PRELIMINARY POLICY NOTE ON ASSESSMENT OF
HEALTH SERVICE DELIVERY SYSTEM
IN LIGHT OF PROPOSED UNIVERSAL HEALTH INSURANCE SCHEME

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Summary
In 2010, the Government of Maldives (GoM) initiated a policy of corporatization of the public health delivery system. This Note considers the potential for this reform strategy to contribute to the aims of universal health coverage based upon an initial review by the World Bank. A conclusion is that these corporations do not appear ready to contribute effectively to the aims of a universal health insurance scheme, and represent the weakest link in the overall reform effort. Policymakers and planners may need to direct much more attention to the service delivery components of the scheme than has been the case to date. In practice, the corporations continue to behave similarly to public budgetary organizations, as budgetary grants, largely unlinked to performance, continue to form the bulk of their resources. The corporations collect the same routine data mandated by the Ministry of Health and Family (MOHF) for all health facilities prior to corporatization, but do not appear to analyze the information; basic data on quality and patient satisfaction are apparently absent. However, we conclude that the Health Service Corporations (HSCs) have the potential to reorganize service delivery to provide high quality care efficiently, however they will need considerable technical support to build capacity to manage the facilities and improve performance.

There does not appear to be any legislation, policy or legal instrument that underlies the Memoranda of Agreement (MoA) between the GoM and HSCs, suggesting that this initiative can be undone as fast as it was constructed. The agreements themselves lack any specifications related to service delivery expected from the corporations. A performance monitoring system within the government that would monitor the HSCs on a regular basis is lacking. There is clearly a need to establish coordinated lines of accountability with the corporations to monitor and improve their performance. There is also an urgent need to define and strengthen primary care so as to improve its gate keeper role and to reduce the hospital centric nature of the Maldivian health service system. The corporations lack human resource management capacity to set strategies or perform core managerial functions and the current infrastructure may be both overbuilt and underutilized. This suggests that the new universal scheme may incorporate a high level of inefficiency in their initial costing and pricing. The policy brief proposes some recommendations and areas for further analysis in order to better ensure that the corporatization contributes to the GOM’s objectives for the health sector.

Background
In 2010, the Government of Maldives (GoM) initiated a policy of corporatization of the public health delivery system, wherein seven regional corporations took over the operating responsibility and management of government health facilities situated in their geographical areas from the MOHF. At the time of drafting this note in September 2011, five corporations had been constituted and two were in the process of formation. Memoranda of Agreement (MOAs) signed between the GoM (represented by the MOHF and facilitated by the Public Enterprises Management Board- PEMB) specify the objectives, obligations and responsibilities of the health service corporations and MOHF. Understanding the opportunities and challenges facing the HSCs will be critical to the success of the universal health coverage scheme proposed by the GoM because HSCs will be the main providers of care under such a scheme.

This note is based on a short visit in which the World Bank team met with officials from the President’s Office, MOHF, MOF, two corporations, and two hospitals (Indhira Gandhi

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conducted a rapid review of incomplete data. As such, the issues highlighted here are somewhat impressionistic. More solid and evidence-based recommendations on the readiness, challenges and technical assistance needs of the corporations can only be made once data become available (and are analyzed) on populations served, physical and human resources, service production, productivity, referral patterns, and the revenues and expenditures of the hospital and primary care facilities of each of the corporations. Finally, many of the issues raised here respond to the nascent and evolving nature of the corporations and their hasty formation and implementation. The governance arrangements, policies, accountabilities, managerial processes and reporting requirements are still under development. The remainder of this note consists of observations on specific aspects of the HSCs.

**General findings**

The proposed universal scheme will ultimately be judged by citizens and politicians in terms of the quality and effectiveness of service provision vis-à-vis the status quo. Our preliminary assessment suggests that taken together the HSCs may not be ready for the universal health insurance scheme. To date, policy makers have focused more on financing and coverage aspects of the universal scheme, and have yet to direct much attention to service delivery components. Whether the HSCs have the capacity to deliver the services in the to-be-formulated packages or respond to the incentives and signals embedded in how they are paid (planned package rates and capitation or global budget payments) needs to be better understood.

Although the HSCs are, in principle, autonomous corporate entities, in practice they continue to behave similarly to public budgetary organizations. To some extent, this is to be expected given the recentness of the corporatization, though the fact that budgetary grants, largely unlinked to performance, continue to contribute bulk of the resources for the corporations (and as the corporations appear to expect such support to continue indefinitely, despite a stated policy by the government of phasing out the budgetary grants and requiring the corporations to be self-sustaining). In short, they have yet to make the “cultural” transformation from a public bureaucracy to a private firm. Even now, staff salaries and allowances remain the same as those under the MOHF; there is little evidence of reduction in staff; the government remains the ultimate residual claimant, especially if the corporations fail or face a financial crisis; service rates (user fees) and other charges are those set by MOHF years ago (and do not vary across the health facilities and corporations despite variations in population, utilization and probably costs); HSCs collect the same routine data mandated for all facilities by the MOHF prior to corporatization, but evidently do not analyze and use the information; basic data on quality and patient satisfaction are apparently absent; incentives exist for the CEO and board members to continue in an 'expansion' mode, including acquisition of new infrastructure and equipment in part to politically make their mark; and financial management capacity appears low as most have problems preparing and submitting claims data to the current national health insurance scheme, Madhana, or to the other insurers in the country.

In practice, even the autonomy available to the corporations appears to be limited. According to HSC representatives, they require permission from the finance ministry to hire additional staff or adjust salaries, which is understandable given that the government would want to monitor expensive HR commitments. Although HSCs can in theory fire personnel and some HSCs do agree that firing is possible and easy, they may refrain from doing so, fearing possible political repercussions. In this regard, international experience suggests that partial autonomy may contribute to lower performance and impede the corporations from taking steps to improve quality and efficiency.

Nevertheless, the HSCs do have the potential to reorganize service delivery to provide high quality care efficiently if institutional arrangements, accountabilities and incentives are more oriented to performance, and the HSCs themselves are given greater decision-making authority over inputs (such as hiring, dismissal and remuneration of staff). Notwithstanding resolving the full autonomy issue, the HSCs will need considerable technical support to build capacity to improve performance and interact with the proposed universal health insurance scheme.

At the time of the Bank team's undertaking discussions with the corporations, all HSCs were preparing business plans to submit to government. However, these plans were mostly aimed at securing new budgetary support or augmenting existing budgets to raise quality and access. Although we have no argument with the latter objective, the plans suggest that rationalization of service delivery, identifying areas for increased efficiency and raising productivity apparently are not high on the agenda. We suggest that the universal scheme needs to consider a transition model that includes built-in incentives for the corporations to improve quality but also rationalize service delivery. This will be no easy task.
In general, the MoAs require significant strengthening particularly in terms of specification of services, volume, quality and other performance criteria for hospital care, primary care and public health interventions. Of equal concern, the MoA mentions that the HSCs must abide by national standards, guidelines, service regulations, and operating procedures. Nevertheless, interviews with both parties suggest that neither is unaware of the content of the same.

Performance Monitoring Arrangements and the Role of MOHF

A performance monitoring system within the government that would monitor the HSCs on a regular basis does not exist. We also have concerns over the MOHF's current capacity to oversee, regulate and monitor the HSCs. In fact, there is little clarity within the MOHF and the HSCs of the role of the former. In theory, the finance ministry should monitor their financing and expenditures while MOHF should oversee volume and quality of services delivered. According to the HSCs, they send data when requested, but requests appear ad hoc: some originate from finance, others from health and still others from the President's Office. Also, this appears to be the only interaction they have with government on their performance. The MOHF appears unclear about its oversight role vis-à-vis the corporations (and vice versa). e.g., some officials are unsure of the MOHF's right to inspect HSC facilities. In general, there is need to undertake a systematic effort by government to establish coordinated lines of accountability with the HSCs to monitor and improve their performance. There appears to be some confusion over which ministry monitors and enforces what aspect of the corporations, and lines of accountability between government and the HSCs appear diffuse and fragmented, which does not augur well for results expected from the corporatization initiative.

Debt Burden

At least three HSC face large debt burdens – inadequate budgetary support, little change in self-generated revenue or in the efficiency of spending, along with the freedom to borrow from the market seem to be the joint culprits for this state of affairs. It is unclear if, how or when this burden will be resolved. Government may want to negotiate a one-time transfer to clear these liabilities but this should be conditioned against improvements in efficiency and a balanced book approach to budgeting, budget execution and financial management by the HSCs.

Primary Care

There is an urgent need to define and strengthen primary care particularly in terms of its gate keeper role and reducing the hospital-centric nature of the Maldivian health service system. According to respondents, Maldivians tend to seek hospital-based care as the first point of contact (while demanding branded drugs). These demand patterns, also observed in other countries, are inherently inequitable (and unaffordable in the long term), favoring those who live close to hospitals while leaving at a disadvantage those who live on distant atolls. Maldivians appear to have little trust in low level facilities to address their health care needs. Further, given the heavy burden from chronic diseases, a case can be made for a coordinated care model that places primary care at the center of the delivery system, combining treatment, prevention and health promotion at primary facilities in part to keep people out of the hospital. Most OECD countries are already moving toward a primary care-centric model which improves quality while containing costs. Finally, there appears to be much confusion regarding the roles of the Councils vis-à-vis the HSCs (and also the MOHF) regarding public health and primary care. This will also need to be clearly outlined and monitoring systems established similar to the recommendations about the corporatized hospitals above.

Management Capacity and Knowhow

The corporations lack capacity to perform core managerial functions such financial management, HR management, asset management, clinical management,
data monitoring and analysis, planning and procurement etc. The MOHF also (correctly) questions their capacity to implement public health programs. Further, it is uncertain if the HSCs have the knowhow to revamp or even improve their delivery system, addressing efficiency and quality concerns. Also, it is unknown the degree to which HSCs are supervising service delivery. To address this, greater capacity building of the corporation board and hospital officials is one option, while the other could be a pooled set of managerial resources which the corporations could share. If each HSC has to hire a cadre of managerial and supervisory personnel, it would raise costs further. A pooled approach in which two or more HSCs share core personnel would be more economical and will make sure that the managerial resources are fully utilized.

**Physical capacity**

Our preliminary assessment suggests that current infrastructure may be overbuilt and underutilized suggesting that if this is not factored in the calculations, the new universal scheme may incorporate a high level of inefficiency in their initial costing and pricing. Many of the atoll facilities are severely underutilized which suggests that consolidation and rationalization may be possible provided there is emphasis on establishing stronger referral and transport linkages to maintain appropriate levels of access. However and as suggested above, most HSCs actually seek to expand infrastructure. This “me too” building spree has been observed in many countries, particularly as a result of decentralized authority over new construction, and needs to be carefully guarded against so that it does not lead to underutilized, poor quality facilities at a high cost, which the country can ill-afford.

**Prices and costs**

Apparently all facilities use the same fees structure put in place by the MOHF several years ago. These fee levels do not have a rational basis: they do not fill the gaps between budgetary revenues and expenditures, nor are they related to costs or market prices. All HSCs understandably want to raise fees to make ends meet and rid themselves of their debt. However, raising fees will certainly have severe equity implications, particularly for the poor. The proposed universal coverage scheme will have to address the degree to which the corporations can charge fees or copayments directly to patients, because if HSCs are allowed to set their fees with no oversight, they will have little incentive to control costs.

**Recommendations for next steps**

To help ensure the HSC reform contributes to the GoM’s universal coverage objectives the team suggests that the MOHF and finance ministry: (i) conduct a break even analysis of HSCs to determine how much financing would be needed to eliminate debt and maintain a balanced budget; (ii) conduct a rapid cost analysis with corresponding performance assessment (efficiency and quality); (iii) provide TA to the HSCs to prepare a performance (efficiency and quality) enhancement business plan; (iv) conduct a capacity analysis to determine HSCs managerial and clinical capacity needs; (v) based on the above, prepare a change management and action plan to enable the HSCs to transition from dependent, budgetary organizations to independent, self-sustaining, autonomous organizations.

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1The brief is based on the mission conducted in September 2011, and at the time of going to print, there has been a change in the number of corporatized entities as well as other reform is already underway.

2This brief is intended to be accompanied by a data matrix compiled by the Maldives government team on these data elements.

3These officials are politically appointed and need to demonstrate visible action to the local community.

4See policy note 1 of this set for a detailed discussion of the Madhura scheme.

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