study's established date.

3.2.3 Research Instruments

The research instrument is this survey questionnaire, consisting of five sections the first handles the respondents' demographic and personal information. The biographical data involve gender, age, educational level, years of service in the specified organization, and position. The second part was a request as an attitudinal response to transformational and charismatic leadership. Then the third section regards an attitudinal reaction to self-efficacy. Next, the fourth section requires an attitudinal response to technology acceptance. The fifth section primarily focuses on an attitudinal response to service quality. The primary healthcare units fit in the final part.

Measurement of exogenous variables

Transformational, and charismatic leadership Instrument;

Transformational leadership uses the MLQ 5-X (Bass & Avolio, 2000). This test has outstanding psychometric qualities and assesses the five components of transformational leadership: inspiring motivation, idealized influence ascribed, idealized influence conduct, intellectual stimulation, and individualized consideration. In addition, charismatic leadership is evaluated based on five factors: environment sensitivity, member requirements responsiveness, tactics, vision, articulation, personal risks, and unusual behaviour. The instrument is used to evaluate adaptability based on the Conger and Kanungo Scales (CKS; Conger & Kanungo, 1998). Thus, these instrument scales were meticulously translated from English to Thai by an expert in organizational psychology and then back to English by a native English speaker (Behling & Law, 2000). On a 5-point scale, participants ranked the opinion of leaders' actions as "1" for "disagree" and "5" for "strongly agree." The subscale values indicate the unweighted means of the various items, whereas the combined measures are ten items for the research instrument.

Measurement of Endogenous Variables

Self-Efficacy Instrument;

Self-Efficacy Instrument: Self-Efficacy Instrument: The General Self-Efficacy Scale (GSE); Self-efficacy Assessment by Schwarzer, Jerusalem, Weinman,

Wright, and Johnston (1995) based on the work of Bandura and Walters (1977) social cognitive theory. The measurement scale was designed to assess a general sense of perceived self-efficacy to predict coping with daily hassles and adaptation after experiencing stressful life events. The self-efficacy instrument scale is the ideology that performs new or challenging tasks or copes with adversity in various domains of human functioning, perceived facilitates goal-setting, effort investment, persistence in the face of barriers, and recovery from a setback. It can regard as a decisive resistance resource factor. The measuring items consist of ten items designed to be co-adhesive with a construct. However, perceived self-efficacy is unidimensional as an operative construct related to subsequent behaviour and behaviour change. Hence, this research tool is a standardized ten questions that measure responses to the following statements. These are based on a five-point Likert-type assessment of intrinsic intention: e.g., (1) “I can always manage to solve difficult problems if I try hard enough”; (2) “If someone opposes me, I can find means and ways to get what I want.”

Technology Acceptance Instrument;

Technology Acceptance Instrument: The Unified Theory of Acceptance and Use of Technology (UTAUT) was formulated with four core determinants of intention and usage. UTAUT thus provides for managers needing to assess the likelihood of success for implementing new technology (Technology Acceptance) introductions and helps them proactively understand the drivers of acceptance to design interventions (including training and practical). Assess the intention of targeted populations of users who may be less inclined to adopt and use new systems. The dominant influences studied here are refining the measurement of the core constructs used in UTAUT and understanding the organizational outcomes associated.

A survey instrument was created with items validated in prior research and adapted to the technologies and organizations studied. Of these, we theorize that four constructs will play a substantial role as direct determinants of user acceptance and usage behaviour: performance expectancy, effort expectancy, social influence, and facilitating conditions. As explained below, attitude toward using technology, self-efficacy, and anxiety is theorized not to be direct determinants of intention. Ward (2013) commented that the Unified Theory of Acceptance and Use of Technology (UTAUT) study was

conducted in public hospitals. However, mainly with administrative rather than clinical staff, the survey rated perceived usefulness (PU) as significantly more important than perceived ease of use (PEOU). Therefore, the alternative measures solutions to the service quality of primary healthcare unit incidents arising from primary healthcare leadership's judgment. Hence, this research tool is a standardized 24-question scale that measures responses to the following statements. These are based on a five-point Likert-type assessment: e.g., (1) "I would find the digital data and social networking system useful in my job"; (2) "I intend to use the digital data and social networking system in the next one months."

Service - Quality Instrument

Service - Quality Instrument: This study has decided to use the PCAT for the following reasons: 1) PCAT has a set of tools designed to assess facilities and systems performance from the perspectives of patients and providers. A foundation for our efforts was built to explore future multidimensional influences on primary healthcare unit service quality. 2) The design of PCAT strictly parallels the definition of primary healthcare promoted by the WHO, which is widely accepted in developing countries. Its consistency with the core attributes of primary care provides a valuable scale structure and taxonomy applied to Thailand. 3) It is theoretical and scientifically practical.

The questionnaire-derived measures in core domains of primary healthcare units successfully represent the primary care scales (Cassady et al., 2000; Flocke, Miller, & Crabtree, 2002; Safran et al., 1998). However, affirmation of the PCAT adult version has been repeatedly used and validated worldwide and complies with primary care's internationally agreed-upon core attributes of primary care. Each domain applies several questions (ranging from 3 to 24) and thus secures the comprehensiveness of measurement. It is a reliable tool to evaluate primary care quality, as indicated in the previous sections' introduction to the PCAT. However, the instrument's validity can be a concern given cultural differences in accessing healthcare between the US and China, which internal validity addresses the "adequacy and accuracy" (AA) of design in "demonstrating an association relationship between the independent variables and dependent variables" while "ruling out." confounding variables. Hence, this research tool is a standardized 36-question scale that measures responses to the following statements.

These are based on a five-point Likert-type assessment: e.g., (1) "The Primary Healthcare Units that you usually go if you are sick or need advice about your health"; (2) "When needing a regular general check-up, you do go to the Primary Healthcare Units before going somewhere else." (3) When the Primary Healthcare Units closed, is there a phone number can call when you get sick.

3.2.4 Operational definitions of Construct and Measurements

As indicated in the literature review, latent variables, transformational leadership and charismatic leadership, self-efficacy, digital health, and service quality are relevant theories for each operational definition of the constructs, allowing the constructs to be objectively tested by the research. Thus, the purpose of observable variables is to ensure consistent data for statistical analysis and measurements to develop a valid, dependable, and helpful instrument. The following tables summarize each variable.

Table 3.2 The measures model of exogenous and endogenous constructs

Model	Latent variables and definitions	Operational definitions
Operational		
Exogenous	<p>Transformational leadership. There is about change —change in the leader, follower, an organization based on a mutually agreed-upon vision set by the leader and acted upon by the leader and followers (Brown & Posner, 2001). Change behaviours can happen, depending on the leader’s abilities and skills.</p> <p>Charismatic leadership is the leadership that emerges from a well-articulated vision that exerts powerful effects on the followers so that they follow the leader intentionally to a stated organization’s vision (Bass, 1990).</p>	<p>Inspirational motivation (IM). Idealized influence attributed (IIa) Idealized influence behaviour (IIb) Intellectual stimulation (IS) Individualized consideration (IC)</p> <p>Sensitivity to the Environment (SE) Sensitivity to Members' Needs (SMN) Strategic Vision and Articulation (SVA) Personal Risk (PR) Unconventional Behaviour (UB)</p>

Table 3.2 The measures model of exogenous and endogenous constructs (Cont.)

Model	Latent variables	Operational definitions
Operational		
Endogenous (mediation)	Self-Efficacy is a predictor of individual behaviour and that enactive attainment and persuasion are two sources of self-efficacy (Bandura, 1986). Technology Acceptance dose formulated with four core determinants of intention and usage. UTAUT thus provides for managers needing to assess the likelihood of success for implementing new technology introductions and helps them proactively understand the drivers of acceptance to design interventions (including training and practical).	facilitates goal setting effort investment persistence in the face of barriers recovery from setbacks performance expectancy (PE) effort expectancy (EE) attitude toward using technology (AT) social influence (SI) facilitating conditions (FC) Self-efficacy (SEF) Anxiety (AX) Behavioural intention to use the system (BI)
Endogenous	Service quality is the ability of an organization to meet the needs, wants, and expectations of the customer (Albrecht & Zemke, 2002; Edvardsson et al., 1994; Martin, 2003). Besides, one more definition, the quality of service is the individual perceptions of the customer. These perceptions formed over time, with customers basing their opinion on experience, the service process, as well as service delivery (Albrecht & Zemke, 2002; Zeithaml et al., 1990).	The extent of affiliation with a place/ Public Health Officer or nurse (EA) First contact-utilization (FCU) First contact-access (FCA) Ongoing Care (OC) Coordination (CO) Coordination (Information Systems) (CIS) Comprehensiveness (services available) (CSV) Comprehensiveness (services provided) (CSP) Family-Centeredness (FCN) Community Orientation (CMO) Culturally Competent (CC)

3.3 Validity and Reliability Measurement

Both major principles in methodology research — the assessed for validity and reliability, for measuring the latent variables based on the previous literature. The validity and reliability of among constructs on the composition be for a conceptual framework to study.

3.3.1 Pre-testing of questionnaire surveys

To assert the validity and reliability of the data collected from the pilot-test implementation period. It gathers attribute data that reflects the conceptual framework model and what the researcher affirms to measure its trust in questionnaire validity. Consistency of the measurement proved through the Cronbach alpha coefficient has a score above 0.7.

Accordingly, pilot testing was conducted. From the Primary Healthcare Units, mixed sizes (S), (M), and (L) were randomly chosen out of a total of 426 places so that the pilot-test settings shared the same character with the population of the study. Preliminary pilot questionnaires distributed to ninety-eighth officials in positions of healthcare managers and administrative employees to services in the primary healthcare units (PCUs) has established in the central region area are described by these the province as follows in table 3.1, the population of collected data. Ninety-eight complete questionnaires were returned after those with missing data were sorted out and excluded from the study. So that the 30 primary healthcare units mixed size (S), (M), (L) executing pilot- testing shared with the rest of the collection of the population of 98 people. This pilot testing played a significant role in material improvements by adding new items, removing words that resulted in ambiguity, adjusting terms to fit the healthcare context, and adopting common terminology to enrich understanding.

3.3.2 Validity Test and Factor Analysis

Cooper and Schindler (2003) have defined "Construct Validity" as the degree to which an instrument measures the trait or theoretical constructs it is trying to measure. This seems pretty straightforward. Also tested construct validity with confirmatory factor analysis (CFA), average variance extracted (AVE), and discriminant validity (DV) in order.

The following measurement process, factor analysis, is conducted step by step. Factor analysis applies an analytical method by the statistical software package tool that reduces the number of variables into smaller sets of factors to measure the constructs in which the researcher is interested effectively. The high value of factor loading affirms congruity between the measuring tool and the hypothetical construct. Loadings of 0.5 and above are acceptable for larger samples for exploratory analysis (J. Hair et al., 2010).

3.3.3 Reliability and Scale Statistics of Constructs from the pilot test

Pallant (2005) states that it is vital to find reliable scales. A standard indicator of internal consistency is Cronbach's alpha coefficient, for which J. F. Hair, Anderson, Tatham, and William (1998); Jum Nunnally (1978), suggestion a minimum value of Cronbach's alpha coefficient of 0.7 or 0.6 in the exploratory research. Thus, the reliability of instruments for each construct is descriptive and display as follows table 3-3

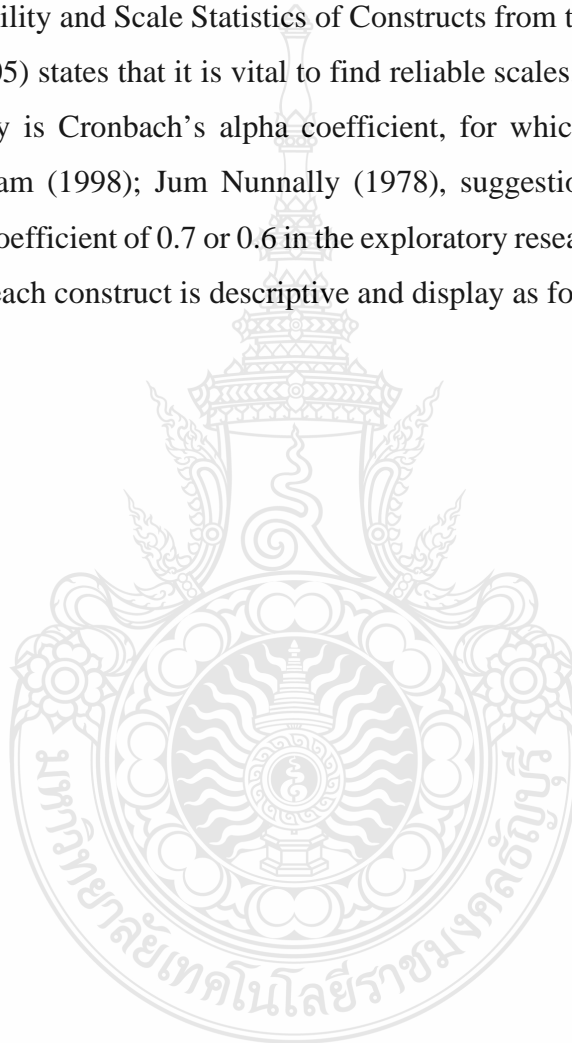


Table 3.3 Means, Standard deviations, and reliabilities of the pilot study (N=98)

Exogenous & Endogenous Variable	Reliability	Summary Item Statistics					
	Statistics Cronbach's Alpha	Mean	Minimum	Maximum	Range	Variance	N of Item
Transformational leadership (TL)	.931	5.642	5.449	5.969	.520	.019	10
Charismatic leadership (CL)	.950	5.519	5.194	5.765	.571	.027	18
Technology Acceptance (TA)	.943	5.457	4.724	5.918	1.194	.092	24
Self - Efficacy (SE)	.948	5.659	5.429	5.867	.439	.017	10
Service Quality (SQ)	.976	5.709	4.923	6.077	1.154	.053	36

3.4 Sequence of Data Analysis

Statistical software package utilized for the analysis of the data collected. The data analysis section has been divided into three parts consequently examined as below:

3.4.1 Descriptive Statistics Analysis

The first part of the analysis of demographic findings. Which apply descriptive and inferential statistical methods are used to analyse demographic data. Thus, the current study utilised the sample demographics to include the participant's ages, educational attainment, and length of service. In part, descriptive statistics analysis as Cronbach's alpha measures instrument reliability and kurtosis statistics to measure data normality with skewness.

3.4.2 Confirm Factors Analysis (CFA)

The second part is applied to demonstrate the confirmatory common factor analysis. Factor analysis attempts to determine which set of observed variables share common variance-covariance characteristics that define theoretical constructs of factor (latent variables). Confirmatory factors analysis of a measuring instrument is most appropriately applies to measures that have fully developed and their (Byrne, 2010). This study was comprehensive information data and applied by first-order factor analysis to examine the factors' transformation leadership, charismatic leadership, Self-Efficacy, Technology Acceptance, and Service – Quality. The model presented here is a common factor analysis model. The among common factors (unobserved variable), transformation leadership, charismatic leadership, Self-Efficacy, Technology Acceptance, and Service – Quality, are allowed to be correlated.

3.4.3. Structure Equation Model (SEM)

The third part involves hypothesis testing. The Structural Modelling Equation (SEM) conducted for each construct shows from a quantitative perspective whether transformation leadership and charismatic leadership behaviours can be positive predictors of service quality through self-efficacy, Technology Acceptance.

The analysis methodology intends to compare and examine influencing the pathway among variables Transformational Leadership and Charismatic Leadership to affect Services Quality, mediating roles through Self-Efficacy and Technology

Acceptance. The theoretical model displayed in Figures 3.1, 3.2, 3.3 and 3.4 to answer the research question be converted into two hypotheses.

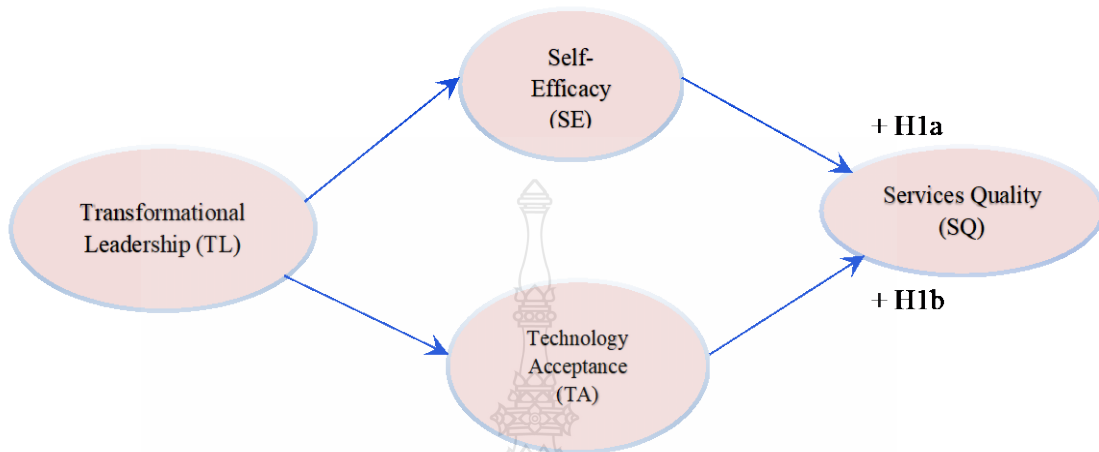


Figure 3.1 An illustration of the hypothesis (H1a, H1b): The conceptual research framework focuses on the mediating roles of Technology acceptance and Self-efficacy in the relationships between Transformational Leadership and Service Quality.

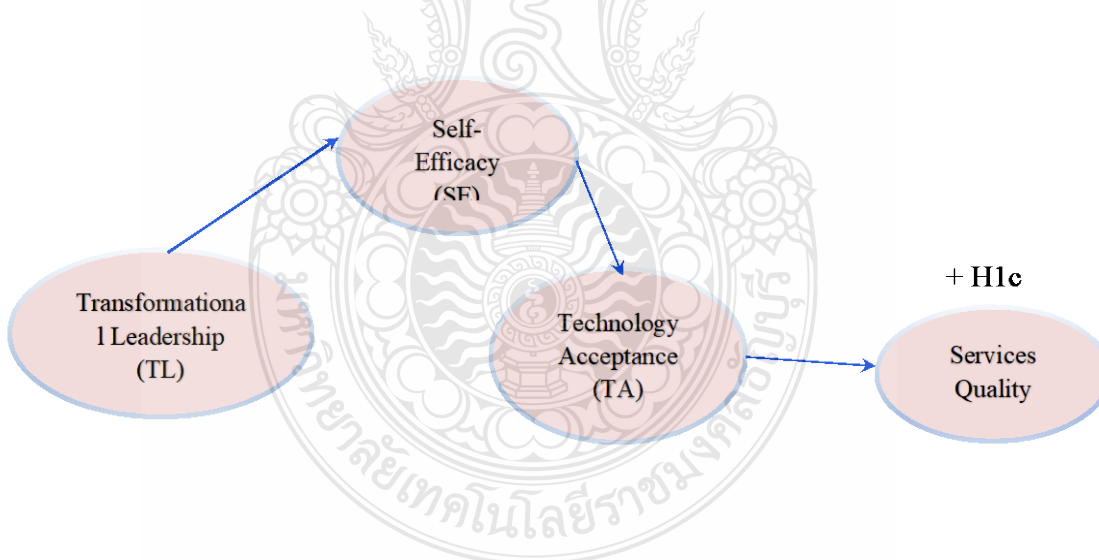


Figure 3.2 An illustration of the hypothesis (H1c,): The conceptual research framework focuses on the mediating roles through Technology acceptance and Self-efficacy in the relationships between Transformational Leadership and Service Quality.

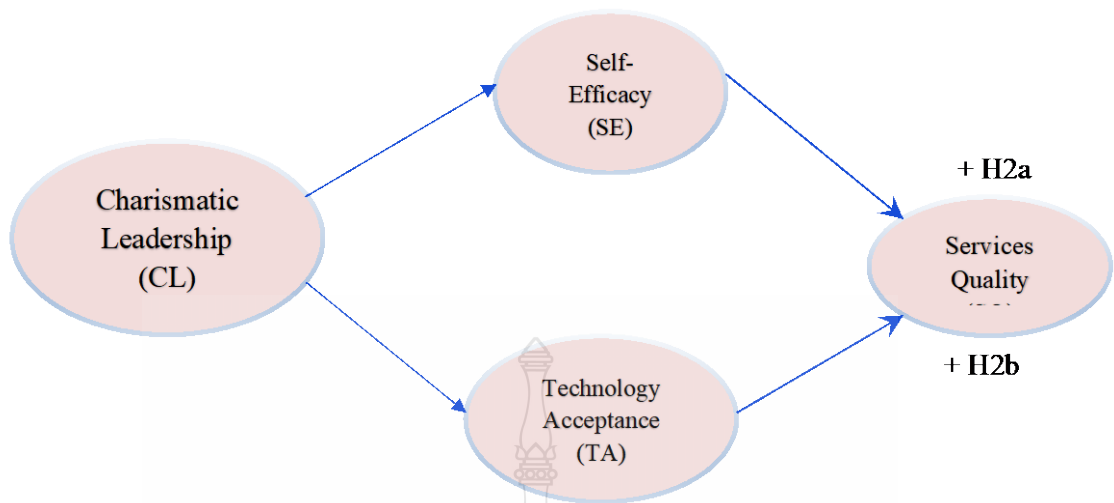


Figure 3.3 An illustration of the hypothesis (H2a, H2b): The conceptual research framework focuses on the mediating roles of Technology acceptance and Self-efficacy in the relationships between Charismatic Leadership and Service Quality.

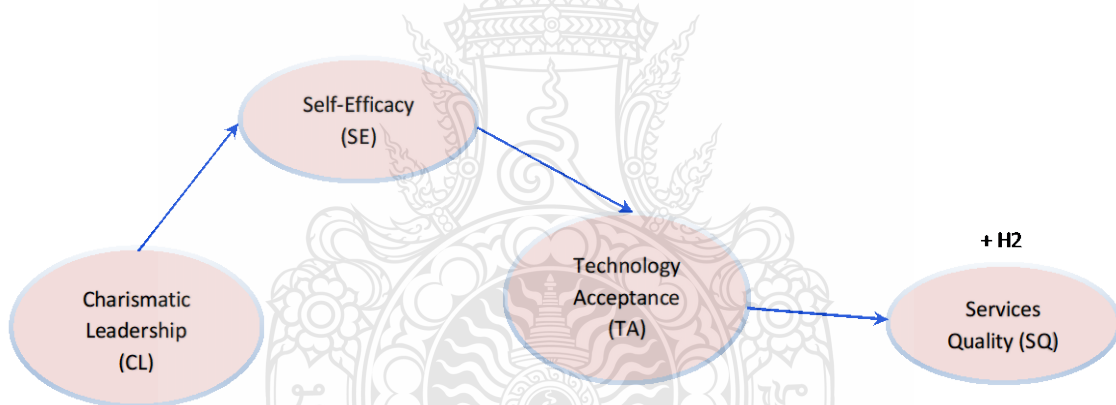


Figure 3.4 An illustration of the hypothesis (H2c,): The conceptual research framework focuses on the mediating roles through Technology acceptance and Self-efficacy in the relationships between Charismatic Leadership and Service Quality.

Regarding the notions as aforementioned, the investigation hypothesis consequently examined reference figure 3.1, 3.2, 3.3 and 3.4 an illustration of the structural theoretical model to test the hypotheses for the answer to the objective, this investigation seeks, which particularly consider the following research question below:

Research question 1. To what extent do technology acceptance and self-efficacy mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit context?

Research question 2. To what extent do technology acceptance and self-efficacy mediate the relationship between charismatic leadership and service quality in Thailand's primary healthcare unit context?

Thus, the investigation methodology intends to examine influencing as an illustration of the structural theoretical model to test hypotheses shall be testable to determine and adequate for possible effects in the research purpose between the exogenous, endogenous, and mediating variables of a conceptual model these research hypotheses. The first dimensions of the hypothesis set related are distinguished: the first set aspects are descriptive of the theoretical tested to determine Hypothesis (H1a, H1b and H1c) to answer the research question RQ1. As following:

H1a: the positive effect to which self-efficacy mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit.

H1b: the positive effect to which technology acceptance mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit.

H1c: the positive effect to which technology acceptance and self-efficacy mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit.

The second dimensions of the hypothesis set related are distinguished: the set aspects are descriptive of the theoretical tested to determine Hypothesis (H2a, H2b and H2c) to answer the research question RQ2. As following:

H2a: the positive effect to which self-efficacy mediate the relationship between charismatic leadership and service quality in Thailand's primary healthcare unit.

H2b: the positive effect to which technology acceptance mediate the relationship between charismatic leadership and service quality in Thailand's primary healthcare unit.

H2c: the positive effect to which technology acceptance and self-efficacy mediate the relationship between charismatic leadership and service quality in Thailand's primary healthcare unit.

Following steps, the AMOS software package applies to test the hypotheses by Structural Equation Modelling (SEM), a family of statistical models. That seeks to explain the relationships among multiple variables or a multivariate technical combining the aspects of factor analysis and multiple regression, enabling the researcher to simultaneously examine a series of interrelations dependence among the measured latent constructs (variants) and several latent constructs (J. Hair et al., 2010).

SEM consists of two components; the first component is that the measurement model as latent variables are proposed and tested through confirmatory factor analysis, while the second component is that the structural models and latent variables are linked together, and latent variables and observed variables are linked together (causal and relational way)(J. Hair et al., 2010).

Regarding the statistical significance, testing has concerned the analysis of covariance structures. The goodness-of-fit statistic, which is presented in Table 3.4, focusing on the first set of fit statistic NPAR (number of parameter), CMIN (minimum discrepancy), DF (degrees of freedom), P (probability value) and CMIN/DF. The value of CMIN represents the discrepancy between the unrestricted sample covariance matrix S , and the restricted covariance matrix $\Sigma(\theta)$, and represent the Likelihood Ratio Test statistic, most commonly expressed to CMIN as the χ^2 Statistic.

The null hypothesis (H_0) postulates that specification of the factor loadings, factor variances, and covariances, and error variance for model under study is valid; the χ^2 test simultaneously tests the extent to which this specification is true. The probability value associated with the χ^2 represent the likelihood of obtain a χ^2 value that exceeds the χ^2 value when H_0 is true. Thus, the higher the probability ($p > 0.05$) of associated with the χ^2 , the closer the fit between the hypothesized model (under H_0) and the perfect fit (Bollen, 1989)

Also, one of the first fit statistics to address this problem was the $\chi^2 /$ degrees of freedom ratio or CMIN/DF, should be less than 5.0 being indicative of good fit (Bentler & Bonett, 1980).

The next group of statistics, RMR, GFI, AGFI, and PGFI. The root means square residual (RMR) represents the average residual value derived from the fitting of the variance covariance matrix $\Sigma(\theta)$ for the hypothesized model to the variance covariance matrix (S) of the sample data. Thus, the standardized RMR, then, represents the average value across all standardized residuals, and range from zero to 1.00, in a well-fitting model, this value will be small is 0.5 or less.

The Goodness-of-fit Index (GFI) is a measure of the relative amount of variance and covariance in matrix S that is jointly explained by matrix Σ . While the Adjusted Goodness-of-Fit Index (AGFI) adjusted for the number of degrees of freedom in the specified model, thus, the GFI and AGFI can be classified as absolute indices of fit because they compare the hypothesized model with no model at all (L.-T. Hu & Bentler, 1995). Although both indices range from zero to 1.00, with value more than 0.9 being indicative of good fit (J. Hair et al., 2010).

The last index of fit in this group, the Parsimony Goodness-of-Fit Index (PGFI), takes into account the complexity of the hypothesized model in the assessment of overall model fit. Thus, the indices range from zero to 1.00, with a value of more than 0.5 being indicative of a good fit (J. Hair et al., 2010).

Normed fit Index (NFI), the practical criterion of choice, as evidenced in large part (Bentler, 1992). The NFI has shown a tendency to underestimate fit in small samples (Byrne, 2010). Also, the NFI to take sample size into account and proposed the Comparative Fit Index (CFI). The value for both the NFI and CFI ranges from zero to 1.00 and is derived from the comparison of a hypothesized model with the independence (or null) model. Although a value $>.90$ was representative of a well-fitting model (Bentler, 1992). The Tucker-Lewis Index (TLI), consistent with the other indices, yields value ranging from zero to 1.00, with values close to $.95$ for large samples being indicative of good fit (L. t. Hu & Bentler, 1999).

The next set of fit statistic on the root mean square error of approximation (RMSEA). The RMSEA expressed per degree of freedom, thus making it sensitive to the number of estimated of the parameter in the model as the complexity of the model if the value less than $.05$ indicate good fit and value as high as $.08$ represent reasonable errors of approximation in the population (Browne & Cudeck, 1993).

In addition, close of fit (PCLOSE). That is, test the hypothesis that the RMSEA is “good” in the population. Specifically, the p-value for this test should be $> .50$ (Byrne, 2010). Moreover, Jöreskog and Sörbom (1996) have suggested that the p-value for the test should be $> .50$.

The Akaike Information Criterion (AIC) and Consistent of the AIC (CAIC) used in the comparison of two or more models, with smaller values representing a better fit of the hypothesized model (L.-T. Hu & Bentler, 1995). The Browne-Cudeck Criterion (BCC) and the Bayes Information Criterion (BIC) operate in the same manner as the AIC and CAIC. In the four fit indices, for the hypothesized model are substantially smaller than they are for either the independence or the saturated models, conclude that it represents the best fit to the data.

The Expected Cross-Validation Index (ECVI) was proposed, initially, as a means of assessing, in a single sample, the likelihood that the model cross-validates across similar-sized samples from the same population. In determining the hypothesized model, compare its ECVI value small then, those of both the saturated model and the independence model, conclude that it represents the best fit for the data.

The last goodness-of-fit statistic is Hoelter Critical N (CN). That is focusing directly on the adequacy of sample size, rather than on model fit. Hoelter proposed that value in excess of 200 is indicative of a model that adequately represents the sample data.

Statistical significance of parameter estimates, the critical ratio (C.R), are represents the parameter estimate divided by its standard error; as such, it operates as a Z-statistic in testing that the estimate is statistically different from Zero. Based on a probability level of .05, then the test statistic needs to be $> \pm 1.96$ before the hypothesis (Byrne, 2010).

Table 3.4 Summary the goodness-of-fit statistic for hypothesized model testing

Statistic GOF Index	Threshold/ Fit Criterion
CMIN, χ^2 Statistic	higher the probability ($p > 0.05$)
χ^2 / CMIN or CMIN/DF ,	less than 5.0 being indicative of good fit
RMR	be small is 0.5 or less
GFI, AGFI	more than 0.9
PGFI.	more than 0.5
NFI and CFI	more than .90
TLI	a value close to .95 for large samples being indicative of good fit
RMSEA	a value less than .05 indicates good fit, and value as high as .08 represent reasonable errors of approximation in the population
PCLOSE	the p-value $> .50$.
AIC and CAIC.	The hypothesized model is substantially smaller than they are for either the independence or the saturated models.
ECVI	The hypothesized model is substantially smaller than they are for either the independence or the saturated models.
CN	Value in excess of 200 is indicative of a model that adequately represents the sample data.

3.4.4 Mediation Model Analysis

The analysis involves mediating roles factors hypothesis testing. The mediating effect was tested, comparing model fit indices between competing and proposed theoretical models. Respecting the strength of influence affecting whom patients have received services is significant and have forecast Service Quality through Self-Efficacy and Technology Acceptance controlled the result endorses full mediation of the transformational leadership style, Charismatic Leadership style the below figure 3.1, 3.2, 3.3 and 3.4.

The first part of the hypothesis testing analysis for Hypothesis (H1a, H1b and H1c), reference figures 3.1 and 3.2, involves mediated factors. There is the mediating effect of Self-Efficacy (SE) and Technology Acceptance (TA) in the relationship between Transformational Leadership (TL) and Service Quality (SQ). These analyses could be comprehensive on two procedures as below:

The initial procedure, considering are There are statistically significant relationships that exist between Transformational Leadership (TL), and expressing positive Services Quality (SQ), has been both are mediated through Self-Efficacy (SE) and Technology Acceptance (TA). These procedures have been described as below: The analysis model, some form of mediation accepted if the influence of Self-Efficacy (SE) and Technology Acceptance (TA) endures significance after controlling for transformational leadership (TL). If transformational leadership (TL) is no longer significant when Self-Efficacy (SE) and Technology Acceptance (TA) have controls, the result endorses complete mediation. Suppose both transformational leadership (TL) and Technology Acceptance (TA) are significant and have forecasted the service quality (SQ), the partial mediation. Also, if both transformational leadership (TL) and Self-Efficacy (SE) are significant and have forecast the service quality (SQ), the partial mediation, both these are supported by Hypothesis (H1a, H1b and H1c).

The second part of the hypothesis testing analysis for Hypothesis (H2a, H2b and H2c), figure 3.3, 3.4 involves mediated factors in hypothesis testing. There are statistically significant relationships that there is a mediating effect of Self-Efficacy (SE) and Technology Acceptance (TA) in the relationship between Charismatic Leadership (CL) and Service Quality (SQ). These are analyses could be comprehensive on two procedures as below:

The analysis considering the model, some form of mediation accepted if the influence of Self-Efficacy (SE) and Technology Acceptance (TA) endures significance after controlling for charismatic leadership (CL). If Charismatic leadership (CL) is no longer significant when Self-Efficacy (SE) and Technology Acceptance (TA) have control, the result endorses full mediation. If both Charismatic leadership (CL) and Technology Acceptance (TA) are significant and have forecasted the service quality (SQ), the partial mediation. Also, if both charismatic leadership (CL) and Self-Efficacy (SE)

are significant and have forecasted the service quality (SQ), the partial mediation of both is supported by Hypothesis (H2a, H2b and H2c).

3.5 Summary

The chapter aimed to support this study's goal as the study sought to answer statistical significance questions, and SEM designs are research tools used to complete this task. Obtaining volunteers from officials in positions of primary healthcare managers and administrative employees to services in the primary healthcare units (PCUs) was appropriate and representative of an ample survey population of healthcare administrators working across the primary healthcare units (PCUs).

The strategy for recruiting volunteers for participants in this study included the circulation of electronic announcements at the primary healthcare unit administrator, facility intranet postings, e-mail invitations through the primary healthcare unit's place lists, and postings on social networking groups site-specific to healthcare administrators. They are obtaining volunteers from officials in primary healthcare managers and administrative employees to provide services in the primary healthcare units (PCUs). Furthermore, e-mail invitations to volunteer from name list officials in work positions of primary healthcare managers and administrative employees were appropriate and representative of obtaining an ample survey population of primary healthcare managers and administrative employees working across the primary healthcare units in Thailand.

CHAPTER 4

RESEARCH RESULT

This chapter's procedure begins with descriptive prepared data reveal to the data arrangement presentation: data analysis, structure equation model of proposal model theoretical framework. Furthermore, hypotheses testing and summaries the results.

4.1 Data Arrangements

4.1.1 Testing of normal distribution verifies of the sample groups test, the principle proceeding of gathered responsiveness is verified by both Normal distribution indices, as skewness and kurtosis scale. The acceptance criteria of the skewness scales should be keeping ranging -3 to 3 referred to Stuart and Ord (1994). The data collected from 1278 respondents, a large sample to support and consistence the Normal distribution principal criteria. The result depicted that the skewness scales were between -0.678 to 0.766, while the value of kurtosis scales was between -1.348 to 1.076 (see Appendix C1). Hence, it concluded that the normal distribution principle of the sample group in this finding was accepted.

4.1.2 The response rate of questionnaires. The sampling groups for the study derived from who work on the Primary healthcare units (PCUs) situated in the specified geographical group covering an area in Thailand. Which were population and sampling designed to be at the total collected population is 1,278 persons consisting of the Public Health Technical Officer, Nurses 639 persons, and had separate data collected only Services Quality variable part from patient or customer 639 persons. So, in total, there were 1,278 respondents. Also, provided the sample size of 98 sets was designed for the pilot study.

Out of the total 1,500 questionnaires to, there were 1,180 questionnaires returned to the researcher; therefore, the rate of response was 78.86 percentage. The respondents (the Public Health Technical Officer, Nurses and patients), come from the Primary healthcare units (PCUs) situated in the specified geographical group covering an area in Thailand.

4.2 The Respondents' Profile Analysis

To gather demographic information. The respondent's profile consists of information consistency of gender, age, marital status, education level, working experience, position. The detail of the acquired information is presented below in table 4.1 and table 4.2.

Table 4.1 Demographic of leadership respondent's (the Public Health Technical Officer, Nurses) portion

Characteristics	Frequency	Percentage
Response rate	639	78.86 %
Region		
The Northern	227	35.5%
The central	142	22.2%
The North East	228	35.7%
The Southern	42	6.6%
Job Category		
Primary Healthcare Unit managers or leadership	352	55.1%
Administration	287	44.9%
Gender		
Male	103	16.1%
Female	536	83.9%
Age (Over 6 months, will be counted as 1 year)		
18 - 30 years	99	15.5%
31 – 40 years	145	22.7%
41 – 50 years	223	34.9%
Over 50 years	172	26.9%
Education		
Secondary School	3	.5%
Vocational Certificate	1	.2%
Diploma	14	2.2%
Bachelor's degree	529	82.8%
Higher than the bachelor's degree	92	14.4%

Table 4.1 Demographic of leadership respondent's (the Public Health Technical Officer, Nurses) portion (Cont.)

Characteristics	Frequency	Percentage
Working experience		
less than 1 year	23	3.6%
more than 1 years but less than 2 years	15	2.3%
more than 2 years but less than 5 years	58	9.1%
more than 5 years but less than 10 years	117	18.3%
more than 10 years but less than 20 years	192	30.0%
more than 20 years	234	36.6%
Period of working in the current unit place		
Less than 1 years	45	7%
More than 1 years but less than 2 years	52	8.1%
more than 2 years but less than 5 years	109	17.1%
More than 5 years but less than 10 months	151	23.6%
more than 10 years	282	44.2%
Marital status		
Single	148	23.2%
Married	418	65.4%
Divorce/widowed	73	11.4%
Average monthly salary		
Less than 15,000 Baht	33	5.2%
More than 15,000 Baht but less than 20,000 Baht	107	16.7%
More than 20,000 Baht but less than 30,000 Baht	88	13.8%
More than 30,000 Baht but less than 50,000 Baht	308	48.2%
More than 50,000 Baht	103	16.1%
Category type of primary healthcare units working places		
Small Size (service provided to the population amount less than 3,000 persons)	129	20.2%
Medium Size (service provided to the population amount more than 3,000 to 8,000 persons)	349	54.6%
Large Size (service provided to the population amount more than 8,000 persons)	161	25.3%

Table 4.1 Demographic of leadership respondent's (the Public Health Technical Officer, Nurses) portion (Cont.)

Characteristics	Frequency	Percentage
The number of employees is there working in your workplace.		
Less than 3 persons	19	3%
More than 3 persons but less than 5 persons	163	25.5%
More than 5 persons but less than 10 persons	346	54.1%
More than 10 persons	111	17.4%
The number of patients obtains daily services.		
Less than 10 persons	15	2.3%
More than 10 persons but less than 30 persons	302	47.3%
More than 30 persons but less than 50 persons	226	35.4%
More than 50 persons	96	15%

Table 4.2 Demographic of patient's respondent's portion

Characteristics	Frequency	Percentage
Response rate	639	78.86 %
Region		
The Northern	148	23.2%
The central	230	36.0%
The North East	182	28.5%
The Southern	79	12.4%
Gender		
Male	89	13.9%
Female	550	86.1%

Table 4.2 Demographic of patient's respondent's portion (Cont.)

Characteristics	Frequency	Percentage
Age (Over 6 months, will be counted as 1 years)		
18 - 30 years	119	18.6%
31 – 40 years	176	27.5%
41 – 50 years	176	27.5%
Over 50 years	168	26.3%
Education		
Less than Secondary School	187	29.3%
Vocational Certificate	114	17.8%
Diploma	91	14.2%
Bachelor's degree	235	36.8%
Higher than bachelor's degree	12	1.9%
Marital status		
Single	165	25.8%
Married	413	64.6%
Divorce/widowed	61	9.5%
Average monthly income		
< 15,000 Baht	431	67.4%
15,001 - 20,000 Baht	102	16.0%
20,001 - 30,000 Baht	37	5.8%
30,001 - 50,000 Baht	55	5.8%
> 50,000 Baht	14	2.2%
The number of a family member		
< 2 persons	56	8.8%
2 - 3 persons	177	27.7%
4 - 5 persons	289	45.2%
> 5 persons	117	18.3%

Table 4.2 Demographic of patient's respondent's portion (Cont.)

Characteristics	Frequency	Percentage
The number of an older		
Without older	304	47.6%
1 person	201	6.1%
2 persons	126	19.7%
≥ 3 persons	8	1.3%
The number of children		
Without child	312	48.8%
1 person	218	34.1%
2 persons	78	12.2%
≥ 3 persons	31	4.9%

4.3 The Descriptive Statistics Analysis

4.3.1 Staff Respondent's Portion (public health technical officers and nurses)

Data collected from the incurrent the public health Technical Officer, Nurses 639 persons come from the Primary healthcare units (PCUs) situated in the specified geographical group covering an area in Thailand, using purposive sampling techniques. The proceeding of data gathering beheld from August 2020 to October 2020, which their attributes of the majority of respondents were shows the descriptive statistics. Almost of quantity, the respondents have had more than two years of the period of working in the current unit place, in the Primary Healthcare Units, with 84.9% (More than 24 months), respectively. The types of primary healthcare units working places for services comprehensive, 20.2 % of the quantity service provided to the population amount less than 3,000 persons are "Small Size". Meanwhile, the quantity 54.6 % are the Medium Size is service provided to the population amount more than 3,000 to 8,000 persons on these services types. Moreover, 25.3% of Large Size types are service provided to the population amount more than 8,000-person amount of value indicated. Proportional of the number of employees is there working in the Primary healthcare units, that 54.1% indicated quantity is more than 5 persons but less than 10 persons, and 25.5% of quantity more than 3 persons but less than 5 persons, respectively.

4.3.2 The Patient's Respondent's Portion

Data collected the same place and period with the Leadership respondent's (the Public Health Technical Officer, Nurses) portion option. Which, table 4.2 shows the attributes of the descriptive statistics of respondents. The majority of the patient's respondent were female, accounting for 86.1 %, with age above 31 years old equal to 81.3 %. Also, about 61.3 % of the education has been less than a bachelor's degree; they have received the health of the service from the Primary healthcare units (PCUs), respectively. Besides, about 67.4% of the respondents have had an average monthly income, less than 15,000 Baht.

4.3.3 Survey Data Pilot Examination

Importance of process the pilot study to examined; some questionnaire items were changed and modified to consistency and improved to explicit content comprehensive. Thus, the scale of Cronbach's alpha for Transformation Leadership (TL) is 0.93, Charismatic Leadership (CL) is 0.95, Technology Acceptance (TA) is 0.96, Self - Efficacy (SE) on the Leadership respondent's (the Public Health Technical Officer, Nurses) is 0.95 and Service Quality (SQ) from the patient's respondent is 0.97. These results have been confirmed the reliability of research instruments and evaluate the possibility of a study. In criteria value to acceptance of each factor loading of among constructs are greater than 0.6, and the p-value is significant. Therefore, revealed of results values could be the conclusion that the instruments of study have been the possibility to apply.

4.4 Purification and Reliability Analysis

The first criteria The purification and reliability of each a Cronbach's alpha are 0.70 or 0.60 in the exploratory research (J. F. Hair, Anderson, Tatham, & Black, 1998; JC Nunnally, 1978). The result of this study indicated that all of the variables produced reliability scale value above the recommended level of 0.70 are described as follows.

4.4.1 Transformational Leadership Scale

The last survey comprises ten items, of which the scale of Cronbach's alpha is 0.889 (see appendix C1). Therefore, it could summarize the assessment using the MLQ

5-X investigation. These are trustworthy for the assessment of transformational leadership.

4.4.2 Charismatic Leadership Scale

The remaining survey data comprises 18 items, of which the scale of Cronbach's alpha is 0.896 (see appendix C1). Therefore, it could summarize the assessment using the Conger and Kanungo Scales or CKS investigation. These are trustworthy for the assessment of charismatic leadership.

4.4.3 Self – Efficacy Scale

The remaining survey data comprises ten questions, of which the scale of Cronbach's alpha is 0.928 (see appendix C1). Therefore, it could be summarized that the assessment uses the General Self-Efficacy Scale (GSE). These are trustworthy for the assessment of self-efficacy.

4.4.4 Technology Acceptance Scale

The remaining survey comprises 24 questions, of which the scale of Cronbach's alpha is 0.846 (see appendix C1). Therefore, it could summarize the assessments using the Unified Theory of Acceptance and Use of Technology (UTAUT). These are trustworthy for the assessment of Technology Acceptance.

4.4.5 Service Quality Scale

The last survey comprises 36 questions, of which the scale of Cronbach's alpha is 0.977 (see appendix C1). Therefore, it could summarize the assessed use of the Primary Care Assessment Tool (PCAT). These are trustworthy for the assessment of service quality.

4.5 Construct Evaluation and Validity Analysis

Testing for the factorial validity of a theoretical construct in the divergent environment and organizational context may influence the structure of each aspect, which was doubtful that these interpreted instrument scales still have the identical structure of each factor as the original editions. Hence, the Amos statistics software was implemented to examine the confirmatory factor analysis (CFA) model was designed to test the multidimensionality of a theoretical construct. The criteria were applied based on the number of observed variables. So, the model fit criteria in this study were compliance

with J. Hair et al. (2010). However, this specification is applied to investigate and explain the general information for a more extensive discussion of the substantive issues and the descriptive findings.

4.5.1 Structure of Transformational Leadership

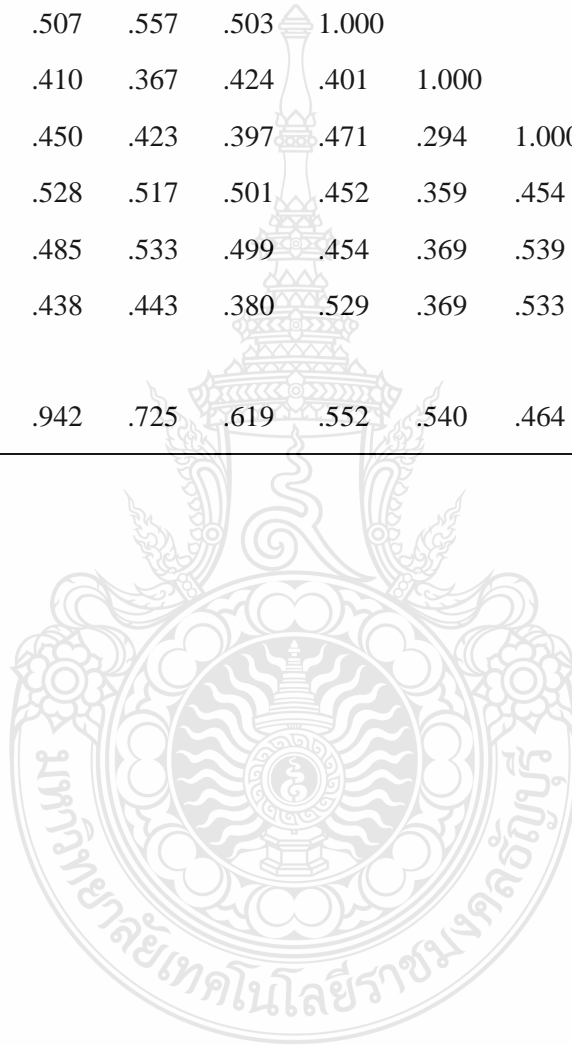
In this first stage, the inquiry focuses on the plausibility of a multidimensional of Transformation Leadership (TL) structure. Both values of sample Covariances and Correlations results of Eigenvalue are greater than 0.5 and p-value is significant. Therefore, outcome illustration that the associations among questions are desirable to proceed with the factors analysis follows on the table no. 4.3 and 4.4. It could be seen that all questions include inspirational motivation (IM1-IM2). Idealized influence attributed (IIa1-IIa2) Idealized influence behaviours (IIb1-IIb2) Intellectual stimulation (IS1-IS2) Individualized consideration (IC1-IC2). The load on factors was entitled "Transformation Leadership" (TL).

Table 4.3 Total sample covariances explained of transformational leadership

	IC2	IC1	IS2	IS1	IIb2	IIb1	IIa2	IIa1	IM2	IM1
IC2	.554									
IC1	.401	.559								
IS2	.285	.331	.536							
IS1	.293	.306	.381	.516						
IIb2	.276	.297	.319	.282	.612					
IIb1	.272	.240	.211	.238	.245	.614				
IIa2	.223	.242	.222	.205	.265	.165	.516			
IIa1	.290	.307	.294	.279	.274	.219	.253	.603		
IM2	.255	.255	.274	.252	.250	.203	.272	.262	.494	
IM1	.252	.251	.248	.209	.317	.221	.293	.238	.367	.586
Eigenvalues	2.979	.516	.433	.351	.321	.304	.252	.160	.145	.128

Table 4.4 Total sample correlations explained of transformational leadership

	IC2	IC1	IS2	IS1	IIb2	IIb1	IIa2	IIa1	IM2	IM1
IC2	1.000									
IC1	.712	1.000								
IS2	.522	.605	1.000							
IS1	.549	.569	.725	1.000						
IIb2	.474	.507	.557	.503	1.000					
IIb1	.466	.410	.367	.424	.401	1.000				
IIa2	.418	.450	.423	.397	.471	.294	1.000			
IIa1	.501	.528	.517	.501	.452	.359	.454	1.000		
IM2	.488	.485	.533	.499	.454	.369	.539	.481	1.000	
IM1	.443	.438	.443	.380	.529	.369	.533	.400	.683	1.000
Eigenvalues	5.355	.942	.725	.619	.552	.540	.464	.293	.271	.238



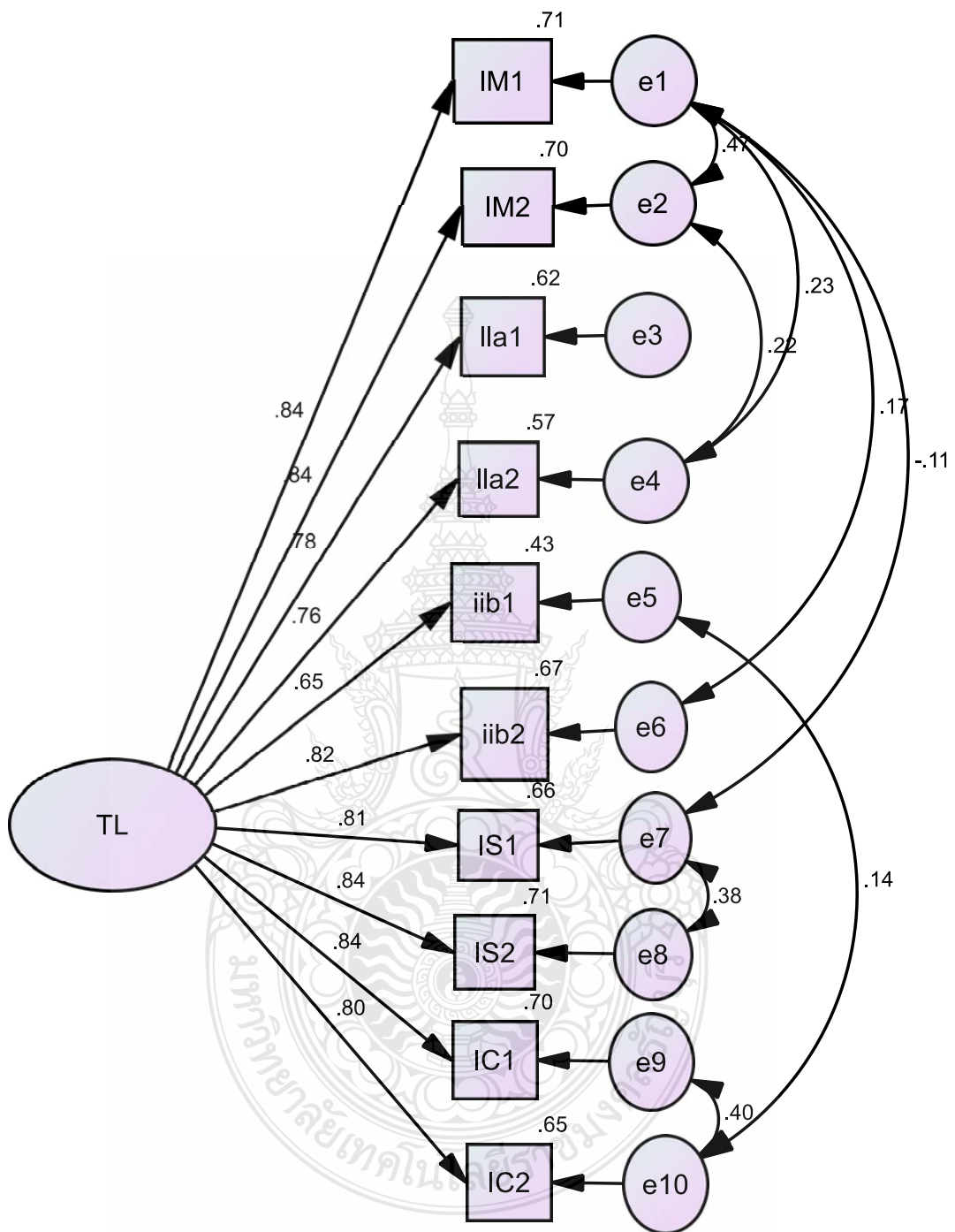


Figure 4.1 The standardized regression weights of the CFA model of transformational leadership (Default model)

The model evaluation, the conceptualizing the Confirmatory Factors Analysis (CFA) model in Figure 4.1 is within the component matrix of Transformation Leadership (TL) testing the factorial validity of score from a measuring instrument framework, as presented in Table 4.5. Therefore, Goodness – of – fit summary concentrated in reviewing the Goodness-of-fit statistics in Table 4.5, it shows that the hypothesized model fits the data very well as evidenced by the Chi-square = 142.762 and Degrees of freedom = 28 and probability level = 0.00. Consequently, they examined the modification indices purely in the interest of completeness. In review, as indicated by the reported parameter change statistics, incorporating these two parameters into the model would result in parameter values, respectively, as shown in Figure 4.1 Model maximum likelihood estimates. Finally, the related standardized estimates are presented in Table 4.6. Therefore, it could be summarized that this the Confirmatory Factors Analysis (CFA) model is appropriate to clarify the interconnections among items and latent variables.

Table 4.5 The model fit statistics result of the second order CFA of transformational leadership (Default model)

CMIN	<i>p</i> -value	df	CMIN/df	CFI	RMR	AGFI	PGFI	RMSEA	NFI	TLI
142.762	.000	28	5.099	0.932	.322	.883	.479	.110	.981	.891

Table 4.6 The standardized regression weights of the CFA of transformational leadership (Default model)

Standardized regression weights		Estimate	<i>p</i> -value
IM1	< -----	TL	.843 ***
IM2	< -----	TL	.836 ***
Ila1	< -----	TL	.785 ***
Ila2	< -----	TL	.758 ***
Ilb1	< -----	TL	.654 ***
Ilb2	< -----	TL	.816 ***
IS1	< -----	TL	.810 ***
IS2	< -----	TL	.844 ***
IC1	< -----	TL	.839 ***
IC2	< -----	TL	.804 ***

significance level: * = .05. ** = .01, *** = .001

4.5.2 Structure of Charismatic Leadership Scale

In the second structure, the inquiry focuses on the plausibility of a multidimensional of Charismatic Leadership (CL) structure. Both values of sample Covariances and Correlations results of Eigenvalue are greater than 0.5 and p-value is significant. Therefore, outcome illustration that the associations among questions are desirable to proceed with the factors analysis follows on the table no. 4.7, and 4.8. It could be seen that all items of factors include that the assessed using the Conger and Kanungo Scales or CKS investigation is Sensitivity to the Environment (SE), Strategic Vision, and Articulation (SVA), Personal Risk (PR1). These are trustworthy for the assessment of Charismatic Leadership construct. The load on factors was entitled " Charismatic Leadership (CL)".



Table 4.7 Total sample covariances explained of charismatic leadership (CL)

	SE1	SE2	SVA1	SVA2	SVA3	SVA5	SVA6	SVA7	PR1
SE1	.846								
SE2	.500	.730							
SVA1	.210	.192	.764						
SVA2	.198	.233	.619	.859					
SVA3	.188	.205	.547	.666	.869				
SVA5	.156	.158	.477	.611	.652	.857			
SVA6	.167	.161	.487	.580	.637	.703	.862		
SVA7	.198	.169	.506	.565	.617	.598	.680	.840	
PR1	.198	.202	.265	.304	.290	.294	.277	.294	.579
Eigenvalues	4.146	1.165	.436	.407	.307	.252	.210	.158	.125

Table 4.8 Total sample correlations explained of charismatic leadership (CL)

	SE1	SE2	SVA1	SVA2	SVA3	SVA5	SVA6	SVA7	PR1
SE1	1.000								
SE2	.637	1.000							
SVA1	.262	.257	1.000						
SVA2	.232	.294	.764	1.000					
SVA3	.220	.257	.671	.771	1.000				
SVA5	.184	.199	.590	.712	.756	1.000			
SVA6	.196	.203	.600	.674	.736	.817	1.000		
SVA7	.235	.216	.632	.666	.723	.704	.799	1.000	
PR1	.284	.310	.398	.431	.409	.417	.392	.422	1.000
Eigenvalues	5.035	1.477	.682	.533	.387	.306	.247	.189	.146

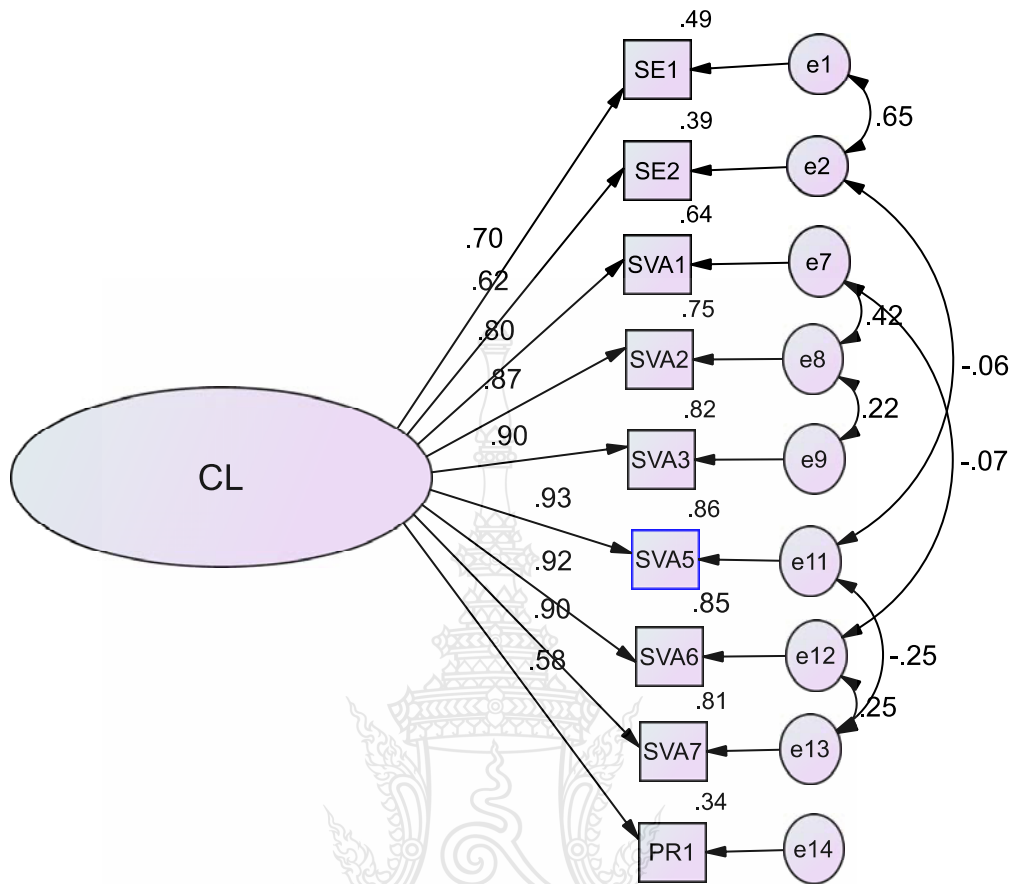


Figure 4.2 The standardized regression weights of the CFA model of charismatic leadership (Default model)

The model evaluation, the conceptualizing the Confirmatory Factors Analysis (CFA) model in Figure 4.2 is within the component matrix of Charismatic Leadership (CL) structure testing the factorial validity of score from a measuring instrument framework, as presented in Table 4.9. Thus, the model components in this format can be beneficial because it is consistent with the methodology by which the results from structural equation modelling (SEM) analyses are commonly reported shows the pattern of parameters to be estimated within matrices: the factors-loading matrix. Therefore, Goodness – of – fit summary concentrated in reviewing the Goodness-of-fit statistics in Table 4.9, it shows that the hypothesized model fits the data very well as evidenced by the Chi-square = 203.978 and Degrees of freedom = 20 and probability level = 0.000. Consequently, they examined the modification indices purely in the interest of

completeness. In reviewing the modification indices (Mis) related to the covariance, two distinctive values emerge that are substantially larger than the rest of the estimates. However, as indicated by the reported parameter change statistics, incorporating these two parameters into the model would result in parameter values, respectively, as shown in Figure 4.2 Model maximum likelihood (ML) estimates. For clarification of the terminology associated with the output, the factor loadings are listed as Regression Weights. Listed first are the second-order factor loadings, followed by the first-order loadings. Finally, the related standardized estimates are presented in Table 4.10. Therefore, it could be summarized that this the Confirmatory Factors Analysis (CFA) model is appropriate to clarify the interconnections among items and latent variables.

Table 4.9 The model fit statistics result of the second order CFA of charismatic leadership (Default model)

CMIN	<i>p</i> - value	df	CMIN /df	CFI	RMR	AGFI	PGFI	RMSEA	NFI	TLI
203.978	.000	20	10.199	.910	.488	.790	.403	.165	.902	.837

Table 4.10 The standardized regression weights of the CFA of charismatic leadership (Default model)

Standardized regression weights	Estimate	<i>p</i> -value
SE1 < ---- CL	.697	***
SE2 < ---- CL	.622	***
SVA1 < ---- CL	.801	***
SVA2 < ---- CL	.866	***
SVA3 < ---- CL	.903	***
SVA5 < ---- CL	.929	***
SVA6 < ---- CL	.920	***
SVA7 < ---- CL	.897	***
PR1 < ---- CL	.582	***

significance level: * = .05. ** = .01, *** = .001

4.5.3 Structure of Self – Efficacy

In the third, the structure of the conceptual framework, the inquiry focuses on the plausibility of a multidimensional of Self – Efficacy scale (SE) structure. Both values of sample Covariances and Correlations results of Eigenvalue are greater than 0.5 and p-value is significant. Therefore, outcome illustration that the associations among questions are desirable to proceed with the factors analysis follows on the table no. 4.11 and 4.12. It could be seen that all items of factors include that the assessed using The General Self-Efficacy Scale (GSE1-GSE10), comprise an investigation facilitated goal-setting, effort investment, persistence in the face of barriers, recovery from setbacks. These are trustworthy for the assessment of Self - Efficacy. The load on factors was entitled " Self - Efficacy (SE)".

Table 4.11 Total sample covariances explained of self - efficacy (SE)

	GSE10	GSE9	GSE8	GSE7	GSE6	GSE5	GSE4	GSE3	GSE2	GSE1
GSE10	.449									
GSE9	.355	.492								
GSE8	.303	.316	.501							
GSE7	.281	.313	.404	.529						
GSE6	.287	.302	.308	.282	.529					
GSE5	.280	.263	.295	.262	.411	.498				
GSE4	.254	.226	.270	.250	.35	.375	.518			
GSE3	.278	.265	.290	.269	.323	.323	.324	.564		
GSE2	.245	.235	.260	.230	.314	.295	.304	.376	.574	
GSE1	.273	.275	.283	.266	.373	.350	.308	.370	.352	.684
Eigenvalues	3.257	.523	.330	.302	.265	.192	.159	.120	.099	.089

Table 4.12 Total sample correlations explained of self - efficacy (SE)

	GSE10	GSE9	GSE8	GSE7	GSE6	GSE5	GSE4	GSE3	GSE2	GSE1
GSE10	1.000									
GSE9	.755	1.000								
GSE8	.640	.636	1.000							
GSE7	.576	.613	.785	1.000						
GSE6	.589	.592	.599	.533	1.000					
GSE5	.591	.530	.590	.510	.800	1.000				
GSE4	.527	.447	.529	.478	.670	.739	1.000			
GSE3	.552	.504	.546	.492	.592	.609	.599	1.000		
GSE2	.483	.442	.485	.417	.571	.551	.557	.661	1.000	
GSE1	.494	.474	.484	.443	.619	.599	.517	.596	.561	1.000
Eigenvalues	6.129	.986	.605	.547	.471	.344	.299	.246	.197	.177



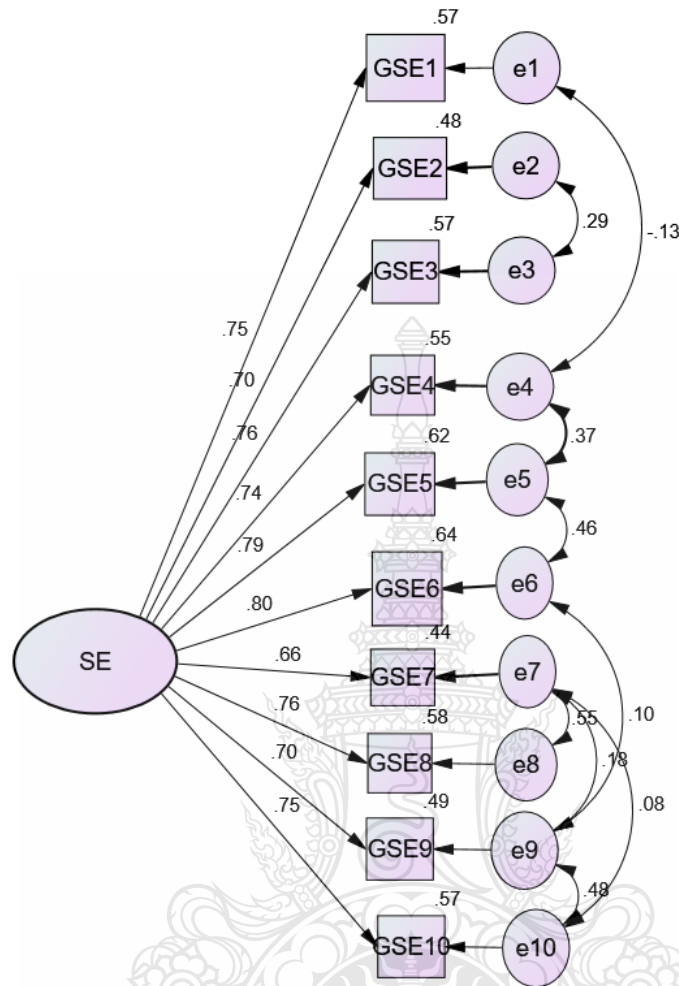


Figure 4.3 The standardized regression weights of the second-order CFA model of self - efficacy (Default model)

The model evaluation, the conceptualizing the Confirmatory Factor Analysis (CFA) model in Figure 4.3 is within the component matrix of Self – Efficacy (SE) structure testing the factorial validity of score from a measuring instrument framework, as presented in Table 4.13. Thus, the model components in this format can be beneficial because it is consistent with the methodology by which the results from structural equation modelling (SEM) analyses are commonly reported shows the pattern of parameters to be estimated within matrices: the factors-loading matrix. Therefore, Goodness – of – fit summary concentrated in reviewing the Goodness-of-fit statistics in Table 4.13, it shows that the hypothesized model fits the data very well as evidenced by

the Chi-square = 78.168 and Degrees of freedom = 20 and probability level = 0.00. Consequently, they examined the modification indices purely in the interest of completeness. In reviewing the modification indices (Mis) related to the covariance, two distinctive values emerge that are substantially larger than the rest of the estimates. However, as indicated by the reported parameter change statistics, incorporating these two parameters into the model would result in parameter values, respectively, as shown in Figure 4.3 Model maximum likelihood (ML) estimates. For clarification of the terminology associated with the output, the factor loadings are listed as Regression Weights. Listed are the first-order factor loadings. Finally, the related standardized estimates are presented in Table 4.14. Therefore, it could be summarized that this the Confirmatory Factors Analysis (CFA) model is appropriate to clarify the interconnections among items and Self – Efficacy (latent variables).

Table 4.13 The model fit statistics result of the second order CFA of self – efficacy (Default model)

CMIN	p-value	df	CMIN/df	CFI	RMR	AGFI	PGFI	RMSEA	NFI	TLI
78.168	.000	20	3.908	.987	.015	.930	.354	.068	.983	.971

Table 4.14 The standardized regression weights of the second order CFA of self – efficacy (Default model)

Standardized regression weights	Estimate	p-value
GSE1 < ---- SE	.755	***
GSE2 < ---- SE	.696	***
GSE3 < ---- SE	.757	***
GSE4 < ---- SE	.741	***
GSE5 < ---- SE	.790	***
GSE6 < ---- SE	.799	***
GSE7 < ---- SE	.662	***
GSE8 < ---- SE	.761	***
GSE9 < ---- SE	.697	***
GSE10 < ---- SE	.752	***

significance level: * = .05. ** = .01, *** = .001

4.5.4 Structure of Technology Acceptance

In the fourth structure, the inquiry focuses on the plausibility of a multidimensional of Technology acceptance (TA) structure. Both values of sample Covariances and Correlations results of Eigenvalue are greater than 0.5 and p-value is significant. Therefore, outcome illustration that the associations among questions are desirable to proceed with the factors analysis follows on the table no. 4.15 and 4.16. Therefore, it could summarize that the assessed using the Unified Theory of Acceptance and Use of Technology (UTAUT) comprise an investigation is performance expectancy (PE), effort expectancy (EE), social influence (SI), facilitating conditions (FC), Self-efficacy (SEF), attitude toward using technology (AT). These are trustworthy for the assessment of Technology acceptance (TA). The load on factors was entitled "Technology acceptance (TA)".

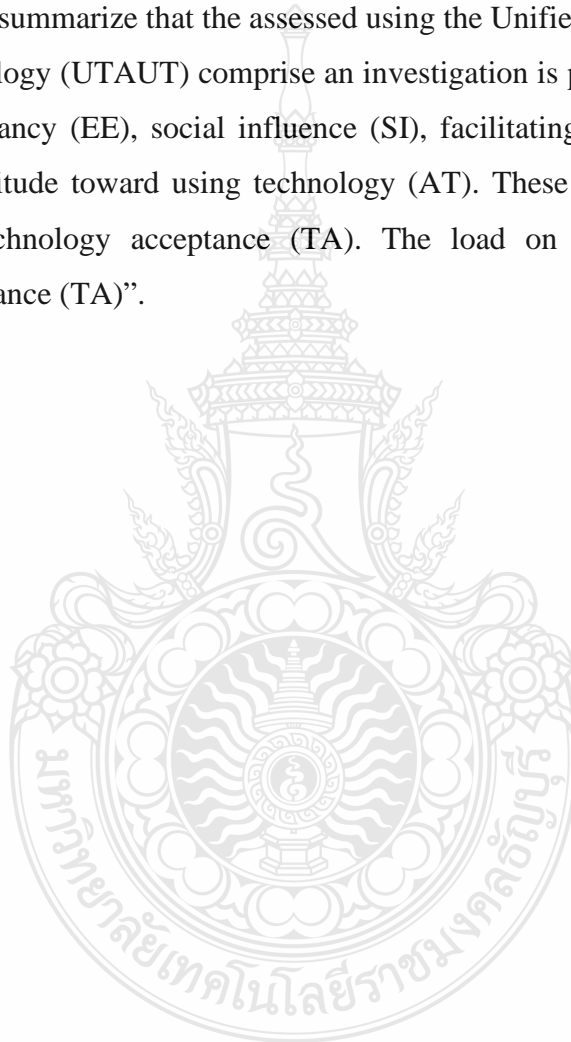


Table 4.15 Total sample covariances explained of technology acceptance (TA)

	SI2	AT3	AT2	EE4	EE3	EE1	PE3	PE2	PE1
SI2	.646								
AT3	.306	.738							
AT2	.313	.501	.773						
EE4	.231	.366	.294	.699					
EE3	.271	.277	.297	.392	.549				
EE1	.267	.328	.299	.380	.411	.535			
PE3	.241	.299	.264	.306	.355	.358	.556		
PE2	.230	.257	.262	.298	.334	.295	.404	.542	
PE1	.209	.254	.266	.305	.313	.304	.358	.425	.552
Eigenvalues	3.137	.690	.442	.414	.268	.249	.162	.131	.096

Table 4.16 Total Sample correlations explained of technology acceptance (TA)

	SI2	AT3	AT2	EE4	EE3	EE1	PE3	PE2	PE1
SI2	1.000								
AT3	.443	1.000							
AT2	.444	.663	1.000						
EE4	.343	.509	.400	1.000					
EE3	.455	.436	.457	.633	1.000				
EE1	.454	.522	.465	.622	.759	1.000			
PE3	.403	.467	.402	.490	.643	.657	1.000		
PE2	.389	.407	.405	.484	.612	.548	.735	1.000	
PE1	.351	.397	.407	.490	.569	.560	.646	.777	1.000
Eigenvalues	.856	.673	.555	.420	.345	.315	.264	.221	.176

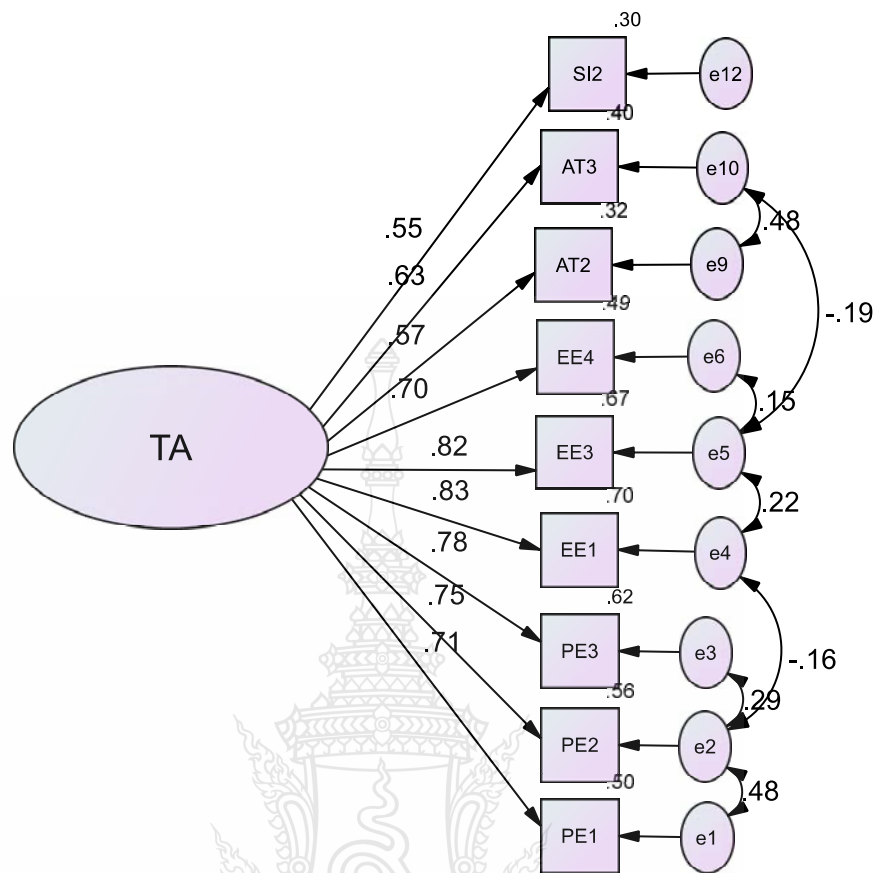


Figure 4.4 The standardized regression weights of the CFA model of technology acceptance (TA) (Default model)

The model evaluation, the conceptualizing the Confirmatory Factors Analysis (CFA) model in Figure 4.4 is within the component matrix of Technology acceptance (TA) structure testing the factorial validity of score from a measuring instrument framework, as presented in Table 4.17. Thus, the model components in this format can be beneficial because it is consistent with the methodology by which the results from structural equation modelling (SEM) analyses are commonly reported shows the pattern of parameters to be estimated within matrices: the factors-loading matrix. Therefore, Goodness – of – fit summary concentrated in reviewing the Goodness-of-fit statistics in Table 4.17, it shows that the hypothesized model fits the data very well as evidenced by the Chi-square = 116.119 and Degrees of freedom = 20 and probability level = .000. Consequently, they examined the modification indices purely in the interest of

completeness. In reviewing the modification indices (Mis) related to the covariance, two distinctive values emerge that are substantially larger than the rest of the estimates. However, as indicated by the reported parameter change statistics, incorporating these two parameters into the model would result in parameter values, respectively, as shown in Figure 4.4 Model maximum likelihood estimates. For clarification of the terminology associated with the output, the factor loadings are listed as Regression Weights. Listed first are the second-order factor loadings, followed by the first-order loadings. Finally, the related standardized estimates are presented in Table 4.18. Therefore, it could be summarized that this the Confirmatory Factors Analysis (CFA) model is appropriate to clarify the interconnections among items and Technology acceptance (TA) (latent variables).

Table 4.17 The model fit statistics result of the second order CFA of technology acceptance (Default model)

CMIN	<i>p</i> -value	df	CMIN /df	CFI	RMR	AGFI	PGFI	RMSEA	NFI	TLI
116.119	.000	20	5.806	.972	.024	.901	.428	.087	.967	.950

Table 4.18 The standardized regression weights of the CFA of technology acceptance (Default model)

	Standardized regression weights	Estimate	<i>p</i> -value
PE1	< ---- TA	.707	***
PE2	< ---- TA	.747	***
PE3	< ---- TA	.784	***
EE1	< ---- TA	.834	***
EE3	< ---- TA	.821	***
EE4	< ---- TA	.699	***
AT2	< ---- TA	.566	***
AT3	< ---- TA	.630	***
SI2	< ---- TA	.550	***

significance level: * = .05. ** = .01, *** = .001

4.5.5 Structure of Service Quality

In the last construct, the inquiry focuses on the plausibility of a multidimensional of Service Quality (SQ) structure. Both values of sample Covariances and Correlations results of Eigenvalue are greater than 0.5 and p-value is significant. Therefore, outcome illustration that the associations among questions are desirable to proceed with the factors analysis follows on the table no. 4.19 and 4.20. Therefore, it could summarize that the assessed use of the Primary Care Assessment Tool (PCAT), the investigation to the extent of affiliation with a place/ Public Health Officer or nurse (EA), First contact-utilization (FCU), First contact-access (FCA), Ongoing Care (OC), Comprehensiveness Service Provided (CSP), Family-centeredness (FCN), Community orientation (CMO), and Culturally Competent (CC). These are trustworthy for the assessment of Service Quality. The load on factors was entitled " Service Quality (SQ)".

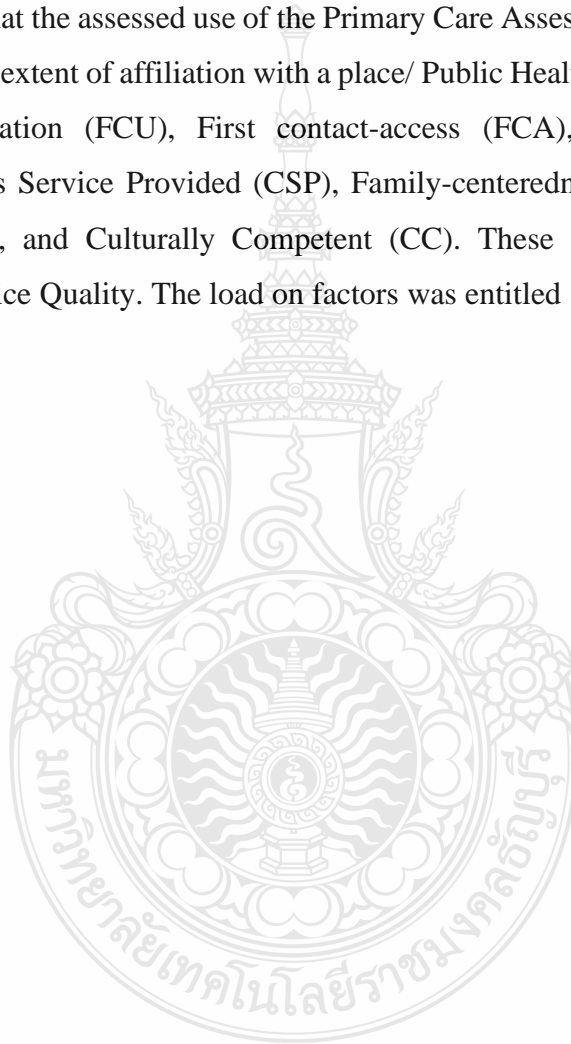


Table 4.19 Total sample covariances explained of service quality (SQ)

	EA3	CSP1	CSP5	FCN2	FCU3	FCU2	FCU1	FCA1	OC3	FCN1	FCN3	CMO1	CMO2	CMO3	CC1	CSV4	EA2
EA3	1.570																
CSP1	1.327	1.973															
CSP5	1.094	1.365	1.564														
FCN2	.892	1.110	1.117	1.265													
FCU3	1.271	1.319	1.108	.914	1.598												
FCU2	1.130	1.165	.985	.818	1.238	1.408											
FCU1	1.115	1.150	.976	.833	1.167	1.228	1.469										
FCA1	1.223	1.340	1.110	.907	1.248	1.092	1.048	1.588									
OC3	1.125	1.230	1.020	.896	1.139	1.018	.973	1.154	1.549								
FCN1	.894	1.096	1.143	1.064	.879	.803	.835	.897	.870	1.232							
FCN3	.985	1.213	1.068	.927	.989	.885	.884	.966	.980	.934	1.353						
CMO1	1.050	1.231	1.216	1.148	1.027	.908	.912	1.020	1.004	1.107	.975	1.531					
CMO2	.945	1.100	1.134	1.130	.916	.834	.831	.938	.952	1.074	.924	1.247	1.362				
CMO3	.987	1.194	1.210	1.138	1.014	.899	.913	1.015	.958	1.079	.968	1.250	1.214	1.388			
CC1	1.158	1.377	1.141	.966	1.117	1.009	.968	1.126	1.081	.962	1.042	1.110	1.010	1.067	1.458		
CSV4	1.257	1.606	1.253	1.017	1.219	1.105	1.069	1.259	1.191	1.006	1.122	1.141	1.062	1.116	1.283	1.845	
EA2	1.343	1.336	1.086	.870	1.257	1.104	1.094	1.212	1.124	.865	1.014	1.026	.902	.978	1.137	1.257	1.542
Eigenvalues	18.796	1.719	.860	.590	.499	.458	.410	.328	.315	.303	.279	.242	.211	.200	.182	.172	.131

Table 4.20 Total Sample Correlations explained of Service Quality (SQ)

	EA3	CSP1	CSP5	FCN2	FCU3	FCU2	FCU1	FCA1	OC3	FCN1	FCN3	CMO1	CMO2	CMO3	CC1	CSV4	EA2
EA3	1.000																
CSP1	.754	1.000															
CSP5	.698	.777	1.000														
FCN2	.633	.703	.795	1.000													
FCU3	.803	.743	.701	.643	1.000												
FCU2	.760	.699	.664	.613	.850	1.000											
FCU1	.734	.675	.644	.611	.762	.854	1.000										
FCA1	.774	.757	.705	.640	.783	.730	.686	1.000									
OC3	.722	.704	.656	.640	.724	.690	.645	.736	1.000								
FCN1	.643	.703	.824	.853	.626	.609	.621	.641	.630	1.000							
FCN3	.676	.742	.734	.709	.672	.641	.627	.659	.677	.723	1.000						
CMO1	.677	.709	.786	.825	.656	.618	.608	.654	.652	.806	.678	1.000					
CMO2	.646	.671	.777	.840	.621	.602	.587	.638	.655	.829	.681	.863	1.000				
CMO3	.669	.722	.821	.859	.681	.643	.639	.684	.654	.825	.706	.858	.883	1.000			
CC1	.765	.812	.756	.712	.732	.704	.661	.740	.719	.718	.742	.743	.716	.750	1.000		
CSV4	.739	.842	.738	.666	.710	.686	.649	.736	.705	.667	.710	.679	.670	.697	.782	1.000	
EA2	.863	.766	.699	.623	.801	.749	.727	.774	.727	.627	.702	.668	.623	.669	.758	.745	1.000
	Eigenvalues																
	12.405	1.201	.539	.379	.338	.297	.264	.219	.201	.200	.174	.161	.145	.131	.128	1.22	.095

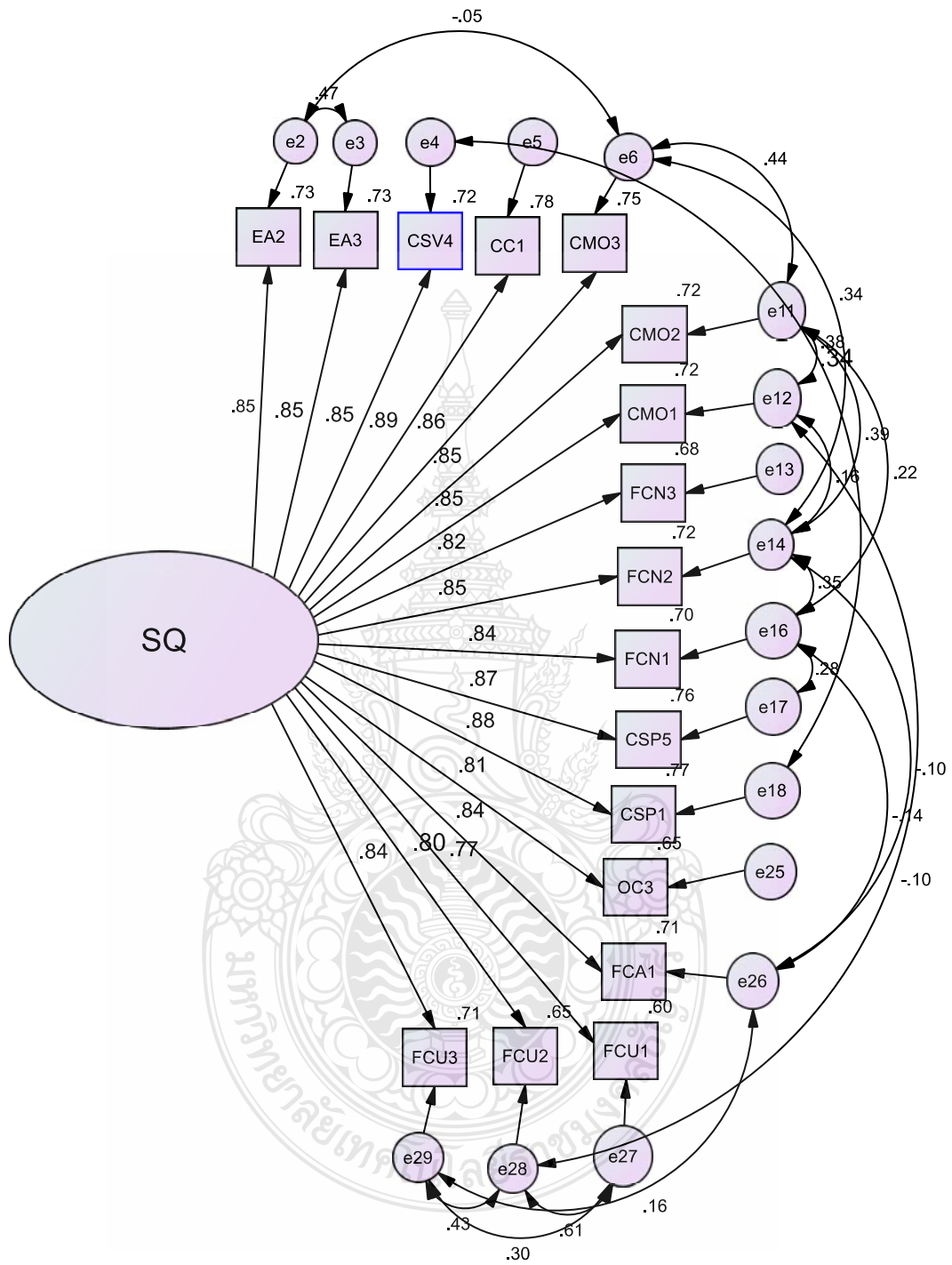


Figure 4.5 The standardized regression weights of the CFA model of service quality (SQ) (Default model)

The model evaluation, the conceptualizing the Confirmatory Factors Analysis (CFA) model in Figure 4.5 is within the component matrix of Service Quality (SQ) structure testing the factorial validity of score from a measuring instrument framework, as presented in Table 4.21. Thus, the model components in this format can be beneficial because it is consistent with the methodology by which the results from structural equation modelling (SEM) analyses are commonly reported shows the pattern of parameters to be estimated within matrices: the factors-loading matrix. Therefore, Goodness – of – fit summary concentrated in reviewing the Goodness-of-fit statistics in Table 4.21, it shows that the hypothesized model fits the data very well as evidenced by the Chi-square = 774.969 and Degrees of freedom = 97 and probability level = .000. Consequently, they examined the modification indices purely in the interest of completeness. In reviewing the modification indices (Mis) related to the covariance, two distinctive values emerge that are substantially larger than the rest of the estimates. However, as indicated by the reported parameter change statistics, incorporating these two parameters into the model would result in parameter values, respectively, as shown in Figure 4.5 Model maximum likelihood (ML) estimates. For clarification of the terminology associated with the output, the factor loadings are listed as Regression Weights. Listed first are the second-order factor loadings, followed by the first-order loadings. Finally, the related standardized estimates are presented in Table 4.22. Therefore, it could be summarized that this the Confirmatory Factors Analysis (CFA) model is appropriate to clarify the interconnections among items and latent variables.

Table 4.21 The model fit statistics result of the CFA of service quality (Default model)

CMIN	<i>p</i> -value	df	CMIN/df	CFI	RMR	AGFI	PGFI	RMSEA	NFI	TLI
774.969	.000	97	7.989	.848	.062	.761	.538	.105	.943	.929

Table 4.22 The standardized regression weights of the CFA of service quality (Default model)

Standardized regression weights		Estimate	<i>p</i> -value	
EA2	< ----	SQ	.852	***
EA3	< ----	SQ	.853	***
CSV4	< ----	SQ	.848	***
CC1	< ----	SQ	.885	***
CMO3	< ----	SQ	.865	***
CMO2	< ----	SQ	.847	***
CMO1	< ----	SQ	.848	***
FCN3	< ----	SQ	.824	***
FCN2	< ----	SQ	.849	***
FCN1	< ----	SQ	.838	***
CSP5	< ----	SQ	.873	***
CSP1	< ----	SQ	.879	***
OC3	< ----	SQ	.809	***
FCA1	< ----	SQ	.845	***
FCU1	< ----	SQ	.772	***
FCU2	< ----	SQ	.804	***
FCU3	< ----	SQ	.844	***

significance level: * = .05, ** = .01, *** = .001

4.5.6 Testing the Factorial Validity of Scores from a Measuring Instrument Validity Analysis of Model

The Construct Validity, all *p*-values related to each the value of loading is a significant value of less than 0.05. Besides, all values of factor loading are more than 0.5 respectively. All value scales of average variance extracted (AVE) of thirty-two items are more than 0.5. In addition, the composite reliability (CR) ranged from .900 to .977, these values exceeded .7, suggesting an adequate acceptance on criteria. Thus, these outcomes are underly acceptable criteria. It could be supported that these thirty-two items best describe the structure of the instrument survey.

Table 4.23 Convergent validity: standardized factor loading (λ), the variance due to the measurement error ($Var.(\delta)$), composite reliability (CR), average variance extracted (AVE)

Constructs	Items (n)	λ	λ^2	$Var. (\delta)$	AVE	CR
F1 (TL)	IC2	.804	.646	.354	.641	.947
	IC1	.839	.704	.296		
	IS2	.844	.712	.288		
	IS1	.810	.656	.344		
	Iib2	.816	.666	.334		
	Iib1	.654	.428	.572		
	Iia2	.758	.575	.425		
	Iia1	.785	.616	.384		
	IM2	.836	.699	.301		
	IM1	.843	.711	.289		
F2 (CL)	SE1	.697	.486	.514	.659	.944
	SE2	.622	.387	.613		
	SVA1	.801	.642	.358		
	SVA2	.866	.750	.250		
	SVA3	.903	.815	.185		
	SVA5	.929	.863	.137		
	SVA6	.920	.846	.154		
	SVA7	.897	.805	.195		
	PR1	.582	.339	.661		
F3 (GSE)	GSE1	.755	.570	.430	.551	.924
	GSE2	.695	.483	.517		
	GSE3	.757	.573	.427		
	GSE4	.741	.549	.451		
	GSE5	.790	.624	.376		
	GSE6	.799	.638	.362		
	GSE7	.662	.438	.562		
	GSE8	.761	.579	.421		
	GSE9	.697	.485	.514		
	GSE10	.752	.565	.434		

Table 4.23 Convergent validity: standardized factor loading (λ), the variance due to the measurement error ($Var.(\delta)$), composite reliability (CR), average variance extracted (AVE) (Cont.)

Constructs	Items (n)	λ	λ^2	$Var. (\delta)$	AVE	CR
F4 (TA)	PE1	.707	.500	.500	.506	.900
	PE2	.747	.558	.442		
	PE3	.784	.615	.385		
	EE1	.834	.696	.304		
	EE3	.821	.674	.326		
	EE4	.699	.489	.511		
	AT2	.566	.320	.680		
	AT3	.630	.397	.603		
	SI2	.550	.303	.698		
F5 (SQ)	EA2	.852	.726	.274	.712	.977
	EA3	.853	.728	.272		
	CSV4	.848	.719	.281		
	CC1	.885	.783	.217		
	CMO3	.865	.748	.252		
	CMO2	.847	.717	.283		
	CMO1	.848	.719	.281		
	FCN3	.824	.679	.321		
	FCN2	.849	.721	.279		
	FCN1	.838	.702	.298		
	CSP5	.873	.762	.238		
	CSP1	.879	.773	.227		
	OC3	.809	.654	.346		
	FCA1	.845	.714	.286		
	FCU1	.772	.596	.404		
	FCU2	.804	.646	.354		
	FCU3	.844	.712	.288		

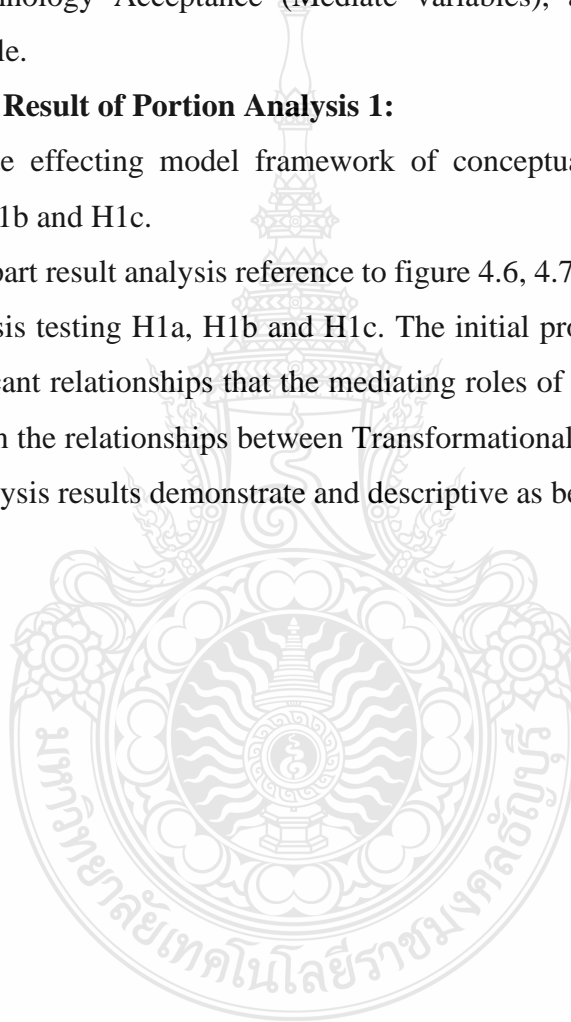
4.6 Structural Equation Model of the Theoretical Framework

Five data bundles of constructs to Purification and Reliability and Validity analysis. Which the initial model was an analysis for evaluated for the goodness-of-fit statistic applying with the structural equation model (SEM). The theoretical model includes the associations among five latent variables that are component with Transformational leadership and Charismatic Leadership (Exogenous variables), Self - Efficacy and Technology Acceptance (Mediate variables), and Service Quality is Endogenous variable.

4.6.1 The Result of Portion Analysis 1:

A Mediate effecting model framework of conceptual diagram analysis for hypothesis: H1a, H1b and H1c.

The first part result analysis reference to figure 4.6, 4.7 involves mediating role factors on hypothesis testing H1a, H1b and H1c. The initial procedure, considering are statistically significant relationships that the mediating roles of Technology Acceptance and Self-Efficacy in the relationships between Transformational Leadership and Service Quality. These analysis results demonstrate and descriptive as below:



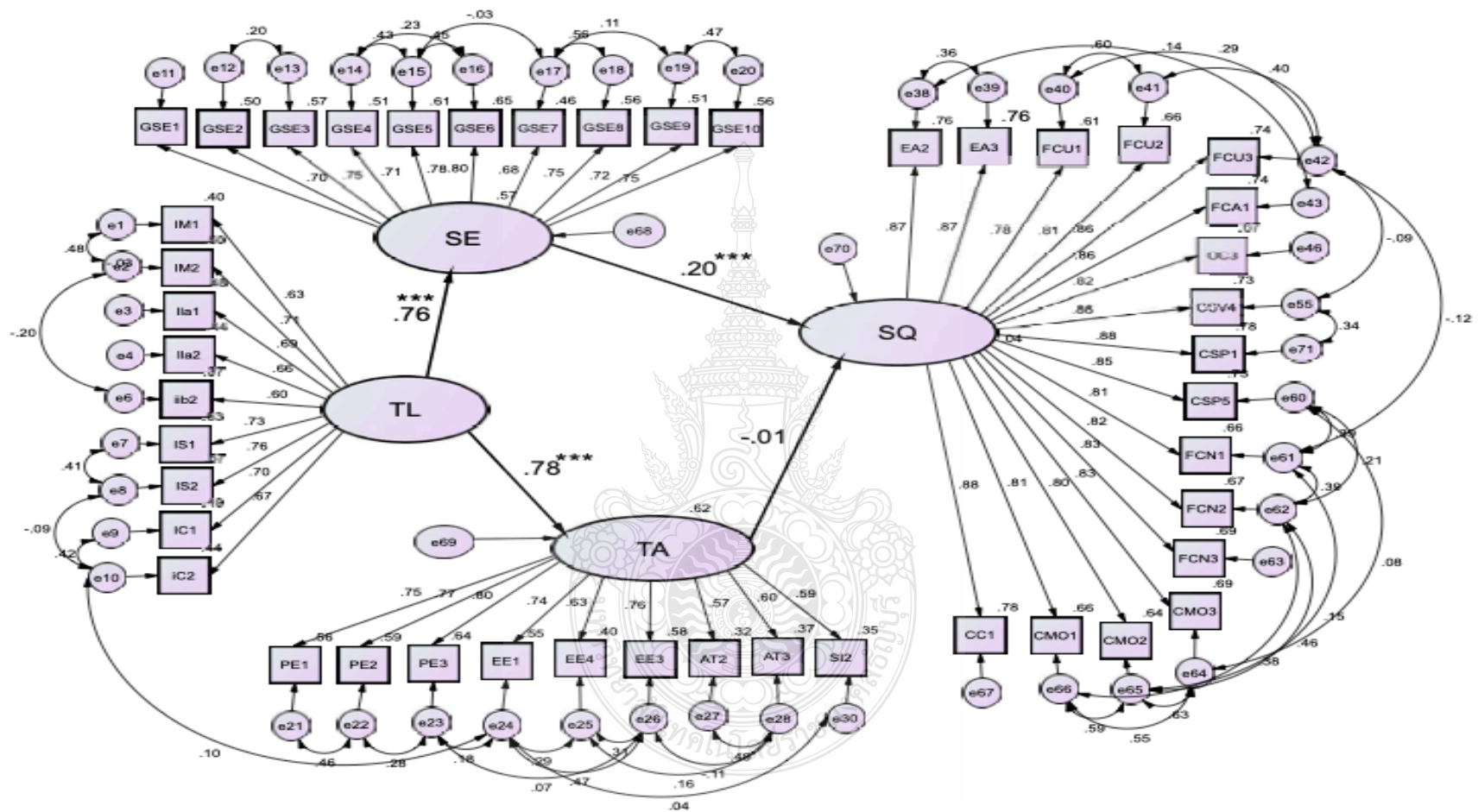


Figure 4.6 Structural model of the theoretical model (Default model) the mediating roles of technology acceptance and Self-Efficacy in the relationships between transformational leadership and service quality (Standardized Regression Weights) H1a, H1b

Table 4.24 For H1a, and H1b, the evaluated value for the goodness-of-fit statistic of the theoretical model (Default model) is the mediating roles of technology acceptance and self-efficacy in the relationships between transformational leadership and service quality

Statistic GOF Index	The statistic value	Threshold/ Fit Criterion
CMIN, χ^2 Statistic	1955.909	higher the probability ($p > 0.05$)
χ^2 / CMIN or CMIN/DF,	2.233	less than 5.0 being indicative of good fit
RMR	.035	be small is 0.5 or less
PGFI.	.742	more than 0.5
NFI and CFI	.927 and .958	more than .90
TLI	.953	a value close to .95 for large samples being indicative of good fit
RMSEA	.044	a value less than .05 indicates good fit, and value as high as .08 represent reasonable errors of approximation in the population
AIC and CAIC.	accepted	The hypothesized model is substantially smaller than they are for either the independence or the saturated models.
ECVI	accepted	The hypothesized model is substantially smaller than they are for either the independence or the saturated models.
*Hoelters CN	319	Value in excess of 200 is indicative of a model that adequately represents the sample data.

* $p < .01$

The theoretical model had an analysis of covariance structures. The analysis results showed that the goodness - of - fit statistic value. Which, it presented in Table 4.24. Focus on the set of fit statistic the value of CMIN represents the discrepancy

between the unrestricted sample covariance matrix S , and the restricted covariance matrix $\Sigma(\theta)$, and represent the Likelihood Ratio Test statistic, most commonly expressed to CMIN as the χ^2 Statistic. So, the Chi-square (CMIN) is 1955.909 at $p = .000$. While the degree of freedom (df) value is 876, CMIN/df value is 2.233. Acceptable, one of the first fit statistics to address this problem was the $\chi^2 / \text{degrees of freedom}$ ratio or CMIN/DF, be less than 5.0 is indicative of a good fit (Bentler & Bonett, 1980).

The next group of statistics is RMR. The standardized RMR, then, represents the average value across all standardized residuals, and range from zero to 1.00, in a well-fitting model, this value will be small is 0.5 or less. Thus, the acceptance RMR value is .035 underlie criteria the goodness - of - fit statistic value.

The last index of fit in this group, the Parsimony Goodness-of-Fit Index (PGFI), takes into account the complexity of the hypothesized model in the assessment of overall model fit. The outcome of the theoretical model analysis has to value that PGFI value is .742, the reference the indices range from zero to 1.00, with a value of more than 0.5 being indicative of a good fit (J. Hair et al., 2010).

Also, the NFI to take sample size into account and proposed the Comparative Fit Index (CFI). The value both of the NFI and CFI. Ranges from zero to 1.00 derived from the comparison of a hypothesized model with the independence (or null) model. Although a value $>.90$ was representative of a well-fitting model (Bentler, 1992). The outcome of the theoretical model analysis has to value that NFI value is .927, and the CFI value is .958, the references the indices. These are accepted.

Another one, The Tucker-Lewis Index (TLI), consistent with the other indices, yields value ranging from zero to 1.00, with values close to .95 for large samples being indicative of good fit (L. t. Hu & Bentler, 1999). The outcome of the theoretical model analysis has to value that the TLI value is .953, the references the indices. Thus, these theoretical model analyses are accepted.

The RMSEA expressed per degree of freedom, thus making it sensitive to the number of estimated of the parameter in the model as the complexity of the model if the value less than .05 indicate good fit and value as high as .08 represent reasonable errors of approximation in the population (Browne & Cudeck, 1993). The outcome of the

theoretical model analysis has to value that the RMSEA value is .044, the references the indices. These are the accepted theoretical model.

The last goodness-of-fit statistic is Hoelter Critical N (CN). That is focusing directly on the adequacy of sample size, rather than on model fit. Hoelter proposed that value above 200 is indicative of a model that adequately represents the sample data. The outcome of the theoretical model analysis has to value that Hoelter's number value is 319, the references the indices. These are accepted.

While, the testing results of H1a, H1b, to answer two research questions (RQ1) of the conceptual model were firsts that the mediating roles of Technology Acceptance and Self-Efficacy in the relationships between Transformational Leadership and Service Quality. The underlying study has summarized present in Table 4.25 below.

Table 4.25 The standardized direct, indirect, and total effect among variables of the proposed theoretical model (Default model) for hypothesis: H1a, H1b

DV	Mediating						Consequences		
	Self-Efficacy (SE)			Technology Acceptance (TA)			Services Quality (SQ)		
	DE	IE	TE	DE	IE	TE	DE	IE	TE
TL	.757***	.000	.757***	.785***	.000	.785***	.000	.146***	.139***
TA	.000	.000	.000	.000	.000	.000	-.014	.000	-.014
SE	.000	.000	.000	.000	.000	.000	.197***	.000	.197***

significance level: **P*-value < 0.05, ***p*-value < 0.01, ****p*-value < 0.001

Findings to answer the research question 1: What are the mediating roles of Technology Acceptance and Self-Efficacy in the relationships between Transformational Leadership and service quality in Thailand's primary healthcare provision context in Thailand? Which explicitly attempts to answer the following research questions and related hypotheses No. H1a, H1b. The demonstrated of H1a, H1b.

The findings of H1a were analysed. The positive effect of self-efficacy mediating the relationship between transformational leadership and service quality in Thailand's primary healthcare unit. The standardised total (direct and indirect) effect of Transformational Leadership (TL) on Self-Efficacy (SE) is .757; the *p*-value was .001,

indicating a significant positive direct relation exists. That is, due to direct effects of transformational leadership (TL) on Self-Efficacy (SE), when TL goes up by one standard deviation, SE goes up by .757 standard deviations.

The following estimate is the standardised total (direct and indirect) effect. The direct effect of self-efficacy (SE) on service quality (SQ) is 0.197, standard deviation p-value was .001, indicating that there are significant direct effects related to existing self-efficacy (SE) affecting service quality (SQ). At the same time, the mediating effect of self-efficacy (SE) in the relationship between transformational leadership (TL) and service quality (SQ) was .139 standard deviations at a p-value of .001. That is, due to indirect (mediated) effects of self-efficacy (SE) on service quality (SQ). Transformational Leadership (TL) goes up by one standard deviation. Services Quality (SQ) goes up by .139. These indicated that there are significant indirect (mediated) effects related to existing self-efficacy (SE) affecting service quality (SQ). Based on the results summarised, the outcome of the hypothesised model portion study answers to accept to support H1a has taken on this portion study.

Furthermore, the H2b quantitative analysis results show statistically significant correlations between transformational leadership (TL) and expressing good service quality (SQ), which are mediated by Technology Acceptance (TA). The standardised total (direct and indirect) effect of Transformational Leadership (TL) on Technology Acceptance (TA) is .785; the p-value is .001, showing the existence of a substantial positive direct relationship. That is, when transformational leadership (TL) increases by one standard deviation, technological acceptance (TA) increases by .785 standard deviations due to the direct (unmediated) effects of TL on TA.

The following estimate is the standardised total (direct and indirect) effect. The direct effect of Technology Acceptance (TA) on service quality (SQ) is -.014 standard deviation p-value was more than .05, indicating that there are non-significant direct (unmediated) effects related to existing Technology Acceptance (TA) affecting service quality (SQ). These indicated that there are non-significant indirect (mediated) effects related to existing transformational leadership (TL) affecting service quality (SQ). Based on the results summarised, the outcome of the hypothesised model portion study answers to reject to support H1b has taken on this portion study.

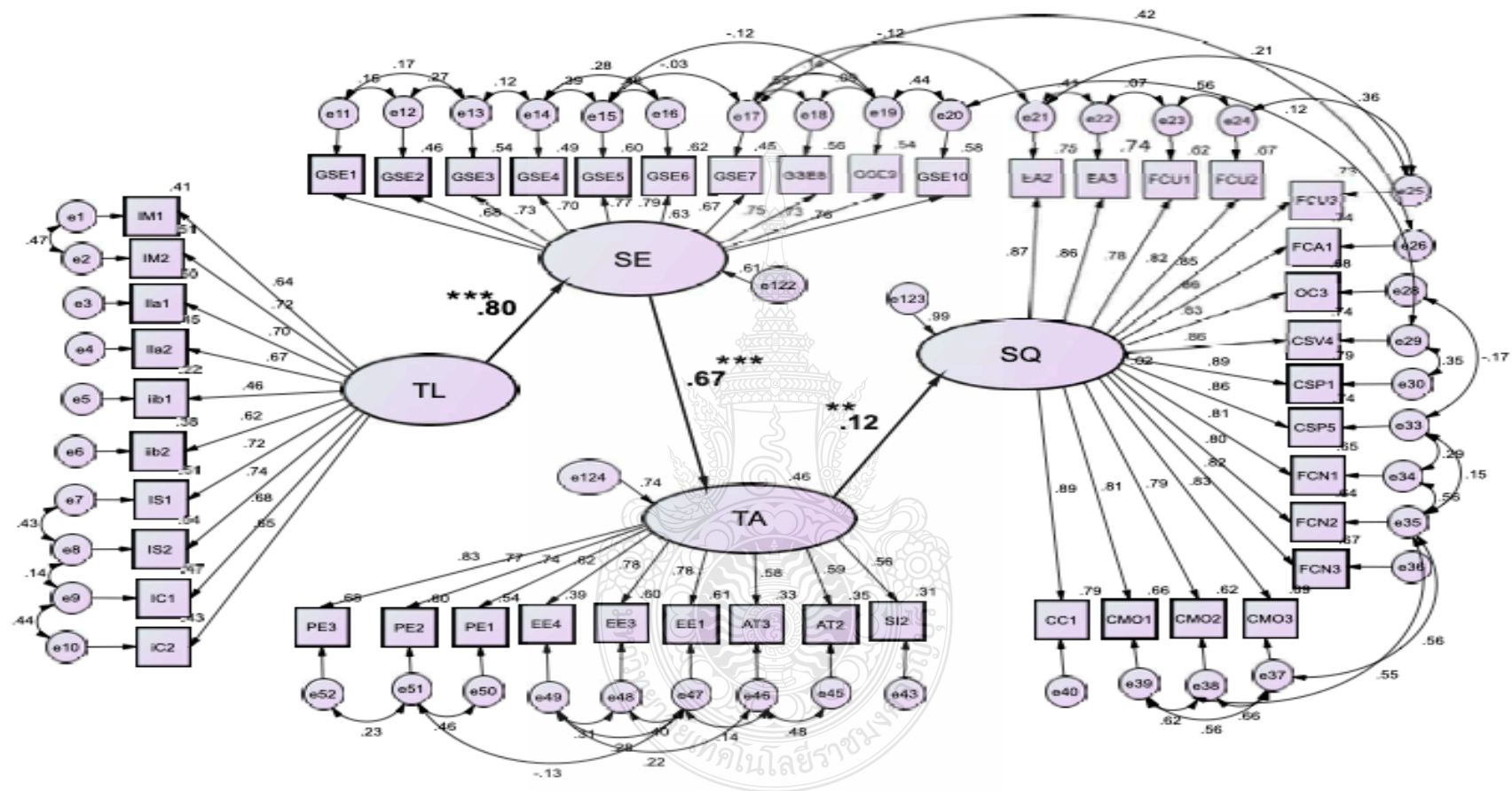


Figure 4.7 Structural model of the theoretical model (Default model) the mediating roles of technology acceptance and self-efficacy in the relationships between transformational leadership and service quality (Standardized Regression Weights) H1c

Table 4.26 For H1c, the evaluated value for the goodness-of-fit statistic of the theoretical model (Default model) is the mediating roles of technology acceptance and self-efficacy in the relationships between transformational leadership and service Quality

Statistic GOF Index	The statistic value	Threshold/ Fit Criterion
CMIN, χ^2 Statistic	1871.969	higher the probability ($p > 0.05$)
χ^2 / CMIN or CMIN/DF,	2.044	less than 5.0 being indicative of good fit
RMR	.047	be small is 0.5 or less
PGFI.	.750	more than 0.5
NFI and CFI	.931 and .963	more than .90
TLI	.959	a value close to .95 for large samples being indicative of good fit
RMSEA	.040	a value less than .05 indicates good fit, and value as high as .08 represent reasonable errors of approximation in the population
AIC and CAIC.	accepted	The hypothesized model is substantially smaller than they are for either the independence or the saturated models.
ECVI	accepted	The hypothesized model is substantially smaller than they are for either the independence or the saturated models.
*Hoelers CN	348	Value in excess of 200 is indicative of a model that adequately represents the sample data.

* $p < .01$

The theoretical model had an analysis of covariance structures. The analysis results showed that the goodness - of - fit statistic value. Which, it presented in Table 4.25. Focus on the set of fit statistic the value of CMIN represents the discrepancy between the unrestricted sample covariance matrix S , and the restricted covariance matrix $\Sigma(\theta)$, and represent the Likelihood Ratio Test statistic, most commonly expressed to CMIN as the χ^2 Statistic. So, the Chi-square (CMIN) is 1871.969 at $p = 0.000$. While the degree of freedom (df) value is 916, CMIN/df value is 2.044. Acceptable, one of the first fit statistics to address this problem was the $\chi^2 / \text{degrees of freedom}$ ratio or CMIN/DF, be less than 5.0 is indicative of a good fit (Bentler & Bonett, 1980).

The next group of statistics is RMR. The standardized RMR, then, represents the average value across all standardized residuals, and range from zero to 1.00, in a well-fitting model, this value will be small is 0.5 or less. Thus, the acceptance RMR value is .047 underlie criteria the goodness - of - fit statistic value.

The last index of fit in this group, the Parsimony Goodness-of-Fit Index (PGFI), takes into account the complexity of the hypothesized model in the assessment of overall model fit. The outcome of the theoretical model analysis has to value that PGFI value is .750, the reference the indices range from zero to 1.00, with a value of more than .5 being indicative of a good fit (J. Hair et al., 2010).

Also, the NFI to take sample size into account and proposed the Comparative Fit Index (CFI). The value both of the NFI and CFI. Ranges from zero to 1.00 derived from the comparison of a hypothesized model with the independence (or null) model. Although a value $>.90$ was representative of a well-fitting model (Bentler, 1992). The outcome of the theoretical model analysis has to value that NFI value is .931, and the CFI value is 0.963, the references the indices. These are accepted.

Another one, The Tucker-Lewis Index (TLI), consistent with the other indices, yields value ranging from zero to 1.00, with values close to .95 for large samples being indicative of good fit (L. t. Hu & Bentler, 1999). The outcome of the theoretical model analysis has to value that the TLI value is .963, the references the indices. Thus, these theoretical model analyses are accepted.

The RMSEA expressed per degree of freedom, thus making it sensitive to the number of estimated of the parameter in the model as the complexity of the model if the

value less than .05 indicate good fit and value as high as .08 represent reasonable errors of approximation in the population (Browne & Cudeck, 1993). The outcome of the theoretical model analysis has to value that the RMSEA value is .04, the references the indices. These are the accepted theoretical model.

The last goodness-of-fit statistic is Hoelter Critical N (CN). That is focusing directly on the adequacy of sample size, rather than on model fit. Hoelter proposed that value above 200 is indicative of a model that adequately represents the sample data. The outcome of the theoretical model analysis has to value that Hoelter's number value is 348, the references the indices. These are accepted.

While, the testing results of H1c, to answer two research questions (RQ1) of the conceptual model were firsts that the mediating roles of Technology Acceptance and Self-Efficacy in the relationships between Transformational Leadership and Service Quality. The underlying study has summarized present in Table 4.26 below.

Table 4.27 The standardized direct, indirect, and total effect among variables of the proposed theoretical model (Default model) for hypothesis: H1c

DV	Mediating						Consequences		
	Self-Efficacy (SE)			Technology Acceptance (TA)			Services Quality (SQ)		
	DE	IE	TE	DE	IE	TE	DE	IE	TE
TL	.796***	.000	.796***	.000	.537***	.537***	.000	.067**	.067**
TA	.000	.000	.000	.000	.000	.000	.125**	.000	.125**
SE	.000	.000	.000	.675***	.000	.675***	.000	.084**	.084**

significance level: * P -value < 0.05, ** p -value < 0.01, *** p -value < 0.001

Findings to answer the research question 1: What are the mediating roles of Technology Acceptance and Self-Efficacy in the relationships between Transformational Leadership and service quality in Thailand's primary healthcare provision context in Thailand? Which explicitly attempts to answer the following research questions and related hypotheses No. H1c. As demonstrated by H1c.

The analysis results of H2c are statistically significant relationships that exist between Transformational Leadership (TL), expressing positive Services Quality (SQ)

have been both mediated through Self-Efficacy (SE) and Technology Acceptance (TA). Thus, the results showed that the standardized direct, indirect, and total effects of transformational leadership (TL) and Self-Efficacy (SE) were, respectively. The standardized total (direct and indirect) effect of transformational leadership (TL) on Self-Efficacy (SE) is .769. That is, due to the direct effects of transformational leadership (TL) on Self-Efficacy (SE) when transformational leadership (TL) goes up by one standard deviation, Self-Efficacy (SE) goes up by .769 standard deviations. The p-value was .001, indicating a significant positive direction related to existing Transformational Leadership (TL) affecting Self-Efficacy (SE).

Furthermore, in the next estimate, the standardized total (direct and indirect) effect of transformational leadership (TL) on Technology Acceptance (TA) is .573. That is, due to the indirect (mediated) effects of Transformational Leadership (TL) on Technology Acceptance (TA), when TL goes up by one standard deviation, TA goes up by .573 standard deviations. The p-value was .001, indicating a significant positive indirect relation to existing Transformational Leadership (TL) affecting Technology Acceptance (TA).

Besides, the standardized total (direct and indirect) effect of Self-Efficacy (SE) on Technology Acceptance (TA) is .675, and the p-value was .001, indicating that there is a significant positive direct relation to exists Self-Efficacy (SE) affecting Technology Acceptance (TA). That is, due to direct (un-mediated) effects of Self-Efficacy (SE) on Technology Acceptance (TA). When Self-Efficacy (SE) goes up by one standard deviation, Technology Acceptance (TA) goes up by .675, indicating that there is a significant positive direct effect related to existing Self-Efficacy (SE) affecting Technology Acceptance (TA).

In addition, the standardized total (direct and indirect) effect of Self-Efficacy (SE) on Services Quality (SQ) is .084, and the p-value was .001, indicating that there is a significant positive direct relation to existing Self-Efficacy (SE) affecting Services Quality (SQ). That is, indirect (mediated) effects of Self-Efficacy (SE) on Services Quality (SQ). When Self-Efficacy (SE) goes up by one standard deviation, Services Quality (SQ) goes up by .084 standard deviations, and the p-value was .001 indicates that

there is a significant positive indirect (mediated) effect related to existing Self-Efficacy (SE) affecting to Services Quality (SQ).

Furthermore, the following estimate, the standardized total effect of Technology Acceptance (TA) on Services Quality (SQ) is .125. That is, due to direct (un-mediated) effects of Technology Acceptance (TA) on Services Quality (SQ). When Technology Acceptance (TA) goes up by one standard deviation, Services Quality (SQ) goes up by .125 standard deviations p-value was .004, indicating that there are significant direct (un-mediated) effects related to existing Technology Acceptance (TA) affecting Services Quality (SQ).

At the same time, the mediating effect of self-efficacy (SE) and technology acceptance (TA) in the relationship between transformational leadership (TL) and service quality (SQ) was .067 standard deviations at a p-value of .000. That is, due to the indirect (mediated) effects of transformational leadership (TL) on service quality (SQ). Transformational Leadership (TL) goes up by one standard deviation. Service Quality (SQ) goes up by .067. These indicated that there are significant indirect (mediated) effects related to existing self-efficacy (SE) affecting service quality (SQ). Based on the results summarised, the outcome of the hypothesised model portion of the study answers to accept to support H1c has taken on this portion of the study.

The summary finds a direct and mediation effect analysis for research question no. 1 to find out the answers supported by H1a, H1b, and H1c on portion study 1, the outcome of an investigation. It could be summed up that this framework is appropriate to clarify the influence of the direct and mediation effects of the analysis demonstrated. The following are the findings to answer research question no. 1: does a mediation analysis of the relationship that exists between Transformational Leadership (TL) and expressing positive service quality (SQ) have been both mediated through Self-Efficacy (SE) and Technology Acceptance (TA), and that the results are significant enough to support H1a and H1c in studies portion-1. However, the results revealed by mediation effect analysis to test hypotheses to find out whether the answer is unsupported H1b has not expressed the mediating roles of technology acceptance in the relationships between transformational leadership and service quality, as summarised in Table 4.30 below.

4.6.2 The result of portion analysis 2:

A Mediate effecting model framework of conceptual diagram analysis for hypothesis: H2a, H2b and H2c.

The second part result analysis, reference to figures 4-8, involves mediated factors in hypothesis testing H2a, H2b and H2c. The initial procedure, considering statistically significant relationships that exist between Charismatic Leadership (CL) and expressing positive Services Quality (SQ), both are mediating roles through Self-Efficacy (SE) and Technology Acceptance (TA). These analysis results demonstrate and descriptive as below:



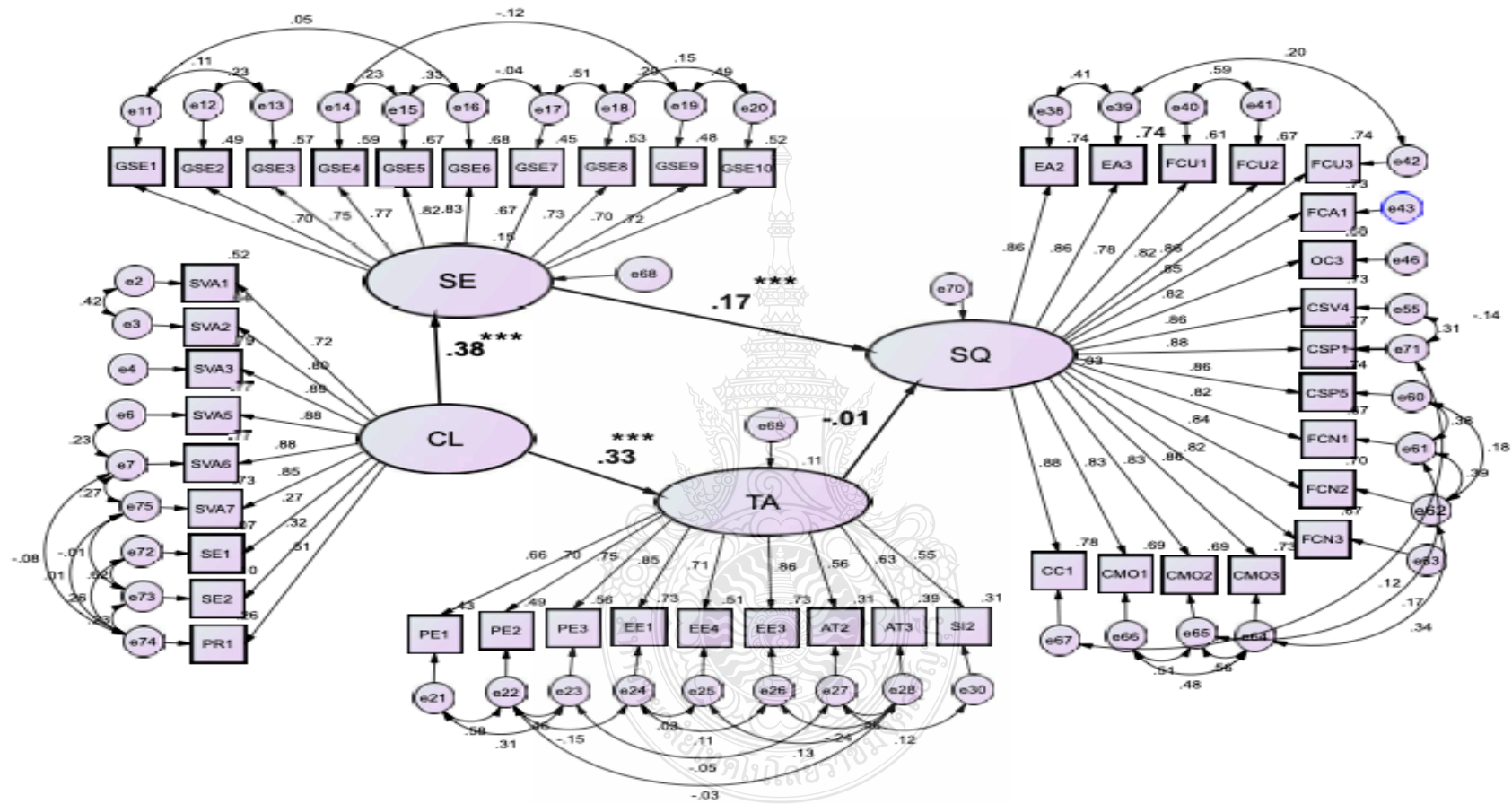


Figure 4.8 Structural model of the theoretical model (Default model) the mediating roles of technology acceptance and self-efficacy in the relationships between charismatic leadership and service quality (Standardized Regression Weights) H2a and H2b

Table 4.28 For H2a, and H2b, the evaluated value for the Goodness-of-Fit statistic of the theoretical model (Default model) the mediating roles of technology acceptance and Self-Efficacy in the relationships between charismatic leadership and service quality

Statistic GOF Index	The statistic value	Threshold/ Fit Criterion
CMIN, χ^2 Statistic	2357.766	higher the probability ($p > 0.05$)
χ^2 / CMIN or CMIN/DF,	2.758	less than 5.0 being indicative of good fit
RMR	.081	be small is 0.5 or less
PGFI.	.695	more than 0.5
NFI and CFI	.919 and .947	more than .90
TLI	.938	a value close to .95 for large samples being indicative of good fit
RMSEA	.052	a value less than .05 indicates good fit, and value as high as .08 represent reasonable errors of approximation in the population
AIC and CAIC.	accepted	The hypothesized model is substantially smaller than they are for either the independence or the saturated models.
ECVI	accepted	The hypothesized model is substantially smaller than they are for either the independence or the saturated models.
*Hoelter CN	259	Value in excess of 200 is indicative of a model that adequately represents the sample data.

* $p < .01$

Considerate on the theoretical model analyses covariance structures. The analysis results showed that the goodness - of - fit statistic value. Which, it presented in Table 4.27. The set of fit statistic the value of CMIN represents the discrepancy between

the unrestricted sample covariance matrix S , and the restricted covariance matrix $\Sigma(\theta)$, and represent the Likelihood Ratio Test statistic, most commonly expressed to CMIN as the χ^2 Statistic. So, the Chi-square (CMIN) is 2357.766 at $P = .000$, The null hypothesis (H_0) postulates that specification of the factor loadings, factor variances, and covariances, and error variance for the model under study is valid; the χ^2 test simultaneously tests the extent to which this specification is true. The probability value associated with the χ^2 represents the likelihood of obtaining a χ^2 value that exceeds the χ^2 value when H_0 is true. Thus, the higher the probability ($p > 0.05$) associated with the χ^2 , the closer the fit between the hypothesized model (under H_0) and the perfect fit (Bollen, 1989a). While the degree of freedom (df) value is 855, CMIN/df value is 2.758. Acceptable, one of the first fit statistics to address this problem was the χ^2 / degrees of freedom ratio or CMIN/DF, be less than 5.0 is indicative of a good fit (Bentler & Bonett, 1980).

The next group of statistics is RMR and PGFI. The standardized RMR, then, represents the average value across all standardized residuals, and range from zero to 1.00, in a well-fitting model, this value will be small is 0.5 or less. Thus, the acceptance RMR value is 0.081 underlie criteria the goodness - of - fit statistic value.

The last index of fit in this group, the Parsimony Goodness-of-Fit Index (PGFI), takes into account the complexity of the hypothesized model in the assessment of overall model fit. The outcome of the theoretical model analysis has to value that PGFI value is 0.695, the reference the indices range from zero to 1.00, with a value of more than 0.5 being indicative of a good fit (J. Hair et al., 2010).

Also, the NFI to take sample size into account and proposed the Comparative Fit Index (CFI). The value both of the NFI and CFI. Ranges from zero to 1.00 derived from the comparison of a hypothesized model with the independence (or null) model. Although a value $> .90$ was representative of a well-fitting model (Bentler, 1992). The outcome of the theoretical model analysis has to value that NFI value is .919, and the CFI value is .947, the references the indices. These are accepted.

Another one, The Tucker-Lewis Index (TLI), consistent with the other indices, yields value ranging from zero to 1.00, with values close to .95 for large samples being indicative of good fit (L. t. Hu & Bentler, 1999). The outcome of the theoretical model

analysis has to value that the TLI value is .938, the references the indices. These are accepted.

The RMSEA expressed per degree of freedom, thus making it sensitive to the number of estimated of the parameter in the model as the complexity of the model if the value less than .05 indicate good fit and value as high as .08 represent reasonable errors of approximation in the population (Browne & Cudeck, 1993). The outcome of the theoretical model analysis has to value that the RMSEA value is 0.052, the references the indices. These are accepted.

The last goodness-of-fit statistic is Hoelter Critical N (CN). That is focusing directly on the adequacy of sample size, rather than on model fit. Hoelter proposed that value over 200 is indicative of a model that adequately represents the sample data. The outcome of the theoretical model analysis has to value that Hoelter's number value is 259, the references the indices. These are accepted.

The testing results of H2a and H2b, to answer research question No.2 of the conceptual model. The following effects to the next to have drawn from the mediating roles of Technology Acceptance and Self-Efficacy in the relationships between Charismatic Leadership and Service Quality underlying study summarized present in Table 4.28 below.

Table 4.29 The standardized direct, indirect, and total effect among variables of the proposed Theoretical model (Default model) self-efficacy as mediator of the effect of charismatic leadership style and technology acceptance on performance services quality. H2a, H2b

DV	Mediating						Consequences		
	Self-Efficacy (SE)			Technology Acceptance (TA)			Services Quality (SQ)		
	DE	IE	TE	DE	IE	TE	DE	IE	TE
CL	.383***	.000	.383***	.326***	.000	.326***	.000	.063***	.063***
TA	.000	.000	.000	.000	.000	.000	-.006	.000	-.006
SE	.000	.000	.000	.000	.000	.000	.170***	.000	.170***

significance level: **P*-value < 0.05, ***p*-value < 0.01, ****p*-value < 0.001

Findings to answer the research question 1: What are the mediating roles of Technology Acceptance and Self-Efficacy in the relationships between Charismatic Leadership and service quality in Thailand's primary healthcare provision context in Thailand? which explicitly attempts to answer the following research questions and related hypotheses H2a or H2b.

The findings of H2a were analysed. The positive effect of self-efficacy mediates the relationship between charismatic leadership and service quality in Thailand's primary healthcare unit. The standardised total (direct and indirect) effect of Charismatic Leadership (CL) on Self-Efficacy (SE) is .383; the p-value was .001, indicating a significant positive direct relationship exists. That is, due to the direct effects of charismatic leadership (CL) on self-efficacy (SE), when CL goes up by one standard deviation, SE goes up by .383 standard deviations.

The following estimate is the standardised total (direct and indirect) effect. The direct effect of self-efficacy (SE) on service quality (SQ) is .170, standard deviation p-value was .001, indicating that there are significant direct (un-mediated) effects related to existing self-efficacy (SE) affecting service quality (SQ). At the same time, the mediating effect of self-efficacy (SE) in the relationship between charismatic leadership (CL) and service quality (SQ) was .063 standard deviations at a p-value of .001. That is, due to indirect (mediated) effects of self-efficacy (SE) on service quality (SQ). Charismatic Leadership (CL) goes up by one standard deviation. Services Quality (SQ) goes up by .063. These indicated that there are significant indirect (mediated) effects related to existing self-efficacy (SE) affecting service quality (SQ). Based on the results summarised, the outcome of the hypothesised model portion of the study has been accepted to support H2a.

Furthermore, the H2b quantitative analysis results show statistically significant correlations between charismatic leadership (CL) and expressing good service quality (SQ), which are mediated by Technology Acceptance (TA). The standardised total (direct and indirect) effect of Charismatic Leadership (CL) on Technology Acceptance (TA) is .326; the p-value is .001, showing the existence of a substantial positive direct relationship. That is, when charismatic leadership (CL) increases by one standard

deviation, technological acceptance (TA) increases by .326 standard deviations due to the direct (unmediated) effects of CL on TA.

The following estimate is the standardised total (direct and indirect) effect. The direct effect of Technology Acceptance (TA) on service quality (SQ) is -.006. The standard deviation p-value was more than .05, indicating that there are non-significant direct (un-mediated) effects related to existing Technology Acceptance (TA) affecting service quality (SQ). These indicated that there are non-significant indirect (mediated) effects related to existing charismatic leadership (CL) affecting service quality (SQ). Based on the results summarised, the outcome of the hypothesised model portion of the study is rejected to support H2b's take on this portion of the study.



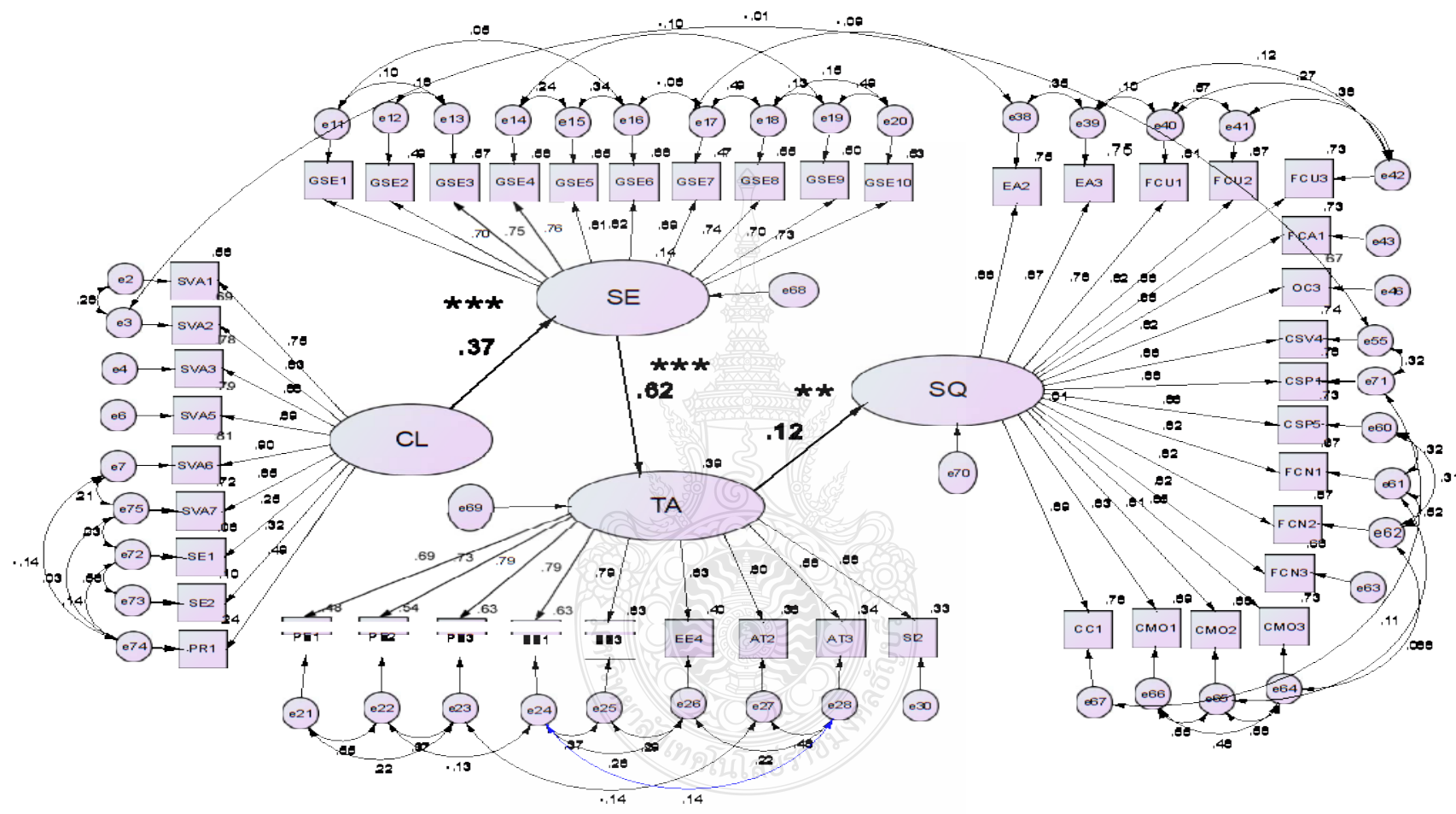


Figure 4.9 Structural model of the theoretical model (Default model) the mediating roles of technology acceptance and self-efficacy in the relationships between charismatic leadership style and service quality (Standardized Regression Weights) H1c

Table 4.30 For H2c, the Evaluated value for the Goodness-of-Fit statistic of the theoretical model (Default model) the mediating roles of technology acceptance and Self-efficacy in the relationships between charismatic leadership and service quality

Statistic GOF Index	The statistic value	Threshold/ Fit Criterion
CMIN, χ^2 Statistic	2796.179	higher the probability ($p > 0.05$)
χ^2 / CMIN or CMIN/DF,	3.207	less than 5.0 being indicative of good fit
RMR	.077	be small is 0.5 or less
PGFI.	.695	more than 0.5
NFI and CFI	.904 and .921	more than .90
TLI	.922	a value close to .95 for large samples being indicative of good fit
RMSEA	.059	a value less than .05 indicates good fit, and value as high as .08 represent reasonable errors of approximation in the population
AIC and CAIC.	accepted	The hypothesized model is substantially smaller than they are for either the independence or the saturated models.
ECVI	accepted	The hypothesized model is substantially smaller than they are for either the independence or the saturated models.
*Hoelter CN	222	Value in excess of 200 is indicative of a model that adequately represents the sample data.

* $p < .01$

The theoretical model had an analysis of covariance structures. The analysis results showed that the goodness - of - fit statistic value. Which, it presented in Table 4.29. Focus on the set of fit statistic the value of CMIN represents the discrepancy between the unrestricted sample covariance matrix S, and the restricted covariance matrix

$\Sigma(\theta)$, and represent the Likelihood Ratio Test statistic, most commonly expressed to CMIN as the χ^2 Statistic. So, the Chi-square (CMIN) is 2796.179 at $p = .001$. While the degree of freedom (df) value is 827, CMIN/df value is 3.207. Acceptable, one of the first fit statistics to address this problem was the $\chi^2 / \text{degrees of freedom}$ ratio or CMIN/DF, be less than 5.0 is indicative of a good fit (Bentler & Bonett, 1980).

The next group of statistics is RMR. The standardized RMR, then, represents the average value across all standardized residuals, and range from zero to 1.00, in a well-fitting model, this value will be small is 0.5 or less. Thus, the acceptance RMR value is .077 underlie criteria the goodness - of - fit statistic value.

The last index of fit in this group, the Parsimony Goodness-of-Fit Index (PGFI), takes into account the complexity of the hypothesized model in the assessment of overall model fit. The outcome of the theoretical model analysis has to value that PGFI value is .695, the reference the indices range from zero to 1.00, with a value of more than 0.5 being indicative of a good fit (J. Hair et al., 2010).

Also, the NFI to take sample size into account and proposed the Comparative Fit Index (CFI). The value both of the NFI and CFI. Ranges from zero to 1.00 derived from the comparison of a hypothesized model with the independence (or null) model. Although a value $>.90$ was representative of a well-fitting model (Bentler, 1992). The outcome of the theoretical model analysis has to value that NFI value is .904, and the CFI value is .932, the references the indices. These are accepted.

Another one, The Tucker-Lewis Index (TLI), consistent with the other indices, yields value ranging from zero to 1.00, with values close to .95 for large samples being indicative of good fit (L. t. Hu & Bentler, 1999). The outcome of the theoretical model analysis has to value that the TLI value is .922, the references the indices. Thus, these theoretical model analyses are accepted.

The RMSEA expressed per degree of freedom, thus making it sensitive to the number of estimated of the parameter in the model as the complexity of the model if the value less than .05 indicate good fit and value as high as .08 represent reasonable errors of approximation in the population (Browne, Cudeck, Bollen, & Long, 1993). The outcome of the theoretical model analysis has to value that the RMSEA value is .059, the references the indices. These are the accepted theoretical model.

The last goodness-of-fit statistic is Hoelter Critical N (CN). That is focusing directly on the adequacy of sample size, rather than on model fit. Hoelter proposed that value above 200 is indicative of a model that adequately represents the sample data. The outcome of the theoretical model analysis has to value that Hoelter's number value is 222, the references the indices. These are accepted.

While, the testing results of H2c, to answer two research questions (RQ2) of the conceptual model were firsts that the mediating roles of Technology Acceptance and Self-Efficacy in the relationships between Charismatic Leadership (CL) and Service Quality. The underlying study has summarized present in Table 4.30 below.

Table 4.31 The standardized direct, indirect, and total effect among variables of the proposed theoretical model (Default model) self-efficacy as mediator of the effect of charismatic leadership Style and technology acceptance on performance services quality. H2c

DV	Mediating						Consequences		
	Self-Efficacy (SE)			Technology Acceptance (TA)			Services Quality (SQ)		
	DE	IE	TE	DE	IE	TE	DE	IE	TE
CL	.374***	.000	.374***	.000	.233***	.233***	.000	.028***	.028***
TA	.000	.000	.000	.000	.000	.000	.121**	.000	.121**
SE	.000	.000	.000	.622***	.000	.622***	.000	.075***	.075***

significance level: **P*-value < 0.05, ***p*-value < 0.01, ****p*-value < 0.001

Findings to answer the research question 2: What are the mediating roles of Technology Acceptance and Self-Efficacy in the relationships between Charismatic Leadership (CL) and service quality in Thailand's primary healthcare provision context in Thailand? Which explicitly attempts to answer the following research questions and related hypotheses No. H2c. As demonstrated by H2c.

The analysis results of H2c are statistically significant relationships that exist between Charismatic Leadership (CL), expressing positive Services Quality (SQ) have been both mediated through Self-Efficacy (SE) and Technology Acceptance (TA). Thus, the results showed that the standardized direct, indirect, and total effects of

transformational leadership (TL) and Self-Efficacy (SE) were, respectively. The standardized total (direct and indirect) effect of Charismatic Leadership (CL) on Self-Efficacy (SE) is .374. That is, due to the direct effects of Charismatic Leadership (CL) on Self-Efficacy (SE) when Charismatic Leadership (CL) goes up by one standard deviation, Self-Efficacy (SE) goes up by .374 standard deviations. The p-value was .001, indicating a significant positive direction related to Charismatic Leadership (CL) affecting Self-Efficacy (SE).

Furthermore, in the next estimate, the standardized total (direct and indirect) effect of Charismatic Leadership (CL) on Technology Acceptance (TA) is .233. That is, due to the indirect (mediated) effects of Charismatic Leadership (CL) on Technology Acceptance (TA), when TL goes up by one standard deviation, TA goes up by .233 standard deviations. The p-value was .001, indicating a significant positive indirect relation to existing Charismatic Leadership (CL) affecting Technology Acceptance (TA).

Besides, the standardized total (direct and indirect) effect of Self-Efficacy (SE) on Technology Acceptance (TA) is .622, and the p-value was .001, indicating that there is a significant positive direct relation to exist Self-Efficacy (SE) affecting Technology Acceptance (TA). That is, due to direct (un-mediated) effects of Self-Efficacy (SE) on Technology Acceptance (TA). When Self-Efficacy (SE) goes up by one standard deviation, Technology Acceptance (TA) goes up by .622, indicating that there is a significant positive direct effect related to existing Self-Efficacy (SE) affecting Technology Acceptance (TA).

In addition, the standardized total (direct and indirect) effect of Self-Efficacy (SE) on Services Quality (SQ) is .075, and the p-value was .001, indicating that there is a significant positive direct relation to existing Self-Efficacy (SE) affecting Services Quality (SQ). That is, indirect (mediated) effects of Self-Efficacy (SE) on Services Quality (SQ). When Self-Efficacy (SE) goes up by one standard deviation, Services Quality (SQ) goes up by .075 standard deviations, and the p-value was .001 indicates that there is a significant positive indirect (mediated) effect related to existing Self-Efficacy (SE) affecting to Services Quality (SQ).

Furthermore, the following estimate, the standardized total effect of Technology Acceptance (TA) on Services Quality (SQ) is .121. That is, due to direct (un-

mediated) effects of Technology Acceptance (TA) on Services Quality (SQ). When Technology Acceptance (TA) goes up by one standard deviation, Services Quality (SQ) goes up by .121 standard deviations p-value was .005, indicating that there are significant direct (un-mediated) effects related to existing Technology Acceptance (TA) affecting Services Quality (SQ).

At the same time, the mediating effect of self-efficacy (SE) and technology acceptance (TA) in the relationship between Charismatic Leadership (CL) and service quality (SQ) was .028 standard deviations at a p-value of .000. That is, due to the indirect (mediated) effects of Charismatic Leadership (CL) on service quality (SQ). Charismatic Leadership (CL) goes up by one standard deviation. Service Quality (SQ) goes up by .028. These indicated that there are significant indirect (mediated) effects related to existing self-efficacy (SE) affecting service quality (SQ). Based on the results summarised, the outcome of the hypothesised model portion of the study answers to accept to support H2c has taken on this portion of the study.

The summary finds a direct and mediation effect analysis for research question no. 2 to find out the answers supported by H2a, H2b, and H2c on portion study 2, the outcome of an investigation. It could be summed up that this framework is appropriate to clarify the influence of the direct and mediation effects of the analysis demonstrated. The following are the findings to answer research question no. 2: does a mediation analysis of the relationship that exists between Charismatic Leadership (CL) and expressing positive service quality (SQ) have been both mediated through Self-Efficacy (SE) and Technology Acceptance (TA), and that the results are significant enough to support H2a and H2c in studies portion2. However, the results revealed by mediation effect analysis to test hypotheses to find out whether the answer is unsupported H2b has not expressed the mediating roles of technology acceptance in the relationships between transformational leadership and service quality, as summarised in Table 4.31 below.

4.7 Hypotheses Examination

The conclusion of hypothesis examination, these sections to describe among the four-items of essential research hypothesis results like the following Table 4.32:

Table 4.32 The summary results of hypothesis testing for the theoretical model

Hypothesis	Results
Hypothesis 1a: the positive effect to which self-efficacy mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit.	Accepted
Hypothesis 1b: the positive effect to which technology acceptance mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit.	Rejected
Hypothesis 1c: H1c: the positive effect to which technology acceptance and self-efficacy mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit.	Accepted
Hypothesis 2a: the positive effect to which self-efficacy mediate the relationship between charismatic leadership and service quality in Thailand's primary healthcare unit.	Accepted
Hypothesis 2b: the positive effect to which technology acceptance mediate the relationship between charismatic leadership and service quality in Thailand's primary healthcare unit.	Rejected
Hypothesis 2c: the positive effect to which technology acceptance and self-efficacy mediate the relationship between charismatic leadership and service quality in Thailand's primary healthcare unit.	Accepted

4.8 Chapter Summary

This summary chapter reports the respondents' representatives, followed by Purification and Reliability Analysis among latent variables. The descriptive outcome of the theoretical framework analysis showed significant positive mediating roles of Technology Acceptance and Self-Efficacy in the relationships between Transformational Leadership, Charismatic Leadership and Service Quality.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

A concludes the findings and discussions, followed by implications for research and practice and limitations of the study. To summarize with an overview of the relevant findings' issues.

5.1 Summary of the Results

This study's result was to analyse a direct effect and mediation effect analysis modelling of the Theoretical framework to find significant positive effects of Transformational Leadership, Charismatic Leadership, and Service Quality. Also, the finding of the first portion shows that there is a full mediate effect of Transformational Leadership, expressing positive Services Quality that has been both mediated through Self-Efficacy and Technology Acceptance. In the second finding portion, there is a full mediate effect of Charismatic Leadership; expressing positive Service Quality has been mediated through Self-Efficacy and Technology Acceptance.

The data collected purpose population for this examination consisted of a sample of 639 persons consisting of the Public Health Technical Officer, Nurses. Besides, data gathered only Services Quality variable part from patients or customers 639 persons so that there were 1,278 participants. The data were drawn from current the Primary Healthcare Units mixed sizes (S), (M), (L), was randomly chosen out of a total of 426 places, and the attributes of the majority of respondents were shown in the descriptive statistics. Demographic of Leadership respondents (the Public Health Technical Officer, Nurses) portion descriptive below follows: Almost gender of the respondents is female, with 83.9%. About the age participating between 10-30 years old is the minority of the population with 15.5%, 31-40 years is 22.7 %, 41-51 years is 34.9% (the majority of the population), and older over 50 years old is 26.9% respectively. While important information about the education level of leadership participants is a bachelor's degree with 82.8%, and 14.4% are higher than a bachelor's degree, respectively.

Moreover, the Category type of primary healthcare units working places for participants, 54.6%, are Medium Size (services provided to the population amount more

than 3,000 to 8,000 persons). Next is Large Size (service provided to the population amount more than 8,000 persons) are 25.3%. Moreover, the minority is 20.2% with Small Size (service provided to the population amount less than 3,000 persons).

The patient respondent's portion has data collected in the same place and period as the Leadership respondent's portion. Most patient respondents were female, accounting for 86.1 %, with an age average of 31-50 years old equal to 55.0 %. About 36.8 % of the bachelor's degrees, around 29.3 %, are education less than secondary school. Regarding average monthly income, 67.4% of the respondents have had less than 15,000 Bath, followed by 16.0 % with More than 15,000 Baht but less than 20,000 Baht, respectively. About the number of family members, around 45.2 % with More than three persons but less than five persons.

In summary, the following are the answers to the research questions:

Research question 1. To what extent do technology acceptance and self-efficacy mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit context?

Research question 2. To what extent do technology acceptance and self-efficacy mediate the relationship between charismatic leadership and service quality in Thailand's primary healthcare unit context?

Theorizing and empirical evidence lead to the following hypothesis: research regarding the mediating effect of self-efficacy and technology acceptance in the relationship between transformational leadership and service quality. The first dimensions of the hypothesis set related are distinguished; the first set aspects are descriptive. Hypotheses H1a, H1b, and H1c have been tested to find the answer to the research question RQ1.

Furthermore, theoretical work on the role whereby charismatic leaders affects the performance of their followers indicates that charismatic leaders have a positive effect on the self-efficacy of their followers. This effect results from the charismatic leader's expression of confidence in the followers' ability to meet high-performance expectations. Hence, the above theorising and empirical evidence point to the following hypothesis research regarding the mediating effect of self-efficacy and technology acceptance in the relationship between charismatic leadership and service quality. These are descriptive and

the theories are tested to determine hypothesis H2a, H2b, and H2c to answer the research questions 2.

5.2 Discussions of the Results

The discussions of the results more express the research questions and hypothesis testing as described below.

5.2.1. Research Question 1:

To what extent do technology acceptance and self-efficacy mediate the relationship between transformational leadership and service quality in Thailand's primary healthcare unit context?

H1a attempted to investigate the results indicated a significant positive direct relation to existing transformational leadership affecting self-efficacy. Consequently, it could be concluded that transformational leadership and self-efficacy have been summarised. The outcome of the hypothesised model portion study answers is accepted to support the hypothesis taken in this portion study. If the load on factors was entitled "Self-Efficacy", through Facilitates Goal-Setting as the Public Health Technical Officer, Nurses were able to manage to solve complex problems if they tried hard enough. If someone opposed them, they could find the means and ways to get what they wanted. The following factors are "effort investment", as they were confident, they could deal efficiently with unexpected events and knew how to handle unforeseen situations. The last factor, recovery from setbacks, is that they are in trouble; they can usually think of a solution. Hence, it has emphasised that the hypothesis has supported latent variables related to the constructs along the premise hypothesis. Avolio and Bass (2004) mention the enhanced self-efficacy of individuals by leaders engaging in transformational leadership behaviours. At the same time, the positive relationship between transformational leadership and self-efficacy has been empirically supported (Nielsen et al., 2009; Shamir et al., 1993; Walumbwa et al., 2008). In an attempt to explain this role, the components of both concepts of transformational leadership and self-efficacy were examined closely. The transformational leadership theory of Bass (1998) suggests that five significant components of transformational leadership: idealised influence (attributes and behaviours), inspirational motivation, intellectual stimulation, and individualised

consideration are the factors that transformational leaders have their followers perform extraordinarily. Shamir et al. (1993) suggest that transformational leaders enhance self-efficacy in their effort to explain the effects of transformational leadership on followers.

In considering the mediating role of hypothesis H1a, the value results indicated that there are accepted relationships between transformational leadership and expressing positive service quality, which has been mediated through self-efficacy. Consequently, it could have been concluded that transformational leadership and self-efficacy summarised as the outcome of the hypothesised model portion study were accepted to support the hypothesis taken in the study. According to the statement by Bandura (1986), social cognitive theory assigns a central role to the self-regulatory mechanisms that motivate behaviour. Self-efficacy is believed to transmit the influence of the environment and the individual's observations of the outcomes of past responses to subsequent actions.

Next, in considering the mediating role of hypothesis H1b, the results of descriptive H1b are the values indicating statistically non-significant relationships between the mediating roles of technology acceptance in the relationships between transformational leadership and service quality. So, it could have been said that the answers to the portion study questions about transformational leadership and technology acceptance did not support the hypothesis taken in the portion study.

The reason is that the patient is not the direct application of technology acceptance in health technology. According to the review literature, the users' assessment of the effort involved in technology use was directly related to their ability to use the relevant technology's functional elements. Lacka and Chong (2016) explained that the health user's effort in technology use was directly related to the user's ability to use relevant technology's functional elements and usability. Since technology acceptance in health technology is involved, a better term would be technology usability. The former suggests digital health technology or users' perception of new technology. Usability refers to users' ability to use modern technology (and its functional elements), and thus the perception of effort involved in health technology use in the process of desired goal attainment (Lacka & Chong, 2016).

When considering the results of the descriptive H1c, the value indicated that there are accepted relationships mediating the effect of self-efficacy and technology

acceptance in the relationship between transformational leadership and service quality. Thus, the summary mentioned above has accepted the strength of the influencing effect of patients who have received services from the primary health care units (PCUs) of service quality through self-efficacy and technology acceptance of a transformational leadership style in a primary healthcare provision context in Thailand.

5.2.2. Research Question 2:

To what extent do technology acceptance and self-efficacy mediate the relationship between charismatic leadership and service quality in Thailand's primary healthcare unit context?

First, considering hypotheses H2a, the results of the descriptive H2a indicate that there is a statistically significant positive direct relation to existing charismatic leadership affecting self-efficacy. As a result, it could have been concluded that Charismatic Leadership and Self-Efficacy summarised the findings of the hypothesised model portion of the study and were accepted to be supported by research. Self-Efficacy, through goal-setting as the Charismatic Leadership of Primary Healthcare provision context in Thailand, can manage to solve complex problems if he or she tries hard enough. If someone opposes them, they can find the means and ways to get what they want. The following factors are "effort investment", as they were confident, they could deal efficiently with unexpected events and knew how to handle unforeseen situations. The hypothesis's emphasis has supported latent variables related to the constructs along premise H2a. According to Smith (1982), charismatic leadership leads to self-efficacy since the followers of charismatic leaders influence subordinates' self-assurance and perceptions of self-worth; charismatic leaders also affect subordinates' self-perceptions of their ability to contribute to the unit's mission. Also, Bandura (1986) presented studies on how charismatic leadership is related to followers' self-efficacy by a social cognitive theory, and charismatic leaders can express confidence in their followers' capability to meet performance expectations. Charismatic leadership, therefore, enhances followers' self-efficacy.

Considering the statistical analysis results of H2a, there is a statistically significant relationship that there is a mediating effect of self-efficacy in the relationship between Charismatic Leadership and Service Quality. Thus, the results showed that the

standardised direct effect, indirect effect, and total effect of charismatic leadership and self-efficacy were, respectively, based on the results summarised in partial, the outcome of the hypothesised model H2a, the development of the investigation, it could be summarised that this framework is appropriate to clarify the interactions among a mediation effect analysis process. According to Shelley Ann Kirkpatrick (1993), the study of quality self-efficacy beliefs mediated the relationship between charismatic leadership and follower performance quality to purpose; charismatic leaders affect followers' self-esteem and affect. It was found that followers' quality self-efficacy beliefs mediated the relationship between vision manipulation and follower performance quality.

Second, considering the analysis results, H2b is the value that revealed that the estimated value p-value had indicated a significant positive direction related to existing Charismatic Leadership affecting Technology Acceptance. Besides, the results showed that the standardised regression weights for charismatic leadership and technology acceptance were similarly accepted. Based on the summarised results, the outcome of the hypothesised model portion of the study was accepted to support a conceptual framework. The summaries of factors loading were entitled "Charismatic Leadership," comprising the Sensibility of the Environment, Strategic Vision and Articulations, and Personal Risk on these latent variable constructs. Hence, the degree of sensibility to members' needs is the extent of affiliation with whom leadership influences others by developing mutual liking and respect and showing sensitivity for the needs and feelings of the other members of the organisation. It often expresses personal concern for the needs and feelings of other organisation members. Leadership has a drive-by, seizes fresh possibilities to achieve goals, gives exciting strategic and organisational goals, and can encourage by communicating the relevance of what primary health care unit (PCU) members are doing consistently producing fresh ideas for the organisation's future and recognising new environmental chances (favourable physical and social factors). Also, personal risk in pursuing organisational objectives engages in activities involving considerable self-sacrifice, takes high personal risks for the sake of the organisation, and often incurs high personal costs for the organisation's good. These attributes or abilities of the charismatic leader mentioned above affect Technology Acceptance. The factor loading on the latent variable was entitled "Technology Acceptance". Thus, performance expectancy, the

extent of affiliation with Charismatic Leadership, would find the digital data and social networks helpful in his or her job. Using digital data and social network systems enables them to accomplish tasks more quickly, and using digital data and social network systems increases productivity. Also, effort expectancy and digital data work together, and the social network system would be easy to understand. It would be easy for Public Health Charismatic Leadership to become skilled at using digital data and social network systems. Charismatic leadership would find the digital data and social network system easy to use, and learning to operate the digital data and social network system is easy.

In considering the mediating role of hypothesis H2b, the results of descriptive H2b are the values indicating statistically non-significant relationships between the mediating roles of technology acceptance in the relationships between Charismatic Leadership and service quality. So, it could have been said that the answers to the portion study questions about Charismatic Leadership and technology acceptance did not support the hypothesis taken in the portion study. Due to the patient is not the direct applier of technology acceptance in health technology. According to the review literature, the users' assessment of the effort involved in technology use was directly related to their ability to use the relevant technology's functional elements. Lacka and Chong (2016) explained that the health user's effort in technology use was directly related to the user's ability to use relevant technology's functional elements and usability. Since technology acceptance in health technology is involved, a better term would be technology usability. It suggests digital health technology or users' perception of new technology. Usability refers to users' ability to use modern technology (and its functional elements), and thus the perception of effort involved in health technology use in the process of desired goal attainment (Lacka & Chong, 2016).

Third, the statistical analysis results of H2c are statistically significant relationships that There is a mediating effect of Self-Efficacy and Technology Acceptance in the relationship between Charismatic Leadership and Service Quality. Thus, the results showed that the standardized direct, indirect, and total effects of Charismatic Leadership and Self-Efficacy were, respectively. The direct effect that Charismatic Leadership have on Self-Efficacy is due to both direct and indirect effects of Technology Acceptance on Services Quality. When Technology Acceptance increases,

Services Quality increases, indicating significant direct and indirect effects related to existing Technology Acceptance affecting Services Quality.

Based on the results summarized of the hypothesized models H2a and H2c in the outcome of the investigation. It could summarize that this framework is appropriate to clarify the relationship in a mediation effect analysis process. According to Shelley Ann Kirkpatrick (1993), the study of quality self-efficacy beliefs mediated the relationship between charismatic leadership and follower performance quality to purpose charismatic leaders on follower self-esteem and affect. That followers' quality self-efficacy beliefs mediated the relationship between vision manipulation and follower performance quality. Also, McLees et al. (2015) revealed the constructs linkage of Technology Acceptance. It is related to service quality. Health information technology has capitalized on applications that improve the efficiency of healthcare operations and care delivery and have fostered more incredible innovation and collaborative care solutions to serve the needs of patients. Besides, Avancha et al. (2012); Shah et al. (2014) are among the scholars on Technology Acceptance. It relates to service quality by proposing that quality, efficiency, and reduced costs result from using IT to improve health care.

5.3 Contribution of the Study

The discussion of the fact-find to applied theoretical and Managerial Implications is as follows:

5.3.1 Theoretical Implications

There is the mediating effect of Self-Efficacy and Technology Acceptance in the relationship between Transformational Leadership and Service Quality.

These results add to the academic information that has been gathered so far. Burns, House, Bass, and Conger are the academic and empirical sources used. In the last four decades of research, one theory on leadership has been extensively developed to show how it improves numerous different kinds of organisations and individuals; the original piece began with a model of transformational leadership theory. Consequently, Bass (1985) took the initial theory of Burns (1978) as a foundation for a built construct of transformational leadership theory. Thailand Primary health care units (PCUs) have

added dimensions to healthcare leadership or healthcare manager, suggesting quantity domains of exceptional leadership capabilities. Moreover, from another viewpoint, management and leadership are understood as the capacity to guide health institutions and stakeholders, organisations, and social groups.

There is a mediating influence of technology acceptance in the relationship between transformational leadership and service quality, according to significant findings confirmed by statistical research. These findings show that leaders who engage in transformational leadership behaviours increase individuals' self-efficacy perceptions (Avolio & Bass, 2004). Similarly, empirical evidence has been gathered on the favourable association between transformative leadership and self-efficacy (Nielsen et al., 2009; Shamir et al., 1993; Walumbwa et al., 2008). The components of transformational leadership and self-efficacy have been thoroughly investigated. According to Shamir et al. (1993), the impacts of transformational leadership on followers can be explained by transformational leaders making followers feel better about themselves.

Furthermore, the concept results generally describe digital health systems and technology as self-explanatory to untrained users (Shultz & Hand, 2015). Moreover, Iqbal et al. (2013) confirmed that self-efficacy and facilitating conditions affect an individual's perceived behavioural control. Intentions, in turn, are a function of beliefs about outcomes, norms, and behavioural control (Powell, Bloomfield, Burgess, Wilt, & Partin, 2013). The users' assessment of the effort involved in technology use was directly related to their ability to use the relevant technology's functional elements. Lacka and Chong (2016) explained that the digital health user's effort in technology use was directly related to the user's ability to use relevant technology's functional elements and usability. Since digital health technology is involved, a better term would be technology usability. The digital health technology or users' perception of new technology. Usability, users' ability to use modern technology (and its functional elements) and the perception of effort involved in digital health technology dose used to attain desired goals (Lacka & Chong, 2016). Hence, the above theorizing and empirical evidence lead to the following hypothesis research regarding the mediating role of self-efficacy in the relationship between Technology Acceptance, Transformational leadership, and service quality. There were first dimensions of Theoretical Implications set related that are distinguished:

first set to aspects these are descriptive the theoretical are tested to answer the research questions 1.

There is a mediating effect of Self-Efficacy (SE) and Technology Acceptance (TA) in the relationship between Charismatic Leadership (CL) and Service Quality (SQ).

The second finding portion, these results to the finding notes that further support for these antecedents was found in the service quality management literature, which states that leadership style and task feedback obtained through employee involvement in the inspection of their work are crucial determinants of continuous implementation (Deming & Edwards, 1982; Juran, 2003). The replication and modification from Shamir et al. (1993) have extended House (1977) earlier theory of charismatic leadership by explaining the role whereby charismatic leadership behaviours affect follower behaviours and attitudes. Specifically, charismatic leaders affect followers' emotions and self-esteem. Thus, they conclude that charismatic leaders increase followers' perceptions of self-efficacy by enhancing the followers' self-esteem and self-worth. Likewise, finding evidence concludes that charismatic leadership leads to self-efficacy since the followers of the charismatic leaders that by influencing subordinates' self-assurance and perceptions of self-worth, charismatic leaders also affect subordinates' self-perceptions of their ability to contribute to the mission of the unit (Smith, 1982).

Further, in the experiment, Shelley Ann Kirkpatrick (1993) found that followers' quality self-efficacy beliefs mediated the relationship between vision manipulation and follower performance quality. As discussed above, verbal persuasion can also enhance self-efficacy cognitive (Bandura, 1986). According to the identity behaviour of charismatic leaders, support is the ability to express confidence in followers' capability to meet performance expectations. Charismatic leadership, therefore, enhances followers' self-efficacy.

Finally, emphasising the research contributes to recommendations regarding developing a system to improve the quality of healthcare and consistent practice study to adapt effectively by taking complete and creative advantage of technology acceptance same standards linkage. Furthermore, the evidence indicates that precise diagnostic results have been proposed to emphasise the development of the theory and phenomenal knowledge of the pathway of transformational leadership, charismatic leadership, self-

efficacy, technology acceptance, and service quality for proportional primary health care service in the public health policy context of the era 4.0. Similarly, digital-health care record implementation and use of information technology sharing have led healthcare providers to examine the effectiveness of information technology (Vest et al., 2014).

5.3.2 Managerial Implications

Results from this study have significant implications for policymakers and the Primary health care units (PCUs) in Thailand practitioner. There is an emergent need for Thailand's primary care system, especially the Primary health care units (PCUs). To be improved to enhance service quality, Settings have always been one of the essential factors to heighten desired primary health care. Service in the public health in the era 4.0 policy "Digital Economic" context in Thailand. How to utilize a combination of leadership aspects to efficiency and Technology Acceptance to implementing an evaluation workload process for personal and expenditure of administering expenditure improve organizational efficiency on health care service quality. Currently, the core competency priority for proportional primary health care services in the public health institution is the era of Thailand 4.0 policy and the digital economy. The government promotes them in this fast-changing modern society. Technology Acceptance care systems are on the way to enhancing service performance and quality under the restraint of health care cost inadequacy. Most of Thailand chooses primary health care unit settings as their major source of primary care. However, the quality of Primary health care units is still the unique feature of the Primary health care units recognized by the public. It, therefore, requires excellent efforts by the government to enhance the system and train competent primary health care unit (PCU) providers who can provide accessible, continuous, comprehensive, coordinated, community-cantered, and culturally adapted primary care.

Based on the findings, the following recommendations are made to improve Thailand's primary health care units. Enhance the primary health care unit workforce by increasing training of the number of generalists works such as implementing upskill and reskilling the digital media of the medical record system. Furthermore, the online access network appointment systems are the principal feature in employing the Technology

Acceptance health care system in the digital information technology-based quality service encounters.

- Improve the referral system so that primary care providers serve as gatekeepers.

- Provide incentives to practise transformational and charismatic leadership to improve cognitive and social reward and assign a central role to the self-regulatory mechanisms that motivate behaviours. As one of these mechanisms, self-efficacy has been believed to transmit the influence of the environment and the individual's observations of the outcomes of past responses to subsequent behaviours in primary health care units (PCUs) providers similar to the level of specialists.

5.4 Limitation of the Study

This study's limitations are that the cross-sectional nature dictates that only associations are identified as causal. Secondly, measures based on self-report by the public health technical officer and nurses may be subject to response bias due to the ability to measure. Third, though the results support the hypothesis, caution should be used to interpret the outcome. The results may be domain-specific and not generalizable to additional settings. Lastly, this study mainly focused on measuring process service quality from patients' perspectives.

5.5 Recommendations for Future Research

Firstly, longitudinal work performance and satisfaction studies have been conducted to examine the trend and identify more influencing factors. Therefore, similar studies should be performed continuously for comparisons. Secondly, providers' perspectives and health outcomes have included quality-of-care measures.

Furthermore, one subset of service systems that have not been given much attention in terms of service quality is those with no customer interaction. Consider e-services, for example. How is the quality of service measured for these services when there is no interaction with the patients? Patient to computer services should be studied to understand which dimensions impact service quality. Examples of computer services include online reservations, treatment, and financial transactions. Self-serve and

automated services, such as the queue line and self-check systems, should also be examined. Lastly, specific populations, especially vulnerable populations, should also focus on future research.

5.6 Conclusions

In the demonstrated non-significant relationship, there is a mediating effect of technology acceptance in the relationship between transformational leadership and service quality.

In addition, the analysis results show statistically significant relationships with the mediating effect of self-efficacy in the relationship between transformational leadership and service quality.

Moreover, the analysis results show statistically significant relationships with the mediating effect of self-efficacy and technology acceptance in the relationship between transformational leadership and service quality. These portions above affect transformational leadership style (as measured by MLQ) on service quality in Thailand's primary healthcare provision context.

In comparison, the next portion of the analysis is that in this non-significant relationship, there is a mediating effect of technology acceptance in the relationship between charismatic leadership and service quality.

In addition, the following result significantly affected the analysed undertaking. There is a mediating effect of self-efficacy in the relationship between Charismatic Leadership and Service Quality.

Moreover, the following result affects the analysed undertaking: a mediating effect of Self-Efficacy and Technology Acceptance in the relationship between Charismatic Leadership and Service Quality. Charismatic Leadership style (measured by CKS) on Service Quality in Thailand's Primary Healthcare provision context. However, the results have demonstrated significant relationships between the strength of the influencing effect of patients receiving services of the Primary health care units of Service Quality through Self-Efficacy, Technology Acceptance, and Charismatic Leadership style in the Primary Healthcare provision context in Thailand.

Thus, the settings in the primary healthcare provision context in Thailand. Need more fulfilling the characteristics of transformational and charismatic leadership styles in Thailand's primary healthcare provision context. A high-quality primary care system requires further efforts through the effect of Self-Efficacy and Technology Acceptance. Due to the patient is not the direct applier of technology acceptance in health technology. The characteristics of users' accessibility to the effort involved in specific technology use were directly related to their ability to use the relevant technology's functional elements.



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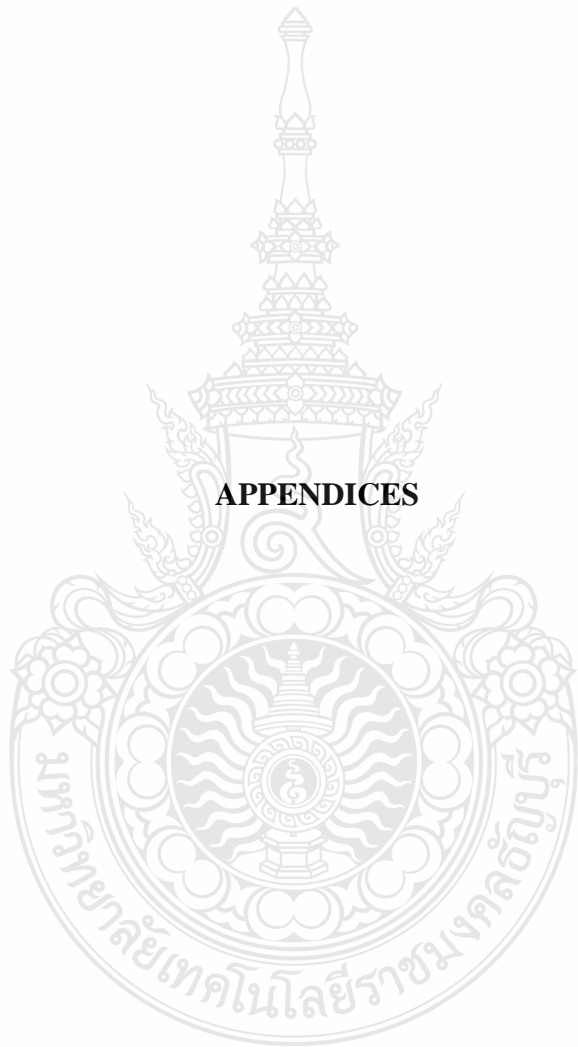
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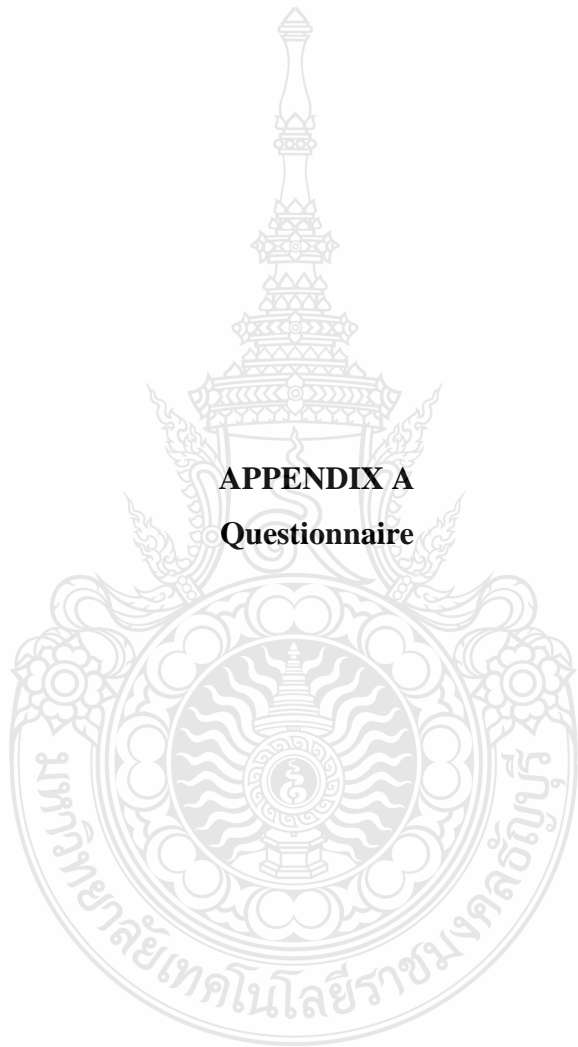
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APPENDICES



APPENDIX A
Questionnaire

Questionnaire of Dissertation for Doctor of Philosophy in Business Management

Version: for the interviewer – Healthcare Manager and Administration employee

Number.....

Part 1: Personal data and Working Condition (Please / (check) into the correct items about you)

1. Where is the region you working?
 - (1) The Northern
 - (2) The central
 - (3) The North East
 - (4) The Southern
2. Your job position in the Primary Healthcare Units
 - (1) Primary Healthcare Unit managers or leadership
 - (2) administrative employees
3. Gender
 - (1) Male
 - (2) Female
4. Age (Over 6 months, will be counted as 1 year)
 - (1) 18 - 30 years
 - (2) 31 – 40 years
 - (3) 41 – 50 years
 - (4) Over 50 years
5. Education
 - (1) Secondary School
 - (2) Vocational Certificate
 - (3) Diploma
 - (4) Bachelor degree
 - (5) Higher than the bachelor degree
6. Working experience in the Primary Healthcare Units
 - (1) less than 1 year
 - (2) more than 1 years but less than 2 years
 - (3) more than 2 years but less than 5 years
 - (4) more than 5 years but less than 10 years
 - (5) more than 10 years but less than 20 years
 - (6) more than 20 years
7. Period of working in the current unit place
 - (1) Less than 1 years

- (2) More than 1 years but less than 2 years
 - (3) More than 2 years but less than 5 years
 - (4) More than 5 years but less than 10 months
 - (5) More than 10 years
8. Marital status
- (1) Single (2) Married (3) Divorce/widowed
9. Average monthly salary
- (1) Less than 15,000 Baht
 - (2) More than 15,000 Baht but less than 20,000 Baht
 - (3) More than 20,000 Baht but less than 30,000 Baht
 - (4) More than 30,000 Baht but less than 50,000 Baht
 - (5) More than 50,000 Baht
10. Category type of primary healthcare units working places.
- (1) Small Size (service provided to the population amount less than 3,000 persons)
 - (2) Medium Size (service provided to the population amount more than 3,000 to 8,000 persons)
 - (3) Large Size (service provided to the population amount more than 8,000 persons)
11. The number of employees is there working in your workplace.
- (1) Less than 3 persons
 - (2) More than 3 persons but less than 5 persons
 - (3) More than 5 persons but less than 10 persons
 - (4) More than 10 persons
12. The number of patients obtains daily services.
- (1) Less than 10 persons
 - (2) More than 10 persons but less than 30 persons
 - (3) More than 30 persons but less than 50 persons
 - (4) More than 50 persons

Part 2: Factors related to Modelling

Please / (check) into the column according to the level of your opinion:
strongly disagree = (1), disagree = (2), slightly disagree = (3), neutral = (4),
slightly agree = (5), agree = (6), strongly agree = (7)

1. Charismatic Leadership (20 items)							
1.1 Sensibility of the Environment							
SE_1. Readily recognizes constraints in the physical environment (technological limitations, lack of resources, etc.) that may stand in the way of achieving organizational objectives.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
SE_2. Readily recognizes constraints in the organization's social and cultural environment (cultural norms, lack of grassroots support, etc.) that may stand in the way of achieving organizational	(1)	(2)	(3)	(4)	(5)	(6)	(7)
SE_3. Recognizes the abilities and skills of other members in the organization	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.2 Sensibility to Members' Needs (SMN)							
SMN_1. Influences others by developing mutual liking and respect	(1)	(2)	(3)	(4)	(5)	(6)	(7)
SMN_2. Shows sensitivity for the needs and feelings of the other members in the organization	(1)	(2)	(3)	(4)	(5)	(6)	(7)
SMN_3. Often expresses personal concern for needs and feelings of other members in the organization	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.3 Strategic Vision and Articulations (SVA)							
SVA_1. Provides inspiring strategic and organizational goals	(1)	(2)	(3)	(4)	(5)	(6)	(7)
SVA_2. Inspirational: able to motivate by articulating effectively the importance of what organizational members are doing	(1)	(2)	(3)	(4)	(5)	(6)	(7)
SVA_3. Consistently generates new ideas for the future of the organization	(1)	(2)	(3)	(4)	(5)	(6)	(7)
SVA_4. Exciting public speaker	(1)	(2)	(3)	(4)	(5)	(6)	(7)
SVA_5. Has a vision: often brings up ideas about opportunities for the future	(1)	(2)	(3)	(4)	(5)	(6)	(7)
SVA_6. Readily recognizes new environmental opportunities (favourable physical and social conditions) that may facilitate the achievement of organizational objectives	(1)	(2)	(3)	(4)	(5)	(6)	(7)

1.4 Personal Risk (PR)

PR_1. In pursuing organizational objectives, engages in activities involving considerable self-sacrifice	(1)	(2)	(3)	(4)	(5)	(6)	(7)
PR_2. Takes high personal risks for the sake of the organization	(1)	(2)	(3)	(4)	(5)	(6)	(7)
PR_3. Often incurs high personal costs for the good of the organization	(1)	(2)	(3)	(4)	(5)	(6)	(7)

1.5 Unconventional Behaviours (UB)

UB_1. Engages in unconventional behaviour to achieve organizational goals	(1)	(2)	(3)	(4)	(5)	(6)	(7)
UB_2. Uses non-traditional means to achieve organizational goals	(1)	(2)	(3)	(4)	(5)	(6)	(7)
UB_3. Often exhibits unique behaviour that surprises other members in the organization	(1)	(2)	(3)	(4)	(5)	(6)	(7)

2. Transformational Leadership (MLQ Form 5X Short 10 ITEMS)

2.1 Inspiration Motivation (IM)

IM_1 I talk enthusiastically about what needs to accomplish	(1)	(2)	(3)	(4)	(5)	(6)	(7)
IM_2 I express confidence that goals will achieve	(1)	(2)	(3)	(4)	(5)	(6)	(7)

2.2 Idealized Influence Attribute (IIA)

IIa_1. I go beyond self-interest for the good of the group	(1)	(2)	(3)	(4)	(5)	(6)	(7)
IIa_2. I act in ways that build others' respect for me	(1)	(2)	(3)	(4)	(5)	(6)	(7)

2.3 Idealized Influence Behaviour (IIB)

IIB_1. I talk about my most important values and beliefs	(1)	(2)	(3)	(4)	(5)	(6)	(7)
IIB_2. I consider the moral and ethical consequences of decisions	(1)	(2)	(3)	(4)	(5)	(6)	(7)

2.4 Intellectual Stimulation (IS)

IS_1. I seek differing perspectives when solving problems	(1)	(2)	(3)	(4)	(5)	(6)	(7)
IS_2. I suggest new ways of looking at how to complete assignments	(1)	(2)	(3)	(4)	(5)	(6)	(7)

2.5 Individualized Consideration (IC)

IC_1. I spend time teaching and coaching	(1)	(2)	(3)	(4)	(5)	(6)	(7)
IC_2. I consider an individual as having different needs, abilities, and aspirations from others	(1)	(2)	(3)	(4)	(5)	(6)	(7)

3. Digital – Health (UTAUT: Unified Theory of Acceptance and Use of Technology 24 ITEMS)

3.1 Performance expectancy (PE)

PE_1. I would find the digital data and social network system useful in my job.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
PE_2. Using the digital data and social network system enables me to accomplish tasks more quickly.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
PE_3. Using the digital data and social network system increases my productivity.	(1)	(2)	(3)	(4)	(5)	(6)	(7)

3.2 Effort expectancy (EE)

EE_1. My interaction with the digital data and social network system would be clear and understandable.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
EE_2. I would find the digital data and social network system easy to use.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
EE_3. Learning to operate the digital data and social network system is easy for me.	(1)	(2)	(3)	(4)	(5)	(6)	(7)

3.3 Attitude toward using technology (AT)

AT_1. Using digital data and social network system is a bad idea. (R)	(1)	(2)	(3)	(4)	(5)	(6)	(7)
AT_2. The digital data and social network system make work more enjoyable.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
AT_3 You like working with the digital data and social network system.	(1)	(2)	(3)	(4)	(5)	(6)	(7)

3.4 Social influence (SI)

SI_1. People who influence my behaviour think that I should use the digital data and social network system.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
SI_2. The senior management of this the organizational has been helpful in the use of the digital data and social network system.	(1)	(2)	(3)	(4)	(5)	(6)	(7)

SI_3. In general, the organization has supported and campaign the use of the digital data and social network system. (1) (2) (3) (4) (5) (6) (7)

3.5 Facilitating conditions (FC)

FC_1. I have the necessary knowledge to use the digital data and social network system. (1) (2) (3) (4) (5) (6) (7)

FC_2. The digital data and social network system are not compatible with other existing systems in use. (1) (2) (3) (4) (5) (6) (7)

FC_3. A specific person (or group) is available for assistance with digital data and social network system difficulties. (1) (2) (3) (4) (5) (6) (7)

3.6 Self-efficacy (SEF)

I could complete a job or task using the digital data and social network system

SEF_1. If I could call someone for help if I got a problem working stuck. (1) (2) (3) (4) (5) (6) (7)

SEF_2. If I had a lot of time to complete the job for which the software provided. (1) (2) (3) (4) (5) (6) (7)

SEF_3. If I had just the built-in help facility for assistance. (1) (2) (3) (4) (5) (6) (7)

3.7 Anxiety (AX)

AX_1. I feel apprehensive about using the digital data and social network system. (1) (2) (3) (4) (5) (6) (7)

AX_2. It scares me to think that I could lose a lot of information using the computer system by hitting the wrong key. (1) (2) (3) (4) (5) (6) (7)

AX_3. I hesitate to use the computer and digital data and social network system for fear of making mistakes I cannot correct. (1) (2) (3) (4) (5) (6) (7)

3.8 Behavioural intention to use the system (BI)

BI_1. I intend to use the digital data and social network system in the next 1 months. (1) (2) (3) (4) (5) (6) (7)

BI_2. I predict I would use the digital data and social network system in the next 6 months. (1) (2) (3) (4) (5) (6) (7)

BI_3. I intend to use the digital data and social network system in the next 1 year. (1) (2) (3) (4) (5) (6) (7)

4. General Self – Efficacy Scale (GSE = 10 ITEMS)

4.1 Facilitates goal-setting,

GSE_1. I can always manage to solve difficult problems if I try hard enough. (1) (2) (3) (4) (5) (6) (7)

GSE_2. If someone opposes me, I can find the means and ways to get what I want (1) (2) (3) (4) (5) (6) (7)

GSE_3. It is easy for me to stick to my aims and accomplish my goals. (1) (2) (3) (4) (5) (6) (7)

4.2 effort investment

GSE_4. I am confident that I could deal efficiently with unexpected events. (1) (2) (3) (4) (5) (6) (7)

GSE_5. Thanks to my resourcefulness, I know how to handle unforeseen situations. (1) (2) (3) (4) (5) (6) (7)

GSE_6. I can solve most problems if I invest the necessary effort. (1) (2) (3) (4) (5) (6) (7)

4.3 persistence in the face of barriers

GSE_7. I can remain calm when facing difficulties because I can rely on my coping abilities. (1) (2) (3) (4) (5) (6) (7)

GSE_8. When I am confronted with a problem, I can usually find several solutions. (1) (2) (3) (4) (5) (6) (7)

4.4 recovery from setbacks.

GSE_9. If I am in trouble, I can usually think of a solution. (1) (2) (3) (4) (5) (6) (7)

GSE_10. I can usually handle whatever comes my way. (1) (2) (3) (4) (5) (6) (7)

Additional Comments

Please fill in your alias or pen name and other details in case the researcher can recheck the data collection process.

Alias (pen name)

.....

Telephone No. or Email

.....

Place for Providing Data

.....

Name of Data Collector

.....



**Questionnaire of Dissertation
for
Doctor of Philosophy in Business Management**

Version: for the interviewer – the consumer – patient survey
Number.....

**Part 1: Personal data and Working Condition
(Please / (check) into the correct items about you)**

13. Where is your living in the region?
(1) The Northern (2) The central
(3) The North East (4) The Southern
14. Gender
(1) Male (2) Female
15. Age (Over 6 months, will be counted as 1 years)
(1) 18 - 30 years (2) 31 – 40 years
(3) 41 – 50 years (4) Over 50 years
16. Education
(1) Less than Secondary School (2) Vocational Certificate
(3) Diploma
(4) Bachelor degree (5) Higher than bachelor degree
17. Marital status
(1) Single (2) Married (3) Divorce/widowed
18. Average monthly income
(1) Less than 15,000 Baht
(2) More than 15,000 Baht but less than 20,000 Baht
(3) More than 20,000 Baht but less than 30,000 Baht
(4) More than 30,000 Baht but less than 50,000 Baht
(5) More than 50,000 Baht
19. The number of a family member, that they are living in your home.
(1) Less than 2 persons
(2) More than 2 persons but less than 3 persons
(3) More than 3 persons but less than 5 persons
(4) More than 5 persons

20. The number of an older person has been a member of their living in your home.

- (1) 1 person
- (2) 2 persons
- (3) 3 persons
- (4) More than 3 persons

21. The number of children person was age not more than 15 years old is a member living in your home.

- (1) 1 person
- (2) 2 persons
- (3) 3 persons
- (4) More than 3 persons

Part 2: Factors related to Project Success

Please / (check) into the column according to the level of your opinion: definitely not = (1), slightly definitely not = (2), probably not = (3), Probably = (4), probably definitely = (5), slightly definitely = (6), definitely absolutely = (7)

1. Service – Quality (PCAT: Primary Care Assessment Tool = 36 ITEMS)							
1.1 The extent of affiliation with a place/ Public Health Officer or nurse (EA)							
EA_1. The Primary Healthcare Units that you usually go if you are sick or need advice about your health.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
EA_2. The Primary Healthcare Units were known as your best as a person familiar.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
EA_3. The Primary Healthcare Units is most responsible for your health care.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.2 First contact-utilization (FCU)							
FCU_1. When needing a regular general check-up, you do go to the Primary Healthcare Units before going somewhere else.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
FCU_2. When you get a new health problem, do need to go to the Primary Healthcare Units before going somewhere else.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
FCU_3. When you have to see a specialist, do the Primary Healthcare Units have to approve or give you referrals.	(1)	(2)	(3)	(4)	(5)	(6)	(7)

1.3 First contact-access (FCA)							
FCA_1. When the Primary Healthcare Units is open, can get advice quickly over the phone if need to call it?	(1)	(2)	(3)	(4)	(5)	(6)	(7)
FCA_2. When the Primary Healthcare Units closed, is there a phone number can call when you get sick.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
FCA_3. When the Primary Healthcare Units is closed, and you get sick during the night, would someone from there see you that night?	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.4 ONGOING CARE (OC)							
OC_1. When you go to the Primary Healthcare Units, are you taken care of by the same Public Health Officer or nurse each time?	(1)	(2)	(3)	(4)	(5)	(6)	(7)
OC_2. If you have a question, can you call and talk to the Public Health Officer or nurse who knows you best?	(1)	(2)	(3)	(4)	(5)	(6)	(7)
OC_3. Primary Healthcare Units know what problems are most important to yours.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.5 COORDINATION (CO)							
CO_1. Primary Healthcare Units discuss with your different places you could have gone to get help with that problem.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CO_2. The Primary Healthcare Units or someone officer helps you make the appointment for that visit.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CO_3. The Primary Healthcare Units write down any information for the specialist about the reason for the visit.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
1.6 COORDINATION (INFORMATION SYSTEMS) (CIS)							
CIS_1. The Primary Healthcare Units, bring any of your medical records to review the applied prompt diagnosis, such as shots records or reports of medical care you had in the past?	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CIS_2. Could you look at your medical record if you wanted to review?	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CIS_3. the Primary Healthcare Units provide your medical record always available.	(1)	(2)	(3)	(4)	(5)	(6)	(7)

1.7 COMPREHENSIVENESS (SERVICES AVAILABLE) (CSV)

Following is a list of services that you or your family might need at some time. For each one, please indicate whether it is available at the Primary Healthcare Units office.

CSV_1. Immunizations (shots)	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CSV_2. Family planning or birth control methods	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CSV_3. Counselling for mental health problems	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CSV_4. Sewing up a cut that needs stitches	(1)	(2)	(3)	(4)	(5)	(6)	(7)

1.8 COMPREHENSIVENESS (SERVICES PROVIDED) (CSP)

The Primary Healthcare Units, are any of the following subjects discussed with you?

CSP_1. Advice about healthy foods and unhealthy foods or getting enough sleep.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CSP_2. Home safety, like getting and checking smoke detectors and storing medicines safety.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CSP_3. Ways to handle family conflicts that may arise from time to time.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CSP_4. Advice about appropriate exercise for you.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CSP_5. Checking on and discussing the medications you are taking	(1)	(2)	(3)	(4)	(5)	(6)	(7)

1.9 FAMILY-CENTEREDNESS (FCN)

FCN_1. The Primary Healthcare Units ask you about your ideas and opinions when planning treatment and care for you or a family member.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
FCN_2. The Primary Healthcare Units asked about illnesses or problems that might run in your family.	(1)	(2)	(3)	(4)	(5)	(6)	(7)
FCN_3. The Primary Healthcare Units would meet with members of your family if you thought it would be helpful.	(1)	(2)	(3)	(4)	(5)	(6)	(7)

1.10 COMMUNITY ORIENTATION (CMO)

CMO_1. Does anyone at you the Primary Healthcare Units office ever make home visits?	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CMO_2. Do the Primary Healthcare Units know about the critical health problems of your neighbourhood?	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CMO_3. The Primary Healthcare Units get opinions and ideas from people that will help to provide better health care.	(1)	(2)	(3)	(4)	(5)	(6)	(7)

1.11 CULTURALLY COMPETENT (CC)

CC_1. Would you recommend the Primary Healthcare Units to a friend or relative?	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CC_2. Would you recommend the Primary Healthcare Units to someone who doesn't read and writing well?	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CC_3. Would you recommend you the Primary Healthcare Units to someone who uses folk medicine, such as herbs or homemade drugs, or has particular beliefs about health care?	(1)	(2)	(3)	(4)	(5)	(6)	(7)

Additional Comments

.....

.....

.....

.....

Please fill in your alias or pen name and other details in case the researcher can recheck the data collection process.

Alias (pen name)
.....

Telephone No. or Email
.....

The place for Providing Data
.....

Name of Data Collector
.....



APPENDIX B
The Permission to Modify and use Survey Instrument

The Permission to modify and use survey instrument

BA Bruce Avolio 9/4/20 ถึง: ratsanan Na >

Ratsanan

All permissions for use of the MLQ Form 5X goes thru www.mindgarden.com, and they can provide you with the forms to access.

Thanks

Bruce

Bruce J. Avolio, Ph.D.
Executive Director, CLST
Cell: 402-212-0033
bavolio@uw.edu

GD Gordon Davis 10/4/20 ถึง: ratsanan Na >

Mrs. Ratsanan Na Kalasindhu
Ph.D. Candidate
Ph.D. Business administration program
Faculty of Business Administration
The Rajamangala University of Technology
Thanyaburi, Thailand

The instrument is in the public domain. You may use it in your research.

Gordon B Davis

On Thu, Apr 9, 2020 at 1:19 AM Rangsimam Uniform <ratsanan@gmail.com> wrote:

สวัสดีค่ะพี่จาย

Dear Sir. Prof. Jay Alden Conger
Address: The Henry Kravis Research Chair Professor of Leadership Kravis Leadership Institute Claremont McKenna College Seaman Hall, Office 226 Claremont, CA 91711
E-mail: jay.conger@claremontmckenna.edu
jconger@marshall.usc.edu

First of all, I would like introduction myself. My name is Mr.Ratsanan Na Kalasindhu am doctoral student in Ph.D. Business Administration Program, faculty of business administration at the Rajamangala University of Technology Thanyaburi Thailand.

My dissertation topic in bundles of the effect transformation leadership, charismatic leadership on service quality through self efficacy ,digital health : proportion of primary health care context in my country. The total collected population is 1,278 persons consist of healthcare managers 426 persons, administrative employees 426 persons, and patient or customer 426 persons.

I am during the methodology of dissertation (proposal). At present, I am considering the structural equation model (SEM) to analysis. I had find and reviewed literature from your article (Charismatic leadership in organizations: Perceived behavioral attributes and their measurement, <https://doi.org/10.1002/job.4030150508>, and a download the information about assessing Charismatic leadership questionnaire scale. (20 ITEMS) from your article-rational and construct validity evidence.

I would like to use this survey instrument for my dissertation. I want to confirm that my study is for non-commercial educational research purpose only, also I agree to share my data (SPSS) with you. Please you're a permit these instruments for my dissertation.

Thanks so much for all the research you've done on about Charismatic leadership questionnaire scale for educational research.

Best regards,
Mrs. Ratsanan Na Kalasindhu
Ph.D. Candidate
Ph.D. Business administration program
Faculty of Business Administration
The Rajamangala University of Technology Thanyaburi, Thailand

Dear Sir. Prof. Cheng-Chuan, Chang
Associate Professor, Taipei Medical University
Primary Care Policy Center Johns Hopkins University School of Hygiene and Public Health
Address: 56, Lane 260 Tung Rung Road Taichung 406, Taiwan
PRIMARY CARE ASSESSMENT TOOL – SHORT VERSION (PCAT) (Consumer-client survey)**
E-mail: cychang@cch.org.tw

First of all, I would like introduction myself. My name is Mr.Ratsanan Na Kalasindhu am doctoral student in Ph.D. Business Administration Program, faculty of business administration at the Rajamangala University of Technology Thanyaburi Thailand.

My dissertation topic in bundles of the effect transformation leadership, charismatic leadership on service quality through self efficacy ,digital health : proportion of primary health care context in my country. The total collected population is 1,278 persons consist of healthcare managers 426 persons, administrative employees 426 persons, and patient or customer 426 persons.

I am during the methodology of dissertation (proposal). At present, I am considering the structural equation model (SEM) to analysis. I had find and reviewed literature from your article-Consumer Experience with the Quality of Primary Care: A Comparison between Community and Hospital Settings in Taiwan and their measurement, <https://scholarship.library.jhu.edu/bitstream/handle/1774.2/39274/CHANG-DISSERTATION-2014.pdf?sequence=1&isAllowed=y> and a download the information about assessing PCAT scale. (11 ITEMS) from your article-rational and construct validity evidence.

I would like to use this survey instrument for my dissertation. I want to confirm that my study is for non-commercial educational research purpose only, also I agree to share my data (SPSS) with you. Please you're a permit these instruments for my dissertation.

Thanks so much for all the research you've done on about PCAT questionnaire scale for educational research.

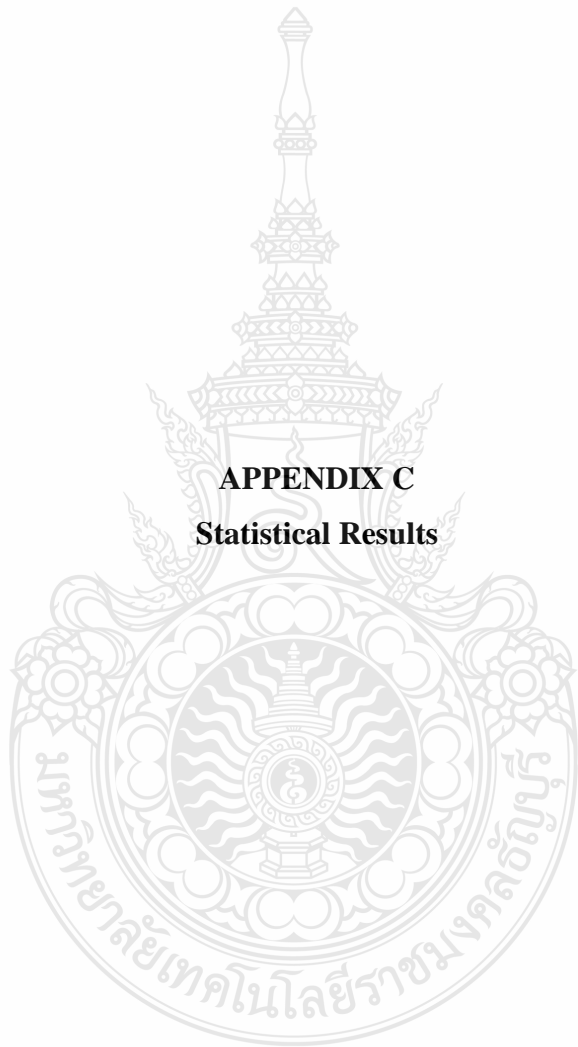
Best regards,
Mrs. Ratsanan Na Kalasindhu
Ph.D. Candidate
Ph.D. Business administration program
Faculty of Business Administration
The Rajamangala University of Technology Thanyaburi, Thailand

RS Ralf Schwarzer 9/4/20 ถึง: ratsanan และอีก 1... >

ตอบกลับ: Letter permission of instrument

see
<http://www.psyc.de/WORDPRESS/wordpress/requests/>

Prof. Dr. Ralf Schwarzer
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ORCID | <http://orcid.org/0000-0002-0069-3826>
Twitter | <https://twitter.com/schwarzer1>
BLOG | <https://themeritus.wordpress.com/>
Research in Wrocław, Poland | <http://www.care-beh.eu/>



APPENDIX C
Statistical Results

Descriptive

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
						Statistic	Std. Error	Statistic	Std. Error
Sensibility of the Environment	639	1.00	5.00	3.8419	.87908	-.520	.097	.050	.193
Sensibility of the Environment	639	1.00	5.00	3.9264	.81670	-.678	.097	.735	.193
Sensibility of the Environment	639	1.00	5.00	4.1049	.75323	-.595	.097	.490	.193
Sensibility to Members' Needs	639	1.00	5.00	3.5869	.93263	-.522	.097	.157	.193
Sensibility to Members' Needs	639	1.00	5.00	3.3646	.99689	-.323	.097	-.254	.193
Sensibility to Members' Needs	639	1.00	5.00	3.0767	1.00877	-.154	.097	-.464	.193
Strategic Vision and Articulations	639	1.00	5.00	3.5243	.90918	-.436	.097	.140	.193
Strategic Vision and Articulations	639	1.00	5.00	3.5102	.96464	-.455	.097	-.019	.193
Strategic Vision and Articulations	639	1.00	6.00	3.4664	.94937	-.322	.097	-.170	.193
Strategic Vision and Articulations	639	1.00	5.00	3.5869	.93263	-.522	.097	.157	.193
Strategic Vision and Articulations	639	1.00	5.00	3.4554	.95550	-.359	.097	-.141	.193
Strategic Vision and Articulations	639	1.00	5.00	3.5790	.97118	-.528	.097	-.016	.193
Strategic Vision and Articulations	639	1.00	5.00	3.6056	.93572	-.464	.097	-.109	.193
Personal Risk	639	1.00	5.00	3.7465	.72886	-.300	.097	.236	.193
Personal Risk	639	1.00	5.00	3.6291	.82771	-.366	.097	.115	.193
Personal Risk	639	1.00	5.00	3.1831	1.00436	-.131	.097	-.332	.193
Unconventional Behaviours	639	1.00	5.00	3.6197	.92729	-.572	.097	.321	.193

Unconventional Behaviours	639	1.00	5.00	3.6682	.83202	-.560	.097	.593	.193
Unconventional Behaviours	639	1.00	5.00	2.8967	1.05580	-.089	.097	-.497	.193
Inspiration Motivation	639	1.00	5.00	3.8466	.75634	-.413	.097	.614	.193
Inspiration Motivation	639	2.00	5.00	3.8858	.69555	-.151	.097	-.243	.193
Idealized Influence Attribute	639	1.00	5.00	3.7496	.77169	-.317	.097	.260	.193
Idealized Influence Attribute	639	1.00	5.00	4.0454	.71008	-.460	.097	.509	.193
Idealized Influence Behaviour	639	1.00	5.00	3.5759	.79188	-.327	.097	.347	.193
Idealized Influence Behaviour	639	1.00	6.00	4.1408	.75047	-.594	.097	.392	.193
Intellectual Stimulation (IS)	639	2.00	5.00	3.8732	.69111	-.142	.097	-.224	.193
Intellectual Stimulation (IS)	639	1.00	5.00	3.8701	.70402	-.407	.097	.746	.193
Individualized Consideration (IC)	639	1.00	5.00	3.7167	.73826	-.293	.097	.174	.193
Individualized Consideration (IC)	639	1.00	5.00	3.7653	.72439	-.207	.097	-.012	.193
Performance expectancy	639	2.00	5.00	4.0798	.74376	-.382	.097	-.391	.193
Performance expectancy	639	2.00	5.00	4.1659	.73687	-.626	.097	.163	.193
Performance expectancy	639	1.00	6.00	4.0845	.74640	-.501	.097	.195	.193
Effort expectancy (EE)	639	1.00	5.00	3.8920	.73167	-.263	.097	-.051	.193

Effort expectancy (EE)	639	1.00	5.00	3.9797	.74145	-.430	.097	.279	.193
Effort expectancy (EE)	639	1.00	5.00	3.8091	.83676	-.563	.097	.534	.193
Effort expectancy (EE)	639	1.00	5.00	2.2394	1.19190	.649	.097	-.647	.193
Attitude toward using technology (AT)	639	1.00	5.00	3.7684	.87969	-.584	.097	.380	.193
Attitude toward using technology (AT)	639	1.00	5.00	3.6275	.85954	-.451	.097	.406	.193
Social influence	639	1.00	5.00	3.5603	.81659	-.281	.097	.160	.193
Social influence	639	1.00	6.00	3.8466	.80454	-.277	.097	-.246	.193
Social influence	639	1.00	5.00	3.8748	.76152	-.298	.097	-.120	.193
Facilitating conditions	639	1.00	5.00	3.7074	.82883	-.520	.097	.630	.193
Facilitating conditions	639	1.00	5.00	2.5290	1.20553	.260	.097	-1.071	.193
Facilitating conditions	639	1.00	5.00	3.4304	.83295	-.309	.097	.346	.193
Self-efficacy	639	1.00	5.00	3.9937	.76357	-.498	.097	.488	.193
Self-efficacy	639	1.00	5.00	3.8294	.76606	-.393	.097	.287	.193
Self-efficacy	639	1.00	5.00	3.9562	.83495	-.647	.097	.589	.193
Anxiety	639	1.00	5.00	2.6745	1.02193	.145	.097	-.630	.193
Anxiety	639	1.00	5.00	2.6213	1.07723	.163	.097	-.708	.193
Anxiety	639	1.00	5.00	2.3912	1.07857	.354	.097	-.740	.193
Behavioural intention to use the system	639	1.00	5.00	3.1862	1.16293	-.313	.097	-.677	.193
Behavioural intention to use the system	639	1.00	5.00	2.9562	1.24868	-.213	.097	-.974	.193
Behavioural intention to use the system	639	1.00	5.00	2.8560	1.30153	-.052	.097	-1.126	.193
Facilitates goal-setting,	639	1.00	5.00	3.8638	.82777	-.623	.097	.631	.193

Facilitates goal-setting,	639	1.00	5.00	3.5368	.75832	-.168	.097	.258	.193
Facilitates goal-setting,	639	1.00	5.00	3.6839	.75132	-.120	.097	.049	.193
effort investment	639	1.00	5.00	3.6620	.72027	-.276	.097	.489	.193
effort investment	639	1.00	5.00	3.7543	.70647	-.227	.097	.552	.193
effort investment	639	1.00	5.00	3.8748	.72784	-.513	.097	1.051	.193
persistence in the face of barriers	639	1.00	5.00	3.8748	.72784	-.195	.097	-.149	.193
persistence in the face of barriers	639	2.00	5.00	3.8623	.70808	-.036	.097	-.504	.193
recovery from setbacks.	639	1.00	5.00	3.9734	.70215	-.208	.097	-.145	.193
recovery from setbacks.	639	2.00	5.00	3.9280	.67034	-.135	.097	-.212	.193
extent of affiliation	639	1.00	5.00	2.8529	1.36697	.042	.097	-1.285	.193
extent of affiliation	639	1.00	5.00	2.5587	1.24288	.170	.097	-1.136	.193
extent of affiliation	639	1.00	5.00	2.7027	1.25415	.121	.097	-1.098	.193
First contact-utilization	639	1.00	5.00	2.8341	1.21280	-.039	.097	-1.063	.193
First contact-utilization	639	1.00	5.00	2.8951	1.18769	-.061	.097	-.959	.193
First contact-utilization	639	1.00	5.00	2.9233	1.26519	-.032	.097	-1.122	.193
First contact-access	639	1.00	5.00	2.8811	1.26129	-.057	.097	-1.144	.193
First contact-access	639	1.00	5.00	3.0329	1.24336	-.190	.097	-1.042	.193
First contact-access	639	1.00	5.00	3.5618	1.10521	-.580	.097	-.320	.193
ONGOING CARE	639	1.00	5.00	3.3772	1.14751	-.549	.097	-.483	.193
ONGOING CARE	639	1.00	5.00	2.6401	1.13177	.122	.097	-.912	.193

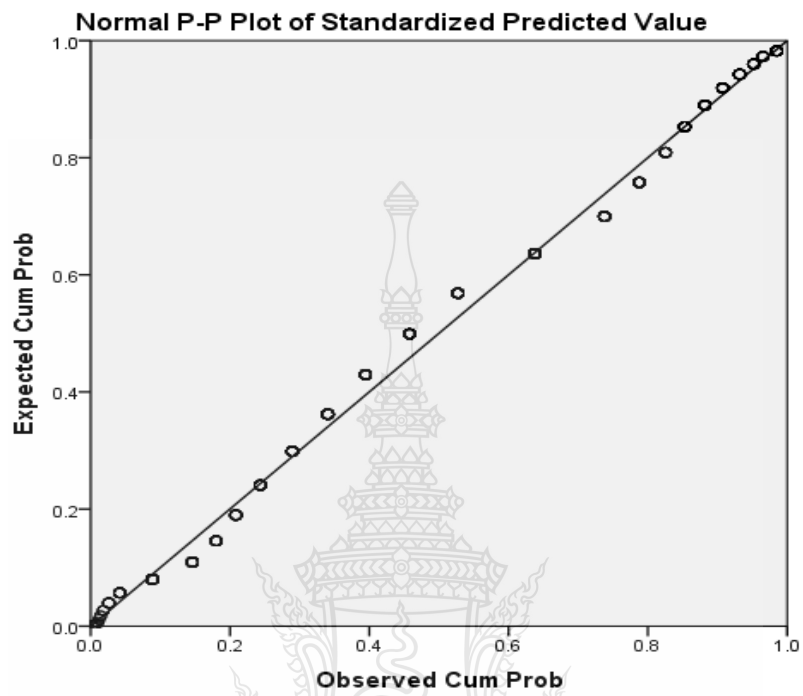
ONGOING CARE	639	1.00	5.00	3.1002	1.24542	-.117	.097	-1.027	.193
COORDINATION	639	1.00	5.00	2.9343	1.15509	.025	.097	-.915	.193
COORDINATION	639	1.00	5.00	3.1002	1.24668	-.069	.097	-1.033	.193
COORDINATION	639	1.00	5.00	2.5336	1.01942	.327	.097	-.421	.193
INFORMATION SYSTEMS	639	1.00	5.00	2.3850	1.00101	.356	.097	-.528	.193
INFORMATION SYSTEMS	639	1.00	5.00	2.3067	1.03986	.460	.097	-.530	.193
INFORMATION SYSTEMS	639	1.00	5.00	2.8858	1.19210	.027	.097	-.904	.193
SERVICES AVAILABLE	639	1.00	5.00	2.2034	1.22765	.688	.097	-.662	.193
SERVICES AVAILABLE	639	1.00	5.00	2.1674	1.22480	.766	.097	-.518	.193
SERVICES AVAILABLE	639	1.00	5.00	2.8075	1.31027	.112	.097	-1.184	.193
SERVICES AVAILABLE	639	1.00	5.00	2.7340	1.35927	.133	.097	-1.313	.193
SERVICES PROVIDED	639	1.00	5.00	2.8560	1.40574	.077	.097	-1.348	.193
SERVICES PROVIDED	639	1.00	5.00	2.7919	1.18064	.048	.097	-.967	.193
SERVICES PROVIDED	639	1.00	5.00	2.8701	1.07859	.020	.097	-.669	.193
SERVICES PROVIDED	639	1.00	5.00	2.3803	1.12160	.435	.097	-.699	.193
SERVICES PROVIDED	639	1.00	5.00	2.5321	1.25139	.322	.097	-1.020	.193
FAMILY-CENTEREDNESSES	639	1.00	5.00	2.6870	1.11093	.276	.097	-.697	.193
FAMILY-CENTEREDNESSES	639	1.00	5.00	2.6354	1.12540	.269	.097	-.737	.193

FAMILY-CENTEREDNES S	639	1.00	5.00	2.7277	1.16413	.167	.097	-.907	.193
COMMUNITY ORIENTATION	639	1.00	5.00	2.5524	1.23811	.342	.097	-.933	.193
COMMUNITY ORIENTATION	639	1.00	5.00	2.7152	1.16786	.202	.097	-.865	.193
COMMUNITY ORIENTATION	639	1.00	5.00	2.6526	1.17902	.279	.097	-.865	.193
CULTURALLY COMPETENT	639	1.00	5.00	2.6933	1.20856	.109	.097	-1.076	.193
CULTURALLY COMPETENT	639	1.00	5.00	2.8404	1.21364	.034	.097	-1.039	.193
CULTURALLY COMPETENT	639	1.00	5.00	2.8044	1.16543	.106	.097	-.899	.193
Valid N (listwise)	639								

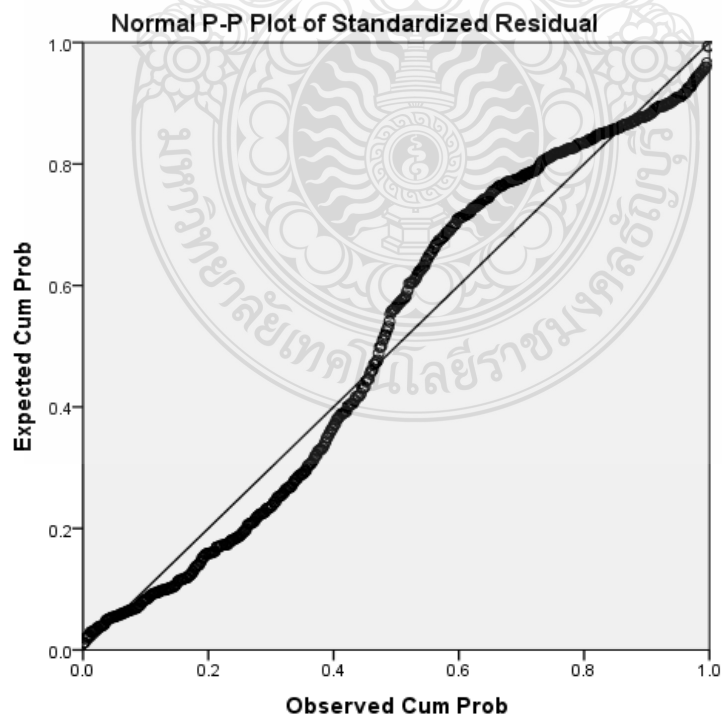


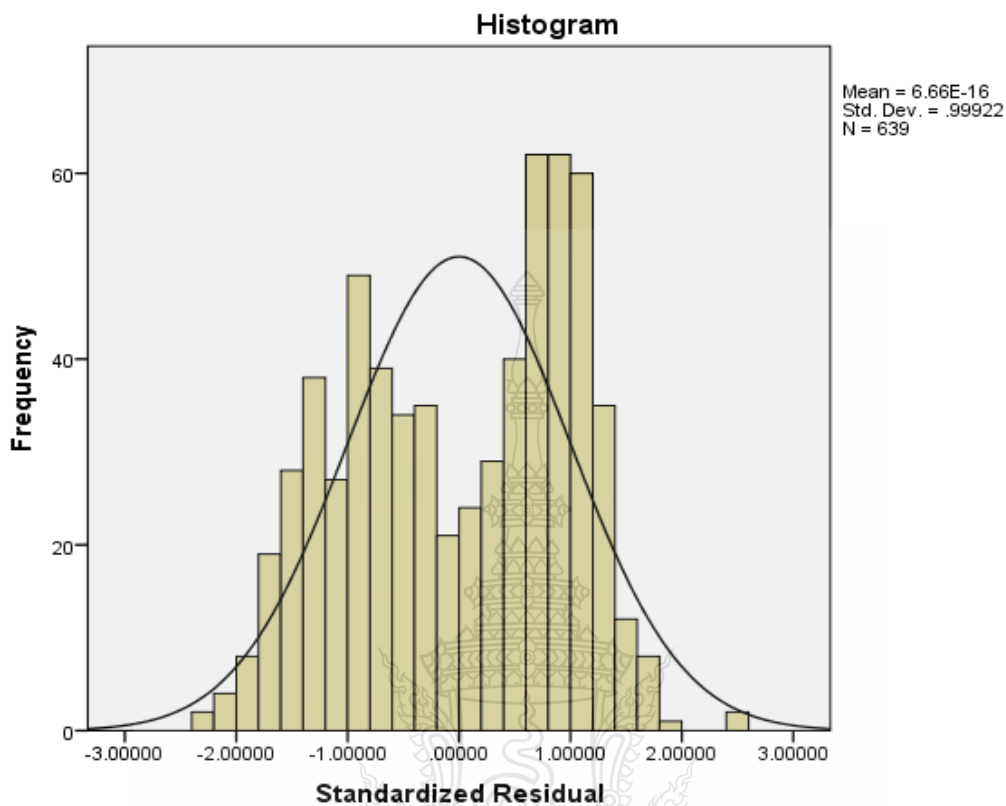
PPlot

Standardized Predicted Value



Standardized Residual





Reliability

Scale: Charismatic Leadership Case Processing Summary

		N	%
Cases	Valid	639	100.0
	Excluded ^a	0	.0
	Total	639	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.896	19

Item Statistics

	Mean	Std. Deviation	N
Sensibility of the Environment	3.8419	.87908	639
Sensibility of the Environment	3.9264	.81670	639
Sensibility of the Environment	4.1049	.75323	639
Sensibility to Members' Needs	3.5869	.93263	639
Sensibility to Members' Needs	3.3646	.99689	639
Sensibility to Members' Needs	3.0767	1.00877	639
Strategic Vision and Articulations	3.5243	.90918	639
Strategic Vision and Articulations	3.5102	.96464	639
Strategic Vision and Articulations	3.4664	.94937	639
Strategic Vision and Articulations	3.5869	.93263	639
Strategic Vision and Articulations	3.4554	.95550	639
Strategic Vision and Articulations	3.5790	.97118	639
Strategic Vision and Articulations	3.6056	.93572	639
Personal Risk	3.7465	.72886	639
Personal Risk	3.6291	.82771	639
Personal Risk	3.1831	1.00436	639
Unconventional Behaviors	3.6197	.92729	639
Unconventional Behaviors	3.6682	.83202	639
Unconventional Behaviors	2.8967	1.05580	639

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
67.3725	106.131	10.30197	19

Reliability

Scale: transformational Leadership Case Processing Summary

		N	%
Cases	Valid	639	100.0
	Excluded ^a	0	.0
	Total	639	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.889	10

Item Statistics

	Mean	Std. Deviation	N
Inspiration Motivation	3.8466	.75634	639
Inspiration Motivation	3.8858	.69555	639
Idealized Influence Attribute	3.7496	.77169	639
Idealized Influence Attribute	4.0454	.71008	639
Idealized Influence Behavior	3.5759	.79188	639
Idealized Influence Behavior	4.1408	.75047	639
Intellectual Stimulation (IS)	3.8732	.69111	639
Intellectual Stimulation (IS)	3.8701	.70402	639
Individualized Consideration (IC)	3.7167	.73826	639
Individualized Consideration (IC)	3.7653	.72439	639

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
38.4695	26.996	5.19572	10

Reliability

Scale: Technology Acceptance Case Processing Summary

		N	%
Cases	Valid	639	100.0
	Excluded ^a	0	.0
	Total	639	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.846	24

Item Statistics

	Mean	Std. Deviation	N
Performance expectancy	4.0798	.74376	639
Performance expectancy	4.1659	.73687	639
Performance expectancy	4.0845	.74640	639
Effort expectancy (EE)	3.8920	.73167	639
Effort expectancy (EE)	3.9797	.74145	639
Effort expectancy (EE)	3.8091	.83676	639
Effort expectancy (EE)	2.2394	1.19190	639
Attitude toward using technology (AT)	3.7684	.87969	639
Attitude toward using technology (AT)	3.6275	.85954	639
Social influence	3.5603	.81659	639
Social influence	3.8466	.80454	639
Social influence	3.8748	.76152	639
Facilitating conditions	3.7074	.82883	639
Facilitating conditions	2.5290	1.20553	639
Facilitating conditions	3.4304	.83295	639
Self-efficacy	3.9937	.76357	639
Self-efficacy	3.8294	.76606	639
Self-efficacy	3.9562	.83495	639

Anxiety	2.6745	1.02193	639
Anxiety	2.6213	1.07723	639
Anxiety	2.3912	1.07857	639
Behavioral intention to use the system	3.1862	1.16293	639
Behavioral intention to use the system	2.9562	1.24868	639
Behavioral intention to use the system	2.8560	1.30153	639

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
83.0595	110.614	10.51732	24

Reliability

Scale: General Self - Efficacy

Case Processing Summary

		N	%
Cases	Valid	639	100.0
	Excluded ^a	0	.0
	Total	639	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.928	10

Item Statistics

	Mean	Std. Deviation	N
Facilitates goal-setting,	3.8638	.82777	639
Facilitates goal-setting,	3.5368	.75832	639
Facilitates goal-setting,	3.6839	.75132	639
effort investment	3.6620	.72027	639
effort investment	3.7543	.70647	639
effort investment	3.8748	.72784	639

persistence in the face of barriers	3.8748	.72784	639
persistence in the face of barriers	3.8623	.70808	639
recovery from setbacks.	3.9734	.70215	639
recovery from setbacks.	3.9280	.67034	639

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
38.0141	32.519	5.70251	10

Reliability Scale: Service - Quality

Case Processing Summary

		N	%
Cases	Valid	639	100.0
	Excluded ^a	0	.0
	Total	639	100.0

a. Listwise deletion based on all variables in the procedure.

Reliability Statistics

Cronbach's Alpha	N of Items
.977	36

Item Statistics

	Mean	Std. Deviation	N
extent of affiliation	2.8529	1.36697	639
extent of affiliation	2.5587	1.24288	639
extent of affiliation	2.7027	1.25415	639
First contact-utilization	2.8341	1.21280	639
First contact-utilization	2.8951	1.18769	639
First contact-utilization	2.9233	1.26519	639
First contact-access	2.8811	1.26129	639

First contact-access	3.0329	1.24336	639
First contact-access	3.5618	1.10521	639
ONGOING CARE	3.3772	1.14751	639
ONGOING CARE	2.6401	1.13177	639
ONGOING CARE	3.1002	1.24542	639
COORDINATION	2.9343	1.15509	639
COORDINATION	3.1002	1.24668	639
COORDINATION	2.5336	1.01942	639
INFORMATION SYSTEMS	2.3850	1.00101	639
INFORMATION SYSTEMS	2.3067	1.03986	639
INFORMATION SYSTEMS	2.8858	1.19210	639
SERVICES AVAILABLE	2.2034	1.22765	639
SERVICES AVAILABLE	2.1674	1.22480	639
SERVICES AVAILABLE	2.8075	1.31027	639
SERVICES AVAILABLE	2.7340	1.35927	639
SERVICES PROVIDED	2.8560	1.40574	639
SERVICES PROVIDED	2.7919	1.18064	639
SERVICES PROVIDED	2.8701	1.07859	639
SERVICES PROVIDED	2.3803	1.12160	639
SERVICES PROVIDED	2.5321	1.25139	639
FAMILY-CENTEREDNESS	2.6870	1.11093	639
FAMILY-CENTEREDNESS	2.6354	1.12540	639
FAMILY-CENTEREDNESS	2.7277	1.16413	639
COMMUNITY ORIENTATION	2.5524	1.23811	639
COMMUNITY ORIENTATION	2.7152	1.16786	639
COMMUNITY ORIENTATION	2.6526	1.17902	639
CULTURALLY COMPETENT	2.6933	1.20856	639
CULTURALLY COMPETENT	2.8404	1.21364	639
CULTURALLY COMPETENT	2.8044	1.16543	639

Scale Statistics

Mean	Variance	Std. Deviation	N of Items
99.1565	1042.615	32.28955	36

Model Fit Summary: Transformational Leadership research framework for the hypothesis (H1a, H1b).

CMIN

Model	NPAR	CMIN	DF	P	CMIN/DF
Default model	159	1955.909	876	.000	2.233
Saturated model	1035	.000	0		
Independence model	45	26929.618	990	.000	27.202

RMR, GFI

Model	RMR	GFI	AGFI	PGFI
Default model	.035	.876	.854	.742
Saturated model	.000	1.000		
Independence model	.422	.137	.098	.131

Baseline Comparisons

Model	NFI Delta1	RFI rho1	IFI Delta2	TLI rho2	CFI
Default model	.927	.918	.959	.953	.958
Saturated model	1.000		1.000		1.000
Independence model	.000	.000	.000	.000	.000

Parsimony-Adjusted Measures

Model	PRATIO	PNFI	PCFI
Default model	.885	.821	.848
Saturated model	.000	.000	.000
Independence model	1.000	.000	.000

NCP

Model	NCP	LO 90	HI 90
Default model	1079.909	955.553	1211.962
Saturated model	.000	.000	.000
Independence model	25939.618	25407.938	26477.656

FMIN

Model	FMIN	F0	LO 90	HI 90
Default model	3.066	1.693	1.498	1.900
Saturated model	.000	.000	.000	.000
Independence model	42.209	40.658	39.824	41.501

RMSEA

Model	RMSEA	LO 90	HI 90	PCLOSE
Default model	.044	.041	.047	1.000
Independence model	.203	.201	.205	.000

AIC

Model	AIC	BCC	BIC	CAIC
Default model	2273.909	2298.619	2983.034	3142.034
Saturated model	2070.000	2230.845	6686.001	7721.001
Independence model	27019.618	27026.611	27220.314	27265.314

HOELTER

Model	HOELTER	HOELTER
Default model	.05	.01
Independence model	309	319
Independence model	26	26

Regression Weights: (Group number 1 - Default model)

			Estimate	S.E.	C.R.	P	Label
TA	<---	TL	.920	.069	13.319	***	par_42
SE	<---	TL	.948	.072	13.097	***	par_43
SQ	<---	SE	.355	.103	3.445	***	par_40
SQ	<---	TA	-.026	.110	-.240	.811	par_41
GSE3	<---	SE	.934	.049	18.938	***	par_1
GSE4	<---	SE	.863	.048	17.990	***	par_2
GSE5	<---	SE	.923	.048	19.162	***	par_3
GSE6	<---	SE	.968	.049	19.860	***	par_4
EA2	<---	SQ	1.000				
EA3	<---	SQ	1.012	.023	43.895	***	par_5
FCU2	<---	SQ	.898	.032	27.942	***	par_6
FCU1	<---	SQ	.883	.033	27.100	***	par_7
OC3	<---	SQ	.951	.034	28.383	***	par_8
CSV4	<---	SQ	1.082	.035	30.782	***	par_9
CSP1	<---	SQ	1.151	.035	32.670	***	par_10
CMO2	<---	SQ	.858	.032	26.822	***	par_11
CMO1	<---	SQ	.934	.034	27.446	***	par_12
CC1	<---	SQ	.991	.030	32.712	***	par_13
iC2	<---	TL	1.013	.071	14.186	***	par_14
IC1	<---	TL	1.087	.074	14.683	***	par_15
IS2	<---	TL	1.116	.072	15.557	***	par_16
IS1	<---	TL	1.050	.070	14.986	***	par_17
iib2	<---	TL	.949	.072	13.163	***	par_18
SI2	<---	TA	.851	.062	13.733	***	par_19
AT3	<---	TA	.925	.065	14.272	***	par_20
AT2	<---	TA	.892	.066	13.587	***	par_21
EE3	<---	TA	1.009	.056	18.161	***	par_22
EE4	<---	TA	.938	.061	15.251	***	par_23
PE1	<---	TA	1.000				
PE2	<---	TA	1.001	.039	25.821	***	par_24
PE3	<---	TA	1.065	.055	19.363	***	par_25
lla2	<---	TL	.986	.069	14.377	***	par_26
GSE8	<---	SE	.882	.048	18.182	***	par_27
GSE7	<---	SE	.813	.048	17.058	***	par_28
FCU3	<---	SQ	1.007	.032	31.855	***	par_31
lla1	<---	TL	1.116	.076	14.713	***	par_33
IM1	<---	TL	1.000				
IM2	<---	TL	1.025	.050	20.520	***	par_34
GSE10	<---	SE	.838	.047	18.011	***	par_35

			Estimate	S.E.	C.R.	P	Label
GSE9	<---	SE	.837	.049	17.230	***	par_36
GSE1	<---	SE	1.000				
GSE2	<---	SE	.890	.049	18.104	***	par_37
FCA1	<---	SQ	1.025	.028	36.646	***	par_38
CSP5	<---	SQ	.991	.033	30.325	***	par_39
FCN2	<---	SQ	.824	.030	27.812	***	par_72
FCN1	<---	SQ	.831	.031	27.175	***	par_73
CMO3	<---	SQ	.911	.032	28.769	***	par_74
FCN3	<---	SQ	.897	.031	28.654	***	par_75
EE1	<---	TA	.965	.055	17.492	***	par_110

Standardized Regression Weights: (Group number 1 - Default model)

			Estimate
TA	<---	TL	.785
SE	<---	TL	.757
SQ	<---	SE	.197
SQ	<---	TA	-.014
GSE3	<---	SE	.754
GSE4	<---	SE	.714
GSE5	<---	SE	.781
GSE6	<---	SE	.803
EA2	<---	SQ	.869
EA3	<---	SQ	.870
FCU2	<---	SQ	.813
FCU1	<---	SQ	.783
OC3	<---	SQ	.821
CSV4	<---	SQ	.857
CSP1	<---	SQ	.881
CMO2	<---	SQ	.803
CMO1	<---	SQ	.811
CC1	<---	SQ	.882
iC2	<---	TL	.667
IC1	<---	TL	.702
IS2	<---	TL	.758
IS1	<---	TL	.727
iib2	<---	TL	.605
SI2	<---	TA	.593
AT3	<---	TA	.605
AT2	<---	TA	.568

			Estimate
EE3	<---	TA	.759
EE4	<---	TA	.630
PE1	<---	TA	.751
PE2	<---	TA	.766
PE3	<---	TA	.799
lla2	<---	TL	.664
GSE8	<---	SE	.747
GSE7	<---	SE	.675
FCU3	<---	SQ	.863
lla1	<---	TL	.691
IM1	<---	TL	.632
IM2	<---	TL	.705
GSE10	<---	SE	.749
GSE9	<---	SE	.715
GSE1	<---	SE	.724
GSE2	<---	SE	.704
FCA1	<---	SQ	.862
CSP5	<---	SQ	.854
FCN2	<---	SQ	.819
FCN1	<---	SQ	.810
CMO3	<---	SQ	.833
FCN3	<---	SQ	.829
EE1	<---	TA	.739

Standardized Total Effects (Group number 1 - Default model)

	TL	TA	SE	SQ
TA	.785	.000	.000	.000
SE	.757	.000	.000	.000
SQ	.139	-.014	.197	.000
FCN2	.114	-.011	.162	.819
FCN1	.112	-.011	.160	.810
FCA1	.120	-.012	.170	.862
GSE10	.567	.000	.749	.000
IM1	.632	.000	.000	.000
IM2	.705	.000	.000	.000
lla1	.691	.000	.000	.000
FCU3	.120	-.012	.170	.863
FCN3	.115	-.011	.164	.829
CMO3	.116	-.011	.164	.833

	TL	TA	SE	SQ
GSE9	.542	.000	.715	.000
PE1	.589	.751	.000	.000
SI2	.466	.593	.000	.000
CC1	.122	-.012	.174	.882
CMO1	.113	-.011	.160	.811
CMO2	.111	-.011	.159	.803
CSP1	.122	-.012	.174	.881
FCU1	.109	-.011	.155	.783
EA3	.121	-.012	.172	.870
EA2	.121	-.012	.172	.869
AT2	.446	.568	.000	.000
AT3	.475	.605	.000	.000
EE1	.580	.739	.000	.000
EE4	.495	.630	.000	.000
EE3	.596	.759	.000	.000
PE2	.601	.766	.000	.000
PE3	.627	.799	.000	.000
GSE8	.566	.000	.747	.000
GSE7	.511	.000	.675	.000
GSE6	.608	.000	.803	.000
GSE5	.591	.000	.781	.000
GSE4	.541	.000	.714	.000
GSE3	.571	.000	.754	.000
GSE2	.533	.000	.704	.000
GSE1	.549	.000	.724	.000
CSP5	.118	-.012	.169	.854
CSV4	.119	-.012	.169	.857
OC3	.114	-.011	.162	.821
FCU2	.113	-.011	.161	.813
lla2	.664	.000	.000	.000
iib2	.605	.000	.000	.000
IS1	.727	.000	.000	.000
IS2	.758	.000	.000	.000
IC1	.702	.000	.000	.000
iC2	.667	.000	.000	.000

Standardized Direct Effects (Group number 1 - Default model)

	TL	TA	SE	SQ
TA	.785	.000	.000	.000

	TL	TA	SE	SQ
SE	.757	.000	.000	.000
SQ	.000	-.014	.197	.000
FCN2	.000	.000	.000	.819
FCN1	.000	.000	.000	.810
FCA1	.000	.000	.000	.862
GSE10	.000	.000	.749	.000
IM1	.632	.000	.000	.000
IM2	.705	.000	.000	.000
lla1	.691	.000	.000	.000
FCU3	.000	.000	.000	.863
FCN3	.000	.000	.000	.829
CMO3	.000	.000	.000	.833
GSE9	.000	.000	.715	.000
PE1	.000	.751	.000	.000
SI2	.000	.593	.000	.000
CC1	.000	.000	.000	.882
CMO1	.000	.000	.000	.811
CMO2	.000	.000	.000	.803
CSP1	.000	.000	.000	.881
FCU1	.000	.000	.000	.783
EA3	.000	.000	.000	.870
EA2	.000	.000	.000	.869
AT2	.000	.568	.000	.000
AT3	.000	.605	.000	.000
EE1	.000	.739	.000	.000
EE4	.000	.630	.000	.000
EE3	.000	.759	.000	.000
PE2	.000	.766	.000	.000
PE3	.000	.799	.000	.000
GSE8	.000	.000	.747	.000
GSE7	.000	.000	.675	.000
GSE6	.000	.000	.803	.000
GSE5	.000	.000	.781	.000
GSE4	.000	.000	.714	.000
GSE3	.000	.000	.754	.000
GSE2	.000	.000	.704	.000
GSE1	.000	.000	.724	.000
CSP5	.000	.000	.000	.854
CSV4	.000	.000	.000	.857
OC3	.000	.000	.000	.821

	TL	TA	SE	SQ
FCU2	.000	.000	.000	.813
lla2	.664	.000	.000	.000
iib2	.605	.000	.000	.000
IS1	.727	.000	.000	.000
IS2	.758	.000	.000	.000
IC1	.702	.000	.000	.000
iC2	.667	.000	.000	.000

Standardized Indirect Effects (Group number 1 - Default model)

	TL	TA	SE	SQ
TA	.000	.000	.000	.000
SE	.000	.000	.000	.000
SQ	.139	.000	.000	.000
FCN2	.114	-.011	.162	.000
FCN1	.112	-.011	.160	.000
FCA1	.120	-.012	.170	.000
GSE10	.567	.000	.000	.000
IM1	.000	.000	.000	.000
IM2	.000	.000	.000	.000
lla1	.000	.000	.000	.000
FCU3	.120	-.012	.170	.000
FCN3	.115	-.011	.164	.000
CMO3	.116	-.011	.164	.000
GSE9	.542	.000	.000	.000
PE1	.589	.000	.000	.000
SI2	.466	.000	.000	.000
CC1	.122	-.012	.174	.000
CMO1	.113	-.011	.160	.000
CMO2	.111	-.011	.159	.000
CSP1	.122	-.012	.174	.000
FCU1	.109	-.011	.155	.000
EA3	.121	-.012	.172	.000
EA2	.121	-.012	.172	.000
AT2	.446	.000	.000	.000
AT3	.475	.000	.000	.000
EE1	.580	.000	.000	.000
EE4	.495	.000	.000	.000
EE3	.596	.000	.000	.000
PE2	.601	.000	.000	.000

	TL	TA	SE	SQ
PE3	.627	.000	.000	.000
GSE8	.566	.000	.000	.000
GSE7	.511	.000	.000	.000
GSE6	.608	.000	.000	.000
GSE5	.591	.000	.000	.000
GSE4	.541	.000	.000	.000
GSE3	.571	.000	.000	.000
GSE2	.533	.000	.000	.000
GSE1	.549	.000	.000	.000
CSP5	.118	-.012	.169	.000
CSV4	.119	-.012	.169	.000
OC3	.114	-.011	.162	.000
FCU2	.113	-.011	.161	.000
lla2	.000	.000	.000	.000
iib2	.000	.000	.000	.000
IS1	.000	.000	.000	.000
IS2	.000	.000	.000	.000
IC1	.000	.000	.000	.000
iC2	.000	.000	.000	.000

Model Fit Summary: Transformational Leadership research framework for the hypothesis (H1c).

Model Fit Summary

CMIN

Model	NPAR	CMIN	DF	P	CMIN/DF
Default model	165	1871.969	916	.000	2.044
Saturated model	1081	.000	0		
Independence model	46	27123.025	1035	.000	26.206

RMR, GFI

Model	RMR	GFI	AGFI	PGFI
Default model	.047	.885	.864	.750
Saturated model	.000	1.000		
Independence model	.414	.138	.100	.132

Baseline Comparisons

Model	NFI Delta1	RFI rho1	IFI Delta2	TLI rho2	CFI
Default model	.931	.922	.964	.959	.963
Saturated model	1.000		1.000		1.000
Independence model	.000	.000	.000	.000	.000

Parsimony-Adjusted Measures

Model	PRATIO	PNFI	PCFI
Default model	.885	.824	.853
Saturated model	.000	.000	.000
Independence model	1.000	.000	.000

NCP

Model	NCP	LO 90	HI 90
Default model	955.969	836.103	1083.576
Saturated model	.000	.000	.000
Independence model	26088.025	25554.620	26627.791

FMIN

Model	FMIN	F0	LO 90	HI 90
Default model	2.934	1.498	1.311	1.698
Saturated model	.000	.000	.000	.000
Independence model	42.513	40.890	40.054	41.736

RMSEA

Model	RMSEA	LO 90	HI 90	PCLOSE
Default model	.040	.038	.043	1.000
Independence model	.199	.197	.201	.000

AIC

Model	AIC	BCC	BIC	CAIC
Default model	2201.969	2228.213	2937.854	3102.854
Saturated model	2162.000	2333.936	6983.157	8064.157
Independence model	27215.025	27222.342	27420.181	27466.181

ECVI

Model	ECVI	LO 90	HI 90	MECVI
Default model	3.451	3.263	3.651	3.492
Saturated model	3.389	3.389	3.389	3.658
Independence model	42.657	41.821	43.503	42.668

HOELTER

Model	HOELTER	HOELTER
	.05	.01
Default model	337	348
Independence model	27	27

Regression Weights: (Group number 1 - Default model)

			Estimate	S.E.	C.R.	P	Label
SE	<---	e122	.347	.022	16.125	***	par_5
SE	<---	TL	.963	.072	13.453	***	par_42
TA	<---	e124	.332	.024	14.098	***	par_40
TA	<---	SE	.530	.049	10.845	***	par_43
SQ	<---	e123	1.060	.037	28.499	***	par_6
SQ	<---	TA	.296	.103	2.884	.004	par_44
GSE3	<---	SE	.947	.049	19.329	***	par_1
GSE4	<---	SE	.867	.052	16.703	***	par_2
GSE5	<---	SE	.940	.052	18.209	***	par_3
GSE6	<---	SE	.991	.053	18.623	***	par_4
EA2	<---	SQ	1.000				
EA3	<---	SQ	1.013	.023	44.102	***	par_7
FCU2	<---	SQ	.907	.032	28.786	***	par_8
FCU1	<---	SQ	.883	.032	27.183	***	par_9
FCA1	<---	SQ	1.024	.030	34.416	***	par_10
OC3	<---	SQ	.962	.033	28.789	***	par_11
CSV4	<---	SQ	1.095	.035	31.324	***	par_12
CSP1	<---	SQ	1.167	.035	33.460	***	par_13
CSP5	<---	SQ	1.006	.033	30.966	***	par_14
FCN1	<---	SQ	.823	.030	27.192	***	par_15
FCN2	<---	SQ	.831	.031	26.736	***	par_16
CMO3	<---	SQ	.914	.032	28.730	***	par_17
CMO2	<---	SQ	.862	.033	26.220	***	par_18
CMO1	<---	SQ	.939	.034	27.657	***	par_19
CC1	<---	SQ	1.002	.030	33.367	***	par_20

			Estimate	S.E.	C.R.	P	Label
iC2	<---	TL	1.000				
IC1	<---	TL	1.064	.053	19.894	***	par_21
IS2	<---	TL	1.093	.069	15.867	***	par_22
IS1	<---	TL	1.044	.067	15.548	***	par_23
iib2	<---	TL	.979	.072	13.520	***	par_24
iib1	<---	TL	.775	.073	10.648	***	par_25
SI2	<---	TA	1.000				
AT2	<---	TA	1.156	.098	11.773	***	par_26
AT3	<---	TA	1.095	.094	11.653	***	par_27
EE1	<---	TA	1.266	.091	13.889	***	par_28
EE3	<---	TA	1.283	.092	13.905	***	par_29
EE4	<---	TA	1.157	.096	12.020	***	par_30
PE3	<---	TA	1.366	.098	13.969	***	par_31
PE2	<---	TA	1.257	.093	13.486	***	par_32
PE1	<---	TA	1.213	.091	13.263	***	par_33
lla2	<---	TL	1.001	.069	14.497	***	par_34
GSE9	<---	SE	.893	.054	16.603	***	par_35
GSE8	<---	SE	.914	.053	17.284	***	par_36
GSE7	<---	SE	.836	.052	16.216	***	par_37
GSE1	<---	SE	1.000				
GSE2	<---	SE	.900	.049	18.313	***	par_38
FCU3	<---	SQ	.992	.028	35.907	***	par_39
lla1	<---	TL	1.147	.075	15.339	***	par_41
IM1	<---	TL	1.018	.073	13.979	***	par_45
IM2	<---	TL	1.049	.069	15.233	***	par_46
GSE10	<---	SE	.888	.051	17.375	***	par_87
FCN3	<---	SQ	.893	.032	28.267	***	par_88

Standardized Regression Weights: (Group number 1 - Default model)

			Estimate
SE	<---	e122	.606
SE	<---	TL	.796
TA	<---	e124	.738
TA	<---	SE	.675
SQ	<---	e123	.992
SQ	<---	TA	.125
GSE3	<---	SE	.734
GSE4	<---	SE	.700
GSE5	<---	SE	.774
GSE6	<---	SE	.789

			Estimate
EA2	<---	SQ	.868
EA3	<---	SQ	.862
FCU2	<---	SQ	.818
FCU1	<---	SQ	.784
FCA1	<---	SQ	.860
OC3	<---	SQ	.826
CSV4	<---	SQ	.858
CSP1	<---	SQ	.887
CSP5	<---	SQ	.860
FCN1	<---	SQ	.806
FCN2	<---	SQ	.799
CMO3	<---	SQ	.829
CMO2	<---	SQ	.790
CMO1	<---	SQ	.812
CC1	<---	SQ	.886
iC2	<---	TL	.654
IC1	<---	TL	.683
IS2	<---	TL	.738
IS1	<---	TL	.716
iib2	<---	TL	.618
iib1	<---	TL	.464
SI2	<---	TA	.560
AT2	<---	TA	.592
AT3	<---	TA	.576
EE1	<---	TA	.780
EE3	<---	TA	.778
EE4	<---	TA	.623
PE3	<---	TA	.826
PE2	<---	TA	.773
PE1	<---	TA	.735
lla2	<---	TL	.668
GSE9	<---	SE	.732
GSE8	<---	SE	.749
GSE7	<---	SE	.669
GSE1	<---	SE	.695
GSE2	<---	SE	.678
FCU3	<---	SQ	.854
lla1	<---	TL	.704
IM1	<---	TL	.638
IM2	<---	TL	.716

		Estimate
GSE10 <---	SE	.759
FCN3 <---	SQ	.819

Standardized Total Effects (Group number 1 - Default model)

	TL	SE	TA	SQ
SE	.796	.000	.000	.000
TA	.537	.675	.000	.000
SQ	.067	.084	.125	.000
GSE10	.604	.759	.000	.000
IM1	.638	.000	.000	.000
IM2	.716	.000	.000	.000
lla1	.704	.000	.000	.000
FCU3	.057	.072	.107	.854
FCN3	.055	.069	.102	.819
GSE9	.582	.732	.000	.000
PE3	.443	.557	.826	.000
SI2	.301	.378	.560	.000
CC1	.059	.075	.111	.886
CMO1	.054	.068	.101	.812
CMO2	.053	.067	.099	.790
CMO3	.055	.070	.103	.829
FCU1	.053	.066	.098	.784
EA3	.058	.073	.108	.862
EA2	.058	.073	.108	.868
AT3	.309	.389	.576	.000
AT2	.318	.399	.592	.000
EE4	.334	.420	.623	.000
EE3	.417	.525	.778	.000
EE1	.418	.526	.780	.000
PE2	.415	.521	.773	.000
PE1	.395	.496	.735	.000
GSE8	.596	.749	.000	.000
GSE7	.533	.669	.000	.000
GSE6	.627	.789	.000	.000
GSE5	.616	.774	.000	.000
GSE4	.557	.700	.000	.000
GSE3	.584	.734	.000	.000
GSE2	.539	.678	.000	.000
GSE1	.553	.695	.000	.000

	TL	SE	TA	SQ
FCA1	.058	.072	.107	.860
FCN2	.053	.067	.100	.799
FCN1	.054	.068	.101	.806
CSP5	.058	.072	.107	.860
CSP1	.059	.075	.111	.887
CSV4	.057	.072	.107	.858
OC3	.055	.069	.103	.826
FCU2	.055	.069	.102	.818
lla2	.668	.000	.000	.000
iib1	.464	.000	.000	.000
iib2	.618	.000	.000	.000
IS1	.716	.000	.000	.000
IS2	.738	.000	.000	.000
IC1	.683	.000	.000	.000
iC2	.654	.000	.000	.000

Standardized Direct Effects (Group number 1 - Default model)

	TL	SE	TA	SQ
SE	.796	.000	.000	.000
TA	.000	.675	.000	.000
SQ	.000	.000	.125	.000
GSE10	.000	.759	.000	.000
IM1	.638	.000	.000	.000
IM2	.716	.000	.000	.000
lla1	.704	.000	.000	.000
FCU3	.000	.000	.000	.854
FCN3	.000	.000	.000	.819
GSE9	.000	.732	.000	.000
PE3	.000	.000	.826	.000
SI2	.000	.000	.560	.000
CC1	.000	.000	.000	.886
CMO1	.000	.000	.000	.812
CMO2	.000	.000	.000	.790
CMO3	.000	.000	.000	.829
FCU1	.000	.000	.000	.784
EA3	.000	.000	.000	.862
EA2	.000	.000	.000	.868
AT3	.000	.000	.576	.000
AT2	.000	.000	.592	.000
EE4	.000	.000	.623	.000

	TL	SE	TA	SQ
EE3	.000	.000	.778	.000
EE1	.000	.000	.780	.000
PE2	.000	.000	.773	.000
PE1	.000	.000	.735	.000
GSE8	.000	.749	.000	.000
GSE7	.000	.669	.000	.000
GSE6	.000	.789	.000	.000
GSE5	.000	.774	.000	.000
GSE4	.000	.700	.000	.000
GSE3	.000	.734	.000	.000
GSE2	.000	.678	.000	.000
GSE1	.000	.695	.000	.000
FCA1	.000	.000	.000	.860
FCN2	.000	.000	.000	.799
FCN1	.000	.000	.000	.806
CSP5	.000	.000	.000	.860
CSP1	.000	.000	.000	.887
CSV4	.000	.000	.000	.858
OC3	.000	.000	.000	.826
FCU2	.000	.000	.000	.818
lla2	.668	.000	.000	.000
iib1	.464	.000	.000	.000
iib2	.618	.000	.000	.000
IS1	.716	.000	.000	.000
IS2	.738	.000	.000	.000
IC1	.683	.000	.000	.000
iC2	.654	.000	.000	.000

Standardized Indirect Effects (Group number 1 - Default model)

	TL	SE	TA	SQ
SE	.000	.000	.000	.000
TA	.537	.000	.000	.000
SQ	.067	.084	.000	.000
GSE10	.604	.000	.000	.000
IM1	.000	.000	.000	.000
IM2	.000	.000	.000	.000
lla1	.000	.000	.000	.000
FCU3	.057	.072	.107	.000
FCN3	.055	.069	.102	.000

	TL	SE	TA	SQ
GSE9	.582	.000	.000	.000
PE3	.443	.557	.000	.000
SI2	.301	.378	.000	.000
CC1	.059	.075	.111	.000
CMO1	.054	.068	.101	.000
CMO2	.053	.067	.099	.000
CMO3	.055	.070	.103	.000
FCU1	.053	.066	.098	.000
EA3	.058	.073	.108	.000
EA2	.058	.073	.108	.000
AT3	.309	.389	.000	.000
AT2	.318	.399	.000	.000
EE4	.334	.420	.000	.000
EE3	.417	.525	.000	.000
EE1	.418	.526	.000	.000
PE2	.415	.521	.000	.000
PE1	.395	.496	.000	.000
GSE8	.596	.000	.000	.000
GSE7	.533	.000	.000	.000
GSE6	.627	.000	.000	.000
GSE5	.616	.000	.000	.000
GSE4	.557	.000	.000	.000
GSE3	.584	.000	.000	.000
GSE2	.539	.000	.000	.000
GSE1	.553	.000	.000	.000
FCA1	.058	.072	.107	.000
FCN2	.053	.067	.100	.000
FCN1	.054	.068	.101	.000
CSP5	.058	.072	.107	.000
CSP1	.059	.075	.111	.000
CSV4	.057	.072	.107	.000
OC3	.055	.069	.103	.000
FCU2	.055	.069	.102	.000
lla2	.000	.000	.000	.000
iib1	.000	.000	.000	.000
iib2	.000	.000	.000	.000
IS1	.000	.000	.000	.000
IS2	.000	.000	.000	.000
IC1	.000	.000	.000	.000
iC2	.000	.000	.000	.000

Model Fit Summary: Charismatic Leadership research framework for the hypothesis (H2a, H2b).

Model Fit Summary

CMIN

Model	NPAR	CMIN	DF	P	CMIN/DF
Default model	180	2357.766	855	.000	2.758
Saturated model	1035	.000	0		
Independence model	45	29156.812	990	.000	29.451

RMR, GFI

Model	RMR	GFI	AGFI	PGFI
Default model	.081	.842	.808	.695
Saturated model	.000	1.000		
Independence model	.428	.147	.108	.140

Baseline Comparisons

Model	NFI Delta1	RFI rho1	IFI Delta2	TLI rho2	CFI
Default model	.919	.906	.947	.938	.947
Saturated model	1.000		1.000		1.000
Independence model	.000	.000	.000	.000	.000

Parsimony-Adjusted Measures

Model	PRATIO	PNFI	PCFI
Default model	.864	.794	.818
Saturated model	.000	.000	.000
Independence model	1.000	.000	.000

NCP

Model	NCP	LO 90	HI 90
Default model	1502.766	1361.992	1651.142
Saturated model	.000	.000	.000
Independence model	28166.812	27613.052	28726.923

FMIN

Model	FMIN	F0	LO 90	HI 90
Default model	3.696	2.355	2.135	2.588

Model	FMIN	F0	LO 90	HI 90
Saturated model	.000	.000	.000	.000
Independence model	45.700	44.149	43.281	45.027

RMSEA

Model	RMSEA	LO 90	HI 90	PCLOSE
Default model	.052	.050	.055	.052
Independence model	.211	.209	.213	.000

AIC

Model	AIC	BCC	BIC	CAIC
Default model	2717.766	2745.739	3520.549	3700.549
Saturated model	2070.000	2230.845	6686.001	7721.001
Independence model	29246.812	29253.805	29447.508	29492.508

ECVI

Model	ECVI	LO 90	HI 90	MECVI
Default model	4.260	4.039	4.492	4.304
Saturated model	3.245	3.245	3.245	3.497
Independence model	45.841	44.973	46.719	45.852

HOELTER

Model	HOELTER	HOELTER
	.05	.01
Default model	251	259
Independence model	24	24

Regression Weights: (Group number 1 - Default model)

			Estimate	S.E.	C.R.	P	Label
SE	<---	CL	.264	.030	8.670	***	par_39
TA	<---	CL	.189	.026	7.183	***	par_40
SQ	<---	SE	.311	.092	3.391	***	par_37
SQ	<---	TA	-.013	.107	-.126	.900	par_38
GSE3	<---	SE	.958	.050	19.192	***	par_1
GSE4	<---	SE	.942	.052	18.245	***	par_2
GSE5	<---	SE	.979	.051	19.034	***	par_3
GSE6	<---	SE	1.026	.051	19.938	***	par_4
EA2	<---	SQ	1.000				

			Estimate	S.E.	C.R.	P	Label
EA3	<---	SQ	1.017	.023	43.491	***	par_5
FCU2	<---	SQ	.914	.032	28.743	***	par_6
FCU1	<---	SQ	.893	.033	27.076	***	par_7
OC3	<---	SQ	.965	.034	28.275	***	par_8
CSV4	<---	SQ	1.084	.034	32.157	***	par_9
CSP1	<---	SQ	1.164	.036	32.285	***	par_10
FCN2	<---	SQ	.864	.029	29.740	***	par_11
CMO3	<---	SQ	.950	.031	30.827	***	par_12
CMO2	<---	SQ	.890	.031	28.554	***	par_13
CMO1	<---	SQ	.956	.033	28.886	***	par_14
CC1	<---	SQ	1.002	.030	33.918	***	par_15
SVA6	<---	CL	1.000				
SVA5	<---	CL	.972	.026	37.156	***	par_16
SVA3	<---	CL	.978	.029	33.571	***	par_17
SVA2	<---	CL	.863	.032	27.190	***	par_18
SVA1	<---	CL	.734	.033	22.075	***	par_19
SI2	<---	TA	.911	.073	12.513	***	par_20
AT3	<---	TA	1.098	.081	13.559	***	par_21
AT2	<---	TA	.999	.079	12.660	***	par_22
EE3	<---	TA	1.291	.077	16.882	***	par_23
EE4	<---	TA	1.217	.080	15.268	***	par_24
EE1	<---	TA	1.275	.076	16.859	***	par_25
PE2	<---	TA	1.055	.045	23.327	***	par_26
PE3	<---	TA	1.140	.058	19.545	***	par_27
GSE8	<---	SE	.882	.052	16.858	***	par_28
GSE7	<---	SE	.814	.051	16.040	***	par_29
FCN3	<---	SQ	.898	.032	27.924	***	par_30
GSE10	<---	SE	.830	.050	16.724	***	par_31
GSE9	<---	SE	.827	.052	15.975	***	par_32
GSE1	<---	SE	1.000				
GSE2	<---	SE	.921	.053	17.484	***	par_33
FCA1	<---	SQ	1.027	.029	35.252	***	par_34
FCN1	<---	SQ	.854	.029	29.383	***	par_35
CSP5	<---	SQ	1.000	.031	32.251	***	par_36
SVA7	<---	CL	.930	.025	36.802	***	par_87
SE1	<---	CL	.285	.041	6.963	***	par_88
SE2	<---	CL	.317	.036	8.860	***	par_89
PR1	<---	CL	.441	.032	13.960	***	par_90
FCU3	<---	SQ	1.006	.029	35.217	***	par_119
PE1	<---	TA	1.000				

Standardized Regression Weights: (Group number 1 - Default model)

			Estimate
SE	<---	CL	.383
TA	<---	CL	.326
SQ	<---	SE	.170
SQ	<---	TA	-.006
GSE3	<---	SE	.752
GSE4	<---	SE	.769
GSE5	<---	SE	.816
GSE6	<---	SE	.826
EA2	<---	SQ	.862
EA3	<---	SQ	.859
FCU2	<---	SQ	.818
FCU1	<---	SQ	.780
OC3	<---	SQ	.823
CSV4	<---	SQ	.857
CSP1	<---	SQ	.879
FCN2	<---	SQ	.838
CMO3	<---	SQ	.857
CMO2	<---	SQ	.829
CMO1	<---	SQ	.829
CC1	<---	SQ	.882
SVA6	<---	CL	.879
SVA5	<---	CL	.877
SVA3	<---	CL	.887
SVA2	<---	CL	.803
SVA1	<---	CL	.720
SI2	<---	TA	.554
AT3	<---	TA	.627
AT2	<---	TA	.559
EE3	<---	TA	.855
EE4	<---	TA	.712
EE1	<---	TA	.852
PE2	<---	TA	.700
PE3	<---	TA	.747
GSE8	<---	SE	.727
GSE7	<---	SE	.669
FCN3	<---	SQ	.819
GSE10	<---	SE	.718
GSE9	<---	SE	.695
GSE1	<---	SE	.705

			Estimate
GSE2	<---	SE	.701
FCA1	<---	SQ	.855
FCN1	<---	SQ	.819
CSP5	<---	SQ	.863
SVA7	<---	CL	.852
SE1	<---	CL	.271
SE2	<---	CL	.323
PR1	<---	CL	.506
FCU3	<---	SQ	.857
PE1	<---	TA	.658

Standardized Total Effects (Group number 1 - Default model)

	CL	TA	SE	SQ
TA	.326	.000	.000	.000
SE	.383	.000	.000	.000
SQ	.063	-.006	.170	.000
PR1	.506	.000	.000	.000
SE2	.323	.000	.000	.000
SE1	.271	.000	.000	.000
SVA7	.852	.000	.000	.000
FCA1	.054	-.005	.145	.855
GSE10	.275	.000	.718	.000
FCU3	.054	-.005	.146	.857
FCN3	.052	-.005	.139	.819
GSE9	.266	.000	.695	.000
PE1	.214	.658	.000	.000
SI2	.180	.554	.000	.000
CC1	.056	-.005	.150	.882
CMO1	.052	-.005	.141	.829
CMO2	.052	-.005	.141	.829
CMO3	.054	-.005	.146	.857
CSP1	.055	-.005	.149	.879
FCU1	.049	-.005	.132	.780
EA3	.054	-.005	.146	.859
EA2	.054	-.005	.146	.862
AT2	.182	.559	.000	.000
AT3	.204	.627	.000	.000
EE1	.278	.852	.000	.000
EE4	.232	.712	.000	.000
EE3	.279	.855	.000	.000

	CL	TA	SE	SQ
PE2	.228	.700	.000	.000
PE3	.243	.747	.000	.000
GSE8	.279	.000	.727	.000
GSE7	.256	.000	.669	.000
GSE6	.316	.000	.826	.000
GSE5	.313	.000	.816	.000
GSE4	.295	.000	.769	.000
GSE3	.288	.000	.752	.000
GSE2	.268	.000	.701	.000
GSE1	.270	.000	.705	.000
FCN2	.053	-.005	.142	.838
FCN1	.052	-.005	.139	.819
CSP5	.054	-.005	.146	.863
CSV4	.054	-.005	.145	.857
OC3	.052	-.005	.140	.823
FCU2	.052	-.005	.139	.818
SVA1	.720	.000	.000	.000
SVA2	.803	.000	.000	.000
SVA3	.887	.000	.000	.000
SVA5	.877	.000	.000	.000
SVA6	.879	.000	.000	.000

Standardized Direct Effects (Group number 1 - Default model)

	CL	TA	SE	SQ
TA	.326	.000	.000	.000
SE	.383	.000	.000	.000
SQ	.000	-.006	.170	.000
PR1	.506	.000	.000	.000
SE2	.323	.000	.000	.000
SE1	.271	.000	.000	.000
SVA7	.852	.000	.000	.000
FCA1	.000	.000	.000	.855
GSE10	.000	.000	.718	.000
FCU3	.000	.000	.000	.857
FCN3	.000	.000	.000	.819
GSE9	.000	.000	.695	.000
PE1	.000	.658	.000	.000
SI2	.000	.554	.000	.000
CC1	.000	.000	.000	.882
CMO1	.000	.000	.000	.829

	CL	TA	SE	SQ
CMO2	.000	.000	.000	.829
CMO3	.000	.000	.000	.857
CSP1	.000	.000	.000	.879
FCU1	.000	.000	.000	.780
EA3	.000	.000	.000	.859
EA2	.000	.000	.000	.862
AT2	.000	.559	.000	.000
AT3	.000	.627	.000	.000
EE1	.000	.852	.000	.000
EE4	.000	.712	.000	.000
EE3	.000	.855	.000	.000
PE2	.000	.700	.000	.000
PE3	.000	.747	.000	.000
GSE8	.000	.000	.727	.000
GSE7	.000	.000	.669	.000
GSE6	.000	.000	.826	.000
GSE5	.000	.000	.816	.000
GSE4	.000	.000	.769	.000
GSE3	.000	.000	.752	.000
GSE2	.000	.000	.701	.000
GSE1	.000	.000	.705	.000
FCN2	.000	.000	.000	.838
FCN1	.000	.000	.000	.819
CSP5	.000	.000	.000	.863
CSV4	.000	.000	.000	.857
OC3	.000	.000	.000	.823
FCU2	.000	.000	.000	.818
SVA1	.720	.000	.000	.000
SVA2	.803	.000	.000	.000
SVA3	.887	.000	.000	.000
SVA5	.877	.000	.000	.000
SVA6	.879	.000	.000	.000

Standardized Indirect Effects (Group number 1 - Default model)

	CL	TA	SE	SQ
TA	.000	.000	.000	.000
SE	.000	.000	.000	.000
SQ	.063	.000	.000	.000
PR1	.000	.000	.000	.000
SE2	.000	.000	.000	.000

	CL	TA	SE	SQ
SE1	.000	.000	.000	.000
SVA7	.000	.000	.000	.000
FCA1	.054	-.005	.145	.000
GSE10	.275	.000	.000	.000
FCU3	.054	-.005	.146	.000
FCN3	.052	-.005	.139	.000
GSE9	.266	.000	.000	.000
PE1	.214	.000	.000	.000
SI2	.180	.000	.000	.000
CC1	.056	-.005	.150	.000
CMO1	.052	-.005	.141	.000
CMO2	.052	-.005	.141	.000
CMO3	.054	-.005	.146	.000
CSP1	.055	-.005	.149	.000
FCU1	.049	-.005	.132	.000
EA3	.054	-.005	.146	.000
EA2	.054	-.005	.146	.000
AT2	.182	.000	.000	.000
AT3	.204	.000	.000	.000
EE1	.278	.000	.000	.000
EE4	.232	.000	.000	.000
EE3	.279	.000	.000	.000
PE2	.228	.000	.000	.000
PE3	.243	.000	.000	.000
GSE8	.279	.000	.000	.000
GSE7	.256	.000	.000	.000
GSE6	.316	.000	.000	.000
GSE5	.313	.000	.000	.000
GSE4	.295	.000	.000	.000
GSE3	.288	.000	.000	.000
GSE2	.268	.000	.000	.000
GSE1	.270	.000	.000	.000
FCN2	.053	-.005	.142	.000
FCN1	.052	-.005	.139	.000
CSP5	.054	-.005	.146	.000
CSV4	.054	-.005	.145	.000
OC3	.052	-.005	.140	.000
FCU2	.052	-.005	.139	.000
SVA1	.000	.000	.000	.000
SVA2	.000	.000	.000	.000

	CL	TA	SE	SQ
SVA3	.000	.000	.000	.000
SVA5	.000	.000	.000	.000
SVA6	.000	.000	.000	.000

Model Fit Summary: Charismatic Leadership research framework for the hypothesis (H2c).

Model Fit Summary

CMIN

Model	NPAR	CMIN	DF	P	CMIN/DF
Default model	163	2796.179	872	.000	3.207
Saturated model	1035	.000	0		
Independence model	45	29156.812	990	.000	29.451

RMR, GFI

Model	RMR	GFI	AGFI	PGFI
Default model	.077	.824	.791	.695
Saturated model	.000	1.000		
Independence model	.428	.147	.108	.140

Baseline Comparisons

Model	NFI Delta1	RFI rho1	IFI Delta2	TLI rho2	CFI
Default model	.904	.891	.932	.922	.932
Saturated model	1.000		1.000		1.000
Independence model	.000	.000	.000	.000	.000

Parsimony-Adjusted Measures

Model	PRATIO	PNFI	PCFI
Default model	.881	.796	.821
Saturated model	.000	.000	.000
Independence model	1.000	.000	.000

NCP

Model	NCP	LO 90	HI 90
Default model	1924.179	1768.084	2087.819

Model	NCP	LO 90	HI 90
Saturated model	.000	.000	.000
Independence model	28166.812	27613.052	28726.923

FMIN

Model	FMIN	F0	LO 90	HI 90
Default model	4.383	3.016	2.771	3.272
Saturated model	.000	.000	.000	.000
Independence model	45.700	44.149	43.281	45.027

RMSEA

Model	RMSEA	LO 90	HI 90	PCLOSE
Default model	.059	.056	.061	.000
Independence model	.211	.209	.213	.000

AIC

Model	AIC	BCC	BIC	CAIC
Default model	3122.179	3147.511	3849.144	4012.144
Saturated model	2070.000	2230.845	6686.001	7721.001
Independence model	29246.812	29253.805	29447.508	29492.508

ECVI

Model	ECVI	LO 90	HI 90	MECVI
Default model	4.894	4.649	5.150	4.933
Saturated model	3.245	3.245	3.245	3.497
Independence model	45.841	44.973	46.719	45.852

HOELTER

Model	HOELTER	HOELTER
	.05	.01
Default model	215	222
Independence model	24	24

Regression Weights: (Group number 1 - Default model)

			Estimate	S.E.	C.R.	P	Label
SE	<---	CL	.332	.040	8.377	***	par_37
TA	<---	SE	.548	.046	11.859	***	par_83

			Estimate	S.E.	C.R.	P	Label
SQ	<---	TA	.250	.090	2.783	.005	par_36
GSE3	<---	SE	.957	.050	19.203	***	par_1
GSE4	<---	SE	.922	.051	18.248	***	par_2
GSE5	<---	SE	.959	.050	19.105	***	par_3
GSE6	<---	SE	1.016	.051	20.041	***	par_4
EA2	<---	SQ	1.000				
EA3	<---	SQ	1.015	.024	42.415	***	par_5
FCU2	<---	SQ	.910	.032	28.565	***	par_6
FCU1	<---	SQ	.886	.033	26.847	***	par_7
OC3	<---	SQ	.958	.034	27.988	***	par_8
CSV4	<---	SQ	1.091	.035	31.607	***	par_9
CSP1	<---	SQ	1.167	.036	32.533	***	par_10
FCN2	<---	SQ	.867	.030	28.754	***	par_11
CMO2	<---	SQ	.882	.032	27.544	***	par_12
CMO1	<---	SQ	.955	.033	28.838	***	par_13
CC1	<---	SQ	1.008	.031	32.752	***	par_14
SVA6	<---	CL	1.304	.054	24.371	***	par_15
SVA5	<---	CL	1.257	.052	24.040	***	par_16
SVA3	<---	CL	1.229	.049	24.841	***	par_17
SVA2	<---	CL	1.170	.042	27.899	***	par_18
SVA1	<---	CL	1.000				
SI2	<---	TA	.904	.071	12.671	***	par_19
AT3	<---	TA	.975	.076	12.919	***	par_20
AT2	<---	TA	1.029	.078	13.219	***	par_21
EE4	<---	TA	1.031	.074	13.920	***	par_22
EE3	<---	TA	1.145	.068	16.862	***	par_23
EE1	<---	TA	1.132	.067	16.852	***	par_24
PE1	<---	TA	1.000				
PE2	<---	TA	1.054	.044	23.821	***	par_25
PE3	<---	TA	1.151	.059	19.623	***	par_26
GSE8	<---	SE	.888	.052	17.146	***	par_27
GSE7	<---	SE	.834	.050	16.514	***	par_28
FCN3	<---	SQ	.901	.032	28.186	***	par_29
GSE10	<---	SE	.836	.049	16.990	***	par_30
GSE9	<---	SE	.845	.052	16.319	***	par_31
GSE1	<---	SE	1.000				
GSE2	<---	SE	.904	.052	17.452	***	par_32
FCA1	<---	SQ	1.025	.029	35.640	***	par_33
FCN1	<---	SQ	.857	.030	28.644	***	par_34
CSP5	<---	SQ	.992	.032	31.062	***	par_35

			Estimate	S.E.	C.R.	P	Label
SVA7	<---	CL	1.186	.051	23.067	***	par_84
SE1	<---	CL	.329	.053	6.194	***	par_85
SE2	<---	CL	.386	.047	8.238	***	par_86
PR1	<---	CL	.538	.044	12.156	***	par_87
CMO3	<---	SQ	.942	.031	30.544	***	par_97
FCU3	<---	SQ	1.006	.032	31.413	***	par_98

Standardized Regression Weights: (Group number 1 - Default model)

			Estimate
SE	<---	CL	.374
TA	<---	SE	.622
SQ	<---	TA	.121
GSE3	<---	SE	.753
GSE4	<---	SE	.763
GSE5	<---	SE	.806
GSE6	<---	SE	.823
EA2	<---	SQ	.864
EA3	<---	SQ	.866
FCU2	<---	SQ	.817
FCU1	<---	SQ	.778
OC3	<---	SQ	.817
CSV4	<---	SQ	.857
CSP1	<---	SQ	.882
FCN2	<---	SQ	.820
CMO2	<---	SQ	.811
CMO1	<---	SQ	.828
CC1	<---	SQ	.885
SVA6	<---	CL	.899
SVA5	<---	CL	.887
SVA3	<---	CL	.881
SVA2	<---	CL	.829
SVA1	<---	CL	.748
SI2	<---	TA	.577
AT3	<---	TA	.585
AT2	<---	TA	.600
EE4	<---	TA	.632
EE3	<---	TA	.793
EE1	<---	TA	.793
PE1	<---	TA	.691

			Estimate
PE2	<---	TA	.734
PE3	<---	TA	.793
GSE8	<---	SE	.738
GSE7	<---	SE	.688
FCN3	<---	SQ	.822
GSE10	<---	SE	.728
GSE9	<---	SE	.704
GSE1	<---	SE	.706
GSE2	<---	SE	.700
FCA1	<---	SQ	.855
FCN1	<---	SQ	.820
CSP5	<---	SQ	.857
SVA7	<---	CL	.851
SE1	<---	CL	.251
SE2	<---	CL	.320
PR1	<---	CL	.486
CMO3	<---	SQ	.855
FCU3	<---	SQ	.855

Standardized Total Effects (Group number 1 - Default model)

	CL	SE	TA	SQ
SE	.374	.000	.000	.000
TA	.233	.622	.000	.000
SQ	.028	.075	.121	.000
PR1	.486	.000	.000	.000
SE2	.320	.000	.000	.000
SE1	.251	.000	.000	.000
SVA7	.851	.000	.000	.000
FCA1	.024	.064	.103	.855
GSE10	.272	.728	.000	.000
FCU3	.024	.064	.104	.855
FCN3	.023	.062	.100	.822
CMO3	.024	.064	.103	.855
GSE9	.263	.704	.000	.000
PE1	.161	.430	.691	.000
SI2	.134	.359	.577	.000
CC1	.025	.067	.107	.885
CMO1	.023	.062	.100	.828
CMO2	.023	.061	.098	.811
CSP1	.025	.066	.107	.882

	CL	SE	TA	SQ
FCU1	.022	.059	.094	.778
EA3	.024	.065	.105	.866
EA2	.024	.065	.105	.864
AT2	.140	.373	.600	.000
AT3	.136	.364	.585	.000
EE1	.185	.494	.793	.000
EE3	.185	.494	.793	.000
EE4	.147	.393	.632	.000
PE2	.171	.457	.734	.000
PE3	.185	.494	.793	.000
GSE8	.276	.738	.000	.000
GSE7	.257	.688	.000	.000
GSE6	.308	.823	.000	.000
GSE5	.302	.806	.000	.000
GSE4	.285	.763	.000	.000
GSE3	.281	.753	.000	.000
GSE2	.262	.700	.000	.000
GSE1	.264	.706	.000	.000
FCN2	.023	.062	.099	.820
FCN1	.023	.062	.099	.820
CSP5	.024	.065	.104	.857
CSV4	.024	.065	.104	.857
OC3	.023	.062	.099	.817
FCU2	.023	.062	.099	.817
SVA1	.748	.000	.000	.000
SVA2	.829	.000	.000	.000
SVA3	.881	.000	.000	.000
SVA5	.887	.000	.000	.000
SVA6	.899	.000	.000	.000

Standardized Direct Effects (Group number 1 - Default model)

	CL	SE	TA	SQ
SE	.374	.000	.000	.000
TA	.000	.622	.000	.000
SQ	.000	.000	.121	.000
PR1	.486	.000	.000	.000
SE2	.320	.000	.000	.000
SE1	.251	.000	.000	.000
SVA7	.851	.000	.000	.000
FCA1	.000	.000	.000	.855

	CL	SE	TA	SQ
GSE10	.000	.728	.000	.000
FCU3	.000	.000	.000	.855
FCN3	.000	.000	.000	.822
CMO3	.000	.000	.000	.855
GSE9	.000	.704	.000	.000
PE1	.000	.000	.691	.000
SI2	.000	.000	.577	.000
CC1	.000	.000	.000	.885
CMO1	.000	.000	.000	.828
CMO2	.000	.000	.000	.811
CSP1	.000	.000	.000	.882
FCU1	.000	.000	.000	.778
EA3	.000	.000	.000	.866
EA2	.000	.000	.000	.864
AT2	.000	.000	.600	.000
AT3	.000	.000	.585	.000
EE1	.000	.000	.793	.000
EE3	.000	.000	.793	.000
EE4	.000	.000	.632	.000
PE2	.000	.000	.734	.000
PE3	.000	.000	.793	.000
GSE8	.000	.738	.000	.000
GSE7	.000	.688	.000	.000
GSE6	.000	.823	.000	.000
GSE5	.000	.806	.000	.000
GSE4	.000	.763	.000	.000
GSE3	.000	.753	.000	.000
GSE2	.000	.700	.000	.000
GSE1	.000	.706	.000	.000
FCN2	.000	.000	.000	.820
FCN1	.000	.000	.000	.820
CSP5	.000	.000	.000	.857
CSV4	.000	.000	.000	.857
OC3	.000	.000	.000	.817
FCU2	.000	.000	.000	.817
SVA1	.748	.000	.000	.000
SVA2	.829	.000	.000	.000
SVA3	.881	.000	.000	.000
SVA5	.887	.000	.000	.000
SVA6	.899	.000	.000	.000

Standardized Indirect Effects (Group number 1 - Default model)

	CL	SE	TA	SQ
SE	.000	.000	.000	.000
TA	.233	.000	.000	.000
SQ	.028	.075	.000	.000
PR1	.000	.000	.000	.000
SE2	.000	.000	.000	.000
SE1	.000	.000	.000	.000
SVA7	.000	.000	.000	.000
FCA1	.024	.064	.103	.000
GSE10	.272	.000	.000	.000
FCU3	.024	.064	.104	.000
FCN3	.023	.062	.100	.000
CMO3	.024	.064	.103	.000
GSE9	.263	.000	.000	.000
PE1	.161	.430	.000	.000
SI2	.134	.359	.000	.000
CC1	.025	.067	.107	.000
CMO1	.023	.062	.100	.000
CMO2	.023	.061	.098	.000
CSP1	.025	.066	.107	.000
FCU1	.022	.059	.094	.000
EA3	.024	.065	.105	.000
EA2	.024	.065	.105	.000
AT2	.140	.373	.000	.000
AT3	.136	.364	.000	.000
EE1	.185	.494	.000	.000
EE3	.185	.494	.000	.000
EE4	.147	.393	.000	.000
PE2	.171	.457	.000	.000
PE3	.185	.494	.000	.000
GSE8	.276	.000	.000	.000
GSE7	.257	.000	.000	.000
GSE6	.308	.000	.000	.000
GSE5	.302	.000	.000	.000
GSE4	.285	.000	.000	.000
GSE3	.281	.000	.000	.000
GSE2	.262	.000	.000	.000
GSE1	.264	.000	.000	.000
FCN2	.023	.062	.099	.000
FCN1	.023	.062	.099	.000

	CL	SE	TA	SQ
CSP5	.024	.065	.104	.000
CSV4	.024	.065	.104	.000
OC3	.023	.062	.099	.000
FCU2	.023	.062	.099	.000
SVA1	.000	.000	.000	.000
SVA2	.000	.000	.000	.000
SVA3	.000	.000	.000	.000
SVA5	.000	.000	.000	.000
SVA6	.000	.000	.000	.000



Biography

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National Institute of Development Administration
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Experience Work

Position : **Deputy Managing Director**
Company : A.J.M. Rangsima Uniform Co., Ltd
Period : Oct 2003 to Present

Position : **Human Resources & Admin Mgr.**
Company : Sathaporn Marketing Co., Ltd
Period : Jan 2003 to Sep 2005

Position : **Human Resources & Admin. Mgr.**
Company : Dyno Paints Co., Ltd
Period : Oct 2000 to Dec 2002

Position : **Assistant Director**
Company : Nakhonratchasima Chamber of Commerce
Period : Feb 1996 to Mar 1998

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