

Family Accommodation for Families of Hospitalized Children: A Gap in Public Service Provision in Thailand

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Abstract

This academic article examines the institutional gap in public service provision for family accommodation for families of hospitalized children in Thailand. Drawing on Public Service-Dominant Logic (PSDL), Family-Centered Care (FCC), and collaborative governance, the article uses qualitative documentary and comparative literature analysis to examine family accommodation through four dimensions: accessibility, service integration, resource and stakeholder management, and health equity. The analysis draws on academic literature, policy documents, and institutional information from Thailand and Singapore. The findings indicate that although Thailand has made substantial progress in universal health coverage and access to medical treatment, family accommodation remains unevenly available and insufficiently integrated into the formal healthcare and social support system. Existing provision depends substantially on hospital initiatives, nonprofit organizations, and charitable partnerships, resulting in variations in accessibility, coordination, and continuity. The Singapore case demonstrates how hospital-linked referral, organizational partnerships, and coordinated service delivery can reduce practical barriers to family

participation in pediatric care. The article argues that Thailand's central challenge is not simply a lack of accommodation facilities but limited institutional integration of family support within the broader health and social service system. It therefore proposes a National Family Accommodation Support System (NFASS) to establish common standards, coordinated referral mechanisms, sustainable financing, and equity-oriented monitoring. The proposed framework aims to reposition family accommodation from a fragmented or charity-dependent service toward a coordinated component of Thailand's public service ecosystem.

Keywords: Public Service-Dominant Logic, Family-Centered Care, Health Governance, Integrated Care, Health Equity

Introduction

Principles and Rationale

Families of children with severe or chronic illnesses requiring prolonged medical treatment often face challenges beyond clinical care, including financial strain, psychosocial stress, employment disruption, and difficulties maintaining everyday family life. These challenges can be particularly significant when families must travel from rural or geographically distant areas to tertiary hospitals or specialized pediatric centers. Access to appropriate accommodation near healthcare facilities can therefore help parents remain involved in their child's treatment and caregiving. Previous research has associated suitable family accommodation with reduced parental stress, greater parental involvement, and more positive healthcare experiences (Franck et al., 2013).

This issue is closely connected to Family-Centered Care (FCC), which recognizes families as active partners in children's healthcare rather than passive recipients of professional services. FCC emphasizes respect for family preferences, information sharing, participation in decision-making, and collaboration between families and healthcare professionals (Shields, 2015). From this perspective, practical resources that enable parents to remain physically close to hospitalized children can be understood as supportive conditions for meaningful family participation in care.

Thailand has made substantial progress in expanding access to healthcare through Universal Health Coverage (UHC). However, access to medical treatment does not necessarily eliminate the practical and social barriers experienced by families during prolonged pediatric treatment. Families may continue to face accommodation, transportation, food, and income-related burdens, particularly when specialized pediatric services are concentrated in tertiary hospitals. Although UHC reforms have strengthened healthcare access and financial protection, accommodation for caregivers accompanying children receiving specialized treatment remains less clearly institutionalized within national health-service arrangements (National Health Security Office [NHSO], 2022a, 2022b).

Family accommodation should therefore be considered within the broader relationship between healthcare and social support. When accommodation, transportation, psychosocial assistance, and healthcare services are administered through separate institutional arrangements, families may bear substantial coordination and indirect costs even when medical treatment itself is financially protected. The issue is consequently

not only whether accommodation facilities exist, but also how supportive services are designed, coordinated, and experienced by families.

From a public administration perspective, family accommodation represents a service need that crosses organizational and sectoral boundaries. Public Service-Dominant Logic (PSDL) views public services as relational processes in which public value emerges through interactions among service users, public organizations, and other actors within a broader service ecosystem (Osborne et al., 2012, 2016). Collaborative governance similarly emphasizes coordinated action among public agencies, private organizations, civil society, and citizens in addressing complex public problems (Emerson et al., 2012). These perspectives are relevant because family accommodation cannot be effectively addressed by healthcare institutions alone.

Against this background, this article examines the institutional and public service gaps surrounding family accommodation for families of hospitalized children in Thailand. It focuses on four dimensions: accessibility, service integration, resource and stakeholder management, and health equity. The article also compares Thailand with Singapore to identify institutional approaches that may inform a more coordinated and family-centered public service system.

Analytical Framework

This article adopts PSDL as its primary analytical perspective. PSDL conceptualizes public services as relational and networked processes in which value is created through interactions among service users, public organizations, and other actors within a wider service ecosystem (Osborne

et al., 2016). This perspective allows family accommodation to be examined not as an isolated welfare facility but as part of a broader public service system supporting children and families.

FCC provides the complementary healthcare perspective. It establishes the importance of family participation in pediatric care and supports the interpretation of accommodation as an enabling condition for sustained parental involvement rather than simply a charitable benefit (Shields, 2015). Collaborative governance further provides a lens for examining how responsibilities, resources, and decision-making can be coordinated among government agencies, healthcare providers, nonprofit organizations, private-sector actors, and families (Emerson et al., 2012).

Based on these perspectives, the analysis examines family accommodation through four dimensions:

1. Accessibility – the extent to which families can obtain safe, appropriate, affordable, and geographically accessible accommodation without excessive financial or administrative barriers.

2. Service Integration – the extent to which accommodation is connected with healthcare, social welfare, referral, and other relevant support services across organizational boundaries.

3. Resource and Stakeholder Management – the institutional arrangements for mobilizing and coordinating financial, human, organizational, and partnership resources among relevant stakeholders.

4. Health Equity – the extent to which accommodation support reduces disparities among families facing different socioeconomic, geographical, and other circumstances.

Together, these dimensions provide the basis for examining Thailand's current arrangements and comparing them with the Singapore case. PSDL establishes the public service ecosystem perspective, FCC addresses the family and healthcare dimension, and collaborative governance provides a framework for examining inter-organizational coordination. The four dimensions operationalize these perspectives for the comparative analysis.

Literature Review

1. Family-Centered Care, Integrated Care, and Health Equity

Family-Centered Care (FCC) recognizes families as active partners in pediatric healthcare rather than passive recipients of information and services. Its core principles include respect and dignity, information sharing, participation, and collaboration between families and healthcare professionals. Recent evidence suggests that FCC interventions can improve parental participation, knowledge, and well-being while reducing parental stress and anxiety, although evidence regarding child-level outcomes remains mixed (Hodgson et al., 2024).

FCC also has implications beyond clinical interactions. Families require practical and environmental conditions that enable them to remain involved in their child's care. For families who live far from specialized or tertiary hospitals, accommodation near the hospital can reduce practical barriers to continuous participation. Previous research indicates that accommodation arrangements influence parents' experiences during pediatric hospitalization and their ability to remain near their children (Franck et al., 2013). Family accommodation can therefore be understood as

supportive infrastructure that enables the implementation of FCC rather than merely as a supplementary welfare service.

The needs of families of hospitalized children also extend beyond medical treatment to transportation, accommodation, financial security, employment, and psychosocial support. These challenges are particularly significant when specialized pediatric services are concentrated in tertiary hospitals. Literature on integrated care emphasizes the importance of coordinating medical and non-medical services for children with complex healthcare needs. Ghotane et al. (2024), for example, found that coordinated care interventions may improve care processes for children and young people with special healthcare needs, although the evidence remains heterogeneous.

The issue is also closely related to health equity. Equal entitlement to medical treatment does not necessarily result in equal capacity to access or benefit from that treatment. Families with limited financial resources or those living far from tertiary hospitals may face greater accommodation and transportation burdens. Research on child health equity similarly emphasizes the influence of social and structural conditions on children's healthcare experiences (Thornton & Yang, 2023; Van Cleave et al., 2022). Family accommodation can therefore be positioned at the intersection of healthcare access, integrated care, and health equity by reducing practical barriers to sustained family participation in treatment.

2. Public Service Ecosystems, Collaborative Governance, and Co- production

From a public administration perspective, family accommodation can be understood through Public Service-Dominant Logic (PSDL) and the

concept of the public service ecosystem. Osborne et al. (2012) conceptualize public services as relational and interorganizational processes through which value is created through interactions among providers, users, and other stakeholders. More recent work emphasizes that public value emerges across interconnected institutional and service arrangements rather than within individual organizations alone (Osborne et al., 2022).

This perspective is particularly relevant to family accommodation because families experience healthcare through multiple interconnected services. Hospital treatment, health financing, accommodation, transportation, and social support may involve different organizations, yet families experience them as part of a single treatment journey. When these services are poorly connected, coordination costs may be transferred to families themselves. Family accommodation can therefore be conceptualized as part of the broader public service ecosystem rather than as an isolated welfare facility.

The interorganizational nature of family accommodation also requires collaborative governance. Emerson et al. (2012) describe collaborative governance as processes through which public agencies and actors from private and civil society sectors work across institutional boundaries to address problems that cannot be effectively resolved by a single organization. Family accommodation may similarly require cooperation among hospitals, government agencies, nonprofit organizations, private-sector partners, and families.

Co-production complements this perspective by emphasizing the active contribution of service users to public service delivery (Osborne et al., 2016). Parents and caregivers possess direct knowledge of the practical

barriers associated with prolonged hospitalization and can therefore contribute to needs assessment, service design, accessibility standards, and evaluation. Co-production extends the principle of family participation from the clinical setting to the design and delivery of supportive public services.

Together, PSDL, collaborative governance, and co-production provide a public administration perspective for examining how family accommodation can move from fragmented initiatives toward a more coordinated and user-centered service system.

3. Policy Gap

The literature establishes that family participation is an important component of pediatric healthcare and that practical support can facilitate the implementation of Family-Centered Care. It also demonstrates the importance of integrated care, health equity, public service ecosystems, collaborative governance, and co-production. However, several gaps remain.

First, existing studies of family accommodation have largely focused on family experiences, parental stress, and psychosocial outcomes, with less attention to the institutional and governance arrangements through which accommodation services are organized and financed.

Second, research on integrated pediatric care has emphasized coordination of healthcare and social services, while the role of accommodation as supportive infrastructure has received comparatively limited attention.

Third, public administration concepts such as collaborative governance and public service ecosystems have rarely been applied specifically to family accommodation for families of hospitalized children.

Within Thailand, evidence is particularly limited regarding whether family accommodation has been incorporated into formal public service structures, how responsibilities are distributed among relevant public agencies, and how existing hospital–nonprofit arrangements affect accessibility and equity. These gaps justify examining family accommodation as a public service governance issue rather than solely as a charitable or healthcare support issue.

Accordingly, this article applies PSDL, FCC, collaborative governance, and co-production to examine family accommodation through four analytical dimensions: accessibility, service integration, resource and stakeholder management, and health equity. These dimensions provide the basis for comparing Thailand with the Singapore case and identifying institutional and policy gaps.

Public Service Systems in Thailand Related to Pediatric Patients and Their Families

1. Health and Social Welfare Institutional Context

Thailand has made substantial progress in expanding access to healthcare through Universal Health Coverage (UHC). The National Health Security Act B.E. 2545 (2002) established the National Health Security Office (NHSO) and the National Health Security Fund as key mechanisms for financing healthcare services under the Universal Coverage Scheme. The Ministry of Public Health (MOPH) is primarily responsible for public health policy and the organization and delivery of health services, while the Ministry of Social Development and Human Security (MSDHS) has responsibilities

related to social welfare, social protection, and family and community development.

This institutional division is relevant to family accommodation for children receiving prolonged or specialized treatment. Accommodation is not solely a medical service; it also involves temporary housing, family welfare, financial vulnerability, and social support. Families may therefore require assistance that extends across the mandates of healthcare and social welfare institutions. However, family accommodation has not been clearly established as a distinct and standardized national service within either system.

The institutional context consequently creates a potential policy gap. Although Thailand has mechanisms for financing medical treatment and providing social welfare assistance, there is limited institutional provision specifically designed to address the accommodation needs of caregivers who must remain near hospitalized children.

2. Health Financing and Practical Access to Care

Thailand's UHC system has substantially reduced financial barriers to medical treatment. More recent reforms, including the NHSO's "OP Anywhere" policy, have also sought to reduce administrative and geographical barriers to accessing primary healthcare by allowing eligible beneficiaries to receive services from participating health facilities without being restricted to their registered hospital (NHSO, 2022a, 2022b).

Nevertheless, access to healthcare involves more than the ability to obtain medical treatment. Families accompanying children who require specialized or prolonged treatment may still face indirect costs, including

transportation, accommodation, food, and loss of income. These burdens can be particularly significant when specialized pediatric services are concentrated in tertiary hospitals and families must travel from other provinces.

Family accommodation therefore represents an interface between healthcare access and social support. Although medical treatment may be financially protected through UHC, the practical conditions required for families to remain near the hospital are not uniformly incorporated into the same public service framework. This creates a distinction between formal access to healthcare and the practical capacity to sustain participation in care.

3. Existing Family Accommodation and Institutional Coordination

Family accommodation services are available in Thailand through a combination of hospital initiatives, nonprofit organizations, and charitable partnerships. These arrangements demonstrate that accommodation can be provided through collaboration between healthcare institutions and non-state organizations. However, provision remains largely institution- and partnership-dependent rather than established as a standardized national service. Availability, capacity, eligibility criteria, and referral arrangements may therefore differ across locations and institutions.

Family accommodation also illustrates the broader challenge of coordinating services across administrative boundaries. Healthcare institutions may be responsible for medical treatment, while social welfare agencies address socioeconomic vulnerability and nonprofit organizations provide accommodation or complementary support. Although these actors

may address different aspects of the same family experience, they can operate through separate administrative and funding arrangements.

At the service-delivery level, the absence of a dedicated national coordination mechanism means that families may need to navigate different organizations to identify available accommodation and related support. The key issue is therefore not simply whether individual organizations provide accommodation, but whether they are connected through clear responsibilities, referral mechanisms, financing arrangements, and shared service standards. This distinction provides the basis for examining the institutional gap in the following sections.

International Public Service Systems Supporting Families of Pediatric Patients

International experiences demonstrate that family accommodation can be organized as part of a broader family-centered and integrated healthcare system. Rather than treating accommodation solely as charitable assistance, some models connect hospitals, nonprofit organizations, and other stakeholders to reduce practical barriers to family participation in children's care.

Singapore provides a relevant comparative example of hospital-linked family accommodation within the Southeast Asian context. At National University Hospital (NUH), Ronald McDonald House Charities Singapore (RMHC Singapore) operates accommodation for families of seriously ill children receiving treatment at the hospital. The Ronald McDonald House provides bedrooms and shared facilities and allows eligible families to stay at no cost while their child is receiving treatment. Access is

connected to the hospital through a referral process, creating a direct operational link between clinical care and family accommodation.

The Singapore model also includes Family Rooms within the hospital, providing parents and caregivers with spaces to rest, eat, shower, and remain close to hospitalized children. The collaboration between NUH and RMHC Singapore demonstrates how healthcare institutions and nonprofit organizations can combine their respective resources to support family-centered care.

Several institutional features of this model are particularly relevant to Thailand. First, accommodation is located close to pediatric services, reducing geographical and logistical barriers. Second, families access accommodation through the healthcare system rather than being required to identify services independently. Third, responsibilities are distributed across organizational actors, with the hospital providing the clinical setting and RMHC contributing accommodation and related resources. Fourth, practical caregiver support is incorporated alongside medical treatment.

The Singapore case also demonstrates that effective family accommodation does not necessarily require direct government ownership or operation of every facility. A nonprofit organization can provide accommodation through donations and partnerships while healthcare institutions provide referral and coordination. From a Public Service-Dominant Logic perspective, this represents a service ecosystem in which different actors contribute complementary resources and capabilities to create value for children and families (Osborne et al., 2021). It also reflects collaborative governance because service delivery depends on cooperation between healthcare and nonprofit organizations (Emerson et al., 2012).

The relevance of the Singapore model to Thailand therefore lies not in direct replication but in the institutional principles it demonstrates: hospital-linked referral, physical proximity to pediatric services, defined eligibility, organizational partnership, and coordinated responsibility for family support. Thailand could adapt these principles through a national framework that establishes common standards, referral mechanisms, financing principles, and accountability while allowing hospitals, nonprofit organizations, local governments, and private-sector partners to contribute service capacity.

Comparative Analysis of Family Accommodation Services: Thailand and Singapore

To examine the institutional implications of family accommodation, this article compares Thailand with Singapore across four dimensions: accessibility, service integration, resource and stakeholder management, and health equity. Singapore is selected as the principal comparative case because it provides a hospital-linked accommodation model within the Southeast Asian context. The comparison focuses on institutional arrangements rather than ranking the two countries' healthcare systems.

1. Accessibility

In Thailand, family accommodation is available through selected hospitals, nonprofit organizations, and charitable initiatives, but access is not standardized across the healthcare system. Availability may therefore depend on geographical location, hospital capacity, eligibility criteria, and external partnerships. Families who cannot access accommodation may

need to arrange lodging independently, creating additional financial and logistical burdens.

In Singapore, hospital-linked family accommodation provides a more direct connection between accommodation and pediatric healthcare. The arrangement reduces both the physical distance between families and hospitals and the informational burden of locating accommodation independently.

The comparison suggests that accessibility should not be measured solely by the number of accommodation places available. It also depends on proximity, affordability, eligibility, and the ease with which families can enter the service system.

2. Service Integration

A key institutional difference concerns the relationship between accommodation and healthcare delivery. In Thailand, accommodation services may operate alongside pediatric healthcare through hospital initiatives or external organizations, but the connection between clinical referral and accommodation is not consistently standardized. Families may therefore need to identify and arrange supportive services separately from their medical treatment.

The Singapore model demonstrates how accommodation can be more closely connected to pediatric healthcare through hospital referral and coordination. Importantly, integration does not require common ownership. A nonprofit organization can provide accommodation while the healthcare institution performs referral and coordination functions.

The comparison therefore indicates that service integration depends less on organizational ownership than on whether different services are connected around the family's treatment journey.

3. Resource and Stakeholder Management

Thailand's existing arrangements demonstrate the value of nonprofit and charitable contributions, but reliance on individual organizations and donations may contribute to differences in capacity and continuity across locations.

Singapore illustrates a structured partnership between a healthcare institution and a nonprofit organization. NUH provides the clinical and institutional setting, while RMHC Singapore contributes accommodation facilities and related resources. This division allows different actors to contribute according to their institutional capacities.

Such an arrangement is consistent with collaborative governance and co-production, in which public and non-state actors contribute complementary resources to address a shared public problem (Emerson et al., 2012; McMullin, 2021). For Thailand, the implication is not to replace nonprofit participation with government provision, but to establish a framework defining responsibilities, minimum standards, financing principles, and accountability.

4. Health Equity

Thailand's UHC system has substantially expanded equitable access to medical treatment. However, families who travel long distances to obtain specialized pediatric services may continue to face indirect costs related to

accommodation, transportation, food, and caregiving. These burdens may have greater consequences for families with limited financial resources.

Hospital-linked accommodation can reduce part of this inequality by lowering the financial and logistical burden of remaining near the child. The Singapore model illustrates how accommodation can function as a practical mechanism for reducing non-medical barriers to continued family participation in care.

The comparison does not suggest that Singapore has eliminated health inequalities. Rather, it demonstrates that institutional design can influence families' practical capacity to benefit from healthcare services. For Thailand, this highlights the importance of incorporating geographical and socioeconomic vulnerability into eligibility and resource-allocation mechanisms for family accommodation.

Analytical Summary

The comparison indicates that the principal difference between the Thai and Singaporean arrangements is not simply the availability of accommodation, but the degree to which accommodation is institutionally connected to healthcare, supported by coordinated stakeholders, and designed around families' practical needs.

Thailand already has relevant actors and examples of family accommodation, particularly through hospitals and nonprofit organizations. The principal policy gap is therefore the absence of a consistent framework connecting these resources through shared standards, referral mechanisms, financing arrangements, and accountability.

The Singapore case suggests that Thailand could strengthen existing arrangements without adopting a single-provider model. A national framework could establish common standards and coordination mechanisms while allowing hospitals, nonprofit organizations, local governments, and private-sector partners to participate according to their respective capacities. Such an approach is consistent with Public Service-Dominant Logic, collaborative governance, and co-production, in which public value is generated through coordinated contributions across a service ecosystem (Emerson et al., 2012; Osborne et al., 2021).

Public Service Delivery Gaps in Thailand: A Public Administration Perspective

The central gap in family accommodation provision in Thailand is not simply the limited availability of accommodation facilities. Rather, it reflects an institutional gap in connecting healthcare, social welfare, and family support within a coherent public service arrangement. From a public administration perspective, the issue concerns the allocation of responsibilities, coordination across organizational boundaries, resource governance, and the capacity of public institutions to respond to a service need that crosses conventional administrative sectors.

1. Fragmented Institutional Mandates

Family accommodation lies at the intersection of healthcare and social welfare. The Ministry of Public Health (MOPH) is primarily responsible for health policy, public health administration, and healthcare service systems, while the Ministry of Social Development and Human Security

(MSDHS) has responsibilities related to social welfare, social protection, and assistance to vulnerable groups.

This division is institutionally understandable because the two ministries have different policy mandates. However, family accommodation does not fit neatly within either sector. It supports continuity of healthcare while also addressing temporary housing, family welfare, financial vulnerability, and caregiving needs.

The absence of a clearly designated institutional responsibility for coordinating family accommodation at the national level can therefore create a boundary problem. Multiple agencies may have relevant responsibilities, but no single actor has an overarching mandate to ensure that accommodation support is consistently available, coordinated, and connected to pediatric healthcare.

2. Limited Operational Integration

Thailand has mechanisms for intersectoral cooperation in health and social policy, but broad policy coordination does not necessarily translate into integration at the point of service delivery.

For families of hospitalized children, medical treatment may be provided through the health system, while accommodation and social assistance may be provided through separate organizations. Without standardized referral pathways, shared eligibility mechanisms, or clearly assigned coordination responsibilities, families may have to navigate these services themselves.

This creates a distinction between organizational coordination and service integration. The existence of multiple organizations does not

automatically produce an integrated service from the user's perspective. Collaborative governance requires mechanisms through which participating actors coordinate responsibilities, resources, and decisions around shared objectives (Emerson et al., 2012).

Family accommodation therefore illustrates a broader public administration challenge: services may exist within different administrative structures without being sufficiently connected around the needs of the same service users.

3. Budgetary and Resource Governance

A further gap concerns the institutional allocation of public resources. Thailand's health financing arrangements have primarily been designed to support medical services and financial protection, while accommodation for caregivers has not been consistently established as a standardized component of pediatric healthcare provision.

This creates a distinction between medical entitlement and practical access to care. A child may have formal access to treatment under UHC, while the family may lack the financial resources necessary to remain near the hospital during prolonged treatment.

The policy issue is not necessarily that government must directly finance and operate every accommodation facility. Rather, there needs to be a clear institutional mechanism for determining responsibility, allocating resources, establishing minimum standards, and coordinating contributions from government and non-state actors. Such an approach is consistent with public service co-production, in which public agencies, service providers,

citizens, and other stakeholders contribute complementary resources to create public value (McMullin, 2021).

4. Administrative Burden and Coordination Costs

Institutional separation can generate administrative burdens for families. When healthcare, accommodation, welfare assistance, and other forms of support are administered separately, families may need to identify services, determine eligibility, provide information, and coordinate assistance across organizations.

These burdens are particularly important during prolonged pediatric hospitalization because caregivers are simultaneously managing medical decisions, transportation, employment disruption, financial pressures, and emotional stress.

From a Public Service-Dominant Logic perspective, public service quality should be considered from the perspective of the overall service experience rather than the performance of individual organizations alone (Osborne et al., 2012). The key issue is therefore whether the interfaces between organizations enable families to navigate the service system effectively.

5. Implications for Health Equity

The institutional gap also has implications for health equity. Families with greater financial resources may be able to compensate for limited public accommodation by renting nearby housing, paying transportation costs, or arranging alternative caregiving support. Families with fewer resources or those traveling from distant areas have fewer alternatives.

Consequently, universal coverage of medical treatment does not necessarily guarantee equal capacity to sustain participation in treatment. Geographic and socioeconomic differences can influence whether families are able to remain near their hospitalized children.

Family accommodation can therefore be understood as an equity-supporting public service. Its role is not simply to provide convenience but to reduce practical barriers that disproportionately affect families with fewer resources and greater geographic burdens.

Synthesis

The analysis identifies three interconnected governance gaps: unclear cross-sectoral responsibility, limited operational integration, and the absence of a stable resource and coordination mechanism. These gaps help explain why family accommodation remains unevenly institutionalized despite Thailand's extensive healthcare infrastructure.

The policy challenge is therefore not simply to increase the number of accommodation facilities. It is to establish an institutional framework that connects healthcare and social welfare responsibilities, defines minimum standards, creates referral and coordination mechanisms, and enables government and non-state actors to contribute resources within a coherent public service system.

Such an approach would reposition family accommodation from an ad hoc or charity-dependent arrangement toward a coordinated component of the public service ecosystem. This is consistent with Public Service-Dominant Logic and collaborative governance, which emphasize public value creation through relationships among government, service providers,

civil society, and service users rather than through isolated organizational provision (Emerson et al., 2012; Osborne et al., 2021).

Policy Recommendations and Institutional Reform Directions

The preceding analysis indicates that family accommodation for families of hospitalized children should be repositioned from a largely charitable or institution-specific service toward a coordinated component of Thailand's public service system. The proposed reforms focus on institutional responsibility, service integration, sustainable financing, and collaborative governance rather than requiring direct government ownership of all accommodation facilities.

1. Establish Family Accommodation as a Component of Continuity of Care

Family accommodation should be formally recognized as a supportive component of pediatric continuity of care, particularly for children requiring prolonged or specialized treatment at tertiary hospitals. The Ministry of Public Health (MOPH), together with the National Health Security Office (NHSO), should establish minimum standards covering accessibility, safety, eligibility, referral procedures, and service quality.

Such recognition would provide an institutional basis for integrating accommodation support into existing healthcare and social support arrangements without necessarily requiring immediate universal coverage as a healthcare benefit.

2. Develop an Intersectoral Coordination Mechanism

A formal coordination mechanism should connect the MOPH, NHSO, Ministry of Social Development and Human Security (MSDHS), local administrative organizations, hospitals, and relevant nonprofit organizations. Its functions should include policy coordination, referral pathways, service standards, and resource planning.

At the operational level, tertiary hospitals could serve as coordination points. Healthcare professionals could identify families requiring accommodation, while designated personnel coordinate available facilities and related social assistance. This would reduce the administrative burden on families and strengthen continuity between clinical and social support.

Such an arrangement reflects collaborative governance by establishing structured cooperation among actors with different institutional responsibilities (Emerson et al., 2012).

3. Establish Sustainable and Flexible Financing

A sustainable financing mechanism should combine public funding with contributions from nonprofit organizations, private-sector partners, and philanthropic actors. Public resources should provide a stable foundation for minimum service standards, while non-state contributions can expand capacity and provide complementary services.

Resource allocation should consider pediatric referral patterns, accommodation demand, geographic distance, and socioeconomic vulnerability. This would allow resources to be directed toward areas where accommodation barriers are greatest.

This approach would preserve the contribution of charitable organizations while reducing dependence on donations as the primary basis for essential family support.

4. Integrate Referral, Information, and Service Coordination

A standardized referral mechanism should connect families identified by pediatric hospitals with available accommodation services. Families should not be required to independently search for facilities or repeatedly provide the same information to different organizations.

A national or regional information system could provide information on facility location, eligibility criteria, available capacity, referral status, and related social support. Such a mechanism would reduce information and administrative barriers while allowing service providers to coordinate capacity more effectively.

From a Public Service-Dominant Logic perspective, shared information and coordination mechanisms can strengthen the public service ecosystem by connecting different actors and resources around users' needs (Osborne et al., 2013).

5. Embed Equity and Family-Centered Care in Service Standards

National standards should incorporate equity and Family-Centered Care principles. Priority should be given to families facing substantial geographic distance, financial hardship, prolonged hospitalization, or other circumstances that limit their ability to remain near their child.

Evaluation should extend beyond the number of accommodation places provided. Potential indicators include:

- proportion of eligible families successfully accessing accommodation;
- waiting time for accommodation;
- continuity of accommodation during prolonged treatment;
- geographic distribution of accommodation services;
- family satisfaction and perceived burden; and
- parents' ability to participate in their child's care.

These indicators would shift evaluation from service output alone toward family experience, equity, and continuity of care.

6. Develop a National Family Accommodation Support System (NFASS)

Based on the preceding analysis, this article proposes a National Family Accommodation Support System (NFASS) as a long-term institutional framework for integrating family accommodation into Thailand's public service system.

NFASS would not require the government to directly operate all accommodation facilities. Instead, it would establish a coordinated governance structure in which public agencies define national policy, minimum standards, eligibility and equity requirements; hospitals identify families in need and coordinate referrals; and nonprofit organizations, local governments, private-sector partners, and philanthropic actors contribute accommodation capacity and complementary resources.

The system would integrate four core components: (1) national standards and eligibility criteria, (2) coordinated referral and information mechanisms, (3) sustainable and mixed-source financing, and (4) equity-oriented monitoring and evaluation. Families should also participate in

service design and evaluation so that their experiences inform continuous improvement.

NFASS therefore represents a shift from fragmented accommodation provision toward a coordinated public service ecosystem based on collaborative governance, co-production, Family-Centered Care, and Public Service-Dominant Logic (Emerson et al., 2012; Osborne et al., 2021).

Conclusion

This article examined the institutional gap in family accommodation for families of hospitalized children in Thailand through the perspectives of Public Service-Dominant Logic (PSDL), Family-Centered Care (FCC), and collaborative governance. The analysis indicates that Thailand has made substantial progress in ensuring access to medical treatment through universal health coverage, but supportive services that enable families to remain close to children during prolonged treatment have not been systematically integrated into the broader healthcare and social support system.

The central finding is that the challenge is not simply a shortage of accommodation facilities. Rather, it reflects a public service governance gap involving fragmented institutional responsibilities, limited service integration, and the absence of stable mechanisms for coordinating resources across healthcare, social welfare, and non-state actors. The comparison with Singapore further demonstrates that family accommodation can be connected to pediatric healthcare through hospital-based referral, organizational partnerships, and coordinated service delivery without requiring government ownership of every facility.

Theoretically, the case demonstrates the value of applying PSDL and collaborative governance to a healthcare-related social support issue. Family accommodation can be understood as part of a public service ecosystem in which public value is co-created through interactions among government agencies, healthcare providers, nonprofit organizations, private actors, and families. FCC further emphasizes that families should be recognized as active partners in children's care and in the design of supportive services.

From a policy perspective, the proposed National Family Accommodation Support System (NFASS) provides a framework for establishing minimum standards, coordinated referral mechanisms, sustainable financing, shared information systems, and equity-oriented monitoring. The proposed model does not seek to replace existing charitable initiatives but to connect them within a more coherent public service framework.

Ultimately, recognizing family accommodation as a component of public service delivery rather than merely a charitable intervention could strengthen family participation in pediatric care, reduce disparities associated with geographic and socioeconomic barriers, and contribute to a more integrated and family-centered healthcare system in Thailand.

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