Sufficiency in Thai healthcare

Thep Himathongkam, MD, FACP, FACE

and

Tanya Vannapruegs, MBA, MPH

The healthcare system for ordinary Thais faces failure unless drastic change happens soon. Although more and more money is being spent on healthcare, increasing numbers of people living in Thailand are experiencing poor healthcare services. A large shortage of medical personnel exists in the public sector, where existing resources are not used efficiently; rural areas suffer from a lack of community doctors and other services; and increasingly, young doctors are turning away from family and community medicine towards speciality medicine. In the private sector, healthcare has changed from a humanised to a commercial service, with a growing focus on medical tourism. This threat to the sustainability of Thai healthcare is in part attributable to a departure from the Sufficiency Economy Philosophy's middle path.

This chapter describes the 30-year experience of a small private diabetes hospital in Bangkok that follows the Sufficiency Economy Philosophy, beginning with embracing a set of virtues and working extensively with up-to-date knowledge. The hospital achieves its outcomes by applying the sufficiency mindset, built around moderation, reasonableness and prudence. The hospital's vision is to improve the lives of people suffering from diabetes in Thailand in particular, with an emphasis on multidisciplinary medical teams engaged in prevention rather than just treatment. The chapter concludes with an analysis of the sustainable leadership behaviours adopted at the hospital.

Introduction

On the initiative of the Royal Family, the Thai healthcare system was westernised with the objective of improving the health of the entire Thai population, thus bringing them a better quality of life.

However, practice and philosophy have since moved away from this lofty goal, and the public healthcare system is now on the verge of collapse for many reasons. A shortage and maldistribution of health personnel, together with skilled health professionals shifting from public to private hospitals and from rural to urban areas, have contributed to inequalities in health outcomes between rich and poor (Kanchanachitra et al., 2011; Pachanee & Wibulpolprasert, 2006). Healthcare has become a commercial product, unaffordable for many (Russell, 2006). One reason is that private hospitals largely target well-off Thais and foreign clients (Cohen, 2008), thus widening health-related inequality and treatment choices between rich and poor (Pannarunothai & Mills, 1997). The private sector offers doctors higher salaries and better working conditions, and about 60–70 per cent of public physicians supplement their income by working in private practices (Prakongsai et al., 2003). This all contributes to a two-tiered health system for rich and poor (Nittayaramphong & Tangcharoensathien, 1994).

The first section summarises the history of the Thai healthcare system, displaying the thinking and practices of the Thai royal family in their quest to improve the health of Thais. The second section details factors that changed the system to reach the position in which it finds itself today. The third section describes a hospital with policies and practices inspired by the Sufficiency Economy Philosophy. The final section discusses how Thailand could move forward to achieve better, more sustainable health and enable a good life for its people.

History of Thai healthcare

The vision and dedication of several Royal Family members influenced much of Thailand's development, including its healthcare. Western medicine started in Thailand with missionary Dr Dan Beach Bradley in 1835, during the reign of King Rama III. Bradley befriended Prince Mongkut (later King Rama IV), and it was this Royal connection that introduced Western medical knowledge. In 1870, King Rama V promulgated the first sanitation law. After visiting Singapore in 1886, King Rama V established the first hospital in Thailand, Siriraj Hospital, to teach medicine and implement widespread smallpox inoculations.

Medical personnel were educated at the Phaetayakorn School, which opened with a three-year medical course in 1889. By 1903, the curriculum included both Western and traditional Thai medicine, with natural sciences being added in 1913. However, in 1915, teaching of traditional Thai medicine ceased. 1921 marked the beginning of a new era for medical education in Thailand when Prince Mahidol sought help from the Rockefeller Foundation to help modernise Siriraj Medical School. The Rockefellers sent medical and nursing experts to assist, and funded numerous scholarships for Thais to study medicine in the United States and then return to teach at the medical college (Becker, 2013).

Turning points and their consequences

Several events forced healthcare in Thailand to deviate from its initial moderate path. First, the country lost many doctors to the United States during the Vietnam War (1955–1975). In 1965, half of the new medical graduates emigrated, mainly to the United States (140 out of 276 medical graduates). Thus Thailand experienced a great shortage of physicians, with fewer than 300 doctors working in the poorer rural areas at the time (Sawetajinda, 1997). Approximately 1500 Thai doctors stayed in the United States (Wibulpolprasert & Pengpaiboon, 2003), mainly because Thailand lacked the infrastructure to support their chosen speciality areas. To counter the lack of doctors in

rural areas, the government mandated three years' compulsory service in rural areas for all medical graduates.

Another problem is specialisation. Like the American system, Thailand's medical training program has focused mainly on specialty training. Between 1964 and 2014, more than half of Thai doctors were specialists (Medical Council of Thailand, 2014). Specialty training is attractive because specialists are paid more highly than general practitioners or family doctors.

Parallel to this, in medical schools, faculty recruitment and training emphasised academic ability, neglecting the human side of medicine. Medical schools thus emphasised academic rigor, but downplayed clinical practice, especially in local communities with their vastly different circumstances from those inside a medical school. The medical curriculum, designed by faculty who lacked real-world Thai experience, emphasised tertiary care and advanced knowledge, rather than other tenets of sufficiency thinking—namely virtue (for example, serving the health needs of all Thais) and reasonableness (for example, keeping costs to poor Thais low).

Private healthcare services have also affected the sector negatively. Historically, the government or missionaries operated medical services in Thailand with a focus purely on health matters, rather than on providing 'services' such as cosmetic surgery. With a growing middle class, demand for services beyond treatment of diseases grew, a gap that private hospitals arose to fill in the 1970s. Early private hospitals provided mainly hospitality services similar to hotels, and relied on government personnel and equipment for medical treatment. However, as business expanded and became popular, private hospitals hired their own full-time specialists and invested in expensive medical equipment. This increased job opportunities for specialists who commanded higher incomes, thereby increasing costs. More than 300 senior specialists from medical schools resigned to join private hospitals during 2005–2006 alone (Kanchanachitra et al., 2011).

Public medical schools were forced to manage their own finances, rather than being funded solely by the government. To generate funds, many set up luxurious private services and charged premium prices comparable to those of private hospitals. Private

hospitals resented this 'unfair' competition from medical schools that could usually attract large donations and still qualify for some government funding. Medical staff salaries continued to rise astronomically. For example, the majority of young doctors received 40,000–60,000 baht a month, compared with a base salary of 15,000 baht for average entry-level workers (Pagaiya et al., 2011).

This resulted in Thailand having difficulty staffing the public sector, with the flow-on effect being reduced health services in rural areas for poor and near-poor populations (Kanchanachitra et al., 2011). According to the Medical Council of Thailand (2014), about 50 per cent of physicians cluster in Bangkok, leaving the other 77 provinces and rural areas short of medical personnel.

Thailand's increasing popularity for medical tourism (Cohen, 2008) has added to the woes of the healthcare system. Numbers increased 16 per cent annually from 500,000 tourists in 2001 to 1.3 million in 2007, generating US$1.3 billion in 2007 and an estimated US$4.3 billion in 2012 (Kanchanachitra et al., 2011). Relatively low labour costs make high-quality healthcare services comparatively cheap. For example, international patients can save up to 90 per cent of the costs in some OECD countries (Woodman, 2007). Moreover, Thailand is an attractive tourist destination and empathetic care is ingrained in Thai culture, making Thailand very attractive for foreigners seeking medical care. Medical tourism accounts for 0.4 per cent of Thailand's gross domestic product, but has drawn health professionals away from the local private and public sectors (NaRanong & NaRanong, 2011).

Consequences

Some of the consequences of the above challenges are described in this section.

Higher prevalence of health problems

Technology and economic development have enabled Thai life expectancy to rise to about 79 years for females and 71 years for males. However, people's overall quality of life and productivity has deteriorated, with an increase in age-related (Wongpanarak &

Chaleoykitti, 2014) and lifestyle-related health problems—changing from a slow to a fast pace, from active to sedentary, and eating well to eating unhealthily. Thus obesity increased by about 60 per cent between 1991 and 2004 (Aekplakorn & Mo-Suwan, 2009). Both weight gain and age are key risk factors for several chronic diseases, which cause low quality of life and disabilities, and incur care expenses (Aekplakorn et al., 2014). In 2000, the number of Thais living with diabetes was approximately 1.5 million. This number rose to 3.2 million in 2013, and is estimated to reach 4.3 million in 2035 (Novo Nordisk, 2013). In other words, current health problems are due as much to societal norms as to germs or diseases, and so have to be addressed from both medical and societal perspectives. Research has demonstrated that changes in lifestyle can lower the risk of developing diabetes, hypertension, cardiovascular diseases and many other conditions (Pan et al., 1997; Ramachandran et al., 2006; Diabetes Prevention Program Research Group, 2002; Tuomilehto et al., 2001). The focus therefore needs to be on prevention rather than on treatment. Sustainable medicine needs to maintain the quality of life while extending it. However, there are problems in the medical system.

The patient–doctor relationship has deteriorated

The neglect of the human side of medicine—largely due to an under-supply of doctors and the increasing demands of keeping up with new medical knowledge—has seen a deterioration in patient–doctor relationships. Good communication is crucial in creating a strong doctor–patient relationship (Buranapanitkit, Uakritdathikarn & Songwathana, 2005), and is especially critical for vulnerable patients who rely more on the physician's competence, skills and goodwill. Without a trusting relationship, doctors are unable to offer reassurance and satisfactory explanations. A lack of trust can easily lead to harsh words and even lawsuits against doctors, who may protect themselves by limiting their scope of practice and refusing to carry out even simple surgery or other procedures associated with potential risk. Without a good patient–doctor relationship, medical practitioners gain less enjoyment from their work and are stressed by it, especially when

they feel they have to protect themselves. This results in doctors demanding higher pay, which generally worsens doctor–patient relationships even more.

Lack of community doctors

Medical students are trained in settings equipped with the highest technology, which is totally inappropriate for community settings where a doctor needs to be able to provide basic care for all problems, and there may be no specialists to whom patients can be referred. Clearly, Thailand today lacks doctors who understand and are part of a community. Medical students required to staff community hospitals—mostly in rural areas—for three years after graduation face a very difficult time without the sophisticated technology with which they were trained, and many look forward to returning home to become specialists. This results in a high turnover of doctors in rural areas. For example, doctor turnover in the public sector increased sharply from 8 per cent in 1994 to 61 per cent in 1996 (Pagaiya & Noree, 2009), with more than two-thirds of young doctors leaving the public service to become specialists in 2003 (Pagaiya & Noree, 2009). Of all the doctors leaving rural public practices, 52.3 per cent joined private hospitals; 83 per cent of specialists in rural public hospitals moved to private hospitals (Thammarangsri, 2005). Correspondingly, the proportion of doctors working in private facilities increased from 19 to 22 per cent between 1999 and 2005 (Pagaiya & Noree, 2009).

Lack of family medicine

Family medicine involves caring for the patient as a whole, focusing not only on diseases or symptoms, but on all factors that can affect an individual's health, such family relationships and environmental, social or financial considerations. Family doctors can be either general practitioners or specialists, but should be the first person to whom patients turn for health-related problems. Instead, many patients demand to see a specialist, which often fails to solve the problem and thus wastes medical resources. For example, one person with heart palpitations decided that she had a heart problem and consulted a cardiologist who, after a thorough and very expensive investigation, found

nothing wrong. This left the problem unsolved, probably increasing her anxiety. A friend then suggested to the patient that thyroid hormone imbalance could cause palpitations, so the patient rushed off to see an endocrinologist, who conducted a thorough, expensive hormone check and found nothing wrong. Fortunately, the endocrinologist followed the principles of family medicine by spending a few more minutes getting to know the patient better, and readily found that the cause of the palpitations was menopausal, which could be treated by simple, inexpensive hormone replacement therapy.

More expensive healthcare

Increases in the cost of healthcare in Thailand are driven by a growth in the number of people suffering from chronic diseases that require lifelong care, the widespread use of advanced technology and specialists as discussed above, and the business structure of private hospitals. Most private hospitals in Thailand are now listed on the stock market and are under pressure to continually increase their profits. This requires expanding the number of customers or increasing sales per patient, driving private hospitals into fierce competition that involves slick and expensive marketing. Sometimes, management pressures doctors to order often-unnecessary diagnostic tests or treatment on under-utilised high-tech equipment. Business has overshadowed medical professionals' freedom to make decisions based on their medical judgement, and has driven healthcare costs up. Estimates suggest that private hospitals charge about six times more for their services than public hospitals (*Daily News*, 2015).

Low incentive to work on prevention

The status and financial rewards of practitioners derive from treatment, with no incentive to focus on prevention. Pressures of treating the sick mean that medical personnel—particularly in the private sector—have no time to consider, or willingness to approach, preventive work; furthermore, their exposure to ideas of prevention in medical schools is limited. In government agencies, politics often intervene: improvements in treatment are easier to sell to the public than preventive measures. Thailand implemented universal health insurance in 2002, and escalating costs have

forced the government to spend more on prevention. However, prevention of chronic diseases, which involves modifying people's behaviours and environments, is still in its infancy in Thailand.

All the above factors have resulted in an inappropriate, expensive, inequitable healthcare system with deterioration in doctor-patient relationships. In practice, all this has shifted today's healthcare system a long way from the noble goals under the sufficiency thinking of the founders.

Theptarin Hospital

Virtually all the big players in Thailand's healthcare system seem to ignore many aspects of the Sufficiency Economy Philosophy, from forming virtuous objectives to a sufficiency mindset around moderation, reasonableness and prudence. They ignore the social consequences of many of their actions in the pursuit of short-term profits. However, one very small private hospital has done otherwise. Perhaps this case study can inspire the bigger players in Thailand's healthcare system to consider adopting sufficiency principles.

Following the dream

The founder and CEO of Theptarin Hospital, Professor Thep Himathongkam, trained as an endocrinologist in the United States. In 1974, when Thailand was losing freshly trained doctors during the Vietnam War, he returned home to realise his dream of creating a multidisciplinary team to work on diabetes. This team would focus on patient education and responsibility for self-care, as opposed to just providing treatment with all responsibility resting on the medical personnel. In the process of educating the patients at Theptarin Hospital, doctors work in multidisciplinary teams such as with dieticians, diabetes educators, foot specialists and exercise specialists.

Disappointed to discover that his dream could never be realised within the bureaucracy of a government medical school, Thep Himathongkam established his own

hospital in 1985 and set up Thailand's first diabetes care team. The dream had started to come true. Despite its small size and after enduring some financial and management turbulence, Theptarin Hospital has contributed several innovations and ideas that could potentially change the whole of Thailand's healthcare system. Building on a set of virtues and appropriate knowledge, Sufficiency Economy Philosophy principles have continuously been embedded into the organisation's culture and practices.

Start-up challenges

Start-up challenges were immense for this unconventional hospital. Normally a private organisation addresses market demand, but Theptarin Hospital did the opposite. The product Theptarin wanted to introduce—patient education and self-care—was not what consumers wanted at the time; instead, patients wanted treatment, believing that it was the doctor's job to treat their diabetes. However, as an endocrinologist, Thep Himathongkam knew that patient education would be extremely beneficial.

At first, Theptarin needed to train a team of diabetes educators and dieticians, and to devise strategies to induce patients to engage in self-care. Many professions essential to treating diabetes were unknown in Thailand when Theptarin was established. No training was available for diabetes educators and dieticians (the profession that specialises in using diet as a supplement or even substitute for medicine). Theptarin staff needed to be educated in-house. Thep Himathongkam took on many other quests, such as pioneering foot care, and opening Thailand's first foot clinic at Theptarin Hospital. Chronic foot wounds and ulcers leading to foot amputation have always been complications of diabetes that reduce patients' quality of life, but doctors had previously not been trained to attend to foot care, nor had patients. Furthermore, feet are considered low and dirty in Thai culture. Thais usually feel uncomfortable when others—especially someone respected, such as doctors or nurses—touch their feet. The foot clinics' purpose was not only to save patients' limbs but, more importantly, to provide knowledge and self-care instruction to prevent foot wounds from occurring in the first place. Foot care is

still not widely practised, but its importance is now well recognised and foot care training for medical personnel is currently in high demand.

Today, several Thai universities offer courses in dietetics, with Theptarin playing a major supporting role in teaching and offering practical training for 50 or more students. A similar story applies to podiatry, whose value the government now recognises and so has facilitated recruitment of participants and partially supports training.

Ongoing successes

Despite early struggles in recruiting staff, convincing colleagues to focus on prevention, and attracting patients willing to be educated about diet and self-care, today the multidisciplinary team approach is very well understood. Increasingly, patients accept and request this kind of care, with many taking responsibility for their own healthcare. Some of the successes viewed through the sufficiency lens are described below.

Creating and applying knowledge

Theptarin Hospital conducts ongoing research into diabetes and systematically analyses published findings. Its work is based on appropriate use of scientific knowledge as the Sufficiency Economy Philosophy suggests. However, Theptarin's small size allows flexibility in implementing academic findings clinically, benefiting patients sooner. For example, more than ten years ago research showed that testing blood glucose *after* meals can help detect diabetes risk much sooner than testing it while fasting. However, checking blood glucose after fasting is still extremely common, even though world authorities have been recommending the non-fasting measure since 2011 (International Diabetes Federation, 2011). Non-fasting measures were introduced at Theptarin almost immediately, a decade ago, providing patients with early treatment, lower risk of complications or, if diagnosed early enough, delay in the onset of the disease.

Sharing knowledge

Theptarin shares its model of how diabetes care should be handled—that is, through patient education for self-care and using a team approach—with national and

international groups. It collaborates with academic and professional institutions and universities to increase the number of medical personnel who understand diabetes care (who might also become future team members). Each year, the hospital welcomes several groups of visitors, mainly medical personnel and even some management teams. It is a World Diabetes Foundation Centre of Excellence, and is responsible for hosting peers from several developing countries.

Innovation

Theptarin has promoted lifestyle modification to prevent diabetes for over a decade. Its Lifestyle Building, opened in 2005, houses services related to disease prevention through lifestyle modification. One entire floor is dedicated to diet, another to exercise and spa, and a third to training staff. The absence of in-patient beds in this expansion signals that its purpose is prevention, not treatment—despite the fact that in-patient services are the biggest source of a hospital's income. On entering the Lifestyle Building, one sees many messages to eat well, move more and be happy. Stair-walking is encouraged by turning this otherwise unpleasant activity into an educational 'Diabetes Escape'. Shifting from treatment to prevention started with developing a preventive mindset and culture in staff. Now Theptarin earns a modest income from lifestyle services by becoming a health promoter—for example, by serving firms with health-promotion policies for employees or clients.

Collaborating with stakeholders

Theptarin collaborates with many stakeholders at home and abroad, some of which have already been mentioned. The hospital has become a respected expert adviser to several government departments and committees, overcoming a strongly ingrained ideological barrier between the government and the private sector. The attitude that a private organisation could not contribute to raising the standard of diabetes care has completely changed over the past twenty years. The hospital also collaborates with competitors. Instead of having to invest its small budget in high-tech equipment to compete with other hospitals, Theptarin opts to cooperate, and sends patients who require high technology

to other facilities. Unlike other hospitals, which fear losing patients if they send them elsewhere, the chance of losing patients is reduced by building good relationships and trust through Theptarin's primary physicians.

Sustainable leadership practices

The ultimate success of any organisation is surviving, while being able to hold true to its original purpose. Thirty years have passed, and Theptarin has achieved both. Theptarin has now entered its second generation. The organisation has pioneered several practices contrary to the norm; however, everything has focused on benefits for patients or the healthcare system as a whole. The reason for adopting a private business model was that it provided Theptarin with the freedom to pioneer new medical approaches, be philanthropic and share its knowledge.

An analysis of Theptarin's management and leadership practices shows that they accord fully with Avery and Bergsteiner's (2010) Rhineland leadership philosophy, more recently referred to as 'honeybee' leadership. All 23 practices displayed in Table 9.1, with illustrative behaviours, align with honeybee leadership, which are consistent with the action principles of the Sufficiency Economy Philosophy model.

Table 9.1: Theptarin's sustainable leadership behaviours

Honeybee practices for sustainable leadership	Behaviours at Theptarin Hospital
Developing people, skilled workforce: strong	Learning and developing is core at Theptarin, which started with the need to train staff in-house on new approaches and to train others; educate patients about self-care; and share learnings with governments and experts from Thailand and neighbouring countries. Theptarin initiated training for several hitherto unknown professions in Thailand, such as diabetes educator, dietician and foot-care specialist. Theptarin also continually adopts new medical knowledge.

Amicable labour relations: strong	Long-term 'happy' staff tenure, people returning after they have left, good teamwork and valuing staff provide evidence of positive relationships between management and workers.
Retaining staff: strong	Theptarin recognises that diabetes treatment and prevention services can only stem from long years of experience working in and understanding the organisation's culture. Approximately 20 per cent of Theptarin's staff has been with the organisation for longer than twenty years.
Internal succession planning: strong	Wherever possible, Theptarin promotes from within.
Valuing people: strong	Veteran paramedical team members who weathered the difficult period of introducing the teamwork approach to patients and Thailand generally are constantly recognised. Management recognises that no one is perfect and tries to look at each person's special abilities, then use them; at the same time, it invests time and patience in improving the person's weaknesses.
Top team leadership: strong	The focus at Theptarin is on team care for patients, and the team focus extends to leadership at the top.
Ethical behaviour: an explicit value	Theptarin adheres to professional ethics even when this goes against the interests of running a private business. Although initially patients did not seek education, Theptarin staff worked for patients' benefit by getting them to understand the importance of self-care.
Long-term perspective: yes	Theptarin invests time and effort in popularising several concepts, the benefits of which will only be seen in the distant future. This includes promoting previously unknown professions, offering a primary physician system and promoting prevention and behaviour modification.
Uncertainty and change: considered process	Since Theptarin continually challenges mainstream approaches, change is not managed but is part of the program: moving from secondary prevention to primary prevention, and from medical services to public health work; shifting the focus from individuals to large groups, and from those who come for help to those who are not yet seeking help; and embracing neglected disciplines such as podiatry and dietetics.
Independence from outside interference: strong	Theptarin was set up as a privately run hospital to enjoy maximum independence in its charter, work practices and medical approach. It took a fiercely independent course from its inception—for example, against the prevailing medical establishment concerned solely with treatment, instead focusing on foot care, diet and exercise as part of diabetes control and prevention.

Environmental responsibility: yes	Theptarin engages in several electricity and water-saving programs, and follows strict guidelines in infectious waste disposal.
Social responsibility: strong	Theptarin devotes its thoughts and energy to taking on a philanthropic role, linking government, private enterprises, universities and professional associations in sharing knowledge and resources, and in working towards a common goal. Its entire mission is socially oriented.
Stakeholders: broad focus	Theptarin is a private company with about 400 shareholders. The Himathongkam family is the largest shareholder, enabling continuity of the founder's vision. The hospital has a strong focus on other stakeholders beyond investors, as shown by its not paying out dividends for 24 years, focusing on patient needs and being concerned with the health problems of the broader Thai society.
Shared vision and values: strong	All employees are expected to share the organisation's dream of improving diabetes care. The organisation's core values are written as ETHICS (Excellence, Teamwork, Hospitality, Integrity, Continuous improvement and Social responsibility).
Devolved, consensual decision making: strong	Teams make decisions about patient care; final decisions are made with the patient and their family.
Self-management: strong	Not only staff, but also patients are expected to be self-managing.
Team orientation: strong	Theptarin revolves around team care, making teamwork a strong practice.
Organisational culture: family values	The culture supports the organisation's dream of improving diabetes care; this is inculcated in staff through practice, meetings, the media and events. All employees understand the need for diabetes prevention, and contribute ideas to advance it. The organisation's core values guide behaviour, and are emphasised to new staff during orientation and repeated constantly, as well as being included in annual staff evaluations. Despite its growth, the management culture is still very much based on family values.
Knowledge management: shared	Theptarin's goal is to introduce diabetes care models to Thailand and to encourage others to follow the path. The team does this through welcoming visits, teaching and sharing experiences. It even goes beyond sharing to seek grants to provide free training for others.
Trust: strong	Trust is a core value at Theptarin, and works in multiple ways: staff are trusted to provide expert patient care; patients are trusted to follow their

	self-care regimes; governments trust Theptarin in developing public health policies.
Innovation: strong	Theptarin is a pioneer in several areas relating to diabetes care, and introduced several new models to the country, including team care for patient education, foot care and behaviour modification for the prevention of diabetes.
Quality: high is a given	Theptarin focuses on providing ethical and high-quality medical care. Implementing a system of primary care is an example, ensuring that all patients have a case manager who oversees medical and other related issues, and is the central contact person for all communications.
Staff engagement: strong	Staff are highly engaged in the mission of the organisation. Theptarin continuously organises lifestyle modifications for disease prevention for staff in order to ingrain the concept into them, empowering them to understand, gain first-hand experience, believe in, want and be able to come up with creative services.

Source: Based on Avery and Bergsteiner's (2010) Sustainable Leadership Pyramid.

Practising the Sufficiency Economy Philosophy in the healthcare sector is not easy. Table 9.2 sets out some of the challenges and benefits of doing so based on Theptarin Hospital's experiences.

Table 9.2: Challenges and gains in following sufficiency principles at Theptarin Hospital

Challenges	Gains
Isolation: There will always be a period of isolation for leaders in culture change. Where several behaviours go against societal norms, it is very difficult to make other people understand the rationale. It thus takes a lot of courage and self-confidence to be strong and maintain the thinking until others gradually agree.	*Reputation:* Theptarin today has gained acceptance from all healthcare sectors, the government having been the most important and most difficult to convince. Consistent practices indicate the sincerity of Theptarin in wanting to help, and now acceptance allows Theptarin to play a coordinating role between different sectors, leading to enhanced impacts.
Patience. SEP practices are slow to pay off. A firm commitment to the goal is	*Attract the like-minded:* Early on, Theptarin's approach was not widely understood, so recruitment was

required, along with gaining enjoyment for doing what one believes in.	difficult. Now more people understand, appreciate and wish to be a part of the venture. With more team members sharing the values and enjoying accomplishing the same goal, work becomes much easier, more fun and more productive. Moreover, these talented people see value in what they are doing beyond increasing their wealth. Theptarin is another example of an organisation that started with a compliance regimen (people basically did what they were told to do), and then progressed through comprehension (we understand and hence believe in what we are doing), to inspiration (we want to teach others).
Teamwork. This tends to be a challenge for most organisations but is even more difficult in situations where new specialist roles had to be 'invented', and specialists then had to learn to cooperate.	*Financial resilience:* By aiming for *moderate* profit and sharing, as the Sufficiency Economy Philosophy model proposes, Theptarin *prudently* reduces risk in investments and maintains *reasonable* fees. Clinical judgement is undistorted by the profit motive.
	Happiness: Many of Theptarin's employees have worked there for over 20 years. Some have returned after working elsewhere. Staff morale is high because the workplace has a good reputation, and is harmonious without fierce competition.

Conclusions: Thai healthcare—the future

For the Thai healthcare system to become sustainable, the current dysfunctional situation would benefit from adopting the Sufficiency Economy mindset. This involves basing decisions on virtuous goals rather than just on profit; applying the latest scientific knowledge; and being moderate in demands, reasonable in dealing with others and prudent in making investment and other major decisions. All these principles operate at Theptarin Hospital.

In terms of actions, the hospital management also conforms to Avery and Bergsteiner's (2010) sustainable leadership practices (refer to Chapter 14), which have been shown to lead to high-performing and enduring enterprises. If sufficiency principles deliver success at Theptarin Hospital, then why can't they be extended to the ailing Thai healthcare system in its entirety? An important challenge lies in turning medical students into the kind of caring professionals the country needs, not just producing expensive specialists who largely benefit wealthy Thais and medical tourists. Universities need to produce doctors who value ethical decision-making, and share attitudes of moderation, reasonableness and prudence. Collaboration rather than fierce competition across the sector, along with removing barriers between sectors, is key to moving towards a more sustainable and equitable healthcare system. Achievements can be multiplied when all parties—health and non-health—share common goals, values, resources and expertise. Only when sufficiency thinking is accepted as common sense will we be able to walk the sustainable middle path.