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# Thailand

## Health Care Reform: Financial Management

## Report 11

### Contents and Structure for Annual Reporting on the Financial Development of the Public Health System

**September 2009**

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## *Contents*

## List of abbreviations

| | |
|---|---|
| CFMU | Central Financial Management and Monitoring Unit |
| CSMBS | Civil Servants' Medical Benefit Scheme |
| EU | European Union |
| EUROSTAT | Statistical Office of the European Union |
| FCG | Financial Coordination Group |
| IHPP | International Health Policy Programme |
| ILO | International Labour Organization or International Labour Office |
| IMF | International Monetary Fund |
| INFIMO | Integrated Financial Monitoring System: Common health financing model for CSMBS, IHPP, NHSO and SSO, including a Financial Cooperation Group (FCG) running and maintaining the common model and related information tools |
| IT | Information Technology |
| MoC | Ministry of Commerce |
| MoF | Ministry of Finance |
| MoPH | Ministry of Public Health |
| NESDB | National Economic and Social Development Board |
| NHA | National Health Accounts |
| NHSO | National Health Security Office |
| NSO | National Statistical Office |
| OECD | Organization of Economic Cooperation and Development |
| SEC/SOC | Social Security Department of the ILO |
| SNA | System of National Accounts (EU, IMF, OECD, UN, WB) |
| SSO | Social Security Office |
| SSS | Social Security Scheme |
| UC | Universal Health Care Scheme |
| UN | United Nations |
| WB | World Bank |
| WHO | World Health Organization |

## Reports produced under the Project

Report 1 Statistical reporting: Structures, methodologies, data and outputs. Initial review

Report 2 The calculation of capitation fees and the estimation of provider payments. Initial review

Report 3 A Financial Coordination Framework. A first general outline

Report 4 Proposal for a Revised Capitation Calculation and Financial Equalization System

Report 5 An International Course in Health Finance for South-East Asia

Report 6 A Common Health Care Financing Model (I) for CSMBS, IHPP, NHSO and SSO, and Proposal for a Financial Management Structure.
*Terms of Reference, Review, Supervision*

Report 7A A Common Health Care Financing Model (II) for the main health purchasing agencies
- Universal Coverage Scheme
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- Civil Servants' Medical Benefits Scheme, and

Projection Module for the National Health Accounts
*User Manual*

Report 7B A Common Health Care Financing Model (II) for the main health purchasing agencies
- Universal Coverage Scheme
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- Civil Servants' Medical Benefits Scheme, and

Projection Module for the National Health Accounts
*Documentation of work and progress*

Report 8 A Common Health Care Financing Model (III) for CSMBS, IHPP, NHSO and SSO, and Proposal for a Financial Management Structure.
*Note on Implementation*

Report 9 A Data Reporting Framework

Report 10 Indicators for the Financial Coordination Group for monitoring the UC scheme and national health budget

Report 11 Contents and Structure for Annual Reporting on the Financial Development of the Public Health System

Report 12 Structure and implementation of an Integrated Financial Monitoring System for the health system of Thailand, and
Project Synopsis

# Introduction

Since May 2003 the European Union (EU) has been committed to supporting health care reform in Thailand through the **Health Care Reform Project** (THA/AIDCO/2002/0411). The support and assistance of the EU followed Thailand's bold step towards achieving full population coverage in health care when in 2001, Universal Health Care was written into the law with the introduction of what became popularly known as the "30 Baht" scheme. Under the scheme full access to health services became available to all Thai citizens.

A separate component was established within this project to address issues relating to the **Financial Management of the Health Care System** (THA/05/01/EEC) to be executed by the Social Security Department of the International Labour Office, Geneva (ILO-SEC/SOC ). Technical assistance activities under the project have been on-going since spring 2006 and will continue until end 2009.

Specific activities were scheduled under the ILO component, to be documented in a series of technical reports. The present report outlines **ILO's proposal for the structure and content of a regular annual reporting on the financial development of Thailand's public health system**,[1] i.e. all finance covered by CSMBS, NHSO or SSO, in annual reports to be written by a Unit or Secretariat – as outlined in Reports 3 and 12: *A Financial Coordination Framework - A first general outline and: Proposed structure of an Integrated Financial Monitoring System*. As such, this report relates to **activities (b)**, **(i) and (s)** of the project document and related **output (h)**.

The notion of *"Unit"* in this report refers to an administrative solution for INFIMO where a new department would be established and formally integrated within the MoPH, whereas *"Secretariat"* refers to a solution whereby a newly established body would independently manage the cooperation (mainly) between the CSMBS, the NHSO and the SSO.

As indicated, this present Report should be read in conjunction with the following other reports in the series:

(1) Report 3: *A Financial Coordination Framework. A first general outline*;

(2) Report 4: *Proposal for a Revised Capitation Calculation and Financial Equalisation System;*

(3) Report 7B: *A Common Health Care Financing Model (II) for the main health purchasing agencies - Universal Coverage Scheme, Social Security Scheme, Civil Servants' Medical Benefits Scheme, and Projection Module for the National Health Accounts. Documentation of work and progress*;

(4) Report 9: *A Data Reporting Framework*; and

(5) Report 10: *Indicators for the Financial Coordination Group for monitoring the UC scheme and national health budget*.

[1] The project document requires: "… a report on the blueprint for annual reports on the operation of the UC scheme and the national health budget on the basis of information generated by INFIMO (Blueprint Annual Reports)."

This report therefore aims to give orientation to the *Unit* or *Secretariat* under INFIMO [2] with respect to the structure and contents of its regular annual reporting to the government/parliament, to the interested general public (media, etc.), to academia dealing with health policy issues, and to an interested international readership.

The statistical indicators (or a selection thereof) proposed in Report 10 as indicators to be used by the *Unit* or *Secretariat* can/must be used as the quantitative basis for this report.

[2] See ILO/Thailand Report 3, op. cit.

# 1. A proposed reporting structure

**Title: Annual Report on the Financial Development of the Public Health System of the Kingdom of Thailand**

*Annotation*: This is a working title.

**Table of Contents**

**Preface**

*Annotation*: Authorship, thanks to contributors, etc.

**Introduction**

*Annotation*: Purpose, policy context, health-relevant legislation and legislative changes, etc.

**Executive summary**

*Annotation*: Avoid highly technical wording, refer to main body of text and to annexes for detailed information, put emphasis on the quality of the executive summary as it will be the main source of information for the media and readers that have no time to read the full report.

## 1. General Demographic and Socio-economic Situation and Development

*Annotation*: Demographic situation and development: explains factors of population development and provides a medium- to long-term population forecast on a revolving basis (i.e., it is renewed every year on the basis of new demographic information).

Macro-economic situation and development: general income situation and development of the population (GDP aggregates); wages and income distribution; labour market situation and development; prices, highlights regional specificities to the extent needed for a comprehensive understanding of the report.

Forecasts of underlying macro-economic and labour market variables: discussion of assumptions and analytical comments, and comments on assumptions (and forecasts) made in the previous report ("variance analysis"), where appropriate.

The chapter focuses on aspects relevant for understanding the "health-contents" of the report.

## 2. Revenue and Expenditure of the Public Health Purchasers and of other Institutions

*Annotation*: Presents revenue and expenditure of the CSMBS, the NHSO and the SSO in an adequately disaggregated manner for the reporting year, using common statistical classification methodology; presents results in relation to the NHAs and to macro-economic indicators (GDP) and population (spending per capita or the like). Analyses and explains findings at a relatively high

aggregate level; focuses on details where necessary for understanding variance.

### *2.1. Expenditure of CSMBS*

*Annotation*: Presents detailed expenditure of the CSMBS for the reporting year. Analyses and explains findings.

### *2.2. Expenditure of NHSO*

*Annotation*: Presents detailed expenditure of the NHSO for the reporting year. Analyses and explains findings.

### *2.3. Revenue and Expenditure of SSO*

*Annotation*: Presents detailed revenue and expenditure of the SSO for the reporting year. Analyses and explains findings.

### *2.4. Revenue and Expenditure of Other Institutions*

*Annotation*: Using the NHA methodology, presents detailed revenue and expenditure of Other Institutions (e.g., MoPH, Municipalities, and teachers) for the reporting year. Analyses and explains findings.

*Annotation*: The focus of the reporting of findings in chapter 2 may change annually, e.g. ambulatory care, inpatient care and rehabilitation, medical drugs, research, selected diseases, international comparisons.

To the extent possible, the statistical classification used for institution-specific reporting in sub-chapters 2.1 to 2.3 should be common methodological classification and nomenclature compatible with the NHAs.

## 3. Revenue and Expenditure of the NHAs in the National Economic Context

*Annotation*: Presents and analyses the Thai NHAs in the national economic context at aggregate level.

Includes a forecast of the NHAs, which are co-dependent on the projections made for the CSMBS, the NHSO and the SSO; requires regular update of the NHAs and close cooperation in projections with the IHPP.

## 4. Private Household Co-payments

*Annotation*: Private copayments are analyzed separately as they are still a *prominent* feature of Thailand's system of purchasing health services. Requires close cooperation with IHPP and the NSO (annual specification of programme of health surveys).

## 5. Provider Cost Developments

*Annotation*: Presents and analyses the cost developments of providers, i.e. mainly of public and private hospitals and clinics, by main cost components.

Base information is *Report #5* (currently a regular report to the MoPH on a relatively small number of selected issues of hospitals, including finance), which must be complemented by additional information from other sources. As long as no representative statistics (from such "other sources") are available, the report may focus on selected hospitals where detailed information, based on hospital-owned accounting, is available.

The business reports of selected private hospitals (published, or delivered to the MoC) may also be used as an information base.

Some of the main items included in this chapter are an analysis of the income of health provider personnel and of the prices of drugs, technical equipment, sundries, etc., a labour market balance for the health sector (by different employment categories and by types of "output of the education system"), and it might also contain an outlook of future personnel requirements, including replacement of retirees from the health provider system.

## 6. Diseases and their Costs

*Annotation*: Presents and analyses the development of a selected number of different diseases, and of their average treatment costs, among the covered population; makes use of administrative data of the CSMBS, the NHSO and the SSO; and includes international comparisons.

While the focus must be on a selected number of "significant" diseases (high cost cases; high frequency of occurrence), their selection should (also) serve the purpose of supporting information to the resource allocation formula as proposed in Thailand Report 4 previously mentioned; the information may be used to further develop the Thai-DRGs.

This chapter includes the presentation and analysis of the health situation (morbidity, health [disease] symptoms, handicaps, consequences of diseases and of treatment, others), of the health behaviour (lifestyle, vaccinations, exposure to violence, environment, accidents) of the population to the extent that it contributes significantly to explaining health finance developments, and of the costs of medical procedures, examinations and treatments.

## 7. International Comparisons

*Annotation*: To the extent possible, makes systematic comparison between Thai domestic developments of expenditure and of costs and respective international developments. Presents, and comments on, significant international developments, policy changes and innovations. Makes use of OECD and WHO data, and other national publications to the extent appropriate and accessible;

Includes international comparison of the Thai NHAs.

## 8. Special focus

*Annotation*: This chapter addresses issues of special interest. The subject matter changes every year and the placement of this chapter within the overall report might change annually, depending on the subject covered.

## 9. Conclusions

*Annotation*: Draws policy conclusions form the analysis presented. Conclusions can be of a short-term nature and/or more long-term oriented while providing guidance for strategic health policy orientation.

Table Annex

*Annotation*: The table annex contains *all* numerical information that has been referred to in the text. The text only refers to numerical information that is contained in the table annex.

As outlined above in Chapter 8: “Special focus”, it is considered useful to include a separate, annually changing topic focusing on a special area of interest. Examples of possible topics for this chapter include general health policy planning questions, a focus on specific diseases, discussion of health technological developments, or the introduction of new social purchasing institutions (such as [old age] long-term care institutions, or many others). If well structured, the report will not become routine over the years and lose public attention. The researchers will also find such alternating topics of great interest, thereby helping health policy move continuously forward.

Publication of the report should always be paralleled by a press release that summarizes the most important findings in a condensed way such that it can easily be absorbed and issued by the media.

## 2. Responsibilities: who writes what and when?

This report is written under the assumption that, as a result of the project, alternatively either a *Unit* or a *Secretariat* will be established.[3] It is further assumed that this new unit (*Unit* or *Secretariat*) will act according to the defined terms of reference.[4]

It is logical that the new unit will be responsible for the technical preparation and publication of the report in due time, under the political supervision of the MoPH. Accordingly, the new unit will be responsible for finalizing and writing large parts of its contents, although this responsibility does not mean that all parts of the report are to be written by the new unit. In other words, some parts of the report might have to be written by other units, institutes, ministries, etc., which will be responsible for its technical correctness. It is the responsibility of the *Unit/Secretariat* to make all contributions mutually consistent in order that the information contained in the report is correct and comprehensively (but without redundancies) reflects the factual and political inputs of all contributing parties.

In order to organize the production process of the report in this manner, a careful review process will need to be established among all contributing parties (institutions). Final and overall political responsibility for the report, its correctness and political bearing, lies with the MoPH. In other words, with respect to the report, the *Unit/Secretariat* has to be accountable to the MoPH.

Participants (invited contributing parties) in the drafting of the report, time-table and agenda of the necessary meetings under the review process will all depend on the contents, the assumed periodicity and the assumed annual publication date of the report.

The contents of the report are defined by the proposed structure in Chapter 1 of this document and the structure requires participation of the following institutions (with preliminary indication of responsibilities for subject matters in brackets):

MoPH: (health policy; conclusions);

MoC: (statistics: prices; wages);

MoF: (macro-economics; budget plan);

NESDB: (SNA; macroeconomic and labour market frame);

CSMBS: (demography and all other relevant information concerning CSMBS);

NHSO: (demography and all other relevant information concerning UC);

SSO: (demography and all other relevant information concerning SSO);

IHPP: (NHAs; health policy);

NSO: (surveys); and possibly

Others: (to be specified).

These institutions should all be invited to contribute factual draft contents to the annual report and, of course, they must all be invited to the editorial meetings required in order to

[3] See ILO/Thailand Report 12, op. cit.

[4] See ILO/Thailand Reports 3 and 12.

transform the draft contributions from the various institutions into one common and consistent product (report).

The procedure of discussing drafted/edited versions of the report in meetings of all involved parties should be subject to progress on a time-axis. The drafting/editing/commenting etc. to be undertaken by the involved institutions should take a relatively short time period out of the calendar year, roughly a maximum of three months.

In this context, the most important activities to be undertaken during this period by the *Unit/Secretariat*, are as follows:

1) Drafting the first annotated table of contents of the report, clearly specifying which institution should contribute which inputs, and sending it out to the institutions listed above according to their indicated responsibilities; set a maximum time limit of six weeks for contributions to be delivered; during this period, the new unit starts drafting its own inputs to the report.

2) First meeting of all participating institutions: clarification of purpose of the report and of the nature of expected inputs.

3) Drafting the first full version of report on the basis of own (unit) inputs and the incoming inputs from the above institutions (this activity should take a maximum of three weeks); sending out this first full version of the report to the contributing parties for comments; set a maximum time limit of two weeks for comments to be sent; technically insert comments received.

4) Second meeting of all participating institutions: clarification/explanation of inputs; possibly revise initial structure (table of contents) of report.

5) Revision of first draft report after meeting and additional comments received during that meeting. There will be two basic types of comments: (i) comments of a factual nature that can be directly incorporated (without prior discussion); (ii) comments requiring (political) discussion among participating institutions and, finally, clearance by the MoPH. Comments of factual nature will be incorporated without further discussion, and the remaining parts of the report, for which no consensus is found, will be edited at director/state secretary level between the involved institutions – MoPH has the final word.

6) Third meeting of all participating institutions: formal final agreement on text and data.

7) Report is sent to Cabinet, after whose approval it is sent to Parliament.

8) Discussion of report in Parliament; publication of report: through Parliament, or MoPH, or both; press release through MoPH.

The agenda of the above three meetings is to be established by the new (*Unit/Secretariat*).

The publication date for the report should be in summer, i.e. by mid-calendar year. This would leave room for establishing a consistent data base for calendar year (-1), and the report could also be synchronized with the government's overall budgeting and policy formulation process. In other words, large parts of the required inputs to the report will most probably have to be produced anyway by the participating institutions as part of their roles within the overall annual policy routine, and therefore the additional work required for the report can thus be kept minimal.

Publication of the report should always be accompanied by a press release of the MoPH (responsible ministry).

As an alternative to annual publications of the report, one could consider its publication every three years only. This would possibly be a suitable option for the initial period following the implementation of INFIMO, when data collection, consistency issues and modelling questions, including the ways and means of cooperation between all involved parties, might still have to undergo a consolidation phase before they turn fully productive for policy formulation. This decision is however a question of availability of resources, governance and political leadership.

# 3. Conclusions

This document proposes a structure (or table of contents) for a comprehensive annual report on the state of Thailand's public health system. It also suggests a sequence of activities that must be undertaken in order to draft and publish that report.

The production and publication of the report depends on the prior implementation of a new administrative structure, INFIMO, which has been called *"Unit/Secretariat"* in this paper.

In purely formal terms, the difference between both notions (*Unit* versus *Secretariat*) would seem to have only a small impact on the importance of the annual report: for example, whether it is called a *Unit* or *Secretariat* – in either case it would follow almost the same terms of reference (see again ILO/Thailand Report 3 as previously mentioned). However, within Thailand's governance reality either set-up would probably have significantly differing implications (see both Reports 3 and 12 as previously referenced) with respect to the political impact of the report proposed herein.

If written under a *Secretariat* solution, the report's contents and political and policy impacts might potentially be weak. If written under a *Unit* (integrated in the MoPH) solution, as favoured by ILO-SEC/SOC, then the report's impact will be potentially high.

Some of these considerations might be eased if the report was published by the MoPH under either of the two solutions (*Unit* or *Secretariat*).

Independent of these considerations, it will be the quality of the report that determines its public recognition and acceptance. The quality of the report depends on the professionalism of the contributors to the report, *especially* on the quality of work, i.e. on the facts-based analytical qualifications of the staff in the new unit (INFIMO). This, in turn, depends on their access to the required information (and, thus, on the administrative arrangement: *Unit* or *Secretariat*).

The success of the report, with structure and contents as proposed in this document, will therefore heavily depend on the terms of reference and staffing of the new unit, and the quality of its work. Its long-term impact on Thailand's health policy depends on the administrative backing given. If the report is to be written in a weak administrative environment (*Secretariat*), its impact will be potentially small; if given access to maximum authority in a strong administrative setting (*Unit*), its impact is potentially high.