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Guest editorial

From past to present: discharge planning in Thailand

Wanpen Pinyopasakul RN PhD
Assistant Professor, Faculty of Nursing, Mahidol University, Bangkok, Thailand

Discharge planning has proved to be one of the key strategies adopted by health professionals in ensuring continuity of patient care, especially during the transition from an acute care hospital to the home environment. This editorial highlights issues underpinning discharge effectiveness and continuity of care for patients in Thailand.

Pichitpornchai *et al* (1999) identified a range of discharge practices among Thai nurses. These arose as a result of differing ideologies in the hospitals and the provision of care services. For the past decade, many hospitals in Thailand, particularly in the large cities, have focused on specialised divisions, such as medical or surgical specialties, while the establishment of linkages between hospitals and communities or primary care has been given less priority (Pongpirul *et al*, 2009). The move to specialty divisions in hospitals was received favourably by both staff and patients, as they perceived that these divisions would ensure quality in healthcare delivery. However, with budget strictures, this approach has proved to be very costly, as many specialists often use expensive technological equipment or special procedures. Hospitals need to focus more on creating linkages with community services and sharing resource facilities to reduce healthcare costs and help patients receive appropriate care at their nearest hospitals (Phoolcharoen, 2004; Srivanichakorn and Van Dormael, 2004). Obviously, differences in the way that the healthcare system is structured can have an impact on both the conduct of healthcare delivery and continuity of care for patients.

In view of the current diversity of healthcare delivery, the issue of fragmentation of care from hospital to home has persisted in Thailand, as well as in many other countries, largely due to shorter length of patient stay and shrinking health service budgets in recent years. As premature discharge and budget issues started to affect the quality of health services in the early 1990s, health professionals have increasingly become innovative and creative in developing modes of appropriate care and best clinical practice for patients. Recent initiatives taken to enhance continuity of care in Thailand include the introduction of a structured hospital discharge planning programme for post-acute cases (Phemphul *et al*, 2011), a nurse-led collaborative community care programme for chronic cases (Sindhu *et al*, 2010), and a community participation programme for diabetes mellitus prevention in a primary care unit (Oba *et al*, 2011). Moreover, primary nursing has been liberally introduced, for example, in psychiatric care (Pakdeemongkon *et al*, 2006), followed by the practice of case management in many healthcare settings (Leenakul *et al*, 2006; Jantarasukree *et al*, 2010). These improved care practices and discharge planning services have the potential to produce better outcomes for a higher proportion of patients who are being discharged from hospital, and should ensure more effective discharge functions of healthcare practitioners in the future.

Despite such initiatives, the constraints imposed by the economic situation coupled with the increasing nursing shortage raise questions about how to maintain quality and continuity of care in the face of persistent change in the healthcare arena. For the past decade, the lack of public monies has caused health administrators to look at more effective hospital management in order to counter financial constraints while trying to ensure equal access to and quality of healthcare for patients (Towse *et al*, 2004). A reduction in hospital costs can be achieved by strengthening ambulatory or home health services. Integrated health services that involve the healthcare institutions, families and community support systems have become a focus of service delivery reform to manage both patient care and budget concerns effectively. In addition, more alternative medicine has now been revitalised for appropriate use in communities. The traditional notion of self-caring and family care is expected to be strengthened by health services in communities and, at the same time, some unnecessary hospitalisation and expenditure is expected to be reduced. For example, herbs are increasingly used by postpartum Thai women to rebalance their energies so as to benefit both themselves and their babies at home (Thasanoh, 2011). Patients are thus seen to benefit from the service delivery reform by gaining integrity

and power with regard to care, as they can care more for themselves and become less dependent on hospital resources and technology.

In the mean time, the government must improve quality of care in hospitals and ensure that patients will receive good-quality care and services. In 2000, a nationwide quality improvement programme was initiated in Thailand's hospitals to foster staff involvement and participation in continuous quality improvement, maximise healthcare resource utilisation, and promote patient-centred care (Sriratanaban and Wanavanichkul, 2004). Many public and private hospitals have started to integrate patient services to either provide choices of care or respond to hospital budget management. In these circumstances, discharge planning is very important, but it will require collaboration between healthcare professionals, patients, families and organisations if it is to be successful (Orchard *et al*, 2005). In future, physicians may be required to join clinical teams as equal partners, which will change the healthcare culture. This will enable nurses to participate more in the decision-making process and to be an effective advocate for patients.

Furthermore, we need to develop predictors for nurses' discharge performance, for example, in relation to roles and perceptions of discharge services, support for discharge functions from unit managers and other co-workers, and also the hospital policies. This will be helpful in establishing appropriate strategies to improve the level of practice in relation to discharge preparation. Qualitative studies in relation to the discharge experiences of patients are also needed to determine how far continuity of care exists. In the future, more awareness among healthcare professionals about the importance of discharge planning will need to be encouraged to ensure continuing care beyond the boundaries of the hospital.

These observations, although based on the Thai experience, can clearly be seen to have wider applications. The UK, the USA and Australia have also gone through a phase of de-institutionalisation following increased specialisation, and handing over of services to community settings (Longley *et al*, 2007; Rich *et al*, 2012; National Health Workforce Taskforce, 2009). With financial cutbacks globally, these messages will need to be taken on board more widely. The insights provided in this guest editorial will be valuable for understanding the issues that underpin continuity of care, which will remain a challenge for governments and healthcare professionals for years to come.

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ADDRESS FOR CORRESPONDENCE

Wanpen Pinyopasakul, Department of Medical Nursing, Faculty of Nursing, Mahidol University, Bangkok, Thailand. Tel: (662) 419 7466–80 ext. 1956; fax: (662) 412 8415; email: wanpen.pin@mahidol.ac.th