JOINT LEARNING NETWORK

For Universal Health Coverage

UHC Primary Health Care Self-Assessment Tool

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ACKNOWLEDGEMENTS

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At right, JLN PHC Initiative members from Malaysia analyze and discuss findings from the tool pilot.

Above, group photo of Initiative members during the site visit to Tengara Clinic in Kuala Lumpur, Malaysia, as part of workshop held in December 2014.

Below, Initiative members learn about the primary health care system in Manila, Philippines on a site visit in May 2014.

Above, Philip Dalingjong (Ghana), James Akazili (Ghana), Siti Haniza (Malaysia), Thirumalaichiry Selvavinayagam (Tamil Nadu, India), and Naniek Isnaini (Indonesia) discuss their experiences implementing the tool.

Contents

ABBREVIATIONS

ANC   antenatal care

DRG   diagnosis-related group

FBO   faith-based organization

FFS   fee-for-service

HFA   health financing agency

HIV   human immunodeficiency virus

HRH   human resources for health

ITN   insecticide-treated net

JLN   Joint Learning Network for Universal Health Coverage

M&E   monitoring and evaluation

MCH   maternal and child health

MDGs   Millennium Development Goals

MOE   Ministry of Education

MOF   Ministry of Finance

MOH   Ministry of Health

MTEF   medium-term expenditure framework

NGO   nongovernmental organization

PHC   primary health care

RUTF   ready-to-use therapeutic foods

TB   tuberculosis

UHC   universal health coverage

Introduction

The Joint Learning Network for Universal Health Coverage (JLN) Primary Health Care (PHC) Initiative created this UHC-Primary Health Care Self-Assessment Tool to support PHC-oriented UHC — a system-wide reform approach for lowering disease burden, achieving the Millennium Development Goals (MDGs), improving efficiency, and offering financial protection within financial limits.

The tool, referred to as the "UHC-PHC Self-Assessment Tool," is a multi-stakeholder survey that helps accomplish the following:

- Document and assess how health insurance or financial coverage institutions interact with other PHC actors and programs

- Identify key areas of improvement and opportunities to align the health financing agency (HFA) or other health financing policymakers with PHC goals

Problem Statement

Despite its importance, primary health care has suffered from low political priority and financing, inefficient organization, weak performance measurement, and lack of practical paths toward improvement. Countries continue to struggle with many details of how to advance a vision of PHC-oriented UHC, and they do not find all the answers they need in international literature and tools.

In many countries, there is a need to improve how health insurance or financial coverage institutions engage and interact with national PHC initia-

tives as part of national UHC reforms. Country policy-makers and practitioners working on health financing reforms and on PHC reforms may work in different agencies, have separate staff who have minimal communication, and have different objectives. Ensuring alignment between the policy priorities and objectives of national health financing reforms and PHC reforms is an essential first step towards PHC-oriented UHC. Many JLN PHC Initiative member countries perceived this as a challenge, but required a tool to help them diagnose their health system's misalignments in an evidence-based manner.

Where UHC and PHC actors and reforms are not working closely together, misalignments between UHC and PHC initiatives can have negative implications for both providers and health seekers. For example, if a national health insurance scheme reimburses providers for PHC services delivered in a facility but not those delivered in the community, it may deter PHC providers from engaging in community outreach. This misalignment limits the number and diversity of individuals who receive PHC services and disproportionately affects people

who are poor, live in remote locations, or are less likely to seek out PHC in formal facilities. If public health systems do not have the capacity to serve the entire population with PHC services, public sector insurers or financers may need to contract with private sector providers to fill service delivery gaps, but processes may not exist to facilitate these engagements. These and other examples of misalignments must be clearly diagnosed before actions are taken to address them.

Background

During a JLN workshop in Accra, Ghana, in November 2013, members came together to discuss PHC as a future initiative for the JLN. The members brainstormed and prioritized potential future activities that the JLN could undertake to advance PHC-oriented UHC. Members expressed a strong interest in better understanding how their countries' health insurance or financial coverage institutions interact with the many actors, roles, and resources involved in their current PHC systems.

Many participants described their own lack of knowledge about how other sectors and institutions promote primary health care. The lack of communication and cooperation between actors within the system, particularly between insurance/financial coverage institutions and those who work directly on PHC, can lead to missed opportunities and misaligned

incentives between UHC and PHC efforts. To remedy this deficiency, members decided to develop a tool that would enable them to assess their countries' UHC-PHC alignment.

Initiative members began developing the tool in their first meeting in November 2013, with discussions about how their countries' health insurance or financial coverage institutions interact with the many actors, roles, and resources in their current PHC systems. This was followed by two workshops. In the first, Initiative members defined the scope of the tool, conducted interviews with key PHC stakeholders in each JLN country, and developed a draft outline and survey questions. In a second, larger workshop, the group collected feedback and refined the tool.

Scope

The UHC-PHC Self-Assessment Tool is a rapid diagnostic instrument for identifying practical policy opportunities in the health system to improve the relationship between health financing and PHC efforts. The tool can be useful for improving coordination among health financing and PHC efforts in countries around the world. It is most suitable for locations in which (a) the government is not sufficiently prioritizing PHC efforts, (b) PHC efforts work poorly or are not coordinated with health financing mechanisms, and, especially,

(c) communication among the relevant stakeholders is limited.

The tool does not provide a complete evaluation or mapping of PHC or UHC in the country. It focuses strongly on UHC, not the entire PHC system, so it looks closely at the role and function of the HFA, which can be crucial to improving UHC-PHC alignment.

The HFA's major functions and means of influence include:

- Setting priorities in the country or state's health policy agenda
- Financing policies (e.g., revenue generation)
- Payment policies (what health care services to cover and how to pay providers)
- Influencing the behavior of the population and providers through regulations and communications
- Monitoring and evaluation (including data sharing)

While the assessment tool will provide useful information and insight, its core strength is its ability to bring together stakeholders and facilitate conversation. Each country or region should use the tool as part of a collaborative process that engages many stakeholders. For example, a country may apply the tool using a combination of workshops, focus group discussions, and key stakeholder interviews—a process that emphasizes gathering in-depth knowledge and facilitating communication between parties.

Tool Pilots

Four PHC Initiative countries piloted the tool and met in December 2014 to discuss their findings and share feedback on the tool. This document makes the tool available to other countries for their own PHC-oriented UHC efforts. The JLN PHC technical facilitators at R4D worked with the following four JLN countries to pilot the Self-Assessment Tool:

- India (Tamil Nadu and Kerala states)
- Indonesia (Tangerang District and Bandar Lampung city)
- Ghana (Upper East Region)
- Malaysia (nationally)

During the piloting process, JLN countries tested and confirmed the assessment tool's validity (i.e., its capacity to identify misalignments and intervention opportunities) and feasibility (i.e., ease of implementation and potential to be a continuously employed M&E tool). That process included the following activities during and after the piloting process:

- Documenting the implementation of the tool
- Creating and sharing guidance on tool implementation for additional countries to use
- Initial work to implement interventions, including engaging stakeholders and facilitating dialogue — a role that can also be played by local partners

Findings from the pilots helped guide the countries' health reform processes, as well as identify challenges that the PHC Initiative is investigating further. For example, findings from the pilot in Malaysia exposed weak integration of the private sector into current health system transformation efforts and found minimal incentives to promote preventive and comprehensive care.

These findings have helped the Malaysian Ministry of Health plan its future actions and strategies for its health system reform. Results and feedback from the pilots have also been used to shape the direction and work of the

Initiative. For example, the Initiative is working to improve private-sector engagement in PHC delivery, a problem that was identified in several countries during piloting.

Collaborating with the JLN PHC Initiative

The JLN encourages countries that use the tool to communicate with the JLN PHC technical facilitators regarding their experience and feedback on the tool. Please contact the JLN at **jln@r4d.org** with this information and any questions. ■

Definitions

During the development of the UHC-PHC Self-Assessment Tool, members of the Initiative developed a list of definitions to reflect the Initiative's common understanding of key terms. Some definitions come directly from the health financing literature.

Alignment: Identifying ways in which the health financing agency (HFA) can better interact with, support, or incentivize primary healthcare actions and goals, through monetary and non-monetary means.[1]

Health financing agency (HFA): This is the assessment tool's main institutional focus. The HFA is assumed to be dedicated primarily to achieving universal health coverage. In some countries, the HFA is the Ministry of Health (MOH); in others, it may be a national health insurance authority or similar institution. For the purposes of this tool, in countries in which the HFA is the MOH, respondents should focus on the parts of the MOH that are more responsible for the financing and payment functions of UHC rather than those that are responsible for PHC organization and delivery.[1]

PHC services:

- **Preventive services:** Services that protect against illness or diseases (e.g., family planning, antenatal care, immunizations).[2]

- **Promotive services:** Services that encourage well-being and healthy living (e.g., sanitation, good nutrition, smoking deterrence, mental health).[1]

- **Curative services:** Services that treat and reduce the probability of disability and death due to entry-level and common high-burden diseases (e.g., deliveries, respiratory illnesses, childhood illnesses).[3]

Primary health care (PHC): The provision of outpatient non-secondary and non-tertiary preventive and curative care, with a particular focus on ensuring the quality delivery of health interventions prioritized by both countries and the global health community against the highest disease burdens.[1]

Primary stakeholders: The tool primarily focuses on stakeholders that work on PHC initiatives (optional or future modules may add others.[4]) They include:

- Ministry of Health (MOH)

- Ministry of Finance (MOF)

- Providers (public and private)

Universal health coverage (UHC): "Ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship." This definition of UHC embodies three related objectives:

- **Equity in access to health services:** Those who need the services should receive them; services should not be available only to those who can pay for them.

- **Quality of health services:** Health services should be good enough to improve the health of those who receive services.

- **Financial risk protection:** The costs of health services should not put people at risk of financial hardship."[5]

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1 Definition developed by members of the JLN PHC Initiative during a workshop held in the Philippines in May 2014
2 Formerly (1998), the WHO defined prevention as "measures not only to prevent the occurrence of disease, such as *risk factor* reduction, but also to arrest its progress and reduce its consequences once established." Starfield, B., J. Hyde, & J. Gervas (2008, Oct 1). "The concept of prevention: a good idea gone astray?" *J. Epidemiology Community Health 62*, 580-83. doi: 10.1136/jech.2007.071027.
3 Hirshon, J.M., N. Risko, E.J.B. Calvello, S. Stewart de Ramirez, M. Narayan, C. Theodosis, & J. O'Neill (2013, Jan 31). "Health systems and services: the role of acute care." *Bulletin of the World Health Organization 91*, 386-88. doi: http://dx.doi.org/10.2471/BLT.12.112664.
4 Such as the Ministry of Education, accreditors/regulators, Ministry of Social Work.
5 World Health Organization. (2010). Retrieved from http://www.who.int/health_financing/universal_coverage_definition/en/

Guiding Principles for Using UHC-PHC Self-Assessment Tool

JLN countries that piloted the Self-Assessment tool suggest the following guiding principles when implementing the tool.

Principles for Selecting Respondents

- **Expertise:** Respondents should be technically qualified to answer most of the questions in a module. They should be familiar enough with the relevant issues and institutions to recommend other respondents who can answer questions that they cannot answer.

- **Representativeness:** As much as possible, respondents should represent the range of perspectives within an institution or set of actors. For example, different divisions of an HFA or MOH, or providers who serve different subpopulations (urban/rural, poorer/richer), may have different experiences with and perceptions of UHC-PHC alignment.

- **Availability:** The tool is intended to be administered during a relatively short period of time (several weeks rather than several months); implementers should select respondents who will be available to respond in such a time period.

- **"Snowball" or iterative selection:** Interviewers should ask the first set of respondents to recommend other respondents for additional interviews.

- **Resource constraints:** The tool is intended to be administered mostly "in-house" by individuals who are already working within a country's health system. The number of respondents and length of time interviewers can spend on data collection and analysis should therefore correspond to those constraints.

Module Order

The modules are organized in the following recommended sequence. While the Initiative recommends implementing the modules in this order, interviewers can adjust the sequence based on respondents' availability:

Module 1. MOH
Module 2. HFA
Module 3. Providers
- **Private outpatient providers**
- **Public outpatient providers**
- **Public inpatient providers**

Module 4. MOF

Modifying the Tool

The tool can be modified in each country by implementers and partners. The Initiative encourages countries to modify the tool based on country needs. Countries should consider:

- **Structure:** The tool is structured around a general framework of actors: the HFA, MOH, MOF, and public and private providers. A country or region might have different actors or a landscape in which this differentiation does not work. (For example, a country might not have an HFA, or it might want to include other actors and subject areas such

as quality/accreditation agencies, community groups, or disease-specific MOH programs.) The country or region can reorganize the modules and/or add questions to the survey.

- **Content:** Countries are encouraged to remove or rephrase modules and questions as needed. Certain modules or questions may not be relevant to a given country, or they may not be appropriately phrased for country context.

- **Language and culture:** Countries are encouraged to reword questions to suit their culture and norms and to best represent the intended objective of each question.

The JLN encourages implementers of the tool to retain the focus on UHC and PHC through editing and modifications.

Timeline

- Most modules should take a respondent one to two hours to complete.

- For open-ended questions or questions that include "please describe," respondents' answers will likely be one to seven sentences. Respondents should feel free to provide whatever level of detail they deem necessary to answer the question. The questions are not intended to be overly cumbersome to answer.

- The duration of tool implementation will vary according to the place and the scale of the implementation

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(e.g., regional vs. national). Estimates range from one to three months for the entire process, which may include the approval processes, selection of consultants to implement the tool (optional), coordination with stakeholders/respondents, administering the tool, compiling the results, and analyzing the results.

Suggested Methodology

JLN member countries that piloted the tool used the following methodology:

- **Preliminary Research:** Before countries administer the tool, they should conduct some preliminary desk-based research to quickly answer some of the questions (e.g., the budgeting questions posed to the MOF in Module 4). This research will provide data against which to cross-check certain answers. In some cases doing so may also increase the quality of data and reduce the amount of time needed to complete the modules. Questions that interviewers should prioritize (and ideally answer in writing) in the desk research phase are shaded in light blue.

> Desk research questions = Shaded in light blue

- **Team composition:** Suggested team composition includes a team lead for the country/state, ideally someone in a management/senior-level position at the health financing

agency, and 3-5 individual collaborators from the other stakeholders/agencies involved. The team may also include any consultants hired, and local or regional partner(s).

- **Sample selection:** Depending on the landscape and actors, implementers will likely (a) sample a certain number of stakeholders or (b) carefully select key respondents. For example, they might sample a selection of public and private providers (given their high number and geographic distribution) but interview only specific individuals from the MOF who are engaged in health financing. There is no set number of respondents for each module, and countries will not be able to interview all possible respondents. The goal is to identify significant policy misalignments, not collect all potential viewpoints.

- **Collection methods:** The implementers can collect responses by conducting a workshop or by in-person interviews. In the workshop approach, implementers can introduce the tool, and then have the responders self-administer the survey. This approach may work best for Module 3 because of the number of providers and their geographic distance. When conducting in-person interviews, implementers should meet with one respondent at a time and work through the survey together, with the implementer asking questions and recording respondent answers.

- **Analysis:** As with data collection, the exact approach that the implementers use to analyze collected data may vary among countries. JLN intends for the data analysis to lead to practical policy findings that can be applied in-country and communicated effectively with other JLN partners — rather than be directly comparable across countries, in a scientific manner. With that core objective in mind, the country or state should consider the following analysis:

  o Develop a systematic approach to analyzing the results. Review the information and data, organize findings into several themes, and present key findings (e.g., areas of misalignment) and conclusions in an accessible format to allow for potential cross-country discussion.

  o Qualitative software (such as Atlas.ti or NVivo) can be helpful for analyzing the results, but are not necessary. In most cases, it will not be possible or feasible (largely due to time).

  o The Initiative does not anticipate that countries will engage in extensive quantitative analysis, but some descriptive statistics or simple tabulations/cross-tabulations can be helpful for identifying patterns in respondents' answers to certain questions and for communicating results to policymakers and partners.

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Expected Outputs

JLN countries that piloted the tool produced concise synopses of findings and recommendations, presented in a 10-15 page report and a PowerPoint presentation tailored for their country policymakers' consumption. Non-JLN countries that use the tool may also consider producing the same type of outputs to share with domestic policymakers. JLN members included the following types of information in their reports:

1. Brief country context related to UHC-PHC and the country's motivation for implementing the tool

2. Methodology

3. Overview of key findings

   • Organized by module or by functions/themes that cut across modules

   • Tables, charts, and narrative to summarize findings

4. Challenges that the team encountered implementing the tool

5. Recommendations for better alignment between UHC and PHC

6. Next steps or recommendations for further research

In some cases, further data analysis or research may be needed to identify interventions that can address the UHC-PHC challenges. In other cases, identified policy or operational adjustments to improve UHC-PHC alignment will be clear, and the country or state's partners can begin designing and carrying out such adjustments. ◼

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UHC-PHC SELF-ASSESSMENT TOOL

Module 1: Ministry of Health

PRIORITIES	**1.** What years does the current national health strategy or policy cover? [5]	
	2. What does the national health strategy or policy identify as the top priorities? Please list in order of relative priority (high to low). [6]	

3. What are the main impediments to achieving PHC objectives? Please identify and rank the top 5.

RANK	IMPEDIMENT
_____	Lack of physical access to services
_____	Human resources for health distribution challenges and shortages
_____	Low service quality and standards
_____	Insufficient funding
_____	Lack of demand/use by consumers
_____	Water supply and sanitation issues
_____	Drug and/or commodity supply issues
_____	Financial barriers for consumers
_____	Transportation barriers
_____	Lack of alignment of incentives
_____	Policy, regulation, and leadership issues
_____	Lack of health education and behavioral change communication
_____	Lack of political visibility
_____	Other (please specify)

5 If the country has a national health strategy document, use the one that is most current and has the longest duration. Where available, please also share it with the tool administrator. Note to tool administrator: Please look to see if/where PHC is mentioned in the document.
6 If the national strategy document lays out goals but does not rank them and other documents (e.g., execution plans) do rank/prioritize them, please refer to those other documents in responding to these questions.

Module 1: Ministry of Health

PRIORITIES	**4.** What are the top priorities of PHC?	
	5. What are the top priorities of UHC?	
PHC AND UHC	**6.** What are the relative rankings of PHC and UHC in the national health strategy?	
	7. Are there explicit linkages between PHC and UHC?	
	8. Do you have any specific examples of instances in which HFA[7] approaches align well with PHC?	☐ No ☐ Yes If Yes, what examples?
	9. Do you have any specific examples of instances in which HFA approaches align poorly with PHC?	☐ No ☐ Yes If Yes, what examples?

7 If the HFA is the MOH, respondents should focus on parts of the MOH that are more responsible for the financing side of UHC rather than those that are responsible for PHC.

Module 1: Ministry of Health

FINANCING AND PAYMENT	**10.** What are the sources of funding for PHC?	
	11. Are those sources of funding different for non-PHC services?	☐ No ☐ Yes If Yes, how?
	12. What are the payment mechanisms for PHC? *(Check all that apply and provide an explanation as needed)*	☐ Fee-for-service: _____ ☐ Supplied inputs: _____ ☐ Capitation: _____ ☐ Payment of salaries: _____ ☐ Results-based financing: _____
	13. What are the payment mechanisms for non-PHC services? *(Check all that apply and provide an explanation as needed)*	☐ Fee-for-service: _____ ☐ Supplied inputs: _____ ☐ Capitation: _____ ☐ Payment of salaries: _____ ☐ Results-based financing: _____
	14. Does funding match the state of PHC priorities and actual funding for PHC? Why?	☐ No ☐ Yes Please explain why:

Module 1: Ministry of Health

WORKFORCE	**15.** What kinds of providers provide PHC services? *(check all that apply)*	☐ MOH ☐ Faith-based organizations ☐ NGOs ☐ Franchises of private providers ☐ Individual private providers ☐ Traditional/informal providers
	16. Which of those can be reimbursed by the HFA? *(Check all that apply)*	☐ MOH ☐ Faith-based organizations ☐ NGOs ☐ Franchises of private providers ☐ Individual private providers ☐ Traditional/informal providers
	17. Are there programs or incentives to encourage workers to practice in rural or disadvantaged locations?	☐ No ☐ Yes If Yes, please elaborate (who, on what scale, etc.).
M&E	**18.** How does the MOH monitor and evaluate PHC?	
	19. Does the MOH use data from the HFA in its M&E efforts?	☐ No (please explain) ☐ Yes (please explain)
	20. Is PHC data collected from both government and private providers?	☐ No (please explain) ☐ Yes (please explain) If Yes, please include any reference documents.

Module 1: Ministry of Health

M&E	**21.** What do the data show?	1. Major successes (please explain) 2. Major challenges (please explain)
	22. How can M&E for PHC be improved?	
REGULATION	**23.** Is initial licensing required for providers to deliver PHC services?	☐ No (please explain) ☐ Yes (please explain)
	24. Is licensing renewal required for providers to continue delivering PHC services?	☐ No (please explain) ☐ Yes (please explain)

25. What regulatory mechanisms are used to ensure the quality of PHC services, and are the MOH and HFA involved in each?

	MOH Y/N	HFA Y/N
Licensing		
Accreditation		
Inspection		
Professional association		
Continuing education regulation		
Clinical guidelines		

Module 1: Ministry of Health

REFERRALS	
26. Is bypassing of primary care an important problem?	☐ No ☐ Yes
27. What percentage of secondary and tertiary care could be provided or prevented at the primary level?	Percentage: _____ Actual or estimated: _____ Source: _____ *[If respondents cannot provide a percentage, ask them to use the following scale:]* ☐ Very small volume ☐ Small volume ☐ Moderate volume ☐ Large volume ☐ Very large volume
28. If bypassing is an important problem, what mechanisms does the MOH use to discourage it?	☐ None ☐ Copayments ☐ Gatekeeping
29. Is referral from outpatient to inpatient care an important problem?	☐ No ☐ Yes
30. Are there guidelines indicating when a patient should be referred to higher-level care?	☐ No ☐ Yes If Yes, please provide a copy of the guidelines.
31. Does the MOH work with the HFA to address bypassing and referrals if there are problems?	☐ No (please explain why not) ☐ Yes (please describe how)

32. In what ways do MOH vertical programs interact with the HFA? *(Please check all that apply.)*

MOH Vertical Programs

	HIV	TB	Malaria	MCH	Vaccines	Other
No interaction						
Dialogue						
Payment aligned						
Funded through grants						
Other						

Module 2: Health Financing Agency

POLICY PRIORITIES	**1.** Does the HFA have a strategy document or annual report that outlines its goals?	☐ No ☐ Yes If Yes, please provide a copy of the document.
	2. Is PHC featured in that document? What are the main PHC features discussed?	
	3. Is the HFA involved in interagency policy discussions on PHC?	☐ No ☐ Yes If Yes, how?
FUNDING	**4.** What are the HFA's funding sources? *(Please check all that apply.)*	☐ Direct budget support ☐ Allocation from MOF/general revenue ☐ Contributions ☐ Earmarked taxes (VAT, sin taxes, etc.) ☐ External donor funds ☐ Investment income ☐ Other (please explain)
FINANCING AND PAYMENT	**5.** Does the HFA pay for any preventive, promotive, or primary curative services?	☐ No ☐ Yes
	6. If yes, what preventive/promotive/ primary curative services are covered?	☐ Preventive:_____ ☐ Promotive: _____ ☐ Primary Curative Services:_____ _____ *(Please attach benefits package if available.)*

Module 2: Health Financing Agency

FINANCING AND PAYMENT		
	7. What linkages, if any, exist between the HFA and PHC services funded by other agencies/initiatives?	☐ Funding ☐ Communications ☐ Data sharing ☐ Other
	8. Has the HFA ever done a financial analysis that focuses on coverage of preventive/promotive services when projecting its future revenue needs?	☐ No (please explain) ☐ Yes (please explain)
	9. What payment mechanisms does the HFA use? *(Select all that apply)*	☐ Fee-for-service ☐ Capitation ☐ Case rates ☐ Diagnosis-related groups (DRGs) ☐ Other (please explain)
	10. Which payment mechanisms are used for preventive or promotive services? *(Select all that apply)*	☐ Fee-for-service ☐ Capitation ☐ Case rates ☐ DRGs ☐ Other (please explain)
	11. Does the HFA use any nonmonetary mechanisms to encourage the delivery of preventive or promotive services by providers?	☐ No ☐ Yes (please explain) If Yes, please list some of these mechanisms (e.g., rules requiring their provision, quality monitoring efforts)
	12. Does the HFA provide incentives to members/beneficiaries to use preventive/promotive services?	☐ No ☐ Yes (please explain — e.g., rewards, discounts to premiums)

Module 2: Health Financing Agency

FINANCING AND PAYMENT		
	13. What share of claims is paid for preventive/promotive services vs. curative PHC services, in terms of value?	☐ Equal ☐ Preventive/promotive services represent higher share than curative PHC services ☐ Preventive/promotive services represent lower share than curative PHC services
	14. How would you assess the priority the HFA places on PHC?	☐ Too low / Should be higher (please explain) ☐ About right ☐ Adequate ☐ Not sure (please explain) If PHC should be given higher priority, please explain what the HFA should do.
	15. What would help the HFA to do more on prevention?	
	16. Do you think current HFA payment methods promote or discourage the delivery of preventive and promotive services?	☐ Promote ☐ Discourage ☐ No impact Please explain.
M&E	**17.** How does the HFA monitor and evaluate PHC?	
	18. Does the HFA use data from the MOH in M&E? If so, how?	

Module 2: Health Financing Agency

COMMUNI-CATION	**19.** Do you provide any direct or indirect effort to communicate about prevention/promotion?	☐ No ☐ Yes If Yes, how?					

OTHER	**20.** In what ways do HFA vertical programs interact with the MOH? *(Please check all apply.)*						
		MOH Vertical Programs					
		HIV	TB	Malaria	MCH	Vaccines	Other
	No interaction						
	Dialogue						
	Payment aligned						
	Funded through grants						
	Other						

Module 3: Providers

PRIVATE OUTPATIENT PROVIDERS
(Representatives from private provider associations or a sample of private outpatient providers)

PAYMENT

1. Who pays for the following PHC service delivery costs? *(Please check all that apply, and add any other applicable services.)*

	Out of pocket	National health insurance	Private insurance	Gov. subsidy	Other (please specify)
Immunizations					
Family planning					
Malaria treatment					
Diarrhea treatment					
Pneumonia					
Bednets					
HIV diagnosis/ treatment					
Other					

2. If your institution receives payment from the HFA, how satisfied are you with this payment?

	Satisfaction Level *(1 to 5, with 5 as most satisfied)*
Speed	
Adequacy of amount	
Type (FFS, capitation, etc.)	

3. Estimate the percentage of your revenue that comes from each source.

	Out of pocket	National health insurance	Private insurance	Gov. subsidy	Other (please specify)
%					

4. How do private providers receive payment for PHC services from the HFA? *(Select all that apply)*

- ☐ Fee-for-service
- ☐ Capitation
- ☐ Lump-sum budget
- ☐ Line-item budget
- ☐ Other

Module 3: Providers

PAYMENT	**5.** Do you receive direct funding or supplies, including drugs, from donors or vertical programs (e.g., HIV, TB, or malaria programs)?	☐ No (why not?) ☐ Yes (please describe)
	6. Do you receive payment specifically for providing preventive services? If yes, are those services profitable?	☐ No (why not?) ☐ Yes (please describe)
REGULATION	**7.** Is accreditation required to practice as a private provider?	☐ No ☐ Yes (please describe, including the frequency of accreditation, period of validity, thoroughness, etc.)
	8. Does the HFA[8] monitor your activity?	☐ No ☐ Yes (please describe, including how the monitoring is done — inspections, supervision, etc.)
	9. Are you required to report PHC data to the HFA (including service statistics and utilization)?	☐ No ☐ Yes (please describe, including frequency, content, inclusion of PHC, feedback provided)

8 As noted previously, if the HFA is the MOH, respondents should focus on parts of the MOH that are responsible for the financing side of UHC rather than those that are responsible for PHC.

Module 3: Providers

OTHER	**10.** What could the HFA do to better support PHC provider training?	
	11. If applicable, what are the top three reasons why more preventive PHC services are not delivered by private providers?	
	12. What are the three most important steps that could be taken to encourage private providers to deliver more preventive services?	

Module 3: Providers

PUBLIC OUTPATIENT PROVIDERS *(Sample of public outpatient providers)*

BUDGET AND AUTONOMY

1. Who pays for which PHC service delivery costs? *(Select all that apply)*

	Facility budget	Central supply	Vertical program	Out of pocket	Insur-ance	Other	Don't know
HRH (salary)							
Drugs							
Family planning							
Vaccines							
RUTF							
ITNs							
Fuel/per diems							
Health education							
Other							

2. How satisfied are you with payment from the HFA?

	Satisfaction Level *(1 to 5, with 5 as most satisfied)*
Speed	
Adequacy of amount	
Type (FFS, capitation, etc.)	

3. Estimate the percentage of your total annual budget that comes from each source.

	MOH	Vertical programs	Out of pocket	Insurance Reimburse-ment	Other
%					

4. How do you use the money that you receive from the HFA (e.g., supple-mental person-nel, bonuses to staff, community outreach)?

UHC-PHC SELF-ASSESSMENT TOOL

Module 3: Providers

BUDGET AND AUTONOMY	**5.** Do you receive payment specifically for providing preventive services? If yes, is it financially sustainable?	☐ No (why not?) ☐ Yes (please describe)
OTHER	**6.** Do you think patients bypass your PHC providers and go to higher-level facilities even though your PHC providers can deliver the same services?	☐ No ☐ Yes (please explain)
	7. Are there any services that you might deliver but cannot for some reason, causing patients to bypass your PHC providers?	☐ No ☐ Yes (please name the services and explain)
	8. What could the HFA do to better support PHC provider training?	
	9. If applicable, what are the top three reasons why more preventive PHC services are not delivered by private providers?	
	10. What are the three most important steps that the HFA could take to encourage private providers to deliver more preventive services?	

UHC-PHC SELF-ASSESSMENT TOOL

Module 3: Providers

PUBLIC INPATIENT PROVIDERS	*(Sample of or selected public inpatient providers)*

ALIGNMENT	**1.** What percentage of your admissions is associated with each of the following cases?	Case	% of Admissions
		Patients that should not be admitted and should be treated at the outpatient levels	
		Patients that could have been treated at the outpatient level but waited too long to seek treatment and had to be admitted as a result	
		Patients who received inappropriate referrals from a PHC provider	
		Patient's condition could have been prevented by PHC but was not	
	2. What are the three most common conditions for admissions among conditions that you feel should have been prevented or treated at the PHC level?	1. _____ 2. _____ 3. _____	

Module 4: Ministry of Finance

ALIGNMENT	**1.** Is the MOF involved in any PHC-related dialogue with any of these actors? *(Select all that apply)*	☐ National Health Insurance Agency ☐ MOH ☐ Ministry of Education (MOE) ☐ Others (please explain — e.g., other government agencies)
	2. Is the MOF involved in any UHC-related dialogue with any of these actors? *(Select all that apply)*	☐ National Health Insurance Agency ☐ MOH ☐ MOE ☐ Others (please explain)
AWARENESS OF PHC PRIORITIES	**3.** Is the MOF aware of the MOH's primary health care priorities?	☐ No (please explain) ☐ Yes (please explain)
	4. Is the MOF aware of the logic and/or reasoning behind PHC priorities?	☐ No ☐ Yes (please explain)
BUDGETING FOR PHC	**5.** Is there a separate allocation for PHC?	☐ No ☐ Yes (please explain how it is determined)
	6. Is it possible to determine what share of the health-sector budget is spent on PHC?	☐ No ☐ Yes
	7. Is there any consideration given to spending more on PHC/preventive services?	☐ No (please explain why not) ☐ Yes (please explain)

Module 4: Ministry of Finance

MONITORING	**8.** What role does the MOF have in how the HFA uses MOF funds for PHC?	☐ No role (please explain) ☐ Has a role (please explain)
SUPPORT FOR PHC PRIORITIES	**9.** Does the MOF demonstrate that PHC is a priority? (e.g. in discussions with oversight of MOH or HFA or by providing oversight)	☐ No (please explain) ☐ Yes (please explain)
	10. Does the MOF have a role in HFA governance (e.g., sit on its board?)	☐ No ☐ Yes
	11. Is the relationship between the HFA and overall national health objectives a topic of discussion among national level actors?	☐ No ☐ Yes
	12. In particular, is the relationship between the HFA and PHC a noted topic?	☐ No ☐ Yes

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UHC-PHC SELF-ASSESSMENT TOOL: OMITTED QUESTIONS AND OPTIONAL MODULES

These items were removed from the main version of the tool but are provided here to help countries that want to broaden their inquiry.

Module 1: Ministry of Health

PAYMENT	1. How are the PHC data regularly used? *(Please check all that apply.)*	☐ Planning and strategy ☐ Hot spot monitoring ☐ Performance-based financing (please explain) ☐ Other
	2. Is there any opportunity for the HFA and the MOH to share data?	☐ No ☐ Yes
	3. Does the MOH tie funding to performance?	☐ No ☐ Yes
	4. If MOH funding is performance-based, who provides performance data?	☐ Public providers and facilities ☐ Private providers and facilities ☐ NGO providers and facilities ☐ FBO providers and facilities
	5. Does the quality of performance data vary between public and privately-owned facilities?	☐ No (please explain) ☐ Yes (please explain)
	6. At what intervals is the performance data collected?	
WORKFORCE	1. Do the MOH and MOE consult and collaborate on any of these categories?	☐ Numbers and types of HRH trained in PHC ☐ Content of curriculum on PHC ☐ Network of training schools ☐ Other (please describe)
	2. Are professional associations involved at all in collaboration between the MOH and MOE?	☐ No ☐ Yes

Module 3: Providers

SERVICES WITH LINKS TO PHC PRIORITIES	**1.** What preventive PHC services do you provide? *(Please check all that apply.)*	☐ Vaccinations ☐ Family planning ☐ Antenatal care ☐ Hypertension/diabetes screening ☐ Cervical cancer screening ☐ Bednet distribution ☐ Other (please describe)
	2. What promotive PHC services do you provide? *(Please check all that apply.)*	☐ HIV prevention ☐ Sanitation education ☐ Other (please describe)
	3. What curative PHC services do you provide? *(Please check all that apply.)*	☐ Malaria treatment ☐ Diarrhea treatment ☐ Antibiotics for pneumonia ☐ HIV diagnosis/treatment
	4. What percentage of time do you spend delivering each of the following PHC services?	Preventive _____% Promotive _____% Curative _____%
	5. Do you receive training in PHC?	☐ No ☐ Yes (please provide the PHC subject and the sponsor)
	6. Are private providers aware of national PHC priorities?	☐ No ☐ Yes (please describe the priorities and how they are communicated)
	7. How do private outpatient providers contribute to national PHC priorities?	

Module 4: Ministry of Finance

BUDGETING FOR PHC		
	1. How are decisions made by the MOF for proposed allocations to the MOH?	☐ Based on previous year's allocations ☐ Based on performance ☐ By MOF/MOH leadership ☐ Legislation and policies ☐ Other (please explain)
	2. What is the basis for formulating the MOH health budget?	☐ Strategic planning (e.g., MTEF) ☐ Historical ☐ Other (please explain)
	3. Is the budget formed using line items, programs, or some other principle? *(Please check all that apply.)*	☐ Line items ☐ Programs ☐ Other principle (please explain)
	4. Are national budgets paid to health facilities as line-item budgets, global budgets, or program budgets?	☐ Line-item budgets ☐ Global budgets ☐ Program budgets ☐ Other (please explain)

District and Other PHC Initiatives

DISTRICT LEVEL

1. What is the overall role of local government in providing PHC?	
2. What is the disparity in the scope of PHC initiatives and outcomes across regions in your country, if any?	

AGRICULTURE/NUTRITION

ALIGNMENT		
	1. What is the role of the HFA in nutrition?	
	2. Does your ministry work with the HFA to plan and implement nutrition strategy?	☐ No ☐ Yes (please explain)
	3. To what extent are nutrition programs targeted to nutrition outputs and public health priorities (e.g., stunting)?	
	4. To what extent are nutrition programs linked to MDG targets and malnutrition?	

District and Other PHC Initiatives

AGRICULTURE/NUTRITION

OPINIONS	**5.** How can the HFA better support nutritional programs other than providing more funding?	
	6. What would be needed to achieve better support from the HFA?	

MEDICAL EDUCATION

LANDSCAPE	**1.** Who are the major PHC providers (e.g., community health workers, nurses, doctors, midwives, pharmacists)?	
	2. What type of services does each PHC provider deliver?	
ALIGNMENT	**3.** How prominent is PHC in the current medical education curriculum for these PHC providers?	☐ Very prominent ☐ Somewhat prominent ☐ Not prominent ☐ Other (please explain)

District and Other PHC Initiatives

MEDICAL EDUCATION

ALIGNMENT	**4.** Is the medical curriculum aligned with national PHC policies and priorities in **public** schools?	☐ Yes ☐ Don't know ☐ No (please explain why not)		
	5. Is the medical curriculum aligned with national PHC policies and priorities in **private** schools?	☐ Yes ☐ Don't know ☐ No (please explain why not)		

6. For each of the major PHC providers identified, how many graduate every year? Is this number sufficient to meet the country's needs?

	# of graduates/year	Sufficient? (Y/N)
Doctors		
Nurses		
Midwives		
Community health workers		
Pharmacists		
Other #1		
Other #2		

7. What percentage of these individuals joins PHC specialties?

	# of graduates/ joining PHC specialities	Sufficient? (Y/N)
Doctors		
Nurses		
Midwives		

District and Other PHC Initiatives

MEDICAL EDUCATION

ALIGNMENT	**8.** In your opinion, is the percentage of doctors choosing PHC specialties more or less than what is needed?	☐ More than needed (please explain) ☐ Less than needed (please explain) ☐ Just right (please explain)
	9. In your opinion, is the percentage of nurses choosing PHC specialties more or less than what is needed?	☐ More than needed (please explain) ☐ Less than needed (please explain) ☐ Just right (please explain)
	10. In your opinion, is the percentage of midwives choosing PHC specialties more or less than what is needed?	☐ More than needed (please explain) ☐ Less than needed (please explain) ☐ Just right (please explain)
PLANNING	**11.** Are HRH pre-service training schools involved in HRH planning/forecasting with the MOH?	☐ No ☐ Yes (please explain)

	12. Is in-service HRH training available and in line with MOH planning and forecasting?	Available: ☐ No
		                ☐ Yes
		If Yes, in line with planning? ☐ No
		                ☐ Yes

	13. Are HRH pre-service training schools and universities involved in discussions about how to improve workforce distribution (both geographically and by specialty) with the MOH?	☐ No ☐ Yes (please explain)

District and Other PHC Initiatives

MEDICAL EDUCATION

CURRICULA		
	14. Is PHC/Family Medicine a designated specialty for physicians?	☐ No ☐ Yes (please explain)
	15. Is any post-graduate training in PHC available for doctors?	
OPINIONS	**16.** What could pre-service schools be doing to better support PHC goals?	
	17. What would be needed to support greater involvement of pre-service schools in PHC goals?	

SOCIAL WORK AGENCY

OVERVIEW		
	1. Who does social work in your country (e.g., a ministry, NGO, association)?	
	2. What is the mission/aim of the entity performing social work?	
	3. How is the mission/aim implemented? For example, are there social workers in communities?	

District and Other PHC Initiatives

SOCIAL WORK AGENCY

OVERVIEW		
	4. Where are social workers located?	
	5. What are the mandates of social workers?	
ALIGNMENT	**6.** Do PHC services enter into the work of social workers?	☐ No (please explain) ☐ Yes (please explain)
	7. Does the social work agency collaborate with the MOH/HFA?	☐ No ☐ Yes (please explain)
	8. Is the social work agency aware of PHC policies and priorities?	
OPINION	**9.** Do you see opportunities for closer collaboration with the MOH on PHC at the national, regional, or local level?	☐ Yes (please explain how) ☐ No (please explain why not)

Evaluation of Assessment Tool Implementation

This evaluation form is intended to (1) assess and document country experiences in adapting and applying the UHC-PHC Self-Assessment tool (2) assess the usefulness of the tool and obtain feedback to improve it. Administrators of the tool are invited to complete the evaluation and submit results and additional feedback to the JLN by emailing **jln@r4d.org**.

TOOL IMPLEMENTATION

1.	Did you make major changes to the assessment tool? (Y/N) ☐ Yes (move to question 2) ☐ No (move to question 3)
2.	If you answered Yes to #1, please note the type of change(s) and briefly describe. ☐ Structure ☐ Content/subject matter ☐ Language/cultural considerations ☐ Other (Please describe):
3.	How long did it take you to tailor the tool? Please provide the estimated working time.
4.	Which modules did you implement at a national level? Please check all that apply, and provide specific details (e.g., where) and your rationale.

	Module	National	Sub-National	Details and Rationale
HFA	☐	☐	☐	
MOF	☐	☐	☐	
MOH	☐	☐	☐	
Private providers	☐	☐	☐	
Public providers	☐	☐	☐	

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EVALUATION (CONT.)

| 5. | How did you choose respondents for each module? Please choose one option for each module and describe. |

	Key Informants	Sampling	Description
HFA	☐	☐	
MOF	☐	☐	
MOH	☐	☐	
Pub. P	☐	☐	
Priv. P	☐	☐	

| 6. | What methods did you use to collect data? Please check all that apply for each module, and describe in more detail if needed. |

	Workshop/meeting (self-administered)	Workshop/meeting (focus group)	Administered 1-on-1 (by consultant)	Other (please describe below)
HFA	☐	☐	☐	☐
MOF	☐	☐	☐	☐
MOH	☐	☐	☐	☐
Pub. P	☐	☐	☐	☐
Priv. P	☐	☐	☐	☐

Description (if needed):

| 7. | Did you use external consultants to implement the tool?
☐ Yes
☐ No |

| 8. | How did you analyze the collected information? |

| 9. | How long did it take to complete the administration of the tool from the initial discussions to the final documentation? |

EVALUATION (CONT.)

10.	How did you arrive at a list of areas of misalignment?

11.	Did you discuss the results with key stakeholders? ☐ Yes (please describe) ☐ No

12.	Did you formulate an action plan based on those results? ☐ Yes (please describe) ☐ No

REFLECTIONS

1.	What were the overall strengths of the tool and/or the administration process (e.g., strengths related to the structure of the questions/modules, clarity of purpose, sampling methodology, and reactions from respondents)?

2.	What were the overall weaknesses of the tool and/or the administration process? (See above for examples.)

3.	Do you see any opportunities for future action after administering the assessment tool (e.g., interventions to address misalignments, collaboration with other actors, and/or use as an M&E tool)?

4.	What type of further guidance would have been beneficial in helping you to administer the tool?

5.	Do you recommend any improvements to the tool (e.g., survey tool questions/structure, process for implementation)?

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