



**JOINT
LEARNING
NETWORK**
For Universal Health Coverage



UHC PRIMARY HEALTH CARE SELF-ASSESSMENT TOOL

SUMMARY REPORT FROM FIVE COUNTRY PILOTS

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Technical Initiative**

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ACRONYMS

BPJS	Badan Penyelenggara Jaminan Sosial (Indonesian Health Financing Agency)
CMCHIS	Chief Minister's Comprehensive Health Insurance Scheme
CHC	Community Health Compound
CHPS	Community-based Health Planning and Services
DHMT	District Health Management Team
DHO	District Health Office
DOH	Department of Health
EPU	Economic Planning Unit
ESI	Employees' State Insurance
FFS	Fee-For-Service
FKTP	Fasilitas Kesehatan Tingkat Pertama (first-level health facilities)
GDP	Gross Domestic Product
HFA	Health Financing Agency
HRH	Human Resources for Health
JLN	Joint Learning Network for Universal Health Coverage
JKN	Jaminan Kesehatan Nasional (Indonesian National Health Insurance Program)
KPI	Key Performance Indicators
LSGI	Local State Government Institutions
MOF	Ministry of Finance
MOH	Ministry of Health
MPLAD	Member of Parliament Local Area Development
MLA	Member of Legislative Assembly
NCD	Non-Communicable Diseases
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
NRHM	National Rural Health Mission
OOP	Out-of-Pocket
OPD	Outpatient Department
PHC	Primary Health Care
RSBY	Rashtriya Swasthya Bima Yojna
SDOH	State Department of Health
SDG	Sustainable Development Goals
TB-DOTS	Tuberculosis- directly observed treatment- short course
TNHSS	Tamil Nadu Health Systems Society
UHC	Universal Health Coverage

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THE IMPORTANCE OF PRIMARY HEALTH CARE IN UNIVERSAL HEALTH COVERAGE

Primary health care (PHC) has been recognized as critical to achieve good health for all since the 1978 Alma Ata Declaration.

First, PHC is often an individual's first point of contact for health care, and makes up the majority of an individual's contacts across the health system, playing a critical role in determining patient health seeking behavior. Additionally, curative, preventive, and promotive PHC services are more cost-effective than higher-level health services, so strengthening PHC can yield greater health and financial efficiencies, providing financial protection to vulnerable populations and resulting in the financial sustainability of public health schemes. PHC is vital to the efficient functioning of the health system as a whole. Countries' efforts to address large infectious disease burdens and achieve Sustainable Development Goals (SDGs) must include effective PHC responses, especially as the incidence of chronic diseases continues to rise globally, particularly in middle-income countries.

As countries progress towards achieving Universal Health Coverage (UHC), countries continue to grapple with the dual challenges of how to ensure financial protection, and, at the same time, provide universal access to essential health services at all levels of care, including the primary level. Often, countries initiate UHC schemes by insuring against patients' hospitalization risk. While this has a significant benefit in protecting patients from catastrophic health expenditures, it can deprioritize the importance of care at the primary level. Members of the JLN-PHC Technical Initiative created the UHC Primary Health Care Self-Assessment Tool (the Tool) because they recognized the importance of improving PHC as a core, initial step on a country's path toward achieving UHC and improving the population's overall health.

UHC PRIMARY HEALTH CARE SELF-ASSESSMENT TOOL

The UHC Primary Health Care Self-Assessment Tool was co-developed by the more than 50 members of the Joint Learning Network for Universal Health Coverage (JLN) Primary Health Care Technical Initiative in 2014 and 2015. The Tool is a multi-stakeholder survey questionnaire created to (1) assess whether a country's or state's health financing approaches are well aligned with PHC initiatives, efforts, and programs in the country or state, and (2) identify opportunities the health financing agency or other health financing policy makers have to improve alignment with PHC goals.

Country representatives from Ghana, India, Indonesia, and Malaysia piloted the Tool between September and November 2014. JLN members from each country formed a piloting team within their respective countries, selected a pilot site, and adapted the Tool and its methodology according to their needs and the country's context. After they collected data using the Tool, they analyzed their data and developed their findings and recommendations. The JLN members who led the piloting efforts in their countries came together in December 2014 in Kuala Lumpur for a workshop organized by the JLN PHC Technical Initiative. The members discussed their findings, and shared feedback on the Tool that JLN then incorporated in the Tool's final design. They also wrote reports to document their experiences in piloting the Tool. These reports are collated in this document to share the countries' experiences with global audiences and to contribute new evidence on countries' experiences implementing PHC-oriented UHC.

To learn more about the UHC Primary Health Care Self-Assessment Tool and to access it online, please visit the JLN website (www.jointlearningnetwork.org).

The Joint Learning Network for Universal Health Coverage (JLN)

The JLN is a consortium of countries at the forefront of the global movement to achieve UHC. The network connects practitioners and policymakers from different countries to help bridge the gap between theory and the practical ‘how to’ of implementing complex reforms of health systems to achieve UHC. India is a central member of the network, and participates in the JLN Primary Health Care (PHC) Technical Initiative through the Department of Health and Family Welfare in Tamil Nadu and Kerala states.

SYNTHESIS OF COUNTRY EXPERIENCES AND FINDINGS



COUNTRY PILOTING PROCESS

JLN members who led the pilots in Ghana, India, Indonesia, and Malaysia demonstrated remarkable leadership and commitment to testing and applying the UHC Primary Health Care Self-Assessment Tool, which was essential to the success of their pilots and the refinement of the Tool. The pilots demonstrated that countries could adapt and rapidly implement the Tool in a variety of settings, either at the national or sub-national level. JLN members completed their pilots within 4 to 12 weeks. Only the team from Malaysia chose to pilot the Tool with national level stakeholders because of the centralized federal organization of public health system in Malaysia; the other country teams piloted the tool in a selected region or district.

All of the pilot teams adapted the Tool to ensure its relevance to their local settings and stakeholders. The teams from Ghana, India, and Indonesia made only slight adjustments to the terminology of the Tool, whereas the team from Malaysia made significant changes to it. The Malaysian team adjusted the health financing sections of the tool to align with the Malaysian public health system's organization, which does not feature a purchaser-provider split.

The teams administered the Tool using a combination of in-person interviews, focus group discussions (FGDs), and/or workshops, based on the most appropriate process within the country's context. Table 1.1 provides an overview of the processes that teams used to administer the Tool and collect data for the pilot.

Table 1.1 – Overview of Country Pilot Processes

MODULES IMPLEMENTED	GHANA: UPPER EAST REGION	INDIA: KERALA & TAMIL NADU STATES	INDONESIA: TANGERANG DISTRICT & BANDAR LAMPUNG CITY		MALAYSIA FEDERAL & REGIONAL
HEALTH FINANCING AGENCY	Interviews with six representatives from the Upper East Region National Health Insurance Authority (NHIA)	Self-administration of Tool at workshop with representative of State Department of Health	Interviews with five representatives from Badan Penyelenggara Jaminan Sosial (BPJS)	Interviews with five representatives from BPJS	Interviews with three representatives from the Finance Division, Ministry of Health

Table 1.1 – Overview of Country Pilot Processes

MODULES IMPLEMENTED	GHANA: UPPER EAST REGION	INDIA: KERALA & TAMIL NADU STATES	INDONESIA: TANGERANG DISTRICT & BANDAR LAMPUNG CITY		MALAYSIA FEDERAL & REGIONAL
MINISTRY OF FINANCE	Not administered; stakeholder mapping indicated no link between district budget officer and NHIA	Self-administration of Tool at workshop with representative of Department of Finance at state level	Not administered due to difficulties scheduling interviews	Interviews with key informants	Interviews with two representatives from Economic Planning Unit (EPU) and one representative from the Ministry of Finance
MINISTRY OF HEALTH	Interviews with regional directorate of health services in Upper East Region and District Health Management Teams	Self-administration of Tool at workshop with representative of State Department of Health (SDOH)	Interviews with representatives of the District Health Office (DHO)	Interviews with key informants	Interviews with five representatives from the Ministry of Health
PRIVATE PROVIDER	Interviews with representatives from 6 districts out of 13 selected based on geographic proximity	Self-administration of Tool at workshop with representatives from private PHC providers	Focus group discussion with 11 managers of private health clinics	Interviews with key informants	Self-administration of Tool at workshop with 23 general practitioners from private PHC clinics
PUBLIC PROVIDER	Interviews with representatives from 6 districts out of 13 selected based on geographic proximity	Self-administration of Tool at workshop with representatives from public primary, secondary, and tertiary level providers	Focus group discussion with 12 managers from district public health outposts (“Puskesmas”)	Interviews with key informants	Self-administration of Tool at workshop with 33 representatives from outpatient service and 9 representatives from inpatient service

ACHIEVEMENTS AND OUTPUTS FROM PILOTS

The pilot teams who administered the Tool and engaged in follow up discussions identified findings and misalignments related to UHC and PHC in their countries and then developed a set of recommended actions to address these misalignments. The teams of JLN members who carried out the pilots reported that the process of engaging and involving different stakeholders in discussions about the tool and reporting their findings was valuable and set the stage for future discussions about PHC-oriented UHC. Each country’s pilot team provided recommendations for next steps for their countries to take to follow up their main findings.

Through virtual and in-person engagement facilitated by R4D, individuals who led the pilot efforts in their countries learned about other countries’ experiences, shared their findings, and obtained feedback from JLN peers.

SUMMARY OF FINDINGS AND KEY THEMES

JLN members used the UHC Primary Health Care Self-Assessment Tool to identify some of the following key country-specific findings:

- **Ghana’s Upper East Region:** Many users bypass PHC facilities in favor of accessing secondary

care. In addition, the primary purchaser, the National Health Insurance Authority (NHIA), does not cover preventive services and often experiences delays in paying for curative PHC.

- **India's Kerala State:** Members observed misalignments in human resources for primary care, especially the lack of incentives (financial or otherwise) to attract health workers to remote areas. They also observed a lack of use of effective evidence and communications to promote PHC as a priority.
- **India's Tamil Nadu State:** Members noted the lack of health education and behavioral change communication as major impediments to achieve PHC objectives. Financial and geographical/environmental barriers are other key factors that limit patient's access to PHC services.
- **Indonesia's Tangerang District and Bandar Lampung City:** Members noted concern among respondents regarding capitation payments' effects on PHC and certain high priority PHC services, such as Tuberculosis-directly observed treatment, short-course (TB-DOTS) services. Another key finding is that the main purchaser, BPJS Kesehatan, does not have performance indicators to assess preventive and promotive services.
- **Malaysia:** Members found that private PHC providers are unaware of national health policies and priorities, yet they provide 51 percent of PHC services.

JLN members also identified the following common challenges, which members discussed at an in-person workshop held in Kuala Lumpur, Malaysia, in December 2014:

- **Creating the best payment/funding mechanisms mix to support PHC priorities:** Integrating capitation with other financing and payment mechanisms (fee-for-service, public funding of preventive/promotive services, pay-for-performance) as part of broader UHC financing reforms.
- **Adjusting PHC benefits package:** Processes to adjust and modify health benefits package contents, and leverage existing health benefits policies.
- **Managing PHC demand vs. secondary care:** Managing referrals and ensuring continuity of care for patients.
- **Engaging private providers:** Initiating communications with private providers and contracting, training, and regulating them.
- **Strategic communications in policy implementation:** Managing communications with policy-makers and health administrators and with health providers and populations, and ensuring messages reach target audiences.

To respond to these challenges, members of the JLN-PHC Technical Initiative have prioritized and delved into two of the above topics: Adjusting PHC benefits package and Engaging private providers. For more information on the work of the JLN PHC Initiative on these topics, please visit the JLN website: www.jointlearningnetwork.org.

PILOT CHALLENGES AND LIMITATIONS OF THE TOOL

JLN members that piloted the Tool reported the following limitations of the Tool and challenges with its administration:

- **Difficulties scheduling a time to meet with key stakeholders.** Given that the Tool was administered within a 4 to 12 week period, JLN members faced challenges in scheduling meetings with some stakeholders due to their limited availability. In India, the implementers of the pilot addressed this challenge by convening a workshop to bring together stakeholders and to rapidly collect their input in a single day. JLN members in Malaysia also brought

together stakeholders by organizing several workshops and they conducted additional individual interviews as needed.

- **The Tool is a rapid assessment and therefore, has a limited scope.** JLN members reported that, in some instances, they wanted to collect more detailed responses to questions in the Tool. While the UHC Primary Health Care Self-Assessment Tool is designed to be a rapid-assessment to cover a wide breadth of topics, members could complete additional data collection to obtain additional information to complement the findings from the Tool.
- **Lack of available data on select topics.** Data availability varies between and within country settings. It is possible that some data requested in the Tool are inaccessible or unavailable; for example, quantitative data on referral patterns. Individual or country teams that use the Tool can address this either by answering the questions as best as they can with the available data, or by modifying the Tool to remove questions that are not applicable. In some cases, it may be useful for teams to document cases in which data are unavailable to highlight and report on information gaps.

NEXT STEPS

Each pilot team developed its own set of recommendations and next steps to be carried out within its respective country to address misalignments between UHC and PHC. Examples of such steps include the following:

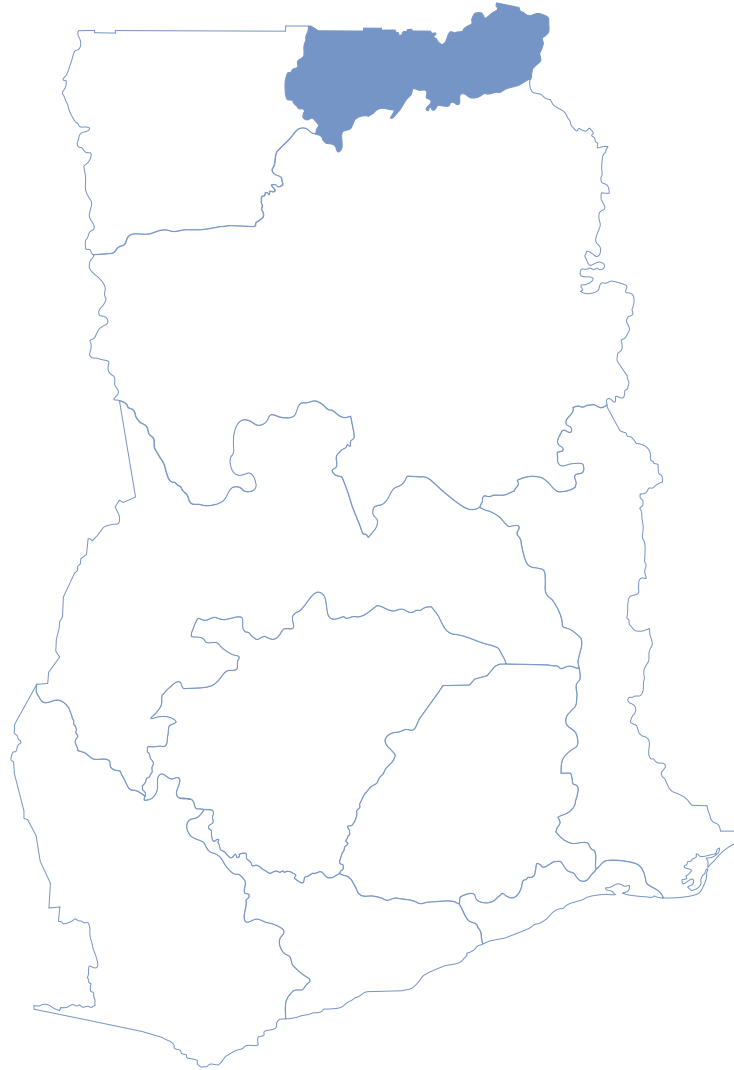
1. Increase the availability of untied funds for PHC facilities and base their disbursement on PHC workload and outputs;
2. Provide training and support to health care providers to strengthen their capacity and capability to deliver preventive services;
3. Develop possible payment options and non-payment incentives to encourage health care providers in both the public and private sectors to provide preventive primary care services; and,
4. Develop best practices for referral management to keep health care costs down and reduce the number of unnecessary inpatient admissions.

COUNTRY SUMMARY REPORTS



GHANA Upper East Region

Findings from Piloting the UHC Primary Health Care Self-Assessment Tool



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BACKGROUND

In 2003, the government of Ghana passed the National Health Insurance Act (Act 650) to protect Ghanaians from incurring financial harm while accessing basic health care. This new Act aimed to replace the “cash and carry system,” an out-of-pocket payment system that limited the ability of many Ghanaians to access quality health care in the country. Since then, the National Health Insurance Authority (NHIA) has stewarded the National Health Insurance Scheme (NHIS) and carried out the following functions:

- Set priorities for the country’s health policy
- Finance functions (e.g., pooling of NHIS revenues)
- Purchase/Payment policies (what health care services to cover and how to pay providers)
- Influence the behavior of the population and providers through regulations and communications
- Monitoring and evaluation (including data sharing)

While the NHIS has been praised globally as an excellent example of how government can promote and implement UHC in low- and middle-income countries, the system has not been without challenges. Stakeholders have voiced increasing concerns about their current lack of knowledge and understanding about how institutions implementing the NHIS interact with other key actors and programs—such as Ghana’s Community-based Health Planning and Services (CHPS) program—to promote universal health coverage (UHC) and primary health care (PHC) goals. The JLN Ghana member team identified the need for an assessment to highlight areas of misalignment between the country’s current health care financing policies and PHC goals under the NHIS.

RATIONALE

Ghana’s main objective in piloting the tool was to assess how institutions implementing the NHIS interact with other actors and programs in the Upper East Region of Ghana to promote primary health care goals. Accordingly, JLN members in Ghana, to investigate ways to ensure that Ghana’s financing system and PHC goals align, piloted the UHC-PHC Self-Assessment Tool in collaboration with the Regional Health Directorate in the Upper East Region and the NHIA. The pilot focused on identifying linkages and alignments of health financing agencies (HFAs), including insurance and institutions providing PHC services at the regional and district levels.



PROCESS AND TIMELINE

The JLN Ghana implementation team members made minor changes to the Self-Assessment Tool to adapt the language and terminology of the Tool to fit the Ghanaian context. They piloted the Tool from January to March 2014 in 6 of the 13 districts in the Upper East Region. Researchers collected qualitative data through key informant interviews using both individual and focus group discussions (FGDs). Researchers typically convened group interviews with health care providers, bringing together medical directors, accountants, and other administrators from the facility to be interviewed simultaneously.

Key Informant Interviews

The JLN Ghana team members identified the key informants that they interviewed through a stakeholder mapping exercise. Researchers identified the following key informants to include in the pilot: (1) the Regional Health Directorate of health services (Ghana Health Service), (2) district health management teams that supervise the health centers and community health compounds (CHCs), (3) the regional coordinator of the NHIA, (4) the district coordinators of the NHIA in six selected districts, and (5) both private and public PHC providers. The implementers did not pilot the tool with the Ministry of Finance (MOF) since their initial mapping exercise suggested that there was no link between the district budget officers and the health insurance authority.

Implementers selected respondents from each of the institutions that the implementers identified during the stakeholder mapping based on their institutional knowledge and expertise. In all, implementers interviewed 56 stakeholders, including 30 men and 26 women, who represented the following institutions:

- 7 representatives from the Ministry of Health
- 6 representatives from the NHIA
- 7 representatives from the Private PHC Provider
- 33 representatives from the Public PHC Provider
- 3 representatives from the Faith-Based Provider

Two research assistants and a senior research officer conducted the qualitative interviews. The majority of the respondents declined to be audio recorded; accordingly, the field personnel took extensive field notes and typed the notes into MS Word. The personnel transcribed interviews that were audio recorded and included them in the analysis.

Stakeholder Workshop

Following the team's completion of the interviews, the pilot team held a workshop in November 2014 to convene the respondents and key stakeholders from the pilot, NHIA management, representatives from the Regional Health Administration, and a JLN technical facilitator. The workshop had the following objectives:

- Validate and achieve consensus among stakeholders on the pilot's preliminary findings of key misalignments between UHC and PHC;

- Facilitate discussion and exchange among key stakeholders for UHC and PHC in Ghana; and,
- Develop recommendations to align and achieve PHC and UHC goals.

The team presented key findings from the key informant interviews, followed by discussions to identify and prioritize the key areas of misalignment and recommendations to align UHC and PHC in Ghana.

ANALYSIS

The Ghana team members qualitatively analyzed the survey results by reviewing transcripts of individual and group interviews and identifying key themes. They integrated notes and key findings from the stakeholders' workshop into the analysis. The Ghana team members entered quantitative data from the questionnaires into a database and analyzed the data by the category of respondents.

Guided by the objectives of this study, the team analyzed the data both deductively and inductively. Three researchers independently reviewed each of the interview notes (either extensive field notes or interview transcripts), and highlighted key themes that emerged from the interviews. This review was followed by a group discussion in which the researchers reviewed the data, compared the various themes, and agreed on the findings.

The researchers then presented these results in the stakeholder workshop in which participants had the opportunity to comment on the findings, provide additional detail, and suggest recommendations. Following the workshop, the team reviewed the issues identified by the participants and ranked the key areas of misalignments based on the results of both the survey and the workshop.

FINDINGS



The findings below are based on the key informant interviews and stakeholder workshop.

PRIORITY SETTING

- **There is some alignment of UHC and PHC priorities, but stakeholders expressed a clear need for a national PHC policy.** The stakeholders that the team interviewed noted that public health education and communication efforts on preventive and promotive services directly align with UHC and PHC priorities. They noted, however, that the lack of a national policy on PHC and the NHIS's emphasis on curative services in its benefits package impede efforts to appropriately align UHC and PHC. Additionally, stakeholders noted that the concepts of UHC and PHC should be clearly defined to inform priority setting within the NHIS, and well communicated to facilitate coordination among stakeholders.

FINANCING AND PAYMENT

- **NHIA does not reimburse preventive or promotive services, which creates a disincentive for providers who otherwise would deliver these services.** The NHIA's reimbursement policy is misaligned because it provides reimbursement only for the provision of curative PHC services. Sixty percent of respondents noted that this policy discourages providers from delivering preventive and promotive services at the PHC level. For instance, the NHIA does not cover home visits, which makes providers reluctant to conduct them. The NHIA reports that it does not

include preventive services in its package because of the high cost of rendering such services at a time when the NHIA struggles to achieve financial sustainability. NHIA's representatives emphasized that even though NHIS does not provide direct reimbursement for preventive and promotive services, the NHIA does implement health promotion activities, such as radio campaigns for issues such as Ebola prevention.

Some respondents stated that if the NHIS covered preventive services, it would significantly raise private service providers' contributions to PHC services and help improve the population's health status. To date, private providers have not added preventive services to their service line. Private providers have explained that their operations are largely based on recovering their costs and generating profits to pay the salaries of workers, purchase medical supplies, and provide and maintain infrastructure. They report that there is currently no incentive for them to provide preventive services. The lack of incentives and of reimbursement does not serve the purpose of promoting UHC and PHC.

- **PHC funding levels are inadequate and payments to providers are inefficient and/or delayed, resulting in limited operational budget to deliver PHC services.** Providers at health center and Community-based Health Planning and Services Program (CHPS) levels experience significant delays in receiving reimbursement. Studies have documented providers' frustration with this process: one study noted that health providers reported a 2 to 6 month delay in being reimbursed, even though the law stipulates claims must be reimbursed by 60 days (Soodzi-Tetty et al., 2012; Dalinjong & Laar, 2012). Further, the NHIS's delays in reimbursing claims for services provided by health care providers serve as a disincentive for service providers to embrace the NHIS.
- **At the same time, the NHIS is plagued by difficulties with its own solvency.** Representatives from the NHIA noted that their funds are kept at the central level and that they have difficulty transferring the funds. In addition, they face unsustainable increases in the costs of drugs and supplies. According to policy, they are required to select the median priced drug. Yet, prices have soared over the past year and a new value-added tax (VAT) tax of 17.5 percent was recently introduced for drugs.
- **Financing management authority is limited at the sub-district and CHPS levels, which can result in delayed action when funds are needed.** The NHIS directs the money that it reimburses to an account for the sub-district health center, which the District Health Management Team (DHMT) manages. There are two underlying reasons for this arrangement. The first is that CHPS are often not accredited institutions because they lack certain core staff or services. As a result, the services that they render are recorded and aggregated with services provided by the sub-district health center, and one reimbursement request is made on behalf of both facilities. Secondly, both CHPS and sub-district health centers often have limited financial management capacities; accordingly, the DHMT fulfills this duty. As a result, however, providers have to request funds from the DHMT, and the sub-district providers complain that it is difficult to take out money when they need it. This structure translates into a lack of operational funds at the facility level with which providers can carry out core functions, such as household visits. This reactive nature of financial management limits providers' abilities to build their own capacities; many do not have knowledge of their current balances.
- **Patients encounter difficulties accessing services due to expired NHIS membership cards, which can result in them having to pay out-of-pocket costs.** Although the NHIS is designed to be a progressive system that subsidizes targeted and vulnerable groups—only 33 percent of its members are paying members; 67 percent receive exemptions—operational challenges prevent patients from accessing services when they need them. For example, many respondents noted that when patients seek care at facilities but have expired insurance cards, providers are put in a difficult position: if they provide care, they will not be reimbursed. Yet, it can take a long time for a patient to receive a renewed membership card. Insurance agents at community levels often wait to process renewals until they have multiple cards to process. (Insurance agents receive a

commission for each card and may need to amass a certain number of cards in order to have the funds for a return trip into the communities to process and deliver renewed cards.) Respondents suggested that any equipment that is necessary to produce the cards be brought to the community or sub-district level so that cards could be processed immediately.

MONITORING AND EVALUATION

- **The NHIA has in place monitoring and evaluation (M&E) activities to monitor PHC providers, but the NHIA does not publicize how it uses the resultant data.** The district coordinators of the NHIA reported that they have a system in place to monitor the activities of the PHC providers—identifying the number of visits to each facility, the patients’ names, their reasons for visiting, etc.—which helps the NHIA track utilization rates at PHC centers and higher levels of care. Some private PHC providers also confirmed that NHIA staff periodically visit their facilities to assess their operations. NHIA staff examine Outpatient Department (OPD) books, diagnoses, the laboratory, and the dispensary, and, at times, they examine waiting times and prescription practices.
- **Although there are many different M&E activities in place, respondents shared their concerns that NHIA were not using the data routinely to inform or change strategy or operations.** Respondents did confirm that the NHIA used data from the NHIS to inform health insurance coverage policy at the municipal, district, and sub-district-levels, to be presented at large management meetings (e.g., the Ministry of Health’s mid year or end year review meeting).

REGULATIONS: REFERRALS/BYPASSING

- **Lack of basic services at the PHC-level and patients’ proximity to district hospitals has led to a misalignment between PHC and UHC.** Findings show that when PHC facilities lack basic items like laboratory services (e.g., analyzer/Hemoglobin (HB) machine) and/or patients are geographically close to higher-level facilities, patients often bypass PHC facilities. Further, patients who are concerned that they may need more specialized services, such as pregnant women who are worried about a complicated delivery, may bypass the PHC level to ensure that they have easy access to more specialized care. However, patients who bypass PHC facilities create a major burden for the health system, which results in inefficiencies at the primary, secondary, and tertiary levels. Regulations do not exist to limit and deter patients from bypassing PHC facilities.

INFRASTRUCTURE AND WORKFORCE

- **Limited human resources capacity hinders ability to provide PHC services.** Respondents identified the overall lack of sufficient human resources at healthcare facilities as a key impediment to Ghana achieving its PHC objectives. Some respondents noted that provider staff often lacked requisite qualifications to provide quality PHC services, which contributes to the issue of patients bypassing PHC centers.

RECOMMENDATIONS

In analyzing the results of the pilot, the team found that the NHIA has many ongoing efforts to help

achieve UHC in Ghana; however, the NHIA has serious challenges to address to ensure that the UHC reform is oriented towards supporting primary health care services. The team prepared the following set of recommendations, largely directed to the NHIA:

1. Create an urgently needed national primary health care policy, which elaborates clear definitions of PHC and UHC. In the policy, the NHIA should clarify the services PHC providers will provide as part of a comprehensive primary health care strategy.
2. Redesign the NHIS benefit package to include payment for preventive and promotive services. Respondents suggested that the NHIA should include both promotive and preventive services, such as family planning and health education, in its package to incentivize providers to deliver these services. Providers will need training as the NHIS switches to capitated payments for primary health care.
3. Create a separate account at the central level for NHIS funds to be held so that the NHIA does not depend on disbursements from the consolidated account. Increasing the authority of the NHIA to tap into its operational funds will improve the situation for providers who depend on NHIA reimbursement to support their ongoing delivery of services.
4. Make the NHIS registration and renewal process accessible at community and sub-district levels so that patients are not denied care because their insurance cards have expired. Also encourage providers to use outreach visits as an opportunity to check whether a patient's insurance card is up to date and valid. The NHIS noted that it will roll out a new system of registration soon in the Upper East and Upper West regions.
5. Upgrade service availability at CHPS and sub-district health centers to decrease the frequency of patients bypassing primary care in the system. Adding missing services, such as laboratory tests to primary care centers may prevent patients from bypassing PHC unnecessarily over time.
6. Currently, the sub-districts receive funding directly from the NHIS, which is then allocated to CHPS. This two-step process complicates operations presumably due to funding allocation delays or mismanagement. To correct for this, CHPS should create more direct access to operational funding. To do so, CHPS and sub-district health centers (HCs) will need to strengthen their financial management processes.
7. Invest in staff training at the PHC-level to ensure delivery of quality primary care and limit bypassing.

NEXT STEPS AND IMPACT



The implementers of the survey reported that the UHC Primary Health Care Self-Assessment Tool was useful in identifying key areas of misalignment between UHC and PHC at the regional and district levels. This pilot study provided an important opportunity for health service providers to communicate with the NHIA and address key concerns in NHIA's implementation of the insurance scheme. The responses from the study suggest that Ghana will benefit from more dialogue between health providers and the NHIA to support the scheme's implementation.

The survey's implementers reported that Ghana faces an urgent need to address the misalignments that they identified during the study, particularly the delays in reimbursement of funds to service providers, to meet national UHC and PHC goals. In addition, the implementation team called for further research (1) to determine which preventive and promotive services to include in an expanded NHIS benefits package, and (2) to assess the quality of public vs. private PHC services, and determine why the insured continue to seek PHC services at private clinics at which they pay out-of-pocket.

SOURCES

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INDIA KERALA STATE

Findings from Piloting the UHC Primary Health Care Self-Assessment Tool



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COUNTRY/STATE CONTEXT



BACKGROUND

Kerala has made large improvements across several health indicators, despite having a comparatively lower per capita income than several other Indian states. Kerala attributes its impressive health standards to the state's infrastructure of primary health care (PHC) centers. There are more than 2,700 government medical institutions in the state, providing a ratio of 330 beds per 100,000 people. This is the highest ratio of beds per capita in India. In addition, Kerala has preventive and promotive programs, including a nutrition program for pregnant and new mothers, which have helped to reduce infant mortality and improve female life expectancy.

However, Kerala also experiences a “low mortality-high morbidity” profile. Non-communicable diseases (NCDs), such as cardiovascular diseases, diabetes, and hypertension, are the major causes of this morbidity. Improved health promotion and disease prevention could help to reduce the incidence of NCDs and reduce Kerala's overall morbidity. In addition, Kerala's PHC teams have focused on family planning and maternal and antenatal care, and have not shifted their attention to address the state's current health needs and the rising incidence of NCDs. Expensive, corporate hospitals have expanded to meet these unaddressed needs, resulting in the increase of out-of-pocket expenditures (OOP) in Kerala.

Kerala's PHC system has historically achieved many successful outcomes, but now needs many improvements to meet residents' current health needs.

RATIONALE

The JLN Kerala team chose to pilot the UHC PHC Self-Assessment tool as part of its broader efforts to improve PHC and align it with its state-level efforts to achieve UHC. The state of Kerala is currently undertaking several initiatives to align UHC and PHC. At the facility level, pilot projects are underway to expand the services offered by PHC centers from maternal/child health services to include comprehensive care. The team carried out assessments at the district-level in Malappuram and Palakkad Districts to identify the strengths and weaknesses of the health systems, and assess the institutional mechanisms and general capacity to achieve UHC. Researchers also evaluated financial protection mechanisms to reduce patients' OOP expenditures for healthcare.

IMPLEMENTATION



CUSTOMIZATION

In January 2015, JLN members in Kerala held a consultative meeting with approximately 15 different department heads from the Kerala Directorate of Health Services to review and customize the Tool and to determine the plan for the pilot. Meeting participants made minor adjustments to the Tool, which largely consisted of rephrasing questions to ensure their relevance to Kerala, and deleting some questions that were not relevant.

PROCESS AND TIMELINE

JLN Members in collaboration with ACCESS Health and Kerala's Health Secretariat piloted the UHC PHC Self-Assessment Tool in Kerala from January to March 2015. The implementers piloted the Tool by administering it to key stakeholders during a workshop held in February 2015. The workshop was a half-day event organized and co-facilitated by ACCESS Health and Kerala's State Health System Resource Center that was attended by the following participants:

- **17** representatives from the State Department of Health;
- **13** representatives from the health financing agencies (HFA) in Kerala, i.e., representatives from the Comprehensive Health Insurance Agency of Kerala, private insurance agencies, and the State Department of Health;
- **22** representatives of providers: 13 public outpatient providers, 8 from public inpatient providers; and,
- **1** representative from the Ministry of Finance (MOF).

Participants completed the module of the Tool relevant to their respective organization and role, and then discussed and achieved consensus on the role of PHC within the UHC context in Kerala. They also completed an additional questionnaire that contained seven open-ended questions aimed at capturing information on (1) their understanding of the concept of UHC and its alignment with PHC, (2) their suggestions to improve PHC in the state, (3) the role different players could play to bring about these improvements, and (4) the financing methods that could be used to better align PHC to UHC.

ANALYSIS

The implementers analyzed data from the questionnaire using qualitative and quantitative methods. The implementers enumerated respondents' responses to the objective questions to capture the representatives' perspective. For the subjective questions that elicited respondents' opinions and suggestions, the implementers identified major themes, issues, or suggested measures, then organized and presented them as key results.

FINDINGS

PRIORITY SETTING

- **Need for greater alignment in PHC and UHC priorities in health policy documents.** Table 1 below shows the State Department of Health's PHC and UHC priorities in Kerala. While there is significant overlap between the PHC and UHC priorities by the State Department of Health (SDOH), as shown in the box below, the majority of respondents did not feel that the alignment of PHC and UHC had been given enough importance in the health policy documents.

Table 1: PHC and UHC Priorities in Kerala – Responses to UHC PHC Self-Assessment Tool

PHC PRIORITIES	UHC PRIORITIES
<ul style="list-style-type: none"> • Treatment of NCDs • Prevention of communicable diseases • Maternal and child health • Health education 	<ul style="list-style-type: none"> • Maternal and child health • Treatment for NCDs and communicable diseases • Health education • Preventive health care • Equitable coverage of all society • Rehabilitative and palliative services • Improve financing methods and incentives • Improve monitoring and evaluation (M&E) methodologies

- **The top priorities of the national health strategy include preventing communicable diseases and NCDs, improving medical education and access to population control and generic medicines, and reducing infant and maternal mortality.** Since there is no state health policy, Kerala follows the National Health Policy that was last formulated in 2002. The top five priorities of the national health strategy vary from some of the current health priorities in Kerala. Respondents from the SDOH shared their perspectives on the major impediments to achieving PHC objectives, the topic of PHC priorities, and the top UHC priorities. The respondents thought that the major impediments to achieving PHC objectives included the distribution and shortage of human resources for health, service quality and standards, and insufficient funding. Secondary impediments included lack of political visibility, will, and leadership; policy and regulation; drug and/or commodity supply; and lack of health education and behavioral change communication.
- **Lack of knowledge about strategy documents by HFA representatives.** Respondents from the HFAs in Kerala reported that they had minimal knowledge of strategy documents that outlined their health priorities and whether PHC is featured in those documents.
- **Mixed reports on inter-agency policy discussions on PHC.** Approximately half of the respondents said that the HFA is involved in inter-agency policy discussions on PHC; the other half disagreed. While the State Ministry of Finance (MOF) reported that it is involved in PHC-related dialogue with SDOH, the Ministry of Rural Development (MRD), and Local Self-Government Institutions (LSGIs), other respondents reported that the MOF is aware of neither the PHC priorities nor the UHC priorities.

FINANCING AND PAYMENT POLICIES

The major sources of funding for PHC services are the central government, the National Rural Health Mission (NRHM) and the state government’s budget, followed by out-of-pocket (OOP) expenditures. The state health insurance agency, private insurance agencies, and the Local Self-Government Institutions (LSGIs) also cover some portion of the services. Lesser levels of funding come from the Member of Parliament Local Area Development Fund (MPLAD) and the Member of Legislative Assembly (MLA) fund.

Health Financing Agencies (HFAs)

- **Most respondents stated that preventive and promotive services represent a lower share of claims than curative PHC services.** HFAs in Kerala pay for promotive, preventive, and curative PHC services through the LSGIs. Promotive services covered by HFAs include sanitation, good nutrition, and health education. Preventive services covered by HFAs include services such as

immunization, vector control, and certain preventive surgeries. Curatives services covered by HFAs include cochlear implantation, deliveries, etc. While the HFAs cover and reimburse the costs of these services, there are not many financing or payment linkages between HFAs and other PHC services funded by other agencies and initiatives.

- **Consensus among respondents that the HFA should give higher priority to PHC services.** Respondents noted that the HFA should prioritize PHC services by improving awareness among beneficiaries, reorganizing financing, and including outpatient services under Rashtriya Swasthya Bima Yojna (RSBY), which is a government health insurance scheme for the poor.
- **Current HFA payment methods may discourage the delivery of preventive and promotive services.** Half of the respondents stated that HFA payment methods discourage delivery of preventive and promotive services. Respondents suggested that HFA's involvement in preventive services could be improved by HFA earmarking funds for infrastructure and manpower at PHC centers, creating government policies and guidelines to include primary care, and allocating funds for awareness and incentives for promotion and outpatient screening.

State Department of Health (SDOH)

- **Very few SDOH programs have aligned their payment and financing with the central government's vertical programs that deliver PHC services.** Kerala's health financing approaches do not align well with PHC programs such as mental health programs, elderly care programs, rehabilitative services, and palliative care programs. However, respondents from the SDOH found some good examples of alignment between the financing of state health programs and PHC programs such as the Revised National Tuberculosis Control Program (RNTCP), National AIDS Control Program (NACP), state-level NCDs control program, the Comprehensive Health Insurance Scheme (CHIS), the Comprehensive Health Insurance Scheme (CHIS) PLUS, and Karunya Benevolent funds.

Providers

- **The HFA reimburses all PHC services offered by public outpatient providers.** Public health facilities, including hospitals empaneled under the Employee's State Insurance Corporation (ESIC), are the major providers of PHC services. Private providers, NGOs, home care providers, and the Department of Ayurveda, Yoga, and Naturopathy, Unani, Siddha, and Homeopathy (AYUSH) also deliver PHC services. PHC centers receive most of their financing for salaries and materials from the state and central governments, as well as fee-for-service (FFS) payments.
- **Public providers reported a high level of satisfaction with timeliness of payments, materials, and supplies received from SDOH, NRHM, and HFAs.** Providers reported that they are adequately satisfied with the payment and material amounts. However, the central and state governments prioritize curative services; therefore, both the funds earmarked for preventive services and the human resources to implement preventive programs are insufficient.

REGULATION

- **Respondents agreed on the importance of licensing and renewal of licensing of PHC facilities to ensure up-to-date knowledge and quality services.** Currently, the Medical Council registers clinics and the government also provides pre-employment training. The Ministry of Health currently uses the following methods to ensure quality PHC services: establishing clinical guidelines, accreditation, inspection, professional associations, continuing medical education, accreditation, and licensing.

MONITORING AND EVALUATION

- **The government collects M&E data from public providers and public programs but not private providers.** The government collects M&E data, which it shares among HFAs, but these data are limited to the public sector and do not present a holistic picture of the health situation in the state. The government's use of these limited data reduces the effectiveness of health forecasting and planning for health needs. As the majority of curative services are provided by the private sector, the government should mandate that private facilities audit and report these services. The government, similarly, should mandate that private providers report other preventive and promotive PHC efforts, such as screening and health education, to improve and strengthen PHC efforts.
- **Data show success in reducing morbidity and mortality, increasing full immunization coverage, and reducing disease prevalence by area.** M&E data show persistent challenges in reducing the prevalence of communicable diseases. There is a lack of data from private hospitals and geriatric care facilities.
- **Several respondents from the HFA stated that they engage in data sharing and communications with other agencies and initiatives that provide PHC services.** Respondents communicate with the state government on the latest trends in prevention and promotion through data analysis.

REFERRALS/BYPASSING

- **Patients' bypassing PHC services for secondary or tertiary care is a major challenge.** Respondents identified that patients receive a large portion of services from secondary or tertiary care facilities that they could have received or that could have been prevented at the PHC level. There are no guidelines indicating when PHC providers should refer patients to higher levels of care. There also are not gatekeeping measures to minimize patients bypassing PHC facilities (e.g., lack of copayments to deter use of higher levels of care). The SDOH currently is working to develop referral guidelines.
- **Providers report that patients bypass PHC centers due to poor quality of services.** Patients bypass PHC services because of the inadequate infrastructure, insufficient human resources, and the resultant poor quality of care. By equipping the primary health care centers with sufficient drugs and diagnostic services, Kerala could reduce the number of patients who bypass PHCs.

HUMAN RESOURCES

- **Insufficient human resource capacity in rural areas.** Kerala has a good level of human resource capacity relative to other parts of India. Nonetheless, respondents identified the lack of human resources as a key impediment to Kerala's achievement of its PHC objectives and as a reason that patients bypass PHCs and seek referrals. Government programs provide incentives to health care providers to work in rural areas by supplying additional pay and admissions to post-graduate courses, but respondents considered these incentives to be inadequate.
- **Insufficient PHC training.** Providers reported that they have insufficient PHC training, which causes them to underprovide these services. Providers suggested several different provider training options to improve skills, including PHC skills training at the undergraduate level, training for field workers to manage common ailments, refresher training programs for all field health workers, and soft skills development training (e.g., interpersonal communication skills). In addition to poor training, providers also reported an absence of supervision and support from the government in the delivery of PHC services. In addition, Kerala has a changing disease burden due to demographic and epidemiological shifts, and the government has not updated provider training to reflect and address the changing health needs of Kerala's population.

RECOMMENDATIONS



The JLN Kerala pilot team recommends that Kerala take several actions to better align health policy to provide UHC and PHC services. Respondents and implementers suggest several specific interventions to address these areas of misalignment (see Table 1 for the full list of interventions for improving alignment between UHC and PHC), including the following key recommendations:

1. Revise health financing policies to better align with PHC goals.
2. Earmark funds to improve infrastructure and human resources at primary health care centers and allocate funds for preventive and promotive efforts.
3. Develop an improved monitoring system, with online tracking, regular field visits, review meetings, and progress reports based on checklists and performance metrics; also develop a quality assurance system, and means of conducting district-level analysis.
4. Standardize the procedures and priorities of human resources for quality assurance including referral protocols. The government should offer and conduct post graduate courses in family medicine—i.e., in service education and training in geriatrics, palliative care, diabetes management, and hospital management for doctors and staff serving in primary health care centers.

Table 1: Recommended Interventions to Improve UHC-PHC Alignment (in detail)

MODULE	INTERVENTIONS
<p>MINISTRY OF HEALTH</p>	<p>To improve monitoring and evaluation of PHC:</p> <ul style="list-style-type: none"> • Regular field visits and review meetings • Online integrated tracking system • Progress reports based on checklist and performance indicators • Develop standards and quality assurance system • Set up District analysis • Regular audits and reporting of basic services like birth, death, communicable diseases, and immunization
	<p>To improve regulation:</p> <ul style="list-style-type: none"> • License providers to deliver primary care, which will discourage patients from bypassing primary health services
	<p>To improve referral management:</p> <ul style="list-style-type: none"> • Referral protocols, gate keeping system, and copayments
	<p>To improve access to services:</p> <ul style="list-style-type: none"> • Reduce out-of-pocket (OOP) expenditures through institutionalization of “slab system” for charges • Introduce strategies such as lean technology for effective utilization of available resources • In-service education and training in geriatrics, palliative care, diabetology • Improve hospital management by the State Department of Health and Family Welfare for medical staff in PHC facilities • Provide sufficient drugs and diagnostic equipment • Improve infrastructure of primary care centers like the pilot project facilities • Finance standing committee at Panchayati Raj institutions to prioritize and allocate funds
<p>HEALTH FINANCING AGENCY</p>	<p>To improve priority to PHC services:</p> <ul style="list-style-type: none"> • Improve awareness among beneficiaries to use services provided under the NRHM • Include outpatient services under RSBY
	<p>To improve funding of PHC services:</p> <ul style="list-style-type: none"> • Untie grants • Provide budgetary support • Supply drugs and equipment • Extend insurance coverage for homeopathy services
	<p>To improve financing methods of PHC services:</p> <ul style="list-style-type: none"> • Community-based insurance systems such as the Kudambashree model • Capitation • Results-based financing • Public-private partnership programs • Insurance support to all services offered by the Department of AYUSH

Table 1: Recommended Interventions to Improve UHC-PHC Alignment (in detail) - continued

	<p>To improve preventive services:</p> <ul style="list-style-type: none"> • Earmark funds for infrastructure and Human Resources for Health (HRH) at PHC facilities • Introduce government policies and guidelines to include PHC • Allocate funds to increase awareness of and provide incentives for promotion • Increase focus on outpatient screening
PROVIDERS	<p>To improve provider training (by central/state government):</p> <ul style="list-style-type: none"> • Introduce soft skills development (e.g., interpersonal communication skills) • Teach PHC skills at undergraduate level • Train field workers to manage common ailments • Provide refresher training for field health workers
	<p>To improve financing methods (by central/state government):</p> <ul style="list-style-type: none"> • Provide performance-based incentives, grants, subsidies, awards, and accreditations to private sector
	<p>To improve coverage of services:</p> <ul style="list-style-type: none"> • Geriatric care, nutritional education on lifestyle and diets, and physiotherapy
	<p>To increase preventive services delivered (to be provided by central/state government):</p> <ul style="list-style-type: none"> • Enhance medical reimbursement package • Provide disease-specific government aid to private providers based on need and performance • Subsidize care in private sector • Provide incentives to institutions undertaking primary care services
MINISTRY OF FINANCE	<ul style="list-style-type: none"> • Increase financial support for (a) training and Human Resources for Health (HRH), and (b) Information, Education and Communication (IEC) and Behavior Change Communication (BCC) activities.

INDIA **TAMIL NADU STATE**

Findings from Piloting the UHC Primary Health Care Self-Assessment Tool



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BACKGROUND

Tamil Nadu has a well-performing public health system with a large network of facilities at the primary, secondary, and tertiary levels. The system has two public insurance programs: (1) the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS), and (2) the Employees' State Insurance (ESI) scheme of dispensaries and hospitals. CMCHIS is a state-funded health insurance scheme that is administered by a public sector insurance agency, and provides tertiary health care through a list of empaneled private and public hospitals to households that have an annual family income of less than 72,000 rupees. The ESI scheme of dispensaries and hospitals provides health care for organized sector employees who have an income of less than 15,000 rupees/month. The state-level Department of Health (SDOH) plays a prominent role in setting priorities for PHC and financing in Tamil Nadu, as does the central government. (Table 1 below lists the full set of public health facilities in the state, and their types and numbers). PHC services in public facilities are free of charge. The state also has a vibrant private health care sector that includes a large network of private sector hospitals.

Table 1: Public Health Facilities in Tamil Nadu

TYPE NO.	TYPE OF FACILITY	NUMBER
1	Medical Colleges	20
2	Hospitals attached to medical colleges	43
3	Tamil Nadu Government multi super specialty hospital	1
4	Dental college and hospital	1
5	District Headquarters hospital	31
6	Taluk and Non-Taluk hospitals	239
7	Primary Health Centers	1750
8	Health Sub Centers	8706
9	Urban Primary Health Centers	134
10	ESI hospitals	8
11	ESI dispensaries	195
12	Indian system of medicine hospitals	4

Source: Government of Tamil Nadu, 2015

Data in Tamil Nadu show the infant mortality rate as 21 per 1000 live births, and the maternal mortality rate as 68 per 100,000 live births (Government of Tamil Nadu, 2015). These rates are among the best in India and come close to achieving the previous Millennium Development Goals (MDGs) targets; and they indicate a strong PHC system in Tamil Nadu.

RATIONALE

JLN representatives from Tamil Nadu are committed to the ideals of PHC-oriented UHC. Tamil Nadu, one of the more progressive states in India, decided to pilot the UHC-PHC Self-Assessment Tool to capture the perspectives of various stakeholders regarding the alignment of health financing agencies (HFAs), including insurance providers, with the provision of PHC services in the state.

IMPLEMENTATION



CUSTOMIZATION

JLN team members customized the Tool to the local context, language, and culture of Tamil Nadu, by adding different respondents to different modules, including a broader variety of payment mechanisms, and adopting other changes. The following examples provide more detail on the changes that the team made to the Tool:

- Implementers adapted and clarified the categories of respondents to fit the local context. For example, in Tamil Nadu the HFA category incorporated both state- and central-level government entities. Implementers expanded the category of 'providers' to include other types of providers, such as faith-based providers, franchises of private providers, traditional/informal providers, and ESI hospitals.
- Implementers defined the payment mechanism categories as follows: payment of salaries (from the government), in-kind contributions (from the government/central programs), insurance-funded fee-for-service (FFS), capitation, out-of-pocket expenditures, and results- or performance-based financing, among others.
- Implementers provided more specific questions concerning, e.g., the top priorities for PHC and UHC, the monitoring and evaluation (M&E) data sources, etc.
- Implementers modified the list of preventive, promotive, and curative services to the Indian context and made these changes uniform across modules. Some examples include immunizations, antenatal care (ANC), tetanus vaccinations, post-natal care, communicable disease (CD) treatment (malaria, tuberculosis, flu, cholera, fever, etc.), non-communicable disease (NCD) treatment (diabetes, hypertension, cancer, etc.), health education, diagnostic services, delivery services, and general outpatient care.

PROCESS AND TIMELINE

JLN members in Kerala, India, led the Tool pilot in Tamil Nadu from November to December 2014 in partnership with the Government of Tamil Nadu and the World Bank. The team chose to pilot the Tool through a workshop in order to bring together key stakeholders from across Tamil Nadu and simultaneously collect their inputs. The Tamil Nadu Health Systems Society (TNHSS) conducted this workshop in collaboration with the JLN in November 2014. The TNHSS is an

initiative of the Government of Tamil Nadu in partnership with the World Bank that works to create a health system that is accessible, equitable, and effective. A total of 57 participants, representing the following institutions, completed the questionnaire:

- **16** representatives from the State Department of Health
- **6** representatives from the State Health Society
- **6** representatives from the Central Ministry of Health-State Department of Health, representing the Health Financing Agency
- **9** representatives from the private outpatient providers
- **5** representatives from the public outpatient providers
- **12** representatives from the public inpatient providers
- **3** representatives from the State Department of Finance

During the workshop, participants had an hour to fill in the module(s) of the Tool that pertained to their work. After the participants completed the Tool, JLN members led a session in which participants discussed any areas of misalignments that they identified between the state's present health financing arrangements and PHC efforts and programs. Participants then completed an additional questionnaire that asked seven open-ended questions regarding how well they understood the concept of UHC and its alignment with PHC, and elicited their opinions on how to improve PHC services and financing mechanisms.

ANALYSIS

The implementers of the Tool analyzed data using two different methods. First, they coded the responses from objective questions and conducted a frequency analysis to understand the respondents' range of perspectives on any specific question. Second, they collected and examined the answers to subjective questions (including the additional questions) and the discussions that followed to identify the major issues and recommendations suggested by respondents.

FINDINGS

Respondents shared that the major impediments to achieve PHC objectives in Tamil Nadu were a lack of health education and behavioral change communication. Respondents identified as lesser impediments the limited supplies of drugs and commodities, human resources for health, service quality standards, policy regulation, and leadership. Respondents also identified other factors that limit patients' access to PHC services, such as financial barriers and physical access due to distance and transportation barriers.

PRIORITY SETTING

The State Department of Health stated that the top priorities for PHC included maternal and child health (MCH), treatment of NCDs, emergency care, prevention of Communicable Diseases (CDs), the setup of electronic health records, and the promotion of sanitation and health education. While these priorities aligned with the respondents' view of the major UHC priorities informally, the majority of the respondents still felt that the state's health policy documents, such as the annual State's Health Policy Note and the five year strategic plans, did not give adequate importance to the alignment of the health financing programs and PHC efforts. Respondents only recognized one or two examples of any alignment (e.g., the role of the Muthulakshmi Reddy Scheme, which is a cash assistance scheme for pregnant women, in improving deliveries at the PHC level). Typically, PHC is not a key priority in insurance in Tamil Nadu; insurance coverage in the state is only for lifesaving tertiary care services (e.g., in CMCHIS). The only PHC services offered under insurance are follow-up visits for certain diseases and neonatal care.

FINANCING AND PAYMENT

- **The major sources of funding for PHC are the state government (the SDOH and the State of Health Society SHS), the central government (NRHM), and some funding from TNHSP.** Both the central and state government's PHC funding comes primarily from budget allocations, followed by external donor funds and earmarked taxes. Overall, respondents found that PHC was under-resourced. In addition, within the existing PHC funds, the SDOH and SHS prioritize curative services over preventive and promotive services.
- **As mentioned in the priority setting section, many of Tamil Nadu's UHC financing approaches do not align well with PHC.** The state health insurance scheme CMCHIS only funds lifesaving tertiary care, which it reimburses on a fee-for-service basis in both public and private facilities. The program largely does not cover preventive, promotive, or curative services at the primary level. The current payment mechanisms for PHC providers discourage or have a very low impact on the delivery of preventive and promotive services, as providers of these services rely heavily on salary payments and have no performance-based incentives.
- **Private PHC providers can see the impact of under-resourced PHC services.** Respondents reported that in private facilities, the major source of financing for MCH, NCD, and CD treatment, and general diagnostic services is out-of-pocket (OOP) expenditures (75%), followed by private insurance and central- and state-funded health insurance (approximately 20%). The majority of private providers stated that they do not receive direct funding or supplies from donors or vertical programs, though some respondents reported that they receive some government subsidies. They do not receive government payment for providing any promotive services. Similar to those in the tertiary-level, state-run CMCHIS, private providers typically receive payment by fee-for-service.
- **Public PHC providers do not receive much of their financing from OOP expenditures.** Public providers reported that they receive all health funding from the following sources, listed in decreasing order: state government, NRHM, vertical programs, insurance reimbursement, and OOP expenditures (for higher-level services). Facilities receive funding from the state- and central-government through (1) per capita based allocations; (2) the appointment of hospital workers, watchmen, and housekeepers, and fuel for outreach services; (3) education and communication support; (4) additional drugs and equipment; and (5) financial support to promote health. There are mixed reports on the government's provision of funds for preventive services: although public providers receive these funds for these services, most admitted that it is financially unsustainable for them to deliver these services due to inadequate financing allocation.

REGULATION

- **There is inadequate licensing and accreditation of PHC providers in Tamil Nadu.** Respondents from the SDOH shared that it is necessary for the government to oversee both licensing and renewal of licensing to ensure quality in PHC services among public and private providers. While private facilities at higher levels of care must be accredited to participate in CMCHIS or other private insurance programs, accreditation is not mandatory or required for private clinics or those hospitals not contracted with an insurance program.
- **Lax enforcement of referral guidelines may contribute to patients' bypassing primary care.** Patients' bypassing primary care is a critical problem both in public and private facilities. There are guidelines available that indicate when health care providers should refer patients to higher-levels of care; however, with the exception of good referrals from outpatient to inpatient care, providers rarely observe these guidelines. Despite the providers' calls for improved gatekeeping, policymakers have not yet instituted any additional measures. Respondents feel that there should be strict clinical protocols to guide the services that health care providers offer at each level of care to prevent patients from bypassing primary care and to establish a referral system.

MONITORING AND EVALUATION

- **M&E efforts are focused on the public sector.** Most respondents stated that the government collects data on PHC services from public but not private providers. The Tool provided respondents with a wide variety of options from which to choose to identify how the SDOH evaluates the data, including regular reviews, monthly review meetings, program-based monitoring, web portal, field inspections, and Health Management Information System (HMIS) monthly review of mortality data (such as infant and maternal mortality), etc. Respondents identified the following data sources as most commonly used: HMIS, Institutional Service Monitoring Report, Integrated Disease Surveillance Program reports, Government Health Systems Online reporting, Pregnancy and Infant Cohort Monitoring and Evaluation, monthly reports, and field inspection data. The SDOH uses the data to study indicators such as infant and maternal mortality, in addition to program-related incidence of CDs and NCDs, morbidity levels, and fever surveillance.
- **Respondents provided mixed reviews of the government's use of data in evaluating the performance of the insurance scheme and in promoting preventive services.** In addition, the majority of private providers reported that they are not required to report on PHC information, although they did agree that the SDOH conducts some monitoring and that they share data on key areas of concern, including TB and HIV/AIDS, among health officials.

REFERRALS/BYPASSING

- **All respondents shared that patients' bypassing PHC services is a problem.** Respondents estimated that a large volume of PHC services could have been delivered to patients, and that PHC providers could have prevented illnesses at the primary level. Specifically, public inpatient providers estimated that avoidable admissions accounted for roughly 10 percent of admissions. It is the norm for patients to bypass PHC for even minor services. As noted above, guidelines that indicate when providers should refer patients to higher levels of care exist, but are rarely observed. Although respondents opined that measures to curb bypassing should be developed and enforced by the SDOH, they reported concerns about increases in volume to PHC facilities, as respondents noted how overcrowded these facilities already are. PHC facilities would need to increase human resources substantially if they implement improved gatekeeping.

- **Lack of training for PHC providers.** While there are regular training programs for PHC providers, they are not comprehensive and don't provide effective training on topics related to primary health care. Moreover, the syllabi and training materials are outdated. Doctors and health staff in the private sector don't receive trainings and should be trained on preventive and promotive care and communication.

HUMAN RESOURCES

- **PHC facilities experience overcrowding and need more human resources.** Existing payment policies and the absence of incentives have led to less motivated providers, particularly among those who work in remote regions or who have high patient loads. The government does not have programs to encourage health workers or doctors to practice in rural areas or to improve their training, despite a strong need for such programs.

RECOMMENDATIONS



Based on the misalignments identified above, stakeholders and implementers recommend that Tamil Nadu take the following actions:

1. Increase the availability of untied funds for PHC facilities and base their disbursement on PHC workload and outputs to increase the funding available for additional medicines, diagnostic equipment, and human resources.
2. Consider the coverage of family health services, specific chronic diseases that cast a higher burden of disease on the population, and other PHC services under the CMCHIS.
3. Improve coordination of private PHC providers with the public health system to improve services at the field level. This coordination may include any of the following efforts: educate providers on preventive services, set PHC targets for the private sector to achieve, and promote competition and collaboration between private and public providers.
4. Increase recruitment and allotment of human resources for PHC facilities.
5. Provide incentives to improve providers' motivation, particularly those who work in remote regions or who have a high patient load.
6. Provide regular, structured trainings to both public and private providers, including refresher training for field staff. Trainings should have updated syllabi that comprehensively cover various topics of PHC services, and also should include lessons on the latest available technologies. These updated and expanded trainings will improve the quality of service delivery and help achieve UHC objectives.
7. Implement strict clinical protocols and improve gatekeeping measures to guide the services that health care providers offer at each level of care to create a functional referral system and decrease inappropriate caseloads and improve quality at the secondary and tertiary levels.
8. Improve regulation of the private sector through acts such as the Clinical Establishment Act, which institutes minimum quality standards.

9. Create feedback system to ensure that both the data collected by the state- and central-government and the data available through the CMCHIS are used to effectively identify gaps in service and lead to responsive, corrective actions.
10. Create health education for the community to improve demand and use of preventive and promotive health services.

IMPACT AND NEXT STEPS

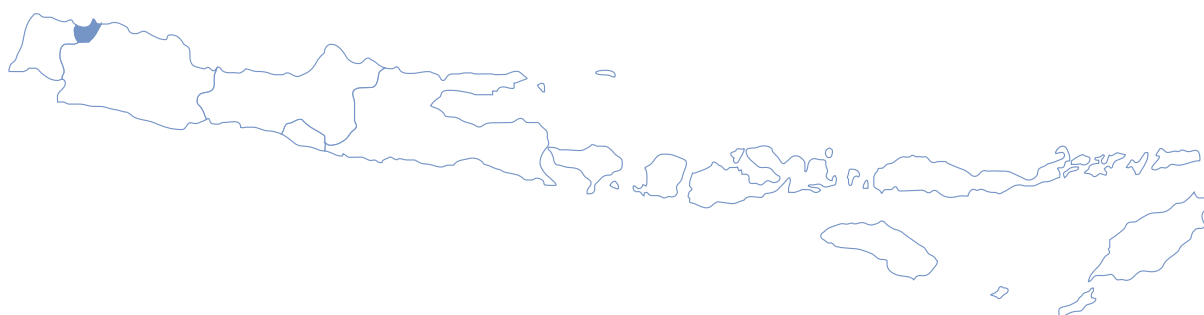


JLN members who led the pilot discussed the findings and the possibility of continued piloting in Tamil Nadu to build on the findings of this workshop. They propose to conduct another pilot study in the state, but with a more diverse mix of sample districts, which will include well performing, moderately performing, and poorly performing districts. A diversity of districts will enable the members to identify the full range and the severity of misalignments in Tamil Nadu and to devise district-specific interventions for improvement. The members anticipate that the findings will help to strengthen PHC in a targeted way throughout the state.

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Findings from Piloting the UHC Primary Health Care Self-Assessment Tool



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BACKGROUND

Indonesia recently transformed its primary health care (PHC) system to improve health coverage rates in the country. In January 2014, in an effort to move towards UHC, the country introduced a new national health insurance program, Jaminan Kesehatan Nasional (JKN) for all Indonesian people that unified several existing health insurance schemes. This is an ambitious undertaking: Indonesia is a large country with a population of 249.9 million people, a decentralized government, and a health coverage rate of 54 percent in 2014. This new insurance scheme, managed by BPJS Kesehatan, provides a comprehensive benefits package of primary, secondary, and tertiary care.

Indonesia, along with other World Health Organization- South-East Asia Regional Office (WHO-SEARO) country members, has agreed on a series of strategic steps to achieve UHC. A central goal of these UHC efforts is strengthening PHC-oriented health systems. Basic primary health care is provided by the public sector via a network of health centers (known as Puskesmas), each of which serves a catchment area at the sub-district level of about 25,000 to 30,000 individuals. Indonesia has more than 9,000 Puskesmas; each is staffed by at least 1 medical doctor. Private doctors also provide primary care; 70 percent of the doctors who work at Puskesmas practice privately after hours.¹ Private facilities also play a key role in delivering PHC; for instance, they are integral in preventing major health problems in Indonesia like maternal and infant mortality. Other major PHC priorities for the Indonesian government include the prevention, diagnosis, and early treatment of tuberculosis (TB), HIV/AIDS, and other communicable diseases.

JLN members in Indonesia piloted the UHC-PHC Self-Assessment Tool in Tangerang District and Bandar Lampung City. Tangerang District is located directly outside of Jakarta and has a population of three million people. There are 29 sub-districts in Tangerang, with a total of 43 Puskesmas and 369 private PHC facilities. There are 21 hospitals in Tangerang District; 2 are public and 19 are private. Bandar Lampung City has 30 Puskesmas, 370 private PHC facilities, and approximately 1 million people. These two localities have the national BPJS plan and the local health insurance (“JAMKESDA”) for poor people who are not yet covered by BPJS.

RATIONALE

Indonesian JLN members were interested in implementing the Tool to explore the relationship between PHC and UHC in a highly autonomous setting in which centralized health coverage schemes had only recently begun. Accordingly, the implementers chose to pilot the Tool in Tangerang District and Bandar Lampung City because of the governments’ autonomous control over health system management and strong political commitment to UHC. Specifically, Tangerang has a large population that has high-income disparity, and is close to Jakarta (the capital of Indonesia), which facilitates easy access to new information. In Bandar Lampung, the city government autonomously manages all public facilities, facilitating more decentralization and freedom.

JLN members in Indonesia piloted the UHC-PHC Self-Assessment Tool to accomplish the following goals: (1) assess the validity and strength of the Tool in the Indonesian health system, (2) document and assess how BPJS interacts with other primary healthcare efforts, and (3) identify areas of misalignment between BPJS and PHC’s stakeholders and programs. JLN members in Indonesia also had the following objectives for their pilot of the Tool:

¹Harimurti, P., Pambudi, E., Pigazzini, A., & Tandon, A. World Bank. (2013). UNICO Studies Series 8. *The nuts & bolts of Jamkesmas Indonesia's government-financed health coverage program*. Retrieved from http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2013/03/25/000333037_20130325130647/Rendered/PDF/749960REVISED0000PUBLIC00Indonesia1.pdf

- Learn more about the commitments of Tangerang District's and Bandar Lampung's leaders (the Regent and Mayor, respectively) in the funding policies of JKN (UHC) programs;
- Shed light on the relationship between UHC and PHC stakeholders (health centers, private clinics, and individual practices);
- Learn about the health financing policies of the district and city to support the goals of PHC;
- Learn more about national BPJS financing policies and their impact on PHC; and,
- Learn about the effect of data and information from monitoring and evaluation programs on JKN (UHC) and PHC.

In addition, by piloting the Tool in late 2014 at the local level, implementers were able to evaluate the state of PHC under the new national UHC policy to inform the government's implementation of JKN. For instance, public PHC centers, referred to as Puskesmas, have had to adjust to the central government's payment policies (capitation), and, as a result, have had to improve their financial management. Puskesmas, however, do not yet have the human resources to manage these changes. Health professionals like midwives and nurses hold many of the financial management positions in Puskesmas, yet they lack educational backgrounds in accounting, HR, or finance. The fact that health professionals' backgrounds and skill sets do not include managerial skills or expertise in budget planning and financial accountability, and do not correspond to their financial management positions in Puskesmas negatively impacts the financing of PHC. The self-assessment Tool explored and validated anecdotal evidence of these limitations, as discussed in more detail below.

IMPLEMENTATION



CUSTOMIZATION

JLN members leading the Tool's pilot test in Indonesia translated the content into Indonesian and adapted the questions to the local context. They also reviewed and pre-tested the pilot's protocols with national and local authorities and key partners to obtain their feedback on the Tool. The Ministry of Health, Provincial Health Office, District and City Health Offices, a local university, a local public health consultant, and BPJS all provided feedback that the implementers used to make the following changes to the Tool:

- Adjusted the questions to ensure their relevance for both the local and national levels;
- Adjusted the questions according to the local context (e.g., added a question for the District Planning Board (BAPPEDA) and the Financial Management and Regional Assets Board (BPKAD), since the planning of the health sector's budget needs the approval of both institutions); and,
- Included some of the additional optional questions in the Tool (in Bandar Lampung).

PROCESS AND TIMELINE

JLN members in Indonesia piloted the Tool during September and October 2014. They used a combination of eight focus group discussions (FGDs) and six in-depth individual interviews in Tangerang and Bandar Lampung, followed by a stakeholder meeting and discussion hosted

by Indonesia’s Ministry of Health (MOH). Respondents included various stakeholders, including policymakers, health financing administrators, and health care providers, among others (see Table 1).

Table 1. Categories of Respondents in Pilot Test of the Self-Assessment Tool

RESPONDENTS IN TANGERANG	RESPONDENTS IN BANDAR LAMPUNG
1. District Planning Board (BAPPEDA)	1. District Planning Board (BAPPEDA)
2. BPKAD (Financial Management Board and the Regional Asset)	2. BPKAD (Financial Management Board and the Regional Asset)
3. District Health Office (DHO)	3. District Health Office (DHO)
4. BPJS	4. BPJS
5. Puskesmas	5. Puskesmas
6. Private clinics	6. Private clinics
	7. Regional hospital
	8. Private hospital
	9. Professional organizations (e.g., physicians’ and nurses’ associations)
	10. Community health association
	11. Health education institution

In Tangerang, the implementers conducted four focus group discussions (FGDs), two each with public and private providers. After the FGDs, implementers conducted in-depth interviews with representatives from the DHO, BAPPEDA, BPKAD, and the BPJS branch office. In Bandar Lampung, the implementers organized stakeholders into FGD groups around four areas: policy, insurance, financing, and services. They also conducted two in-depth interviews with individuals from BPKAD and the DHO.

ANALYSIS

JLN members implementing the Tool documented key themes that emerged from the interviews and FGDs throughout the course of the pilot and synthesized their findings at the end of the pilot.

FINDINGS

PRIORITY SETTING AND POLICY

- UHC and PHC align in several ways in priority setting and general policy.** In both Tangerang District and Bandar Lampung, the local leaders have stated that they are committed to the financial prioritization of health policies, and PHC policy already exists in the local development and strategy plans, with the aim to strengthen a PHC-oriented UHC. At the national level, BPJS’s strategy documents also include policies to increase preventive and promotive care. Bandar Lampung has also set aside funds for community groups to implement public health efforts, such as mosquito larvae control.

- **Misalignment on priority disease burden in PHC and UHC.** The BPJS benefits package includes 144 diseases in its PHC service package; however, the benefits package does not emphasize or address the areas of priority disease burden (e.g., TB and HIV/AIDS).
- **The BPJS benefit package does not explicitly define priority diseases.** The benefit package is designed to cater to facility-based care at all levels (primary, secondary, and tertiary). However, the implementers expect that providers of PHC services are capable of diagnosing and treating the 144 diseases identified by the Indonesian Medical Council. The BPJS categorizes TB and HIV/AIDS diagnostic and treatment programs as public health programs funded in part by government and international agencies' funding for PHC, and partly by BPJS funding for curative and lab services.
 - » BPJS, pursuant to its regulation, covers treatment for 155 diagnoses as long as the health care providers deliver appropriate standards of care.

FINANCING AND PAYMENT

- **Sources of revenue for PHC come primarily from the government and insurance premiums.** The main sources of revenue for PHC, as well as other levels of care, in the two pilot areas include the central, provincial, and district budgets, and insurance premiums. PHC also receives some funding from grants and corporate social responsibility mechanisms.
- **Capitation is the dominant form of provider payment for PHC services.** BPJS provides the largest source of PHC funding for Puskesmas (60-80%) through capitation payments. Local and state governments fund facilities, salaries, maintenance, and health equipment. Jamkesmas, the local insurance for poor people who are not yet covered by BPJS, also provides PHC funding, particularly for the poor, and reimburses PHC claims from Puskesmas. Private health facilities in both Tangerang and Bandar Lampung also receive capitation payments from BPJS for PHC services. Private providers who are not contracted by BPJS still deliver services on a fee-for-service basis.
- **There are many way to improve the alignment of UHC and PHC, including the following:**
 - » **Stakeholders have conflicting views on the BPJS capitation policy, which may result in misaligned incentives for providers of PHC services.** Providers stated that capitation payments from BPJS could be used only for curative services, but the BPJS stakeholders that the team interviewed said that the capitation payments also could be used for preventive services. Stakeholders and providers had not resolved this issue by the end of the Tool's implementation. The lack of clarity around what BPJS does and does not include in the capitation payments may reduce providers' motivation to provide some PHC services. For example, private providers noted that they are less motivated to promote antenatal care and family planning to BPJS members under the capitation system, and, therefore, deliver more curative services. Additionally, both public and private providers stated that they have little motivation to provide outreach services for BPJS members, although such services are included in the benefits package, because they are covered by the capitation system.
 - » **Private providers are not adequately prepared to provide preventive and promotive services.** Although private providers play a role in delivering PHC services, they have not

received sufficient training and clarification of their roles within this area. For example, although Indonesia has focused on achieving its HIV and TB-related MDG targets, MOH and BPJS have provided little comprehensive training to private providers on diagnosing and treating these diseases. Moreover, the MOH and BPJS have not yet clarified the duties and functions of private providers in addressing the prevention of priority chronic diseases.

- » **Health is a lower priority compared to other sectors.** Additionally, while PHC is relatively well prioritized within the health sector, government funding for health generally is under-prioritized, relative to other sectors. For example in Tangerang district, less than 10 percent of the district's total budget is allocated to health. This is less than the percentage required by the 2009 Health Law No. 36, which mandates that the health budget be at least 15 percent of the total district budget.

REGULATION

- **Lack of PHC performance indicators and reporting mechanisms on quality of care.** While the Tool did not extensively cover regulation, respondents' answers to the Tool's questions indicated that BPJS does not have any defined PHC performance indicators to evaluate the quality of promotive and preventive services delivered by providers. In addition, providers' reports to BPJS only cover information on the number of visits and the diagnoses.

INFRASTRUCTURE AND WORKFORCE

- **Weak health infrastructure and insufficient human resources at public facilities.** Facilities do not have enough employees with financial management skills to manage the new influx of funding provided by the BPJS and capitation system. In addition, many health workers do not receive the proper financial incentives; they are contracted by the central and local government but are not fully employed and do not receive any social security. This is related to the facilities' limited power to hire permanent employees.

RECOMMENDATIONS

JLN members in Indonesia recommend that BPJS and government actors take the following actions based on their findings:

1. BPJS should provide additional clarity in its policy regarding the use of capitation funds, and possibly amend the policy. This policy is extremely important, as providers receive much of their funding through capitation payments from BPJS. As a result of providers' interpretation of the policy, there appear to be less incentive for them to provide PHC services compared to curative services.
2. Local authorities should increase financing for public health relative to financing for other sectors (e.g., education). The public facilities need more financing for public health efforts.
3. BPJS and MOH should clarify the PHC duties and functions of private providers and offer them more training in preventive and promotive care in order to encourage private facilities to play a larger role in providing PHC services.

4. Financing authorities should mandate that facilities incorporate, track, and report on PHC performance indicators, to better guide PHC facilities' work and progress.

NEXT STEPS

Following the implementation of the UHC-PHC Self-Assessment Tool in Indonesia, the implementers of the Tool also shared their experience and results in a Country Core Group held at the Ministry of Health (MOH) in Jakarta, Indonesia. They shared their recommendations, proposed next steps, and discussed the potential use of the Tool in other districts and autonomous regions. Indonesian implementers agreed to undertake the following next steps after the completion of the pilot:

1. Form a network of stakeholders from local government and providers to improve communication in PHC;
2. Work with the Ministry of Health (MOH) and BPJS to clarify payment policies and clearly state the duties and functions of the providers in addressing the prevention of priority chronic diseases;
3. Propose to the Minister of Health that the Ministry evaluate the use of capitation funds in supporting PHC in public health facilities (FKTP);
4. Encourage BPJS to build and use a Key Performance Index (KPI) for PHC activities and provider incentives to adequately assess and motivate providers; and,
5. Carry out the Self-Assessment Tool in other regions and at the central level.

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MALAYSIA

Findings from Piloting the UHC Primary Health Care Self-Assessment Tool



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COUNTRY CONTEXT



BACKGROUND

Malaysia is an upper middle-income country that has a population of approximately 30 million people (World Bank Indicators, 2013). Malaysia has benefited from steady annual GDP growth ranging from 5 to 6 percent in the last 10 years, which has contributed to its ability to effectively attain universal coverage for comprehensive primary health care services for its population (World Bank Indicators).

Malaysia's Ministry of Health (MOH) functions as the primary funder, provider, and regulator of the health system. Some of the MOH's roles include (a) policy formulation and analysis, (b) health development planning and implementation of development projects, (c) broad programming and target setting, (d) setting norms and standards, (e) obtaining and allocating resources, (f) monitoring and control, (g) review and promulgation of health legislations, and (h) evaluation. The MOH plans and regulates most of the public sector health services, and to a lesser degree, the private sector health services. Malaysia is comprised of 14 states and the MOH's functions are replicated through the State Health Departments.

The Ministry of Finance determines allocations for health care and sets the annual budgets for the Ministry of Health as shown in the five-year Malaysia Health plan. The Ministry of Finance funds the MOH through direct and indirect tax revenues and non-tax revenues. The Ministry's annual financial allocation to MOH between 2000 and 2010 has been between five and eight percent of the national budget. MOH funds public health care with general revenues and taxes collected by the government (approximately 55% of total health expenditure); private health care is funded principally by patients' out-of-pocket payments (approximately 80% of private spending) and private health insurance premiums.

The MOH is the main provider of public health services, which are delivered by an extensive network of primary care clinics that either are free of charge or are heavily subsidized. The private sector provides health services primarily in urban areas through clinics and hospitals. The utilization rates of outpatient services at public and private facilities are almost equal, but the utilization of services differs. MOH's primary health care providers treat more chronic illnesses, whereas private facilities primarily treat acute illnesses and provide curative care.

Malaysia is addressing two main challenges related to its primary health care system: the population's rising expectations with regards to healthcare services delivered by the government, and increasing health expenditures. Malaysia spends 4.5 percent of its GDP on health (MNHA, 2013). Primary care accounts for 16 percent of Malaysia's total expenditures on health (THE), with 40 percent of national expenditures on primary health care paid for by public funds (i.e., government) and 60 percent by non-government funds.

RATIONALE

The MOH views UHC as a goal and providing Primary Health Care (PHC) as a way to achieve that goal. As such, the MOH has a strong interest in ensuring alignment between UHC and PHC. The JLN UHC Primary Health Care Self-Assessment Tool provides a unique method of identifying key misalignments between UHC and PHC and providing strategies to address them. The MOH applied the Tool to obtain new information on alignment between UHC and PHC with the aim of using key findings as part of a broader assessment of its health system to strengthen UHC, including its financing and payment systems and service delivery.

IMPLEMENTATION



CUSTOMIZATION

The original JLN UHC-PHC Self-Assessment Tool was designed with a focus on a single-payer health insurance mechanism, because the majority of the JLN member countries have a health finance model that involves a national health insurance scheme. Because Malaysia does not have a single-payer scheme, the JLN members who led the implementation of the Tool in Malaysia adapted the Tool's content to the local context. The notable changes that the team made to the Tool included replacing references to the health financing agency with the Finance Division at the Ministry of Health, and adjusting the modules related to health service provision to represent Malaysia's dichotomous public and private service delivery systems. Other changes included adding instructions to each module and including a consent form for respondents.

PROCESS AND TIMELINE

The implementers pre-tested the Tool and adapted it to the Malaysian context in July 2014. They carried out data collection during a three-month period from August to November 2014 using a combination of interviews and self-administration of the Tool. Table 1 includes an overview of the implementers' process to implement the Tool.

Table 1 – Overview of Process to Implement UHC-PHC Self-Assessment Tool in Malaysia

MODULES IMPLEMENTED	MALAYSIA
Health Financing Agency	Interviews with three representatives from the Finance Division, Ministry of Health
Ministry of Finance	Interviews with two representatives from the Economic Planning Unit (EPU) and one representative from the Ministry of Finance
Ministry of Health	Interviews with five representatives from the Ministry of Health
Private Provider	Self-administration of the Tool at workshop with 23 general practitioners from private PHC clinics
Public Provider	Self-administration of the Tool at workshop with 33 representatives from PHC service and 9 representatives from inpatient service

ANALYSIS

The JLN UHC Primary Health Care Self-Assessment Tool is designed to collect both quantitative and qualitative data. The implementers entered data into Microsoft Access, following a quality control check. The implementers analyzed quantitative data using SPSS, and coded and analyzed qualitative data in Excel. The team of JLN members leading the implementation of the Tool collaboratively discussed key findings and recommendations and wrote the final report.



JLN members identified human resource and funding constraints as the top impediments to achieving PHC and UHC objectives in Malaysia. Other key barriers are poor quality of service and standards, accessibility, alignment of incentives, financial barriers to use by consumers, and limited supplies of drugs and commodities.

PRIORITY SETTING

- **PHC is a main priority in national health policies and plans.** Primary health care has a central focus in the health priorities documented in the 10th Malaysia Plan and it is expected to have a prominent role in the forthcoming 11th Malaysia Plan. It also has a strong role in other policy and health planning documents. Malaysia formulates health policies and plans at the central level; district health offices and health providers implement them at the district and local levels.
- **Private sector facilities lack awareness and training on current national health priorities.** Both public and private PHC providers reported a high level of awareness about their role in supporting PHC delivery more broadly in Malaysia. Private providers reported that they lack awareness on national policies and priorities and that they don't receive training on them, which is indicative of the dichotomous manner in which public and private health providers operate in Malaysia.
- **Misalignment between PHC policy and service provision.** Private PHC facilities provide 51 percent of outpatient services, as compared to 49 percent for the public sector (NHMS, 2011). Despite the important role of the private sector in PHC service delivery, the types of services that the private sector provides, namely largely curative care, are not aligned with PHC priorities, such as preventive care.

PREVENTIVE SERVICES MORE AVAILABLE IN PUBLIC CLINICS

The 2012 National Healthcare Establishment Workforce and Establishment Primary Care Survey had shown that preventive services were offered more in the public as compared to the private clinics. Only 16.7 percent of the private clinics offered smoking cessation services as compared to 75 percent of the public clinics; antenatal and postnatal services were offered in 91.2 percent of public clinics versus 67.5 percent of private clinics; all the public clinics offered Pap smears versus 73.3 percent of private clinics; and clinical breast examinations were offered in 98.5 percent of public clinics versus 74.2 percent of private clinics.

FINANCING AND PAYMENT

- **Whereas PHC has a central focus in health policy documents, secondary and tertiary health care services receive the majority of health resources.** Secondary and tertiary services received 70 percent of the total patient care expenditures compared to 26 percent for primary health care (MNHA, 2013). This distribution of funds is largely due to the current operational structure of the health system, which places more resources (including human resources) in hospitals.
- **Overall funding for PHC is insufficient due to lack of budget space for health as a whole within the government, rather than a lack of priority for PHC.** Respondents attributed the lack of funding for PHC to the broader lack of funding for health. Respondents' general perception was that the proportion of the health budget allocated towards PHC is sufficient, but they acknowledged that there is a lack of clarity and information on the optimum allocation for PHC. The MOH's budget allocation is determined by the Ministry of Finance (MOF) based on MOH's

past spending plus an incremental increase determined by estimated rises in the consumer price index (WHO, 2012). The MOF provides additional funding for health if emergencies occur. The MOH is addressing this issue by continuing its dialogue with the MOF and by working on broader systemic reforms for health financing and service delivery. Respondents from the MOH stated that it would be difficult to shift the current budget allocation from hospitals to primary care; instead they proposed developing new funding channels specifically for PHC.

- **Payment mechanisms for public providers don't offer incentives for providers to deliver high quality care.** Payments to health facilities are made based on a fixed annual budget. Providers receive the majority of their funds through salary payments, which are unrelated to the provision of high quality care. In addition, public providers report low satisfaction with the speed and amount of their payments.
- **Payment mechanisms in public and private facilities do not offer incentives for providers to deliver preventive care.** In the private sector, the payment mechanism for PHC services is fee-for-service (FFS). Most respondents who are the private providers agreed that most of their revenue comes from OOP payments. This is in line with findings from a study conducted in 2011 that found that on average a private medical clinic receives 70 percent of its revenue from OOP payments (Mahmud et al., 2013). No representatives from private facilities reported receiving funding or supplies (including drugs) from donors or vertical programs. The providers in the private sector did not receive incentives for delivering appropriate primary care services. Regarding preventive services, most private providers reported that they did not receive payment specifically for providing preventive services. Further, they stated that preventive services are not profitable unless combined with consultations. Private providers agreed that providing preventive services is time consuming, accounting for approximately 20-40 percent of their time, but that these services do not generate income. This explains the distinctly different case mix seen in the public and private sectors. In 2012, the top three reasons why patients sought care in public clinics were for chronic diseases, while the top reasons patients sought care in the private sector were acute complaints (The National Medical Care Statistics Study, 2012). The private providers also stated that their clinics are poorly equipped for preventive services. For example, they lack refrigerators needed to store vaccines (Gopal-Krishnan et al., 2014).

REGULATION

- **Weak regulation of private health facilities.** The Ministry of Health of Malaysia uses the following mechanisms to regulate the health care industry: 1) a set of standards, titled the "Private Health Care Facilities and Services Act," 2) the provision of an Annual Practicing Certificate to facilities, and 3) accreditation. MOH has used these mechanisms successfully to regulate public facilities, but the MOH has had limited reach with its efforts to regulate private PHC facilities. The only regulation that is followed by both public and private facilities is an annual renewal of the Annual Practicing Certificate.

MONITORING AND EVALUATION

- **The MOH monitors quality of health services, including regulations and referrals.** The MOH is responsible for monitoring quality of services ranging from preventive and PHC to tertiary hospital care and uses a set of Key Performance Indicators developed in 2002 and a more recently developed Outcome Based Budgeting Indicator (KPI) to do so. However, the absence of a comprehensive IT system hinders the availability of accurate and comprehensive data on the key performance indicators. The MOH also lacks an accrual accounting mechanism, which limits its ability to track and forecast budgets.

- **Monitoring and evaluation of the private sector is weak.** Respondents from the MOH stated that monitoring of the private sector is weak; respondents from private providers corroborated this statement. While the Private Healthcare Facilities and Services Act mandates that private providers report on their service delivery to the MOH, reporting is not enforced and few private providers submit data.

REFERRALS/BYPASSING

- **Public health services have a good referral system, but not the private sector.** The implementers' findings from administering the Tool reveal that between 1 and 10 percent of the total number of patients admitted to hospitals could have been treated in outpatient care. Similarly, respondents reported when asked about cases that could have been treated at the outpatient level, but resulted in hospital admissions because of delays in treatment, that these cases account for 1 to 10 percent of total admissions. When respondents were asked about the percentage of inappropriate referrals from PHC, respondents stated that between 1 to 20 percent of referrals were inappropriate. Overall, these data show that Malaysia has a good referral system, which generally works well in the public sector, but that patients still bypass PHC. Patients can go directly to see a specialist or to hospitals in the public sector by paying a small additional fee. The main reasons that patients bypass public PHC facilities include lack of human resources and long wait times, and the inability or inadequacy of the public sector to deliver certain services. Survey respondents recognized that the fact that patients bypass PHC services in the private sector is an important issue. Some private health insurance companies and employer groups require that patients receive a referral to be eligible to receive reimbursement for their inpatient care fees, which helps to enforce referrals in the private sector.

HUMAN RESOURCES

- **Lack of human resources in public PHC clinics is a key barrier to achieving PHC objectives, particularly in rural areas.** Primary care services in Malaysia are under considerable strain due to shortages in human resources. In urban areas, the lack of human resources in public facilities results in long waiting times for patients, which can lead patients to bypass PHC. There is also a lack of human resources for health in rural areas that limits patients' access to and quality of health care.
- **Insufficient training on PHC, particularly for private providers.** Only 7 out of 24 (29%) private providers reported that they had received training in primary health care. The providers involved in the study recognized their need for additional training and other approaches to communicate updates about policies and new treatment regimens, along with the use of incentives, encouragement, and collaborations.

RECOMMENDATIONS

The team of JLN members who implemented the Tool and led the analysis of its findings developed the following recommendations:

1. Create a communication strategy to engage the private sector and improve integration between the public and private sectors;

2. Provide training and support to private primary care providers to strengthen their capacity and capability to deliver preventive services;
3. Develop possible payment options and non-payment incentives to encourage the private sector to provide preventive primary care services to meet the challenge of the increased burden of chronic diseases facing the country;
4. Develop best practices for referral management to keep health care costs down and reduce the number of unnecessary inpatient admissions;
5. Develop appropriate indicators to monitor PHC that can be used in both the public and private sectors;
6. Improve monitoring and evaluation by using an electronic database and mandating reporting via an information technology system.

IMPACT AND NEXT STEPS



The team of JLN members from Malaysia who piloted the Tool validated the content of the Tool and confirmed that it is a useful instrument to identify key alignments and misalignments between UHC and PHC. The team produced a detailed report and presented the main findings to the Ministry of Health. Ultimately, the Malaysian government is using the findings of this report to inform ongoing health financing and system reforms in Malaysia.

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