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Thailand

Health Care Reform: Financial Management

Report 8

A Common Health Care Financing Model (III) for CSMBS, IHPP, NHSO & SSO, and

Proposal for a Financial Management Structure

Note on Implementation

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Contents

List of abbreviations

BoB	Bureau of Budget
CPI	Consumer Price Index
CSMBS	Civil Servants' Medical Benefit Scheme
EU	European Union
FCF	Financial Coordination Framework
FCG	Financial Coordination Group
HCRP	EU/Thailand Health Care Reform Project
HSRI	Health System Research Institute
IHPP	International Health Policy Programme
ILO	International Labour Organization or International Labour Office
INFIMO	Integrated Financial Monitoring System – Common health financing model for CSMBS, IHPP, NHSO and SSO, including FCG that runs and maintains the common model and related information tools
MoC	Ministry of Commerce
MoI	Ministry of the Interior
MoPH	Ministry of Health
NESDB	National Economic and Social Development Board
NHSO	National Health Security Office
SEC/SOC	Social Security Department of the ILO
SSO	Social Security Office
SSS	Social Security Scheme
UC	Universal Health Care Scheme

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.
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- Universal Coverage Scheme
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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 the bold initiative taken by Thailand towards achieving full population coverage in health care when, in 2001, Universal Health Care was written into 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** to be executed by the Social Security Department of the International Labour Office, Geneva (THA/05/01/EEC). Technical assistance activities under the project have been on-going since spring 2006 and will continue until late-2009.

Specific activities were scheduled under the ILO component, to be documented in a series of technical reports. The present report relates to ILO's task of supervising the **implementation of the software** (model) developed under output (e) [the activity (k)] of the project document. The note must be read in conjunction with the two reports

(1) ILO/Thailand Report 7B: *A Health Care Financing Model (II) for the Universal Coverage Scheme, the Social Security Scheme, the Civil Servants' Medical Benefits Scheme, including a Projection Module for Thailand's National Health Accounts. Documentation of work and progress* under ILO/EU: Financial Management of the Thai Health Care System (THA/05/01/EEC), and

(2) ILO/Thailand Report 6: *Terms of Reference, Review and Supervision for the Development of a Common Health Model for CSMBS, IHPP, NHSO and SSO and a Proposal for the Implementation of a Financial Management Structure ("INFIMO")* under ILO/EU: Financial Management of the Thai Health Care System (THA/05/01/EEC)

While the first report focuses mainly on technical aspects of the software and model development – including activities undertaken with respect to the hand-over of the model to Thai counterparts (training, etc.), the second report documents the terms of reference that formed the basis to the software / model development, and supervision of the respective work and activities; it includes a proposal for the implementation of an Integrated Financial Management System (INFIMO).

Both reports contain – explicitly and implicitly – notes on implementation of the technical work at the Thai counterpart level. The present report, therefore, focuses only on the issue of the formal institutional implementation of INFIMO in the Thai government / governance context. In this respect, reference is made to the second of the above reports, and its chapter five: "The Financial Cooperation Group (FCG) – maintaining the information base and making the budget and the resource allocation models work".

1. State of institutional implementation of "INFIMO" [1] at December 2008

At the end of 2008, it is still not fully clear how the Thai government will eventually make use of the model (and its related "infrastructure"), and where and how – administratively – it will be implemented and maintained. Clearly, there is concrete willingness and readiness, up to director and director-general levels in the institutions concerned (CSMBS, NHSO, SSO), to strive for a concerted routine approach. The question as to under which institutional roof this should take place has to date, however, not been settled.

The issue of the intra-governmental institutionalization of INFIMO was from the outset core to the Financial Management component of the Health Care Reform Project. The ILO project initially aimed at a solution that would have formally established INFIMO as a separate government unit with clearly defined competences within the overall government structure, an approach which was supported by the underlying project document. However, in the course of project implementation it became clear that the Thai project counterparts had a different interpretation, more compatible with the Thai viewpoint and situation. Their interpretation favoured an understanding of INFIMO as more of an informal working-group among existing government institutions (CSMBS, IHPP, NHSO, SSO, BoB, others). This interpretation was bolstered not least by concerns that formal implementation of a new authoritative institution would break up established influence and competences of a multitude of existing institutions that are directly or indirectly involved in formulating health budgeting and resource allocation.

Nevertheless, Thai authorities and counterparts involved in the project are aware that the implementation of a new, separate institution (government entity) might in the long run be preferable to a probably sub-optimal informal INFIMO solution. In order to achieve this long-term goal the Thai government prefers, however, a step-by-step approach. ILO thus developed during 2006/2007 and proposed as an interim solution the idea of a permanent Financial Coordination Group (FCG), instead of a formal administrative entity (institute). The core idea for such a Group is to establish equal membership within the group of CSMBS, IHPP, NHSO and SSO, providing it with clear Terms of Reference and the objective of producing pre-defined outputs that serve specific purposes within the Thai government's annually revolving health budget policies and health resource allocation. The concept of the FCG and its operations have already been described in some detail in a previous report. [2]

The present report, while

(i) taking advantage of the detailed knowledge accumulated during project execution of the institutional setting of Thai health policies;

(ii) accepting that for the time being the "maximum" solution possible in practice is an informal INFIMO with an FCG, and

(iii) focusing solely on a possible structure of a formally institutionalized INFIMO –

[1] ILO/Thailand Report 3: *A Financial Coordination Framework – A first general outline*, under ILO/EU: Financial Management of the Thai Health Care System (THA/05/01/EEC).

[2] ibid.

addresses again the issue of the formal implementation of a separate entity with government authority. In so doing, ILO-SEC/SOC admittedly reverts, to some extent, to the beginnings of the project and the initial idea of an institutionalized INFIMO; the reasoning, however, is based on a vastly improved understanding of concrete policy options – and their limitations.

Reverting to the original idea is also justified because the many background talks and discussions in formal meetings with Thai authorities suggest that there is sympathy for such a solution whilst needing more information as to how such a solution might look. For example, the Bureau of Budget (BoB), one of the dominant players in health budget formulation, has signalled - although only informally - an interest in taking over formal responsibility for the (annual) process of estimating health budgets. Given the fiscal problems connected with the foreseeable financial developments especially of the CSMBS, but also the NHSO (UC) and to a lesser extent of the health expenses of SSO, BoB's interest is understandable and welcome.

Nevertheless, from a governance viewpoint, it would be problem-inadequate to vest BoB with the tasks under a formalized (institutionalized) INFIMO, as health systems generally – and the Thai system especially – require a high professional focus on health systems, and respective specializations, to an extent that might surpass BoB staff expertise both in principle and in practice. An institutional setting that better allows a focus on health financing issues would need to be found.

In the long run, therefore, a solution in terms of a new and separate government entity, under the roof of the MoPH, should be strived for. *The reasoning for this is provided in chapter 2.*

2. A formal institutional implementation of INFIMO (separate government entity)

At this end-stage of the ILO's financial management component of the EU/Thai project it has become clear that ***theoretically the most appropriate solution for INFIMO would be its formal institutional implementation as a separate – and new – government entity with clearly defined responsibilities within the context of overall health policies, including budgeting and resource allocation (provider payment)***. It is accepted however that this currently cannot be implemented in practice and must for the time being remain a long-term goal, for the reasons outlined in the preceding chapter.

The logic and reasoning behind a – theoretically optimal – formal institutional solution to INFIMO are as follows:

1. Thailand has achieved full health coverage for its population; this assessment is correct in legal terms but also, widely, in real terms despite the fact that concrete access, i.e. in terms of quantity and quality, still needs to be improved for many.

2. Like virtually all countries establishing health coverage for all, Thailand will also in the future have to cope with growing public health costs as a result of growing demand of a better health-educated population, and improved health services supply; public health costs will further increase as implementation of "care services" for the fast ageing Thai population will be unavoidable.

3. Consequently, Thailand will have to prepare for much better rational financial planning (budgeting), and allocation to providers of available resources, of all public health purchasing schemes.

4. Better rational financial planning (budgeting) implies overcoming (current) mutually independent budget planning procedures of the three main public purchasing institutions (CSMBS, NHSO, SSO); in other words, the ***competitive*** budgeting model must be replaced with a ***cooperative*** one. Accordingly, as a first step, the annual budgeting process must be coordinated among those institutions with respect to timing, demographic and economic assumptions, and scheme-specific assumptions. Professionally, coordination of budgeting and resource allocation is primarily of a technical nature (see point 6, below); accordingly, the respective tasks can best be achieved by a separate government entity with competency and authority, i.e. under 'the roof' of the MoPH.

5. Placing the coordination mechanism (as part of INFIMO) under the roof of MoPH guarantees close interdependency between budgeting (resource allocation) and general health policy.

6. Allocation to providers of available (budgeted) resources has to be based on technical procedures which must be decided upon politically - there needs to be a political decision on the allocation 'formula'. At the same time, any politically decided allocation mechanism must be technically do-able (with respect to statistical information and administrative and mathematical feasibility); in other words, there must be close interdependency, in purely technical terms, between "policy" and "administration" with respect to the feasibility of policy proposals. For example, there is consensus in Thailand that the allocation mechanisms under NHSO (UC) and SSO (SSS), and – in future possibly – also under CSMBS must be further developed and

improved;[3] for the time being the allocation procedures under SSS and UC are well established and are being revised - annually or occasionally - only on a marginal basis. Future systematic changes, while policy induced, would clearly require precise and manageable definitions and societal and political acceptance of both, a goal / target (that might be moving) *and* a reasonably long transition period. Again, this would best be done under a common institutional set-up having both its own technocratic expertise (technical staff) and strong institutional authority, i.e. again, under MoPH.

7. In the longer run, and in order to avoid growing rifts among broad segments of its population, Thailand cannot avoid improving and "asymptotically" unifying its health legislation. As health is one of the very basic common needs (and demands) of any society and population, unifying legislation and *effectively* establishing maximum equity of health access among members of that society will substantially help to overcome societal tensions; the concrete circumstances and conditions under which such unification of legislation may take place, even if implemented step by step, is also dependent on the financial – budgeted and allocated – resources available; in other words, any legislative improvements as indicated here must be accompanied by sound financial evaluations. Again, an authoritative institution under the roof of the MoPH would be best suited to perform the respective tasks.

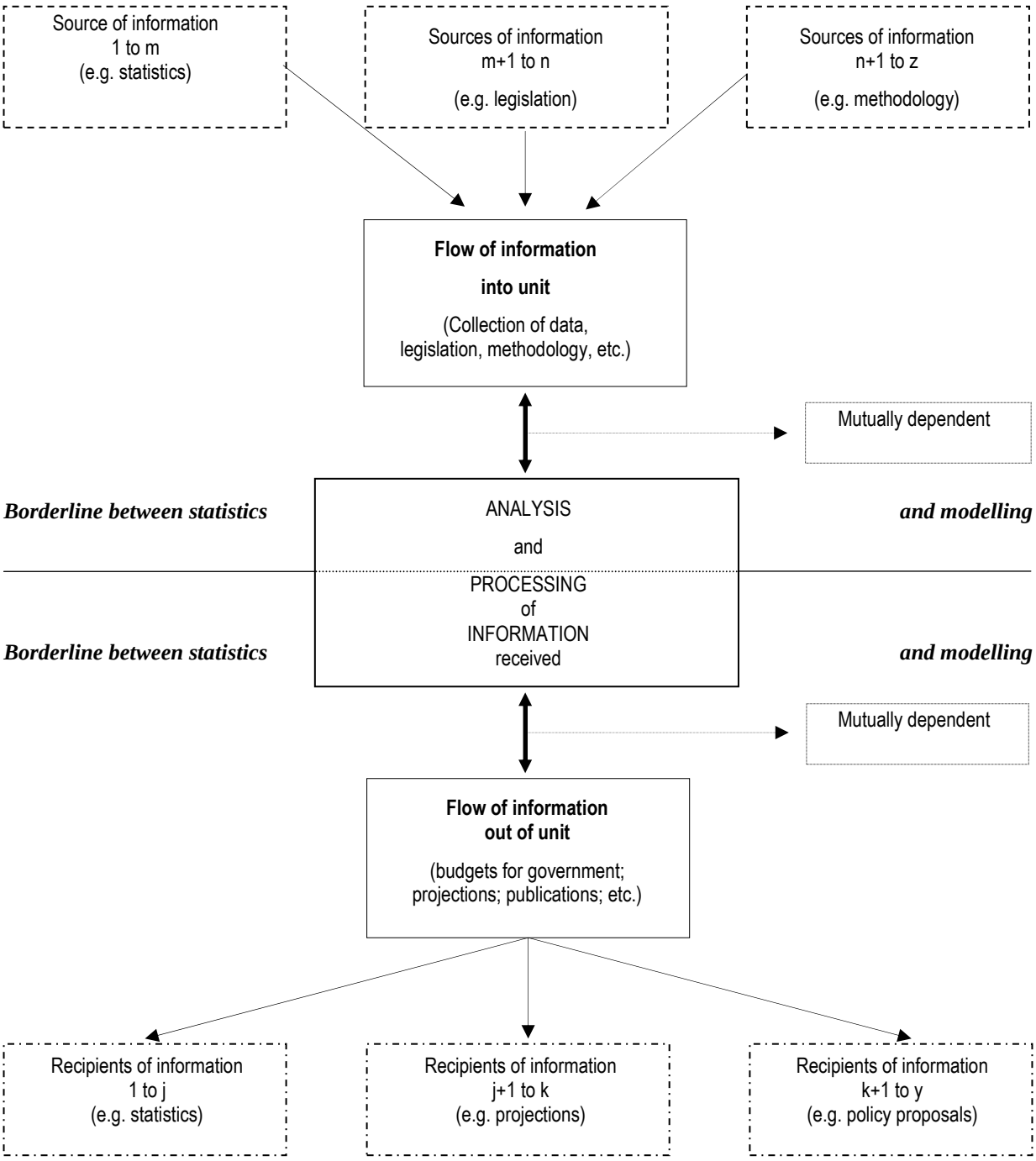
8. Asymptotic unification of health legislation would imply, for various reasons, asymptotic unification of allocation-of-resources-to-providers procedures; again, definition of the goal / target and a transition period are an indispensable part of the process. In its practical realization, such a process would be of a highly technical nature (with political implications, of course) requiring substantial technocratic – and political – expertise; an authoritative institution under the roof of the MoPH would be best suited to perform the respective tasks.

While a version of the terms of reference for such a separate new (authoritative) institution was described earlier[4] – its formal flow-of-information operations are repeated in Chart 1 below. The 8 points above could be read as a guide for formulating the concrete tasks or terms of reference of that new institution in the context of its interrelations with other existing institutes.

[3] The allocation problem has been addressed in several activities, and reports, under the project. See, for example: (1) ILO/Thailand 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*, under ILO/EU: Financial Management of the Thai Health Care System (THA/05/01/EEC); and (2) ILO/Thailand Report 4: *Proposal for a Revised Capitation Calculation and Financial Equalisation System*, under ILO/EU: Financial Management of the Thai Health Care System (THA/05/01/EEC).

[4] ILO/Thailand Report 6: *A Common Health Care Financing Model (I) for CSMBS, IHPP, NHSO and SSO, and Proposal for the Implementation of a Financial Management Structure. Terms of Reference, Review, Supervision*; under ILO/EU: Financial Management of the Thai Health Care System (THA/05/01/EEC); chapter 5.

Chart 1. Abstract structure of information flow in a 'Financial Coordination Group' or new institution [5]



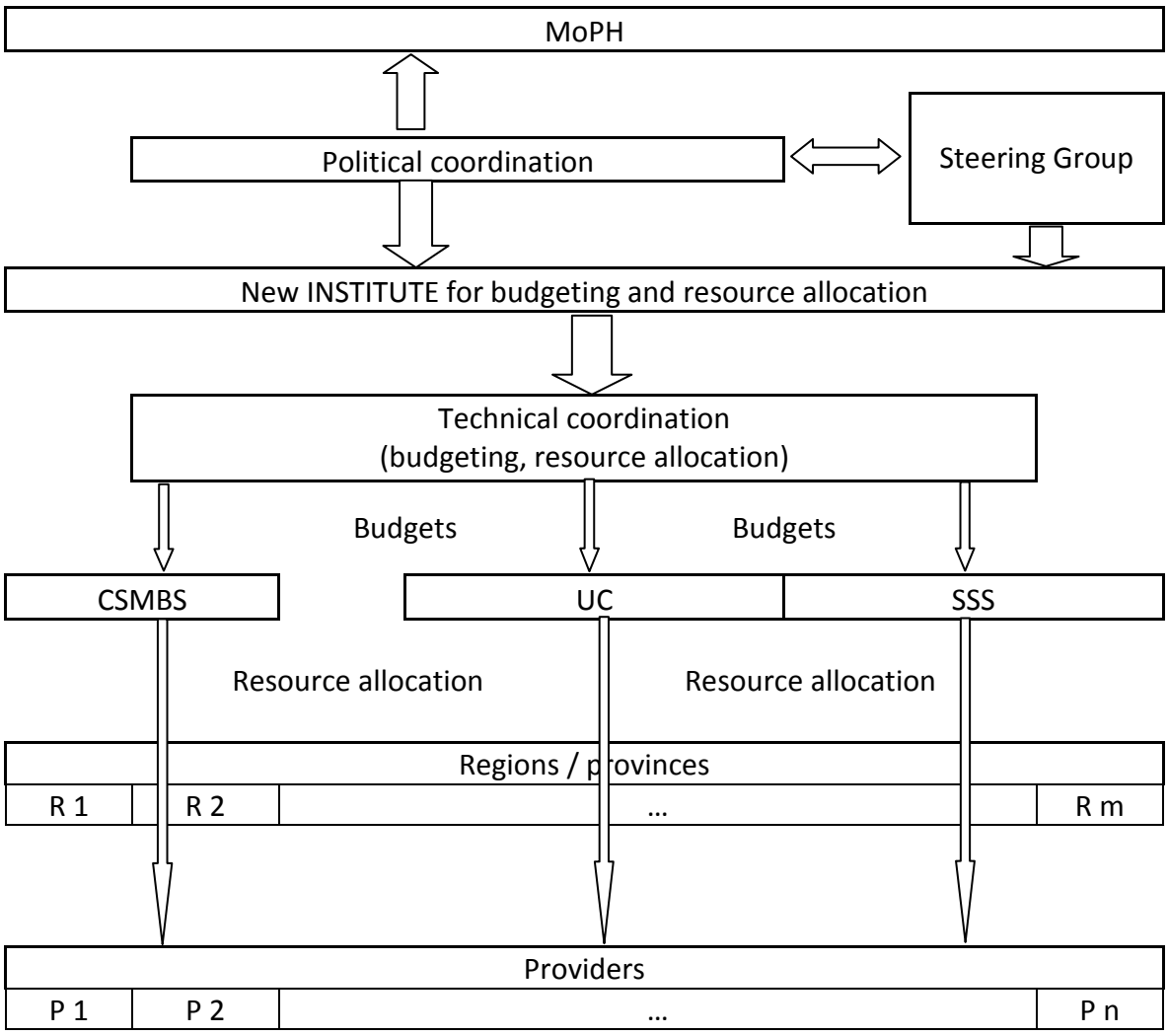
Notes (related to chart):

[1] Inflow (collection) of information has to be organized among involved institutions, i.e., CSMBS, SSO, and NHSO/UC. [2] Analysis of information depends on information received, on analytical instruments available and on information requested by recipients. [3] Processing of information depends on information received, on analytical instruments available and on information requested by recipients. [4] Outflow (dissemination) of information (incl. periodical statistical publications) has to be organized. [5] The FCG would be advised to develop a matrix that shows the type of work to be done by the FCG over time, **for example**, as indicated by the following blueprint (to be enlarged and filled).

[5] In this chart we make equal reference to a "Financial Coordination Group" and a separate "Institute" without expressing any preference for either. For reasons already explained (see text), the Thai government has not as of December 2008 decided how it will proceed. The information flow as depicted would apply in either case.

In a new institutional setting, tentatively taking into account the tasks described under the 8 points above, the flow of information could be described more concretely as follows:

Chart 2. A new institute (for budgeting and resource allocation)



The new institute would

- run the model for budgeting, relying for the respective activities on its own expertise as well as on statistical information from and assumptions set by "outside" sources (NESDB (econ, lab), MoI (pop), CPI (MoC), and others);
- on the basis of pre-defined policy, propose the allocation of resources to providers (technical allocation would be implemented through the three institution themselves: CSMBS, NHSO, SSO);
- coordinate the above tasks with the MoPH and other government institutions (e.g. BoB).

Alternatively, the new institute would perform its tasks according to this specified shortlist but would allocate resources only to the 15 regions. Allocation of resources from those regional levels to providers in the regions – which could be formula-based, would be left to the discretion of the three institutions CSMBS, NHSO, SSO.

It should be noted that the CSMBS has been put under the new institute only for consistency-of-presentation reasons. In practice, because the CSMBS payment-to-provider mechanism is strictly different from the other two institutions (fee-for-services versus capitation) it would probably take a longer transition period before CSMBS could be unified with any mechanism prevailing under the other two schemes (which itself might change over time).

A proposed periodicity of activities for the new Institute could possibly resemble that depicted in the following two matrixes:

Matrix of new Institute activities during year

	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.	Sep.	Oct.	Nov.	Dec.
Budgeting	X	X	X	X	X	X				X	X	X
Resource allocation	X	X	X	X	X	X	X	X	X	X	X	V

(Matrix may be set up in more detail, by weeks 1 to 52.)

Matrix of new Institute activities over several years (optional)

Activity	Y 1	Y 2	Y 3	...	Y t
Budgeting	Y	Y	Y	...	Y
Resource allocation	Y	Y	Y	...	Y
Revision of allocation formula					Y
Overhaul of statistical system	...	...	Y	...	Y
Others	Y	Y	Y	...	Y

Chart 2 presumes close coordination between MoPH and the new *INSTITUTE for budgeting and resource allocation*. In order to guarantee cooperation, organizational measures would need to be taken on the side of MoPH; as a minimum, a MIRROR-UNIT to the new INSTITUTE should be established.

Under the supervision and guidance of a director, the MIRROR-UNIT would formally deal with issues of policy formulation (guidance) for the new INSTITUTE, while at the same time informing and advising Minister and State Secretaries and providing, within MoPH, information on the new INSTITUTE's operations.

Staffing of the MIRROR-UNIT would consist of a director and two to three professional staff (economists; statistician), including support staff and secretary.

The new INSTITUTE would, by construction, play an essentially technical ("technocratic") role within overall health finance, "turning policy into numbers", but would also use its broad and deep information base for policy formulation and the preparation of policy decisions.

Once established, it should consist of a director and six professionals (economists, mathematician, statistician), with two covering each scheme (CSMBS, SSO, NHSO/UC).

The professional staff should be complemented by support staff, especially with respect to regular (and continuous) statistical work (collecting and double-checking statistical information on a regular basis).

Furthermore, the new INSTITUTE would require three information specialists / programmers and one or two additional support staff; a secretary.

The costs for the new INSTITUTE must be fully borne by MoPH.

As an alternative to establishing such a new, separate INSTITUTE, the Thai government (MoPH) could consider integrating the tasks (of such an INSTITUTE) as described above, *in and as a separate unit*, in the existing Health System Research Institute (HSRI).

Such a "mini" solution would have its own attractiveness as it would

(i) fit into the present orientation of the HSRI and, also,

(ii) given HSRI's current and future focus on the development of an (older persons) care system for Thailand, strengthen the links between this important policy direction and any related financial questions.

3. Conclusions

Within the group of middle-income countries, Thailand has without doubt developed one of the best health systems. Covering the full national population was a courageous step forward, serving as a positive example for many countries in similar development situations and actually and potentially improving significantly health and health access for many.

It is impossible, however, to maintain and improve such a system over the medium to longer term without situation-(system-) adequate financial management. There is no country that has achieved health coverage rates similar to those in Thailand while disregarding the requirements and possibilities of modern financial management in health. One cannot have one without the other.

The Thai government has understood the governance obligations resulting from this situation.

This project undertook to provide several instruments and activities aiming at fostering the Thai government's health finance management capacities:

- a set of formal models has been developed that help to support the budgeting process for the three main public health purchasing schemes and map the resource allocation process for two of the schemes;

- in parallel, a significant number of staff involved in Thai health finance institutions was trained in quantitative techniques in social policy (and health especially) at the School of Governance, Maastricht, The Netherlands;

- further, possibilities of informally – or formally – implementing a financial management and monitoring system for Thailand (INFIMO) were explored in order to find a most adequate non-institutional or institutional setting.

Taking everything together it can be stated that the necessary ingredients for implementing INFIMO - and for ensuring that it functions in the concrete Thai governance context, as foreseen under the project, are now available. Of course, necessary as they might be, these ingredients are not sufficient for implementation. The final task of implementing the system in reality – and of maintaining it in the long run, and making it productive for the financial management of the health system, in a concrete administrative and governance context – remains the task of the Thai government.