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# EXPLORING THE INSTITUTIONAL ARRANGEMENTS FOR LINKING HEALTH FINANCING TO THE QUALITY OF CARE: LESSONS FROM INDONESIA, THE PHILIPPINES, AND THAILAND



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It was prepared by Altea Cico, Adam Koon, Mignote Haile, and Kelley Laird for the Health Finance and Governance Project.

## The Health Finance and Governance Project

The Health Finance and Governance (HFG) Project works to address some of the greatest challenges facing health systems today. Drawing on the latest research, the project implements strategies to help countries increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The project also assists countries in developing robust governance systems to ensure that financial investments for health achieve their intended results.

With activities in more than 40 countries, HFG collaborates with health stakeholders to protect families from catastrophic health care costs, expand access to priority services – such as maternal and child health care – and ensure equitable population coverage through:

- Improving financing by mobilizing domestic resources, reducing financial barriers, expanding health insurance, and implementing provider payment systems;
- Enhancing governance for better health system management and greater accountability and transparency;
- Improving management and operations systems to advance the delivery and effectiveness of health care, for example, through mobile money and public financial management; and
- Advancing techniques to measure progress in health systems performance, especially around universal health coverage.

The HFG project (2012-2018) is funded by the U.S. Agency for International Development (USAID) and is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., the Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc. To learn more, visit [www.hfgproject.org](http://www.hfgproject.org)

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## ACRONYMS

<b>BPJS</b>	Badan Penyelenggara Jaminan Sosial (Indonesia's Social Security Agency)
<b>DOH</b>	Philippines Department of Health
<b>HAI</b>	Thailand's Healthcare Accreditation Institute
<b>HFG</b>	USAID's Health Finance and Governance Project
<b>JCI</b>	Joint Commission International
<b>JKN</b>	Jaminan Kesehatan Nasional (Indonesia's National Health Insurance Scheme)
<b>KARS</b>	Komisi Akreditasi Rumah Sakit (Indonesia's Commission for Accreditation of Hospitals)
<b>KPI</b>	Key Performance Indicator
<b>LMIC</b>	Low- and Middle-Income Countries
<b>MOH</b>	Ministry of Health
<b>MOPH</b>	Ministry of Public Health
<b>NHSO</b>	Thailand's National Health Security Office
<b>PHC</b>	Primary Health Care
<b>PhilHealth</b>	Philippine Health Insurance Corporation
<b>SRA</b>	Senior Research Advisor
<b>UHC</b>	Universal Health Coverage
<b>USAID</b>	United States Agency for International Development





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# EXECUTIVE SUMMARY

While universal health coverage (UHC) has assumed a prominent place on the global health policy agenda, global health advocates are increasingly trying to address the quality of health service delivery in low- and middle-income countries (LMICs). International researchers are only beginning to understand how to leverage financing arrangements to improve the efficiency and quality of health systems. Strategic purchasing has demonstrated progress in many countries, including in LMIC (i.e., Tanzania). Yet, much remains unknown about the structural and functional arrangements that create an enabling environment for quality health care, and what aspects might be considered for other LMICs attempting to leverage health financing to further quality health care. Furthermore, the roles and relationships of various actors in strengthening the quality of service delivery in LMICs remain unclear.

This study uses well-established qualitative methods to explore these dynamics in Southeast Asia, a region that has seen rapid economic growth, but where quality concerns threaten progressive achievement of UHC. More specifically, we wanted to know *What institutional arrangements facilitate the delivery of quality health care and how are these linked to health financing in South East Asia?* To answer this question, HFG conducted a desk review and in-depth semi-structured interviews with stakeholders in Indonesia, the Philippines, and Thailand in 2017 and 2018. In total, 66 individuals were interviewed across the three study countries, representing a variety of perspectives. This included representatives of ministries of health, accreditation and licensing bodies, health insurance agencies, private and public healthcare providers, professional/trade associations, academics, and international development partners. Interviews were also conducted at the subnational level in Indonesia and the Philippines because the health system in both countries is highly decentralized. In this way, the study was well-positioned to learn from the experiences of multiple stakeholders to identify emerging themes and points of comparison between the three countries.

## Indonesia

In Indonesia, the health system is undergoing a highly publicized transformation on account of the relatively new *Jaminan Kesehatan Nasional* (Indonesia's National Health Insurance Scheme, JKN). JKN has carved out a significant role for *Badan Penyelenggara Jaminan Sosial* (Indonesia's Social Security Agency, BPJS) in strengthening quality of service delivery, a role that respondents seem to think often oversteps, perhaps at the expense of the Ministry of Health (MOH). In addition to such large-scale transformations, the system continues to experiment with other ways to strengthen quality of care, such as through the *puskesmas paladan* (public health center of excellence) award, which recognizes excellence in service delivery. Also, capitation using performance-based indicators and INACBGs (Indonesian-specific diagnosis-related groups) are the subject of experimentation, though some key informants worry that this potentially prioritizes treatment ahead of prevention. The health system reforms are underpinned by a strong regulatory and legal framework, the details of which were frequently cited by respondents; however, a lack of clarity exists for how the various elements fit together strategically. In addition to confusion associated with the health system transformation,

Indonesian stakeholders voice frustrations with improving the supply side of service delivery on account of its geographic and demographic heterogeneity. Some innovations, such as the inter-professional Quality and Cost Control Teams implemented at each strata of the health system, show promise, but implementation remains problematic. Together, the recent health reforms and decentralized nature of service delivery in Indonesia present communication and management challenges across the health system that limit efforts to strengthen the quality of health care.

## The Philippines

In the Philippines, the study found the Department of Health (DOH) was perceived as the main institution responsible to oversee quality; however, in the absence of a coherent strategy, the Philippine Health Insurance Corporation (Philhealth) has assumed a prominent role. Its work in the area is seen as helpful, but insufficient, particularly with respect to stewardship, purchasing, and accreditation. Providers occupy a position of power and influence in the Philippines and they exercise their voice through policy and regulation. Respondents generally felt that the role of civil society is underdeveloped and should be enhanced to foster an adequate culture of quality in the health system. Also, because service delivery is largely privatized, the health system appears to be particularly receptive to self-regulatory means of improving quality care. For example, many advanced facilities have independently pursued accreditation through the Joint Commission International, a feat that many felt could be recognized formally by DOH through special licensing, accreditation, and monitoring privileges. In addition, the health system appears to be fertile ground for exploring innovative public-private partnerships for addressing advanced service delivery needs that strengthen the quality of care. Finally, many respondents were quick to stress that recent and pending legislative changes hold the promise of quality-enhancing reforms; however, historically the health system has struggled with realizing these goals when shifting to implementation.

## Thailand

In Thailand, structural improvements have dramatically improved institutional arrangements for quality service delivery with effective linkages to financing. For example, the National Health Security Office, which oversees the Universal Coverage Scheme, was developed with a dual governing board, one of which has the explicit mandate of improving service delivery and ensuring quality improvement. Respondents felt that this governance structure, which includes strong representation from civil society, provides a foundation for quality initiatives, such as its Quality Outcomes Framework that includes regionally-tailored Key Performance Indicators, among other innovations. Thailand has also pursued a voluntary process of accreditation through the Healthcare Accreditation Institute, which operates autonomously as a process – as opposed to audit – oriented regulatory instrument. The centralized nature of policy and planning in Thailand renders seemingly difficult challenges surmountable through nimble legislative revisions to strengthen the quality of service delivery. Non-monetary incentives were also seen to help foster a culture of quality whereby excellence in service delivery is recognized and active media engagement holds stakeholders accountable for inadequacies. Finally, some respondents were quick to stress that while improvements have been made in linking financing to the quality of care, this should not overshadow decades of investment in strengthening the supply side, including investments in supply chains, infrastructure, and human resources for health.

## Cross-country Findings

A number of important findings emerge when comparing the experiences of Indonesia, the Philippines, and Thailand. The first is that conceptual clarity on the meaning and measurement of quality in a given context is critical for developing strategic priorities. While the importance of this seems to be acknowledged in all three countries, Indonesia and the Philippines have yet to put measures in place to adopt a common definition of quality and means of measuring improvement over time. Second, accreditation was seen as a vital component of any quality agenda and, perhaps more importantly, the accrediting body should be free of political influence. Moreover, countries where the payer is responsible for accreditation, such as the Philippines, often struggle to adequately mobilize resources and expertise in support of accreditation, in addition to their primary task of filling claims. Third, a culture of quality can only be nurtured and sustained through civil society engagement. In order for patients, communities, and the media to hold providers accountable, and demand higher quality services, they need to be equipped with the right information to shape their preferences and develop strategies for mobilizing their interests. Fourth, complex health financing reforms require strategic communication to coordinate actors and further refine effective modes of service delivery. This can occur through formal channels, whereby legislation governs the activity of boards dedicated to ensuring quality or through less formal platforms such as technical working groups, communities of practice, and online knowledge-sharing platforms. Fifth, our research suggests that health policymakers and planners should think strategically about generating demand for quality, establishing linkages to financing, all while continuing to invest in supply side measures to strengthen the health system. As the Thailand example illustrates, increased access to quality services was not only dependent on careful planning, but was enabled by investments in commodities procurement/management, infrastructure, and human resources for health. Finally, health systems are dynamic, socially-contingent, and deeply tied to political movements. While the lessons from one country may inform the choices of another, models are not directly transferable across contexts.

## Conclusion

Our research demonstrates that there are many paths to strengthening the quality of health care and linkages with financing should be a strong consideration. However, the mechanics of this process and the institutional arrangements that help bring them about, not only vary across countries, but also help to provide a basis for further experimentation and refinement over time. Only by passing through the process and installing routine methods of critical introspection can countries strengthen the quality of health services and march down the path of progressive attainment of UHC.



# I. INTRODUCTION

## I.1 Background

With most countries reaffirming commitment to achieving UHC by 2030, there has been a rapid expansion of access to health care. However, half of the world's population still does not have access to essential health services (WHO, OECD, WB, 2018). Given the increased investment in health, both domestic and external, increasing emphasis is also being placed on delivering quality health services to achieve sustainable outcomes (NASEM 2018). But it remains unclear how improved governance can improve health system performance and quality (Kruk et al 2018). Without this evidence, decision-makers lack a sound basis for investing scarce health funds in health systems strengthening interventions, including quality improvement.

This study built on a literature review (Cico et al., 2016) conducted by the HFG project on the governance of quality in 25 countries. Findings from the review provided some indication of how countries govern for quality at national and subnational levels. However, a major finding of the research was that the evidence base is thin and that the effectiveness of various arrangements, the extent to which they are enforced, the resources required, and the challenges encountered are mostly undocumented. An important recommendation of the review was to comprehensively assess specific country experiences with the purpose of enhancing the global understanding of what works in governing quality in health care. As countries plan for UHC, and health purchasers or payers (i.e. national health insurance programs) expand and gain importance, new institutional arrangements, including the roles and responsibilities of actors, should be revised to consider how the payer can best be leveraged. This includes the mechanisms health financing institutions employ to further promote, enhance, and ensure quality of health service delivery. HFG's engagement with country officials and the Joint Learning Network for UHC (JLN) on this topic has helped to identify best practices and lessons learned from countries that have engaged health financing institutions in purchasing strategies to promote quality service delivery.

The institutional arrangements, including the roles and responsibilities of actors, that link health financing to the quality of service delivery are of particular interest. Countries in the Asia region have varied experiences with enabling health financing institutions (i.e. the payers of health care) to influence the quality of service delivery. This study seeks to understand more about these experiences. In this report, we outline a list of key considerations for countries as they seek to improve the roles, responsibilities, and interrelationships of various institutions at national and subnational levels, including insurance agencies, ministries of health, accreditation agencies, and subnational health authorities.



## I.2 Research Objectives

The goal of this study was to better understand the institutional arrangements designed to enable health financing actors to ensure and promote the quality of health service delivery in Southeast Asia. The main research question explored in the study was: *What institutional arrangements facilitate the delivery of quality health care and how are these linked to health financing in South East Asia?*

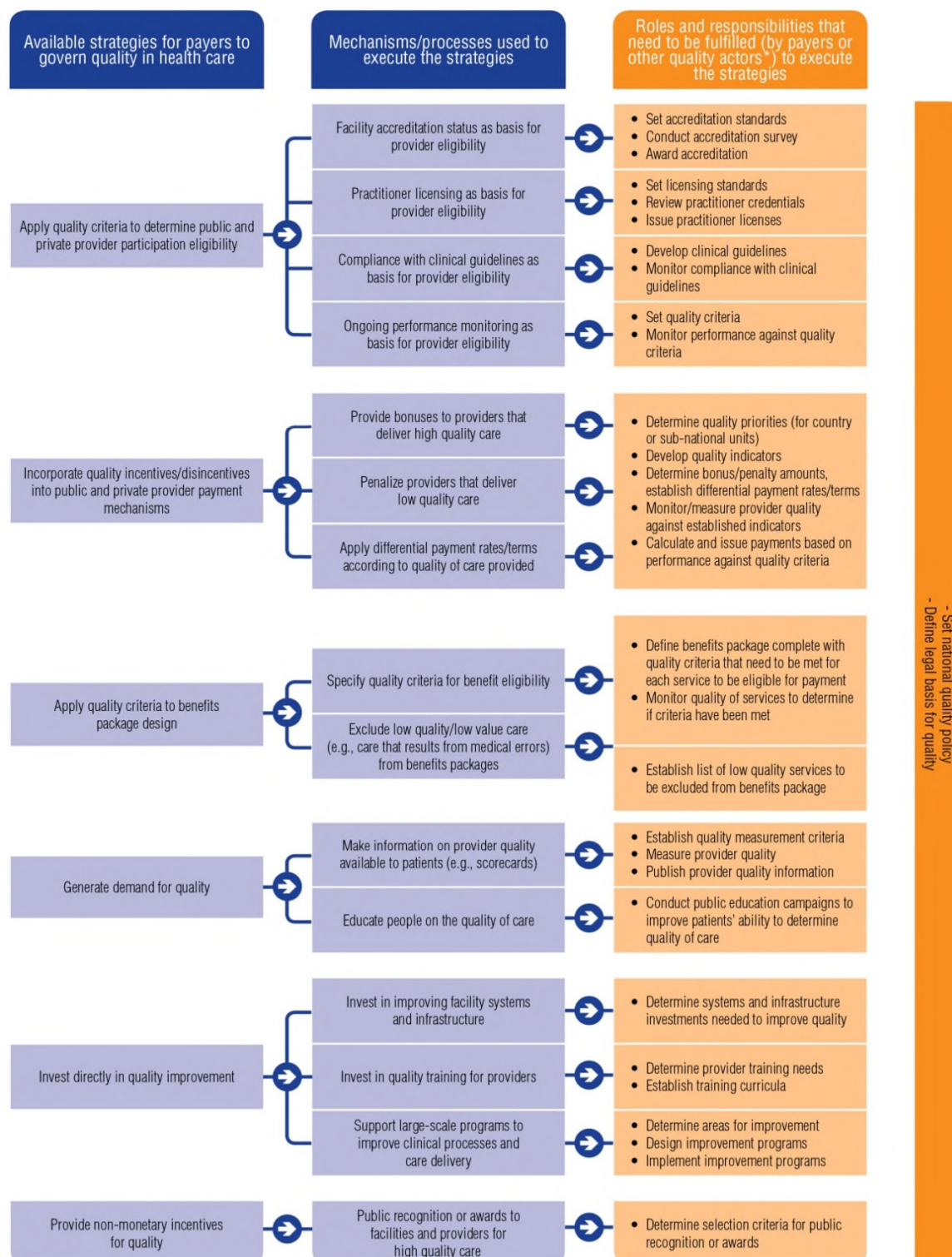
The primary objectives of the study were:

- To analyze the design of institutional arrangements, roles and responsibilities that have been established to govern the quality of health care and how they have evolved over time, and
- To explore the roles and responsibilities of various institutions in establishing, implementing, and monitoring links between the quality of health care and health financing.

The conceptual framework presented in Figure I below outlines the strategies that payers have at their disposal to influence quality, the mechanisms that may be used to execute those strategies, and the roles and responsibilities that must be fulfilled in order for the strategies to be executed. These roles and responsibilities may be fulfilled by payers directly, or by other actors who interact with the payers to sustain them. The focus of this research was to determine how these roles and responsibilities are structured, how they were established, and whether they are perceived to be effective and why.



**Figure 1: Framework for the role of payers in governing quality in collaboration with other actors**



\*Other quality actors may include: ministries of health, professional or provider associations, subnational or local health authorities, government-owned or independent accreditation bodies, consumer or civil society organizations, etc.



## 2. METHODOLOGY

### 2.1 Study Design

The study used documents and in-depth interviews to capture the dynamic aspects in designing the institutional arrangements that govern the quality of healthcare service delivery, with a focus on how payers in three Southeast Asian countries collaborate with other institutions to promote and ensure quality. The study team used well-established qualitative methods (described below), which are uniquely placed to understand the “how” and “why” of social phenomena (Marshall & Rossman 2011). This enabled the study team to capture narrative data that can reveal the actors’ understanding of how institutional arrangements have been developed, are organized, and function in each country at national and subnational levels. While some research has been conducted on the governance of quality of care at the facility level in these countries (i.e. Honda et al 2016; Tangcharoensathien et al 2015), the full architecture of institutional arrangements for governing quality, including health financing initiatives to purchase quality services at the national and subnational levels, is less well documented.

The study consisted of an initial desk review followed by 66 in-depth interviews with national and subnational actors involved in promoting quality health care. The interview guide is included in Annex A.

### 2.2 Sampling

The study population consisted primarily of government health officials working at the national and subnational levels in Indonesia, the Philippines, and Thailand. In addition, employees of international development organizations, including bilateral and multilateral organizations, and other members of private sector organizations involved in the governance of quality were considered eligible for inclusion in this study.

The study was conducted in Indonesia, the Philippines, and Thailand. While the focus of this research was on collecting data at the national level (in Jakarta, Manila, and Bangkok), data were also collected at the subnational level in Indonesia (Yogyakarta, East Jakarta, Nusa Tenggara Barat, and Tapanuli Selatan) and the Philippines (National Capital Region, Soccsksargen, Western Visayas, Davao, and MIMAROPA), in order to reflect the more decentralized nature of health governance in those countries. A sample of districts to conduct subnational level interviews in each of the countries was determined based on the advice of a Senior Research Advisor (SRA) hired to assist with data collection in each country. Criteria for subnational unit selection included urban/rural setting and proximity to national stakeholders. Geographical feasibility of collecting data within the limits of the study team’s resources was a priority consideration for the research team in selecting subnational data collection sites.

This study used a purposive sampling strategy. Health system actors were recruited from study locations (national and subnational) based on their knowledge of the thematic areas of interest. Within

each location, a local consultant was responsible for developing a list of relevant interview participants that represented a range of backgrounds. The study team interviewed 16-25 participants in each of the three study countries. Details on the types of participants interviewed in each country are presented in Table 1.

**Table 1: Study Respondents**

<b>Respondent Role</b>	<b>Indonesia (# respondents)</b>	<b>The Philippines (# respondents)</b>	<b>Thailand (# respondents)</b>
Ministry of Health	6	2	1
Insurance Agency	3	7	1
Accreditation Body	3		2
Professional/Trade Associations	3	2	1
Providers	5	9	3
Academics	1	2	5
Other	4	3	3
<b>TOTAL</b>	<b>25</b>	<b>25</b>	<b>16</b>

## 2.3 Data Collection

All data collection team members, including those conducting the interviews underwent training before data collection commenced. Interviews were conducted in English, and local languages when needed. Only eligible participants who had provided their informed consent were interviewed. 1-2 study team members (Senior Research Advisor (SRA) and/or HFG team members) interviewed each study participant. The SRA hired in each study location and members of the HFG study team recorded responses, compiled field notes and attached them to the audio recordings. External services were contracted in each country to transcribe all recorded interviews. Where necessary, translation services were also used. HFG members of the study team checked transcripts for accuracy. All data were de-identified prior to analysis.

## 2.4 Data Analysis

A coding framework was established based on the conceptual framework (Figure 1) prior to data collection. This included key concepts related to quality and health financing. After transcribing and cleaning the transcripts, the HFG study team conducted a thematic content analysis of the interview data. Transcripts were coded using NVivo 11, a qualitative analytical software package.

The HFG study team then conducted an interpretation workshop with SRAs in each study location and the team members responsible for the coding and analysis. The purpose of this workshop was to engage in a collaborative interpretation of data, where meaning-making is largely seen as interactive and socially constructed (Schwartz-Shea & Yanow 2012). Furthermore, a regional dissemination and validation workshop was held with key stakeholders from all three countries in Manila, Philippines, to share and validate findings from the study and identify cross-country lessons.

## 2.5 Limitations

There are some limitations with the methods used for this study, particularly with respect to in-depth interviews and the ability to assess the performance of the subject of inquiry:

*Potential for response bias among study participants.* Study participants responses may not accurately reflect actual arrangements in practice. While the interpretive nature of the study design accommodated for the ways in which actors may strategically portray issues in a favorable (or even unfavorable) light, the study team was hesitant to equate understandings with portrayals of various ideas. More importantly, the study team addressed some of these issues when training data collectors and during the interpretation workshop following data collection. Similarly, the interview guide was designed in a proper sequence to build up to more contentious issues to ensure a candid and comfortable interview process. Further, the field notes offered a potential venue to identify and discuss any of these shortcomings or insights from study team members.

*Ability of the study design to assess the actual benefits or outcomes of institutional arrangements.* This study is not merely descriptive; rather, it is analytical in its approach to understanding situated social phenomena which provides the basis for human behavior. This study rested on actors' understandings and the ability of researchers to find the right actors, and eliciting genuine response to relevant questions was critical. Nevertheless, one expected outcome from interested parties was the positive outcomes associated with the design of institutional arrangements that enable health financing institutions to ensure and promote quality health care. Our ability to draw inferences as to the success of these initiatives was somewhat limited and researchers were cautioned about refraining from speculation in the analysis phase.

*Generalizability of subnational level findings.* Due to budgetary and practical considerations, the number of subnational level units included in the analysis was limited. We attempted to select subnational units that, together, help provide a picture of the arrangements throughout the country. However, it is likely that the subnational units covered by this study do not reflect to its full extent the variation that may exist among different geographic entities.

*Potential for misinterpretation on account of cross-cultural communication.* In all three countries, at least some segments of interviews were translated into local languages. This introduces analytical complexity into the data in that translations reflect the interviewer's ability to render the interview guide into local expressions and the ability of the transcribers to accurately translate the audio recordings into English. We attempted to control for this by having the SRAs who conducted the interviews review (and correct) the full English translations prior to analysis. Still, in some cases, particularly in Indonesia, translations led to broken or incomplete thoughts in some instances which limited our ability to source direct quotes from these segments of the transcripts.



## 3. FINDINGS

### 3.1 Indonesia

In recent years, Indonesia has been implementing large-scale reforms aimed at improving its health system performance. The roll-out of *Jaminan Kesehatan Nasional* (Indonesia's National Health Insurance Scheme, JKN) has placed *Badan Penyelenggara Jaminan Sosial* (Indonesia's Social Security Agency, BPJS) at the heart of these reform efforts. Its ascendancy means that it is frequently tasked with making the system work, including addressing quality of care functions. Often, respondents commented, this leads to BPJS operating beyond its mandate. Among other things, BPJS works on setting up payments, incentives, provider capacity strengthening, monitoring indicators, and setting standards. Also, while many see the MOH as a natural steward of health services, its decentralized nature contrasts sharply with the top-down administrative apparatus of BPJS. Thus, the roles and relationships among all institutions are somewhat fluid and will likely continue to be so during this transitional phase of implementation.

In addition to such large-scale transformations, the system continues to experiment with other ways to strengthen quality of care. For example, this includes the *puskesmas paladan* award, which was formed before JKN or the creation of BPJS. High performing providers are nominated from their districts, which then advance to provincial and ultimately national review processes. This award, along with individual-level provider awards (for doctors, nurses, and midwives), is offered on an annual basis. In addition to this, capitation using performance-based indicators and INACBGs (Indonesian-specific diagnosis-related groups) are the subject of experimentation. Accreditation of hospitals by *Komisi Akreditasi Rumah Sakit* (KARS, The Commission for Accreditation of Hospitals), Indonesia's autonomous hospital accreditation agency, is required for contracting with BPJS. The vision for the future is to further enhance the links between KARS accreditation and payment, such that facility payment amounts would differ based on the tier of KARS accreditation achieved. At the primary health care level, the responsibility for quality oversight and accreditation lies with the Directorate for Quality Safety and Accreditation, a newly established directorate within the MOH.

During key informant interviews, specific laws and regulations were frequently cited by number. This suggests actors frequently understood quality in a particular way, which was seen as complying with universally accepted standards and speaks to a larger organizational theme on the bureaucratic nature of public administration in Indonesia. It is possible that this has developed in an effort to bring policy coherence and strategy to otherwise diverse features of Indonesian society. This diversity necessarily carries the threat of systems fragmentation, which public services attempt to overcome through regulation.

Indonesia is highly diverse and decentralized, both geographically and demographically. This places a great deal of responsibility on local actors to ensure quality primary care through *puskesmas* and most

use a performance-based capitation system. However, this system of capitation accounts for performance, but the structure complicates systemic efforts to strengthen quality. On one hand, performance-based capitation incentivizes primary care service delivery, i.e. reduced referrals, contact rates, and outreach for chronic care. On the other hand, reimbursement is also based on patient headcounts. For example, payment is deducted from underperforming facilities based on a sum determined by number of patients. Some respondents understood that this potentially distorts priorities causing primary care facilities to focus on curative care at the expense of prevention and promotion.

Some respondents also discussed Quality and Cost Control Teams as innovative diffuse mechanisms for ensuring that quality is supported by interdisciplinary teams, including BPJS. This is supported by a binding regulation of the MOH, No. 71, article 37, in 2013. These teams are responsible for overall technical assistance and are present at national, provincial, and local levels as well as in health facilities. Some of their tasks include determining professional authority, utilization review and medical audit, ethical and disciplinary standards, and monitoring consumption of medicines and other commodities. This is a promising strategy to ensure facility compliance with established standards, fidelity to acceptable service delivery processes, and monitoring health outcomes.

The highly decentralized context in Indonesia also means that fragmentation of service delivery is a persistent obstacle. Thus, the lines of communication between national and sub-national levels of the health system are vital to quality of care. Some sub-national actors suggested that binding top down national regulations are delivered with little clarification or space for feedback and flexibility. Views on this were mixed, with many sympathetic and implying that this situation is improving. Still, there seems to be a consensus that more flexibility should be given to local actors for establishing priorities and communicating to national authorities about chronic challenges encountered during implementation.

There is also room for enhancing the role of patients in improving health care quality in Indonesia. While BPJS operates a call-center intended to address patients' complaints and questions, the extent to which it is able to address such matters is currently limited. Furthermore, patient feedback is collected unevenly across health facilities, and it is seldom used to improve service quality.

## 3.2 The Philippines

In the Philippines, the study found that the Department of Health (DOH) was perceived as the main institution responsible to oversee quality. But the DOH was seen as lacking coherent strategy to implement its mandate. This is perhaps exemplified by the absence of an office or bureau responsible for the quality of care within the DOH. Some respondents suggested that there was no clear point-of-contact for driving a quality agenda, redressing problems, and developing a coordinated approach across institutions. This was seen to be a gap in the institutional arrangements that govern quality in the Philippines. Another main stakeholder identified through the interviews was the Philippine Health Insurance Corporation (PhilHealth), who is seen to incorporate quality considerations at a basic level. By virtue of being the nation's largest purchaser of health services, PhilHealth has become the de facto government body responsible for ensuring that basic quality standards are incorporated into service delivery. The data suggest a widespread acknowledgement that PhilHealth could do more, but that



quality considerations have to-date been somewhat overshadowed by an emphasis on increasing coverage and containing escalating costs. Many respondents also felt that PhilHealth could push for stringent quality criteria, though providers were skeptical about the additional burden this might entail for their staff.

When discussing accreditation, currently conducted by PhilHealth, respondents pointed out that, by law, PhilHealth is required to work with a third party accreditor. Some understood that a third party accreditor would help to relieve the pressure of resource shortages (human and financial) within PhilHealth and would enhance accountability/transparency in the accreditation process, thereby strengthening institutional support for quality of care.

Furthermore, another key finding from the Philippines is the key role that providers play in advancing policy for the quality of care. They have an influential role in determining quality metrics, standards, and protocols that guide licensing, accreditation, and purchasing. PhilHealth also relies on them to set the case rate for reimbursement. Specialty societies collaborate with government agencies, but are also used as an instrument for advancing providers' interests. This means that any moves to advance quality of care need to not only account for the role of providers in a privatized system of care, but should also recruit the support of providers (perhaps via specialty societies) at all stages of the policy process.

On the other hand, there is scope for further engagement with civil society and patient advocacy groups, as they are frequently overlooked in service quality improvements and yet they frequently lobby providers to improve the quality of care. In interviews, PhilHealth employees acknowledged that they could also benefit from more interaction with civil society in order to strengthen their image and enhance the voice of beneficiaries. Nevertheless, it remains unclear what venues exist for civic engagement. It appears as though PhilHealth, for example, has yet to decide on types of forums, the degree of formalization, and the frequency of such interactions. Thus, institutional arrangements for incorporating civil society appear in need of further development.

The Philippines' health system is largely privatized and thus receptive to self-regulatory mechanisms for advancing quality of care. The privatized nature of service delivery in a growing regional market for tertiary care means that large facilities are already investing in quality of care improvements, beyond the Accreditation Benchmark requirements. Some facilities adhere to the more stringent Joint Commission International (JCI) standards (the international gold standard in healthcare accreditation). PhilHealth and the DOH recognize this and have developed award initiatives, such as the Centers of Excellence (facilities demonstrating a higher level of quality than simple accreditation), to further incentivize providers. Even at the basic level, there is some discussion about developing special administrative licensing privileges for International Organization for Standardization -certified facilities. It remains unclear whether or not these types of self-regulatory mechanisms have developed in the absence of national stewardship or by design.

Respondents also suggested several institutional investments and changes that might engender a better collaboration among health financing and quality actors such as increased investment in health information systems. Many facilities still use paper-based records and the ones that have moved to electronic systems remain uncoordinated. Investment in strengthening data management and the flow of



patient information was seen as a priority for some respondents. Another example is developing a high-tech public-private partnership for advanced diagnostics and care. As one respondent explained, many facilities cannot afford state-of-the-art equipment for specialty care, but a shared facility, with financing from government, might help to attract more medical tourists, while simultaneously advancing quality of care. Furthermore, House Bill 5784, also known as the Universal Health Coverage Act, was recently passed by the House of Representatives and is under review with the Senate. This Bill would roll out a National Health Security Program that absorbs central tenets of the UHC movement. The current bill would subsequently enroll all citizens in the renamed Philippines Health Security Corporation (previously PhilHealth), and carries provisions for licensing and cost containment. In addition to this, it is hoped that the bill will address some of the shortcomings previously identified, which include reinforcing the mandate of DOH in quality oversight, institutionalizing knowledge to support decision-making, and enhancing accountability by reorienting service delivery around local governance units.

### 3.3 Thailand

Thailand as a country has invested extensively in building human and institutional capital to expand health service delivery and improve quality of care. This research-driven health system reform included the establishment of the Healthcare Accreditation Institute (HAI), which represents an interesting model for institutionalizing quality of care. One of the most notable themes to emerge from the Thai data was the extent to which HAI is seen as the primary champion for quality. This is notable because it is not a government body, remains voluntary, and is focused on the process of quality improvement. The organization started as a research project and then was formalized as an autonomous organization affiliated with the Ministry of Public Health (MOPH). It is financed through contributions by providers (who pay for accreditation) as well as through government (50%). As opposed to the regulative dimensions of institutionalization represented in audit models (JCI), HAI is much more focused on normative and cultural-cognitive dimensions of process evaluation and peer learning. Respondents saw this as an asset.

Thailand's National Health Security office implements the Quality Outcomes Framework to purchase quality services that are adaptable to suit local needs and conditions. This allows the payer to incentivize quality improvement by tailoring key performance indicators (KPIs) to fit different circumstances. For example, there are national-level KPIs, but there are also regional KPIs. These were developed through consultation with an array of stakeholders and piloted in each of the regions. They are evidence-based but also refined through pilot-testing, implementation, and troubleshooting. Providers are able to get points based on performance, which ultimately translate into a variable monetary reward.

In addition to purchasing services, the role of the payer can also be enhanced by deliberative processes that institutionalize quality. Under the National Health Security Act of 2002, the National Health Security Office (NHSO) was established with two governing Boards. The National Health Security Board includes representatives from various ministries, is chaired by the Minister of Public Health, and is responsible for policy guidance and systems development. The Health Service Standard and Quality Control Board is responsible for controlling, monitoring, and supporting the quality of care delivered by health providers, is similarly represented by government offices, and is chaired by the NHSO Secretary-

General. Perhaps, more importantly, there is representation on both boards by professional bodies, industry, administrators from various tiers of government, and different segments of civil society, especially representatives of vulnerable groups. This structure provides a venue for consistent deliberation about important decisions that affect the governance of quality healthcare. Moreover, they institutionalize the voice of groups traditionally marginalized in society.

Respondents also pointed out institutional weaknesses that threaten quality of care, and these may require legislative reinforcement. For example, under a new program called Universal Coverage for Emergency Patients, funds have been pooled across the three financing schemes to pay for emergency care. This caps payment to providers which causes them to discharge patients prematurely or refer them to lower levels of care. A law was created, and administered by the National Institute for Emergency Medicine, to limit this practice by mandating all hospitals treat patients for a minimum of 72 hours. Providers remain critical about reimbursement from this scheme (both the frequency and the levels), and it is unclear how the relationship is being managed, but many saw this as an important step to curb a harmful practice.

In Thailand, non-monetary strategies are used as potential avenues for cultivating a culture of quality. Examples of ways in which quality is incentivized and enhanced include the voluntary accreditation process and accreditation award offered during a ceremony by HAI. Furthermore, facilities that pursue HAI accreditation are exempt from rigorous MOPH oversight. A culture of quality is also fostered through the Thai quality award that spans multiple sectors through the Ministry of Industrial Affairs under the Foundation of productivity improvement. In addition to this, NHSO supports a complaint hotline and is engaged in social media for fielding patient dissatisfaction. A final example of ways in which quality is nurtured is through media engagement and civil society participation, as described in greater detail below. Additionally, media engagement also seems to be a vehicle for systematic quality assurance through accountability and patient advocacy. One distinguishing feature of the Thai data is the reference to the media as a somewhat less obvious, but still important, actor in ensuring the provision of quality healthcare. Shortcomings with provider practices are highly publicized, including patients being asked to pay additional costs for care or being asked to move from a private to a public hospital. Public discourse frequently elevates these debates and spurs internal deliberations about appropriate remediation measures. This role is enhanced by strong and vocal support from non-governmental organizations who are quick to mobilize around health issues.

Respondents have also pointed out that broader structure and governance of the health system are at least equally as important as quality improvement initiatives. Some situated political priority for quality of care within a larger historical narrative of UHC in Thailand. According to some, key investments were made in strengthening the quality of care through human resources for health, primary care infrastructure, and a system capable of handling complex management of commodities. When the universal coverage scheme was started in 2002, the focus was largely placed on rolling it out, where coverage, equity, and efficiency were key considerations. Then, as the scheme matured, attention has returned to thinking about quality in a more systematic way, such as creating linkages with financing. This perspective perhaps raises the question about timing and the role of quality in strengthening health systems in light of competing demands.



## 4. DISCUSSION

Several promising practices, challenges, and lessons emerged across the three countries related to establishing and strengthening institutional arrangements for the quality of care and linking health care quality to financing.

### *Consensus on definition and measurement of quality*

Defining what is meant by quality in each context, and ensuring that all actors have a common understanding is important (WHO, OECD, WB 2018; NASEM 2018). Quality is often equated with accreditation or with the ability to satisfy requirements, but many perspectives on quality exist, and all stakeholders need to be clear on how quality is perceived (Kruk 2018). In fact, this is one of the first steps countries must accomplish in developing a National Quality Policy and Strategy (WHO 2018).

There are differences across the three countries in how this is executed. In Philippines, there appears to be divergent views as to what constitutes quality and how to strategically align institutions to enhance it systemically. In Indonesia, where quality policy and strategy are fragmented, a new unit for quality was recently established in the MOH. In Thailand, the Health Service Standard and Quality Control Board was created as one of two governing boards of the National Health Security Office, in part to fulfill this function. These arrangements help countries develop a common understanding, vision, and strategy for quality.

Agreeing on and standardizing how different actors' measure quality is equally important. In Indonesia, significant challenges with measuring quality have arisen due to the existence of too many indicators and the lack of consensus among the three main stakeholders—the regulator (the MOH), providers, and the payer. Developing common KPIs that are adapted to national and subnational needs, as has been done in Thailand, appears to be a promising practice. In the Philippines, these measures surface in basic processes of accreditation, but are planned to receive greater attention through components of pending legislation.

### *Independent accreditation body*

Accreditation is identified as a key factor in driving quality throughout all three countries. This is consistent with the limited body of evidence from other LMICs that suggests accreditation is a key step in aligning UHC and quality agendas (NASEM 2018). Consensus exists among stakeholders that having an independent accreditation body is an optimal way to ensure accountability and strategic alignment of health system initiatives. This further reinforces the findings of other researchers who see independent accreditation as essential for the progressive attainment of UHC (Mate et al 2014). However, the reality may be different in some countries. Inadequate financing, lack of political commitment, and legal challenges all create barriers to independent accreditation across two of the three countries. In Indonesia, the main reason the primary health care (PHC) accreditation institution is not independent is

due to the need for financial sustainability. While there has been strong commitment to the accreditation of hospitals, this has not been the case for PHC accreditation, which has translated to less funding for PHC accreditation. In the Philippines, PhilHealth is responsible for both accrediting and paying providers. Previously, a third party accreditation commission was created, but it could not function due to legal challenges related to public procurement requirements. In contrast, in Thailand, where a semi-autonomous accreditation agency (HAI) exists, that agency has a leading role and is perceived to be the driving force for quality improvement.

### ***Patient engagement and accountability***

Patients and communities must be engaged to drive the quality of care agenda by having a voice in decision-making. In order for this to occur, civil society should be empowered with the information necessary to demand quality health care, and to hold providers accountable. Our research has found that complaints and grievance mechanisms, such as the efficient hotline used by the NHSO in Thailand, are a powerful mechanism to involve people in ensuring quality. Key characteristics that seem to contribute to the success of the Thai hotline system are the ability to track complaints by linking them with national IDs, the collaboration between NHSO and professional councils to address malpractice, and the general emphasis on harmony and discouragement of conflict, whereby penalties are not used as a main mechanism to drive quality improvement. In the Philippines and Indonesia, complaints and grievance mechanisms are gaining visibility but, to date, appear to be comparatively underdeveloped.

### ***Strategic communication about linking financing to quality and education of stakeholders***

In countries with a long practice of fee-for-service payments, familiarizing stakeholders and obtaining their acceptance of the concept of linking health financing to quality is crucial. Targeted education and training of regulators and providers is needed on the concept linking of health financing to quality of care, and their distinct responsibilities and functions. Furthermore, media should be utilized to effectively communicate and sensitize providers and communities.

Tensions can arise between purchasers and regulators (ministries of health), as encountered in Indonesia and the Philippines, with each institution hesitant to relinquish responsibilities that fall outside their mandate, under the pretense that quality of health services will suffer. Thailand experienced similar tensions during the development of HAI, but one important lesson arising from the Thai experience is the need to focus on changing mindsets. Main actors joined the reform movements due to targeted engagement with all stakeholders, particularly with providers, leading to peer pressure for all actors to accept the changing roles. Significant efforts were made in Thailand to educate providers on the “how” of quality care within limited resources, including social movements and training that eventually led to providers buying in to the idea. Thailand engaged big, prominent teaching hospitals as champions who trained the new medical professionals with this paradigm of thinking and practice.

### ***Access versus quality trade-off***

While there does not need to be a trade-off between access to health care and quality, these aspects should be carefully balanced. In some instances, provider choice, particularly in rural areas, may be limited, and therefore the ability to address quality without limiting access can be challenging. When adequate human resources are not available, addressing quality may be difficult, as has been the case in Indonesia and the Philippines. On the other hand, Thai respondents stressed the critical role that generations of supply side improvements played in enabling quality and financing innovations to take hold in the country.

### ***Adaptation to context***

There is no one model, no one size fits all for how institutional arrangements for quality should be structured to optimize links between quality and financing. The most appropriate model in each case depends on the peculiarity of the environment and culture. While the Thai model appears to work well, it would not be possible to replicate the exact same model in another context. For example, the geography of the Philippines and Indonesia alone present serious challenges to service delivery and supply chain management. A key factor that contributes to its success is the existence of strong public infrastructure in Thailand. The same model could not be replicated in a system oriented around the private provision of care, such as the Philippines. Rather than trying to replicate that model, therefore, it is important to focus on key elements of its design, such as the emphasis on systems learning and continuous learning. In this respect, achieving UHC may very well be dependent on the principles of quality improvement, a recent proposition by international researchers (Abrampah et al., 2018).





## 5. CONCLUSION

Our research demonstrates that there are many paths to strengthening the quality of health care and linkages with financing should be a strong consideration. Payers, whether they are new or existing institutions, are well-positioned and have powerful tools at their disposal to influence quality. However, tensions that may arise due to this shift from traditional institutional roles need to be anticipated and carefully addressed by strategically communicating with and educating stakeholders.

The strategies and mechanisms for involving payers in quality and the institutional arrangements that help bring them about vary across countries. The various characteristics and arrangements identified in Indonesia, the Philippines, and Thailand help to provide a basis for further experimentation and refinement over time. Our research has shed some light on contextual factors that contribute to the success of various arrangements in the three countries, but readily replicable models do not exist. Stakeholders in other countries may identify elements that they wish to replicate and adapt to their contexts, but only by passing through the process and installing routine methods of critical introspection can they strengthen the quality of health care on the path of progressive attainment of UHC. A step-by-step process for doing this is outlined in *Defining Institutional Arrangements When Linking Financing to Quality in Health Care: A Practical Guide* (Cico et al., 2018).



## ANNEX A: INTERVIEW GUIDE

### Key Informant Interview Guide: Exploring the institutional arrangements for linking health financing to the quality of care

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#### Consent script:

*For use with adult professionals involved with health care quality and health financing at organizations such as Ministries of Health, parastatal agencies such as public insurance funds, accreditation agencies, professional associations, non-governmental organizations, development partners, and private sector corporations.*

Hello, my name is \_\_\_\_\_ [HFG employee/consultant]. I am working on a study about health financing and quality in health care in [COUNTRY]. The study is being conducted by Abt Associates on behalf of USAID's Health Finance and Governance project.

HFG is conducting 3 case studies, in Indonesia, the Philippines and Thailand. These countries are working to involve health financing actors in improving quality in health care. We are interviewing people who are or have been involved in health care quality and/or health financing policy development. As part of this study, we would like to ask you questions about quality in health care as well as the links between quality and health financing in [COUNTRY].

The outcome of the work will be a technical report that presents recommendations for policy makers across all countries to promote quality in health care and achieve universal health coverage. This research is not intended to be about your performance as an individual.

We would very much appreciate your participation in this interview. It will take about one hour to complete. Your participation is voluntary. There is no direct benefit to you for participating. Choosing not to participate will not affect you negatively. You may opt out at any point during the interview and you do not have to answer all questions. There are no right answers; we are just looking for your perspective on these issues.

We will combine the information you provide us with the information provided by about 20 other people we interview. We will keep any personal information about you confidential to the best of our ability. Only authorized researchers will have access to your personal information. We will remove your personal information before we share your de-identified responses with anyone outside of the research team.

If you have any questions or concerns about your participation in this study, you may contact Altea Cico at Abt Associates. I will give you her contact information to write down at the end of the interview.

Do you want to ask me anything about the interview or study?

- Yes [Answer all their questions as best you can]
- No [Move to next item]

Do you agree to participate?

- Yes [Thank them and ask about audio recording]

- No [Thank them for their time, indicate result in spreadsheet]

Can I audio record the interview? Only authorized researchers will have access to the recording for documentation purposes.

- Yes [Thank them and proceed to the interview questions]
- No [Say it is no problem and proceed to the interview questions]

### **Consent to Participate**

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(Study Interviewer Signature)

HFG contact:

Altea Cico

Associate/Scientist

1-301-347-5061

[Altea\\_Cico@abtassoc.com](mailto:Altea_Cico@abtassoc.com)

### **Respondent's role**

- I. Can you tell me about your current position?
  - a. How long have you worked there?
  - b. How does your work relate to health care quality or financing?
  - c. What is your expertise and/or disciplinary training?

### **Research Questions:**

(Ask as many of the primary questions as is feasible given the time constraints and as are appropriate for the respondent. Ask probe questions as applicable. If running short on time, priority questions are in bold. Questions do not have to be read exactly as written.)

- 2. What does quality improvement in health care mean to you?**
  - a. Where did you first hear this concept?
  - b. Who uses this concept?
- 3. Which institution or organization do you think has the primary mandate is to oversee the quality of health care in [COUNTRY]?**
  - a. Is this a government agency or is it autonomous?
  - b. Are there laws to support this arrangement?
  - c. How long has this organization existed?
  - d. How is it financed?
  - e. What are its primary roles or functions?**
  - f. Are they also responsible for collecting and compiling data on the quality of care?
  - g. Do any health financing institutions have a mandate to promote quality in health care? How so?
- 4. In your view, who are the “champions” for improving the quality of healthcare in [COUNTRY]? Why/how so?**
  - a. Has it always been this way?
  - b. At what level are the quality champions (national, subnational, facility)?
  - c. How do health financing institutions champion health care quality, if at all?
- 5. Are there any laws or regulations about health care quality that you know about?**

- a. Since when have these laws or regulations existed?
  - b. Were health financing institutions involved their development or revision?**
  - c. What other stakeholders were involved in their development?
  - d. To what extent are they enforced?
- 6. Can you tell us a little more about the development of the guiding national strategy or plan for quality in health care in [COUNTRY]?**
- a. What institutions led this planning? Were health financing institutions involved in this planning?**
  - b. What other stakeholders participated in this planning? How did the organizers try to get input from stakeholders?
  - c. To what extent are these plans or strategies being implemented?
- 7. Sometimes it is beneficial to explore other countries' experiences with major policy initiatives, like health financing reforms or quality improvement initiatives. To what extent do you think other countries' experiences influenced [COUNTRY'S] policy reforms around health care quality?**
- a. How did [officials in this country] learn of this?
  - b. How do you think they influenced the design of the institutional architecture for quality in your country?
- 8. To what extent do health financing institutions apply quality criteria to determine which health care providers can receive payments from them?**
- a. What are the criteria (e.g. accreditation, licensing, compliance with clinical guidelines, ongoing performance monitoring, etc.)?
  - b. How were these criteria established?
  - c. Who established them?**
  - d. Who monitors whether they are met?**
  - e. To what extent are they enforced?
  - f. In your opinion, is the collaboration between health financing institutions and other actors involved in determining provider eligibility effective? Why or why not? If not, how can it be improved?
- 9. We know that [COUNTRY] uses mechanisms like [e.g., salaries, capitation, and diagnosis-related groups (DRGs)] to reimburse its providers. Now we want to better understand how these payments may or may not be adjusted for quality.**

- a. What quality incentives/disincentives are incorporated into these mechanisms, if any (e.g., bonuses, penalties, differential payment rates/terms, etc.)?
- b. **Who determines how quality should be addressed through these mechanisms?**
- c. **Who develops and selects the quality indicators associated with these mechanisms? How does this work? What is the process?**
- d. **Who determines bonus/penalty amounts, or establishes differential payment rates/terms?**
- e. **Who monitors provider quality against the established indicators?**
- f. To what extent are the established quality criteria for payment enforced?
- g. In your opinion, is the collaboration between health financing institutions and other actors involved effective? Why or why not? If not, how can it be improved?

**10. We know that [COUNTRY] has a standard benefits package in place that specifies which services are eligible for reimbursement. Now we want to better understand how this benefits package may or may not be adjusted for quality.**

- a. To what extent were quality considerations taken into account in its design (e.g., does it exclude low quality or low value care)?
- b. Are any quality criteria in place that determine benefit eligibility? If so, what are they?
- c. **Who established these quality criteria?**
- d. **Who monitors whether these criteria are being met?**
- e. To what extent are the established quality criteria for benefit eligibility enforced?
- f. In your opinion, is the collaboration between health financing institutions and other actors involved effective? Why or why not? If not, how can it be improved?

**11. How are patients encouraged to select higher quality providers? How can they figure out which providers are better quality?**

- a. Are data on provider quality publicly available (if so, ask about frequency and perceived accuracy)? What kinds of indicators are available?
- b. **Who developed the quality measurement criteria/indicators?**
- c. **Who measures these indicators?**
- d. **Are health financing institutions directly conducting or collaborating with other actors to conduct public education campaigns on the quality of care?**

- e. In your opinion, is the collaboration between health financing institutions and other actors involved effective? Why or why not? If not, how can it be improved?
12. Do health financing institutions make direct investments in quality improvement? Is that considered part of their purview, or does another institution have responsibility for this?
- a. Do they invest directly in facility infrastructure/systems? If so, who determines what investments are needed (and how)?
  - b. Do they invest in educating providers on quality and building their capacity for improvement (i.e., quality training)? If so, who determines the provider training needs? Who establishes the curricula?
  - c. Do they support large-scale programs to improve clinical processes and care delivery? If so, who determines areas for improvement? Who designs improvement programs? Who implements them?
  - d. In your opinion, is the collaboration between health financing institutions and other actors involved effective? Why or why not? If not, how can it be improved?
13. Do health financing institutions provide non-financial incentives to encourage quality improvement (e.g., public recognition or awards to providers or facilities for high quality of care)?
- a. If so, who sets the criteria for receiving these non-financial incentives?
  - b. Who selects the providers or facilities that will receive the incentives?
14. **In your opinion, to what extent do you feel that health financing institutions have clear roles and clear responsibilities in promoting the quality of care in your country?**
- a. Do these conflict or overlap with roles of any other actors? How so?
  - b. What could be done to more clearly define these roles and responsibilities?
15. **Based on your experience here in [COUNTRY], what would you recommend to other countries about how to involve health financing institutions in influencing the quality of care provided?**
- a. **What is the most successful aspect of how health financing institutions and other actors work together to promote quality in your opinion?**
  - b. **What hasn't worked the way it was intended?**
  - c. What have been the challenges in managing this collaboration?
  - d. Would you advise other governments to do the same?
  - e. What are some of the difficulties in extending this to other countries?



**Is there anything else we have not discussed that you would like to share with us?**

**Do you have any questions for us?**

**Thank you for your time!**



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