# People and Partnerships with a focus on involvement of the people working in health organisations and partners working with health organisations.

## FROM PARTNERSHIP TO IMPACT: Thailand's Journey in Driving Quality and Safety

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# Overview of Thailand's healthcare system

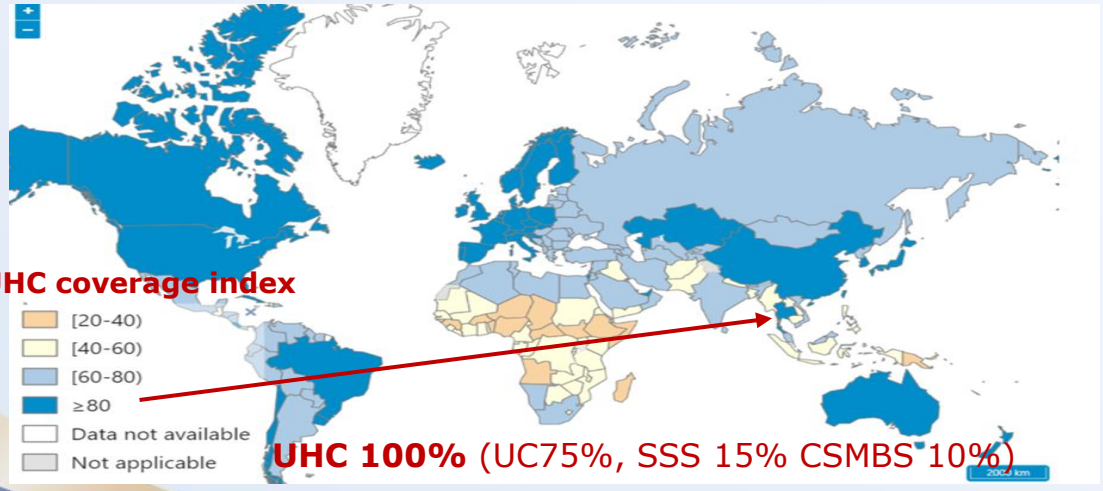
**MoPH is the principle of National health system**

- 1.107 government hospitals
- 384 private hospitals
- 9,768 government health centres
- 25,615 private clinics
- 1,000,000 village health volunteers

**Health Business Establishments Act, B.E. 2559 (2016).**

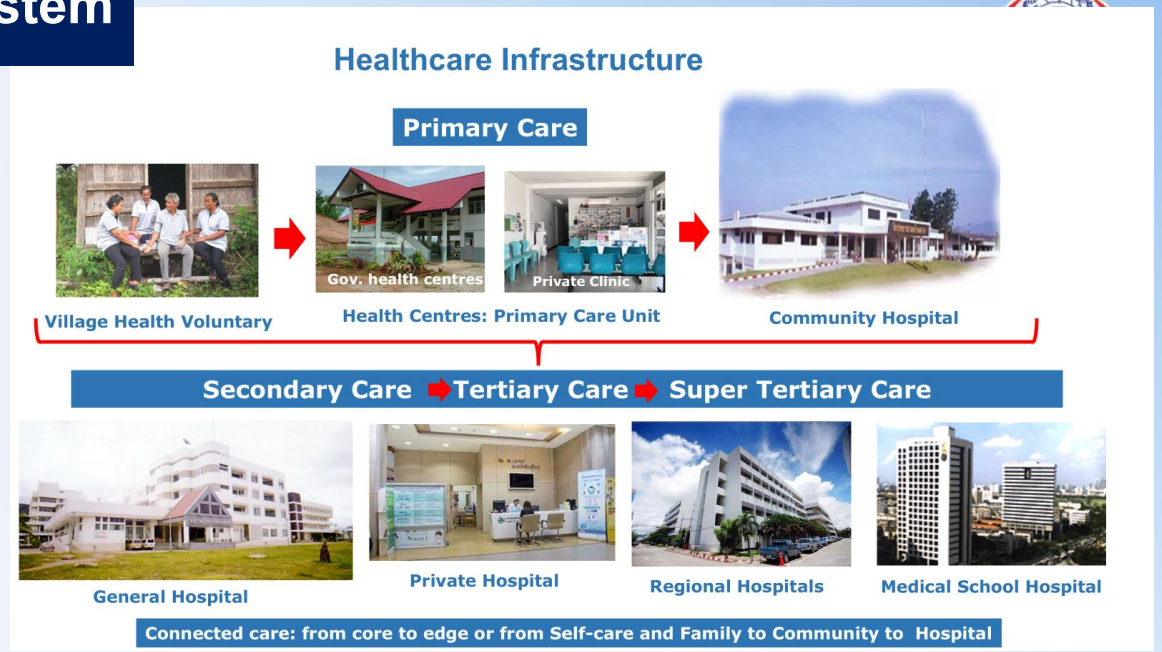
## Health status

- Population growth rate −0.046% (2023)
- Life expectancy at birth 77.92 years (2024)




**Total Health Expenditure (2021)**

- Per Capita: 364.37 USD
- As a Percentage of GDP: 4.3%




**Quality of Care is fundamental to UHC.**
**Access without quality and safety can be considered an empty UHC promise**

## Healthcare Accreditation Institute, HAI

- HAI is a non-profit public organization in Thailand.
- Objectives of HAI, outlined in the Royal Decree on the Establishment (2009) that was established with **the goal of enhancing patient safety and improving healthcare services.**

## The Coverage of Hospital Accreditation

- 1053 HAI-accredited hospitals, out of a total of 1,491 hospitals in the country 70.62%
- 83.56% of Government Hospital and 46.61% of Private Hospital

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# From partnership to Impact: Lesson Learned from HAI

**Thailand's healthcare accreditation journey did not begin with an accreditation organisation.**
It began with a small group of people who shared one belief — that healthcare could be safer and better if we learned and improved together.

Almost three decades later, that small collaborative initiative has **grown into a nationwide quality movement.**
Today, I would like to share not only what we have built, but what we have learned about **people, partnership and leadership** along the way.

*People • Partnership • Co-production • Collective Action*

## 1 Research initiative (early 1990s)

- A small group of people with a **shared belief**
- Learning from evidence and international experience
- Exploring how to improve quality and patient safety in Thailand

## 2 Multi-stakeholder collaboration

- Research Institute
- Ministry of Public Health
- Social Security Office
- Volunteer Hospitals
- Universities
- Experts & Professionals

## 3 Healthcare Quality Improvement Movement

- Learning and sharing across hospitals
- Developing and testing quality improvement tools
- Building networks and capacity

## 4 Hospital Accreditation




- Development of standards
- Survey and accreditation
- Support for improvement

## 5 The HAI Institute (Public Organization)



- National mandate
- Nationwide quality and safety promotion
- Sustainable system and impact

| 93 | 94 | 95 | 96 | 97 | 98 | 99 | 00 | 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TQM Project | | SOS basic standards | | 1st HA Standards | | HA Project | | HA Unit under HSRI | | 3 Steps to HA | | | UHC | Politician demanded for quality & access | | | | | | The HA Institute (Public Organization) | | |

**"HAI was not created first and then looked for partners. Partnership created HAI."**

# One Purpose. Different Forms of Partnership.




## Partnership Evolves into Co-production

## Develop HA Standards and 3P Safety in Action

# PARTNERSHIP ENABLES SCALE

Different partners. A stronger quality and safety ecosystem for Thailand

# Expanding HA Coverage and Impact

## Towards a Safer, Higher Quality Healthcare System




**"We did not try to make HAI bigger. We tried to make the ecosystem stronger."**

## PARTNERSHIP CLOSER TO WHERE CHANGE HAPPENS

**Universities**
Academic expertise and training

**Regional Hospitals**
Clinical experience and practical learning

**Health Regions**
Regional coordination and implementation

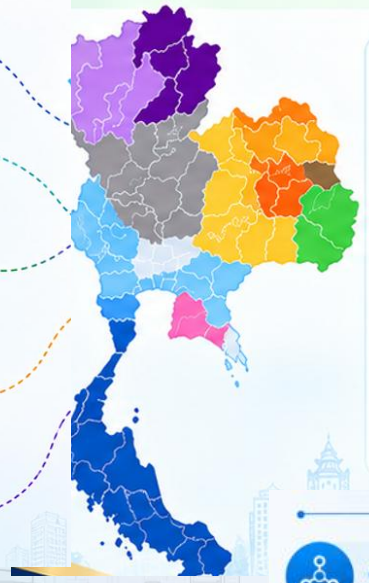
**Local Quality Networks**
Peer support and collaborative improvement

**Specialized Partners**
Specific expertise for priority areas

## 1 Hospital Accreditation Collaborating Center (HACC)

**11 HACC** (10 area-based)

**1 agenda-based** (e.g. Military Healthcare Network)



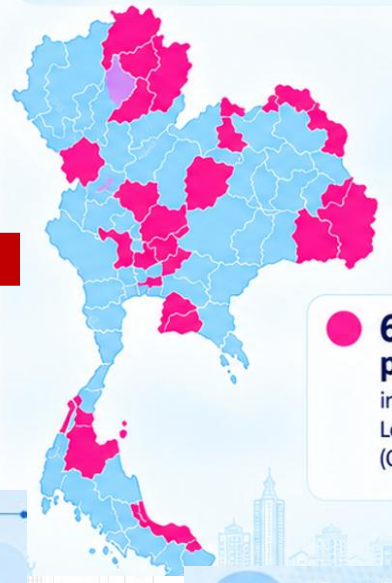
- HACC 1 Northern Upper
- HACC 2 Northern Lower
- HACC 3 Central
- HACC 4 North-Eastern Upper
- HACC 5 North-Eastern Lower
- HACC 6 Eastern
- HACC 7 Western
- HACC 8 Southern
- HACC 9 Agenda-based (Military Healthcare Network)
- HACC 10 (Area-based)

**KEY FUNCTIONS**

- **CONNECT** — Link people, expertise and resources across the region
- **COACH** — Support and mentor for improvement
- **BUILD CAPABILITY** — Develop people, organisations and networks
- **SHARE & LEARN** — Facilitate knowledge exchange and collective learning

## 2 Quality Learning Network (QLN)

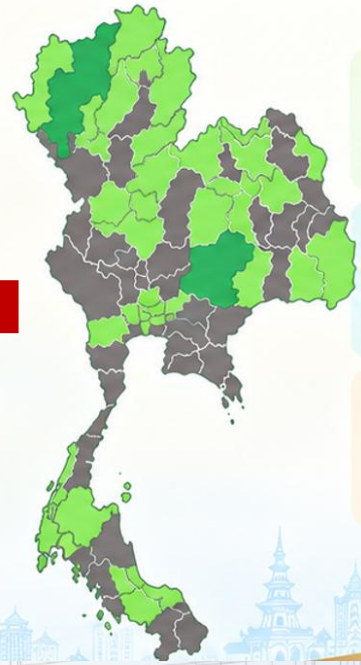
**68 provinces** in the Quality Learning Network



**68 provinces** in the Quality Learning Network (QLN)

- Capability close to where change happens
- Peer support and learning
- Stronger and more sustainable improvement

## 3 Surveyors and Quality Coach & QMR



**200** Surveyors

**132** Quality Coaches (QC)

**306** QMR (Quality Management Representation)

**DEVELOP** — Build capability and expertise → **CONNECT** — Create networks and collaboration → **EMPOWER** — Support and share knowledge → **MULTIPLY** — Enable others to lead and improve

Regional collaboration platforms for quality and safety, bringing together local strengths with national alignment.

**Local partnership • National alignment**

## PEOPLE BECOME THE INFRASTRUCTURE FOR QUALITY

Distributed Quality Capability Across Thailand

# Lesson Learned from Thailand: Develop HA Standards

## Partnership Evolves into Co-production

From working together → to shaping together → to better health for all

*“Partnership is strongest when people move from participants to co-owners.”*




### Our Partnership Network

- **Hospitals**
- **Surveyors, Quality coach & QMR**
- **Stakeholders**
- **Policy makers, Experts, Provider, Purchaser**
- **People, Public (Patients, Families and Communities)**

### Co-production of Hospital and Healthcare Standards

1. **Shared Goals**
   - Set common goals for safe, high-quality and people-centered health care
   - Build mutual understanding among all stakeholders
2. **Co-design**
   - Co-create standards and tools with inputs from all stakeholders
   - Use evidence, patient experience, and practical insights
3. **Implement and Evaluate**
   - Put standards into practice together
   - Monitor and evaluate with real-world data and multi-perspectives
4. **Feedback and Response**
   - Listen to feedback from patients, families, communities and professionals
   - Use multiple channels (onsite, online, surveys)
5. **Co-re-design**
   - Refine and improve standards based on feedback and lessons learned
   - Continue the cycle for better and more relevant standards

**Continuous Collaboration and Learning**

### Results & Impact

- **More relevant and practical standards** reflecting real needs of hospitals and people
- **Greater ownership and commitment** from all stakeholders
- **Better implementation and quality improvement** in daily practice
- **Improved patient and people experience** safer, more responsive and more equitable care
- **Sustainable health system** through shared responsibility

# Partnership Evolves into Co-production: 3P Safety Hospital Program in Action

## Thailand's 3P Safety Hospital Program: A catalyst for bottom-up policy

| 1997–present | 2013–2015 | 2016 | 2017–2018 | 2018–2020 | 2022–present |
|---|---|---|---|---|---|
| Integrated quality and safety in hospital development for Hospital Accreditation | Engagement for Patient Safety program | Country self-assessment for Patient Safety Announcement National Policy | National Committee National Strategy and National Goals | 2P Safety Hospital Project and World Patient Safety Day | Integrated in Hospital standards and criteria for accreditation |
|  |  |  |  |  |  |

## Patient Safety in Action in Thailand with the WHO Global Patient Safety Action Plan2021-2030

| 2019 | 2020 | 2021 | 2022 | 2023 | 2024 |
|---|---|---|---|---|---|
| ROV of SEAR country for supporting agenda12.5 Global Action on Patient Safety, WHA 72nd | The 1st World Patient Safety Day and The 3rd Thailand Patient and Personnel Safety Day | WHO announced Global Patient Safety Action Plan 2021-2030 | Matching Global Action on Patient Safety with the National Patient and Personnel Safety Strategies | Self-assessment to Identify GAP as area for improvement between 2P Safety Strategy and GPSA | Announced 3P Safety policy and strategy and GPSA Report |
|  |  |  |  |  |  |

"Born from national partnerships, strengthened by global collaboration, and translated into collective action for safer care."

# WHY 3P SAFETY

## Can patients be truly safe, if the people who care for them, and the communities around them, are not safe?

**2002 — Global Agenda**

Patient Safety becomes a global agenda (WHO World Health Assembly Resolution)



**2002–2007 — Building the Foundation**

Thailand develops Patient Safety in parallel with quality improvement and hospital accreditation.



**2008 — Thailand Patient Safety Goals SIMPLE**

From lessons learned from accreditation surveys, Thailand defined national priorities: SIMPLE.




**2010–2015 — Moving from Goals to Practice**

- Develop tools, training and guidance
- Promote learning networks, measurement and continuous improvement



**2016 — A Turning Point**

- Many lawsuits and complaints related to care
- Prosonne feel unsafe
- Workers harmed from infection, accidents, violence and workload

"Patients cannot be safe unless the people who care for them are also safe."

**2018 — 2P Safety Policy**

Thailand announces Patient and Personnel Safety Policy (2P Safety) and establishes National 2P Safety Goals.

**2020–2022 — COVID-19 Pandemic**

- Safety must extend beyond hospitals
- Impact on people, communities and the whole health system
- Sustainability of healthcare system



**2023–2024 — 3P Safety Policy**

Thailand expands to **Patient, Personnel and People Safety Policy (3P Safety)** and establishes **National 3P Safety Goals (2024).**



### Harm to Patients

- Adverse events from care
- Infections
- Medication & procedure errors
- Emergency & critical incidents

### Impact on Healthcare Workers

- Many lawsuits & complaints
- Psychological stress and fear
- Loss of confidence
- Feeling unsafe at work

### Harm to Healthcare Workers

- Infection from patient care
- Accidents during transportation
- Violence and workplace threats
- Burnout and mental health

**One health service. Three safety lenses.**

### ONE SIMPLE ARCHITECTURE – EXPANDING THE BOUNDARY OF SAFETY



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# WHAT 3P SAFETY

Patient, Personnel, People: Different Partners.

One Shared Purpose: 3P Safety

## The National 3P Safety Goals

### Patient Safety
The absence of avoidable harm to a patient during the process of health care.

### Personnel Safety
The absence of avoidable harm to a personnel during the process of work.

### People Safety
The absence of avoidable harm to people from healthcare system and health system.




## Developed SIMPLE Guides to Goals with Experts

### ONE SIMPLE ARCHITECTURE
Common framework across Patient, Personnel and People Safety

Hospitals select priority topics, implement, monitor and improve to achieve safety goals.

## Integrated to HA standards







### Patient Safety Goals SIMPLE (2008)
S: Safe Surgery
I: Infection Control
M: Medication & Blood
P: Process of Care
L: Line, Tube & Lab
E: Emergency Response




### Personnel Safety Goals SIMPLE (2018)
S: Security & Privacy
I: Infection & Exposure
M: Mental Health & Mediation
P: Process of Work
L: Lane (Ambulance) & Legal
E: Environment & Working Conditions




### People Safety Goals SIMPLE (2024)
S: Social Responsibility
I: Information System Mgt.
M: Medication & Product Safety
P: Promotion of Health & Safety
L: Legislation/Rules & Lifestyle Medicine
E: Emergency Response

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# 3P Safety: Partnership in Action

## INTEGRATED FOR IMPACT

**Global Agenda (WHO)**
Patient Safety Action Plan (2002, 2019, 2021)

**National Policy**
2P Safety Policy (2016)
3P Safety Policy (2023)

**Safety Goals & Practical Guides**
SIMPLE Goals & Guides for 3P Safety

**Hospital Action**
Implementation in hospitals & healthcare organizations

**HA Standards & Accreditation**
Integrated standards for quality & safety

**Learning System for Sustainability**
NRLS, CoPs, RCA, Learning & Continuous Improvement




Direct alignment with the WHO Global Patient Safety Action Plan 2021-2030.

**Access**
UHC guarantees the right to care. Opens the door.

**Quality**
Ensures care is clinically safe and person-centered. Creates value.

**Safety**
Drives public utilization and compliance. Builds trust & economic productivity.

## The Evolution of Safety in Thailand

**"2P Safety Hospitals" as a platform for implementation (2018-present) and "World Patient Safety Day" for sharing and recognition (2019-present)**

**65.52% from 1,491 hospitals**

**2P Safety Hospitals**

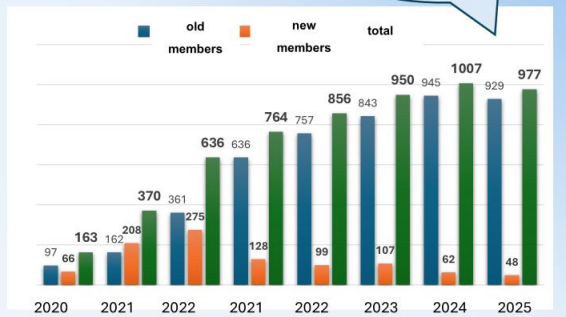
- 1,014 hospitals
- Leader announced **2P Safety policy** and **2P safety Goals** in hospitals
- **HA Standards** as a tool for developing
- **RM** in hospital and report incident to **NRLS**
- Platform for **RCA** with experts
- **Safety Culture** survey
- Sharing and Learning in **CoPs**
- **Patient experience** program
- **World Patient Safety Day**
- 2P Safety Tech produced 36 **safety innovations**

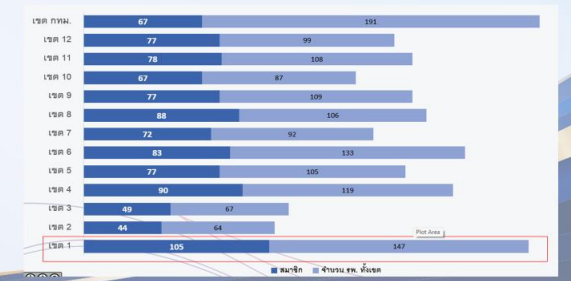










# The 3P Safety operating model

**Leadership • Patients • Workforce • Community**

**National Policy & Goals**




**Hospital Implementation**

**HA Standards & Accreditation**

**Measurement & Reporting**

**Learning & Improvement Community of Practice**

**HAI synthesis: 3P Safety Membership + HA Standards + National Quality Tools.**



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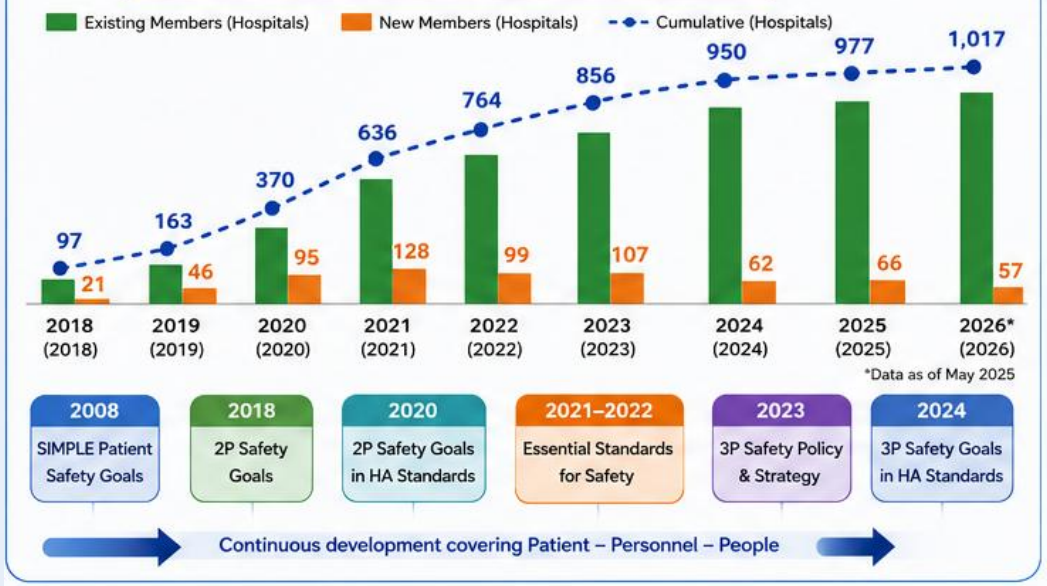
# Scaling 3P Safety Hospitals: Scale is already national, but participation is not the endpoint

## GROWTH OF 3P SAFETY HOSPITALS MEMBERSHIP




**Increase number of incidents report**

## INCIDENT TREND




## Developed Platform for Sharing and Learning online and on-site



## EVIDENCE OF PROGRESS (2018–2025)

**1,018** hospitals reporting safety data

Severe incidents decreased **9.96% → 5.3%**

MTTC improved **40.82 → 19.21 days**

Public trust in HA hospitals **87.25%**

**The reform was not reporting alone – it was turning reporting into learning, and learning into accreditation standards.**

1 **DATA & ANALYSIS** What happened? → 2 **LEARNING & INSIGHTS** What did we learn? → 3 **SYSTEM DESIGN** How do we use data to design better systems? → 4 **SYSTEM CHANGE** What change do we see?

# Lesson Learn from Thailand: People Are Partners in Creating Quality

## FROM CARE FOR PEOPLE → TO CARE WITH PEOPLE

### STANDARDS
Help define what good care should look like.



### VOICE
Create channels for what matters to people.





**PATIENTS • FAMILIES • COMMUNITIES**

### IMPROVEMENT
Contribute lived experience to quality improvement.



### EXPERIENCE
Turn patient experience into improvement intelligence.



> “People are not only beneficiaries of quality. They are partners in creating it.”

# Our Journey Started with Listening

From Patient Voice to Partnership

**2014 — Patients for Patient Safety Thailand**

Connecting with the WHO global movement; patients recognized as partners, not recipients.

**Patients & Families as Partners**

Formal roles in care teams and in hospital governance; voice embedded in accreditation thinking.

**Patient Safety Guidance Co-Produced**

Public and patient groups co-write national safety guidance — from consultation to co-authorship.

**Patient Experience Program (PEP)**

Structured PREMs collected nationally; patient voice informs hospital improvement cycles.

**Patient Voice → National Quality & Safety**

Individual experience shapes policy, standards, and system-wide learning.

The evolution is clear:

**Voice ⟶ Partnership ⟶ System Change.**

## Patients for Patient Safety Thailand to Patients and Family Partners



> "Patients are not only recipients of safety. They are producers of safety."

## Co-Production Happens at Three Levels

From care *for* people ⟶ care *with* people




Thailand's journey reflects a fundamental shift, from asking patients how care felt, to inviting them to shape how care is delivered.

# Level 1: The Person as a Care Partner

## "Care WITH me"

- Shared decision-making
- Patient + family as care team
- Information for safe self-care
- Respect, empathy & dignity

**Embedded in HA Standards for Routine Practice in All Hospitals**




### Accreditation as the System's DNA

**Continuous Quality Improvement & Hospital Accreditation**

**Part I-3 (Patient / Customer)**

Listen ↓ Understand ↓ Design

Hospitals must systematically use patient needs and expectations to design services.

**Part III (Patient Care Process)**

Partner ↓ Decide ↓ Care Together

Patients and families must be integrated as active partners in shared decision-making during clinical care.

**Accreditation turns patient partnership from a temporary project into everyday, mandatory practice.**

# Level 2: The Hospital System

## 1 Patient Experience Program (PEP): Thailand

Turning Patient Voice into Better Care

The Healthcare Accreditation Institute (Public Organization)



**Patient Voice**
Patients and families share their real experiences



**Digital Feedback**
Easy and accessible via QR code



**Data & Insights**
Real-time results for hospitals



**Learning**
Understand strengths and areas for improvement



**Improvement**
Better, safer and more people-centered care

### WHAT DO WE LISTEN TO?

17 experience-based questions across the care journey

- **Listening & Communication** — Were patients listened to? Were their questions clearly answered?
- **Information & Understanding** — Did they receive clear information about treatment, medication and follow-up?
- **Participation in Care** — Were patients and families involved in decisions about their care?
- **Compassion & Equity** — Did they feel cared for, supported and treated equally?
- **Safety & Self-Care** — Did they receive enough information to safely care for themselves?
- **Overall Experience & Engagement** — Were they satisfied with their overall experience, and would they recommend the hospital?

### Highest Scores in 2026

| | | |
|---|---|---|
| 1 | Doctors give careful physical examinations to support accurate diagnosis. | 4.63 |
| 2 | Care is provided equally and without discrimination. | 4.62 |
| 3 | Overall satisfaction with the hospital services. | 4.62 |
| 3 | Receiving clear and adequate information about symptoms, warning signs and when to return for medical care. | 4.62 |

### PEP IN ACTION (2026)

- **741** Hospitals registered for PEP
- **587** Hospitals conducted patient experience surveys
- **57.6%** of HAI member hospitals conducted surveys

Overall average patient experience score (5-point scale): 4.51 (2024) → 4.57 (2025) → 4.60 (2026)

## 2 PUBLIC VOICE FOR BETTER HEALTHCARE

"Bok Khun" — Turning People's Voices into Quality Improvement

### 1 ENGAGE
Everyone Has a Voice

Patients, families, citizens and community health volunteers can share their real experiences of healthcare services, making the public an active partner in quality and safety.



Patients and families · Citizens · Community health volunteers · Healthcare personnel

### 2 LISTEN
Four Voices That Matter

- **Appreciate** (Positive experiences)
- **Tell Us** (Problems/Concerns)
- **Watch** (Unsafe situations/Risks)
- **Encourage** (Morale for healthcare workers)




### 3 CONNECT
Easy Access for Everyone

"Bok Khun" is a user-friendly mobile application that enables people to send feedback on their healthcare experiences. The feedback is directed to relevant organizations while protecting the identity of the reporter.

Download Bok Khun App — App Store · Google Play

### 4 TURN VOICE INTO DATA
Nationwide Participation

- **15,492** People entered the reporting system
- **7,028** Completed reports

Types of feedback (among 7,028 reports)

| Something to Appreciate | Something to Share | Something to Watch | Something to Improve |
|---|---|---|---|
| 28.47% | 16.65% | 13.88% | 41.0% |

### 5 CLOSE THE LOOP
From Voice to Better Care

- **People's Voice** — Real experiences, suggestions and safety concerns
- **Data** — Analyze and identify insights
- **Learning** — Understand what matters to people and recognize good practice
- **Improvement** — Take action to improve care processes and address safety issues
- **Safer & Better Care** — More people-centered, compassionate and high-quality healthcare

**"Different channels, one learning system."**

# Level 3: Shaping the National System

Co-production scales up.

At the national level, patient advocates and public groups actively participate in setting safety priorities, developing policies, and driving nationwide health literacy campaigns.
The public shapes the system they rely on.





# WHAT MAKES PARTNERSHIP EFFECTIVE AND SUSTAINABLE?




> Leadership is not the centre of partnership. Leadership creates the conditions for partnership to work.

# WHAT WE LEARNED THE HARD WAY



**NETWORK** ≠ **PARTNERSHIP**

Connection without ownership becomes activity.



**PARTICIPATION** ≠ **CO-PRODUCTION**

Being invited does not mean sharing decisions.



**POLICY** ≠ **SUSTAINABILITY**

Direction without capability and learning does not sustain change.

> **Partnership requires more than bringing people together.**

# FROM PARTNERSHIP TO COLLECTIVE IMPACT

No single organization can build a safer, better health system alone.

**ORGANIZATION**
People working together for change



**THAILAND**
A national movement with local solutions



**ASIA**
Sharing and learning across diverse systems



**GLOBAL COMMUNITY**
Connecting for a safer, better future



QUALITY

SAFETY

TRUST

**Together, partnership turns individual strengths into collective impact.**



# THANK YOU