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THAI AUTONOMOUS HOSPITALS OPERATIONS MANUAL

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GLOSSARY OF TERMS

AH	Autonomous hospital
BoB	Bureau of Budget
CEO	Chief Executive Officer (of an autonomous hospital)
CSC	Civil Service Commission
CSMBS	Civil Servant Medical Benefit Scheme
CSPF	Civil Service Provident Fund
DRG	Diagnosis-related group
GC	Governing Committee of an autonomous hospital
HMIS	Management information system/hospital information system
IP	Inpatient
LICS	Low Income Card Scheme
MOF	Ministry of Finance
MOPH	Ministry of Public Health
OP	Outpatient
PCMO	Provincial Chief Medical Officer
PCP	Primary Care Provider
PHA	Provincial Health Authority
PHO	Provincial Health Office
POA	Public Organization Act
PTC	Pharmaceutical and Therapeutic Committee
SEPA	Staff Evaluation and Performance Appraisal
SODA	Supportive Office for Development and Autonomous Hospitals
TAPS	Traffic Accident Protection Scheme
VHCS	Voluntary Health Card Scheme
WCS	Workman's Compensation Scheme

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EXECUTIVE SUMMARY

Establishment of hospital autonomy in Thailand is based on the belief that a well functioning public health sector can play a crucial role and make a substantial contribution to improving the health of Thai people. Hospital autonomy addresses the division of economic and administrative power/responsibility between the Ministry of Public Health (MOPH) and autonomous government hospitals. Hospital autonomy will achieve the following objectives: 1) improve communication and reduce administrative complexity; 2) enhance effectiveness and efficiency of hospital management; 3) increase accountability to the public; 4) improve resource mobilization and improve local knowledge of development priorities; and 5) achieve political objectives. Decentralized decision making will be enhanced in six main areas: strategic management, procurement, financial management, human resources management, administration, and clinical governance**.**

AN AUTONOMOUS HOSPITAL (AH) IS AN INSTITUTION:

- Constituted under the Public Organization Act (POA) and accountable to the community, a juridical entity, capable of suing and being sued, and with authority to enter into contractual relationships and operating under State supervision;
- Primarily responsible for curative care provision, but providing preventive and promotive health services financed by State subsidies;
- With physical assets that are owned by the Ministry of Public Health (MOPH), Government of Thailand, but whose operation is not under the direct day-to-day control of the MOPH as defined in the Public Organization Act;
- Whose full-time, part-time, and casual staff are either: a) autonomous hospital employees; b) civil servants on secondment; or c) full civil servants during the transitional phase;
- Responsible to the MOPH for adhering to the appropriate functions defined for autonomous public hospitals as part of a coherent Thai health services system and meeting basic minimum standards for its technical and administrative functions.
- Operating under a general memorandum of administrative agreement defining the operational relationship between the MOPH and the autonomous hospital.
- Financed through a system of vertical block grants and/or transfers from the MOPH and locally generated revenue (in that order of importance), with clear and transparent lines of authority both within the hospital and between the hospital and and the MOPH and provincial health administration.
- Able to retain surpluses within limits set by the MOPH, fully responsible for all hospital resources and openly and transparently accounting for all resources regardless of source.
- Governed by a Governing Committee (GC) and run by a Chief Executive Officer (CEO).[1]

[1] The Public Organizations Act indicates that an autonomous institution will be government by a Board of Directors. In this document, a Governing Committee is the equivalent of a Board of Directors.

MISSION OF AN AUTONOMOUS HOSPITAL

The mission of an autonomous hospital is to provide comprehensive care services of high quality and relevant to community needs, in the most efficient manner possible within available resources.

THE GOVERNANCE MANDATE

Autonomous hospitals, having been set up basically for charitable purposes, will have no stock ownership and may accumulate surpluses but not profits. Governing Committees (GCs) will be bound by certain legal requirements and will have taxing authority in that they can set fees for service. To offset any deficits or to maintain financial solvency, the Government will subsidize these hospitals through block grants.

EXECUTIVE LIMITATIONS

The GC is the "boss" of the CEO but, since it is not involved in day-to-day operations, should develop a policy of ***"executive limitations"*** which limit the power of the CEO. Need for such a policy comes from desire for prudence and ethics. Common executive limitations include:

- **Vendor relations** – basics of fair treatment of hospital vendors.
- **Treatment of patients** – minimum standards of treatment of patients including promulgation of a "patient bill of rights," policies on exemptions and waivers, and policies for provision of subsidized services.
- **Indebtedness** – limits on circumstances in which the CEO can incur debt.
- **Asset protection** – limits on unacceptable risk and treatment of fixed assets.
- **Financial condition** – conditions of fiscal jeopardy to be avoided.
- **Budgeting** – characteristics of what is acceptable and unacceptable in any budget.
- **Funded depreciation** – limits on the amounts and conditions under which the CEO can spend money from funded depreciation reserves (if any).[2]
- **Spending limits** – limits on the size of spending over a specific period of time without GC authorization.
- **Growth** – Limits on growth of the hospital in any given period of time regardless of availability of funds, including foundation-funded capital investments.
- **Compensation and benefits** – characteristics not tolerated in any wage and salary plan, including provision of incentives.
- **Private sector involvement and joint ventures** – limits on the freedom of the CEO to enter into any hospital–private sector partnership and the establishment of any hospital–private sector joint venture.

RELATIONSHIP TO THE MINISTRY OF PUBLIC HEALTH

With regard to autonomous hospitals, the Ministry of Public Health will:

- Develop a coherent strategy for the Thai health system within which autonomous hospitals will operate.

[2] Some institutions require that reserves be set aside for the replacement of large capital items. This limitation restricts the CEO's access to these funds.

- Monitor implementation of autonomous hospitals.
- Assure core funding through block grants (either conditional or unconditional), budget support, and other financial subsidies and/or transfers as appropriate.
- Lead, direct, and monitor the transition to autonomous hospital status.
- Develop a national plan for capital expenditure and issue "certificates of need."
- Assure transitional funding.
- Finance and conduct development activities for key systems.
- Conduct general monitoring and evaluation activities.
- Provide comprehensive health services with primary focus on curative care provision, but including also preventive and promotive health services financed by the State.
- Select and appoint members of the autonomous hospital Governing Committees.
- Issue hospital licenses (and renewals) or accredit autonomous hospitals as appropriate.

HUMAN RESOURCES MANAGEMENT

Human resources management will be the most important aspect of establishing autonomous hospitals. The first issue is the transition of staff from their historical civil service positions to hospital employees. The second issue is the determination of benefits and levels of remuneration.

The principles underlying personnel policies for autonomous hospitals during the transition period include the guarantee of a job for everyone who performs to a set standard. Staff of autonomous hospitals can initially be of three types:

a) staff on hospital terms;
b) staff on secondment from civil service (during the transitional phase);
c) staff retaining their present status as members of the civil service (during the transitional phase).

Full civil servants (not necessarily those on secondment) will not be compelled to accept the new service terms. All of the *vacant* posts in the hospital must be filled only by qualified employees currently working in that hospital. These individuals must be hospital employees on hospital terms, not civil servants. Temporary secondment of civil servants is a second possibility, as is the placement of existing civil servants who are staff of that hospital. Secondment from other public hospitals should be avoided. The power to hire and fire autonomous hospital staff should be exercised at the hospital level except for certain senior posts. Recruitment to fill senior posts should involve the Governing Committee of the hospital as appropriate and in accordance with Government regulations.

PLANNING AND BUDGETING

Autonomous hospitals will be required to prepare annual recurrent budget plans and biennial capital budget plans based on MOPH guidelines. Accounting guidelines, a chart of accounts, and a list of cost centers for autonomous hospitals will be developed as part of the transition process.

The Public Organization Act does not allow autonomous hospitals to be profit making institutions; rather, each AH must register as a non-profit entity under the POA and apply for and receive Certificates of Need for capital items.

CAPITAL INVESTMENT PLANS AND CERTIFICATES OF NEED

Each autonomous hospital will be required to submit a request for capital expenditure (primarily for large and sophisticated equipment and capital construction) in line with their hospital's three- to five-year rolling capital budget plan. If the capital investment is approved by the MOPH, the MOPH will grant a "certificate of need" for the item under consideration.

GOVERNMENT GRANTS AND TRANSFERS: BASELINE BUDGETS AND FUTURE ALLOCATIONS

The initial year's budget for an autonomous hospital should include: the recurrent budget, containing full funding for all posts (current and approved); the existing level of operating budget from the government received though the MOPH; a budget for fringe benefits; and funds for development activities during the transition period. If there is any capital budget that has not been fully implemented prior to transition, funds to complete the projects should be transferred to the autonomous hospitals for completion of the project. Capital budgets will be reviewed every 2 years with the recurrent budget determined annually. Initial recurrent budgets will be based on inflation adjusted previous year's allocation. This will remain so for a period of up to 5 years. After the 5th year, all recurrent budgets will be based performance and costs.

REVENUE GENERATION: RATE/FEE SETTING

The hospital should be allowed to generate revenue from service provision in order to: a) be more self-reliant; b) prevent reverse subsidies; and c) be able to provide incentives for the staff. However, this should be undertaken on condition that the poor will not be turned away and that the efficiency of the referral system will be strengthened.

Those who are going to use services beyond a basic service package should bear the full cost of care. Those who bypass the referral chain should be penalized by a copayment in order to discourage further bypassing.

Each autonomous hospital's Governing Committee has the authority to set its own fees within guidelines set by the MOPH. Principles of revenue generation outlined in this manual should be followed.

TRANSITIONAL MECHANISM

Transformation of public hospitals to autonomous status will require strong commitment and support from many parties. Support from the Bureau of Budget (BOB), contributions from the Civil Service Commission during the transformation phase of personnel status, close involvement of the MOPH in the budget planning process, and involvement of other key organizations will be needed. New hospital systems, e.g., hospital/management information system (HMIS), accounting system, and training, will be needed to assure the efficiency of autonomous hospitals. These requirements have to be fulfilled in the short, medium, and long term.

Given bureaucratic limitations within the MOPH, it is strongly recommended that the responsibility for the transition function be set up independently from the MOPH as an Executive Agency. Draft legislation is proposed (see Appendix A) allowing for the establishment of a "Supportive Office for Development and Autonomous Hospitals" (SODA), which will act as the executive agency.

I. RATIONAL AND BACKGROUND

The public sector in Thailand has been the major player in Thailand's health service system from the introduction of modern health services. It is undeniable that the public sector is crucial in meeting the health needs of the population, especially the underprivileged and the poor. Given Thailand's economic crisis and experience with rapid growth and then decline of the private sector over the last fifteen years, the government services' delivery system has been a force for stability in the country. However, health services operating under the conventional civil service system and are not without problems. There are examples illustrating the weaknesses of a health services delivery system being managed under a highly centralized bureaucracy. For example, staff working in the public sector lack motivation to deal with the large volume of work due to the fixed salary system and rigid manpower management rules and regulation. In addition, efficiency in the use of resources has not been ensured. Finally, systems to ensure transparency and accountability of the public sector resources still need to be improved.

Given the above background, the public sector needs to change its methods of delivering services and dealing with its hospitals in ways that improve efficiency and accountability but also allow for better governance. In many countries, such changes in public hospitals have been called either "privatization" or "corporatization". In the Thai context, it is best to refer to these changes as a process of creating autonomous public hospitals. This nomenclature is in line with the current effort of civil service reform which is trying to make certain public services delivery more autonomous and free from conventional bureaucratic red tape, rules and regulations and Thailand's historical organization culture.

In this respect, creating autonomous hospitals should be taken as a form of decentralization. Hospital autonomy is essentially a form of decentralization[3] addressing the division of economic and administrative power/responsibility between the central (in this case, the Ministry of Public Health [MOPH]) and sub-national units of government. Like decentralization, hospital autonomy is an attempt to achieve the following objectives:

- Improve communication and reducing administrative complexity, thereby improving government's responsiveness to local needs.
- Enhance effectiveness and efficiency of management by allowing greater discretion.
- Increase accountability to the public
- Improve resource mobilization for national and local development policies, and improve local knowledge of development priorities.
- Achieve political objectives such as self-reliance, self-determination, and democratization.
- Increase the role of the local community in ensuring good governance.

"Autonomy", as this manual defines to it, refers to the extent of decentralized decision-making in six main areas:

[3] "Decentralization" is the term used throughout this manual. It may also imply devolution, delegation, or deconcentration.

Strategic management refers to the function of defining overall mission of the hospital, setting broad strategic goals, managing the hospital's assets, and bearing ultimate responsibility for the hospital's operational policies.
Procurement refers to the purchase of drugs, medical and non-medical hospital supplies, and hospital equipment.
Financial management refers to the generation of resources for running the hospital, and the proper planning, accounting, and allocation of those resources. It also refers to a readiness to accept the consequences of wrongdoing and being subject to audit.
Human resources management refers to hiring and firing, training, and management—including recruitment and deployment—of various categories of hospital personnel and the CEO.
Administration refers to all other responsibilities involved in the day-to-day running of the hospital and the discharge of its functions.
Clinical governance refers to clinicians who participate in running clinical care under peer supervision, and who are accountable to the CEO.

The spectrum of hospital autonomy is wide as outlined in Table 1 below. This manual does not advocate (nor does it dictate) a fully privatized or for-profit form of autonomy, but one that is a step away from "fully public" towards "fully private." Autonomous public hospitals are not "public entities" capable of making a profit, but "public organizations" whose role it is to serve the community. The reader will note, for example, that the "governance" aspect of the manual shows greater movement towards the fully private model, while the financing aspect calls for support in the form of performance-based block grants; a method closer to the fully public model. In this regard, the Government is not abdicating its responsibility for providing health services to the people of Thailand since many of the policies and standards remain the responsibility of the MOPH.

Hospital autonomy will still operate in a health system based on social equity principles where fees are set based on ability to pay, and service use is based on need. Since the differences between historical organizational function and that which is expected under autonomy are significant, a transition period will be required before full autonomy can be achieved. During this period the full contents of this manual, or a manual based on this foundation, will be implemented. This manual reflects an ideal state of "autonomy" for a large hospital (≥120 beds). Its contents may need to be simplified for smaller hospitals.

Experience from Singapore and Hong Kong provides insight into the process of hospital autonomy. According to the reports of a study tour to Singapore and Hong Kong, the crucial characteristics for hospital autonomy are:

- Separation of financing from provision of care.
- Well-defined sources of financing and payment methods.
- Identification of revenue and cost centers.
- Development of an appropriate accounting and management information system, including performance indicators.
- Introduction of fair staff rewards and incentives.

- Appropriate human resources development with emphasis on management training and corporate-style team building.
- Reorientation of services towards customer demand.
- Restructuring of hospital management and governance towards greater autonomy, flexibility, and accountability.

Table 1: *Spectrum of Forms of Hospital Autonomy by Component*

Degree → Component	FULLY PUBLIC			FULLY PRIVATE
Type	**Fully government**	**Government corporate**	**Non-profit institution**	**For-profit institution**
Governance	MOH	Board of trustees/Directors from Government	Board of Trustees/ Directors (from local * community, government representatives, non-profit or private sector)	Board of Directors (from private sector)
Management	Government employees	Contract or service agreement	Wage contract or profit sharing	Private employees
Capital financing	Full government subsidy	Partial government subsidy	Lease or lending of government assets	Sale of government assets
Recurrent financing	Full government subsidy (indirect or direct)	Revolving funds (retention of locally generated funds)	Regulated user charges retained with government subsidy and insurance	Cost plus pricing (profit) and insurance

Source: *Modification of Newbrander, W. "Policy Options for Financing Health Services in Pakistan: Hospital Autonomy Financing Issues." Health Financing and Sustainability Project Technical Report, February 1993.*

The experience from Singapore[4] and Hong Kong stresses that there is no best way to prepare for autonomy except to begin and adopt a research and development mentality. In Thailand, the process should begin and adjustments made along the way using the results of monitoring and evaluation.

Taking the Singapore and Hong Kong experience to heart, the MOPH proposes to begin the transition to hospital autonomy with a number of hospitals using this manual as a guide. This manual is neither perfect nor complete and will require improvements and modifications over time.

[4] MOPH, "Report of a Study Visit for Hospital Corporatization in Singapore," 25-27 March 1998.

II. DEFINITION OF AN AUTONOMOUS HOSPITAL

An autonomous hospital (AH) is an institution:

- Constituted under the Public Organization Act (POA) and accountable to the community; a juridical entity, capable of suing and being sued, and with authority to enter into contractual relationships; and operating under State supervision.
- Provides Comprehensive health services with primary focus on curative care provision, but including also preventive and promotive health services financed by the State.
- With physical assets purchased by Government funds owned by the Ministry of Public Health (MOPH), Government of Thailand but whose operation is not under the direct day-to-day control of the MOPH as defined in the Public Organization Act.
- Whose full-time, part-time, and casual staff are either: a) autonomous hospital employees; b) civil servants on secondment to the autonomous hospital; or c) full civil servants during the transitional phase.
- Responsible to the MOPH for adhering to the appropriate functions defined for autonomous public hospitals as part of a coherent Thai health services system and meeting basic minimum standards for its technical and administrative functions.
- Operating under a general memorandum of administrative agreement defining the operational relationship between the MOPH and the autonomous hospital.
- Financed through a system of vertical block grants and/or transfers from the MOPH and locally generated revenue (in that order of importance), with clear and transparent lines of authority both within the hospital and between the higher levels of the health system including the province and the MOPH.
- Able to retain surpluses within limits set by the MOPH and fully responsible for all hospital resources and openly and transparently accounting for all resources regardless of source.
- Governed by a Governing Committee (GC) and run by a Chief Executive Officer (CEO).

It is useful also to be explicit about what hospital autonomy will not be expected to accomplish.

Autonomous hospital will not be:

- Expected to be a way of the Government abdicating its responsibility for financing health care for the Thai people. The government will continue to fulfill its commitment to better health of the population; however, by not operating hospitals directly it becomes better able to promote efficiency in meeting the stated government goals and objectives.
- Allowed to operate with a for profit motive. An autonomous hospital's prime function will be to carry out policies and priorities set by the government.
- Tightly controlled concerning the types of services and population the autonomous will serve as long as it meets the priority goals and targets set forth by the Government. However the government will also try to ensure that there will not be unregulated growth taking into consideration the overall picture of the Thai health care system.

- A means of downsizing public hospitals. The size of the hospitals will remain or even expand as much as the hospitals can show that there is a need for their services and that there is financing available from whatever source. This is no guarantee that inefficient workers in public hospitals will remain working if productivity is low.
- Expected to solve the problems of underpaid personnel in the public sector. It is believed that once autonomous hospitals achieve an efficient level of management, health personnel will gain individually from this improvement. Close monitoring of changes will be required to assure that autonomous hospitals will not become self-perpetuating income-generating machnes for the sole benefit of health personnel.

III. MISSION OF AN AUTONOMOUS HOSPITAL

The Board of Directors of each individual autonomous hospital may wish to develop its own mission statement. In general terms, though, the mission of an autonomous hospital is to provide comprehensive care services, of high quality and relevant to community needs, in the most efficient manner possible within available resources.

IV. OWNERSHIP

The Autonomous Hospitals will be created under the Public Organization Act, B.E. 2542 through a Royal Decree, and owned by the Royal Thai Government. This means that the ownership over all assets, including land, rests with the State. Existing plots of land at the time of transformation into public hospital status will be registered under the name of Treasury Department, MOF. Acquisition of new land, I fit occurs after transformation, can be registered under the name of each individual hospital which at the time will be a legally recognized entity. Autonomous hospitals will be allowed to make use of all these assets, land and equipment to fulfill their mandate under the Act.

V. GOVERNANCE

An autonomous hospital must have its own Governing Committee to oversee the operations of the hospital and be accountable to the constituency its serves.

A. VISION OF ROLE AND FUNCTION OF THE GOVERNING COMMITTEE (GC)[5]

Effective leadership is exercised to define a strategic plan which is consistent with the hospital's mission and vision, and which fulfills its vision by providing the framework to accomplish the goals of the strategic plan (The Joint Commission on Accreditation of Healthcare Organizations: 1993). Governing Committees (GCs) will be responsible for this leadership, identifying the hospital's vision and overseeing the operations of the facility.

[5] This vision of the roles and functions of Governing Committees relies heavily on the writings of John Carver as outlined in his book *Boards that Make a Difference: A New Design for Leadership in Nonprofit and Public Organizations* (Jossey-Bass Publishers, 1997).

1. The governance mandate

The Governing Committee, having full corporate accountability, will function as a governing board and will be accountable to the State as well as the community. Its total authority is matched by its total accountability for all autonomous hospital activities, the hospital's organizational activity and its accomplishments. The GC must have control over the complexity of the hospital and details of operations, but be free from these complexities as they perform their functions.

The key roles of governance are to define purpose, clarify vision, and develop strategies and directions. The Governing Committee discharges the governance responsibility by setting policies for the organization to pursue and ensures that hospital executives are doing the right things right and that the organization, through the CEO, performs according to the stated purposes. Management's role is to support the Governing Committee in developing corporate directions and policies. It is responsible for executing the Governing Committee's strategies and the organization's day-to-day operations within designated authority limits.

Autonomous hospitals, having been set up basically for charitable purposes, will have no stock ownership and will be established under the Public Organization Act. Hospitals in this category may accumulate surpluses—but not profits—and will have no ability to distribute surpluses to holders of equity, since there will be no shareholders.

Governing Committees, equivalent to Boards of Directors as defined by the Public Organization Act, will be bound by certain legal requirements. Governing Committees will have regulated taxing authority in that they can set fees for service, but will only derive part of the necessary revenue for the hospital from this source.

Autonomous hospitals will provide services, under GC guidance, to their communities irrespective of ability to pay. To offset any deficits, Government will subsidize these hospitals through block grants. For many patients there will be no consumer assessment of the hospital's service based on service price, since services will frequently be provided on a free or subsidized basis. Market forces will only partially impact the autonomous hospital's function, service pricing, and financial management. In other words, there will be no true market test of the worth of autonomous hospital services, so "success" or "failure" will not be possible to determine on a truly financial basis. In the absence of this market test, the Governing Committee must perform the valuation function by defining "success" in non-financial terms. The GC will have to assess, with input from the community and staff, whether services are of value, not just whether they have been delivered efficiently or not. The GC must see that the autonomous hospital achieves its mandate within the guidelines set by the MOPH.

2. Past flaws

Many government hospital executives have stated that advisory committees rarely function effectively—that boards/committees can easily be manipulated by professional staff. These committees normally

operate on a reactive basis, work with a short-term time horizon, and are frequently involved in management details. Often, these committees address issues of the past, rather than challenges of the future, re-visit work of senior management, work directly with staff other than the CEO, and operate with an unclear mandate and diffuse authority. This is **not** how Governing Committees should function.

3. What the Governing Committee is NOT

There are many prescriptive roles that Governing Committees (GC) may take. Although none of the roles are totally inappropriate, they should not be the total focus of GCs; however, at one time or other they are all reasonable.

- *GC as watchdog*. The GC is not to watch over staff and should not be an advocate for staff or management.
- *GC as cheer leader*. The GC's role is not to cheer on staff and management to bigger and better performance.
- *GC as manager*. The GC is not to function as an adjunct to the CEO.
- *GC as tactical planner*. The GC is not a tactical planning group, looking at short-term objectives and addressing short-term problems. The GC role is not to develop plans.
- *GC as communicator*. The GC is not responsible for improved communications within the hospital. It is not a "spokesman" for the hospital or the CEO.
- *GC as rubber stamp*. The GC is not just to rubber stamp proposals coming from the CEO or senior management.

4. What the Governing Committee IS

Governing Committees should be less involved in day-to-day management and workings of autonomous hospitals. They are not auxiliary staff members. Their job is to select the best CEO and then leave management to him/her.

The GC is accountable to its major stakeholders: the State and the community. Practically this means that the GC reports to the MOPH who may in turn provide general guidelines, policies, and procedures, as well as to the Provinsial Health Authority that finances the hospital through block grants. Members of the GC are not "volunteers" and are not managers, but, as Carver writes (1997), a Governing Committee should have the following features:

- *Function as advocate of a vision.* The GC must be the creator and advocate of a vision of the autonomous hospital and its role of servant to the community.
- *Be the guardian of fundamental values*. The GC is the guardian of the values of the organization. It should not address day-to-day hospital functions, but focus on why the organization exists.
- *Maintain external focus.* The GC should not focus just on the hospital, but on forces that influence the hospital and the hospital's role in the health system.
- *Address large issues.* The GC should not get bogged down in small issues, but focus on large ones.
- *Look forward and be proactive*. The GC should force the entire hospital to look forward to its future role and functioning in a changing health system. It should make sure that management doesn't

get lost in historical details. Forward thinking should allow for proactively addressing problems before they begin to affect the hospital's performance.

- *Encourage diversity of input but speak with one voice.* GC composition must foster diversity of ideas, but ultimately speak with one voice.
- *Balance over-control and under-control.* GCs must be able to set an appropriate balance between being too controlling and not controlling enough over the functions of the hospital.
- *Make efficient use of time.* GCs will be made up of important and busy people. The time they have to devote to hospital business will be severely limited. The GC together with hospital management must be able to sort out what is truly important from what isn't. Board time should not be wasted.
- *Encourage policy-based leadership.* GCs should focus their time and energy on developing policies that force the hospital to think big, and reducing the tendency to address small issues. GCs, in providing strategic leadership, should develop and/or clarify policies and expect the hospital to implement them.
- *Focus on results.* The GC should realize that the only reason for hospital existence is to produce good results for the community. Results in this instance related to better health outcome. It is not adequate for the GC to focus on the processes of service delivery if those processes do not lead to outcomes.

5. GC-CEO relationship and Executive Limitations

The GC's job is to hire and fire a CEO and let him/her manage the institution under the policies and guidelines set by the GC within limits imposed by the Public Organization Act, the Royal Decree establishing the autonomous hospital, and MOPH guidelines.

The GC is the "boss" of the CEO, but since it is not involved in day-to-day operations, it should develop a policy of ***"executive limitations."*** Need for such a policy comes from the need for prudence and ethics. Common executive limitations include:

- **Vendor relations** – basics of fair treatment of hospital vendors.
- **Treatment of patients** – minimum standards of treatment of patients including promulgation of a "patient bill of rights," policies on exemptions and waivers, and policies for provision of subsidized services.
- **Indebtedness** – limits on circumstances in which the CEO can incur debt.
- **Asset protection** – limits on unacceptable risk and treatment of fixed assets.
- **Financial condition** – conditions of fiscal jeopardy to be avoided.
- **Budgeting** – characteristics of what is acceptable and unacceptable in any budget.
- **Funded depreciation** – limits on the amounts and conditions under which the CEO can spend money from funded depreciation reserves (if any).[6]
- **Spending limits** – limits on the size of spending over a specific period of time without GC authorization.

[6] Some institutions require that reserves be set aside for the replacement of large capital items. This limitation restricts the CEO's access to these funds.

- **Growth** – Limits on growth of the hospital in any given period of time regardless of availability of funds, including foundation-funded capital investments.
- **Compensation and benefits** – characteristics not tolerated in any wage and salary plan, including provision of incentives.
- **Private sector involvement and joint ventures** – limits on the freedom of the CEO to enter into any hospital–private sector partnership and the establishment of any hospital–private sector joint venture.

In addition, all debt write-off must be approved or implemented by the GC.

B. GC COMPOSITION AND APPOINTMENT

The appointment and recruitment process should be stated in the Royal Decree to meet the following objectives:

- Maintenance of organizational efficiency and quality.
- Enhancement of community participation.
- Transparent merit system based on job performance standards.

In order for the concept of autonomous hospitals to work, Governance Committee members must understand and be committed to the work of governance. This requires significant individual time commitment and other contributions. It is important to make explicit the roles and responsibilities of the appointed members and the time burden that may be involved. In addition, a formal appointment letter spelling out the roles and responsibilities of the chairman of the Governance Committee should be considered as the chairman can have significant influence over the effective functioning of the Governance Committee and can ensure an effective partnership with the CEO. To ensure effective governance performance, it will be useful to introduce the concept of board evaluation and re-appointment of members may be subject to results of such evaluation.

According to the Public Organization Act and these objectives, the makeup of the GC should be have three types of appointments.

1) Ex officio members, who are representatives of the stakeholders such as the MOPH Provincial Chief Medical Officer (PCMO). This group must be no greater than three people, nominated by their respective superiors who are entrusted with the authority for nomination.
2) Community representatives, selected by a selection committee from a pool of all those nominated by the community.
3) Technical experts, chosen by a selection committee after carrying out a thorough search from various sources.

The CEO will be the secretariat of the GC according to the POA. The chairperson should be a senior person from community members or technical experts.

The first selection committee for the GC will be appointed by the MOPH, while subsequent selection committees will be appointed by the GC, with a forum for public declaration of any possible objection.

If there is any dispute or disagreement about any member, the MOPH will be asked to make the final decision on the appointment of that person to the selection committee. Names of new GC members will be approved by the existing GC before being forwarded to the Cabinet as stipulated in the POA.

The selection committee will determine the procedures and the number required for the nomination of the community representatives, as well as criteria for the final selection from among the list. It will also determine the criteria for the selection of the technical expert members of the GC, as well as compiling a short list before the final selection. Each individual member of the selection committee will be asked to fill in his/her score for each criterion for each potential member. The final decisions need not be made according to the summation of the scores, but all the related papers will have to be kept for possible review later when necessary. One important aspect that should be considered in selecting a GC member is the past performance of that GC member. In this respect a system for board evaluation and performance as well as contribution of individual members of GC may help with reappointment.

C. CHIEF EXECUTIVE OFFICER (CEO)

The Chief Executive Officer (CEO) is the main person responsible for the operation of the autonomous hospital. He/she will be selected by the GC of the respective hospital and appointed by the GC. The CEO will be freely selected; the choice will not necessarily be limited to the existing hospital directors within the MOPH. Possible eligibility criteria include experience in hospital management or a related field for at least five years, and a training background in business management, public administration, or a related field. Once selected, the CEO will be offered a maximum four-year contract. The CEO may be reappointed, but not for more than two consecutive terms in the same hospital. A CEO's performance will be assessed by the GC according to terms in his/her contract. Contract termination may be possible before the term ends. A new CEO will have to be selected if the present CEO:

- dies.
- resigns.
- is terminated under the terms of the contract.
- is found to be unqualified and unfit for the job.
- is proven guilty of crimes and misdemeanors.
- is found to violates crucial criteria of a CEO.

On transformation of the selected hospital, the current Hospital Director will automatically be appointed the CEO during the transitional stage. The GC may consider appointing him/her only for a transitional period of 3-6 months during which time a full search for the new CEO may take place. A CEO will be held accountable for the overall performance of the hospitals as agreed upon between the government and the hospital, as well as those terms specified in the contract between the CEO and the GC. Any liability from performing those functions will be the responsibility of the State. The CEO will be held liable according to Section 4 of the Tort Liability of Government Officer Act, B.E. 2539. However, the CEO will also be held liable by the GC with regard to any other damages to the assets of the hospitals, if applicable.

D. SUB-COMMITTEES

The GC may consider setting up sub-committees to help with the function of the GC. However it should be cautious that such sub-committees should not interfere with the excutive power of the CEO. The role of committees is to deliberate on policy or implementation matters and assist the Governance Committee in making decisions. These committees will submit policy recommendations to the Governance Committee for setting various corporate policies on strategic direction, service standards, prioritization/rationalization and development, financial and human resources matters, audit, complaints management and hospital governance. They should be formed on an exceptional or ad-hoc basis rather than as standing Sub-committees. The sub-committees mechanism can also serve the purpose of creating more active participation of the GC member who otherwise might feel quite distant from the hospital affairs.

E. SENIOR MANAGEMENT

The hospital management structure will be a mechanism to ensure the participatory approach deemed an essential management style for efficient operations. The structure for senior management—including the hospital director, director of medical services, director of nursing services, chief financial officer, and head of information systems (or their equivalent)—will be established by the GC for each autonomous hospital. Each hospital might consider making certain senior management posts board-appointed positions. Senior management has the job of translating GC policies into action and managing the autonomous hospital within the guidelines set by the MOPH. Managing in this fashion requires four activities, suggested by The Joint Commission on Accreditation of Healthcare Organizations (1993):

1) **Planning for services.** The GC establishes a mission statement that is reflected in long-range, strategic, and operational plans, resource allocation, and organizational policies to be implemented by management.
2) **Directing services.** Senior management organizes, directs, and hires staff for patient care and support services in a manner that is commensurate with the scope of services offered.
3) **Implementing and coordinating services.** Senior Management integrates patient care and support services throughout the organization.
4) **Improving services**. Senior management establishes expectations and plans, and manages processes to measure, assess, and improve the performance of the hospital's management, clinical and support services.

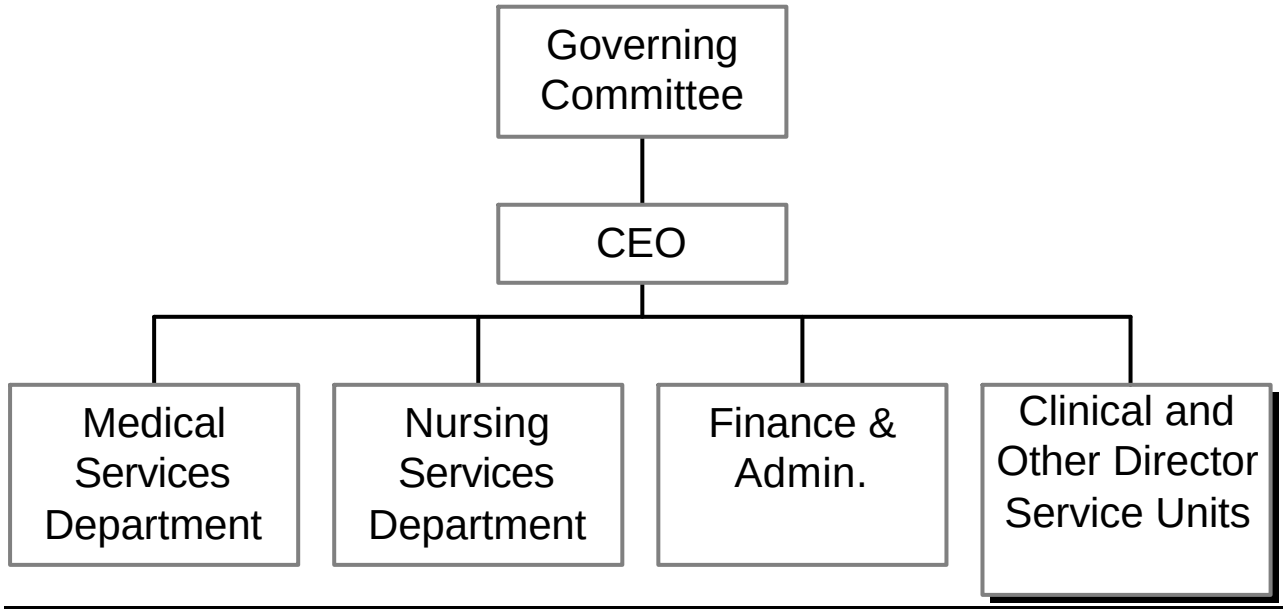
F. HOSPITAL STRUCTURE

No attempt will be made to dictate the structure of autonomous hospitals; however, a model hospital structure is outlined in Figure 1 and includes the following functions that should be approximately the same in all autonomous hospitals.

- Administration
- Admissions/registration
- Ambulatory services, including outpatient (OP) care
- Central services
- Clinical engineering
- Emergency

- Energy management and maintenance
- Finance and accounting
- Food services
- Information systems
- Laboratory
- Laundry
- Maintenance
- Marketing
- Material management
- Medical staff office
- Pharmacy
- Physical therapy
- Planning
- Public relations
- Quality assurance
- Radiation therapy and radiology
- Risk management
- Social services
- Surgical suite
- Telecommunications
- Transportation
- Others as deemed necessary

Figure 1: *Suggested Functional Structure of an Autonomous Hospital*



The organization structure should:

- Be as flat as possible to reduce the chain of command.
- Enhance coordination and integration of work between units, especially the direct services units and other service support and development units.
- Allow top management to interact and facilitate the work of the care units that carry out the main function of the hospital.
- Be flexible to adjust to each hospital's needs and management capacity.

G. RELATIONSHIP TO THE MINISTRY OF PUBLIC HEALTH

The MOPH will remain a key player in a system of autonomous hospitals. Under such a system, the authority, roles, and responsibilities of the Ministry of Public Health are as follows:

- *Developing a coherent strategy* for the Thai health system, including definition of roles and functions of public autonomous and private hospitals.
- *Monitoring implementation of autonomous hospitals* to assure coherence with overall health system design and achievement of the objectives of autonomy.
- *Assuring core funding* for autonomous hospitals (both recurrent and capital) in order to achieve minimum quality standards, promotion of equity or equality, or other purposes as determined by the MOPH, through any combination of matching or non-matching grants, either conditional or unconditional.
- *Providing budget support* if different from the above.
- *Coordinating financial subsidies* and/or transfers as appropriate.
- *Monitoring the transition* of hospitals from their status as government institutions to autonomous hospitals.
- *Developing a national plan* for high-technology equipment and other major capital items (including buildings) and, based on this plan, issuing "Certificates of Need" for major capital investments and significant public/private joint ventures.
- *Assuring transitional funding* during the period when a public hospital becomes an autonomous hospital.
- *Providing support for development activities* for key systems needed for autonomous hospitals, including accounting and financial management systems, systems for documenting clinical services, management and health information systems, and systems for personnel management.[7] The services of groups or companies with appropriated expertise should be used and avoid using mechanisms or people who have been used to operating in a bureaucratic culture.
- *Conducting general monitoring activities* against standards and performance indicators.
- *Coordinating in selecting and appointing members* of the autonomous hospital GCs.
- *Issuing facility operating licenses* and renewals as appropriate.

[7] Transition funding will be needed for: a) front loading of cash for new terms of employment; b) initial design work for autonomous hospital systems, including those for accounting and financial management; c) set-up costs for hospital systems, including the purchase of necessary equipment; d) cost of initial management training; e) payment of existing commitments; and f) cost of improvements to the hospital to meet good quality of care standards set by MOPH.

Many of these roles could be carried out by existing units or through the creation of new units in the MOPH. It is recommended that many of these roles be carried out by a new public organization. (See Section XIV: Transitional Mechanism)

H. PUBLIC ACCOUNTABILITY OF AN AUTONOMOUS HOSPITAL

According to the provisions of the Public Organization Act, members of the Governing Committee shall not directly or indirectly have any business interests with the hospital. He/she also may not be a party to any contract with the autonomous hospital, nor undertake any transactions competing with those of the autonomous hospital.

The transparent, merit-based system of GC appointment should be stated in the Royal Decree as suggested in Section III.B. The GC also consists of a certain number of community representatives.

The GC should report to the Minister of Public Health and make public information on the following topics:

- Mission, aim, objectives, and service plan of the hospital.
- Policy statements on patients' rights, quality of service, and equity of medical treatment (which should be guaranteed to all patients).
- Policy statements on fee/rate setting of hospital services, e.g., medically necessary treatment shall not be withheld from any patient because of his/her social or economic status.
- The annual certified financial report of the hospital.
- The hospital performance and the formal hospital performance evaluation.

In addition, the GC should:

- Lead the hospital toward more cooperation and more participation with the communities.
- Set up mechanisms to monitor and evaluate satisfaction and complaints from the patients and community.
- Foster hospital cooperation with other government or private hospitals to render good and appropriate service to people in that community.
- Promote a sense of belonging to and support from the community it serves.

VI. HUMAN RESOURCES MANAGEMENT

A. GENERAL GUIDELINES

Human resources management will be the most important aspect of establishing autonomous hospitals. The first issue is the transition of staff from their historical civil service positions to new status as hospital employees. The second issue is the determination of benefits and levels of performance-based remuneration.

The MOPH and the unit responsible for hospital autonomy transition functions should consult the Civil Service Commission and Bureaucratic Reform Committee to set up the broad parameters related to personnel matters in autonomous hospitals. The guidelines should include set terms and conditions of employment for all categories of staff; in addition, the guidelines should be clear enough to enable staff to decide whether or not to accept hospital employment, secondment, or no change in status (i.e. remain as civil servants).

B. AUTONOMOUS HOSPITAL STAFF SYSTEM

1. Terms of Employment

Autonomous hospital staff should be employed under full-time, part-time, or temporary contract terms that conform to hospital personnel policies. Each contract should be set up prospectively to "roll over" at appropriate intervals in order to secure individual staff status as well as hospital manpower.

2. Power to hire and fire

The power to hire and fire autonomous hospital staff should be exercised at the hospital level. The CEO will be selected and hired by the GC using performance agreements and/or service contracts as the basis for future assessments and contracting. Other staff will be hired by the CEO through individual or group contracts that may not require frequent annual re-negotiations, but through a system of rolling contracts. (See next Section C) For certain senior management pasts, the GC may prefer that some be "board appointed" but the selection of management posts could be left with the CEO. This might ensure continuity of senior management positions.

3. Staff appointment and promotion

Promotions should be dealt with at two levels. The CEO and senior management positions should be filled by open recruitment. Persons hired for these positions should be autonomous hospital employees[6] and not civil servants. The GC should approve the appointment and promotion of the hospital CEO. Appointment and promotion of all other hospital staff should be delegated to each hospital's CEO.

Promotion is a matter of utmost concern to staff, and so it is essential that promotions in all autonomous hospitals be dealt with equitably between the different categories of staff. To comply with the principle of equity and fairness, all staff in an autonomous hospital, regardless of their terms of service, should have equal opportunities for promotion.

Promotion exercises should normally be initiated and carried out by the hospitals in which the vacancies exist. Such exercises could, however, be conducted centrally or by groups of hospitals if individual hospitals so request. The new arrangements should be implemented in the pilot hospitals as soon as the new management system has been introduced, and should evolve gradually in the light of experience.

[6] It is recognized that initially senior management positions will be filled with existing hospital employees in transition status. At a later date open recruitment will occur.

In order to maintain fairness and consistent standards, it is proposed that a set of detailed rules on appointment and promotion procedures be drawn up. Promotion boards should also be appointed for the selection of suitable candidates where the vacancies are open to staff outside the particular hospital, and wherever appropriate GC representatives and outside experts should be appointed to sit on the boards for some senior posts. Selection of officers for promotion should be on the basis of relative merits rather than seniority. A channel of appeal to the GC should be established to enable staff to voice their views and grievances on appointment and promotion matters.

Acting appointments for administrative convenience should be made to the extent practically possible within the hospital where the vacancies occur. Terms of an acting period should not exceed 2-3 months maximum.

C. STAFF EVALUATION AND PERFORMANCE APPRAISAL

The major objectives of staff evaluation and performance appraisal are to:

1) Create a working environment (context) in which staff are have sufficient motivation to perform well consistently.
2) Foster the spirit of teamwork among staff.
3) Justify the rewards (e.g., salary and allowance) given to individuals, thereby distinguishing between high and low performance.
4) Justify the renewal or modification of a contract.

Performance-based operations are a key feature to differentiate autonomous hospitals from the current hospital system. To ensure that this feature will be well in place, staff evaluation and performance appraisal (SEPA) has to be part of the organizational culture or context. This context will promote awareness among the staff to perform well on a regular basis. Since the overall outputs of a hospital are the sum of individual contributions, SEPA has to foster the spirit of teamwork. These two objectives will be met if and only if SEPA is linked to staff compensation; otherwise, no one will pay attention to it. Staff must realize that the degree of compensation depends on the overall achievement of the hospital. Finally, SEPA should be linked to job security, in that better performance means a more secure job. In practice, this principle will be achieved by tying SEPA to contract renewal for each individual staff member.

The Health System Research Institute, an autonomous agency under the MOPH, has had an interesting experience using a so-called “rolling contract” to address this final point. This means each staff person will be evaluated annually by a peer group on his/her performance. The results will then be used to renew the term of contract either for one, three, or five years. In this manner, the term of contract could differ from year to year depending on the level of performance.

Apart from the major objectives, the following objectives could be included later in the SEPA system:

- To align hospital and individual objectives.

- To provide coaching to solve performance problems.
- To develop staff in their current jobs.
- To provide a link to the career development and succession planning system.
- To evaluate training.
- To identify training needs.
- To develop staff for future positions.

Staff at all levels—from the CEO down to operational staff—have to be subjected to annual evaluation. A systematic approach to the evaluation encompasses the following issues: **domains, criteria,** and **methods of evaluation**.

- For specific groups of staff, expected outputs with respect to major responsibilities or assignments should constitute the **domain** of evaluation. For instance, number of operations performed in one month directly reflects the outputs of a surgeon. Number of outpatients seen in a month could be used as an output measure for a general practitioner or an internist. Outputs should also be viewed qualitatively using peer rating and/or outcome related measures such as case-fatality rate, patient satisfaction, complication rate, etc. Describing good performance with words is not only feasible but, in many cases, makes more sense than using numerical measures. For example, patient communication could be described as follows: "The way that Mrs. Tippawon talked to patients about their illnesses was so humane, gentle, and comprehensible that most of them clearly understood the nature of their illnesses and complied very well with the treatment regimens." In addition to output dimension, activities could be used to appraise staff performance, especially when measurement of outputs is not straightforward. Examples are participation in academic activities or group meetings. In this case, number of training courses attended or meetings held are examples of activity measures.

- **Criteria** are needed to help judge whether performance meets certain standards or the expectations of the hospital. There are different ways of looking at standards. One is perfection; that is, no errors will be allowed for any output of work. Some kinds of work demand perfection, including brain surgery, hazardous material handling, security, etc. But with "zero errors" as a standard there is no way to "exceed expectations." As a result there is no way to distinguish the good performers from the outstanding performers. So in practice, the perfection standard should be applied only if absolutely required. For general work demands, a predetermined target should be used as a standard. This kind of standard could be modified over time as the requirements or expectations of a hospital are changed.

- Once the domains and criteria are set up, one needs to figure out **methods** for SEPA. These include data collection, data analysis, and assignment of responsible persons for the activities. The design for data collection should be aimed at verifiability rather than measurability, because some numbers are meaningless and sometimes the most meaningful aspects of the work can only be described. Next, one needs to check to ensure that data will be worth more than the time needed to collect it (practicality), and that there is at least a 75 percent chance of reaching the standard ("do ability"). Decisions on the level of performance of individual staff members should be made by peer

reviewers who are supervisors (heads of the departments), a representative of the staff whose performance will be appraised, and other staff in the same department.

Given the fact that hospital services encompass a wide variety of products (outputs) and that performance improvement is an endless process, a participatory approach should be employed to select domains, to set up criteria, and to establish methods for performance appraisal. This means that all stakeholders should be allowed to share their ideas. Experiences and expert opinions contend that staff involvement in SEPA will result in staff acceptance of the system and minimize its cost. Having staff collect the data not only saves supervisors' time, but also avoids criticism from the staff on the accuracy of the data. Having an individual staff member nominate a representative to sit in the peer group reviewing his/her performance will minimize the feeling that the CEO or management team has been given too much authority in the process.

Irrespective of the system to be introduced, it will be necessary to establish an effective channel for dealing with individual grievances relating to performance appraisal. There should be a staff relation function at the hospital management level to address this.

Under hospital autonomy, CEO performance will be one of the most crucial attributes to a particular hospital's achievement. Thus an in-depth discussion of evaluation and appraisal of the CEO's performance will be offered here. First, we will examine the expectations for the CEO during the transitional phase. During this phase the CEO should devote his/her efforts to setting up new work systems for the hospital. These include:

- In collaboration with the MOPH and through services of relevant technical teams/organization, working out systems for accounting, personnel management and training, financial management, hospital/management information system (HMIS), allocating budget to hospital, and monitoring and evaluation from the first month forward.
- Supporting the GC in formulating vision, mission and strategics for the hospital,
- Formulating , budgetary, and operational plans inaccordance with the vision, mission and strategies for GC approval by the fourth month.
- Building a hospital management team by the first month.
- With the approval of the GC, working out rules and regulations for internal management by the ninth month.
- Collaborating with the CSC and the MOPH in transformation of personnel status by the fourth month.
- Communication to hospital personnel and the community to get support for hospital autonomy during the first year.
- Working with the GC in laying down organizational structure.
- Reporting annually to the GC on hospital performance.

During the full implementation phase of hospital autonomy, the expectations for a hospital CEO might be as follows:

- Overall achievement level of the hospital according to annual operational and budgetary plan.

- Annually updating mission, strategic, budgetary and operational plans for GC approval.
- Implementing, monitoring, and further developing the work systems.
- In collaboration with the GC, updating rules and regulations for internal management.
- Directing the hospital team towards the goals of the hospital.

The following table depicts domains, criteria, methods, and responsible persons to evaluate and appraise performance of the CEO during the transitional and full implementation phases, respectively.

Table 2: *CEO Performance Appraisal Guidelines*

DOMAINS	**CRITERIA**	**METHODS**	**RESPONSIBLE PERSONS**
Transitional phase			
• Work system development • Planning • Management team building • Transformation of personnel • Laying down organizational structure • Mobilization of support from staff and community	Within the timeframe, presence of: • CEO commitment to the development of work systems • Clear, sensible strategic, budgetary and operational plans • Capable management team • Personnel with new status • Flat organizational structure conducive to efficient operation • At least 60% of staff and community members are supportive of hospital autonomy	• Opinion survey of staff and SODA on the CEO commitment • GC approval of the plans • GC rating of the team • Cabinet resolution on personnel status • Peer review of organizational structure • Opinion survey of staff and community members	GC & SODA

DOMAINS	CRITERIA	METHODS	RESPONSIBLE PERSONS
Full implementation phase			
• Overall achievement of the hospital • Planning • Work systems development • Updating rules and regulations • Directing the team	• % achievement according to predetermined targets • Presence of sensible and clear strategic, budgetary, and operational plans • Presence of new/modified work systems suitable to hospital's needs • Presence of new rules and/or regulations suitable to hospital's needs • % hospital management and staff who clearly understand and are aware of the goals and directions	• Annual report review • GC approval of the plans • Management and staff assessment of the work systems, rules, and regulations • Survey of management's and staff's understanding and awareness of the goals and directions	GC

1. Posting and transfers

As a general principle, intra- and inter-hospital personnel transfers should be effected as much as possible through the staff person's own initiative and with the mutual agreement of the hospitals concerned. All staff, irrespective of their terms of employment, should be equally free to apply for transfer and to work in any autonomous hospital or other government organization. Transfer back to civil service status must abide by the civil service regulations and the Public Organization Act.

Postings and transfers for career development purposes should normally be initiated by management after identifying the needs of staff, but should be up to the individuals concerned whether to accept such career postings. Staff should also be able to initiate requests for transfers to meet their own career development needs, or for personal reasons such as change of residence address.

Subject to the availability of vacancies and service needs, staff should be free to apply for transfer to another unit within the same hospital. Transfers should be dealt with by the hospital CEO in consultation with the unit heads concerned.

2. Application of Discipline Policies

The disciplinary process set up by the GC should be applied equally to hospital employees and the seconded staff. While in the transitional period there might also be the purely civil servant staff. Such a complicated situation—namely, that staff working side-by-side will be subject to different disciplinary

codes—may well cause problems in management and supervision. Given the circumstances, it is proposed that a new disciplinary code should be devised. The GC, together with the MOPH, should look into this concern and minimize the differences between policies.

Staff on civil service terms should be required to observe the day-to-day administrative procedures, rules, and regulations established by the GC, as well as the provisions of the civil service regulations. For operational efficiency and subject to the legal implications being clarified, it is proposed that the Government should delegate the informal disciplinary system of verbal and written warnings to the hospital CEO. However, formal disciplinary proceedings against staff on civil service terms would continue to be instituted and punishments awarded by Government.

In view of the high degree of autonomy vested in autonomous hospitals, it is considered necessary to lay down clear guidelines to ensure that disciplinary cases are handled fairly and consistently. However, it is important that there be a channel of appeal to the GC of the hospital. Staff on civil service terms should continue to have a right to appeal to the Government. The principle that an officer should not be punished twice for the same offense should be followed.

For staff management reasons, the CEO should be able to terminate seconded staff on civil service terms.

3. Training and career development opportunities

The basic principle for the provision of training within the autonomous hospital should be that all staff, irrespective of their terms of service, should have equal opportunities to benefit from training provided by the hospital. The unit responsible for transition functions should be responsible for organizing centralized training courses, formulating training and human resource development strategies, deployment of resources, and monitoring standards and evaluating achievements. The hospital's CEO should have authority to provide both specialized and management training designed to address the needs at the hospital level. Central committees should be set up to coordinate the various types of training.

A significant increase in resources will be required to meet the increased training demands of autonomous hospitals. Training needs arising from the transition from government to autonomous status will be significant, and access to training facilities of the MOPH and the Government may be curtailed. For this reason, the hospital and MOPH should negotiate early on an adequate training budget and develop a joint training plan.

The selection of staff to attend training courses, both local and overseas, should be based on service need, aptitude, interest, performance and the potential for development. Selection should be made with regard for an individual's experience and the relevance of training to his/her functions in the hospital. All staff, regardless of their employment status, should be considered on an equal footing.

An assessment of training activities in four private hospitals was undertaken under the Health Management and Financing Study Project. Objectives of the study were to: 1) obtain the opinion of the

hospital CEOs regarding likely training needs of autonomous public hospital management; and 2) formulate guidelines for the training of hospital management staff (Paibul and Sutham, October 1998).

The skills required for autonomous hospital management are summarized in Table 3, which follows:

Table 3: *Skills Required for Management of an Autonomous Hospital*

Core topics	**Hospital Director**	**Middle management**	**Operational back office staff**	**Operational front office staff**
Planning, vision formulation	Problem solving	Comprehension		
Personnel management	Comprehension	Problem solving		
Financial management	Comprehension	Comprehension	Problem solving	
Performance audit	Comprehension	Problem solving	Problem solving	Comprehension
Contract formulation	Comprehension	Comprehension	Problem solving	Comprehension
HMIS	Comprehension	Comprehension	Problem solving	Comprehension
Communication skills, conflict resolution	Problem solving	Problem solving	Comprehension	Problem solving
Health system, public health concepts, health services system	Comprehension	Comprehension	Comprehension	Comprehension
Marketing	Comprehension	Comprehension	Comprehension	Comprehension
Decision making	Problem solving	Problem solving	Comprehension	Comprehension
Service concept	Comprehension	Comprehension	Comprehension	Comprehension
Special topics for hospital management, e.g., pharmacy, infection control, nursing	Comprehension	Problem solving		Problem solving

With regards to training:

- A specific department under the MOPH (or any future body taking care of hospital autonomy) should be set up to oversee the process of organizing training for all levels of hospital personnel. This would include the development of training curricula specifically for hospital administration and management.
- During the early days of implementing hospital autonomy, a formal training program should be set up for top executives and middle managers. At the very least, the program should address the topics shown above. In addition to the two levels of managers, back office staff dealing with accounting and financial management should be retrained in contemporary business accounting and financial management tools such as cost accounting, accrual-based accounting, and cash flow analysis.

In the long run, a process similar to that used by Hong Kong's Hospital Authority to systematically organize training activities for hospital staff at all levels should be adopted, supported by a strong policy and financial backing.

4. Remuneration

The payment and benefits for hospital staff will be classified into three categories.

1) Contracted wage or salary.
2) Overtime or professional extra work.
3) Fringe benefits.

The key concept of an autonomous hospital is its authority to set its own remuneration system within the national framework.

The framework should allow the hospital to adjust its payments according to the local need or shortage of professional staff, as well as hospital financial status.

The GC should set up a system that aims to:

- Increase quality of service and productivity.
- Maintain the qualified professional staff within the system.
- Ensure the implementation of a performance-based merit compensation system.

5. Salaries and wages

Since a performance-based approach is going to be the pillar of hospital finance, individual staff payments will consequently follow the same principle. This means the amount of staff remuneration, either in salary or wage, will depend upon total income of the hospital. Another principle worth considering is the use of financial incentives as a tool to retain and recruit capable and high performing staff. In this regard, market value of each type of staff should be taken into account.

Based on the aforementioned principles, different payment methods are suggested for different types of staff as follows. Physicians will be paid on basic salary and wage, adjusted for workload and quality of work. The basic salary should cover average or minimal workload for specific specialties. The wage portion should reflect any extra contribution from each individual, as compared to the average or the minimum. In order to discourage overwork, which will jeopardize the quality of care, an upper limit should be set. Managers will be paid primarily on salary plus some incentives, which will be in terms of percentage of total hospital surplus. Similarly, other professional staff and support staff will be paid in the same manner as the managers, but with a different percentage of incentives.

To be more specific on the payment methods, the salary scale may be structured as follows:

1) The staff will be classified into 3 groups: a) CEO and manager, b) Professional, and c) Support. Staff in each group will be sub-classified into several bands. Definitions of each band should be generalized enough to refer to the Civil Service System and other hospitals.
2) In each band, the GC can flexibly set the range of pay taking into consideration the civil servant pay scale and the market rate for each professional and category. The following table is an example of schematic representation of such a payment scale.

Table 4: *Schematic representation of a flexible pay scale*

Major category	Subcategory		Band	Range
Management	CEO		12	
	Manager	Senior	11	
		Middle	10	
Professional	Senior		9	
			8	
	Middle		7	
			6	
	Junior		5	
			4	
Support	Skilled workers		3	
	Semi-skilled		2	
	Labor		1	

Transforming civil service staff to hospital employees must be based on new initial salary payments that are attractive enough to encourage qualified staff to shift over. The transfer of individual staff should follow the process of:

1) Collective decisions of the CEO and senior managers.
2) Fitting him/her into specific category and band starting with the minimum value.
3) Additional adjustment from the minimum should be based on:
   a) experience (equivalent years of working in the assigned job).
   b) past performance.
   c) terms of reference of the contract.

The details of the transformation procedure must be set up by the GC with assistance from the MOPH.

6. Fringe Benefits

Fringe benefits will be a mechanism to:

1) Enssure social and staff security (pension, medical benefits, death, disability).
2) Increase allowance or decrease expense.
3) Enhance staff and system productivity.

Fringe benefits will be both in kind and in cash. In kind benefits must be calculated in cash and integrated into the overall fringe benefits for each staff person. The MOPH has the responsibility and authority to provide fringe benefits according to the Public Organization Act, with its own budget. The autonomous hospital may organize the fringe benefit system itself or may contract this task out. We suggest setting up a contribution system or co-payment from the beneficiary for the appropriate fringe benefits.

The medical benefits and the royal decoration system should be negotiated to tie with the civil service system. The hospital—while setting the essential benefits (death, disabilities, sick leave, insurance)—may leave room for individual personnel to select "cafeteria items" of benefits such as house rent, children's education, transportation, training, uniform, etc. up to their allowance limit. The total amount of "cafeteria fringe benefits" for an individual staff person should be based on his/her performance.

D. FORMATION MECHANISMS

1. Personnel-transformation strategy

During transformation the hospital should create its organization structure or revise the current structure. Fitting the personnel into new system should follow these steps.

1) Fill in as many of the senior management and key staff positions as possible.
2) This core group will set a mechanism to select and appoint civil servants intended to apply for a position (as employee) in the autonomous hospital by negotiating with him/her on terms of reference and compensation. Qualified civil servants who intend to be seconded into the autonomous hospital will be the next priority group.
3) After filling in those applicants in 2), if there are still vacant positions, the remaining civil servants in that hospital will be filled into those positions where appropriate. Yet, the degree of responsibility under the new position should be not less than the previous one.
4) Recruitment of brand-new hospital employee from outside and secondment from other public hospital should be considered cautiously in order to avoid over-staffing.

2. Problems arising from a mixed staff

1) Situation and Proposed Solutions

However attractive an autonomous hospital's new package of payment and benefits may be, some of the staff of the Hospital, for various reasons, will not wish to take up the new terms; and these staff will be permitted to remain in their present terms of service as civil servants. Because of this, the hospital will inevitably face a mixed staff situation comprising the following three categories of staff:

a) Staff on hospital terms.
b) Staff on secondment from civil service.
c) Staff retaining their present status as members of the civil service.

This mixed staff situation could in theory continue for many years. It is advisable to make this situation as short as possible, preferably not exceeding 4 years after which all staff should be classified as above.

2) The hospital should recognize that one fundamental problem will be the disparity among the three sets of terms and conditions of service (i.e., for staff on civil service terms, seconded staff, or as full autonomous hospital employees), and the fear of staff that they may be discriminated against. The ultimate solution to this problem will be to encourage staff to opt for the new terms and to secure as smooth a path as possible for them to transfer to these new terms. However, some staff will inevitably choose to remain on their existing terms; in these circumstances, it is considered that the principle of equity of treatment should be adopted, irrespective of the terms of employment of individual staff members.

   In terms of salary increases, promotions and employmentduration for group C, the CEO will have to make agreement with the respective supervisors and bosses so that the CEO will have the same manpower management decision making power in deciding on these related issues. The CEO can also decide to send those in group C back to their original civil service units whenever the CEO wishes, in which case they will have to return to the jobs in the civil services.

3) To reassure the staff that this principle of equity will actually be put into practice, detailed guidelines and arrangements should be proposed in all the major areas by the hospital's GC.

The concept of equality of treatment may have some unsolved difficulties in the following areas:

a) Controlling and commanding civil servants by CEO.
b) Rewards and punishment for civil servants by the management team may be limited as they are under the CSC regulation.
c) Civil servants may have difficulties adapting to work in a new corporate culture environment.

3. Staff Consultative Mechanisms/Systems

It is very likely that various problems will arise in a mixed staffing environment, particularly in the early years of reform. As a result, it is important that consultative mechanisms/systems be provided not only for staff of the hospital, but also for seconded staff. To tackle this, the hospital with the MOPH and Civil Service Commission should establish a mechanism for joint consultation on staffing issues.

At the hospital level, a Personnel Committee should be formed. On the management side, it should be composed of representives from GC, the CEO, and key senior officers from the hospital. On the employee side, elected representatives of various grades, irrespective of terms of employment, should also be on the committee. Matters to be discussed should include, but not be limited to, personnel and management issues that impact all hospital staff including proposals to improve quality and efficiency of service, personnel policies and procedures, conditions of employment, performance criteria, working environment, quarters, uniforms, leave arrangements, and so on. It is expected that once the new management and personnel systems are in place almost all personnel issues will be within the hospital's jurisdiction to resolve. Establishment of this interim consultative system is in line with the principle that autonomous hospitals should be given wide latitude to address personnel issues. The activities must be reported to the GC for information purposes.

This interim Personnel Committee will be an advocate for staff to the GC on any personnel issues that may arise, and encourage the GC to set up personnel policies and regulations for the hospital.

E. PROFESSIONAL CODE OF PRACTICE

The autonomous hospital system needs its own staff to contribute all of their efforts to the system. It also needs professionals to work in an appropriate environment to drive their potential. The GC should set up the code of practice and detailed rules for professionals in these areas.

Regarding private practice, ideally, hospital staff should be motivated not to do private practice either inside or outside the hospital. In practice, this principle might not be applicable in the short term. Consequently, a compromise has to be worked out in particular hospitals.

VII. FINANCE AND FINANCIAL MANAGEMENT

A. GENERAL PRINCIPLES

Neither the MOPH nor the Budget Bureau abdicates responsibility for providing core financing for autonomous hospitals. Core funding (to be defined later) will continue to be provided to autonomous hospitals from Government sources working under the principle that the Government should allow as much flexibility and independence as possible in the use of those resources. Core funding initially may be greater than historical levels.

The Government will continue to own the existing physical structure of the facilities at the time of transition to autonomous status. Future capital investments, financed by any sources, will also be

Government owned. Any future capital investment will require issuance of a Certificate of Need from the MOPH.

The Government will transfer all of the existing hospital properties to autonomous hospitals, including those under construction at the time of transformation into autonomous hospitals. Government should continue to provide budgetary supports for the unfinished projects to allow the hospital to complete construction and start the services as planned.

The current liabilities of existing hospitals will also be transferred to the autonomous hospitals on negotiation.

B. REVENUE

Sources of income for autonomous hospitals will be in several categories.

1. Government budget as a block grant based on performance, possibly not including capital investments during the early phase of transition.
2. User charges
3. Insurance payments
4. Earmarked funds.
5. Donations and hospital foundation.
6. Others, e.g., intellectual property, property rentals.

1. Government budget and capital formation

Future needs for capital budget will be requested on a biennial basis. This will have to be accompained by "Certificate of Need" to be issued by the MOPH based on the national master plan (See Section III G, Section V J, and XIV E). Budgets received for subsequent years will be based on the previous year's budget adjusted by inflation. This will continue up to the maximum of 5 years after which budgets will be based on tangible outputs and unitcosts.

The initial year's budget request will include a recurrent budget consisting of amounts for all posts based on current year and those for the approved posts the may budget filled up. Also included will be an operating budget received through the MOPH (excluding programs where specific outputs can be clearly defined). There will be budgeted for based on agreed upon targets for that particular year. The amount will equal that which was received in the previous year adjusted for inflation. The initial budget request will also include a development budget to allow the hospital to set up new work system, information system, accounts system and related manpower development activities. Finally, included will also be an amount for fringe benefits as percent of overall salary applicable to the large pool of civil servants. This will exclude medical benefits and pension gratuities which will be dealt with the separately.

Budget plans will outline not only the amount of resources required, but include the proposed sources of funds. All proposed hospital resources must be included in these budget plans, including funds flowing from government, from donations, foundations, anticipated user fees, and all other sources. No

resources should be withheld from the budgeting process, and all should be entered into the accounting system so that they can be monitored and audited.

2. User charges

2.1. Fee collection

Revenue generated from outpatient and inpatient services will be the responsibility of the Finance Office (for cash paying patients) and the Accounts Receivable Office for non-cash and insurance patients. These two offices may be combined in smaller hospitals.

For financial management purposes, patients should be identified by the source of payment at time of entrance/admission to the hospital. At least seven sources of finance exist including:

- Out-of-pocket or cash paying patients
- Civil Servants Medical Benefit Scheme (CSMBS)
- Social Security Scheme (SSS)
- Workman's Compensation Scheme (WCS)
- Voluntary Health Card Scheme (VHCS)
- Low Income Card Scheme (LICS), and other indigent or those requesting service on credit,
- Traffic Accident Program (TAP).

The Finance Office should prepare insurance benefit eligibility determination profiles for various public and private agencies so that this it is available for prompt benefit verification (eligibility determination) by the outpatient and inpatient units of the Finance Office, and for scheduling payment terms by the Accounts Receivable Office.

Hospital personnel dealing with revenue collections in the Finance and Accounts Receivable Offices, as well as their related personnel, must be specifically trained and continuously informed about any changes in hospital and insurance scheme policies. Hospital personnel should also be actively involved in fee collection efforts.

Hospital fee/charge determination or issuance of waivers, or exemptions at point of service, is the responsibility of the Finance Office. Inpatient charges/fees should be accumulated as the patient stays in the hospital and reviewed every three days by the Finance Office. Charges should be presented to the patients periodically to obtain payment before charges have accumulated.

Non-cash insured patients, patients with contracts, and bad-debt (non-paying) patients will be handled by the Accounts Receivable Office, which is responsible for setting reasonable terms of payment, billing, and payment collection. However, approval of waivers for the poor will remain the responsibility of hospital management, not the Accounts Receivable Office.

Computerization of this entire system is recommended. Care must be taken for messengers who collect cash from different units of the hospital.

2.2. Rate/fee setting

Each autonomous hospital's Governing Committee has the authority to set its own fees within guidelines set by the MOPH. Fees should be set in compliance with certain principles as defined below. This manual does not dictate the number and type of fees that can be charged by autonomous hospitals; but it does include the principles that must be followed by an autonomous hospital as it determines its fees for service and the prices to the patients for other services.

1) **Principle of graduated fee levels.** In general, fees should be set lower for "lower" levels of service or "lower" level facilities. This will encourage patients not to bypass lower-level facilities and enhance efficiency in consumption.

2) **Principle of price differentiation and cost recovery.** Autonomous hospitals are encouraged to generate fee-for-service revenue through whatever means possible. In some instances this will include the establishment of different classes of wards and services within service departments. In general terms, charges for services provided in private wards should exceed total cost (e.g., be profit maximizing), while charges for services in general wards should approximate costs. Services for the poorest people should be free or with fees set at below cost. In this way positive cross subsidies can be used to offset deficits from some services with surplus from others. The objective of the hospital in overall terms should not be profit making.

   To achieve this level of price differentiation, each hospital must conduct service costing exercises to know the true ***full cost*** of services before setting fees and waiver policies.

3) **Principle of subsidizing services with public good characteristics.** User charges for services with public good characteristics, e.g., immunizations, should either be set at zero, or at highly subsidized levels.

4) **Threat of dual standards of care.** Some hospitals will attempt to provide two levels of care at the same time. For example, some hospitals, in order to generate additional revenue, will set up "private" clinics alongside "normal" clinics. Those patients willing to pay would get quicker and more luxurious hotel services. All patients should be guaranteed the same quality of medical care. It is recommended that this type of dual standard of care not be allowed to operate in the same location of a hospital at the same time, because it encourages staff to over serve paying patients, and underserve others.

5) **Principle of horizontal imbalance**. GCs should set hospital fees with full knowledge of the fees set by other nearby facilities of similar type and range of services. If fees for service are either much higher or lower than neighboring institutions, patients will tend to gravitate to where prices are lowest. This shift in demand could upset the referral chain and also create undue financial hardships on some hospitals or patients.

6) **Principle of service department accountability.** Each service department is ultimately accountable for the cash value of services rendered in that department. In this light, each department

is a cost center with inputs and outputs and revenue. Departmental records should reflect: a) total services rendered; b) total cash value of services rendered (volume times fee); c) total cash received; d) cash value of subsidized or free services rendered. The total cash revenue of the hospital should be able to be traced back to each service department and standard values of fees to be ***expected*** should be established by the hospital. In this way expected revenue can be compared to actual revenue and service departments held accountable for any difference.

7) **Principle of transparency and full disclosure.** Fees should be collected openly and all payments should result in a receipt. There should be no under-the-table collections and no tips received for favored service. All transactions should be "official", all collections receipted, and all revenue accounted for and banked the same day.

3. Insured Patients

Since an autonomous hospital is a public hospital, it will be required to provide services to patients with every type of public insurance protection. It will also provide services to patients with private insurance coverage. In provision of services to these patients, the hospital needs to establish systems in terms of financial management, services, and information required by a particular insurance scheme.

4. Earmarked Funds

The use of earmarked funds by either MOPH or Provincial Health Boards should be done sparingly as a mechanism for financing autonomous hospitals, since it limits management autonomy. Matching investment funds may be introduced to gain more participation from the community.

5. Donations and Hospital Foundations

Hospitals are allowed to accept donations or additional financial contributions from patients or other sources. They should be included as another source of revenue unless there are specific purposes declared. In that case, contributions will be handled as a donation and must follow the rules and requirements governing donations to autonomous hospitals.

The cash value of donations and other hospital income should be reported to the accounts office and transparently entered into the balance sheet of the hospital. Maintaining records of such resources is the responsibility of the Accounts Office.

Autonomous hospitals have the ability to enter into agreements with individual donors as they see fit unless it entails capital investment. If it does, the same requirements outlined above for approval of capital projects must be met.

The GC should set up guidelines for receiving donations and granting privileges to donors. This will protect against abuse of donation for the personal benefit of donors. For instance, a person might donate a sum of money to set up renal dialysis for his/her personal use while the hospital has to maintain the service through cross subsidy from other sources. It is suggested that the outdated current guidelines of the MOPH should be amended. In order to encourage people to donate, tax exemption to these donors is required. Thus, the names of autonomous hospitals should be officially listed in the related document of MOF.

6. Benefits from Properties, Intellectual Properties and Related Services

The autonomous hospital should set rules and regulations to manage these sources of benefits transparently and fairly to all concerned parties. All of this income must be collected exclusively as hospital revenue.

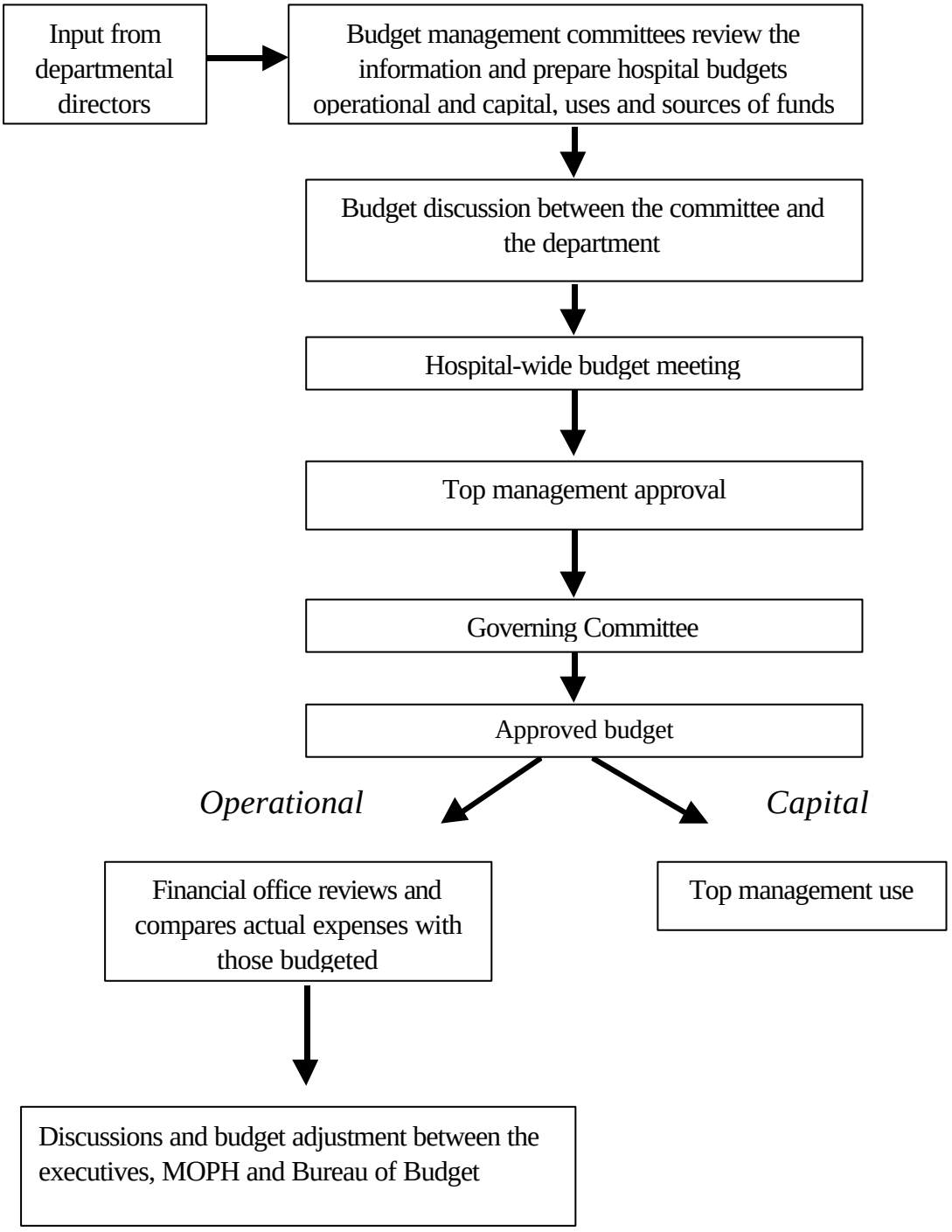
C. BUDGETING

1. Process and mechanism

The MOPH will provide guidance on budget planning principles, process, and format, but each individual hospital GC can dictate its own format as long as MOPH guidelines are not violated. A chart of accounts and list of cost centers for autonomous hospitals will be developed as part of the transition process.

Within the hospital, the budget process should be bi-directional; i.e., inputs from departments and from executive management will be included. A budget management committee should be established and made responsible for finalizing plans for operational and capital budgets, and for monitoring and control of budget utilization. The GC ultimately approves the budget upon the recommendation of the CEO. The budget should be presented as projects and justified by expected measurable returns.

The following figure presents an overview of the budget process.



Key specifications:

- The hospital sets up hospital budget committees to review and plan hospital budgets. Each hospital department provides inputs for its budget.
- At least two budgets should be planned—operational budget (including projected income, budgeted expenses, and personnel) and capital budget (including planned capital investment).

- There should be budget discussion sessions between the committee and each department's representatives to work out details. The capital budget should be presented as projects and justified by expected measurable returns (monetary or non-monetary).

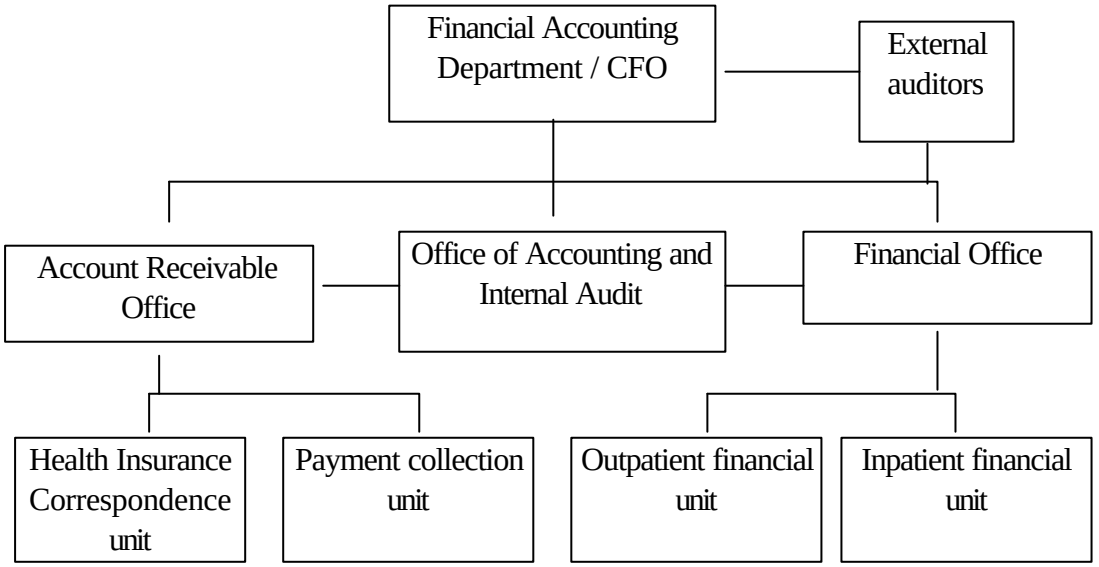
2. Budget utilization

Each department as a cost center should be encouraged to flexibly use the budget according to the plan with monitoring and feedback from hospital management using information from the Accounting Office and Internal Audit. In order to promote an efficient use of budget, departments might be allowed to keep any if they were found to fulfill the agreed upon performance after careful evaluation. Unused budget found as a result of not being able to fulfill the agreement, should lead to a negative assessment and require corrective measures. On the other hand, departments that overuse their budget by more than a preset limit have to be dealt with systematically and seriously by top management.

D. FINANCIAL MANAGEMENT

1. Overall system

1.1. Organizational structure



2. Accounting system

2.1. General principles

It is essential that, whatever the extent of financial autonomy, some fundamental rules and guidelines must be laid down. All autonomous hospitals should conform to a standard set of accounting policies and procedures and chart of accounts.[8] Management will have to assure the MOPH and SODA that

[8] Responsibility for developing these standards rests with the unit responsible for transition functions.

the hospital has adequate and proper safeguards for the effective monitoring, safe-keeping, and control of hospital and government resources, including budget control and asset management.

A survey of three private hospitals in the Bangkok area was conducted in September 1998 to review their accounting systems, revenue generation process, budgeting skills, skills in personnel management and their overall governance (Sriratanaban, September 1998). The hospitals ranged from 80 to 435 beds. From this review and from other documents, recommendations are being made on specifications for autonomous hospitals below.

Accounting systems of autonomous hospitals should be accrual-based with income and cash status updated daily. A cash system is needed for cash flow management. All hospitals should ultimately conform to a standard set of accounting policies and chart of accounts (developed by the Transitional Unit). Each hospital will be required to meet standards for monitoring, safekeeping and control of resources including asset management.

Cost centers in the hospital should be identified. Computerized accounting systems should be considered, however they require additional assessment and system design. Computerization would aid in improving efficiency. While off-the-shelf packages are available, they would require modification. Locally developed systems are also possible but require local expertise for maintenance and development.

Several offices should be established under the guidance of the Director of the Financial Accounting Department as detailed below [9]. In principle, the system must be designed to allow for checks and balances between accounting and cash management (see the above diagram as an example).

2.2. Key issues related to accounting:

Office of Accounting and Internal Audit. This unit handles general accounting functions, management of financial records and internal financial audit activities, budget control, and financial analysis. In large hospitals, the function should be translated into sub-offices operating in every cost center of the hospital. Hospital accounts should include an income account, expense account, accounts payable account, inventory account, and doctor's fee account. Multiple sets of books (accounting records) are no longer allowed.

- Each autonomous hospitals hould have at least one auditor who reports directly to the GC. Finance and program audits should be done routinely, comparing expected outputs and costs with actuals. Policies and procedures for internal audit should be developed by the CEO and approved by the GC. Where appropriate, this person(s) should also conduct regular (periodic) audits of contractors.
- Internal financial audit is an important mechanism to provide accurate and timely feedback on financial performance of autonomous hospitals. Financial audits are to review financial

[9] We speak here of "offices." Large hospitals may want to have separate offices, while smaller hospitals may want to speak of "functions" that are located in fewer offices.

statements and internal operating efficiency. Hence, hospital management could make necessary and timely adjustment to resource use and revenue generation. Additionally, by having a reliable internal financial audit function in place, the credibility of the hospitals could be built and maintained. Standard operating procedures of the audit should be set up and strictly enforced. The procedures should be in keeping with the guidelines of the Audit Office and with standard accounting.

While financial controls can be extremely helpful to top management, precautions should be taken against the following pitfalls: [10]

- Failing to tailor financial controls to the specific requirements of the hospitals.
- Neglecting to link financial controls to the strategic planning process.
- Instituting controls that send mixed messages about desired behaviors.
- Allowing financial controls to stifle innovation and creativity.
- Forcing the same financial controls on various subunits that have different control requirements.
- Implementing financial controls that are too sophisticated for organisation needs.

Financial Office. This unit manages incoming and outgoing cash transactions including maintaining cash record and bank accounts. Large hospitals may want to have units in the outpatient and inpatient departments since many cash transactions will take place in these units.

Accounts Receivable Office. This office manages non-cash income including insurance reimbursements, billing, debt payment, and collections.

4) **External auditor.** According to the Public Organization Act, the General Auditing Office will be acting as external auditor to all autonomous hospitals. In practice, the Office might delegate this task to an approved private auditor.

Financial reporting. Routine financial reports should include the following:

- Daily report of hospital utilization statistics, as well as income and expenses of the day before.
- Monthly summary report of cash flow status: incoming cash, outgoing cash, cash balances, cash-based versus accrual-based income.
- Monthly accrual financial statement, including balance sheet and income statement, and a statement of cash flow.
- Externally audited annual financial report, including balance sheet, income statement and statement of cash flow (this should also be submitted to MOPH).

Standard financial indicators. Standard financial indicators are needed to measure profitability, capital structure, capital efficiency, and liquidity.

Links with medical records. The accounting and financial management system should link to patient records so that a value of all services rendered in the hospital can be accounted for, and measures of

[10] Bartol KM& Martin DC. Information System for Management. In Management.. McGraw-Hill, Inc.1991. Toronto: 638.

efficiency can be monitored routinely. The number and type of services should be recorded down to the service delivery department. The amount of revenue earned - as well as collected in cash - should also be recorded down to the service delivery department, allowing for efficiency calculations at the lowest unit responsible for service provision.

Revenue forgone. All autonomous hospitals will be required on occasion to provide services at either a subsidized rate (or free of charge in the case of service to indigents). In other words, no patients will be turned away because of the inability to pay or lack of proof of such ability. In both instances the cash value equal to the revenue forgone should be captured in the accounting system of the hospital and reported periodically to the GC, Provincial Health Board and MOPH. In instances where hospital budgetary income is obtained through the application of formula-based grants, such a formula should take into consideration not only the potential for earning cash revenue through the sale of services, but also the cash value of revenue forgone through the provision of free or subsidized services.

E. BORROWING

Each autonomous hospital should be allowed to borrow commercially (debt finance) with the approval of the GC and under the guidelines established by the MOPH, the Budget Bureau and, as dictated, by the Public Organization Act.

F. TAXES

The Public Organization Act does not allow autonomous hospitals to be profit-making institutions. As non-profit entities, autonomous hospitals will not be subjected to income tax. This authorization needs to be amended in the Tax Royal Decree. To obtain non-profit status, the autonomous hospital must be licensed as such by the MOPH, and registered as a non-profit entity under the Public Organization Act.

G. JOINT VENTURE

Under Section 13 of the Public Organization Act, public organizations (i.e. autonomus hospital in this case) may hold stake or enter into partnership or joint venture with another legal entity under the rules laid down by Ministry of Finance with approval of the Cabinet.

H. INSURANCE

Autonomous hospitals should meet the insurance requirements as stipulated by the MOPH (i.e. fire, theft and other forms of insurance) which may be obtained from the recurrent budget. The MOPH should continue to carry the risk for all damage to hospital property (see also the hospital liability in Section VIII).

I. EQUIPMENT LEASING

After comparing price quotations for equipment if leasing is more cost effective than purchasing the same or similar item, equipment leasing is encouraged.

J. "CERTIFICATE OF NEED" AND CAPITAL INVESTMENT PLANS

The MOPH is responsible for developing a capital investment plan for the entire health sector in Thailand. This plan will dictate where and what type of capital investment can take place, both construction and major medical equipment. Each autonomous hospital will be required to submit a

request for capital expenditure (primarily for large and sophisticated equipment and capital construction) in line with their hospital's biennial capital budget plan. If the capital investment is approved by the MOPH, the MOPH will grant a "Certificate of Need" for the item under consideration.

Capital construction financed by government is allowed, provided that: a) it is included in the biennial capital budget plan prepared by the autonomous hospital; b) the capital budget is approved by the GC; and c) the autonomous hospital received a Certificate of Need from the MOPH. If capital construction is financed by private sources, it is allowed provided it meets all the above conditions. The MOPH does not need to issue a Certificate of Need for privately financed construction. If, however, the running costs of new buildings or construction are to be financed by government grant allocations or any other government sources, a Certificate of Need will be required. This is to ensure that the recurrent cost implications of capital projects are considered before construction begins.

K. CONTRACTING

Autonomous hospitals may rely heavily on contracting and contract management. Service agreements with the MOPH will essentially be contracts and allocations from the MOPH will have many contract aspects. In addition, district hospitals may one day become fund holders and contract with larger hospitals for services. For this reason, this manual will outline important aspects of the contracting process.

In general, contracting can be an effective method of extending services, focusing on core business, or improving operational efficiency of a hospital. Contracting is not always appropriate and decisions to operate in a contracting mode should be considered carefully.

1. Contracting out

Each individual autonomous hospital may consider contracting out as a strategy for improving operating efficiency. Four categories of questions should be asked by hospital management prior to moving forward on contracting*:*

- *Are there an adequate number of firms to allow for price competition to occur*? Will real competition take place? Are all firms qualified to bid on contracts and is the hospital assured of obtaining quality services?
- *Will competition promote efficiency*? Will competition, induced by the contracts process, actually reduce input prices while maintaining quality services?
- *Does the hospital have adequate funds* to finance a contract to the level where quality services can be provided?
- *Does the hospital have adequate skills* in bidding, awarding, managing and evaluating contract compliance?

2. Contracting in

There may be instances where the hospital may wish to bid on contracts to provide services in its target area. The objective of entering into such contracts could either be to generate additional resources for the hospital or to obtain alternative funding for services the hospital already is responsible for providing. Before embarking on such contracts, the hospital should answer the following questions:

- By entering into a service contract, will the hospital *dilute its prime mission* of providing curative services to its target population?
- Has *adequate cost analysis* been done to assure that services can be provided at contracted prices?
- Does the hospital have *adequate skills* in proposal writing, bidding on and managing service contracts?

3. Internal contracting/ Departmental budget holding

In some instances the structure of the autonomous hospital may allow for considerable autonomy of departments within the hospital. In this instance the CEO, with approval of the GC, may allow for block grants to departments with service agreements (contracts) specifying the number and type of services to be provided. This type of internal contracting requires a clear specification of services to be provided.

4. Contract content

Regardless of the type, contracts should generally follow these guidelines (Beracochea, no year given):

4.1. Type of contract. The type of contract should be clearly specified (e.g., block contract with indicative volumes; cost and volume contract; cost per person per time period; or other form.

4.2. Reason for the contract. Evidence of cost-effectiveness and an assessment of the feasibility of managing the contract should be provided to support the decision to contract.

4.3. Definition of the services to be rendered. A detailed description or list of the services to be provided by the contractor should be included to avoid confusion and improve monitoring. Service delivery should be stated in output or activity terms. The manner in which services are to be delivered should not be specified or implied in the contract. Finally, the contract should not specify that a particular individual is required to personally provide contracted services (in the case of contracting for primary care services).

4.4. Indicators of quality of service to be delivered. Indicators of expected quality should be specified in the contract.

4.5. Management of the contracted service(s). The contract should state who will oversee the contract and assess contractor performance, receive reports, and ensure that payments are processed without delay. On the contractor's side, the terms should specify the contact person and the responsibility for ensuring that terms are fulfilled.

4.6. Agreement on the number of staff employed. It may be desirable to indicate the optimal number of workers that should be dedicated to the contract and that the contractor meet minimum wage and other employment conditions required by the government.

4.7. Staff qualifications. The training requirements of staff that will be in contact with patients, if any, should be specified and their skills checked.

4.8. Property rights over equipment. Where the contractor takes over the service from the hospital, and hospital equipment is to be used by the contractor, the contract should indicate if these remain the property of the hospital, or if they are sold (at what price) or donated to the contractor. A list of this equipment should be attached to the contract.

4.9. Payment terms and other financial arrangements. These terms should specify the frequency and timing of billings and payments. Payment after services have been rendered protects the government from poor performance by the contractor. The facility where the services are to be provided should be empowered to recommend that payments be stopped in case of disputes. Payments should be linked to the delivery of certain services or the completion of certain tasks.

4.10. Information, accounts and other reports. The contractor should be required to submit the reports considered necessary for the effective management of the contract. Details of information requirements should be specified; type of information and the frequency with which data are required must be specified as well.

4.11. Productivity level agreement. A monthly workload should be agreed to facilitate performance monitoring.

4.12. Contract review. There should be a mid-term review, to discuss and overcome problems in contract implementation.

4.13. Contract duration. The date of expiry of the contract should be clearly stated.

4.14. Contract termination. The contract should specify that it may be terminated by any of the parties in writing with an agreed upon grace period. In case of performance failure, shorter notice should be specified. The mechanism to initiate termination should be defined and a safety deposit equal to at least one month's service should be required.

4.15. Penalties for poor performance. In the case of poor contract performance, penalties should be the last resort. Resources necessary for contract compliance and monitoring need to be planned and budgeted for (see Appendix E for checklists of contracting issues and content).

L. BANKING

All revenue (fees, insurance reimbursements, donations, block grants and other hospital revenue) should be banked daily, and openly and transparently accounted for by the Accounting Office. No spending of revenue should be allowed before banking and no hidden pooling of funds should be allowed. The hospital is allowed one or more than one bank account, but all accounts should be summarized, accounted for, and audited monthly. All revenue should be official revenue.

M. COST CONTAINMENT

The financial survival of autonomous hospitals will be the result of several factors, one being the ability of the hospital to contain costs and produce maximum output for the least possible input. In this regard, each hospital is encouraged to implement many if not all of the following cost containment strategies: utilization review; use of an essential drug list; use of generic drugs; monitoring length of stay; efficient management of drugs and supplies including the control of ward stocks; development of staffing norms and performance measures for staff; development of referral and other treatment protocols; monitoring of wastage of supplies.

In addition, when hospitals enter into contractual relationships, the contracts should include cost containment-enhancing aspects. For example, fee-for-service reimbursement should be avoided in favor of capitation or other payment mechanisms that are likely to provide incentives for more efficient use of resources.

N. FREE OR SUBSIDIZED SERVICES (WAIVERS AND EXEMPTIONS)

Some services will be provided free of charge. A national principle is that people will not be turned away because of inability to pay, or that some services (or clients) should be provided with services free of charge to stimulate demand. Each hospital should establish a system of waivers and exemptions, within MOPH guidelines, which are transparent and not too cumbersome for the patient. The cash value of services provided free of charge (revenue forgone) should be captured in the accounting system of the hospital.

A waiver system for outpatient services should be a simple process. If a waiver is required, the staff person in charge of the the outpatient services department should be allowed to grant the waiver. The value of inpatient services is greater than outpatients services. For this reason, waivers for IP care should be a two-step process. Patients payment status should be determined at time of arrival at the hospital, and hospital counselors responsible for authorizing waivers for free care. The total value of all waivers should be accounted for in hospital accounting financial records.

VIII. MANAGEMENT INFORMATION SYSTEM/HOSPITAL INFORMATION SYSTEM (HMIS), ACCOUNTING SYSTEMS

Information technology will be one of the cornerstones of successful management of autonomous hospitals. Exploring a number of public and private hospitals indicated that information technology is needed to:

- Increase the efficiency and effectiveness of the individual course of treatment and the overall process of health care.
- Allocate, manage and control hospital resources.
- Improve quality and outcomes of patient care.
- Enhance public health intervention monitoring and evaluation.

If the above conditions are to be fulfilled, the hospital information systems should provide key users with:

- Access to timely and comprehensive information about health service delivery, costs, and performance.
- Necessary information for tactical and strategic planning.
- Necessary information allowing for the monitoring of service, and staff and the functions of the hospital in general.
- Concurrent indicators of hospital utilization and functioning.

Chawla and Govindaraj (1996) note that hospitals have at least eight subsystems to be served by their information systems:

- Patient diagnosis and treatment system that includes various clinical and non-clinical departments of the hospital.
- Accounting and financial management systems.
- Expenditure and general accounting systems.
- Personnel systems.
- Support services systems.
- Management control systems.

All these systems are supported in the information management unit and managed by the Director of Information and Planning. In this manual, the accounting and financial management information systems are addressed in the Finance and Financial Management section.

The Health Management and Financing Study Project implemented an assessment of several hospitals' management information systems (HMIS) (Sriratanaban, 1998). The objective of the assessment was to describe existing HMISs and to formulate recommendations for future HMIS development for autonomous hospitals. Following are the recommendations of this assessment.

The desirable features of HMIS include:

- The capacity to address information needs at all management levels in a hospital. The short term priority should be given to information for financial management at operational and middle management levels, since this is currently the weakest area in hospitals (but the most sensitive).
- The capacity to meet the basic requirements as outlined by the MOPH in terms of the national policy process and health services system management, e.g., disease surveillance, national health accounts, hospital accreditation, and budgeting.
- A structure amenable to future development to suit ever-changing needs of hospital management and national policy process.
- A database system which allows for simultaneous accessing and processing by many eligible users.

The HMIS should be centrally developed in order to ensure standardization of data communication across multiple levels of management and different interrelated agencies. An additional advantage of a centrally developed HMIS is economies of scale in investment, achieved through making use of existing expertise in HMIS in both public and private sectors. Existing expertise should be mobilized to set up terms of reference for HMIS development with the SODA (see Section XIII) responsible for this task in the short to medium term.

Training of personnel to maintain the HMIS in each hospital was considered as one alternative to guarantee smooth operation of HMIS. Given a certain degree of experience and expertise, existing hospitals with HMIS could participate in organising and providing the training. The second alternative is to contract out maintainance service. This alternative is based on two assumptions, namely: a) the public sector payment scale will not be attractive enough to retain the personnel in this field, and b) it will be more cost-effective to contract private firms to adopt the first alternative.

Financing agencies such as the Social Security Office, Comptroller-General Department, and the Health Insurance Office should jointly provide financial support to on-going development of an HMIS.

Approximate time frame for implementation of functional modules for public hospital HMIS			
	1 to 8 months	9 months to 2 years	3 to 5 years
1) Patient Management Module			
Patient registration	X		
Patient admission and discharge	X		
Bed availability, assignment, transfers	X		
2) Medical Records Module			
Master patients medical record index	X		
Medical record abstrating system		X	
Chart control	X		
Case mix database	X		
Classification system groupers(DRGs)	X		
Utilization management		X	
Quality assurance		X	
3) Clinical Departmental Modules			
Resource scheduling			X
Laboratory	X		
Radiology	X		
Pharmacy	X		
Operating room		X	
Other therapeutic services			X
4) Clinical Care Management: Physicians & Nurses			
Order entry			X
Results reporting			X
Staffing and scheduling			X
Medication administration records		X	
Patient assessment, care planning, and documentation		X	
5) Service Billing Module			
Patient billing account index	X		
Inpatient and outpatient billing	X		
Accounts receivable and collections		X	
6) General Administrative and Financial Modules			
Personnel and human resources	X		
Payroll	X		
Accounts payable	X		
Materials management/purchasing	X		
Fixed assets management			
General ledger	X		
Cost accounting	X		
Charge master/transaction register	X		
Financial management and reporting	X		
Third party contract management		X	

IX. LEGAL AND REGULATORY ISSUES

A. GC AND CEO LIABILITY (HOSPITAL LIABILITY)

The Governing Committee of an autonomous can be held liable by the government for any wrongful acts committed by its officers; however, any liability from performing hospital functions will be the responsibility of the State. The CEO may be held liable by the GC with regards to any other damages to the assets of the hospitals, if applicable, and is accountable to the GC for the overall performance of the hospital. The CEO's liability is based on Section 4 of the Tort Liability of Government Officer Act, B.E. 2539. The CEO also may also be liable only for his own gross negligence as stated in the tort liability of Government Officer Act, B.E. 2540. Any ultra vires acts performed by a member of the GC or by the CEO shall create civil or criminal liability for such person, as the case may be.

B. MEDICAL RECORDS

Since an autonomous hospital shall be interpreted as a government unit under Section 4 of the Government Information Act, B.E. 2540, any disclosure of a medical report or personal information, which shall unreasonably infringe one's personal right, shall be protected under Section 15 (5). There is an exception to the general rule, i.e. any government unit with information under its possession or control, may be required to release such information under certain conditions with justifiable reasons and at the officer's own discretion. However, this order may be appealed to the committee appointed under this Act.

C. STAFF LICENSING

All professional staff in an autonomous hospital shall be required to hold a license for practising in their professions, as directed by the Control of Medical Practice Act, B.E. 2479. A medical doctor shall not practice his/her profession unless he/she has a medical license to practice as required under the Medical Profession Act, B.E. 2525. A pharmacist, dentist, or nurse shall not practice without his/her professional license under the Pharmaceutical Profession Act, B.E. 2537, or the Dental Profession Act B.E. 2537, or the Nurse and Midwifery Profession Act, B.E. 2538 respectively. Therefore, all medical professions who are required by law to hold a professional license in order to practice in a government hospital must also be required to follow similar requirements in an autonomous hospital.

X. SERVICES

Although the mission of autonomous hospitals is to provide curative care, it is unrealistic to assume that primary medical care services will not be provided in a hospital setting. The target population of primary medical care services should be the people living in the vicinity of the hospital. These services might be provided as an integral part of ambulatory and emergency service, as in Hong Kong public hospitals where specialists in this field are responsible for delivering the care. If this is going to be the case, postgraduate training in emergency medicine and ambulatory care should be set up. This alternative will not only serve the above purposes but will also help improve the chronic ailing emergency medical services of the country.

Curative medicine and public health (disease prevention and health promotion) are interconnected. On one hand, hospitals could benefit public health planning and intervention through the provision of clinical information (e.g., disease surveillance, trauma registry), advocating public health policy (e.g., smoke-free environment, safe sex practices, prevention of drunk driving), and participation in outbreak investigations. On the other hand, public health benefits the hospital by reducing unnecessary curative care workload.

Similarly, medical care service is a spectrum of primary medical care to tertiary medical care. Each level of care will reach its maximum capacity and efficiency only through concerted efforts in provision of care within a referral system. Consequently, a mechanism should be set up to coordinate the plan and operation of all levels.

The Provincial Health Board, a possible future version of the current Provincial Health Office, could be such a mechanism for service planning. It could purchase hospital services at all levels through contractual relationships. It could coordinate public and private health care providers, and be an interface between the health sector and other sectors in organizing public health programs. Consumer right protection will be another role of this body. Although this body will still be a bureaucratic institution, its structure would need to be modified so that its mission will better serve the needs of the local community rather than the central organizations. One major change in its structure should be the appointment of the Provincial Chief Medical Officer (PCMO). The current system should be replaced by a transparent and merit system which will result in a better qualified/more capable and more independent PCMO. The promotion, incentive structure, and evaluation of the PCMO and his/her team should be based on clearly defined and more objective performance.

XI. DRUG MANAGEMENT

Drugs and medical supplies are two of the most important inputs for hospital services. Proper management of these inputs will lead to better efficiency in the use of hospital resources, and may also lead to better quality of services. In this respect the hospitals should consider the following aspects of drug and medical supplies management:

- Procurement to ensure drugs of good quality at the lowest prices possible.
- Inventory management to ensure efficient use of drug supplies and proper inventory levels.
- Rational drug use in the hospitals.

This section will deal with an overall system for good drug management in autonomous hospitals, and will cover the issue of drug procurement and inventory management. The part on rational drug use within the hospitals is not within the scope of this document.

Overall System for Drug Management

For efficient drug management, each autonomous hospitals should establish a Pharmaceutical and Therapeutic Committee (PTC). Its main functions will be the following:

- Drawing up the hospital drug list that will ensure efficient inventory and rational drug use in the hospital rather than having an open-ended drug list (and thus large inventory) that is difficult to manage.
- Ensuring that there will be good quality drugs procured at reasonable prices. This might be accomplished by setting up sub-committees or workig groups that will help in selecting and bargaining with the drug suppliers.
- Monitoring drug use as well as drug management in the hospital and giving advice to hospital management to take proper corrective actions, if necessary.

The PTC should consist of doctors in good standing and respect who understand the issues of drug use as well as management, the pharmacist(s), and a representative from general management. The PTC's functions are both executive and advisory. The term of the PTC should be limited to two to three years in order to allow broad-based participation and more opportunity to serve and be educated through the work of the PTC. Its achievement should be reported to and monitored by the GC of the hospitals. The results of its drug procurement should be made openly known to all the management teams in the hospitals.

Besides the PTC, hospitals should also introduce a drug management information system. Such a system would consist of three basic interconnected modules. First, a drug inventory management module, including pharmacies and other outlets in the hospitals should be established. Second, a drug use information system, capturing data about drug prescriptions and thus overall drug use pattern by providers in the hospitals would be useful. Third, a drug pricing information system should be developed to allow the review of drug prices purchased from various sources. In the future, if the MOPH establishes a network of drug procurement and pricing, autonomous hospitals will benefit from as well as contribute to the network. This third module will be used for the selection of proper drug companies and prices for negotiation during drug procurement.

Drug procurement in autonomous hospitals has to ensure good quality as well as reasonable prices. One approach that may help to meet these objectives is to negotiate prices based on bulk procurement estimates based on annual drug use, rather than separated individual procurement every month or every few months basis. The bulk purchase negotiation should be carried out at the beginning of the fiscal year using data from the drug use of previous years. Different drug items can be negotiated with different distributors rather than having to lump all items into a single distributor. As autonomous hospitals will not be constrained by government rules and regulations for procurement, it should employ such flexibility to the fullest extent possible. However they should also try to ensure accountability and transparency to ensure the efficiency of this overall process. Some of the practical steps may be as follows:

1) The PTC appoints a working group for drug procurement and negotiation.
2) The working group analyzes the pattern of drug use and estimates the requirement for each drug in conjunction with the hospital drug list based on generic names.
3) The working group goes through the list of all possible distributors/manufacturers with the aim of selecting only those with acceptable drug quality for the needed items.
4) The working group negotiates with individual distributors/manufacturers for each of the drug items found to be of acceptable quality.

5) The prices offered by each distributor/manufacturer for each drug item can then be compared, selecting those only of acceptable quality with the lowest prices.
6) The issuance of orders for the drugs should be phased at proper intervals over the year to avoid inventory overstocking or shortages of drugs. The terms of payment for the annual bulk purchase will also be negotiated with periodic ordering.
7) Drugs procured through this system should be double-checked for quality. Those failing to yield acceptable quality will be excluded from the following year's bulk procurement negotiation.
8) Each of the actual drug orders sent to the manufacturer/distributor will be computerized and shared with other hospitals or kept as records for future use in the negotiation of drug prices. This information will also be shared with others through the information network that the MOPH may establish later.

A. ESSENTIAL DRUG LIST

Autonomous hospitals should comply with national drug policy by putting major emphasis on the procurement of essential drugs. The current practice of spending at least 80 percent of the drug budget on the essential drug list should be maintained. At the national level, the mechanism to update the essential drug list has to be improved in order to convince clinicians that cost-effective drugs will be included in due time. Having a hospital-level pharmaco-therapeutic-committee is an essential mechanism to promote use of the essential drug list through a selection and education process. There should be practice guidelines in dealing with representatives of private drug companies so that the market mechanism can be brought under control. For instance, direct contact between the representatives and the clinicians should be curtailed. There must also be a drug formulary.

B. CONTROLLED SUBSTANCES

In principle, the current practice of prescribing addictive drugs such as morphine and other controlled substances should be maintained. At the same time, there is a need to cut down on paperwork in order to facilitate appropriate use of opioid analgesics, which so far have been under-prescribed in terminally ill patients.

C. GENERICS AND BRAND NAME DRUGS

Currently, clinicians tend to believe that generic drugs are inferior to brand-name drugs in terms of bio-availability, pharmaco-dynamics, and pharmaco-kinetics. The Department of Medical Science should collaborate with the Food and Drug Committee and universities to ensure quality control in drug manufacturing. Information on drug quality should be made available to the clinicians.

XII. COORDINATION WITH PRIMARY HEALTH CARE, PREVENTIVE AND PROMOTIVE SERVICES

A. PRIMARY HEALTH CARE

Autonomous hospitals should be supportive of primary health care by empowering patients and family to adopt self care attitudes and behaviors. For instance, hospitals might facilitate development of self-help groups for cancer patients which they and their family can share feelings, experiences, and knowledge related to cancer treatment. At the same time, autonomous hospitals might set up a patient

resource center to provide relevant information in various forms and resource persons whom patients and family can contact for necessary support. In terms of producing new knowledge, autonomous hospitals can take part in research to develop appropriate technology for primary health care, such as a randomized trial to test the efficacy of herbal medicine commonly used by the community.

B. PREVENTIVE AND PROMOTIVE SERVICES

Given the wide recognition of hospitals as a reliable source of curative care, they are in a good position to encourage and deliver preventive and promotive services which seem to be more subtle and under-demanded by patients, family, and community. At least, autonomous hospitals should engage in the provision of clinical preventive services like those recommended by the US Task Force of Clinical Preventive Services. As far as non-communicable diseases are concerned, autonomous hospitals could take the initiative to launch screening programs for cervical cancer, a major preventable malignancy. Based on a powerful hospital information system, autonomous hospitals could use the information to provide feedback or mobilize concern of the public and other sectors about major public health conditions such as traffic injuries, or smoking-related conditions.

C. SPECIALTY SERVICES

Instead of adopting a discipline-oriented approach to setting up specialty services, future speciality services of autonomous hospitals should be established according to objective and well defined patients' and community needs. Concern for system efficiency should be strengthened among hospital management and clinical staff whenever setting up specialty services are being considered. In practice, this will lead to better (more cost-effective) distribution of specialty services, in particular the referral network which most of the time means heavy investment of human resource and equipment. There seems to be a need for a coordinating mechanism in planning for specialty services among health care providers in certain geographical areas (a big province or group of small provinces). A built-in monitoring and evaluation process should be part of the plan.

XIII. QUALITY ASSURANCE

Widespread acceptance of the hospital accreditation movement in the past few years among public and private hospitals is good evidence that quality of care is a major issue in provision of hospital services. This momentum should be further sustained and developed. An important element of the issue is quality assessment. A bottom-up approach to develop performance indicators for quality assessment should be encouraged in autonomous hospitals. Hospital management should take leadership in the development of performance indicators and in the process of using the indicators to continuously improve quality of care.

Hospital management should set up key teams to develop standards or guidelines and administer and monitor their implementation to assure the quality of the following services:

- General medical care
- Drugs and pharmaceutical prescribing
- Review of mortality and morbidity

- Clinical-pathological review
- Risk management and mass casualty
- Nursing standards
- Medical ethics
- Facility utilization review

The activities and their results and recommendations should be passed to the CEO, the medical director, and GC as appropriate.

XIV. REFERRAL LINKS UPWARD AND DOWNWARD IN THE SYSTEM

In the network of a referral system, patient flow as well as relevant information could be both upward and downward. The cost of referral cases will be covered by a predetermined budget allocation, based on the historical service workload of each provider. Clinical information is an essential element of effective referral system. This area has been neglected so far, so ways and means to improve the information should be identified and seriously employed. Better hospital information could be an alternative. Quality of clinical information should be part of the performance indicators for individual clinicians. In addition, ambulance service has to be improved substantially in terms of manpower and vehicles for transportation. Better qualified personnel could be obtained by training and retraining. It seems as if the British system, in which a specialized center was set up to offer training and services, is an efficient alternative. The second alternative is to incorporate the training as part of emergency medicine, a specialty which is not available in Thailand.

Failure of the current referral system is in part due to excessive freedom of choice of the consumers. Co-payment is a suggested solution to this problem. Non-emergency patients who bypass lower levels should be penalized by co-payment or by curtailing their privileges. However, in many instances, bypassing is a result of poor quality of care at the lower level facilities. Before co-payment are fully enforced, quality of care at lower levels has to be improved. Priority should be given to care for common conditions such as URI, diarrhoea, dyspepsia, etc. Providers at immediate higher level of care should be given a mandate to help improve the quality of care at lower levels. This will at the same time improve working relationships between providers, an essential element of a good referral system.

XV. TRANSITIONAL PHASE

Before hospital autonomy can be fully implemented, a transitional phase of approximately one year in duration will be needed to prepare for several necessary conditions such as personnel transformation, formulation of allocation criteria for block grants, and recruitment and appointment of GC's and CEO's. During the first two years of transitional phase, the following activities are proposed, as outlined in the following table.

Activity	Month											
	2	4	6	8	10	12	14	16	18	20	22	24

MOPH												
• Endorse the Royal Decrees for setting up 1st group of AHs and SODA	X											
• Assign responsible authorities to work with SODA	X											
• Endorse the Royal Decrees for setting up 2nd group of AHs							X					
Cabinet												
• Promulgate the Royal Decrees	X						X					
Bureau of Budget												
• Assign responsible authorities to work with SODA	X											
• Allocate block grants to SODA	X											
• Allocate block grants to AHs											X	
Civil Service Commission												
• Assign responsible authorities to work with SODA	X											
• Collaborate with SODA and MOPH in personnel transformation for												
- 1st batch AHs		X	X	X								
- 2nd batch AHs							X	X	X			
• Collaborate with SODA and MOPH to set up pension system for the hospital personnel		X	X	X								
AHs												
• CEO's, hospital management, and SODA propose to MOPH for appointment of GCs	X											
• GC work out rules and regulations for personnel and financial management		X	X	X	X							
• Formulate strategic plan and work plan		X	X	X	X							
• GC and CEO work with SODA to determine level of budget supports		X	X	X	X							
• Communicate with personnel and community		X	X	X	X							
SODA(see also transitional mechanism in the next section)												
• Capacity development for AHs		X	X	X	X	X	X	X	X	X	X	X
• Work with GCs and CEO's to determine level of budget supports		X	X	X	X	X	X	X	X	X	X	X
• Work with CSC and MOPH to transform hospital personnel		X	X	X	X	X	X	X	X	X	X	X
		X	X	X	X	X	X	X	X	X	X	X
• Develop work systems for AHs		X	X	X	X	X	X	X	X	X	X	X
• Communicate with community and all concerned parties		X	X	X	X	X	X	X	X	X	X	X
• Work with AHs, CSC, MOPH, BoB in designing system for monitoring and evaluation / R&D strategy and workplan												

Note: AH = autonomous hospital

XIV. TRANSITIONAL MECHANISMS AND SELECTION OF HOSPITALS[11]

In order to ensure the smooth transition as well as provide necessary support and render essential development for the autonomous hospital, a transitional mechanism will be crucial. Such a transitional mechanism will be expected to perform the following roles and functions:

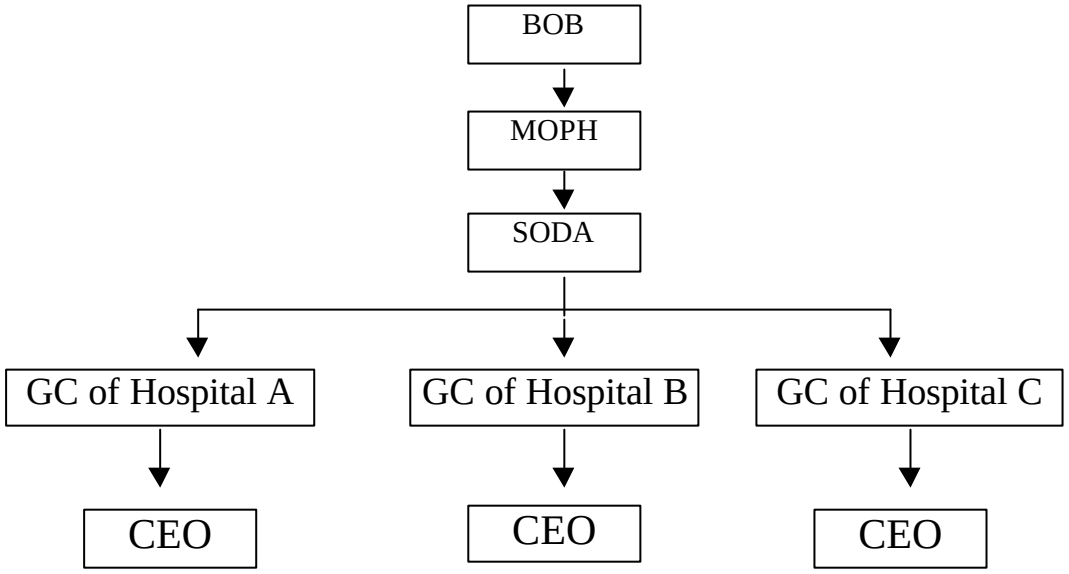
1) *Develop an essential work system for autonomous hospitals*. This includes an accounting system and management information system, external and internal audit, and performance appraisal (both for intra-hospital and external).
2) *Develop capacity* for autonomous hospitals, including all the training of management and other core staff as outlined in the section on "Capacity Development in the Transition".
3) *Nurture the initial pilot* autonomous hospital to ensure smooth takeoff.
4) *Advocate* for autonomous hospitals, as well as act on behalf of the autonomous hospitals when dealing with the central government offices such as the Bureau of Budget, and General Auditing Office.
5) Work with autonomous hospitals to *determine the level of budget support* necessary for each hospital. It will also work to ensure that budgetary supports to autonomous hospitals will be performance-based in the next five years.
6) *Determine the optimal size and types of service*, thus providing background for the expansion and future investment plan for the autonomous hospitals to ensure efficiency of the overall system. This will also ensure that autonomous hospitals will receive equal attention from the central government in terms of capital formation (which will still be determined by the central government).
7) Take care of the *evaluation* of the policies on autonomous hospitals as well as individual hospital performance assessment and evaluation. The transitional mechanism will not carry out the assessement or evaluation by itself, but will determine the terms of reference and identify the proper team to carry out the functions.
8) In order to ensure that autonomous hospitals will not lead to a less integrated health service delivery system, the transitional mechanism will also work out and *help develop a provincial health system* that will closely interface with the autonomous hospitals.
9) Ensure that there will be necessary *research and development* that will help the development of autonomous hospitals, either for intra-hospital management issues or the overall system supports.

A. ORGANIZATION AND STRUCTURE OF THE TRANSITIONAL MECHANISM

The transitional mechanism, A Supportive Office for Development and Autonomous Hospitals (SODA) will be established as an Executive Agency to ensure effective and flexible support along with efficient management and continuity of supports that might not be easily obtainable within the conventional bureaucratic culture. It will be governed by a Board of Directors consisting of ex-officio members from key organizations involved, such as Bureau of Budget, MOPH, Office of the Civil Service Commission, General Auditing Office and appointed members who possess technical merit with regard to health services and system development. The Board will select and appoint the CEO according to the Public

[11] BY "TRANSITIONAL" WE MEAN TEMPORARY WITH THE RESPONSIBILITY FOR TRANSITIONAL ACTIVITIES TO BE DECIDED.

Organization Act. The necessary budget for its operation will be provided by the government through a well-defined budget line in the form of a block grant to ensure flexibility of its use in executing the said functions. The SODA should be established at the beginning of the initiation of the autonomous hospital program. The need to continue the SODA will be determined periodically by evaluating it against its achievement of expected roles and functions. The first evaluation will take place after the first five years of operation. In order to minimise the attempt to continue the operation of this mechanism, its staffs might consist mostly of seconded civil servants. Its relationship with the MOPH and the autonomous hospitals is depicted in the following diagram.



Although the SODA will not be in a direct line command under the MOPH it is important that it maintains certain lines of relationship with the MOPH and the autonomous hospitals.

B. SODA AND BUDGETING OF AUTONOMOUS HOSPITALS

Because the MOPH will not have direct control over the autonomous hospitals except through certain appointed members in the GC (such as the Provincial Chief Medical Officer - PCMO from the respective provinces, and certain appointed members from the central ministry), the MOPH will function only as the conduit for budget support for the autonomous hospitals. However, the MOPH will employ the SODA to work out a detailed budgets with each autonomous hospital based on the principles set forth. The SODA will thus function as the technical arm for the MOPH in the budget negotiation process. Any disagreement or other results of such negotiations will be summarised and be finally decided by the MOPH executive committee before passing on to the budget request process.

C. THE SODA AND HOSPITAL PERFORMANCE ASSESSMENT AND EVALUATION

The SODA will also work to have the performance of individual hospitals assessed and evaluated according to the terms agreed upon as a results from the budget negotiation process, and then report to the MOPH and the Bureau of Budget as well as other agencies through its Board members. The SODA will not conduct the evaluation directly but define detailed terms of reference and subcontract for proper

evaluation teams. The evaluation will provide certain inputs as a basis for the following year's budget negotiation as well as necessary decisions in the related offices in the budget scrutiny process. The SODA will act on behalf of the autonomous hospitals in dealing with the central government offices if necessary. This will be determined jointly between an individual hospital and the SODA executive in their regular negotiation process. The SODA will also be responsible for the overall evaluation of the creation and function of the autonomous hospitals in terms of system equity, efficiency, and prospects.

D. THE SODA AND OTHER DEVELOPMENT FUNCTIONS

The SODA will work with each individual hospital to develop plans and carry out support activities – such as capacity development and development of work system, providig necessary support based on a certain degree of systematic assessment carried out by the SODA. The education or system development services will be rendered by subcontractors to be identified and monitored by the SODA.

E. DETERMINING THE OPTIMAL SIZE AND TYPES OF FUNCTIONS OF AUTONOMOUS HOSPITALS

In order to determine the optimal size and types of services to be rendered by the autonomous hospitals, the SODA will carry out optimal facility planning for different areas in the country with priority attention be given to those areas with autonomous hospitals. The results of the technical work will be submitted to the MOPH for final decisions and subsequent budget requests, if necessary. The SODA will then work with individual hospitals to ensure that the implementation plan is followed and give advice to the MOPH on any of the related issues or problems that may result from such implementation. The SODA will not have direct authority over the autonomous hospitals in this respect but will only work out the techical details necessary for the MOPH. The SODA will also initiate any research necessary based on its work with the MOPH and other related agencies and the autonomous hospitals. The funds for such research will be provided from the budget of the SODA.

F. THE SODA AND ADVOCACY OF AUTONOMOUS HOSPITALS

In the operation of autonomous hospitals there will be questions arising from the general public, hospital staff, hospital board members, and other related agencies. Many of these questions may be easily addressed or clarifed and should be attended promptly to ensure smooth operation of the autonomus hospitals and prevent possible disruption of services. On the other hand, when there is a need to proactively communicate with both the general public and hospital staff, the SODA will work out a detailed plan to ensure that those concerned will be properly informed.

G. SELECTION CRITERIA FOR CANDIDATE AUTONOMOUS HOSPITALS

A number of criteria should be used to select which hospitals should be initial sites for autonomy.

1) Having a strong desire to change.
2) Showing clear goals and needs for change which are compatible with the concerns of the Government, the people, and the staff.
3) Showing clear and promising approaches to achieve the goals.
4) Good track records of hospital management.
5) Having support of the staff.
6) Having leadership for change.

7) Taking account of prospective roles of creating snowball effects on system changes.
8) Participating in the Hospital Accreditation Project.

H. SUCCESS FACTORS FOR HOSPITAL AUTONOMY

Success will be the result of a number of factors:

1) Government should provide tangible support in terms of money and administrative support for an indefinite period of time.
2) Hospital management and staff should be trained and retrained in order to instill a new mind set, skills, and knowledge conducive to autonomization.
3) Strong political must exist at the highest political levels.
4) Good candidate hospitals should be selected so that a success story can be obtained
5) Short term quantifiable goals should be identified in order to demonstrate tangible and timely achievement to all stakeholders (e.g., improvement in physical facilities; visible staff benefits - new uniforms; shortened waiting time; financial indicators; activities outlined by patients, community, staff, management team and the clinicians).
6) Repeated communication with staff, the community, bureaucracy and the media
7) Active community participation.
8) information and education.

XVII. MONITORING AND EVALUATION OF HOSPITAL AUTONOMY

A. BACKGROUND

The Ministry of Public health routinely monitors health system performance and occasionally evaluates system cost, efficiency, and impact. These types of activities will continue under a system of autonomous hospitals. However, the introduction of autonomous hospitals alters the means by which health system objectives are achieved and alters the relationships between different parts of the health system, possibly affecting system performance. For this reason, it is proposed that hospital autonomy be closely monitored and evaluated (M&E).

B. THE FOCUS OF MONITORING AND EVALUATION UNDER HOSPITAL AUTONOMY

Service monitoring Hospital autonomy will go through several stages in the coming years. Routine health services will need to be delivered as they have always been done. The movement from being government-owned and operated to autonomous status should not affect the number, type, location, or quality of health services delivered to the community. The delivery of health services needs to be continuously monitored

Transformation to autonomous status Selected hospitals will be transformed in a number of ways with the support and assistance of SODA. This transformation will require system design and installation, personnel training, equipment purchasing, and so on. Are policy, legal and regulatory factors appropriately established and implemented? Are transition support systems in place? Are transition activities being implemented according to plan? Are systems being designed, installed, and implemented and having the desired affects? Has the SODA been established and is it functioning as expected? Are resources flowing as planned to autonomous hospitals?

C. IMPACT ON THE HEALTH SYSTEM

If designed and implemented appropriately, hospital autonomy should lead to notable improvements. In order to assess this, a M&E plan needs to be put in place to monitor access and availability of services, quality of care, sustainability of finances, systems and consumer demand, referrals to and from autonomous hospitals to other parts of the health system and improvements in the policy, legal and regulatory environment. These environmental aspects should be evaluated carefully.

D. MONITORING AND EVALUATION FRAMEWORK

Hospital-specific M&E A framework for the monitoring and evaluation of hospital autonomy in Thailand calls for activities related to access to and availability of health services, quality of care, sustainability and the autonomous hospital's enabling environment. Each of the four areas to be monitored is subdivided further into one or more sub-categories. For example, sustainability really refers to financial sustainability, the sustainability of critical hospital systems, and sustainability of demand for hospital services. Each box in the diagram represents a specific area to be monitored or evaluated and each should have a core set of indicators and definitions.

For example, under the quality area, provider performance should be routinely monitored using defined performance indicators. Examples of indicators could be as follows:

- Bed occupancy rate
- Average length of stay (ALOS)
- Case fatality rate
- Admissions per 1,000 population
- OP visits per 1,000 population
- Etc.

Some indicators would be defined and used for national monitoring and evaluation, while others will used specifically by an individual hospital.

E. DEFINING PERFORMANCE INDICATORS

Performance indicators should be time bound, truly measure what is intended, and be measurable. Performance indicators for routine monitoring should be readily availabile from data already being collected (e.g., bed occupancy rates are calculated from data available routinely in all hospitals). Evaluations, occurring less frequently, can include indicators requiring specific data collection efforts repeated periodically. For example, efficiency measures may require unit cost data not routinely available in a facility although volume statistics may be available.

F. RESPONSIBILITY FOR M&E

As a new national program, it is proposed that SODA be held responsible for the evaluation of possible systemic impacts of autonomous hospitals while individual hospitals would be held responsible for monitoring individual performance on service quality, cost and so forth. SODA should develop an initial set of minimum standard performance indicators and then, with individual autonomous hospitals, work towards identifying other indicators individual hospitals would like to use.

The budget for systemic monitoring and evaluation should be included in the budget of the SODA, but routine hospitals M&E should be financed by the individual hospital.

G. TIMETABLE

The following table shows proposed areas and timeframe for M&E at the overall system level. Each of the five years in the time frame is split into two halved (i.e., six month periods). As mentioned earlier, a clinical management information system will be a crucial component for M&E especially at hospital level. This underscores the importance of strong commitment by all concerned parties in developing hospital information systems.

	Year 1		Year 2		Year 3		Year 4		Year 5	
Areas	1	2	1	2	1	2	1	2	1	2
Allocating budget to SODA & autonomous hospitals	✓		✓		✓		✓		✓	
Presence of GC for each autonomous hospital	✓		✓		✓		✓		✓	
Presence of work systems to support autonomous hospitals	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Transfering hospital management and staff from civil servants to seconded hospital employees	✓									
Training hospital management and staff to implement the work systems	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Implementation of M&E at • Overall system level • Intrahospital level		✓	✓	✓	✓	✓	✓	✓	✓	✓
Setting up pension system for hospital staff		✓								
The SODA functions and achievement			✓		✓		✓		✓	
Development of PHO towards PHA			✓		✓		✓		✓	
Amendment or issuing required laws, rules and regulations		✓		✓		✓		✓		✓
Reporting outputs of M&E to authorities and the public		✓		✓		✓		✓		✓

H. MECHANISMS AND MANAGEMENT FOR MONITORING AND EVALUATION

Since hospital autonomy will be part of bureaucratic reform, its performance and achievement should be assessed by the Bureaucratic Reform Committee, chaired by the Deputy Prime Minister. Given the technical details required in monitoring and evaluation, it is suggested that the SODA should take care of monitoring and evaluation at both levels by setting up terms of reference with approval of the Committee and monitoring the monitoring and evaluation process. Under the terms of reference, a single or multiple independent agencies will be commissioned to carry out monitoring and evaluation and report to the Committee.

The budget for implementing M&E should be included as part of the SODA's regular budget.

As mentioned earlier, a clinical and management information system will be a crucial component for monitoring and evaluation especially at hospital level. This underlines the importance of strong commitment by all concerned parties in developing hospital information systems.

REFERENCES

Beck, Gregory "Recommendations: Strategy for Achieving Health Facility Autonomy" unpublished paper.

Beracochea, Elvira "Contracting out of non-clinical services: The experience of Papua New Guinea".

Carver, John *Boards That Make a Difference: A New Design for Leadership in Nonprofit and Public Organizations* Jossey-Bass 1997.

Chawla, Mukesh and Ramesh Govindaraj "Improving Hospital Performance through Policies to Increase Hospital Autonomy: Implementation Guidelines" August, 1996 Data for Decision Making Project, Harvard School of Public Health.

Chawla, Mukesh, Ramesh Govindaraj, Peter Berman and Jack Needleman "Improving Hospital Performance through Policies to Increase Hospital Autonomy: Methodological Guidelines" August 1996 Harvard University, Health and Human Resources Analysis for Africa, USAID.

Chung, S.Y., et. al. "Report of the Provisional Hospital Authority" Hong Kong December, 1989.

Glaser, William A. *Paying the Hospital* Jossey-Bass Publishers 1987.

Joint Commission for the Accreditation of Health Care Organizations, 1994 *Accreditation Manual for Hospitals: Volume II, Scoring Guidelines.*

Kimunya, Amos "Draft Specifications for Accounting Systems" Management Sciences for Health, APHIA Project 1997.

Newbrander, W. "Policy Options for Financing Health Services in Pakistan: Hospital Autonomy Financing Issues" Health Financing and Sustainability Project Technical Report February, 1993.

Paibool and Sutham "Exploring Training Needs: A Report of Exploring Training Needs for Hospital Management" October, 1998 Health Management and Financing Study Project.

Rowland, Howard S. and Beatrice L. Rowland *Hospital Administration Handbook* Aspen Publishers 1984.

Shah, Anwar *Perspectives on the Design of Intergovernmental Fiscal Relations*, 1991.

Skurka, Margaret A. *Principles and Organization for Health Record Services* Revised Edition, American Hospital Association Press,1998.

Sriratanaban, Jiruth MD PhD "Survey Report of Three Private Hospitals in the Bangkok Area on the Financial, Personnel Management and Governance Systems: Recommendations for Autonomous Public Hospitals." September, 1998.

USAID Regional Economic Development Service Office for East and Southern Africa and University of the Witwatersrand, *Proceedings of the Health Services Contracting Workshop* Johannesburg, South Africa September, 1997.

APPENDIX A

DRAFT PUBLIC ORGANIZATION ACT

Public Organization Act,

B.E. 2542

BHUMIPOL ADULYADEJ,REX

Given on the 13rd Days of February B.E. 2542,

Being the 54th Year of the Present Reign,

His Majesty King Bhumipol Adulyadej is graciously pleased to proclaim that:

Whereas it is expedient to have a law on public organization. Be it, therefore, enacted by the King, by and with the advice and consent of the National Assembly, as follows:

Section 1. This Act is called the "Public Organization Act, B.E. 2542"

Section 2. This Act shall come into force as from the day following the date of its publication in the Government Gazette.

Section 3. In this Act:

"Public organization" means the public organization which is established under the Royal Decree issued under the provision of this Act;

"State official" means a government official, officer, official, or any person working in a ministry, sub-ministry, department, provincial administration, local administration, State enterprise or any other organization of State;

"Committee" means the public organization executive committee or the Committee of any other name which is responsible for the administration of the public organization as prescribed in the establishing Royal Decree;

"Director" means the director or the chief under any other name of a public organization.

Section 4. The Prime Minister shall have charge and control of the execution of this Act.

CHAPTER I

Establishment and Objective of Public Organization

……..

Section 5. When the Government has a plan or policy to provide public service of any specific branch and it is appropriate to establish a new administration agency apart from the existing Government agencies of State enterprise for the purpose of the most efficiently utilizing of resources and personnel, there shall be the establishment of the public organization by the Royal Decree under this Act.

Public service activities for which the public organization may be established to be responsible under paragraph one are the accreditation of standard and evaluation of education quality, training and development of Government officials, nourishing of arts and culture, development and promotion of

sports, promotion and supporting of study and research, the transfer and development of science and technology, the preservation of environment and natural resources, the medical and public health service, social welfare, provision of services for people, or the implementation of other public services. In this connection, the foregoing activities shall not be the activities with the main objective to seek profits.

Section 6. The public organization shall be a State agency and enjoy the status of juristic person.

Section 7. The Royal Decree establishing a public organization under Section 5 shall contain the following statements as the minimum requirement:

(1) name of public organization;

(2) site of its head office;

(3) objectives and power to engage in various activities within the scope of its objectives;

(4) composition of the Committee, qualifications and prohibitions, term of office, removal from office, as well as the powers and duties of the Committee;

(5) qualifications and prohibitions, term of office, removal from office, as well as the powers and duties of the director;

(6) qualifications and prohibitions of its officials;

(7) personnel administration, welfare and other benefits;

(8) capital, income, budget and property;

(9) supervision, review and evaluation of its work;

(10) abolition of public organization which is established for performing of any specific duties or under specified period;

(11) other requirements necessary for the good order and efficiency of the implementation of its work;

(12) Minister having charge and control of the execution of the Royal Decree.

The statements under (3) to (11) shall be in accordance with the provisions of this Act, unless the provisions of this Act provided that there shall be otherwise prescribed in the Royal Decree, the provision of such Royal Decree shall prevail.

Section 8. In the case where there is a problem concerning the overlapping or conflict of performance of duties of public organization and the Government agencies or other State agencies under the laws, it shall be deemed that the Royal Decree establishing a public organization under this Act is *jus speciale*.

The problem concerning the performance of duties of public organization or other State agencies under paragraph one shall be subject to the judgment of the Council of Ministers. In this connection, the Council of Ministers shall prescribe principles and rules for performance of duty or cooperation among Public organizations, Government agencies and State agencies concerned by entrusting the Council of State to give recommendation and submit the draft of priciples and rules for consideration.

Judgment, principles and rules prescribed by the Council of Ministers under paragraph two shall be deemed to be guidelines for the implementation of works of public organizations, Government agencies and other State agencies.

Section 9. In the case the Royal Decree establishing a public organization under this Act to perform any duties under the scope of powers and duties of any Government agency, State enterprise or other State agencies is going to be issued and shall cause a problem of overlapping or conflicting of their performance of duties, if the Council of Ministers is of the opinion that it is appropriate to transfer the powers and duties, activities, properties, rights, obligations, and appropriations of such Government agency, State enterprise or other State agencies to the public organization, the said powers and duties, activities, properties, rights, obligations, and appropriations of such Government agency, State enterprise or other State agencies shall be transfer to the public organization on the date on which the establishing Royal Decree comes into force, except that the salary and fixed wages as a part of appropriations which is set aside for holders of positions attached to any Government agency shall continue to belong to such Government agency until such positions are abolished.

The rights under paragraph one shall include the right to utilize, or the right under the contract of hire of *Ratchaphatsadu* land, or *domain public* of the State which Government agencies, State enterprises or other State agencies hold on the date on which the establishing Royal Decree comes into force.

Section 10. State officials or employees of State agencies, State enterprises or other State agencies under Section 9 who want to transfer to be officials or employees of the public organization shall notify their intentions in writing and submit to their Superior, and shall take any process of recruitment or evaluation in accordance with the rules as prescribed by the Council of Ministers.

Section 11. If the State official, who transfers to be official or employee under Section 10 is a government official; he shall be deemed to be removed from Government service because of cessation

or abolition of position under the law on Government gratuities and pensions or the law on Government pensions fund, as the case may be.

If the State official, who transfers to be official or employee of the public organization under Section 10 is an employee of Government agency; he shall be deemed to be removed from Government service because the position is ceased or abolished, or the removal without any fault and he shall receive the gratuities under the Regulation of Ministry of Finance concerning gratuities of employee.

For the purpose of counting the term of work for the calculation of benefits under the rule of public organization, the Government official or employee who transfers to be official or employee of the public organization under this section and is desirous of counting the term of work as Government official or employee together with the term of work as officials or employees of the public organization, as the case may be, he shall have the right to do so by notifying his intention in writing that he shall not receive any gratuities or pensions.

The refusal to receive gratuities or pensions under paragraph three shall be committed within thirty days as from the date of transfer. In the case of Government official, it shall be proceeded under the law on Government gratuities and pensions. In the case of employee, a written notice shall be made and signed by the employee as evidence to be submitted to the employee in order to proceed to the Ministry of Finance for acknowledgement.

CHAPTER II

Capital, Income and Properties

…….

Section 12. Capital and properties for the performance of duties of public organization consist of the following:

(1) money or properties transferred;

(2) money budgeted by the Government as the capital at the outset;

(3) block grants allocated by the Government as appropriate in each year;

(4) subsidies from private sector or other organizations, including foreign countries or international organizations, and money or properties donated;

(5) fee, due, compensation, service charge, or income from its performance of duties;

(6) interest of money or income occurring from its properties.

Section 13. Subject to its objectives, the public organization shall have the power to request for fee, due, compensation or service charge for the performance of its duties as prescribed in the establishing Royal Decree.

Section 14. All income of the public organization shall not be remitted to the Ministry of Finance as State revenue under the law concerning treasury reserves and the law concerning budgetary procedure.

Section 15. Properties of public organization shall not be subject to any execution of judgment.

Section 16. Immovable property which the public organization has derived from donation or buying by its own revenue shall be under its ownership.

Public organization shall have the power to administer, supervise, maintenance, utilize, dispose of, and manage to get benefits from its properties.

Section 17. The spending of money of public organization shall be made particularly for financing the performance of its duties.

The keeping and withdrawal of money of public organization shall be subject to the regulations prescribed by the Committee.

Section 18. The borrowing of money, holding of shares, or being a partner of, or investing in the business of other juristic persons, as well as the disposal of properties from the list as valueless account shall be in accordance with the rules prescribed by the Council of Ministers.

CHAPTER III

Administration and Performance of duties

……..……

Section 19. There shall be a Committee of each public organization consisting of a chairman and other members, the composition of which shall be as determined in the establishing Royal Decree, and the Director shall be the member of the Committee and the Secretary.

The Council of Ministers shall appoint Chairman and members of the Committee.

The Committee of public organization may consist of representatives of Government agencies, as *ex officio* members, but this type of Committee shall not be more than half in number.

There shall be a number of members of the Committee as prescribed in the establishing Royal Decree, but it shall not be more than eleven, and this member shall include the expertists who are not Government officials or ones who work in any State agency.

Section 20. The Chairman and the member of the Committee of public organization who are not an *ex officio* members shall possess the qualifications and not be under prohibitions, as follows:

(1) being of Thai nationality;

(2) being under the range of ages prescribed in the establishing Royal Decree, but not more than seventy years of age;

(3) having academic qualifications and experiences appropriate for the activities of public organization as prescribed in the establishing Royal Decree;

(4) not being a bankrupt, incompetent or quasi-incompetent person;

(5) not being imprisoned by a final judgment, except for an offence committed through negligence or a petty offence;

(6) not being a person holding a political office, a member of a local assembly, an executive member, a member of a committee, or a person responsible for the administration, consultant or an officer of a political party;

(7) not being under any of other prohibitions prescribed in the establishing Royal Decree.

The provision of (1) shall not imply to the foreign member of the Committee appointed in pursuance of the binding obligation or nature of activities of such public organization.

Section 21. The Chairman and the member of the Committee of any public organization shall not directly or indirectly have interests in any business dealing with such public organization, or competing with such public organization, except for being entrusted by the Committee to be the Chairman or member of the board of the limited company or public company of which the public organization is a shareholder.

Section 22. The Chairman and the member of the Committee who is not an *ex officio* member shall hold office for the term prescribed in the establishing Royal Decree, but not longer than four years.

In the case the Chairman or the member of the Committee who is not an *ex officio* member vacates office before the expiration of the term, or in the case where an additional member is appointed by the Council of Ministers during the term of the Committee, the appointee shall hold office for the remaining term of the members already appointed.

Upon the expiration of the term of office under paragraph one, if the new Chairman or members have not yet been appointed, the outgoing Chairman or members who vacate upon the expiration of the term of office shall remain in office until the newly appointed Chairman or members assume the office.

The chairman or the number of the Committee who vacates office upon the expiration of the term of office may be re-appointed, but he shall not hold office more than two consecutive terms.

Section 23. Apart from vacating office at the expiration of the term, the Chairman and the member who are not an *ex officio* members shall vacate office upon:

(1) death;

(2) resignation;

(3) being removed by the Council of Ministers for failure to carry out his duties, improper conduct or incompetency;

(4) lacking of qualifications or being under prohibitions, or involving in any prohibited activity under Section 21.

Section 24. The Committee shall have the power and duty to control and supervise the activities of the public organization in accordance with the objectives prescribed, and such power and duty shall include:

(1) laying down policy and approving implementation plans of the public organization;

(2) approving investment plans and financial plans of the public organization;

(3) controlling and supervising general implementation and administration, including issuing of orders, regulations, notifications, or stipulations concerning the public organization in the following affairs:

(a) distribution of works of the public organization and the scope of such works;

(b) determining positions, specification of position, rates of salary, wages, and other monetary benefits of official and employee of the public organization;

(c) recruitment, appointment, removal, discipline and disciplinary action, retirement, petition process, and appeal against punishment of official and employee of the public organization, including methods and conditions of employment of the public organization;

(d) administration and management of finance, supplies, and properties of the public organization;

(e) providing of welfare and other benefits for official or employee of the public organization;

(f) scope of powers and duties, and regulation concerning the performance of duties of internal auditor;

(4) other powers and duties as prescribed in the establishing Royal Decree.

Section 25. The Committee shall have the power to appoint qualified person as its consultant in accordance with the establishing Royal Decree and shall have the power to appoint sub-committee to be responsible for any consideration or mission as entrusted by the Committee.

Section 26. The Chairman, member, consultant of the Committee and sub-committee shall receive bonus and other benefits in accordance with the rules prescribed by the Council of Ministers.

Section 27. There shall be a Director of the public organization, may be referred to as other name prescribed in the establishing Royal Decree.

The Committee shall have the power to appoint and remove the Director.

Section 28. The Director shall possess qualifications and not being under prohibitions as prescribed in the establishing Royal Decree, and shall be able to work full time with the public organization.

Section 29. The Director shall hold office for the term prescribed in the establishing Royal Decree, but not longer than four years, and may be reappointed for not more than two consecutive terms.

Section 30. Apart from vacating office at the expiration of the terms, the Director shall vacate his post upon:

(1) death;

(2) resignation;

(3) vacating his office in pursuance of the agreement between the Committee and the Director;

(4) being removed by the Committee for failure to carry out his duties, improper conduct or incompetency;

(5) being an incompetent or quasi-incompetent person;

(6) lacking of qualifications or being under prohibitions prescribed for being the Director.

The resolution of the Committee to remove the Director under (4) shall be voted by not less than two-thirds of the existing number of members of the Committee, but not including the Director.

Section 31. The Director have the duty to administer the affairs of public organization in accordance with the laws, objectives of the public organization, orders, regulations, stipulations, policies, resolutions and notifications of the Committee, and shall be the Chief of every official and employee of the public organization.

The Director shall be responsible to the Committee for the administration of the affairs of public organization.

Section 32. The Director have the power to:

(1) recruit, appoint, promote, reduce, cut salary or wages, impose disciplinary actions on officials or employees of the public organization, as well as to remove officials or employees from office, in accordance with the regulations prescribed by the Committee;

(2) lay down regulations concerning the operation of public organization, which are not inconsistent with or contrary to the rules, regulations, requirements, policies, resolutions or notifications prescribed by the Committee.

Section 33. With respect to the outsiders, the Director shall be representative of the public organization. For this purpose, the Director may delegate power to any person to perform any specific duty on his behalf, subject to the regulation prescribed by the Committee.

Section 34. The Committee shall determine the rate of salary and other benefits of the Director in pursuance of the rules prescribed by the Council of Ministers.

CHAPTER IV

Official and Worker of Public Organization

……

Section 35. Officials of public organization shall possess not only qualifications and not being under prohibitions as prescribed in the establishing Royal Decree, but also possess qualifications and not being under prohibitions, as follows:

(1) being of Thai nationality;

(2) being not under eighteen years of age and not over sixty years of age;

(3) being able to work full time for the public organization;

(4) not being Government official or employee of Government agency, State enterprise, other organization of State or local administration;

(5) not being under the prohibitions under Section 20 (4), (5) and (6).

The provisions of Section 20 paragraph two and Section 21 shall apply to the official of public organization *mutatis mutandis*.

Section 36. For the benefit of the administration of the public organization, the Minister having charge and control of the execution of the establishing Royal Decree may request, upon the approval of the Chief or employer as the case may be, any State official to perform duty as officials or employees of the public organization for a temporary period.

Any State official who gets approval to perform duty as official or employee of public organization under paragraph one shall be deemed to be permitted to resign from the Government

service or from his work to perform any duty, and the period of the performance of duty in public organization shall be counted for the purpose of the calculation of pension or other benefits of the same kind under the same conditions as if he has devoted full time to perform his Government work, or his work, as the case may be.

Section 37. In the case the State official under Section 36 requests for returning to the Government service or working at Government unit where he used to work within the approved period, such person shall have the right to be recruited and appointed in the position and shall receive salary as agreed upon the approval under Section 36.

Section 38. The works of public organization shall not subject to the enforcement of the law concerning labour protection, the law concerning labour relation, the law concerning social insurance, and the law concerning monetary compensation; provided that the Director, officials and employees of the public organization shall receive benefits not less than those provided in the law concerning labour protection, the law concerning social insurance, and the law concerning monetary compensation.

CHAPTER V

Account, Audit and Evaluation of Work of Public Organization

……

Section 39. The account of public organization shall be in pursuance of the universal principles and in accordance with the forms and rules prescribed by the Committee. In addition, there shall be the

internal audit of finance, account and supply of public organization, including the report of audit submitted to the Committee at least once a year.

There shall be the official of the public organization to be specifically responsible for the internal audit, and shall be of directly responsible to the Committee in accordance with the Regulation prescribed by the Committee, unless otherwise prescribed in the establishing Royal Decree.

Section 40. The public organization shall prepare its balance sheet, financial account and working account, and submit to the auditor within one hundred and twenty days as from the end of each accounting year.

Each cycle of year, the Office of the Auditor-General or the outside person appointed by the Committee with the approval of the Office of the Auditor-General shall examine and evaluate the spending of money and properties of the public organization and give comments by analyzing whether such spending of money is in accordance with the objectives and economical, and how much it meets the target, then reports the result of Auditing to the Committee.

Section 41. Public organization shall, once in each year, report to the Minister having charge and control under the establishing Royal Decree the result of its performance of duties in the passing year together with the explaination relating to policies of the Committee, projects and plans which shall be arranged in the future.

Section 42. For the purpose of promotion of efficiency of the performance of duties of public organization by providing it the autonomy to perform its duties appropriately under supervision and with the clear target, the public organization shall subject to the evaluation system of the public organization as prescribed by the Council of Ministers, except otherwise provided in the establishing Royal Decree.

CHAPTER VI

Supervision

……

Section 43. The Minister having charge and control of the execution of the establishing Royal Decree of any public organization shall have the power and duty to supervise the consistency of the performance of duties of such public organization with the laws, objectives of the establishment of the public organization, Government policies and Resolutions of the Council of Ministers concerning such public organization. In this connection, the Minister shall have the power to order the public organization to explain, give comments, or prepare report, or to cease its act which is contrary to its objectives of the establishment of such public organization, Government policies, or Resolutions of the Council of Ministers concerning such public organization, including to investigate the fact concerning its performance of duties.

CHAPTER VII

Abolition

……..…

Section 44. Public organization shall be abolished upon any of the following cases:

(1) the expiration of the period of performance of its duties prescribed in the establishing Royal Decree;

(2) the completeness of performance of its duties under the objectives prescribed in the establishing Royal Decree, and the Minister having charge and control of the execution of the said Royal Decree establishing public organization has already announced the abolition of its operation in the Government Gazette;

(3) apart from (1) and (2), whenever the Government is of the opinion that it is appropriate to abolish the public organization, a royal decree for abolition shall be issues thereafter.

The public organization shall continuously maintain its status of juristic person for the period as long as it is necessary for the proceeding under section 45.

Section 45. Properties of public organization are State properties. When public organization is abolished, there shall be the official to inspect its properties and to liquidate its business, including to transfer or to dispose of the remaining properties and to deal with its personnel in accordance with the rules, procedure and conditions prescribed by the Council of Ministers.

APPENDIX B

PROPOSED REGULATIONS UNDER THE ACT RELATED TO HOSPITAL AUTONOMY

(Draft)

Royal Decree

establishing……Hospital

B. E. …. .

_____

……..….

……..…….….

…….……..….

Whereas it is expedient to establish…….. Hospital in form of a public organization;

By virtue of Section 221 of the Constitution of the Kingdom of Thailand and Section 5 of the Public Organization Act, B.E.2542, a Royal Decree is hereby enacted, as follows :

Section 1 This Royal Decree shall be called the "Royal Decree Establishing ……Hospital, B. E. …. ".

Section 2 This Royal Decree shall come into force as and from the day following the date of its publication in the Government Gazette.

Section 3 In this Royal Decree,

"Hospital" means …… Hospital ;

"Governing Committee" means Governing Committee of …….. Hospital;

"Director" means Director of ……. Hospital;

"Minister" means Minister who shall take charge of this Royal Decree.

Section 4 The Minister of Public Health shall take charge and control of the execution of this Royal Decree and shall be empowered to issue announcements for the execution of this Royal Decree.

The Announcement under paragraph 1 shall come into force when it is published in the Government Gazette.

CHAPTER 1

Establishment , Capital and Reserve Fund

……..…

Section 5 An public organization shall be established and called "……..Hospital".

Section 6 …… Hospital is a State agency and it is under control of the Ministry of Public Heath; its head office is situated in …….

Section 7 The Hospital has its objectives, as the following:

(1) to render curative care services up to general standard of medical profession of the Ministry of Public Health;

(2) to proceed preventive care and to promote and support public health services under the government policy;

(3) to proceed other activities according to policy of government and needs of the community;

The activities carrying out under the first paragraph shall not, in principle, seek for profits.

Section 8 The Hospital is empowered to carry out any activities within the scope of its objectives under Section 7, and such power shall include:

(1) to hold ownership, possessory rights, or other real rights, to build, buy, provide, sell, expose, let, lease, hire-purchase, borrow, lend, pledge, mortgage, exchange, transfer, accept transfer, or to carry out any transactions concerning with property, both inside and outside the Kingdom, and to accept property donated;

(2) to manage to have accessories and equipments for medical services and public health;

(3) to determine due, charge and service charge for patient treatments, medical and public health services within the appropriate range determined by the Ministry of Public Health;

(4) to ask for a loan or to borrow money;

(5) to issue bonds or any instruments for carrying on its works;

(6) to hold shares or enter into partnership or join with others for development of its services;

(7) to hire or entrust to any person to do any part of the jobs of the Hospital or other works for benefits of the Hospital;

(8) to do all works relating to achievement of its objectives.

Section 9 Capital and asset for running the Hospital shall consist of :

(1) money and asset transferred under Section 10 of the Public Organization Act,B.E.2542;

(2) money paid by the Government at the outset;

(3) block grant annually budgeted by the Government;

(4) due, charge and service charge;

(5)money and property donated by donor;

(6) income or any benefits of the Hospital derived from asset of the Hospital;

(7) money or property devolved to the Hospital.

Section 10 The block grant budgeted to the Hospital under section 9 (3) shall be directly budgeted under suggestion of the Minister of Public Health up to the sum which shall be sufficient for all necessary expenses to carry out all duties assigned by the Government.

If the income budgeted under the first paragraph is not enough for necessity to run the Hospital or to build a new building or to buy any materials or equipments which are important for render medical services and the Hospital is not able to get from other sources, the Government shall allocate additional budget as it needs.

Section 11 The Hospital shall set aside a sum of money not less than twenty percent of its residue after all expenses is taken out into reserve fund which shall be earmarked for shortage of money, for expansion of the Hospital and for other purposes as the Governing Committee considered appropriate.

The reserve fund under the first paragraph shall be used only when it is approved by the Governing Committee.

CHAPTER 2

Governing Committee

Section 12 There shall be a governing committee which consists of following:

(1) three members from government sector which are a representative appointed by the Secretary General of Ministry of Public Health, Provincial Chief Medical Officer or representative and an officer from other government unit in that province appointed by the governor of such province;

(2) three members from the community which shall be selected from the community where the hospital is located;

(3) four expert members which shall be selected from ones who have knowledge and experiences in the area of public health, management, finance, accounting, law, or other related areas;

The chairman of Governing Committee shall be elected by all members from the members in (2) and (3).

The Director shall be member and secretary of the Governing Committee.

Section 13 In the process of selecting persons to be appointed as members of the Governing Committee under Section 12(2) and (3), the Governing Committee shall appoint a committee consisting of not less than three but not more than five members.

To consider the appointment of the Selecting Committee, the Governing Committee shall select qualified persons to be appointed as members of the Selecting Committee and then shall post the list of the said persons in the Hospital and other places, that it can be easily seen, for a period not less than fifteen days.

Any person, who is desirous of objecting any person(s) selected under the paragraph two, shall make an objection to the Permanent Secretary of Ministry of Public Health in writing together with reasons to object through the Governing Committee within the period of time prescribed in the paragraph two.

The ruling of the Permanent Secretary of Ministry of Public Health shall be final.

Section 14 The Chairman of the Governing Committee shall submit the list the Governing Committee which has been selected to the Minister in order to propose to the Council of Ministers to be appointed.

Section 15 The Governing Committee shall have powers and duties, beyond what stated in Section 24 of the Public Organization Act, B.E.2542, as follows;

(1) to determine policy, roles and direction of hospital development to be in line with the change of health system;

(2) to approve plans, projects and annual budget of the Hospital;

(3) to control and supervise the operations of the Hospital and give advice to the management of the Hospital;

(4) to establish regulation concerning selection of director, work performance of director and assignment of work to the other to act on his behalf;

(5) to establish regulation concerning the meeting of Governing Committee and Subcommittee;

(6) to establish regulation concerning work performance of each group of officer and services rendered to each group of patients in the Hospital;

(7) to establish regulation concerning meeting allowance and other benefit in return;

(8) to appoint and vacate the Director;

(9) to approve the appointment, removal and vacation of officer in management level;

(10) to consider appeals and grievances of officer of the Hospital;

(11) to determine rate of fee and charge for services rendered in the Hospital;

(12) to co-operate with other government agencies;

(13) to perform other duties as assigned by the Supportive Committee.

To perform duties of the Governing Committee under the first paragraph, the Governing Committee may assign a member or sub-committee to act on his behalf, and then report to the Committee thereafter.

Section 16 The Governing Committee shall have qualifications, not only what stated in Section 20 of the Public Organization Act, B.E.2542, but also the following qualifications:

(1) members who are representatives of government sector shall be in the position not less than Level 8 or equivalent,

(2) members who are representatives of community shall not be less than twenty five years of age, but not more than seventy years of age; and each of these members shall have domicile in that community not less than two years;

(3) expert members shall hold at least bachelor degree and shall not be more than seventy years of age.

Section 17 The Governing Committee under Section 12(2) and (3) shall hold office for the term of four years.

Section 18 The Governing Committee is empowered to appoint experts as advisors of the committee and to appoint sub-committee to consider or perform any duties as assigned by the Committee.

CHAPTER 3

Management and Execution

Section 19 There shall be a director selected by the Governing Committee from one who has experiences in management of organization as determined by the Governing Committee, but the experiences earned should not less than three years.

The Chairman of Govering Committee, on behalf of the Governing Committee, shall enter into contract to hire a director of the Hospital for the term not more than three years for each contract.

Section 20 The Director shall have powers and duties in general management of hospital, as long as he acts in pursuance of rules, regulations or resolutions of the Governing Committee.

Under the rules or regulations relating to work performance laid down by the Governing Committee, if there are any statements limiting the Director's powers to enter into certain juristic acts, such rules or regulations shall be published in the Government Gazette.

Section 21 Whenever the Director may not perform his duties or position of director is vacant and the appointment of director has not been done, the Governing Committee shall appoint an officer as acting director.

The acting director shall have the same powers and duties as that of the Director, except the powers and duties of the Director as the member of Governing Committee.

Section 22 Whenever the Hospital proposes any matters to the Council of Ministers, it has to submit to the Permanent Secretary of Ministry of Public Health in order to proceed to the Council of Ministers,.

Section 23 There shall be three types of officer in the Hospital, as the following:

(1) full time officer

(2) part-time officer

(3) temporary officer

The term of contract to hire any officer shall not more than four years.

Section 24 The rights of patient set forth by the Minister shall not be infringed in the course of hospital management.

CHAPTER 4

Welfare

Section 25 The officer under section 23(1) shall be entitled to receive the royal decoration as well as that of civil service.

The Principle of equation of positions between the two systems shall be in pursuance of the Regulation of the Officer of Priminister concerning Royal Decoration.

Section 26 Each type of officer shall be entitled to welfare under the regulations set forth by the Governing Committee, however, it shall not be less than that of the Civil Service.

CHAPTER 5

Control, Examination and Evaluation

Section 27 the control, examination and evaluation of the Hospital shall be complied with the regulations and methods set forth in the ministerial regulations.

The Hospital shall report its annual operation to the Minister for examination and evaluation every year and summarize the annual report in order to announce to the public by posting in public places in the community.

Transitional Provision

Section 28 The director of……..Hospital who holds the post of Director on the day this Royal Decree on the day this Royal Decree comes into force shall be the Director untill the appointment of the Director in pursuance of Section 19 take place.

Section 29 At the outset, the members of Governing Committee under Section 12(1) and the Director shall appoint the the Selecting Committee to select the member of Governing Committee under Section 12(2) and (3) from the persons who hold the qualifications under Section 16.

Section 30 The civil servant or employee of the ……. Hospital, who is desirous of being an officer in the Hospital, shall submit a letter of intent to be an officer to the Director within ……days commencing from the date this Royal Decree comes into force.

For those civil servants or employees of the …….Hospital, who is desirous of being officer for certain period of probation under section 36 of the Public Organization Act, B.E.2542, shall maintain status of civil servant or employee of government; the Director shall present the list of names of such persons through the Ministry of Public Health for approval of the Coucil of Ministers in order to work temporarily in the Hospital, but not longer than four years.

Section 31 The civil servants and employees of ……..Hospital, who is not desivious of working in the Hospital, shall be transferred to work in other hospitals nearby or in other government units as

appropriate. However the Permanent Secretary of Ministry of Public Health or his assignee may order these civil servants and employees to work temporarily in the Hospital.

The Director shall have power to command all civil servants and employees, who are ordered to work in the Hospital, as well as the power stated in the law concerning civil service administration.

Section 32 The government shall allocate the budget as capital at the outset by calculating from the sums of money from all types of welfare which the civil servants and employees entitled to receive if they still work with the government until the retire, except medical welfare, in order that the Hospital shall be able to bring this amount of budget to pay as welfare under Section 38 of the Public Organization Act, B.E.2542 in the future.

Section 33 The civil servants and employees under Section 30 paragraph two shall still receive medical welfare under the Royal Decree concerning Medical Welfare of Civil Service.

Section 34 The government shall allocation the budget as capital at the outset by calculating from the sums of pension which all civil servants shall receive after retire until they die. The period of time to be used to calculate the pension is the average age of the Thai citizen. The Hospital shall bring this sum of money to be a part of fund in new pension system for those civil servants who become officers of the Hospital.

Countersigned by:

_____

Prime Minister

March 31,1999

APPENDIX C

SPECIFICATIONS FOR AUTONOMOUS HOSPITAL ACCOUNTING SYSTEMS

Modules in an Accounting System

General Ledger

Chart of Accounts:

General Ledger:

The system should list all balance sheet and statement of income accounts (broken into Revenue and Expense accounts).

Trial Balance:

The system should maintain and provide information on debit and credit balances for the various accounts, and prepare and print the T/B for management review as needed.

When period closes, the remaining balances are carried forward as opening balances.

Statement of Income (P&L Statement):

Results of operations (net income) for a given period.

Balance Sheets:

Financial position of the concern -- comparative balance sheets (one reporting period to another) and common-size balance sheets (Percentage of each account to the total in a particular account category) for management.

Ratio Analysis:

The system should generate selected ratio statistics.

Government Authorities Reporting:

Bank and Cash Book - the system should have a Cash Book Facility, which should contain the following features:

1) Outstanding Cheques - those received yet have not been cleared (remain outstanding).
2) Cheque Reconciliation - enters cheques (receipts) cleared by bank, verifies amount paid and clears it from outstanding cheques list.
3) Cheque Register - show cheques written by cheque number, including the payee, amounts etc.
4) Process Manually prepared cheques, as well as print cheques for selelected invoices
5) Flag voided or cancelled cheques.
6) Reconciliation Audit Report - the system should balance total cheques (receipts) appearing on bank statement with total cheques cleared from the outstanding cheques list. After cheque reconciliation, the system should print an updated list of all cheques then remaining outstanding.

7) The system should have a facility for lodgements in transit.
8) The system should deal with Foreign Currency Receipts by providing information required by the Government Authorities.

Petty Cash

The system should have a Petty Cash Facility.

Invoices and Accounts Receivable

1) The system should show all obligations owed to the organization from sales on credit. This information should come from the invoices written by the organization and payments made against these invoices.
2) The system should have a Debtors Ledger (Accounts Receivable) with the accounts used in the organization's accounting system.
3) The system should accurately reflect payments received by the organization from customers.
4) Payments are posted to the accounts in the ledger.
5) The system should have the ability to:
   a) Create and maintain Customer Master File.
   b) Process billings - posting of payments received.
   c) Generate aging of accounts receivable.
   d) Provide audit trail of accounts receivable transactions since last system update.
6) The system should also have the ability to:
   a) Review Open Transactions -- those not paid.
   b) Add and Delete new accounts.
   c) Perform on-line inquiry in order to determine current status of debtors accounts and review of payments received.
   d) Provide Control Reports
   e) Provide Sales Analysis Information.
   f) Generate management information reports specified by the operator.

Bills and Accounts Payable

The Accounts Payable System should quickly and accurately record liabilities incurred for merchandise, equipment, or other goods/services incurred in running the organization that have been purchased on account. The system should:

1) Maintain current payables records through on-line automatic posting of transactions to the financial reporting (or general ledger) module. -- Provides access to up-to-date information on bills and vendors.
2) Contain the following typical features:
   a) Vendor Master File - files of current vendors.
   b) Bills Register File - list of current invoices which are outstanding and payable.
   c) Payment discount dates - the dates by which the payment must be made in order to take advantage of discounts.
   d) Cheque Register File - monitor calculation and printing of bank cheques for payments of previously selected invoices.
   e) Accounts Payable Aging Report - Vendor number; vendor name; invoice number; and invoice date.

f) Vendor Status Report -- Summary Accounts Payable Information for each vendor.
g) Vendor Activity Report -- gross amounts invoiced, discounts taken, number of invoices, and other vendor data.
h) Monthly Cheque Register -- hard copy of audit trail of payments made to vendors.

Point of Sale

Point of sale is quite an advanced module in the computerization process. At a paying point (cash register) a cash register or computer can be programmed to record what is being purchased, read the prices off the inventory module, and automatically update the inventory module.

It is not usually included with standard accounting systems. It can usually be purchased from a third-party vendor, together with point of sale bar-code readers, printers and even cash-tills.

The advantages are automatic maintenance of stock levels, and speed in processing purchases (usually using bar codes). If your organization thinks it might ever need a Point-of-Sale system, it should be ascertained whether the selected accounting system can interface with a good point of sale system.

Stock Control

Whether or not you use a stock control module will depend on how complex your control of stocks needs to be. Computerized stock systems will require a computer in the main store (and subsidiary stores, like the pharmacy). So the stores will have to be on a network, or can possibly use a stand-alone stock system, which will not integrate with the other accounting modules.

In some cases, a simple manual card-system will suffice. In larger organizations, the main store might be computerized, as well as the pharmacy and other subsidiary stores.

The Stock Control / Inventory Module should include as a minimum the following five important factors:

1) Inventory Status -- how much of each items is in the current inventory based on a Perpetual Inventory System, e.g., a running balance of quantities of issued and stored items.
2) Inventory Variance -- differences between physical inventory and the running (perpetual) balance maintained by the computer system. The system should produce an Inventory Variance Report.
3) Inventory Valuation -- valuation of items in inventory. The system should determine the cost of goods and/or replacement costs of items in inventory.
4) Inventory Re-ordering – based on minimum stock levels, issue rates, ordering time and stock levels, the system should report on which items need to be reordered, and the quantities that should be ordered.
5) Inventory Usage Reporting – the system should report on the quantities of items issued, broken down by issue point (whether another internal unit like a pharmacy, a clinic, or end patient numbers).

Drug Expiry Dates

Most standard small-end accounting systems' stock modules do not include the ability to track expiry dates on the inventory. Namely, a condom is a condom. As most family planning supplies have expiry dates, the need for tracking expiry dates needs to be considered.

There is a high cost involved with tracking expiry dates. If you want to track expiry dates, this means:

1) Whenever you receive items, you will have to enter the quantities received into the system with expiry dates.
2) Whenever you issue or sell items, you will have to enter the quantities issued with expiry dates.
3) You will have to spend a great deal of money to purchase a good stock module that will let you track expiry dates.

The benefit of tracking by expiry dates is that the system will be able to tell you at any point in time exactly how much of each item you have in stock and when it will expire. For large warehouses, this information can help prevent wastage due to over-stocking and expiration.

Purchasing

The Purchasing Module should enhance management's control over purchase ordering and receiving practices. Important factors are:

1) The Purchase Order File should be organized by vendor and Purchase Order Number. It should automatically generate purchase orders based on inventory data and/or projected sales forecast data.
2) The system should establish the Minimum Quantity, and, when inventory gets to that point, an order should automatically be prepared in the quantities established by Management, based on:
3) the established Minimum/Maximum Order quantities,
4) the established Maximum Quantity -- the point above which the quantity on-hand should not rise,
5) the established Usage Rate -- the rate at which purchase units are used
6) Lead Time Quantity -- the anticipated number of purchase units withdrawn from inventory between the time an order is placed and time it is delivered.
7) Calculate and establish Order Point -- that point where when number of purchased units in inventory equals lead time quantity plus (+) safety factor (the point below which you do not want to fall by the time the order is received).
8) When shipments are received, the amounts (quantities of inventory items received) are input into the computer and applied against open Purchase Orders. The inventory files (on-hand) are then updated by the computer (e.g. added to the perpetual inventory).
9) Valuation: Inventory is re-valued based on new levels.

Budgeting

There may be a Budgeting Module for the Operations Budget, the Cash Budget and/or the Capital Budgets.

1) Operations Budget -- this includes: management's plans for generating revenue and incurring expenditures for a given accounting period; operations budgets for various departments; operations budgets for support centres.

2) Cash Budget -- this reflects estimated cash receipts and cash disbursements for a given accounting period. If estimated cash receipts and beginning cash (estimated available cash) are not adequate to cover projected cash disbursements, then management should be advised. The system may show excess cash, in which case the excess cash may be invested in short term notes to increase revenue.
3) Capital Budget -- this the combination of Operations Budget and Cash Budget. If Operations Budget shows sales will increase beyond present equipment, then one can look in Cash Budget to determine if cash is available to make a capital investment.

Payroll

The payroll system should meet the statutory requirements of the country of operation for hourly and salaried personnel. As such, the payroll systems that come with integrated accounting systems written in the USA or UK, are usually inappropriate to the organization's needs. Therefore, organizations usually purchase a separate system for payroll. The payroll system should provide the full range of statutory reports including:

1) Payroll and Personnel reports
2) Withholdings and Taxes reports
3) Contributions to pensions, national social security schemes
4) Staff Loans
5) Time Accounting reports.

Note concerning the integration of payroll and other accounting modules:

It is not necessary that the payroll interfaces directly with the other accounting modules. However, the procedures which are used in transferring data from the payroll to the accounts system should be spelled out. (This normally involves entering monthly totals for gross wages, taxes, contributions, etc. into the general ledger).

Fixed Assets Module

The Fixed Assets Module should handle data related to depreciation expense (reported on income statement) and accumulated depreciation expense (reported on balance sheet). It should include the organization's property and equipment which has a useful life of is more than one year. This would include: buildings; furnishings and equipment; vehicles; computers, etc.

It should allow for the following:

1) Cost of Fixed Asset -- Purchase (construction) cost + freight + installation.
2) Estimated Useful Life -- the period of time the item is expected to be used in generating income.
3) Estimated Salvage Value -- the estimated market value at the end of item's useful life.
4) Total Cost minus Estimated Salvage Value equals Amount subject to Depreciation.
5) Depreciation schedules subject to the allowable amounts in the country of use.

Advanced Financial Analysis

For those who want to know the nitty gritty of their projects.

Criteria for Accounting Software Selection

General System Capabilities	
Multi-User Capability – including simultaneous access?	
Is it a true Multi-Currency System?	
Ability to handle organization's future needs	
Ability to handle organization's number of transactions.	
Ability to use your countries settings for date formatting, currency, number formatting, etc.	
Year 2000 compliance?	
Account Identification	
Ability to accept your chart of account coding structure	
Ability to accept your account sub-classifications / analyses	
Limit to number of accounts and account sub-classifications.	
Ability to provide detailed analyses by donor, projects, clinics etc	
System Methodologies	
Are entries immediately posted into the ledgers upon entry (less security and control), or are they entered into a temporary state, and then posted in batches after checking (more control)?	
Can previous entries be modified, or do they need to be changed through adjustment entries?	
Does the system 'close' accounting periods, and not allow modifications to closed periods, or does the whole system remain 'open' for modifications?	
Integration with Other Systems	
Ability to import / export data – does the system just allow import / export of lists (e.g: chart of accounts, vendor lists, etc) or does it allow you to import / export accounting transactions?	
User Interface	
User-friendly interface	
Customizable interface (The ability to customize the input screens to remove superfluous fields of data and add user-defined fields)	
On-line help and context-sensitive help.	
Interactive tutorial	
System manual	
Reporting	
Ability to see reports on screen, and then redirect them to a printer or to an export file.	
Ability to drill-down on reports to see line item detail.	
User customizable reporting – the ability to change reporting dates,	

reporting breaks, columns on reports, etc.	
Ability to provide information / reports based on certain variables or criteria (e.g. seminar cost in a certain area, total costs of Clinic A only)	
Graphical depiction of certain reports.	
Ability to customize printed reports, especially statements, invoices, etc.	
Security	
Password protection for general system access and for specific 'sensitive' system functions.	
Audit trail	
Training	
How much training is included with the system	
Does the training just teach how to use the system in general, or is the training combined with implementation, so that by the end of training, the organization will be up-and-running with their own accounts?	
Is there any training for management provided – interpretation of reports.	
Support	
Can you get immediate telephone / on-site support with the system? What is the extra charge for this support? Support on the Web?	
Is the support company an established company that is likely to be in business for the next 5 years? Possibility of support by another company?	
How many staff in the support company know the system? How long have they worked in the company?	
Licensing	
Are you purchasing the ownership of the system (including the ability to modify the source code, and distribute the system to other sites in your organization), or are you just buying a license to use the system on a single computer installation? Is supplier willing to appoint an escrow agent to hold the source code?	
Do you have to pay an annual license fee to keep using the software?	

APPENDIX D

OPTIONS FOR FORMULAE OR BLOCK GRANT ALLOCATIONS

Formula for block grant allocations to provinces should follow the objectives to be achieved.

Transfer Name	**Description**
Existing cost reimbursement	Cost reimbursement on the basis of Ministry of Public Health fee schedule, case mix, and number of services delivered.
Formula grant	Size of capitation grant varies with determinants (poverty and age) of use and cost; municipalities are prohibited from reducing their current levels of finance.
Formula grant with minimum expenditure mandate	Same as above except it mandates some minimum expenditure per beneficiary.
Open-ended variable matching grand	Size of central government grant varies directly with hospital finance, with the matching rate determined by fiscal capacity.
Open ended variable matching grant with minimum expenditure mandate	Same as above with the addition of a mandate that expenditures per capita not be less than the existing national average.

There are recommended principles to be followed in grant design and in the grant process:

1. *Capacity*: Lack of capacity is one factor likely to inhibit the process of hospital autonomy. MOPH as well as local administrative and system capacity for service contracting and contract monitoring, revenue collection, monitoring and evaluation and reporting needs to be developed.

2. *Objectives:* The MOPH should be clear on the objectives for decentralizing the financing of hospitals and in particular, the use of grants and other resource transfers. Clear and specific rules for what resources an autonomous hospital can spend, clear guidelines on what revenue authority they have,, transparent formulae for intergovernmental grant funding, and the proper restructuring and training of MOPH and hospital stall will be needed in line with new assignments are needed.

3. *Grant or resource transfer design:* The objective to be achieved should dictate the transfer design

4. *Simplicity*: Simple grant design is more transparent and preferred to one that is complex

5. *Incentives:* Incorporating incentives into grant design is preferable to using the "stick" approach where central government mandates certain activities. This approach is equally effective and will interfere less with grantee autonomy;

6. *Conditionality*: Conditionality in the form of either minimum expenditure mandates or maintenance of expenditure requirements is needed to prevent grant recipients from reducing their efforts in key service areas including primary health care.

7. *Own revenue generating capacity:* The MOPH or Budget Bureau can best leverage the effect of transfers on total expenditures by including some measure of the hospital's revenue generating capacity in the grant formula thereby providing incentive to collect and spend on high priority programs.

APPENDIX E

A STRATEGIC FRAMEWORK TO DEVELOP EFFECTIVE CONTRACTING OF HEALTH SERVICES [12]

1) Which service or components of a service qualify for contracting out?
2) Why may contracting be justified given the strategic objectives and resource position of autonomous hospitals?
   a) Is the service to be contracted in line with policies and strategic objectives of the health system?
   b) Can the contractor clearly provide a similar or higher quality service at lower cost than the autonomous hospital?
      i) Does the autonmous hospital know its own production costs and quality?
      ii) What efficiency advantage might contractors have, e.g., expertise, economies of scale, technology, release from hospital administrative constraints?
      iii) Have full costs been taken into account in the comparison; i.e., do they include hospital production costs such as services provided by other departments; have both contract and price and transaction costs been included?
   c) Does the contractor fill a gap faced by the autonomous hospital in skills, capacity or resources?
      i) Is the gap due to deficits in skills, capacity, or lack of capital resources?
      ii) Is the gap regarded as temporary or permanent?
      iii) If temporary, can you ensure that the hospital will develop skills or capacities in the long term, preventing entrenchment of the gap?
      iv) Does the contract include mechanisms to ensure skills transfer from contractor to hospital?
      v) If the contract would be with existing services:
         (1) Does the hospital have the capacity to provide service directly, and if not, can this be developed?
         (2) What are the total costs (capital and recurrent) of bringing the service back "in house"?
         (3) What potential for significant service disruption exits in bringing the service back into the hospital?
         (4) What are the potential consequences of failing to contract with providers at all or more effectively?
   d) Is the service to be contracted out regarded as peripheral to the core competencies and objectives of the hospital?
      i) Will contracting out allow the hospital to focus more on its core activities?
      ii) Will contracting out allow the hospital to focus its efforts and energies on more urgent priorities?
      iii) Is this strategy a permanent or temporary measure?

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[12] USAID Regional Economic Development Service Office for East and Southern Africa and University of the Witwatersrand, Proceedings of the Health Services Contracting Workshop Johannesburg, South Africa September, 1997

iv) Could contracting out reduce flexibility to reallocate resources or re-prioritize services at a later stage?

3) Is contracting out feasible and what are the obstacles to effective contracting?
   a) Does the hospital have adequate capacity in terms of skills and systems to:
      i) Develop a strategy around contracting?
      ii) Collect information to inform contract design, including analysis of economic benefits of contracts?
      iii) Set objectives of the contract in line with health sector priorities and needs?
      iv) Design and specify components of the contract (coordinated legal and health planning exercise)?
      v) Manage tendering processes and/or negotiate the contract?
      vi) Monitor the contract?
      vii) Enforce sanctions for poor performance?
      viii) If capacity is inadequate, can assistance be obtained from elsewhere in government or outside technical advisors, or how could capacity be built?
   b) Are sufficient financial resources available for funding the contract so that it will function effectively?
   c) Are there qualified contractors capable of fulfilling the contract specifications?
   d) Are there sufficient contractors to allow for competition between contractors?
      i) If there is limited competition, can the hospital still ensure a good price, and avoid long term dependency on the contractor?
      ii) How?
   e) Is contracting out politically feasible?
      i) What is the attitude of workers at institutional level and of trade unions to the contract?
      ii) What is the attitude of the local community to the contract?
      iii) What is the attitude of politicians?
      iv) What are the attitudes of key donors?
   f) Do any laws or regulations make contracting difficult or unworkable?
      i) Are tendering procedures adequate for effective contracting?
      ii) What other legal/regulatory obstacles might need to be addressed?

APPENDIX F

MONITORING AND EVALUATION FRAMEWORK