C H A P T E R 19

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

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

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บทคัดย่อ

การวิจัยนี้มีวัตถุประสงค์เพื่อศึกษาระบบการจัดการในรูปแบบภาคเอกชนของโรงพยาบาลศิริราช ปิยมหาราชการุณย์โดยนำ 5 ส่วนประกอบหลักจากระบบการบริการภาคเอกชนและประชาชนจาก มาตราฐานด้านการจัดการและสัมฤทธิ์ผลของงานภาครัฐมาใช้เป็นกรอบแนวคิด ว่าด้วยเรื่อง ประสิทธิภาพ คุณภาพ ความเท่าเทียม การตอบสนอง และความพร้อมในการให้บริการ เพื่อใช้เป็นแนวทางในการสร้าง ระบบการจัดการมาตราฐานโรงพยาบาลภาครัฐในรูปแบบเอกชน การวิจัยเรื่องนี้ดำเนินการวิจัยตามระเบียบ วิธีวิจัยเชิงคุณภาพ โดยใช้วิธีการศึกษาเอกสารจากข้อปฏิบัติในระบบการบริการภาคเอกชนและประชาชน และงานวรรณกรรมอื่นๆ ที่เกี่ยวข้องกับ กรอบความคิดการดำเนินการรูปแบบเอกชนและการบริการ สาธารณสุข เพื่อใช้อธิบายว่าการนำรูปแบบการดำเนินการแบบเอกชนมาใช้ในภาคสาธารณสุขสามารถสร้าง ค่านิยมทางสังคมและส่งผลกระทบต่อสังคมอย่างไรได้บ้าง อีกหนึ่งวิธีที่ใช้คือ วิธีการสัมภาษณ์แบบกึ่ง

โครงสร้าง และการสัมภาษณ์เชิงลึก เพื่อที่จะสามารถได้รับข้อมูลที่ถูกต้องและตรงตามสาระสำคัญสำหรับการศึกษาในครั้งนี้

ผลการวิจัยพบว่า การนำรูปแบบการดำเนินการภาคเอกชนมาใช้ในโรงพยาบาลศิริราชปิยมหาราชการุณย์ ช่วยให้โรงพยาบาลสามารถพัฒนาได้ในระดับหนึ่ง เช่น เรื่องประสิทธิภาพในการใช้ทรัพยากรบุคคลให้เกิดประโยชน์สูงสุด ประสิทธิภาพในพัฒนาทางการเงิน ประสิทธิภาพในการให้บริการการวดเร็วยิ่งขึ้น หรือเรื่องคุณภาพของการให้บริการสุขภาพที่ได้รับการรับรองจากมาตรฐานสากล JCI ซึ่งทำให้โรงพยาบาลศิริราชปิยมหาราชการุณย์สามารถยกระดับการบริการด้านสุขภาพให้ดีกว่าโรงพยาบาลศิริราชภาครัฐ ที่ยึดปฏิบัติตามเกณฑ์มาตราฐาน HA อย่างไรก็ตาม ทั้งสองโรงพยาบาลยึดมั่นในคุณภาพการรักษาเดียวกัน ถึงแม้ว่าโครงการบริการการแพทย์ในรูปแบบเอกชนจะตอบสนองความต้องการของบุคลากรทางการแพทย์และผู้ป่วยที่สามารถจ่ายได้ ข้อเสียที่ปรากฏขึ้นจากการก่อตั้งโรงพยาบาลศิริราชปิยมหาราชการุณย์ คือ ปัญหาเรื่องความไม่เท่าเทียม เช่น อุปสรรคทางการเงินที่เกิดจากให้บริการสุขภาพรูปแบบเอกชน อุปสรรคในการเข้าถึงการให้บริการสำหรับผู้ป่วยที่มีข้อกำจัดเรื่องการใช้จ่ายซึ่งเกิดจากการติดตั้งสิ่งอำนวยความสะดวกแบบเอกชน และอุปสรรคทางวัฒนธรรมทางองค์กรที่ส่งผลให้บุคลากรทางการแพทย์ปฏิบัติตนไม่เป็นธรรมหลังจากนำรูปแบบการดำเนินการภาคเอกชนมาปรับใช้ในโรงพยาบาล

คำสำคัญ: การดำเนินการภาคเอกชน, เกณฑ์การจัดการ, การบริการสุขภาพ, ความเท่าเทียม, ความรับผิดชอบ

Abstracts

The objectives of this research were to (1) study the privatized management system of Siriraj Piyamaharajkarun Hospital by using 5 specific components of P.S.O. 1107 as a conceptual framework (efficiency, quality, equity, responsiveness, availability); (2) to initiate an innovative privatized public hospital standard management system. The research is conducted as an 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 brought medical personnel to conduct unfair practices.

Keywords: Privatization, Management standard, Public health service, Equity, Responsibility

Introduction

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 in which it 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 cited in Hughes, 1998). This approach, later termed as Entrepreneurial Government by Osborne and Gaebler (1993 cited in Hughes, 1998), 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.

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 topics 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 known as Thailand International Public Sector Standard Management System and Outcomes (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. PSO is composed of ten standard systems as follows; (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.

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. In case of Thailand, the framework of HA is a perceptible platform and guideline for all public and private hospitals in Thailand to follow and conduct. This framework of HA standards consists of multidisciplinary team, medical staff organization, clinical quality improvement, risk management, quality review, internal survey, and etc.

However, for the case study of Siriraj Piyamaharajkarun Hospital, SiPH developed their own autonomous public hospital with privatized management system that complies with Joint Commission International Accreditation standards (JCI standards), operating under the Faculty of Medicine Siriraj Hospital. Joint Commission International standards define the performance expectations, structures, and functions that must be in place for a hospital to be accredited by JCI. 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.

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. However, it still remains unclear whether Super Tertiary Hospital like SiPH is currently running its operation properly as announced in the Super Tertiary Standard. Therefore, the principle of P.S.O. 1107 (service for private sector and people system) was used as observation tool to identify the outcomes. P.S.O. 1107 is composed of 10 components which include 1) Efficiency 2) Quality 3) Coverage 4) Equity 5) Justice 6) Responsiveness 7) Satisfaction 8) Continuity 9) Convenience 10) Availability. However, only 5 specific components (efficiency, quality, equity, responsiveness, availability) were selected to be used as a conceptual framework since they were fundamentally the most relevant subject to the theme privatization and public health service in which plenty of theoretical supports are available and valid.

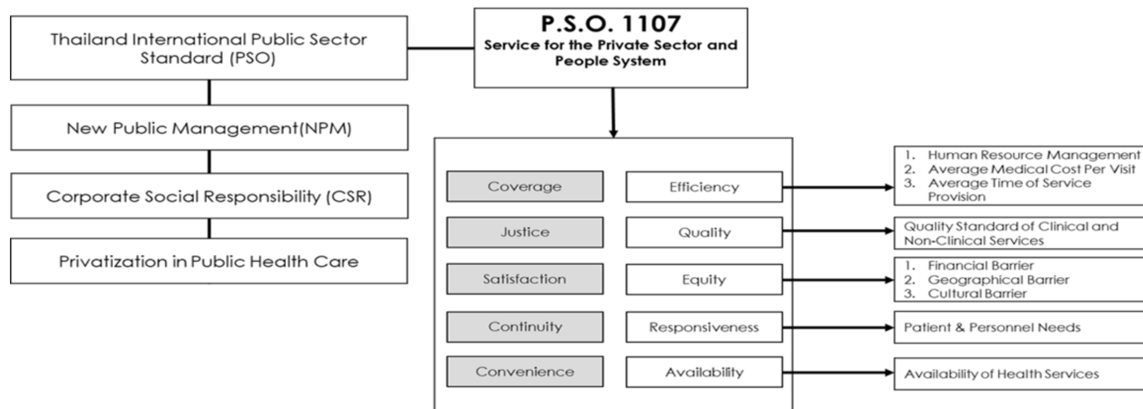
Objectives

1. To study the privatized management system of Siriraj Piyamaharajkarun Hospital by using 5 specific components of P.S.O. 1107 as a conceptual framework (efficiency, quality, equity, responsiveness, availability).

2. To use outcomes derived from the study to initiate an innovative privatized public hospital standard management system for future public hospitals that may be emerged as SiPH.

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.



Scope of the Research

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. This research was conducted for the approximately 5-month period, started from December 2018 and completed by the end of May 2019.

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. Social Responsibility: A 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. 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).

3. 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 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 health service provision in public hospitals or perhaps abolishment of some inexpensive basic health 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.

On the other hand, many also have claimed that privatization can boost up competition into service provision by increasing quality and efficiency as well as reduce the government cost burden through cost-sharing scheme. When all these assumptions were 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. It is likely that patients 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. Therefore, it turned out that patients usually have 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. (Phua Kai Hong, 1991)

4. 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. (Paibul Suriyawongpaisal, 1999).

Research Methodology

This research was conducted as qualitative study, using 2 main collecting methods which include documentary research and interview approaches. Documentary research was used to collect the primary data from the principle of P.S.O 1107 and work of literatures while interviews approaches

including semi-structured interview and in-depth interview were used to collect the secondary data from target respondents. All collective information were collected based on the 5 selected components stated in a conceptual framework, research questions, and objectives of the study in order to explain how privatized management model can lead to enhancement and to point out potential issues when applied privatization into health sector as well as to ultimately initiate the new privatized public 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 SiPH acted accordingly while the descriptive analysis was used with semi-structure interview and in-depth interview to scrutinize and interpret information acquired from the perspective of stakeholders. For the data collecting process through the use of interviews, 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 is 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.

After the interviews completed, primary data from the principle of P.S.O. 1107 and work of literatures were used to assess and compare the alignment of information. Then, outcomes of the study were proposed and used as the innovative standard management system of privatized public hospital.

Research Findings

Results of Efficiency Component

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.

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

The findings revealed that SiPH was more capable of maximizing human resources than Siriraj Hospital because privatization allowed maximum flexibility to introduce innovative and cost-sharing. In this case, SiPH selectively recruited a total of 110 external doctors to run full-time shifts while allocating 600 medical personnel from Siriraj Hospital to run part-time shifts as medical consultants. 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 theme of privatization. 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.

In contrary, Siriraj Hospital contained the total of 15,965 human resources (Medical Record Division, Faculty of Medicine Siriraj Hospital), which can 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 medical staff mentioned above, Siriraj Hospital also has created an alternative training program in various medical fields for alumni who have been graduated from the Faculty of Medicine Siriraj Hospital for over 7 years to join. They are defined as Residents and their tasks are to train Fellows. In this case, Residents and Fellows are also incorporated as training medical assistants to help the main medical staff in Siriraj Hospital provide health services and medical advises to patients.

To sum up, the structure of human resource management in SiPH can 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, but also to maintain organizational-brains and to promote medical mission with high quality of medical cares aligned with Siriraj Hospital. The privatized management system 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 to compete with other private hospitals.

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

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

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.

What is an average time that patients have to wait to get services 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.

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 is 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 is 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.

CHAPTER 19

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

Quality component in this thesis consisted of 2 indicators which included quality of medical treatment and quality of health service. 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. 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.

In this regard, the findings on quality of health services including clinical and non-clinical related between SiPH and Siriraj hospital presented a big gap in quality level. The fact showed that health services provided by SiPH were strictly required to be measured, evaluated, and graded 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.

All in all, with the implementation of privatization, it enabled SiPH to provide a better-quality 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)

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?*

This dimension demonstrated how patients have unconsciously faced with the issue of cost-inflation in health care expenses after privatization was implemented in SiPH. The findings revealed that the application of privatization was 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.

The emergence of SiPH as a 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. 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?*

This dimension presented the fact that 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 allowed them to become more convenient and comfortable.

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. Therefore, the geographical barrier in this context explained that the development of privatized hospital facilities in SiPH placed more financial burden on patients. As a result, these patients would have less opportunity to access to services provided by SiPH and often ended up having to go to Siriraj Hospital.

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

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 can be categorized as the following barriers. Firstly, Financial Barrier to services, in which health services and medical care in SiPH are 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 are provided only for affordable patients in which it somehow obstructs other potential patients to access to services in SiPH due to the fact higher quality in hospital facilities means more expensive hospital bills. Thirdly, Cultural Barrier to services, in which discrepancies in earnings and rewards become 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 "Full-time staff" who could enjoy the unlimited earnings from privatization. SiPH permitted these medical specialists in each specific medical 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.

The second beneficial group was medical personnel in Siriraj Hospital who were given the opportunities of part-time consultations in SiPH. The privatized incentive policy was applied to part-time consultants which allowed them to earn incomes as privatize hospitals. In addition, the establishment of SiPH also solved the problem of time of travel. By joining the privatized scheme, medical personnel from Siriraj Hospital could 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, the findings revealed that only middle-class to upper-class patients 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 in exchange with higher level of convenience, faster services, and newly privatized hospital

facilities. In this case, there were 2 main reasons why they chose to come to SiPH; (1) SiPH holds the reputation of Siriraj's excellent medical standard which is considered most reliable, (2) the rate of medical fee charged by SiPH is cheap when compared to other private hospitals. Additionally, many patients also wanted to be a part of social contribution through the theme "Recipient and Giver". "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 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, some expensive treatments and services in that missing 1 % can actually be found available in Siriraj Hospital in which SiPH was allowed to utilize them at any time and thus it is unnecessary to duplicate them.

The findings revealed that there were more advanced-medical treatments and personalized health services available in SiPH than Siriraj Hospital. For example, Women's Center, Children's Center, Kidney Center, Plastic Surgery Center, Cardiac Rehabilitation Center, Diabetes Thyroid and Endocrine Clinic, Eye Nose Throat Center, and many more. This proved that SiPH put an emphasis on specialty medical centers that applied high level of medical technology into the functions because these specialty centers would yield high profitability for the hospital while abolishing less-profit ones to be under the responsibility of Siriraj Hospital.

Conclusion

Although the mechanism of privatization seemed to have brought efficiency and quality in SiPH to be improved in certain ways, there were still some potential drawbacks 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. In this case, some non-profit medical treatments and health services were neglected and left to be available at Siriraj Hospital. Also, the establishment of SiPH only responded to the needs of medical personnel who worked in both part-time and full-time shifts at SiPH and also affordable patients who were satisfied to exchange their money with Siriraj's quality of medical treatments and faster personalized health services from the privatized scheme. Obviously, an aim in boosting financial incomes for SiPH somehow deprived away the moral medical management as announced in Super Tertiary Standard.

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

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).

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 5 specific components of P.S.O. 1107 and the responsibility of SiPH under privatization in order to figure out the potential outcomes received therefrom. Such outcomes were used to design a new privatized public hospital standard management system in which future public hospitals that may be emerged as SiPH could adopt accordingly. However, there are still other 5 components (coverage, justice, satisfaction, continuity, convenience) in the criteria of P.S.O. 1107 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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