THE DESIGN OF THAILAND INTERNATIONAL PUBLIC SECTOR STANDARD MANAGEMENT SYSTEM AND OUTCOMES IN SERVICE FOR THE PRIVATE SECTOR AND PEOPLE SYSTEM (P.S.O 1107):

CASE STUDY OF SIRIRAJ HOSPITAL

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การออกแบบระบบมาตรฐานด้านการจัดการและสัมฤทธิ์ผลของงานภาครัฐ ในเรื่องระบบบริการภาคเอกชนและประชาชน (P.S.O. 1107) ของโรงพยาบาลศิริราช

นาย ภีมเดช ศิวพรพิทักษ์

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วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรรัฐศาสตรมหาบัณฑิต

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ภีมเดช ศิวพรพิทักษ์ : การออกแบบระบบมาตรฐานด้านการจัดการและสัมฤทธิ์ผลของงานภาครัฐ ในเรื่องระบบบริการภาคเอกชนและประชาชน (P.S.O. 1107) ของโรงพยาบาลศิริราช (THE DESIGN OF THAILAND INTERNATIONAL PUBLIC SECTOR STANDARD MANAGEMENT SYSTEM AND OUTCOMES IN SERVICE FOR THE PRIVATE SECTOR AND PEOPLE SYSTEM (P.S.O 1107): CASE STUDY OF SIRIRAJ HOSPITAL อ.ที่ปรึกษาวิทยานิพนธ์หลัก: ผู้ช่วยศาสตราจารย์ ดร.อัครเดช ไชยเพิ่ม, 88 หน้า

การนำรูปแบบการดำเนินการแบบเอกชนมาใช้ในองค์กรภาครัฐ เป็นการแปรรูปเชิงกลยุทธ์ประเภทหนึ่งที่ช่วยส่งเสริมให้เกิดการพัฒนาในเชิงประสิทธิภาพและคุณภาพต่อองค์กรอย่างมาก ซึ่งผลที่ตามมาคือการพัฒนาทางการเงินในรูปแบบรายรับและผลกำไรอย่างต่อเนื่อง การพัฒนาการดังกล่าวจะสอดคล้องกับการแข่งขันในตลาดซึ่งมักเป็นตัวชี้วัดความสำเร็จขององค์กร อย่างไรก็ตาม รูปแบบการดำเนินการภาคเอกชนสามารถส่งผลกระทบโดยตรงต่อองค์กรภาครัฐและผู้ถือประโยชน์ร่วมได้เช่นกัน หากถูกนำไปประยุกต์ใช้กับองค์กรของรัฐที่เน้นในเรื่องการให้บริการด้านสุขภาพแก่ประชาชน เช่น โรงพยาบาลรัฐ ที่มีผลิตผลคือ การรักษาร่างกาย หรือ การให้บริการทางแพทย์ การวิจัยนี้มีวัตถุประสงค์เพื่อศึกษาระบบการจัดการในรูปแบบภาคเอกชนของโรงพยาบาลศิริราชปิยมหาราชการุณย์ ซึ่งเป็นอีกหนึ่งโรงพยาบาลภาครัฐระดับทุติยภูมิในเครือของคณะแพทย์ศาสตร์ มหาวิทยาลัยมหิดล โดยนำ 5 ส่วนประกอบหลักจากระบบการบริการภาคเอกชนและประชาชนจากมาตรฐานด้านการจัดการและสัมฤทธิ์ผลของงานภาครัฐมาใช้เป็นกรอบแนวคิด ว่าด้วยเรื่อง ประสิทธิภาพคุณภาพ ความเท่าเทียม การตอบสนอง และความพร้อมในการให้บริการ เพื่อใช้เป็นแนวทางในการสร้างระบบการจัดการมาตรฐานของโรงพยาบาลภาครัฐในรูปแบบการดำเนินการแบบเอกชน การวิจัยเรื่องนี้ดำเนินการวิจัยตามระเบียบ

วิธีวิจัยเชิงคุณภาพ โดยใช้วิธีการศึกษาเอกสารจากข้อปฏิบัติในระบบการบริการภาคเอกชนและประชาชนจากมาตรฐานด้านการจัดการและสัมฤทธิ์ผลของงานภาครัฐและงานวรรณกรรมอื่นๆที่เกี่ยวข้องกับกรอบความคิดการดำเนินการรูปแบบเอกชนและการบริการสาธารณสุข เพื่อใช้อธิบายว่าการนำรูปแบบการดำเนินการแบบเอกชนมาใช้ในภาคสาธารณสุขสามารถสร้างค่านิยมทางสังคมและส่งผลกระทบต่อสังคมอย่างไรได้บ้าง อีกหนึ่งวิธีที่ใช้คือวิธีการสัมภาษณ์แบบกึ่งโครงสร้าง และการสัมภาษณ์เชิงลึก เพื่อที่จะสามารถได้รับข้อมูลที่ถูกต้องและตรงตามสาระสำคัญสำหรับการศึกษาในครั้งนี้

ผลการวิจัยพบว่า การนำรูปแบบการดำเนินการภาคเอกชนมาใช้ในโรงพยาบาลศิริราชปิยมหาราชการุณย์ ช่วยนำพาให้โรงพยาบาลเกิดการพัฒนาได้ในระดับหนึ่ง เช่น เรื่องประสิทธิภาพในการใช้ทรัพยากรบุคคลให้เกิดประโยชน์สูงสุด ประสิทธิภาพในพัฒนาทางการเงิน ประสิทธิภาพในการให้บริการรวดเร็วยิ่งขึ้น หรือ เรื่องคุณภาพของการให้บริการสุขภาพที่ได้รับการรับรองจากมาตรฐานสากล JCI ซึ่งทำให้โรงพยาบาลศิริราชปิยมหาราชการุณย์สามารถยกระดับการบริการด้านสุขภาพให้ดีกว่าโรงพยาบาลศิริราช ภาครัฐ ที่ยึดปฏิบัติตามเกณฑ์มาตรฐาน HA อย่างไรก็ตาม ทั้งสองโรงพยาบาลยึดมั่นในคุณภาพการรักษาเดียวกัน ถึงแม้ว่าโครงการบริการการแพทย์ในรูปแบบภาคเอกชนจะตอบสนองความต้องการของบุคลากรทางการแพทย์และกลุ่มผู้ป่วยที่สามารถจ่ายได้ ข้อเสียที่ปรากฏขึ้นจากการก่อตั้งโรงพยาบาลศิริราชปิยมหาราชการุณย์ คือ ปัญหาเรื่องความไม่เท่าเทียม เช่น อุปสรรคทางการเงินที่เกิดจากการให้บริการสุขภาพในรูปแบบภาคเอกชน ซึ่งทำให้การให้บริการดังกล่าวขึ้นอยู่กับความสามารถในการจ่ายมากกว่าความพึงปรารถนาของผู้รับที่จะได้รับบริการ อุปสรรคที่เกิดจากการติดตั้งสิ่งอำนวยความสะดวกในโรงพยาบาลแบบภาคเอกชน ซึ่งส่งผลให้เกิดข้อกำจัดในการเข้ารับบริการสำหรับผู้ป่วยที่มีศักยภาพในการจ่ายที่น้อยกว่า และอุปสรรคทางวัฒนธรรม

ขององค์กรที่เกิดจากการนำรูปแบบการให้บริการภาคเอกชนมาใช้ในโรงพยาบาล ซึ่งส่งผลให้บุคลากรทางการแพทย์ปฏิบัติตนไม่เป็นธรรมเพราะผู้ป่วยที่มีศักยภาพในการจ่ายเท่านั้นที่สามารถตอบสนองความต้องการแก่แพทย์เหล่านี้ได้ อีกหนึ่งปัญหาสุดท้ายที่สังเกตได้จากการนำรูปแบบการให้บริการภาคเอกชนมาใช้ในโรงพยาบาลภาครัฐคือ จำนวนการให้บริการรักษาทางการแพทย์ที่มีราคาสูงและเฉพาะทางที่เท่าไม่กัน ซึ่งโรงพยาบาลศิริราชปิยมหาราชการุณย์มีมากกว่าโรงพยาบาลศิริราชภาครัฐ เพราะการดำเนินการในรูปแบบเอกชนมักให้ความสำคัญกับเรื่องการพัฒนาทางการเงินมากกว่าความเท่าเทียม

สาขาวิชา ธรรมาภิบาล ลายมือชื่อนิสิต

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PIMADEJ SIWAPORNPITAK : THE DESIGN OF THAILAND INTERNATIONAL PUBLIC SECTOR STANDARD MANAGEMENT SYSTEM AND OUTCOMES IN SERVICE FOR THE PRIVATE SECTOR AND PEOPLE SYSTEM (P.S.O. 1107): CASE STUDY OF SIRIRAJ PIYAMAHARAJKARUN HOSPITAL

ADVISOR: ASSISTANT PROFESSOR ACKADEJ CHAIPERM, DR.RER.PUBL.,88 pp.

The application of privatization in public sector is a one of strategic transformations that significantly helps promoting the organizational development in terms of efficiency and quality which subsequently resulted to the continuous financial development which refers to as revenue and profitability. Such development usually will be corresponded to the competitive market which indicates the organizational achievement. However, privatization can possibly create direct impacts on public sector and stakeholders as well if it was conducted in the public sector that emphasized on public health services such as public hospital where the core product is health care or medical treatment. The objectives of this research were to (1) study the privatized management system of Siriraj Piyamaharajkarun Hospital, which is another Government Super Tertiary Hospital affiliated with the Faculty of Medicine Siriraj Hospital, Mahidol University, by using five specific components of P.S.O. 1107 as a conceptual framework (efficiency, quality, equity, responsiveness, availability); (2) to initiate an innovative privatized super tertiary hospital standard management system. The research is conducted as a qualitative study, using (1) documentary researches which include the principle of P.S.O. 1107, work of literatures regarding the concept of privatization and public health service, to explain how adoption of

privatization in public health sector can generate social values and social impacts (2) interview approaches; in-depth and semi-structured interviews, to engage people with the right form of information and knowledge needed to address the theme emerging from the study.

The findings were that the application of privatization in SiPH led to certain degree of improvements, especially on the level of (1) efficiency which can be referred to as the maximization of human resources, financial development, and faster-timing in service provision; (2) quality in term of health services which showed that privatized medical scheme accredited by JCI Standards, enabled SiPH to provide better health services than Siriraj Hospital where HA Standard is held, however, both hospitals adhered to the same quality standard of medical treatments. Although privatized medical scheme is responsive to the needs of medical personnel and affordable patients, what emerged as potential drawback from the establishment of SiPH is an issue of inequity which can be referred to as (1) financial barrier that health service provision is dramatically depended on affordability than desirability (2) geographical barrier that hospital facilities in privatized scheme prevent accessibility from least affordable patients (3) cultural barrier that privatization influenced medical personnel to conduct unfair practices since only affordable patients could actually respond to their needs. Last but not least, it was also observable that the quantities of advanced and expensive medical specialties listed in SiPH were more than Siriraj Hospital because privatization granted SiPH to prioritize on financial development aspect rather than equity.

Field of Study: Governance Student's Signature……

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Second of all, I also would like to express my appreciation to all administrative staff who always provided me their assistances along with essential information regarding class-registration, thesis proposal timelines, academic documents, examination, and other useful information necessary for the completion of my master degree.

Furthermore, I am proud to say that it is my honor and pleasure to be a part of MAG programme. The journey throughout these semesters with other fellow classmates is very meaningful and memorable. With all the encouragement, friendship, and sincerity that we shared both internally and externally, it shaped us altogether and we finally have become the first generation of this curriculum.

Last but not least, my greatest thankfulness is dedicated to my parents and family who always give me the warmest love and support, encouragement, and motivation to complete this study. This achievement is counted as one of my best achievements so far. Therefore, I would like to dedicate all credits to those who involved with this Master degree.

CONTENTS

CHAPTER I

INTRODUCTION

1.1 Background and Significance of the Study

Since 1980s, there were enormous changes in the global conventional mainstream of public sector management in which it shifted from Traditional Bureaucratic Administrative into Managerialism. Consequently, during 1990s many of scholars advocated themselves in supporting modern management. For example, a New Management Paradigm *(Aucoin 1990),* Managerialism *(Pollitt, 199*3), and New Public Management (NPM) *(Hood, 1996a, 1996b).* These concepts of modern management significantly led the trend of the public sector management toward a theory of "Market-Based Public Administration" which emerged in 1992 *(Lan and Rosenbloom, 1992).* This approach, later termed as Entrepreneurial Government by *Osborne and Gaebler (1993),* emphasizes on the entrepreneurial roles in the public sector and is fundamentally guided by market mechanisms. This Entrepreneurial Government does not only focus on achieving the outcomes, but also on the improvement of efficiency, effectiveness, service quality, and management for change.

During the transformation period of Bureaucratic Administrative Government into the Entrepreneurial Government, the concept of privatization was vastly introduced to public sector and somehow it became a major global development. Many public entities were encouraged to integrate an old-fashioned bureaucracy with the trend of privatization as they believed that the private-public mixed management system would yield to greater benefits described as follows: Firstly, by allowing great participation of private sector in government sectors, a new form of privatized management would lead to make changes in public services to be in line with the private

market forces. Secondly, an application of privatization would inject competition into public service provision by promoting more efficiency and quality in which it would subsequently lead to financial development as well. Thirdly, a synchronized management between public sector and private sector would allow greater autonomy and flexibility in the use of resources. Lastly, an adoption of privatized mechanism in public sector would reduce the cost burden on the government through cost-sharing scheme. However, these advantageous assumptions have become one of the most controversial subjects for decades and still remain in an institutional discussion on public service provision, especially when applied to the health sector.

However, in case of Thailand, the important approach for public sector reform is public sector standard. In 2000 the cabinet approved and adopted Thailand International Public Sector Standard Management System and Outcomes (Thailand International PSO), an innovative policy that brought new insights for public sector reform. The goals of PSO are to enhance public interests, social equity and equality in services. Through this scheme all public agencies including state enterprises are encouraged to develop quality standard in public services.

Public Sector Standard Management System and Outcomes

In 1997, the committees on Enhancing efficiency and Standard Performance for Public Sector was recommended to consider developing the Public Sector Standard Management System and Outcomes (PSO) for Thailand. This initiative mainly aims to improve operations and tries to initiate best practices as well as a system of good governance for Thailand's administrative system. As a result, PSO was proclaimed for an initial preparation in October 27 1998, requiring all public agencies including state enterprises to develop PSO and apply it into the functions. In March 2000, the cabinet and Office of the Prime Minister had ultimately approved the proposal on Thailand International PSO and thus it was certified and permitted for official execution. In this case, Bureau

of the Budget was assigned to proportionately allocate the budgets to support all public sectors for policy implementation. At the same time, the Office of the Civil Service Commission was named as the body responsible for implementation and collaboration amongst other public service sectors in order to lead the whole government sectors to an achievement of total system outcomes. The effort of establishing PSO is also in line with and responsive to Article 75 of the new constitution which reflects the fundamental state policy in enhancing public services efficiency to fulfil people needs and satisfaction. However, in order to be able to achieve the goals of PSO which include enhancing public interests, social equity and equality in services, it is necessary to first develop standard achievement outcomes. The components of standard achievement outcomes are as follows: (1) Standard Performance/Output of the sector (2) Standard Outcomes of the sector (3) The ultimate Outcomes (4) Prevention system of Unintended Consequences.

PSO is composed of ten standard systems which have been identified as essential parts of the whole standard management system.

1. P.S.O. 1101: Information and Data System
2. P.S.O. 1102: Communication System
3. P.S.O. 1103: Decision-making System
4. P.S.O. 1104: Personnel Development System
5. P.S.O. 1105: Check and Balance System
6. P.S.O. 1106: Participatory System
7. P.S.O. 1107: Service for the Private Sector and People System
8. P.S.O. 1108: Evaluation system

9. P.S.O 1109: Prediction and Crisis Resolving System

10. P.S.O. 1110: Cultural and Professional Ethics System

These ten standard systems of Thailand International PSO mentioned above served as guidelines for all public agencies in developing the quality of their standard management systems as it led the whole public sector to an achievement of various ultimate outcomes which included 1) Evenness in administration 2) Justice in delivering services 3) Protection of life and property of people 4) Protection of citizens' rights and freedoms 5) Provision of services to everyone equally 6) Citizen satisfaction with public work and services 7) Efficiency of service units in delivering services 8) Economic delivery of services to people 9) Production of high quality, valid official documents (eg., property titles, passports, etc.) 10) Public benefit protection, happiness, and total quality of life of people.

Obviously, with PSO being developed and implemented through the delivery of public services, all citizens eventually were insured that they received good quality of services in equally manner in which it significantly fulfilled their needs and satisfaction. In this case, there were plenty of governmental units that had already been certified by Thailand International Public Sector Standard Management System and Outcomes. For example, Office of the Civil Service Commission, Public Hospital, Land Development Department, Provincial Office, Provincial Police Station, Social Security Office, Provincial Education Office and many more. Nonetheless, these public units only implement a particular standard system which is directly corresponded to the units' tasks and objectives.

Overall, the establishment of Thailand International PSO within various public sectors had positively brought Thailand to witness tremendous changes on the quality of public services. In

this case, Thailand International PSO enabled the whole public sectors to enhance public interests, social equity and equality in services as anticipated. Therefore, Thailand International PSO was publicly admitted to be the first outstanding government policy that literally led the whole public sector toward great improvement on public service delivery and public service standardization. No matter how many years have gone by, this innovative policy would still be considered as the most remarkable governmental guidelines which had ever been originated in the Kingdom of Thailand.

Hospital Accreditation (HA)

Speaking of public services delivery, public health sector is one of most important public units that fundamentally serves as the center of maintenance or improvement of health. Generally, most public and private hospitals around the globe are principally required to go through an accreditation process, which is a process that assesses a hospital's performance against a set of standards. However, the standards from various countries may be different from one another depending on the application of domestic law and format of governance in that particular country. In case of Thailand, the historical establishment of Hospital Accreditation (HA) can be dated back in 1993 when Thailand initially started implementing a trial of Total Quality Management (TQM) in 8 public hospitals. The concepts and tools for quality improvement from global standards were introduced and educated amongst medical institutions and medical personnel in Thailand and the first Thailand hospital standards were launched in 1996. Then, a total of 35 public and private hospitals were invited to implement the standards under the umbrella of the Health Systems Research Institute (HSRI) in 1997. As research and development on a field trial continuously progressed, the framework of HA standards gradually became a perceptible platform and guideline for all hospitals in Thailand to follow and conduct. The framework of HA standards consisted of multidisciplinary team, medical staff organization, clinical quality improvement, risk

management, quality review, internal survey, and etc. After a while, many hospitals volunteered to join the trial and tested this framework of HA standards. The results were pleasurable when these participated hospitals started to absorb and recognize the importance of HA standards, which could be further applied for many hospital policies or innovative changes within its organizations. The first accreditation decision was made in 1999 for 4 hospitals.

HA program in Thailand first started in 1997 as a project. In 1999, it became an institute under the HSRI known as "The Hospital Quality Improvement and Accreditation Institute". Later on, it was changed to be "The Healthcare Accreditation Institute" (Public Organization) or HAI in 2009. The HAI is a formal government agency with its own governing body accountable to the Ministry of Public Health. The purpose of HAI is to promote quality improvement of healthcare organizations in Thailand, using self-assessment and self-improvement together with external evaluation and recognition as an incentive. The current accreditation program mainly concentrates on hospital services and plans to further extend for other services such as primary care network in the future. With the introduction of the government's universal coverage policy in 2011, it is a mandate that the HA program must adapt itself to match with the needs of broader access to quality care. In this case, the stepwise recognition program was initiated to assist the hospitals with limited resources comparing to their workloads to be able to get along with the quality journey.

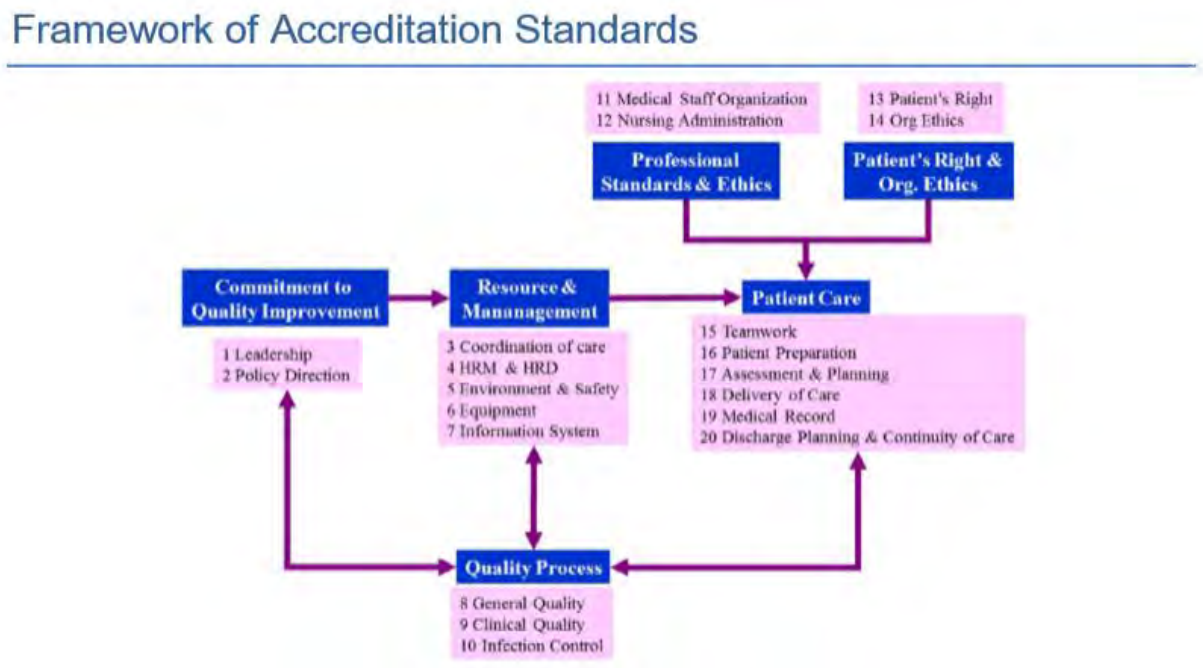
<u>Through HA program, there are 3 main steps to follow:</u>

1. Quality Review: This step is to allow the hospitals to gain the opportunity to ascertain their quality of activities so that they could able to identify rooms for improvement or risk prevention.

2. Quality Assurance and Quality Improvement: This step is to allow the hospitals to concentrate on their quality assurance and quality improvement in order to fulfil the purpose of the hospitals or its unit.

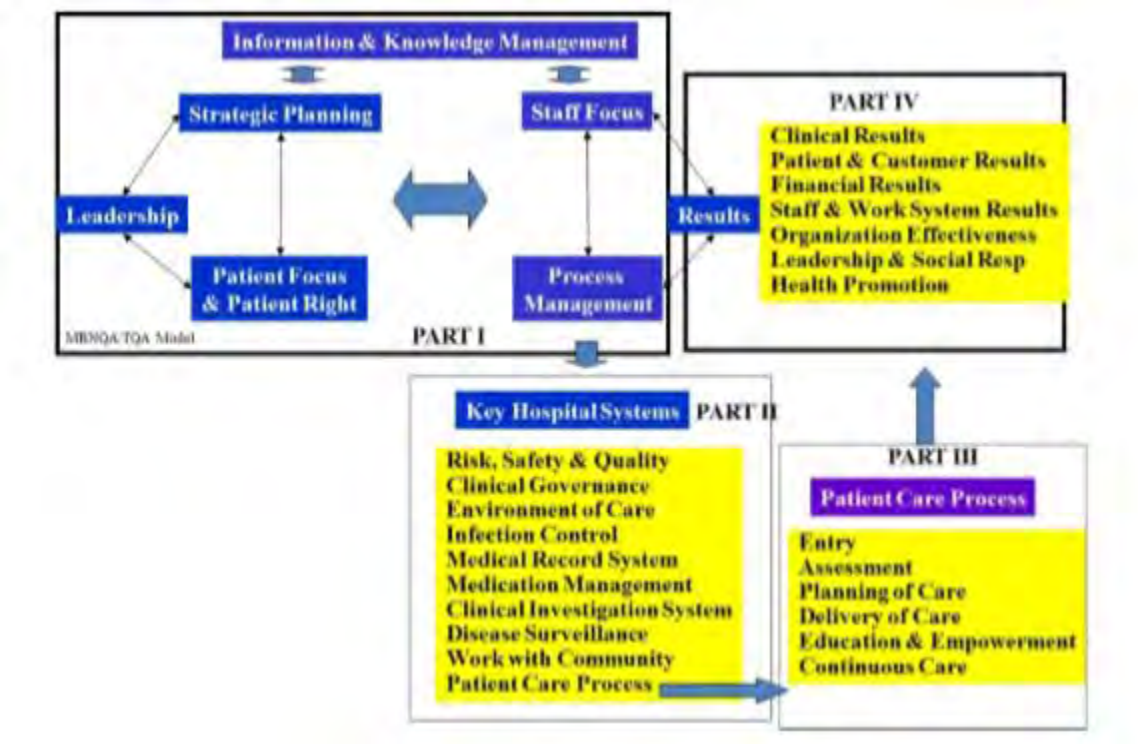
3. Full Hospital Accreditation Program: This step is to emphasize on compliance to HA standards in a learning mode.

The hospital that registers for the third step to HA is required to submit self-assessment report which shows the process of implementing HA standards and the results along with an aim to encourage learning of the hospital staff. An on-site survey will be conducted within 3-4 months after receiving the application. Documentation and medical record review, individual hospital staff and team interview, observation, and tracer methodology are used during the site visit. A scoring of 1 to 5 will be given to 89 items of the standards. The accreditation subcommittee reviews the survey report and suggests a decision to give accreditation award to the HAI Board. The decision has to be made within 90 days after the survey.



The 1st Accreditation Standards Framework

In 2004, a second version of the HA standards was drafted, combining key concepts of patient safety and quality from HA, focus on health and empowerment from HPH, and learning and integration from TQA. The Standards was launched in 2006 and has been accredited by the International Society for Quality in Healthcare (ISQua) in 2010.



The 2nd Accreditation Standards Framework

Joint Commission International Accreditation standards (JCI)

For the case study of Siriraj Piyamaharajkarun Hospital, this hospital span off itself from Siriraj Hospital to develop their own autonomous public hospital with privatization medical management system that complies with Joint Commission International Accreditation standards (JCI standards). JCI standards were initially launched in 1994 by the Joint Commission and were

continued to be developed consistently. In the present, more than 90 countries have adopted JCI standards into their hospitals or health care organizations to solve the issues or challenges of ineffective and unsafe cares. Joint Commission International is a part of a global enterprise of dynamic and nonprofit organizations that identifies, measures, and shares best practice in quality care and patient safety through the provision of education, publications, consultation, and evaluation services. It also provides leadership and innovative solutions to help health care organizations across all settings improve performance and outcomes. Joint Commission International standards define the performance expectations, structures, and functions that must be in place for a hospital to be accredited by JCI.

JCI helps health care organizations to help themselves through:

- Earning JCI accreditation and certification, recognized as the global Gold Seal of Approval
- Providing leading education
- Delivering evidence-based advisory services

Joint Commission International Accreditation Standards for Hospitals including Standards for Academic Medical Center Hospitals consist of 4 main sections as follows

1. **Section 1** - Accreditation Participation Requirements: This section specifically states that the participative hospitals need to meet all the requirements that Joint Commission International (JCI) has set as well as to provide JCI with an accurate complete information throughout all phases of the accreditation process and within the timelines.
2. **Section 2** – Patient-Centered Standards: This section strictly requires that the participative hospitals conform to all standards and are able to provide the patients with effective and

safe cares. These standards are separated into chapters which include International Patient Safety Goals (IPSG), Access to Care and Continuity of Care (ACC), Patient and Family Rights (PFR), Assessment of Patients (AOP), Care of Patients (COP), Anesthesia and Surgical Care (ASC), Medication Management and Use (MMU), and Patient and Family Education (PFE).

3. **Section 3** – Health Care Organization Management Standards: This section particularly emphasizes that the participative hospitals must recognize the importance of hospital's responsibilities in terms of risk prevention, quality-management, quality-control, quality-improvement in all kind of activities involved with the patient safety. This includes any medical information, procedure, implementation, and operational process of the hospital's program conducted by qualified medical individuals or even the management of medical supplies, hospital facilities, hospital brains and education, and hospital ethics and environment. The standards in this section are comprised of Quality Improvement and Patient Safety (QPS), Prevention and Control of Infections (PCI), Governance, Leadership, and Direction (GLD), Facility Management and Safety (FMS), Staff Qualification and Education (SQE), and Management of Information (MOI).
4. **Section 4** – Academic Medical Center Hospital Standards: This section solely focuses on the provision of medical education. The participative hospitals need to make sure that medical education or medical supervision is provided amongst each level of medical student, trainee, and staff member. Also, the participative hospitals must ensure that these medical individuals comply with all hospital policies and procedures, and all care is provided within the quality and patient safety parameters of the hospital. However, they must be granted permission before providing any services through the hospital's

established credentialing, privileging, job specification, or other relevant processes. The standards in this section can be classified as Medical Professional Education (MPE) and Human Subject Resource Programs (HRP).

Based on this, it can be guaranteed that no other health care accreditors except JCI have as many sets of standards approved and endorsed by the International Society for Quality in Health Care (ISQua). This accreditation provides assurance that the standards, training, and processes used by JCI to survey the performance of health care organizations meet the highest international benchmarks for accreditation entities. JCI usually works with hospitals and other health care organizations, health systems, government ministries, public health agencies, academic institutions, and businesses to achieve peak performance in patient care.

Public Health Situation

Since 2002, the advancement of Universal Health Coverage in Thailand has intensively increased access to both outpatient (OP) and inpatient (IP) services. Even though such policy was deemed to be beneficial to the society as a whole, especially for those underprivileged and disadvantaged patients, the over-utilization of government health insurance schemes somehow created a realistic direct impact on the level of efficiency and effectiveness in public hospital management and medical service provision due to fact that overall numbers of outpatient (OP) and inpatient (IP) services particularly from the low-income group, are seriously too overwhelmed. Therefore, one of the most fundamental issues that the public hospitals in Thailand often inevitably encounter with today is a capacity issue.

According to the Health and Welfare Survey data in 2017 conducted by the Ministry of Digital Economy and Society, Thai population were consistently given more of medical welfare benefits from 96% in 2006 to 99.2% in 2017. In comparing the ratio between types of medical welfare benefits provided by the government, Golden ticket is the highest at 75.7%, followed by the social security card or compensation fund at 17.2%, and government welfare or government pension at 7.1% respectively *(ISSN 1906-2885)*. This indicates that the majority of patients in public hospitals are basically covered by the government health insurance schemes while a minority of patients would be classified as general patients who can afford to pay for medical services on their own. Moreover, the statistical data of Inpatient (IP) and Outpatient (OP) services in public hospitals in 2017 also showed that the ratio of OP had been increased continually from 28.2 % in 2006 to 30.1% in 2017 whereas the ratio of IP had been decreased from 6.4% in 2006 to 4.6% in 2017.

There are many potential factors involved with the increment and decrement of above consumption rate such as patients' symptoms, economic recession, hospital facility constraints, and so on. However, the overall increasing rate of OP services had apparently disproportioned to the rate of IP services and this drastically caused a congested hostile environment in public hospitals. When there are excessive numbers of patients using the hospital facilities and lining up to receive medical cares and health services, public hospitals face workloads and thus are unable to provide their services in a professional and timely manner. Furthermore, public health sector in Thailand has been managed as a highly centralized bureaucracy for a long time. It is widely known that this historical governance format of Thailand's organizational culture had caused an ineffectiveness and inefficiency in health service delivery and management system in public hospitals. With the form of bureaucratic centralization in public hospitals that refers as rigid

manpower management rules and fixed payroll structure system, it is not surprising why health personnel who work for public hospitals often feel unmotivated to deal with workloads.

Other potential factors that may be the cause of workloads are the limitation on numbers of medical personnel and hospital facility constraints. In this case, many public hospitals seem to be lack of hospital resources when comparing with its patient's traffics. Hospital resources include doctors, medical staff, patient beds, patient rooms, and medical equipment or medical technology. Therefore, insufficient resources usually result to the minutes of waiting and the delay of service delivery. Nowadays, the waiting queues for the patients to get to see the doctors and to receive their medical treatments take longer than ever before. In circumstances that patients do not have patient's privileges or personal connections with doctors, they would possibly have to wait for hours prior to receiving the services. Some patients make appointments in advance because they believe that it would shorten waiting time, but they somehow forget the fact that public hospitals are always fully occupied and thus no priority is guaranteed. There are many incidences that patients are seriously in a critical condition and are desperate to acquire urgent cares, but the hospitals could not serve the need due to workloads and inadequate resources. Undoubtedly, the problems of workloads and insufficient hospital resources in public hospitals have dramatically created enormous impacts on uncountable lives, especially lives of those poor patients who are in greatest needs of health services.

There is also an issue of budget allocation in public hospitals. Usually, public hospitals receive subvention from the government to help subsidizing the operating deficit from subsidized care, projects expansion, research and development, medical innovation, and purchase of high-tech medical equipment and other hospital facilities. However, nowadays many public hospitals

claim that the government subsidy is reduced and disproportionately provided which consequently leads them to perform less effective in providing health services and medical cares to the patients. Moreover, public hospitals are also facing with dilapidated hospital facilities and lagging of medical equipment, old hospital buildings with low maintenance, and low incentive and compensation structures. Because of the overall declination in hospital quality standard, public hospitals become less reliable for the population. Thus, there is a need to review and make proper amendment on public policy regarding budget allocation for public health sector. When comparing with the private hospitals, it is obvious that public hospitals are so far behind. This is why affordable patients always choose to go to the private hospitals where there are excellent facility management and are full of highly skilled medical personnel who are ready to provide them the best cure solution, medical treatment, and other essential health services in time.

In this case, private hospitals are able to achieve such demands because they are financially independent from the government and they are capable of generating high revenues and profits through privatized medical management system in which it enables them to proportionately distribute their budgets to support future potential projects and development plans of the organizations. However, when speaking of the qualifications of medical personnel between public and private hospitals, the truth is many of them are actually comparable to one another in terms of skill and knowledge, but the most persuasive factor that creates a significance impact on individuals' decision-making to select their workplaces is the rates of compensation and incentive offered by these hospitals. In fact, many medical experts found it better to work for private hospitals since their obligations would still remain the same, but what they receive in returns can obviously enhance their lives and living standards. With all these issues being addressed, it is vital

that the management standard system of public hospitals in Thailand needs to be improved in order to overcome hinderances of provision on health services and medical care.

Emergence of Super Tertiary System

When talking about the delivery of health services by public hospitals in Thailand, it is a mandate that such services should be provided inclusively in terms of health promotion, disease prevention, medical treatment and rehabilitation, management of medical personnel (Professional Care) and community & family health services (Non – Professional Care). Likewise, it is a requirement announced by the Ministry of Public Health that Health Care Management System ought to be organized appropriately and be responsive to the necessity or actual needs of the society. According to the mentioned expectations, an Integrated Healthcare System had been created as forms of care provision. The Integrated Healthcare System is a medical principle-based approach that can be used to classify the medical levels as well as to identify the key aspects proposed in these particular medical levels. Within each medical level, there will be a variety of different health services and medical treatment techniques. The more complexity of health services and medical treatments, a higher and better level of advanced-medical technology installments would be applied. The ultimate goals of an Integrated Healthcare System are to promote justification, quality, effectiveness, and efficiency in public hospitals. However, it is important that an Integrated Healthcare System must be corresponded to the social changes where there could be more of variety of mixed services, continuity of service provision, inclusive and easy access services. All in all, the Integrated Healthcare System mentioned above is served as a socially responsible tool which helps nourishing a positive relationship with the patients and communities as a whole. In this regard, the structures of an Integrated Healthcare System are composed of 3

forms of care provision which are Primary Care, Secondary Care, and Tertiary Care and Excellence Center.

Primary Care (การบริการปฐมภูมิ) is an inclusive health services center which is easily and conveniently accessible for the population. Primary Care is usually established in the community areas and thus can be classified as community health center, community hospital, general hospital, hospital center or other health service departments operated by both public and private units. The mission of Primary Care is to provide a variety of medical services which can be ranged from medical treatment, health promotion, disease prevention, rehabilitation, to outpatient department services (OPD). However, Primary Care, if provided in a rural district, it will be operated by the Public Health Center and Community Health Center whereas Primacy Care available in an urban district will be operated by Health Center Bangkok and Community Medical Center. All medical personnel who work in Primary Care will often be arranged in circle-shifts. Also, doctors who work in the Primary Care should be qualified as general medical practitioners and hold qualification certificate of Family medicine, Preventative medicine, Occupational medicine or epidemiology.

The Criteria of Primary Care Standard is as follows:

- It is the first aid station which is easily and conveniently accessible for the population and provides health care including all basic diseases for all age groups.
- It is responsible for providing continuous health care for the population since before illness takes place until being sick or since born until death.
- It is a mixture of health care for the population, concerning about related factors such as physical, phycological, society, and economy.

- It is a unit obligating on referral to patient and coordinating with other service departments such as medical service or social service.

The services required for the primary care are as follows:

- Medical treatment
- Health promotion
- Basic physical and phycological rehabilitations and promotion on child development
- Disease Prevention and Disease-Control on individuals and families. For example, preventative vaccination, health-checkup, symptoms diagnostic, and patient watch.
- Supportive physical health information & Practical information for self-alleviation
- Medication services including medicine supply, dispensation, and drug education

Secondary Care (การบริการทุติยภูมิ) is more advanced health service center that utilizes medical technology for higher level of medical standard. It emphasizes on more difficulty and more complexity in medical treatment. Secondary Care is operated by Community Hospitals in district level, General Provincial Hospitals, and Hospitals under the Ministry of Defense. Secondary Care is composed of 3 levels which include primary level, intermediate level, advance level. For primary level of Secondary Care, the services are being provided by large community hospitals, general hospitals, hospital centers, or other health service departments operated by both public and private units. Primary level provides hospital beds and inpatient department services (IPD). Also, there are general medical practitioners to be consulted on the subject of uncomplicated medication such as Family medicine, Preventative medicine, Occupational medicine or epidemiology. Next, for intermediate level of Secondary Care, the services are being provided by large community hospitals, general hospitals, hospital centers, or other health service departments

operated by both public and private units. The medical treatment mission of intermediate level is more complicated and is usually required specialized doctors from the main medical branches that include obstetrics, surgery, internal medicine, pediatrics, Orthopedic Surgeons, and Anesthesiologist. Last but not least, the services in advance level of Secondary Care are being provided by large community hospitals, general hospitals, hospital centers, or other health service departments operated by both public and private units. The scope of medical treatment mission is very complicated which is not only required specialized doctors from the main branches, but is also required medical specialists from secondary branches that include Ophthalmology, Otolaryngology, Radiology, Psychiatry, Rehabilitation medicine, and Critical care medicine.

Tertiary Care and Excellence Center or Super Tertiary Care (การบริการตติยภูมิ และศูนย์การแพทย์เฉพาะทาง) is the highest form of care provision. It is a health service center that applies advanced-medical technology into its operation. There are more intensive complexities which require medical specialists from very particular branches. This medical care level is operating by the Hospital Centers which are under Ministry of Public Health, specialized hospital and super tertiary care such as Hospitals with referral system under Medical School.

Tertiary Care

The services in Tertiary Care are being provided by some general hospitals, hospital centers, medical school-hospitals, specialized hospitals, or other health service departments operated by both public and private units. The scope of medical treatment mission in Tertiary Care is potentially expandable and thus will necessarily require sub-specialty doctors. For example, sub-specialty of internal medicine is Kidney internal medicine, Cardiology, Respiratory tract disease, Endocrine system disease, blood disease**,** Dermatology, Gastrointestinal disease, and Infectious

disease. Also, sub-specialty of surgery is Neurosurgery, Urology Surgery, Chest Surgery, pediatrics, Anal Colitis surgery, Vascular Surgery, and Decorative Surgery. Moreover, sub-specialty of pediatrics is respiratory system, heart disease, kidney disease, and vascular disease. Last but not least, sub-specialty of other branches is pathology, Anatomical Pathology, Radiation therapy, radiodiagnosis, Nuclear medicine, and oncology.

Excellence Center or Super Tertiary Care

The services in Excellence Center or Super Tertiary Care are being provided by some hospital centers, medical school-hospitals, specialized hospitals, or other hospitals including health service departments operated by both public and private units. Beside the medical treatment mission of Tertiary care, Excellence center or Super Tertiary Care is also defined as specific treatment center which requires top level of resources. For instance, Heart Disease Center where it specifically requires doctors from various branches that include Chest Surgery, Cardiology, Respiratory tract disease, General pediatrics, and pediatric cardiology. Also, Cancer Center where it specifically requires doctors from various branches that include Radiation Therapy, Diagnostic Radiography, nuclear medicine, pathology, anatomy, and hematology. Furthermore, Trauma Center where it specifically requires doctor from orthopedic surgery, forensic medicine, and Pediatric surgery. Last of all, Organ transplantation center.

The Criteria of Secondary Care Standard, Tertiary Care Standard and Excellence Center or Super Tertiary Standard are as follows

- It is a health center where there must be standardized buildings and appropriate medical equipment to support the provision of medical services that are conservatively and environment-friendly to the community

- It is a health center where there are sufficient numbers of medical personnel who are highly qualified and holding professional medical license coherent with Hospital Standard Minimum Services act.
- It is a health center where emergency services are well-prepared in terms of medical equipment, personnel, and ambulance while at least 1 doctor and 2 nurses must be placed on duty around the clock (24 hours).
- It is a health center where the provision of outpatient service (OP) is effective and efficient. Also, hospital buildings and facilities are in the supportable scale to the patients and the queue for services is within acceptable timeframe.
- It is a health center where the provision of inpatient service (IP) is convenient. Also, the patient buildings and medical equipment are well-prepared for the services and there must be educated medical personnel with full expertise being placed on shifts. Also, at least 1 doctor and 1 nurse are obligated to be responsible for 30 hospital beds and 1 patient assistant is obligated to be responsible for 10 hospital beds.
- It is a health center where Medical records service is provided.
- It is a health center where Radiology service is provided.
- It is a health center where Pathology and autopsy services are provided.
- It is a health center where Pharmacy service is provided.
- It is a health center where General surgery service is provided (1 operation room per 50 hospital-beds / at least 2 rooms not including Birth delivery room).
- It is a health center where Anesthesia service is provided.

Emergence of Siriraj Piyamaharajkarun Hospital (SiPH)

Prior to the year of 2003, all public hospitals were placed under the government support. However, in 2003 the government had drafted out the policy on the reduction of government subsidy for public hospitals, especially medical school-hospitals. This meant Siriraj Hospital was left to be responsible on their own organizational financial structure. Previously, the government used to subsidize approximately 30 – 40% out of the total of hospital expenditures just to maintain the operational system of Siriraj Hospital. When this policy was officially enacted, Siriraj Hospital inevitably encountered with financial burden due to the fact that Siriraj Hospital was not objectively created to make profits, but was instituted with strong intention to serve their services in the lowest possible costs particularly to the ordinary group of patients including disadvantaged and unaffordable individuals. Some services in Siriraj Hospital were even provided with free of charges. Therefore, with this hospitalized normative approach, it is impossible to increase service fees or demand patients to pay for medical treatments and health services that were previously provided with free of charges. Hence, the best solution to solve this financial issue in Siriraj Hospital was to set up a new income channel to compensate a deficit from government subsidized cares.

As a result, Siriraj Piyamaharajkarun Hospital (SiPH) span off itself from Siriraj Hospital to develop their own autonomous public hospital (Super Tertiary Care) with privatization medical management system that complies with Joint Commission International Accreditation standards (JCI), operating under the Faculty of Medicine Siriraj Hospital. It is also part of a project to develop Siriraj Hospital into an Excellent Medical Center of Southeast Asia under the name "Sayamindradhiraj Medical Institute". Also, SiPH promotes the concept of corporate social

responsibility (CSR) and encourage potential patients to be a part of social contribution through the theme "Recipient and Giver". A recipient receives Siriraj's excellent medical services guaranteed by an internationally acclaimed standard of Joint Commission International (JCI) while a Giver gives benefits to Siriraj and society as a whole. Beside top leading private hospitals in Thailand, SiPH is known as the first and only public hospital that adheres to Joint Commission International Standard (JCI) while Siriraj Hospital adheres to Hospital Accreditation Standard (HA). Currently, SiPH offers total of 20 specialty medical centers served by physicians from the Faculty of Medicine Siriraj Hospital. The main objectives of the establishment of SiPH are composed of three main points which include creating a new revenue channel to offset a cutoff from government subsidy in Siriraj Hospital, preventing organizational brain-drained, and providing the best clinical care with higher level of convenient to the patients.

Firstly, when talking about the channel of incomes in the Faculty of Medicine Siriraj Hospital, there are 2 medical programs existed which are Premium Services and Regular Services. The Premium Services provided by SiPH serve as a new alternative for the patients who are willing to compensate their money for faster services. However, Premium Services in SiPH are more easily accessible than health services provided by other private hospitals due to a cheaper cost of payment. On the other hand, Regular Services are still available at Siriraj Hospital for all patients, but it would take a lot of time before the patients can reach out to the services due to the congestion. The strategic financial planning of SiPH is that a portion of the profits generated from premium medical service program in SiPH will be contributed back to Siriraj Hospital to support a number of projects of the faculty and Siriraj's underprivileged patients.

Secondly, with the fast pace of global development in health sector, many medical institutions believe that the privatized medical management system would be vastly introduced and rapidly extent to other public hospitals in the near future. Therefore, the establishment of SiPH is also aimed to prevent the possibility of having organizational brain-leaks or numbers of medical personnel's resignation. In this case, an introduction of privatization model in SiPH encourages and motivates those hard-working doctors from Siriraj hospital to work part-time as a consultant at SiPH after public-office hours instead of going to work for other private hospitals. This could significantly improve the quality of lives amongst internal medical personnel of the faculty since the rate of compensation and incentive in private hospitals is adoptive to SiPH.

Thirdly, another core mandate of SiPH is to provide best clinical care that is in line with Siriraj Hospital's standard. Yet, SiPH adopted JCI standards as measurement and assessment tools for quality assurance of service provision to make sure that SiPH could achieve their ultimate goal in becoming the privatized public hospital. In this case, the primacy concern on service provision in SiPH is a timing in service delivery. The mission of SiPH is to fulfil and satisfy those in needs of services by providing them with Siriraj Hospital's medical treatment and health services in the shortest timeframe. In this case, SiPH is intent to withdraw the affordable group of patients who do not wish to wait for services in Siriraj Hospital due to the congestion. Therefore, to drive SiPH as privatization, not only that patients can be satisfied, but also the Faculty of Medicine Siriraj Hospital could boost their incomes.

Unsolved question of equity

Even though "SiPH" has been established as the new model of public hospital operating as privatization with a strong intention to cope with the issues of financial deficit, capacity, and

inefficiency of hospital management and service provision, there is still an unsolved issue of equity. The questions of equity have been raised recently whether the opening of SiPH really serves the needs of all stakeholders. This is an ongoing debate amongst the socialists and activists including the Ministry of Public Health. In this regard, it is an undeniable truth that the creation of SiPH model actually has generated plenty of positive organizational values and social contributions. For example, revenue-sharing within the Faculty of Medicine Siriraj Hospital, prevention of organizational brain-drained, financial contribution to Siriraj Hospital and its underprivileged patients, provision of the best privatized public mix clinical care to respond to the patients' needs and so on.

However, the goal of privatization mostly tends to concentrate more on financial development than any other aspects. Therefore, in case of SiPH which is a public hospital using privatized medical management system, it is observable that privatized services provided by SiPH come with expensive cost comparable to private hospitals. In fact, the key product of the hospital is health of the population. Hence, if public health care, health maintenance, and health improvement are being calculated as the cost of privatized services, some stakeholders are unlikely to be beneficial because they would have no financial ability to access to SiPH. As a result, this implies that an issue of inequity still does exist regardless of any innovation or improvement evolved from the application of privatization in public hospital. It appears that SiPH model seems to satisfy only certain groups of patients which include middle and upper-class individuals who can afford to pay for health services and medical treatments provided by SiPH. Privatization raises the cost of services in which it automatically dissociates the lower-class patients from receiving the opportunity to experience such privatized medical treatments and health services. The only privilege lower-class patients are entitled to during their lifetime is the government health

insurances that can only be claimed in general public hospitals like Siriraj Hospital, but not SiPH. As a result, they are permanently placed into the disadvantaged spot as they always had been through in the day's past.

Another case of inequity we can observe from the establishment of SiPH is an unbalanced construction of hospital facilities including clinical and non-clinical related between SiPH and Siriraj Hospital. Privatization usually requires a high level of facility to be available for potential users. This is one of the most essential requirements because impression amongst users is prioritized as a key that brings high returns to the organization. Potential users always expect to experience the best facilities in exchange with their payments. In this case, when comparing the quality and quantity of hospital facilities between SiPH and Siriraj Hospital, it appears that SiPH seems to have more numbers of newer hospital facilities built with modern luxury styles corresponding to the trend of privatization whereas Siriraj Hospital seems to contain less numbers of hospital facilities and most of them remain in lower quality. Such inequity of hospital resources allocation can ultimately create impact on an operation because low quality of hospital facility may result to the health outcomes and low quantity might delay the time of service delivery.

Last but not least, there is also an issue of inequity regarding numbers of work that medical personnel are expected to do in a specific time and their compensation rate. In this case, the conflict of interest arises when workloads of medical personnel in Siriraj Hospital are disproportionated to their rates of compensation. Medical personnel in Siriraj Hospital always have a tight schedule and handful of work due to the fact that numbers of both IP and OP in Siriraj Hospital are overwhelmed which can be estimated around 85,000 IP per annual and 3,00,000 OP per annual. However, the amount of compensation they receive is considerably low compared to their work performance. In comparison, medical personnel in SiPH are rotatable and balanceable with their assigned tasks

since there are less patients in SiPH due to unaffordability. Even though medical personnel in privatized scheme and Siriraj Hospital spend equal hours of work per day, their workloads and rates of incentive are unequal because SiPH adopts privatized incentive scheme including welfare and benefit of privatization. This clearly proves that issue of inequity existed when privatization comes to play its role in health sector. It is unjustified that those having less workloads in privatized scheme could earn twice or more than ones who work harder and deal with more cases in each day at Siriraj Hospital.

1.2 Statement of Problem

P.S.O. 1107 (Service for the Private Sector and People System) for Siriraj Hospital

Regardless of any improvement from the establishment of privatized scheme, it still remains unclear whether Super Tertiary Hospital like Siriraj Piyamaharajkarun Hospital is currently running its operation properly as announced in the Super Tertiary Standard. It is possible that the application of privatization in SiPH may have mislead the objectives in delivering public health services to population. Therefore, for this thesis, the comparative qualitative study between SiPH and Siriraj Hospital was conducted, using the principle of P.S.O. 1107 as the conceptual framework of good governance to identify the means of privatization and public management system which can ultimately lead to fair and socially rationalized layers of productivity. The principle of P.S.O. 1107 is composed of 10 standards which include 1) Efficiency 2) Quality 3) Coverage 4) Equity 5) Justice 6) Responsiveness 7) Satisfaction 8) Continuity 9) Convenience 10) Availability. However, only five specific components (efficiency, quality, equity, responsiveness, availability) were selected to be used in the conceptual framework since they were fundamentally

the most relevant subject to the themes of privatization and public health service in which plenty of theoretical supports are available and valid.

Objectives of the Study

1. To study the hospital management system of Siriraj Piyamaharajkarun Hospital and Siriraj Hospital in order to conduct the comparative qualitative study by using five specific components of P.S.O. 1107 as the conceptual framework of good governance (efficiency, quality, equity, responsiveness, availability).
2. To use the outcomes derived from the comparative qualitative study to initiate the innovative privatized super tertiary hospital standard management system for future public hospitals that may be emerged as SiPH.

To achieve this aim, this research investigated the managerial responsibility of SiPH and Siriraj Hospital in running its operation as private and public sectors by using five specific components of P.S.O. 1107 as the conceptual framework of good governance. Furthermore, this research identified the social contributions that "Siriraj Piyamaharajkarun Hospital" has successfully created for the society as a whole as well as pointed out some potential drawbacks emerged from the privatized scheme.

Research Questions

In order to introduce the innovative privatized super tertiary hospital standard management system for future public hospitals, the five specific components of P.S.O. 1107 which include efficiency, quality, equity, responsiveness, and availability were selected to be used as the conceptual framework of good governance since they were principally and theoretically

considered as the most crucial elements required to be developed for public health care. In this case, the comparative qualitative study between SiPH and Siriraj Hospital was conducted as the purpose was to specifically define how different hospital management system would yield to different outcomes.

The research questions are as follows:

1. **Efficiency:**
    - **1.1** *How effective can SiPH manage to maximize their human resources compared to Siriraj Hospital?*
    - **1.2** *What is the average rate of the medical cost charged per visit by SiPH compared to Siriraj Hospital?*
    - **1.3** *What is an average time that patients have to wait to get services in SiPH compared to Siriraj Hospital?*
2. **Quality:**

    How is the quality standard of medical treatments and health services in SiPH compared to Siriraj Hospital?
3. **Equity**:
    - **3.1 Financial Barrier**

        Can all patients access to medical treatments and health services provided by SiPH?
    - **3.2 Geographical Barrier**

        How does the development of hospital facilities in SiPH create impacts on an access to services?
    - **3.3 Cultural Barrier**

Do health care providers in SiPH and Siriraj Hospital perform their roles differently?

4. **Responsiveness:**

   How does the establishment of SiPH respond to the needs of patients and medical personnel?

5. **Availability:**

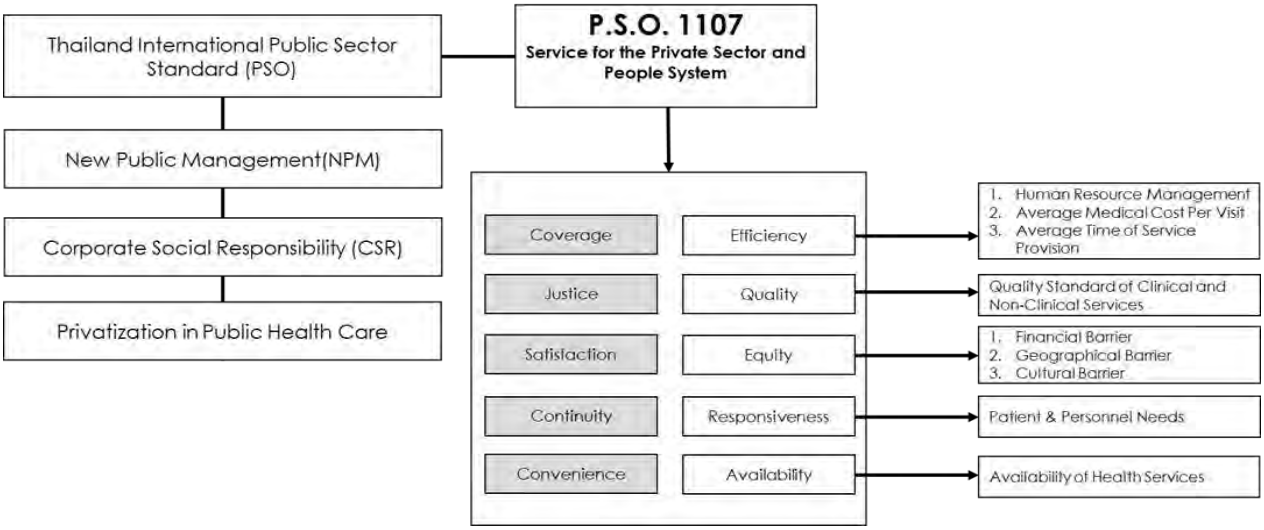
   Does SiPH provide all kind of essential medical treatments and health services for patients including the basic services that are nonprofitable?

Scope of the Study

For the research content, primary data in this study was gathered within the areas of Siriraj Piyamaharajkarun Hospital (SiPH) located at 2 Wangrang Road, Siriraj Sub-area, Bangkoknoi Area, Bangkok. In this case, the Vice President of SiPH, 5 medical personnel from SiPH and Siriraj Hospital, and 20 patients (IP and OP) from each hospital were involved as a target population to be consulted and interviewed. The sampling technique was therefore a purposive one. The advantage with purposive sampling is that the researcher gets the opportunity to engage people with the right form of information and knowledge needed to address the theme emerging from the study (Ghauri & Gronhaung, 2012). This research was conducted for the approximately 5-month period, started from December 2018 and completed by the end of May 2019.

Conceptual Framework

The conceptual framework to be used for this thesis in studying the concept of "Good Governance" for SiPH could be demonstrated as below.



Expected Benefit Gain

It was expected that this study would demonstrate the key benefits and potential drawbacks gained from the implementation of privatized medical management system in SiPH. The overall results found in this study could ultimately be used to initiate the new privatized super tertiary hospital standard management system for other public hospitals in the future. This involved introducing the principle of P.S.O. 1107 and its five specific components in order to construct the conceptual framework of good governance for the comparison between SiPH's privatized management system and Siriraj Hospital which fully operates as public sector. The results from the comparative qualitative study would enable us to visualize whether the privatized medical management system of SiPH should be partly or fully imitated by other public hospitals in Thailand.

LITERATURE REIVEW

Concepts and Theoretical Background

1. New Public Management: NPM

NPM is a theory of public management that incorporates social benefits, financial efficiency and effectiveness of service provision for public services (Gudelis & Guogis, 2011). Key principles of NPM include maximization of the public benefits of the service provided and openness, transparency, and accountability for the services provided (Behn, 1998; Luke, et al., 2011). This set of theories of public management does have some weaknesses, including an excessive focus on the financial efficiency of performance (Luke, et al., 2011), which this research will need to balance against other factors. However, it is ideal for examining the management effectiveness of Siriraj Piyamaharajkarun Hospital.

2. Corporate Social Responsibility: CSR

The theoretical basis of CSR is the stakeholder theory of the firm, which argues that the firm's activities must be oriented to meeting the needs of every stakeholder, not just shareholders (Schwarz, 2011). Theories and models of CSR will be used to examine the contribution of the hospital to employees, communities, patients, and the general public, which are key stakeholder groups (Schwarz, 2011).

3. Social Responsibility: A New Paradigm of Hospital Governance

According to the Health Care Analysis in "Social Responsibility", the changes in modern societies were driven by several factors such as economic and culture globalization, scientific and technological progress, increased access to information, or the acknowledgement of customers' rights. All these changes originate the perception that

ethical behavior is essential in organization's practices especially in the way they deal with aspects such as human rights. Recently, the Report of the international Bio-ethics Committee of UNESCO on social responsibility and Health has addressed the concept of social responsibility in the context of health care delivery suggesting a new paradigm in hospital governance. This indicates that the new models of hospital management need robust corporate mechanisms of corporate governance to fulfill its social responsiveness.

In the article "Social Responsibility: A New Paradigm of Hospital", Bruce and Stuart (1999) explained that the concept of "social responsibility" means that organizations meet its fundamental goals of accomplishing a particular public endeavor. To apply this concept into the study, we must ensure that SiPH fulfils its social and market objectives which are in accordance to the law and general ethical standards in order to create organization value through performance, conformance, and responsibility to meet the stakeholder's demands. (Cristina Branda, Guilhermina Rego, Ivone Duarte, Rui Nunes, 2012).

4. Privatization & Restructuring of Health Service in Singapore

In Singapore, there had been contemporary social debate on the use of privatization in health sector whether it was really beneficial to the public as a whole or only to certain groups of elite population and professional individuals. Therefore, this article is attempted to address some aspects of critical issues affecting privatization and restructuring of the health services in Singapore. The privatization movement had emerged the theme of autonomous management with an initial experimental project of the government hospitals as the purpose was to avoid the problem of a welfare state system on taxation such as

National Health Service (NHS) and shift the burden of financing increasingly expensive health care to individual, the family and the employer, as well as the voluntary and private sectors. The adoption of privatization to restructure public hospitals raised public fears that privatization may lead to an excessive-charge on medical bills, especially with privatized mechanism being applied, there is a high possibility of reduction on the scopes of service provision in public hospitals or perhaps abolishment of some inexpensive basic services necessary for lives of low-income population since such services do not generate revenues for the hospitals. it is also theoretically believed that privatized-government hospitals would place their concentration on the development of high-tech medical treatment and innovative programs which are costly, but affordable for wealthy population.

However, in fulfilling its community responsibility of providing medical care for the poor, committees in the restructuring program claimed that an annual subvention would be received from the Ministry of Finance to offset the operating deficit from subsidized care *(Straits Times, 13 January 1985).* This basically showed that the restructuring program of government hospitals is proceeded with the formation of a government-owned subsidiary company. Initially, the idea of privatization in Singapore officially evolved in the budget speech made by the Ministry of Finance in March 1985. This proposing idea of privatization became the influence of economic growth in which it implied that private sector should be put in the position to drive Singapore to a better direction of new economic era, not the government. As a result, several high-powered committees were set up in order to review the Singapore economy to identify new directions for its future growth as well as to recommend divestment of public sector. *(Phua, p.6, 1991).* From there, the trend of

privatization started to penetrate into the health services, reinforced by various government policies to promote Singapore as the regional service center.

In moving into privatization era, there often be the terms that may create confusion with "privatization" such as restructuring, corporatization, and decentralization. Therefore, to distinguish the differences in between, there is a need to clarify key concept of privatization. In general, privatization is directly involved with the introduction of user-charges as an alternative to financing of public goods and services out of tax revenue and the liberalization of regulations within which certain goods and services are produced and consumed in the public and private sector *(Thynne and Ariff, 1989).* These terms mentioned above may be related in one way, but different in certain aspects of development. For example, the Economic Committee and Public Sector Divestment Committee of Singapore considered "Privatization of health care financing" as the reduction of public subsidy and increase of direct user-charges. On the other hand, they referred "Restructuring" as the redevelopment of public hospitals with conventional privatization policies. However, the restructuring of government hospitals is remained wholly-owned and controlled by the government while receiving incorporated subsidiaries. The First Deputy Prime Minister also stated that the privatization autonomous could create greater efficiency and freedom of choice for the individual, pushing the standards of all kind of services such as health, housing, and transport to much higher levels. On the other hand, he explained that the term restructuring meant the hospitals could set their own rates and employ doctors and nurses of their choice, thus attaining higher standards of service, and patients could also choose the class of wards they wanted while those poor patients who cannot afford to pay for the higher cost of medical services are always eligible to utilize a subsidized medical care in

government hospitals even though the policy was proclaimed that there were limit of subsidies for certain kind of social services and under particular circumstances. *(Straits Times, 6 November 1989).*

During the introduction of privatization, the term "decentralization" within the public sector around the global gradually became the key concept of government policy and management in which it led social services towards changes. Initially, the concept of privatization began as a form of decentralization to involve 'the transfer of government functions to voluntary organizations or private enterprises' *(Rondinelli, 1981).* However, it appeared that the involvement of the government still remained strong as some regulations and governmental subsidies are still inevitably required to monitor possible side-effects and to prevent an excessive administration of privatization during the transformation from decentralization of governmental functions to privatized functions. In a general sense on state participation, the government can usually be involved with social and economic activities through provision, subsidy or regulation. For example, the roles of the government are comprised of providing a specific service, employing the personnel to operate in the assigned functioning, subsidizing the services through the use of public funds to support unaffordable population, and regulating the provision of services by controlling the cost, quantity, quality, licensing, and accreditation standards. However, when privatization was introduced in government policies, these forms of state participation were changed accordingly. The spectrum of privatization schemes could range from partial to complete transfer of ownership and control of assets to profit-maximizing businesses instead of state enterprises. For instance, contracting out hospital support services or

privatizing social security through purchase of private health insurance to provide sickness benefits and so on.

Overall, it could be concluded that privatization allows greater participation of private sector to organize public services to be in line with private market forces. Also, privatization boosts up competition into service provision by increasing quality and efficiency. Last but not least, privatization reduces the government cost burden through cost-sharing scheme. However, when these assumptions are being applied into the health sector, they became the most controversial topic. Speaking of health sector, it is unlike any other sectors due to the fact that there are limitations for the competition. The factors that limit level of competitive market in health sector are comprised of customer ignorance, unusual role of supplier because of doctor-patient relationship, professional monopoly, uncertainty and other externalities. For patients, which are known to be the customers of privatization system, it is likely that they often have no access to full market information due to the fact that some information such as quality care or ability and expertise of the doctor cannot be comprehensively assessed by the patients themselves. Obviously, such information requires ones to possess depth-understanding and specific knowledges on subject matters. Therefore, it turned out that patients usually had to rely on superficial assessments of a non-medical nature based on things like bedside manners, communication skills, personalities or reputation of their doctors. As a result, doctors who are considered to be agents in privatization system, can supply most forms of health care without having to concern about customer sovereignty, especially when third-party financing is available and patients are willing to collude to increase individual consumption. Whatsoever, health service is unlike any other goods. It is a long-term investment with unpredictable outcomes.

Also, there are professional controls over certification and restriction on advertising. Therefore, it is very difficult to calculate the actual value or even create comparative pricing or costing *(Phua, p.14, 1991).*

5. Potential Implications of Hospital Autonomy on Human Resources Management

This article is written by Paibul Suriyawongpaisal, Secretary General, National Health Foundation of Thailand, in which it talks about how hospital autonomy (HA) or known as "privatization or corporation "can enhance the process of administration and management in public hospital. The introduction of HA has pushed the public sector to one step further toward private model. At this point, autonomous management usually takes place through decentralization as the objectives are to (1) improve communication and reduce administrative complexity which results to the enhancement of government's responsiveness to public needs (2) Increase level of effectiveness and efficiency of management (3) increase public accountability (4) maximize the existing resources and prioritize on important activities through development policies (5) create transparency and self-reliance for public acknowledgement (6) increase the role of local community for a better governance. In this article, the author puts an emphasis on HA in human resource management of the public hospital in which he stated that the expected outcomes can be viewed as the utilization of human resources within the budget-control where recruitment and deployment are depended on the actual performance rather than qualification. Also, the planning and development become independent from the discretion of the government and is left to be under the responsibility of the organization alone. Last but not least, HA also allows internal training services and education with free of charges to be conducted within the organization as the ultimate goal is to escalate performance of the health

personnel and to produce a higher profitability through their service provision *(Paibul Suriyawongpaisal, 1999).*

6. What Lies Ahead for Malaysian Healthcare

This article is written by Lee Poh Onn in which it talks about the challenges of health service provision in Malaysia due to continuous growth in number of populations along with increase of ageing over time which means higher demands are expected with greater longevity. The increase in demand for health services over the years has reported placed strains on the public healthcare system. To solve such issue, Malaysian policymakers adopted privatization and corporation as the solutions. However, privatization led by political elites with links to the government has actually resulted in a less optimal outcome manifested by higher cost of medical care *(Lee Poh Onn, 2015)*. In this respect, privatization, as it is generally defined as the enhancement of economic efficiency, had conceptualized the public understandings that public healthcare is ought to be provided for the poor whereas private healthcare is only for the rich since the rich can afford to pay for privatize hospitals where there are better equipped with more advanced medical equipment. Moreover, privatization also led to an outflow of medical professionals from public sector to the private sector because higher incentive allowance was only set in private hospitals.

An increase in medical fee was also forced by privatization which resulted directly to the end-users. In this case, affordable patients had to be solely responsible to pay for such expensive medical fee out of their own pockets, but in return they would be acquired a higher quality of health services. Because of expensive medical bills, private health insurance schemes, which were proposed as the worthiest option for newly privatized

welfares and benefits, were subsequently introduced as to cover the cost for those affordable groups. In addition, social inequity is obviously appeared to be observable issue after the introduction of privatization. Those underprivileged and disadvantaged individuals became the victim since most of them had no chances to access to private hospitals and eventually left to be all packed to wait for subsidized health services at the public hospitals.

Regardless of any development on privatization, it is likely that public healthcare sector in Malaysia still needs to be available and accessible for all. Nonetheless, privatization had brought financial burden to public sector due to the fact that there were more subsidized patients than out of pocket patients coming to use the hospital services. With the inflation in medical fee, national health insurance scheme was eventually required to be involved to finance the health needs for the population provided by both public and private healthcare sectors *(Lee Poh Onn, 2015)*.

In conclusion, the authors states that the most important thing to be considered now is not how to manage private healthcare sector, but the emphasis is placed on how to manage public healthcare sector as privatized one. One of the best ways to make changes is to increase level of compensation for those working in public hospitals so that they would have more motivation to serve patient's needs and work on completion of their assignment. Another best way is to adopt corporatization into some segments of public hospitals so that level of efficiency would increase. Nonetheless, all above mentioned would not be achievable without an amendment on public health regulations to create more competitive healthcare services in order to maximize profits for subsidized cares provided in public

hospitals *(Lee Poh Onn, 2015)*. When an overall performance of public healthcare sector is increased, the invasion of privatization is no longer needed to be concerned.

DATA & METHODOLOGY

Research design

This research was conducted as comparative qualitative study. The comparative qualitative nature of the study meant the researcher sought to gain understanding about the reasons, motivations, and factors that influenced SiPH and Siriraj Hospital to execute their operational management system as private and public sectors. Then, the comparison on applied components between both hospitals allowed the researcher to explore how different standard management system could lead to different procedures and outcomes derived therefrom. Once this was done in the comparative manner, the researcher would be in the comprehensive position to propose the findings which subsequently were used to initiate the new innovative standard of "Good Governance" for potential super tertiary hospitals in the future. In addition, researcher was also be able to illustrate social benefits or potential drawbacks emerged from the establishment of privatized model.

Research Methodologies

To design the innovative privatized super tertiary hospital standard management system for other public hospitals, this research used componential and descriptive analysis and presented research findings in terms of comparative analytical description. Research methodologies of this study were separated into two parts as below:

1. **Documentary Research**

This thesis studied five specific components of P.S.O. 1107 and used them as the conceptual framework of "Good Governance" to investigate how each component was harmonized with the responsibility of Siriraj Piyamaharajkarun Hospital and Siriraj Hospital. This research also paid close attention on the concepts of privatization and public health service explained in articles, theories, writings, previous researches, internet resources, and other related documents.

- Primary data: The information were obtained through the process of literature reviews and collection of data from other available sources.

2. **In-depth Interview**

Semi-Structure Interview

Purposive Sampling Technique

In order to obtain information profoundly, this thesis planned to consult and interview 51 individuals, using purposive sampling technique as the purpose was to engage people with the right form of information and knowledge needed to address the theme emerging from the study.

Sample groups were separated into 4 parts as below

- Group 1: Vice President of SiPH (1)
- Group 2: Medical Personnel in SiPH (3) & Patients (OP&IP) in SiPH (20)
- Group 3: Medical Personnel in Siriraj Hospital (3) & Patients (OP&IP) in Siriraj Hospital (20)

- Group 4: Medical Personnel who work in both hospitals (4)

Population and Sample

For this study, the factual information from the criteria of Super Tertiary Standard and both medical management systems of SiPH and Siriraj Hospital were used in assessing the validity and reliability of the Innovative Privatized Super Tertiary Hospital Standard Management System as the purpose of this approach was to prevent information bias or distortion of information. In this regard, the identification of the population and sample were specific and directly related to the research questions as follows:

1. **Efficiency:**

   How effective can SiPH manage to maximize their human resources compared to Siriraj Hospital?

   Population = Human resource management in the Super Tertiary Hospital

   Sample = Human resource management in SiPH

   What is an average rate of the medical cost charged per visit by SiPH compared to Siriraj Hospital?

   Population = Average rate of medical cost charged per visit by the Super Tertiary Hospital

   Sample = Average rate of medical cost charged per visit by SiPH

   What is an average time that patients have to wait to get services in SiPH compared to Siriraj Hospital?

   Population = Average time of waiting for services in the Super Tertiary Hospital

   Sample = Average time of waiting for services in SiPH

2. **Quality:**

   How is the quality standard of medical treatments and health services in SiPH compared to Siriraj Hospital?

   Population = Quality standard of clinical and non-clinical services in the Super Tertiary Hospital (HA)

   Sample = Quality standard of clinical and non-clinical services provided by SiPH (JCI)

3. **Equity**:

   Financial Barrier - *Can all patients access to medical treatments and health services provided by SiPH?*

   Population = Patient access of medical treatments and health services in the Super Tertiary Hospital

   Sample = Patient access of medical treatments and health services in SiPH

   Geographical Barrier - *How does the development of hospital facilities in SiPH create impacts on an access to services?*

   Population = Development of hospital facilities in the Super Tertiary Hospital

   Sample = Development of hospital facilities in SiPH

   Cultural Barrier - *Do health care providers in SiPH and Siriraj Hospital perform their roles differently?*

   Population = Ration of medical personnel, workloads, and rates of incentives provided by the Super Tertiary Hospital

   Sample = Ration of medical personnel, workloads, and rates of incentives provided by SiPH

4. **Responsiveness:**

   How does the establishment of SiPH respond to the needs of patients and medical personnel?

   Population = Feedback from patients and medical personnel in the Super Tertiary Hospital

   Sample = Feedback from patients and medical personnel in SiPH

5. **Availability:**

   Does SiPH provide all kind of essential medical treatments and health services for patients including the basic services that are nonprofitable?

   Population = Quantity of health services and medical treatments in the Super Tertiary Hospital

   Sample = Quantity of health services and medical treatments in SiPH

Research Instrument

The main research instrument to be used in this study was an interview guide, containing 3-5 questions. All responses received from the interviewees were analyzed in a descriptive manner.

Data Collecting Method

The main data collecting methods to be used in this study were composed of 2 approaches according to research methodologies.

1) **Collecting data from documentary research:** This approach required the researcher to study and collect the primary data from the principle of P.S.O. 1107 (five specific components) and understand key information on the concept of "Good Governance" for public hospital. Data collection included articles, theories, writings, previous

researches, internet sources, and factual information acquired from the criteria of Super Tertiary Standard and SiPH's responsibility.

2) **Collecting data from in-depth interview:** This approach was used to collect the secondary data from target respondents through the use of an interview. For the data collecting process, face-to-face interview sessions with 51 respondents were conducted using purposive sampling technique. In this case, all respondents were expected to answer 3 – 5 questions through discussion. Interview time was approximately 15 – 20 minutes per each session. All expressing information were allowed to be recorded during the interviews so that the researcher would be able to profoundly present the research findings in terms of analytical description with validity and reliability.

Research Analysis Method

All collective information were collected based on the five selected components stated in the conceptual framework, research questions, and objectives of the study in order to compare the hospital management systems between SiPH and Siriraj Hospital and explain how privatized management model can lead to greater enhancement on hospital standard as well as to point out potential issues that emerged from the application of privatization in health sector. The results of this study were ultimately used to initiate the new privatized super tertiary hospital standard management system for future public hospitals in Thailand to follow. In this case, the componential analysis was used with the principle of P.S.O. 1107 as the purpose was to examine the alignment and interpret specific responsibilities that both hospitals acted accordingly while the descriptive analysis was used with in-depth interview and semi-structure interview to scrutinize and interpret information acquired from the perspective of stakeholders. After the interviews completed, primary data from the principle of P.S.O. 1107 and work of literatures were used for

the assessment on comparative information. Then, outcomes of the study were proposed and introduced as the innovative standard management system of privatized super tertiary hospital.

CHAPTER IV

RESULTS AND DISCUSSION

The information gained from works of literature and in-depth interview were mainly used in this thesis to demonstrate the managerial responsibility of both hospitals in which it was conceptually relevant to the five specific components of P.S.O. 1107. The collected data were conducted based on the conceptual framework of Good Governance and interview questions and the results were interpreted accordingly, using a componential analysis and descriptive analysis methods to ensure that the content validity and reliability process are carefully placed through a scrutinized study. The following results are described as below:

Results of Efficiency Component

When considering the terms efficiency and equity in health sector, it is very difficult to interpret its definitions and measurements because inputs such as health resources and costs in the health production function are discernible while outputs are more complexed and unpredictable. For example, intermediate outputs such as units of health care produced may have no relationship with the final output in health effects since health status is determined by multi-factorial variables other than medical care alone *(Phua Kai Hong, 1991)*. However, for indicators of efficiency adopted into this study, there were 3 main sections to be discussed. The first section focused on the exercise of human resources in SiPH compared to Siriraj Hospital. The second section focused on an

average cost of medical bill charged per visit by SiPH compared to Siriraj Hospital. The last section focused on an average time of service provision in SiPH compared to Siriraj Hospital.

1.1) How effective can SiPH manage to maximize their human resources compared to Siriraj Hospital?

Even though the term "efficiency" refers to as an improvement on medical science and technological innovations which have led the output of health status in target population groups to be enhanced, the concept of cost-effectiveness seems to be crucial and more related to health care than efficiency, especially when considering the maximization of resources for the most productivity in outputs. In this case, cost-effectiveness in health care means using the limited resources in the most appropriate manner in order to achieve the largest possible gains in health status for the population *(Phua Kai Hong 1991).* According to the personal interview with the Vice President of SiPH, human resource management in SiPH is also objectively structured to aim for maximization of internal resources through the concept of cost-effectiveness. As SiPH has become the privatized public hospital, autonomy in management is evolved in which it allowed maximum flexibility to introduce innovative and cost-sharing to motivate and retain good staff.

To illustrate the structure of human resource management in SiPH, the Vice President of SiPH initially explained how this privatized medical scheme was originated. During an initial experimental stage of privatized medical scheme in 2009, SiPH had requested Siriraj Hospital to recruit the key medical personnel from the Faculty of Medicine Siriraj Hospital to help setting up this pilot project due to a lack of human resource. The first recruited group was known as "Exhibit Allowance Group" which included at least 1 Hospital Director, 1 Deputy Hospital Director, and 11 branch managers from various medical fields. These branch managers also recruited their own teams consisted of appropriate numbers of nurses and nursing assistants. In the meantime, SiPH

also recruited 200 external employees to support in non-clinical departments necessary for the organization to run. Meanwhile, the Exhibit Allowance Group was signed under the secondment contract which meant they were still entitled to government welfares and benefits under the provision of the Faculty of Medicine Siriraj Hospital. Nevertheless, upon the time they were filled into privatized medical scheme, they were labeled as University personnel not public officials. In preventing the loss of privileges and promoting risk management for the Exhibit Allowance Group, SiPH proposed itself to be responsible for payrolls of these individuals in Siriraj Hospital and were also willing to pay an additional 10% on top of compensation received in Siriraj Hospital. This was to ensure that those joining SiPH during an initial experimental stage of privatized scheme were secured for their spots in Siriraj Hospital and they could return to Siriraj Hospital as soon as the secondment contract is expired.

As privatized medical scheme was continued to be developed, SiPH simultaneously started to form a whole new HR team as the objective was to be able to recruit and monitor new lines of human resources separated from the Faculty of Medicine Siriraj Hospital to further execute SiPH as private sector in the long run. SiPH was officially launched in April 2012. In comparing numbers of human resources (Confidential information) between SiPH and Siriraj Hospital, the findings showed that SiPH selectively recruited a total of 110 external doctors as full-time staff to operate the privatized medical scheme. SiPH considers this number as an appropriate number because SiPH is the privatized public hospital where patient's traffic is not as jammed as Siriraj Hospital due to the fact that higher medical expenses lessened an access of lower-class patients. Moreover, there were also other non-core human resources which composed of 600 part-time medical consultants from Siriraj Hospital to operate the privatized scheme. This proved that SiPH could effectively allocate their medical staff to provide health services and medical treatments to

the patients in a timely manner. Beside medical staff, there were approximately 2,500-3,000 hired employees working in other non-clinical areas such as back-office, nursing department, support service department, reception, and etc while general support such as kitchen, laundry, hospital security and so on were operated by specialized outsources in order to promote the full theme of privatization.

Below is the structure of human resource in Siriraj Hospital

(human resource statistic in 2017)

จำนวนบุคลากรทางการแพทย์ จำแนกตามตำแหน่ง โรงพยาบาลศิริราช							
จำนวนบุคลากร							
โรงพยาบาล	แพทย์	ทันตแพทย์	เภสัชกร	พยาบาล	ผู้ช่วยพยาบาล	บุคลากรอื่นๆ	รวม
ศิริราช	2,139	21	219	3,141	2,328	7,790	15,965

In contrary, Siriraj Hospital contained the total of 15,965 human resources (Medical Record Division, Faculty of Medicine Siriraj Hospital), which could be subdivided as follows: 2,139 medical personnel, 21 dentists, 219 pharmacist, 3,141 nurses, 2,328 nursing assistants, and 7,790 general employees. Beside the main human resources mentioned above, Siriraj Hospital also created an alternative training program in various medical fields for the alumni who have been graduated from the Faculty of Medicine Siriraj Hospital for over 7 years to join. They were defined as Residents and their tasks are to train Fellows. In this case, Residents and Fellows were also incorporated as training medical assistants to help the main medical staff in Siriraj Hospital provide health services and medical advises to patients.

The big different in gap numbers of human resources between Siriraj Hospital and SiPH explicitly indicated that privatization was a key that led SiPH to become more capable of

maximizing human resources than Siriraj Hospital because it allowed maximum flexibility to introduce innovative and cost-sharing as stated earlier. In this case, SiPH was able to make the best use of internal resources from Siriraj Hospital by handling out the opportunity of part-time medical consultation or moonlight shifts as a private earning option to be considered. This strategy of human resource management was mainly aimed to prevent the organizational brain-leaks, maintain the core medical mission of the Faculty of Medicine Siriraj Hospital as well as encourage and motivate those dealing with workloads at Siriraj Hospital to get a chance to improve their earnings through the privatized scheme instead of going to work part-time at other private hospitals.

To sum up, the structure of human resource management in SiPH could be viewed as both fully internal rotation and partly external recruitment. This strategic human resource management not only enabled SiPH to become more efficient in maximizing their limited internal human resources than Siriraj Hospital, but also to maintain organizational-brains and to promote medical mission with high quality of medical cares that are in line with Siriraj Hospital in which it certainly produced a similar level of productivity in outputs comparable to the top private hospitals in Thailand. Such innovative and cost-sharing through the privatized scheme somehow allowed SiPH to be freed from the centralization management. While Siriraj Hospital was still under the government's control, SiPH developed self-governance to enhance overall hospital management standard system in order to compete with other private hospitals. As of today, SiPH has been running its privatized medical management system for 8 years and still keeps looking forward to improving the functions and achieving its ultimate goal in becoming number one privatized public hospital in Thailand. In this regard, the possible benefits gained from such exercise on human resource management could be demonstrated as follows: (1) SiPH can effectively control the rate

of resignation, employee's engagement, and patient's satisfaction. (2) The quality of medical cares is guaranteed by medical personnel from Siriraj Hospital (3) Patients become more engaged with the Faculty of Medicine Siriraj Hospital because faster and better personalized health cares are provided to the target group of patients. (4) Medical personnel in Siriraj Hospital are given the opportunity to balance their time to work for extra hours at SiPH instead of other hospitals in which it allowed them to gain more incomes through the privatized scheme

1.2) What is an average rate of the medical cost charged per visit by SiPH compared to Siriraj Hospital?

The second section focused on the average cost of medical bill charged per visit by SiPH compared to Siriraj Hospital. Generally, the use of market forces to keep costs down is a key concept in privatization. It is commonly expected that private sector, public organizations, and individuals will apply this concept into their competitions to provide higher quality of services at the lowest prices. However, in health sector, this concept of privatization becomes unusual and thus cannot be fit it into above description. The nature of privatized structure encouraged SiPH to mark up the prices as high as possible in order to maximize profits and to recover cost deficits from the reductions of government subsidy in Siriraj Hospital.

In this case, the Vice President of SiPH revealed that the medical cost in SiPH was set to be approximately 80 % of leading private hospitals in Thailand whereas Siriraj Hospital remained its pricing as general public hospitals. According to the personal interview with 10 OP and IP patients from SiPH and Siriraj Hospital, the average rate of medical payments that these individuals were charged per visit were hugely disproportionated to one another.

The table below illustrates the average rate of medical expense per visit in both hospitals

Average Cost of Medical Payment per Visit (IP)												Unit: THB
Type of Patient	Hospital	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10	Average
OP	SiPH	3,000	3,500	2,500	3,000	2,000	3,000	3,500	2,800	2,500	3,000	2,880
	SIriraj	500	600	450	650	500	500	600	300	400	500	500
IP	SiPH	9,000	8,000	10,000	8,500	8,500	8,000	10,000	8,000	8,500	9,000	8,750
	SIriraj	1,000	1,500	1,500	1,000	1,200	1,800	1,500	1,200	2,000	2,000	1,470

Based on this table, it can be concluded that the average rate of medical payment charged per visit for OP in SiPH is 5 times-higher than Siriraj Hospital while the average rate of medical payment charged per visit for IP in SiPH is about 6 times-higher than Siriraj Hospital. It was obvious that the profit-sharing approach of SiPH acted as a powerful incentive in privatization which meant there was a high possibility that the health care provider and business interests could collude to over-sell medical treatments and health services at the expenses of patients through an increasing of unnecessary procedures generated by the supply side while strong control measures are absent and public education is inadequate.

1.3) What is an average time that patients have to wait to get services in SiPH compared to Siriraj Hospital?

The last section focused on the average time of service provision in SiPH compared to Siriraj Hospital. The Vice President of SiPH stated that SiPH has adopted "Lean Process" to help them minimize the time in delivering services to patients. Lean Process identifies, qualifies, and prioritizes the key activities that are most important for performance improvement. Therefore, to find out an average time that patients have to wait for services in SiPH compared to Siriraj

Hospital, the use of interview with 10 IP and OP patients from each hospital was conducted. The results could be viewed in the table below:

Average Waiting Time to Get Services													Unit: Minute
Hospital	Type of Patient	Type of Waiting	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10	Average
SiPH	IP	Walk-in	20	25	25	30	15	20	20	30	20	30	24
		Appointment	15	20	15	20	15	15	20	15	15	15	17
	OP	Walk-in	10	15	15	15	15	15	10	15	20	10	14
		Appointment	10	5	10	5	10	10	5	10	10	5	8
Siriraj	IP	Walk-in	120	120	180	150	150	180	120	150	120	150	144
		Appointment	90	60	80	60	90	90	50	60	50	90	72
	OP	Walk-in	80	90	120	120	90	80	80	90	120	80	95
		Appointment	40	30	40	30	30	20	30	30	30	20	30

According to this table, there are 2 types of waiting for both IP and OP. The first type was an average time of waiting for walk-in patients to get services, the findings indicated that out of 10 walk-in IP and OP patients in SiPH, the average time for them to wait prior to receiving services was 24 minutes and 14 minutes. In contrast, the average time for 10 walk-in IP and OP patients in Siriraj Hospital was 144 minutes and 95 minutes. To compare the average time of waiting between walk-in IP and OP patients in both hospitals, the fact showed that SiPH could provide services approximately 6 times-faster for IP and 6.8 times-faster for OP than Siriraj Hospital.

The second type was an average time of waiting for patients with appointment to get services, the findings revealed that out of 10 IP and OP with appointment in SiPH, the average time of waiting was 17 minutes and 8 minutes whereas the average time of waiting for 10 IP and OP with appointment in Siriraj hospital was 72 minutes and 30 minutes. To compare the average time of waiting between IP and OP with appointment in both hospitals, the fact showed that SiPH could

provide services approximately 4.2 times-faster for IP and 3.75 times-faster for OP than Siriraj Hospital.

To sum up, the transformation of management system from Traditional Bureaucratic Administrative to Privatization significantly led SiPH to become more efficient in managing timeframe to provide services to the patients. Nonetheless, we have to bear in mind that fast services under privatization usually come with higher cost of payment. Therefore, it is a trade-off only for those affordable patients to exchange their money with time of service delivery.

Results of Quality Component – ***How is the quality standard of medical treatments and health services in SiPH compared to Siriraj Hospital?***

According to the vision of SiPH, there are 2 steps being described as their ultimate vision. Step one, within 5 years after the establishment of SiPH, they aimed to become one of the most admired privatized public hospitals in Thailand compared to other top 5 leading private hospitals. The first step has already been achieved as it was assessed and measured by the external audits. Step two, they aimed to become the most admired privatized public hospital in Thailand by the year of 2021. To achieve this aim, the Vice President of SiPH stated that it is crucial that SiPH needs to continue to improve the quality in terms of medical treatment and health service provision as guided by JCI standards.

Therefore, quality component in this thesis consisted of 2 indicators which included quality of medical treatment and quality of health service. According to the personnel interview with the Vice President of SiPH, SiPH applied Siriraj's medical care as the core hospital's medical standard because both hospitals are operating under the umbrella of the Faculty of Medicine Siriraj Hospital. Therefore, both hospitals delivered the same quality level of medical treatments. The reputation of

SiPH's quality of medical treatment has been rapidly extended through words of mouth because SiPH was officially recognized as the private sector of Siriraj Hospital. In this case, the Faculty of Medicine Siriraj Hospital was authorized to conduct an annual quality assurance in order to ensure that SiPH performed equally as good as Siriraj Hospital. However, for quality of health services including clinical and non-clinical related, both hospitals adhered to a different accreditation standard in which health services in SiPH were thoroughly set to follow JCI Standards while Siriraj Hospital conformed to HA Standard.

Speaking of JCI Standards, it has been used globally by many international private hospitals. JCI Standards identifies, measures, and shares best practice in quality care and patient safety through the provision of education, publications, consultation, and evaluation services. It also provides leadership and innovative solutions to help health care organizations across all settings improve performance and outcomes. JCI Standards defines the performance expectations, structures, and functions that must be in place for a hospital to be accredited by JCI. As a result, SiPH is required to reaccredit JCI Standards every 4 year. There will be JCI accreditors doing the assessment and grading in order to investigate whether SiPH is fully obeyed to the requirement set by JCI Standards.

In this regard, the findings on health services including clinical and non-clinical related between SiPH and Siriraj hospital presented a big gap. The fact showed that the quality of health services provided by SiPH were strictly required to be measured, evaluated, and graded in term of quality by JCI accreditors in order to ensure that the hospital was consistently qualified to be accredited by JCI International Standards. For example, Clinical Care Service Program for Total Knee Replacement. This clinical service program was accredited by JCI Standards, requiring medical personnel in SiPH to study intensively in details on specialized care of knee replacement.

Based on the operational statistic in 2014, 99% of patients could walk again within 24 hours after the operation. Another example of non-clinical service accredited by JCI was home-call service which provided the patients with 3 months – 1-year tracking on the results. Last but not least, education tools accredited by JCI provided patients with a clear in-depth information about before and after conditions of services along with medical guidebook and therapy video.

In addition, quality of health services was also partly depended on the development budget. In this case, SiPH actually obtained one-time subvention (confidential amount) from the government during the introduction of privatized medical scheme to invest in constructions of hospital buildings, hospital facilities, and procurement of medical equipment that were essential for health services in privatized scheme. All in all, with the implementation of privatization, it enabled SiPH to provide better quality of health services than Siriraj Hospital where there remained old and lack of maintenance and development on hospital buildings, facilities, and medical equipment.

Results of Equity, Component – (Financial Barrier, Geographical Barrier, Cultural Barrier)

- *Financial Barrier - Can all patients access to medical treatments and health services provided by SiPH?*
- *Geographical Barrier – How does the development of hospital facilities in SiPH create impacts on an access to services?*
- *Cultural barrier - Do health care providers in SiPH and Siriraj Hospital perform their roles differently?*

The concepts of equity are applicable in discussing the optimal provision of public resources, including manpower, medical treatment and health services, hospital facilities, and finances. However, the goals of efficiency and equity in health care produced by privatization may

be contradicted with one another. Although we can assume that by applying privatization into health care, level of efficiency would increase significantly. Yet, there is also a high possibility that level of equity may be reduced consistently due to the fact that greater efficiency often leads to an ignorance of humane. The example of an imbalanced trade-off could be the promotion on efficiency which mainly focus on several activities including restructuring of the government hospitals by adopting privatization system into the administration and management system as well as enhancing standards of medical excellence by utilizing an expensive 'high-tech' medical equipment in order to produce very high quality of medical services comparable with top private hospitals. Though the use of privatization is an instrument that helps boosting incomes for the health providers, it turns out that other factors like equity was overlooked because the main attention was paid overwhelmingly to efficiency factor.

In considering the indicators of inequity emerged from the establishment of SiPH, there were 3 dimensions needed to be clarified as they were relatively defined as barriers to equity which included (1) Financial Barrier, (2) Geographical Barrier, and (3) Cultural Barrier.

Financial Barrier – *Can all patients access to medical treatments and health services provided by SiPH?*

The first proposing issue of inequity found in SiPH is Financial Barrier to get services. This dimension demonstrated how patients have unconsciously faced with the issue of cost-inflation in health care expenses after privatization was implemented in SiPH. There was also a social skepticism on the governance format of SiPH since its operational mechanism actually seemed to be opposite with an initial purposive statement on the provision of health care services announced in Super Tertiary Standard which stated that the ultimate goal of public hospitals is to provide a principled health care to all individuals in an equal manner within the lowest possible

price in order to maintain lives, prevent loss, and fulfil patient's satisfaction regardless of their social status. Therefore, the question is *Can all patients access to medical treatments and health services provided by SiPH?*

The findings revealed that the application of privatization in SiPH could be viewed as the financial boosting tool which allowed supply side to increase the cost of medical bill as they considered appropriate through additional unnecessary services in which it led many potential patients, especially unaffordable ones, to encounter with financial burden. According to the personal interview with patients in SiPH and Siriraj Hospital, it could be summarized that only middle-class to upper-class patients were qualified in terms of financial affordability to access to SiPH. These individuals usually could earn incomes up to 65,000 - 80,000 THB per month. Although SiPH declared itself as a public hospital, privatization has systematically developed SiPH as a private hospital. Hence, the emergence of SiPH as the privatized public hospital somehow falsified self-presumption that SiPH conformed to the objective of public hospital. It turned out that the master medical missions of the Faculty of Medicine Siriraj Hospital (Super Tertiary Hospital) which are to serve equal health cares to the population as well as to monitor the rate of medical cost at lowest possible range for patients have been changed to financial boosting and profit-sharing instead. As a result, financial barrier to get services in SiPH became the inevitable issue amongst group of patients. Obviously, the affordable individuals known as "elite population" were the only eligible group that could acquire privatized public health services from SiPH because they willingly agreed with the payment conditions while those unaffordable and underprivileged patients were neglected and eventually left to be under the responsibility of Siriraj Hospital where issue of congestion has never been solved.

Additionally, SiPH also adopted private health insurance policy as to enhance its hospital standard to be fully aligned with private hospitals. In fact, private health insurance is quite expensive because it entails to premium welfares and benefits. This basically meant not only that privatization isolates lower group of patients away from accessing to SiPH, but it also disqualifies them from using public health insurances. Overall, the creation of SiPH subjectively tended to concentrate more on monetary values than human lives. Thus, it is undeniable that financial barrier to equity is the result of privatization. As long as privatization still plays its role in the health sector, it is likely that this issue of inequity would be long-remained and could hardly be solved.

Geographical Barrier - ***How does the development of hospital facilities in SiPH create impacts on an access to services?***

The second issue of inequity found in the establishment of SiPH is Geographical Barrier. This dimension presented the fact how the installation of better hospital facilities in privatized scheme including clinical and non-clinical related could subsequently lead to unequal access to services amongst potential patients. The findings showed that all hospital facilities in SiPH were wholly developed as private hospital as the intention was to enhance the hospital standard to be in line with top leading private hospitals as well as to accommodate and facilitate the target group of affordable patients. In this case, SiPH aimed to satisfy paid users by providing them with high quality of hospital facilities which made them become more convenient and comfortable.

Speaking of the quantity and the quality of hospital facilities in both hospitals, it was apparent that Geographical Barrier was visible in which it created unsolved issue of inequity. In this regard, the utilization of advanced-medical technology and medical equipment or the renovation of luxurious hospital facilities in privatized style undoubtedly allowed SiPH to increase the total cost of hospital bill tremendously. Such promotion on privatized hospital facilities was

actually a marketing strategy that SiPH used to improve its images and financial income in the long run. However, as hospital facilities were continued to be developed as the privatized public hospital, more lower-class patients became struggling with a swing in hospital bill and payment deficit. Hence, the Geographical Barrier in this context explained that privatized hospital facilities in SiPH placed more financial burden on lower-class patients which meant they would have no opportunity to access to services provided by SiPH. As a result, these patients often ended up having to go to Siriraj Hospital.

Cultural Barrier - *Do health care providers in SiPH and Siriraj Hospital perform their roles differently?*

As privatization is normalizing public health main stream, it has also created public fear followed with the question how much should doctors earn and perform their roles in providing services to poorer patients. In health care, the behaviors of doctors who have monopoly of information can determine level of patients' demands in terms of quality and quantity of health care provided because there is a big gap on specific knowledges between both parties regarding medical treatments, physical and mental conditions, and types of disease or symptoms. Therefore, patients in SiPH who are labeled as customers which are ignorant about their medical conditions, inevitably become subordinates since they merely are in needs of services and thus having to follow doctors' instructions and terms of payment with no bargains.

In this regard, privatization seemed to be the main cause of Cultural Barrier. According to the personal interview with patients in SiPH, some medical experts in privatized scheme were most likely intent to provide only expensive medical treatments and health services to the affordable patients while abolishing of lower-class wards that do not generate revenues for them to be under the responsibility of other medical personnel. In this case, the behavior of these medical experts

spontaneously led to unfair practices and the development of self-demand generated by provider themselves. Apparently, the consequences of Cultural Barrier have created enormous impacts on uncountable lives, especially lives of those patients who were deprived of most basic health care in SiPH.

Overall, it can be summarized that the aim to privatize public hospital in order to improve the level of efficiency can result directly to inequality. Such inequality was defined as the following barriers. Firstly, Financial Barrier to services, in which health services and medical care in SiPH were provided only for the higher-income group of patients. Secondly, Geographical Barrier to services, in which better quality and more quantity of hospital facilities including clinical and non-clinical related in SiPH somehow obstructed other least affordable patients from accessing to services in SiPH due to the fact that higher quality of hospital facilities resulted to more expensive hospital bills. Thirdly, Cultural Barrier to services, in which discrepancies in earnings and rewards became wider as lucrative projects are developed to the neglect of needed but unremunerative services.

Results of Responsiveness Component – *How does the establishment of SiPH respond to the needs of patients and medical personnel?*

There are 2 specific types of responsiveness gained from the establishment of SiPH. First of all, responsiveness in term of incentives, the findings showed that there were two main beneficial groups of medical personnel. The first group was medical personnel who were the main human resources running the privatized scheme in SiPH known as “Full-time staff”. These medical personnel could enjoy the unlimited earnings from privatization because SiPH permitted these medical specialists in each specific branch to set up their own reasonable rate of medical treatment within the upper limit stated in the hospital compensation policy. Furthermore, SiPH also

committed to subsidize a deficit amount of compensation if their medical staff could not earn up to the amount as negotiated in the employment contract. This mutual agreement was constructed to help sustaining new-coming medical staff who might not yet have a personal patient on their list during the beginning period of work.

The second beneficial group is medical personnel in Siriraj Hospital who are given the opportunities of part-time consultations in SiPH. As stated earlier that SiPH adopts privatization as the main hospital management system. Therefore, the privatized incentive policy was applied to part-time consultants accordingly. Hence, medical consultants in SiPH can earn incomes as much as they could possibly earn from privatize hospitals. However, SiPH requires that all pricings of medical treatments and health services set by both full-time medical personnel and part-time medical consultants in SiPH must be opened to the public so that patients can access to data and use it as price references for their consideration. This is mainly to emphasize on transparency and to prevent corruption in the organization. Sometime, there could be an overcharge in medical expense exceeded from the informed rates because some particular patients' cases may be more complexed than usual and thus consuming a lot of time for cures. Under this scenario, medical staff would be required to write their request in a letter form and there will be hospital committees considering whether to approve or reject it. In addition, the establishment of SiPH also solved the problem of travel time for those medical personnel in Siriraj Hospital who joined the privatized scheme. This alternative privatized program allowed them to avoid unpredictable traffic jam in Bangkok. Instead of driving in a long distance to work for extra-hour at other private hospitals, they could now just walk to SiPH where it took only 5 minutes. Such option could literally help them enhance their living standards and work-life balances.

Second of all, responsiveness in terms of medical treatments and health services provision in the privatized scheme, the findings revealed that there were only middle-class to upper-class patients who could access to medical treatments and health care services provided by SiPH due to the fact that they were financially stable to afford to pay for higher medical fee out of their own pockets in exchange with higher level of convenience, faster services, and newly privatized hospital facilities. In this case, there were 2 main reasons why affordable patients chose to come to SiPH. The first reason was because SiPH holds the reputation of Siriraj's excellent medical standard which is most reliable. However, they could not access to Siriraj Hospital because there were many hospital restrictions which delayed the timing in service delivery. For example, patient's traffic, insufficient human resources compared to numbers of patients, and limited hospital facilities and so on. The second reason why affordable patients preferred to go to SiPH was because the rate of medical fee charged by this hospital is fair and cheap when compared to other private hospitals. Last but not least, many of them wanted to be a part of social contribution through the theme "Recipient and Giver" which stated that "Recipient means patients who come to SiPH can obtain the best clinical cares guaranteed by the Medicine of Siriraj Hospital while Giver means their medical payments are collected as a portion of hospital profitability which will be donated back to the Faculty of Medicine Siriraj Hospital in order to help underprivileged patients and to develop Siriraj's future projects".

Results of Availability Component - ***Does SiPH provide all kind of essential medical treatments and health services for patients including the basic services that are less profitable?***

According to the collected information obtained from the personal interview with the Vice President of SiPH, SiPH is a specialty medical center where 99% of medical treatments and health services including check-ups are available whereas the missing of 1 % unavailability is due to fact

that those treatments or services may require the hospital to fill more numbers of medical experts and medical technologies in which it may not be worth of hospital's investment. Moreover, he also stated that some expensive treatments and services in that missing 1 % can actually be found available in Siriraj Hospital in which SiPH is allowed to utilize them at any time and thus it is unnecessary to duplicate them. For example, Positron Emission Tomography Scan (PET Scan) which is a nuclear medicine functional imaging technique that is used to observe metabolic processes in the body and brain as an aid to the diagnosis of disease. However, there is a mutual agreement between SiPH and Siriraj Hospital that patients in Siriraj Hospital must be placed as the first priority in case that they are in needs of these treatments or services. At this point, list of medical treatments and health services available in SiPH compared to Siriraj Hospital can be demonstrated as below:

Hospital		List of Medical Treatments and Health Services
SiPH	Siriraj Hospital	
×	×	Orthopedic Center
×	×	Heart Center
×	×	Gastrointestinal & Liver Center
×		Cancer Center
×		Kidney Center
×		Children's Center
×	×	Eye Center
×		Ear Nose Throat Center
×		Allergy Center
×	×	Health Checkup Clinic
×		Skin and Plastic Surgery Center
×	×	Internal Medicine Center
×	×	General Surgery Center
×		Rehabilitation Center
×	×	Dental Center
×	×	X-Ray Center
×		Cardiac Rehabilitation Center
×		Women's Center
×		Diabetes thyroid and Endocrine Clinic
×	×	Emergency Clinic
	×	Palliative Care Center
	×	Ophthalmology
	×	Psychiatry
	×	Child and Adolescent Psychiatric Nursing
	×	Otorhinolaryngology
	×	Organ Change
	×	Multidisciplinary Endoscopic Training Center
	×	Biological Pulp Center
×	×	Diabetes Center
	×	Bone Marrow and Stem cell Transplantation Center
	×	Thanyarak Breast Center

This table above confirms that there are more advanced-medical treatments and personalized health services available in SiPH than Siriraj Hospital. According to personal interview with the Vice President of SiPH, top 5 specialty medical centers in SiPH are 1) Internal Medicine Center 2) Orthopedic Center 3) Children's Center 4) Skin and Plastic Surgery Center 5) Heart Center. It is likely that privatization tends to lead SiPH to put an emphasis on specialty medical centers that applied high level of medical technology into the functions because these centers can maximize the highest revenues and profits for the hospital while abolishing less-profit ones to be under the responsibility of Siriraj Hospital. This proves that privatization in health sector can lead to unfair practices. In this case, the main disadvantaged groups include patients in both hospitals. On one hand, affordable group of patients is looking forward to receiving all kind of medical treatments and health services provided by SiPH within the fastest time frame, but they end up being transferred to acquire such less-profit treatments or services in Siriraj Hospital where hospital facilities are less efficient and service delivery is very slow due to congestion. On the other hand, the unaffordable group of patients who is already suffered with patient's traffic in Siriraj Hospital, have no other choices other than accepting an increase in numbers of patients which would result to the longer waiting time for them to get health cares.

CHAPTER V

CONCLUSION AND AREA FOR FUTURE RESEARCH

Privatization can be viewed as one of the most popular forms or concepts of good governance to be used amongst many organizations across the world. However, when privatization is being introduced into the health sector, it can be referred to as the act of providing or taking ownership and responsibility of providing health care services to the population. At first glance,

the theoretical background of privatization, especially when applied into health care, may suggest various positive benefits such as a lead to higher market competition, higher efficiency and quality of service provision, lower costs of medical payment, greater customer choice. In fact, we can observe from the realistic practices that such particular privatization initiative may be difficult to implement in health sector unless there is a proper arrangement, management, and development plans.

For this case study, five criterions from P.S.O. 1107 which include efficiency, quality, equity, responsiveness, and availability were used as the conceptual framework of good governance to investigate how the responsibility of SiPH would be perceptible after privatization was injected into the hospital standard management system compared to Siriraj Hospital. The overall findings showed that although the mechanism of privatization seemed to have brought SiPH to certain degrees of improvement, there were still some potential drawbacks that emerged from the application of privatization. In this regard, the main issue found in SiPH is inequality. The practical privatization in health care resulted to the social divisiveness in the hospital where there would be a well-differentiated two-class system of health care with those affordable patients going to SiPH and those unaffordable remaining in Siriraj Hospital. Moreover, the issue of availability of expensive and inexpensive medical treatments and health services under privatization was also visible. As SiPH became the privatized public hospital, some of the service provision that are considerably non-profitable were being neglected and left to be available at Siriraj Hospital. Obviously, the aim in boosting financial incomes for SiPH somehow deprived away the moral medical management as announced in Super Tertiary Standard. Last but not least, this study also ensured that the establishment of SiPH could only respond to the needs of some stakeholders, but not all. The beneficial groups include medical personnel who worked in both

part-time and full-time shifts at SiPH as well as affordable patients who satisfied to exchange their money with Siriraj's quality of medical treatments and faster personalized health services from the privatized scheme. Unfortunately, lower-class patients were not entitled to any of such responsiveness due to the fact that they were not financially affordable to access to SiPH. In addition, speaking of social contribution through the privatized scheme, cost-sharing initiative of "Recipient and Giver" allowed potential affordable patients in SiPH to be a part of donation to help subsidizing health cares for underprivileged patients in Siriraj Hospital as well as to develop future projects in the Faculty of Medicine Siriraj Hospital.

All in all, the questions of how much precisely and what level exactly should privatization be embraced and conducted in the public sector are still unanswerable due to the fact that there are various operational functions and fundamental objectives that each different public sector is adhered for actual implementation. However, for this case study, I intensively placed my emphasis on privatization in SiPH. Therefore, the results from the componential analysis on five specific components of P.S.O. 1107 could ultimately be used to propose how many indicators in each component under privatization should be added, adjusted, or dropped out so that the design of innovative privatized super tertiary hospital standard management system could be further utilized and maximized for the best possible performance in future privatized public hospitals.

According to all findings mentioned in previous paragraphs, we can conclude that 1) The adoption of privatization in public hospital can definitely enhance the level of efficiency in terms of the maximization of human resource, financial development, and faster service provision with more convenient hospital facilities. However, the caution is strictly required as higher-level of efficiency often simultaneously leads to wider gap of inequality for accessibility. The nature of

privatization usually influences the organization to place their concentration overwhelmingly on the level of efficiency until its overbalanced against other factors. Thus, privatization should not be over-conducted otherwise it would create social injustice or social unfairness since the organization would possibly disregard the ethical standard of Super Tertiary Hospital and solely give values on functional development that ultimately yields to organizational financial improvement. In this case, higher level of efficiency also leads to an increase in operational cost in which the hospital would directly pass on the responsibility of hospital payment to the patients' bills. As a result, the majority of unaffordable or underprivileged patients who are in greatest need of medical treatments and health services are deprived away the opportunity to experience such services in privatized scheme and are eventually left out to be under the responsibility of congested public hospital. Hence, based on my point of view, I strongly suggest that in order to create more balances on the trade-off between efficiency and equality, some adjustments on the role of supply-side is required. In this case, I believe that the indicators of efficiency component need no changes, but the government 's involvement under privatization is absolutely necessary as there should be the center that is authorized to fairly weight between level of efficiency and equality in order to prevent bias on practices from private side as well as to promote the theme of public services in which any individual can be eligible to access.

2) For the quality component, the adoption of privatization in SiPH has successfully brought the quality level of health services to be enormously improved as greater numbers of personalized health services are served and accredited by JCI standards. In this case, JCI standards are principally adopted by many private hospitals around the world as it thoroughly covers more critical identification, measurements, assessment on best practices in quality care and patient safety through the provision of education, publications, consultation, and evaluation services than HA

standard. Meanwhile, budget allocation in privatized scheme, which was independent from the government's control, also enabled SiPH to allocate its budgets to invest in more advanced-medical technologies and privatized hospital facilities in order to accommodate and facilitate the target group of patients. Overall, I literally recommend that the quality component in terms of health services and medical treatments performed by SiPH should be consistently maintained its standard at this level so that potential stakeholders can be ensured that their health conditions and lives are in good hands and fully guaranteed by the providers themselves.

3) For equality component, as I stated earlier that when level of efficiency increased, level of equality would simultaneously be decreased respectively, especially if the management was under privatization. The improvement on the level of efficiency inevitably required heavier investments from the supply-side and thus automatically leading the overall cost of payment for end-users to be higher. When this scenario happened, least affordable patients became the victims since they would have to encounter with financial burden and obtain less chances for accessibility. Even if they could afford to pay for more expensive services provided by the privatized scheme, issue of inequality still existed because the medical personnel under privatization often prioritized on the elite group of patients who could generate the most revenues for the hospital. As a result, unfair practices amongst medical personnel can be viewed as norms because they would be willing to serve only expensive health services and medical treatments while leaving basic health services or inexpensive medical treatments to be under the responsibility of public sector instead. In my opinion, I really oppose to the idea that better efficiency must be exchanged with worse equality because public health service is one of the most essential elements that is objectively created for the sake of human existence. Regardless of monetary values, all human beings are emerged as the same type of creature and thus each individual should be given equal opportunity to maintain their

lives and be treated in the same way. Overall, level of equality should be of primary concern before making any further adjustment. In fact, without equality component being allocated proportionately, the improvement on other components would somehow be limited because there will surely have a social debate referred to as the controversial on the right of human, which consequently interrupts the development process of the organization since unethical behavior of medical personnel is observable and public health policy is being violated by the hospital's management.

4) For the responsiveness component, I understand that privatization can significantly serve the needs of many affordable patients because health services and medical treatments produced by privatized scheme were upgraded to be aligned with the private hospitals in which it undoubtedly helped shortening the timeframe of service delivery which was the biggest concern amongst all patients. Also, medical personnel in privatized scheme could easily earn higher incomes and overcome with workloads because privatization allowed more flexibility and innovative. However, I genuinely believe that there is still a room for privatization to be improved as privatized scheme in SiPH is obviously not responsive to the public at large. Many unaffordable patients are currently suffering from the implementation of privatization in public hospitals as it obstructs them from obtaining public health services in the lowest possible cost and using public health insurances. In fact, it is technically believed that once privatization is being injected into the organization, the core products of the public hospitals would no longer be called "public health services" because equality on accessibility becomes absent while privilege becomes present. Therefore, I think that the intensity of responsiveness in the privatized public hospital must be added up in order to promote full accessibility and to equalize the right of stakeholders.

5) Lastly, the results of availability component showed that when privatization was conducted in health sector, the hospital often focused on the provision of profitable health services and medical treatments as it would lead the organization to the growth of financial viability. With more variety of expensive cares being listed, it would create more reputations for the hospital and likewise the rate of interests and engagement would be rising accordingly. However, I honestly suggest that the degree of cost-sharing between government and the private sector needs to be more specifically defined because if the prices of medical care are not within the government's control, there would be attempts from private side to cut off some inexpensive medical services while rising the hospital fees through the emphasis on the implementation of advanced and profitable health cares.

Although we can observe great improvements in many aspects as well as potential drawbacks from the establishment of privatized scheme, there definitely should be none left out components to be conducted, but proper adjustment is absolutely needed so that the privatized public hospital can thrive toward higher position as a social contributor and the center of health improvement or health maintenance. In addition, if by any chances that the government could revise budget allocation or amount of government subsidies for Super Tertiary Public Hospitals in the future, one of the questions that I would be curious is would these public hospitals be able to improve its standard without the use of privatization? It would be very interesting to further explore whether the current issues of public hospitals implicitly come from a lack of investment budget or the rooted-management system of public sector. Anyhow, I positively believe that the provision of optimal level of government subsidies can encourage efficient or equitable production and consumption.

Before closing my qualitative study, I shall propose the philosophy of privatization as to clearly identify whether privatization in health care context has been interpreted as the original form of privatization. In general, the term privatization has long been described as the transfer of an economic activity from the government to the private sector domain for economic, social, or political reasons. In this case, the objectives of the government may be changed from time to time as financial resources are also subjected to be varied depending on social economic, market price, and market competition. However, to scrutinize the meaning of privatization in health sector, it may be difficult to apply this definition into the same concept because the products in health sector are health conditions which cannot actually be estimated as specific amount of money and the information regarding the products itself require ones to possess very high level of medical education in order to understand details. With respect, it is literally beyond buyers' capability to acquire such knowledges unless they academically pursue medical study. Furthermore, privatization in health sector does not purely deal with economic context, but it appears to be corresponded with the management theory that suggests rationale of pricing and maximization of resources for the most productivity in outputs which in this case means the sustainable health of the population. Therefore, since all citizens are equal in respect of these rights in virtue of their equality in citizenship and belonging to the society, privatization in health sector should then be related with human-oriented rather than financial aspects. Last but not least, work performance in health sector should also not be subjectively conducted based on profitability, but objectively be conducted based on affordability for end-users.

Research Recommendation

1. Ethics recommendation

To mitigate the issue of cost-inflation in privatized medical scheme, the suggestion is that a new generation of medical students in the Faculty of Medicine Siriraj Hospital should be taught medical economics to help them appreciate the cost of health care and to realize that unnecessary medical procedures can lead to higher costs of patient's medical payments and thus should not be conducted. With this recognition being advised in advance, future doctors would be able to evaluate all medical practices and procedures in a reasonable manner to ensure that the outcome justifies the expenditure incurred *(Phua Kai Hong, 1991).*

2. Operational recommendation

a) While the public health sector allows greater autonomy, caution is required to prevent a swing to other extreme of inadequate checks and balances. In this case, empire-building and irregular practice are possible if there is a lack of strong administrative controls and monitoring of standards during the expansion of health services in privatization. Therefore, this study suggests that a certain degree of controls and monitoring are needed in most situations when allowing a proper flexibility for innovation. This implies that privatization should be of close observation and partly controlled by or coordinated with the center (external inspectors) in order to prevent bias, undesirable effects or unexpected situations including corruption, increased chance of interruption services, and so on *(Phua Kai Hong, 1991).*

b) If possible, the government subsidy and subvention should be maintained and provided at a sufficient balance to Siriraj Hospital so that the regular services in Siriraj Hospital could

be further developed in order to serve patient's needs. Moreover, there should be one common standard of hospitalization benefits to be used for all classes of patients in SiPH and Siriraj Hospital as most employers often base their employee's medical benefits on standards set by public hospitals.

3. Academic Recommendation

This research is a part of a dissertation in Degree of Master of Arts in Governance Program which mainly aimed to study the relation between five specific components of P.S.O. 1107 and the responsibility of SiPH under privatization and Siriraj Hospital as public sector in order to figure out the potential outcomes received therefrom. Such outcomes were used to design the new privatized super tertiary hospital standard management system in which future public hospitals that may be emerged as SiPH can adopt accordingly. However, there are still other five components in the criteria of P.S.O. 1107 which include coverage, justice, satisfaction, continuity, and convenience that have not yet been studied in this research. Therefore, these components are also noteworthy to be conducted for further research in public health science field in order to point out more correlations and rooms for improvement of future privatized public hospitals.

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