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HEALTH FORUM 2020

In collaboration with Villa College, Villa Foundation and ADK Hospital

Improving Health Services in the Maldives: Stakeholder Perspectives on the Maldivian Health Sector – the North Region

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Executive Summary

In November 2020, MaldivesResearch organized a health forum to explore stakeholders' perspectives on the healthcare services in the northern atolls in the Maldives. Together with key healthcare workers, the respective council representatives of Haa Alif, Haa Dhaal, Shaviyani, Noonu, Raa, Baa and Lhaviyani, policymakers and private sector healthcare service providers, the forum undertook rich and engaging discussions in a range of areas from trust in the healthcare system to limitations in the existing legislations in the sector affecting prompt and efficient service delivery for the atolls. Our key objective was to engage with the stakeholders to determine their perspectives in relation to five key themes (trust, human resources, legislation, affordability and equity of healthcare access) using the following five research questions:

1. ***To what extent does the public have trust in the healthcare system, service and staff?***
2. ***What issues are there regarding the healthcare human resources development meeting minimum human resource requirements for the atolls?***
3. ***What are the healthcare legislative requirements and changes needed for efficient medical services in the atolls?***
4. ***What benefits and challenges are there regarding the delivering and receiving of an affordable National Health Insurance service?***
5. ***What issues of equity (if any) of healthcare access exist in healthcare services in the 7 atolls?***

The above themes, research questions and follow up questions were discussed online amongst stakeholders in groups. After analysis of the qualitative data, 37 recommendations for policy and practice were identified: The following are 9 priority recommendations identified from the analysis of the data from the five themes.

1. Trust

The analysis identified 10 recommendations out of which the following was identified as a priority action.

PRIORITY ACTION: Strengthen performance monitoring of health sector services as a priority (Trust, HR and Legislation). In addition, there is a need to publish performance related data and conducting assessments on affordability and health service costs (see also, HR section below).

PRIORITY ACTION: Implement frameworks to pave the way for the roles of the healthcare provider and the regulator to be managed by two independent bodies. The present administrative arrangement does not ensure independence between these two roles.

2. Human Resources

Seven recommendations identified, out of which the following three were identified as priority action that would enhance the Human Resources for Healthcare (HRH) in the system.

PRIORITY ACTION: Identify creative ways to motivate the workforce and attract quality recruits; one way identified in the forum was to introduce study scholarships the completion of which will require graduates to work in the region's healthcare facilities. This was seen as a priority action as motivating the workforce and attracting highly qualified personnel were identified through the discussions in 3 of the forum's 5 themes: equity, human resources and legislation.

PRIORITY ACTION: There is an indication of a greater trust towards local doctors compared to expatriate doctors. Policy direction on increasing local capacity is required. Currently, a health sector human resources plan identifying the local or region-specific needs is not available at policy level. . of the urgent need to strengthen the capacity of local doctors was identified in three themes of Trust, Human Resources and Equity and therefore, is viewed as a priority.

PRIORITY ACTION: Each regional hospital needs to be developed to a level that can cater for the islands around it, resourced with specialist doctors. In addition, strengthen the referral system within and between the islands and the processes to deliver a service that is not discriminatory towards patients coming from other islands. This action is also a priority as it addresses issues of trust, HR and equity.

3. Legislation in the Healthcare System

Out of five recommendations, the following is as a priority action relevant to healthcare legislation:

PRIORITY ACTION: Consider new legislation on Occupational Health and Safety legislation to cover use of equipment, workers' safety in high-risk areas and to cover localised aspects of working in the various healthcare facilities in the region.

4. Affordability and Accessibility of Healthcare Services

For this theme, the recommendations are:

PRIORITY ACTION: In all 5 group discussions of the forum's focus areas of trust, HR, legislation, affordability of healthcare and equity, there was a unanimous agreement that an increase in uniformity

of services across regional hospitals is a priority and is needed to reduce the burden on tertiary health service centres.

5. Equity

The analysis of forum's data led to 6 recommendations to address inequity in the system, out of which the following three are highlighted as priority action.

PRIORITY ACTION: Investigate how widespread is any unequal distribution of medicines and consequences to patients (including fatalities, increased risks to life) and take necessary procurement-related or procedural/logistical remedial action. An effective procurement and supply chain mechanism needs to be implemented to monitor stocking and refilling of essential medicines. If mechanisms already exist, feedback should be taken from all pharmacies, hospitals and health centres to find out the challenges in the maintenance of adequate medical stocks and take the necessary remedial action. The issue of the availability of medication was a recurring priority theme in aspects of Trust, Affordability and Equity.

PRIORITY ACTION: Given the unequal access to medical services in islands within the same atolls and region, service providers should ensure that all islands are equipped with basic medical services irrespective of the size, political alignment and nearness to the regional hospitals. Part of the remedial action may be implementing measures to eliminate some patients' use of political influence or high-status positions to bypass procedures and guidelines to obtain medical services at the expense of other patient's entitlement. This issue of undue political action negatively affects levels of trust and equity in the system and therefore, it was seen as a priority action.

PRIORITY ACTION: Prioritize the establishment of a reliable and timely transport mechanism available between the islands and inter-atoll, which includes emergency medical services, to be ensured by the local councils, who are involved in ensuring that the transport system is functioning.

COVID-19 pandemic has exposed the weaknesses in almost all the healthcare systems, and the Maldives is no exception. With limited resources and the inherent geographical challenges in providing these services, especially to outer atolls, this Forum from a public policy review perspective, regards the Healthcare system is presented with an important opportunity to review the service in the northern atolls as well as in the nation and provide an agile advocacy response by the stakeholder in the health sector. Given that forum took place in the first year of the pandemic, the qualitative data and the recommendations that have surfaced as described above could be a useful set of evaluative resources to start from in achieving a more equitable healthcare system.

Introduction

Maldives has achieved an impressive record in improving health outcomes. For instance, for decades, Maldives has sustained the immunisation coverage against all antigens around 98% and incidence of vaccine preventable diseases are extremely low (WHO, 2018). The country has also successfully accomplished all Millennium Development Goals Health targets. However, against these successes, Maldives has faced significant health challenges. The rates of non-communicable diseases is at 80% of total deaths (WHO, 2018). In addition, there is an aging population who needs a good care system, while quality of health services depends mainly on foreign health professionals. As people's lifestyles change, health issues are increasing, such as unhealthy dietary practices, tobacco use and substance abuse, to mention a few. Increasing consumption of fast food and lack of physical activities are adding to health problems in the country.

To understand the impact of these and other issues on people's wellbeing, MaldivesResearch conducted the Health Forum delving into current health issues facing Maldivians. The Forum sought to explore views and concerns from different stakeholders on the issues through interacting with experts, practitioners and users of health services in the Maldives.

The forum was hosted through a collaborative partnership between Villa College, ADK and MaldivesResearch. The Forum was financed mainly through sponsorships as well as MaldivesResearch's own funds.

Purpose, Key Objective and Research Questions

The purpose of the regional research forum was to explore healthcare stakeholders' perspectives on the healthcare services in the 7 northern atolls in the Maldives. These atolls are the atolls of Haa Alif, Haa Dhaal, Shaviyani, Noonu, Raa, Baa and Lhaviyani. Our key objective was to engage with the atolls' healthcare workers including doctors, nurses and other staff, service users from the public, policymakers and any private sector healthcare service providers in order to determine their perspective in relation to five key themes (trust, human resources, legislation, affordability and equity of healthcare access) using the following five research questions:

1. To what extent does the public have trust in the healthcare system, service and staff?
2. What issues are there regarding the healthcare human resources development meeting minimum human resource requirements for the atolls?
3. What are the healthcare legislative requirements and changes for medical services in the atolls?

4. What benefits and challenges are there regarding the delivering and receiving of an affordable National Health Insurance service?
5. What issues of equity (if any) of healthcare access exist in healthcare services in the 7 atolls?

The above themes, research questions and follow up questions were discussed online amongst stakeholders as described in the methodology section.

Significance of the Study

At a time when the Maldives, as the rest of the world, is faced with a global pandemic, it is important to review the quality and level of healthcare service provided in the atolls. A credible way of finding the quality of service is by capturing the perspectives of both the policymakers and service users in the sector. To date, there has been no independent research conducted in the Maldives focussed solely on the seven atolls with the objective of obtaining the perspectives of a wide range of stakeholders in healthcare. The focus on the atoll level service is significant as the country has seen an increasing level of decentralisation of public services in recent years (UNICEF, 2013, Transparency Maldives, 2019). The key benefits include useful information that could be utilised in future policymaking and in identify areas of improvement at service implementation and at points of delivery of healthcare service.

Definitions of Terms

Stakeholders in this proposal mean anyone who has an interest in the healthcare system in the Maldives, in particular health experts, practitioners, politicians, academic researchers, health service providers (public and private) and the public.

A universal definition of **Human Resource Development (HRD)** does not exist, but it can be broadly defined as a process of developing work-based knowledge, skills, expertise, relationships, satisfaction or productivity for the benefit of a society, an organisation or a nation (Wang et al., 2017).

Some academic sources may define **healthcare legislation** very broadly and as the law of all areas of study that focus on the intersection between law and health (Longdom, 2020). However, in the proposed research, healthcare legislation is more narrowly focussed on the law of healthcare delivery, financing and associated resources.

1. Format of the Forum

1.1. Forum Design

The Forum was held online via Zoom on 14 November 2020. We used an interpretivist approach in the forum's design. The data/evidence set collected consisted of participants' perspectives of the health system as they had experienced. The Forum was held for one whole day and two keynote speakers, Dr. Abdul Sattar Yousuf and Dr. Ali Niyaf addressed the forum. Dr. Yousuf presented an insightful historical perspective of the national healthcare system, while Dr. Niyaf shared his ongoing research on public's trust in the sector. The keynote speakers' speeches were followed by in-depth group discussions of the forums themes and research questions and their group presentations on the summary of their discussions. Figure 1 below gives an illustration of how the group discussions were carried out the Forum:

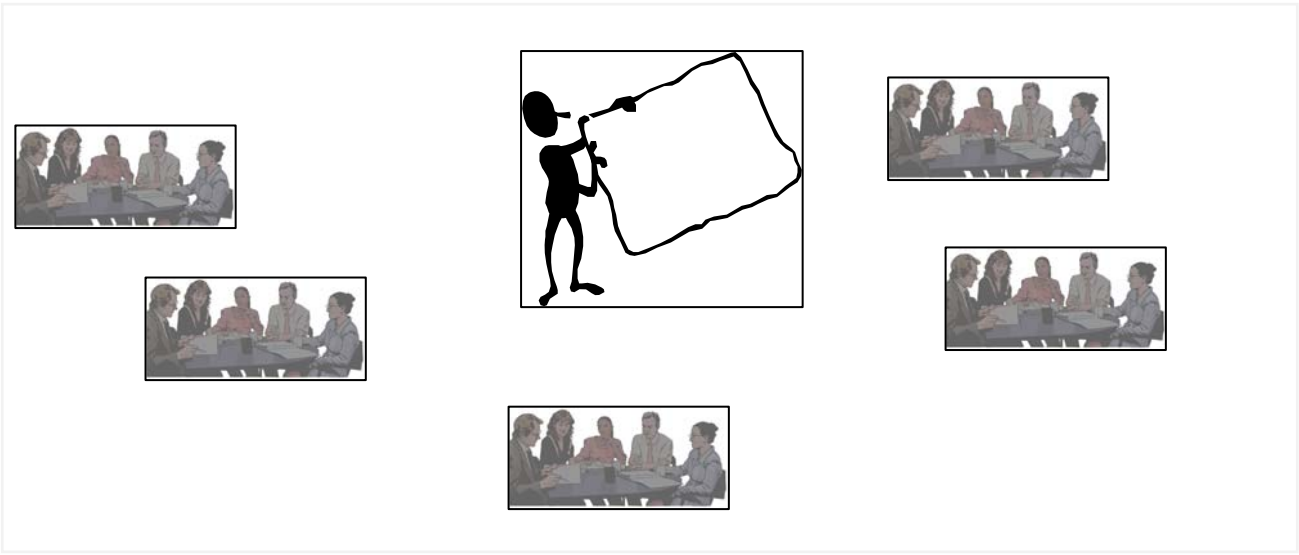


Figure 1: An illustration of how the 5 themes were discussed in Zoom in groups

Organisation of Group Discussions:

There were 5 groups of 6-9 participants in each to conduct the discussions. The participants were grouped so that where possible, at least one or two from each of the 7 stakeholder areas (see section 1.2) were represented in each of the 5 discussion groups.

a. The aim of group discussions was to respond and arrive at answers to the questions/issues provided to them through thorough discussion within their group.
b. They were instructed to formulate relevant questions or headings on the subject and seek answers within their group.

c. Within each group a rapporteur was selected to present the group findings to the forum after each group discussion.

1.2. Sample, Subjects (Forum Delegates)

Altogether 32 stakeholder participants participated in the Forum amongst a total attendance of 45 participants. Stakeholders included 7 stakeholder groups:

- medical doctors and nurses (from the 7 atolls)
- healthcare facility managers (from the 7 atolls)
- staff from the atoll and island councils (from the 7 atolls)
- general members of public (from the 7 atolls)
- public healthcare public officials from the Ministry of Health
- representatives of pharmaceutical companies (based in the capital) and
- healthcare education and training academics from the Maldives National University and Villa College.

Data Collection and Data Instruments:

The data/evidence from this forum was qualitative data within the perspectives captured during the group discussions and group presentations. The contributions from the stakeholders were recorded in Zoom. Note-takers (data collectors in each group) took notes on data sheets containing the 5 themes as headings. These notes were guided by the research themes and the forum's key research questions.

1.3. Data Management and Data Analysis

The notes from each of the 5 theme groups were analysed against the recording after the event for data validation and themes relevant to the 5 themes were identified. All recordings were securely stored in the forum leaders' password-protected Zoom account.

All analysis was conducted manually rather than electronic analytical software as the data/evidence was in Divehi, a language not yet supported by data analysis software. Further data validation and analysis of the emergent findings took place, where participant stakeholders were invited to comment on the findings, and existing research data and evidence from official publications were used to throw further insight into the findings.

Each theme's initial findings were further reviewed by allocated theme leaders within the research team. The draft report was first reviewed by an expert in the Maldives healthcare sector and externally reviewed by two experts in the sector.

After analysis of anonymised raw data (audio/video recordings) were deleted from the account within 1 year from the forum date for to enhance anonymity of data sources and to facilitate data security.

1.4. Dissemination of the Forum Outcome

This report will be published on MaldivesResearch website. In addition, the report will be shared with the forum's participants and the Health Ministry. MaldivesResearch will invite the Ministry of Health and the Maldives Parliament to consider the recommendations.

1.5. Delimitations, Limitations and Significance of the Study

The perspectives collected may not represent facts but perspectives of individuals. In addition, their perspectives may be applicable to their locations: islands and atolls in the North of the country. They cannot be generalized for experiences in other parts of the country.

The perspectives and recommendations may be an invaluable source of information when considering future directions on health policy. To-date there has been no research conducted into the health sector in the North region encompassing, policymakers, policy implementers, service providers (healthcare workers) and healthcare service users as conducted in this study.

Theme 1: Trust in the Healthcare System, Service and Staff

1.0 Background and Context

Theme 1 discussion in the health forum focussed on "trust in the healthcare system, service and staff". Trust is a concept involving both confidence and reliance on the service provider. In the context of trust, the recipient is susceptible to the service providers intentions and motivations. Trust relationships in healthcare are between patients and health professionals, and the institutions. To establish and maintain trust, healthcare professionals must operate consistently in the patient's best interest, have the required competences and create a fiduciary relationship. A trustworthy health care system will improve the quality of interactions with the health care provider, allowing for better and enhanced health care, treatment acceptability, increased access and acceptance of health care services within a community.

Trust holds a vital value in the delivery and acceptance in the level of effectiveness and success of every health care system. However, there are no known public opinion surveys conducted in the Maldives so far on trust related themes in the areas of health care. The presence of trust has an impact on the perceived value of health care system and also forms an important part of patient experience and a measure of the overall performance of the health care system.

Theme 1 discussion focused on the following two guiding questions:

- **To what extent does the public have trust in the healthcare system, service and staff?**
- **What essential medicines are available and should be made available in pharmacies that cater for regional hospitals' patients?**

The lack and erosion of trust in the health care system was visible during the discussions. At times it is evident the erosion of trust is associated with institutions at management level, while at other times it is associated with the healthcare personnel. Equally it was also evident that the trust in the health care system is also affected by the political divergence in the country and use of political influence. The following sections elaborate on the findings from Theme 1 discussions.

1.1 Trust in the healthcare system, service and staff

The discussion on the present level of trust in the healthcare system, services and staff generated two main themes: factors or determinants that led to mistrust and factors that are required to build trust. Many participants had the view that people do trust the system, services and staff to some level but much has to be done to build trust too.

Under factors that lead to low or erosion of trust, participants highlighted that the undue influence of politicians or powerful individuals bypassing the existing structures and procedures of the health system is one of the means that undermines the trust public has on the system.

Participant 1: "...when political influence enters, the work ethics and values of our health staff are compromised."
Participant 3: "when an incident happens, many times the media will be given totally a different picture from what actually happened because of political pressure"

With regard to services, lack of awareness of the available services in the country was another factor that participants believed may lead to undermining the strength of the existing health system.

Participant 6 and 7: "We need to make people aware of the services that are available in the country, many do not know that brain surgery can be done in the Maldives. Many do not know that telemedicine is available even for first time consultations. Lack of such knowledge leads to mistrust."
Participant 2: "Public sector health facilities also need to market their own services like the private sector do..."

It was also noted that system related other issues also affect access to care such as transport difficulties and financial restrictions as indirect costs are not covered by the Aasandha health insurance schemes.

Participant 5: "It takes 40 minutes to reach the regional hospital...and it's hard to get an appointment...when you finally get one, you have to cross seas even if you are pregnant, old or infant, and even after all that effort your appointment may get cancelled...and sometimes patients have had to be admitted in the health centre after returning from the regional hospitals because of the stress of travel"
Participant 4 and 1: "Through our health financing scheme, we tend to differentiate between the person who travels to Male' for treatment and the person who travels abroad for treatment. This encourages people to go abroad than to seek care in the country."

Participants also noted that the way negligence issues are addressed in the country which also paves the way to erosion of trust.

Participant 1 and 7: "People trust our doctors but the moment an incident happens, trust is challenged because of the way the doctors and management deals with the incident. The regulatory body (Ministry of Health -MOH) and the provider (80% of the facilities are operated by MOH) being the same institutions imposes restrictions to investigate medical errors and to be accountable to the public."

Discussion on ways to build trust identified the importance of closing the gaps in human resource training and communication process between patients and staff, between staff and seniors, between management and public and through motivation of health care professionals.

Participant 7: "We live in very small communities where everyone knows each other, so sometimes patients tend to hesitate to explain everything to the doctor as the clinical assistant or another staff might hear about it."
Participant 2: "the trust that our patients have on our own local doctors is high. This shows the importance of building our local capacity to address shortages in the atolls but yet there is no comprehensive human resource plan for health staff in the country. We need to motivate our health professionals instead of penalising them"
Participant 1: "We treat our own people (staff) as substandard…so we always view that the grass on the other side as greener…our health professionals work in Canada and in developed countries but our system is designed in a way that people lose trust in our own staff."

Another way to build trust was to make available essential medicines and very simple procedures (example collect and send blood samples to regional hospitals) on the island where people live.

Participant 7: "if simple tests and procedures can be made available in islands, patients would not have to cross seas to seek that treatment"
Participant 6: "friends of my parents have said that it is only because of travel restrictions that they are seeking care in the Maldives, if not they would have gone abroad"

Participants also noted that creation of a culture that takes ethical responsibility to talk about mistakes without fear of legal consequence is important to build trust. This can be done by educating staff knowledge on code of conduct and healthcare legislation.

Participant 6: "When people complain about a doctor several times, there needs to be a system where such complaints are attended to"
Participant 4: "We find that our training students do not have the knowledge of policy documents like the Health act and the code of conduct, which is necessary to protect them and their patients from being mistreated...this limits them in understanding their own rights...and makes them hesitant to discuss medical errors with supervisors"

1.2 Availability of essential medicines

Access to essential medicines and basic health services is a universal right. The right to enjoy health is one of the fundamental rights of every human being irrespective of all backgrounds. One of the main objectives of the Health Services Act of the Maldives 29/2015 was to ensure the sustainability of services and equipment's provided by the state for the general public.

Health Service Act of Maldives (2015) Chapter 1, under acquiring machinery and resources required for provision of health services states that "A procurement system shall be established and implemented under the Ministry or by a party assigned by the Ministry, to ensure quality and sustainable provision of machinery, equipment, medical consumables and other related resources to all government operated health facilities within the national health services system" which emphasizes equitable access of health to all the citizens of the Maldives. Nevertheless, the monitoring, implementation and enforcement of this is far from the vision. To provide additional understanding and insight into this, below are some of the statements from the participants:

Participants stated trust on availability of essential medicines are low and especially is the case that most of their experience is that the stocks are not refilled.

Participant 3: "Many times stocks are not refilled. For example, injection paracetamol may not be available. These are basic needs. Diabetic medicines may not be available. Patients sometimes discontinue these medicines due to non-availability or find alternatives to this. Essential medicines are most of the time available, but if it is unavailable then it is unavailable in all the stores".

In addition to the uncertainty on the available of essential medicines, participants also highlighted the lack of basic examinations at island health centres and for this reason, patients are forced to travel to the nearby atoll or regional hospital.

Participant 5: "Basic investigations are not available. Basic investigations such as X rays and CBC (Complete Blood Count). Patients have to travel to nearby Atoll or Regional Hospitals through Aasandha. Basic medical examinations such as this needs to be made available at all the health facilities. Due to non-availability of these basic investigations, the trust on the health system is lost. There might be a cost factor involved here. But even then, would it be more cost effective if they are travelling via Aasandha every time for an examination or to make these examinations being made available at the island level".

The system built to address the availability of essential medicines is not seen to be working as expected. For instance, medicine replacement procedures and/or the stock reserved in the hospitals seem inadequate.

Participant 7: "Some efforts are being made to decentralize, but not totally. Procurement of medicines through decentralization is essential. All pharmacies operate with a licence. When a particular essential medicine is not available, the medicine is taken from the stock of the hospital. So, the stock becomes zero. So until this patient replaces the medicine, the stock remains at zero".
Participant 4: "Many times when a couple of patients are admitted for antibiotics and analgesics, we run out of stock".

Participants recognise that some efforts have been done to decentralise the health care system but not enough has been done to have lessons learnt for improvement based on performance data

These issues are already recognised by the Health Ministry which highlights a 'lack of inventory management at health service centres, dependency on branded drugs, installation of larger than required medical equipment installed at some health centres' as aspects in the system that need review (Ministry of Finance, 2020). Such inadequate establishments raise to bigger issues to the service sector such as inefficient and high levels of health sector spending (IMF, 2019) which may have indirect impacts on levels of trust in the wider national healthcare system.

1.3 Conclusions and Recommendation: Trust in Healthcare

Theme 1 discussion identified a list of areas that need addressing for improving the trust in the health care system. These have been summarised below.

Regulatory framework and transparency

1. The present administrative arrangement does not ensure independence between the role of health service provider and the regulator. Implement frameworks to pave the way for these two roles to be discharged by two independent bodies.
2. Introduce mechanisms to raise concerns and complaints (by both public and employees in the organisation) with a guaranteed feedback duration on the issues raised.
3. Performance monitoring of public health sector is inadequate, and publication of performance related data is not available. Similarly, the health sector lacks assessment of affordability costs.
4. Implement measures to eliminate use of political influence or position to bypass procedures and guidelines to achieve medical services that would otherwise be not qualified.
5. Introduce greater transparency on incidents of medical negligence and how these are reported to the public.
6. The concerned authorities need to establish why still a larger population of the patients seeking medical treatment choose to travel abroad while treatments are available in the country.
7. Since travelling to an appointment is a challenge via sea transport and is subject to weather conditions for services in atolls, consider introducing measures to ensure appointments will not be cancelled for delayed arrivals due to weather conditions. Such cases may be put on the queue for next day or ask doctors for attendance for a delayed appointment and compensate the doctors for out of office hour services.
8. Introduce mandatory refresher trainings every two years for medical professional on "code of conduct" and legislation, for instance the Healthcare Act. There is a perception that medical professionals lack knowledge of the obligations and protections imposed on them by these guidelines.

Public awareness

1. Increase public awareness on available treatments and surgeries in the country. Inform the public on the health care model implemented (general practitioner model) in island health centres. Currently, there is mistrust of the doctors in islands on their competence.
2. Distribute information on Aasandha scheme and NSPA, scheme limitation, fairness and coverage. There is a perception of inequality between cost coverage for treatment within and outside country - potentially due to lack of information amongst the public on the scheme. There is also

a strong perception in the public that medical services abroad (for the same treatment) are superior compared to the in-country treatment and getting an appointment for a specialist is much easier if patients travel abroad for treatment. This perception has created a strong desire for the patient or patient representative to push for qualifications for Aasandha through any means possible, such as through networking and personal approach to medical professions to create a case for going abroad for treatments available within the country.

3. Greater push for usage of online consultation and implementation of specific days to be reserved for appointments for patients travelling from nearby islands to atoll or reginal hospitals.

Human Resource

There is an indication of a greater trust towards local doctors compared to foreign doctors. Policy direction on increasing local capacity is required. There is no human resource health plan available at policy level, identifying at the very minimum, the local or region-specific needs.

Availability of essential medicines and basic tests

1. An effective mechanism is to be provided to implement and monitor stocking and refilling of essential medicines. If mechanisms already exist, feedback should be taken from all pharmacies, hospitals and health centres as to why medical stock is not adequately maintained.

2. Many health centres in islands lack basic tests such as complete blood count and this often forces people to make journeys that could have been avoided to nearby health facilities for very basic needs that could have been avoided. The cost of supporting such trips via Aasandha versus such tests being available in the islands needs (or implementing means of blood samples to be sent for regional hospitals) to be established.

Theme 2: Human Resources in Healthcare

2.0 Background and context

For a strong health system to exist, it is essential to have an adequate, well prepared health workforce, working under proper working conditions. According to WHO, the world needs millions more health professionals such as medical doctors and nurses in order to achieve the SDG goal of universal health coverage by 2030. Among the health-related SDGs, the health worker density of physicians' target of SDG focuses on substantially increasing the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and Small Island developing States.

Although Maldives is not listed among the countries with serious shortage of health workforce (WHO, 2020), the emerging issue of Human Resource Development (HRD) deficiency is considered as a major issue in the health sector (Ministry of Health 2019; Moos 2019). The survival and growth of the health sector depends on HRD (Sharma and Goyal, 2017), and a shortage of skilled healthcare workforce means Maldives as a country cannot provide quality services that the stakeholder demands from the country's health system.

Maldivian health standards have significantly improved in the past few decades, (SAP 2019-2020), and is reflected in the higher life expectancies experienced by the Maldivian population and the decline in infant and maternal mortality rates. However, due to the geographic nature of the country, the health services are somewhat centralized in the country and access to affordable, inclusive and quality health care services are limited or non-existent in some islands, which has been a daunting challenge to the sector.

Human Resource for Development (HRD)

Regarding the quality of care afforded to patients, recruitment and retention of adequately trained health professionals remain key issues hindering service delivery. (Kawsar, 2021)

Statistics published by Maldives Bureau of Statistics (MBS, 2021) in their Statistical Yearbook of Maldives, 2021, in 2019 there were 1,194 doctors of which 52% were spread across all the atolls and the rest in the capital city Male'. While 57% of the doctors working in the country were general doctors, 42% were specialists. 63% of the general doctors were dispersed across the islands while only 37% of the specialist doctors were working out of Male' city. Data also revealed that 52% of nurses, 43% of the Allied Health Staff, 99% of Community Health Personnel and 100% of Traditional Birthing attendants were working out of Male' city, in the atolls. Amongst the 1194 doctors, 64% were expatriates, and this is somewhat

seen across general doctors (63%) and specialist doctors (65%). Among the nurses, 42% were expatriates while 58% were locals. This was the latest data available on the number of health care personnel.

Discussions

Given the shortage of health care personnel and the high turnover rate of the HR in healthcare, group 2 discussions were focused on the following basic questions:

- What areas of health services need developing its Human Resources for Health?
- What minimum healthcare services staff are needed for the islands with small populations? And how can these staff be provided in the longer term?

2.1 Areas of the health service which need manning and HRD

The group discussed the different areas in which shortage of health care personnel were emergent in their localities. Due to the shortage of local doctors, and the significant number of foreign doctors in the Maldives, especially in the atolls, there is a high turnover within the regional healthcare sector. This creates two major issues; by the time the foreign doctors get fully acquainted with the protocols and the rules of the health facility, their contracted time ends, and a new recruitment is processed as a replacement, and the language barrier is not clearly surpassed due to interpreters' lack of knowledge and communication skills.

Due to the shortage of doctors in the atolls, the availability of well-trained, highly motivated nurses is crucial. Although at a national level, there is a significant number of well-trained nurses, for various reasons, they are not in the labour force, or more specifically they choose not to work in the health sector. Since most undergoing training as nurses are female, and once they start a family, some tend to choose to stay at home and care for their children. These are largely due to the environment and the working conditions, lengthy work hours, and low pay compared to the hardships of being a nurse. Furthermore, the process of recruitment and selection is centrally controlled, and the process at times gets purposefully delayed due to political and cultural reasons, and hence the candidate chooses not to pursue work in the sector, especially in the smaller communities. Moreover, specialized nurses such as those required in critical care, for midwifery and as theatre nurses are non-existent in the islands. Equipping the available nurses in these areas is critical, especially in the islands as they attend to the patients if and when the hospital or health care facility finds itself without a doctor due to leave or when the recruitment is in process.

Some specific areas identified by the group as key areas where human capital needs to be developed were radiologists, radio-technologists and lab-technologists. These personnel were essential to equip the facilities with expertise for issuing specialist reports, in addition to just getting X-rays and tests carried out.

The group also discussed that apart from the medical personnel, administrative and management personnel in the sector also needs upscaling and training. According to the discussion, a new recruit to the reception is largely a fresh graduate from high school and they lack soft skills such as customer service skills, empathy and communication skills. The orientation process, which a new recruit undergoes, does not address these skills, and this issue needs to be addressed. Moreover, procurement staff are ill-equipped with stock maintenance, and hence the inventory is not managed properly leading to lack of medicinal and other resources when needed.

Incompetent political appointees at the helm of a health care facility, with limited or no knowledge or training on medical or management field, according to the group discussions, creates an inharmonious environment which deters the service rendered to the care receiver. As per the group, this practice needs to be investigated and addressed urgently.

Possible solutions from the discussion

Personnel	Need/skills required	Solution suggested by group	Costs anticipated
Nurses to obtain specialized skills	Critical care / midwife / theatre nurse	Utilize the tertiary hospitals in the country to train	minimal costs, as they will be learning by practising
Reception staff	Customer care skills Communication skills	Nearby resorts can assist in training the reception staff	Resorts under their CSR can provide them at the request from the hospital management
Call Centre staff	Communication skills	Nearby resorts can assist in training the call centre staff	Resorts under their CSR can provide them at the request from the hospital management
Procurement Staff	Inventory Management skills	Adopt a clearly written Standard Operating Procedure on inventory management and monthly reporting mandated, opt for a software	Purchase of a simple yet working software for inventory management.

2.2 What minimum healthcare services staff are needed for the islands with small populations? Can these staff be provided in the long term?

Majority of the discussion revolved around the issue that the communities, although small in population, are Maldivians, and it is their right to a healthcare facility that provides at least the basic and essential services. Among the essential specialist areas, the foremost was a gynaecologist or at least a nurse specialized and well-trained in midwifery. In some situations, travel by sea, even to a close-by regional hospital may not be possible or safe, for instance premature deliveries or complications during pregnancies that are life threatening. Majority of the group called for a doctor, and not just a nurse with midwifery training.

Secondly, the discussion focussed on the requirement of a well-harnessed, experienced general doctor (more experienced), who is better equipped for a wider range of ailments, rather than a novice doctor with only a few years of experience. The discussion led to highlighting that in most islands, the majority of the time, the single doctor available at the health facility is young, and with only a few years of practice.

Discussions also focussed on to the fact that in smaller communities, the skills of specialized doctors may be wasted as they have access to fewer patients, and fewer opportunities to practise and develop their skills, which may lead to dissatisfied doctors.

2.3 Conclusion and Recommendations: Human Resources

Short term solutions

1. Hiring dedicated, experienced and well-harnessed doctors with MBBS qualifications, and each medical facility to at least have one medical doctor, and nurses with varying speciality experience. During the hiring process, HR managers should cater for the identified speciality gaps in the HRD.

2. Arrange specialized mobile clinics at specified frequencies (for instance every quarter) in areas where certain ailments are persistent.

3. Modifying the tertiary education curriculum relevant to the medical field, especially planning for nurses to specialize in certain areas that are highly essential, and multi-disciplinary within the medical faculty.

Longer term solutions

4. Regional Hospitals to be developed to a level that can cater for the islands around it, manned with specialist doctors. To strengthen the referral system within and between the islands and the processes to deliver a service that is non discriminative to those coming from other islands.

5. A reliable and timely transport mechanism to be made available between the islands, that has a general service and an emergency service, and modify policies for the councils to be responsible and involved in ensuring that the transport system is functioning.

Access to affordable, inclusive and quality health services is the pledge by the government of Maldives, and to be able to deliver this, developing the HR in healthcare across the whole country is essential (WHO, 2016; Maldives Partnership Forum, 2019). Local doctors from islands prefer to work in the urban centres for reasons such as higher take-home-pay and the possibility of other income generating activities, and more significantly, the enhanced opportunity to practise their skills, given the number of patients. The resulting outcome is a concern, where a significant percentage of medical personnel working outside of the urban centres are expatriates. In addition to the language barrier between such doctors and local patients, there appears to be a high turnover of these doctors, which is more pronounced in the rural and outer islands. The resulting effect is a weakened

bond between the community and its health care personnel. The high turnover also results in new doctors taking time to understand the standard protocols and rules that the health facility stands for. The newly started medical school of the Maldives at Maldives National University (MNU, 2021) is a promising for those new entrants into the medical profession, in that the country is geared towards increasing not just the number of medical personnel, but also the capacities as well through refresher and other skill building opportunities.

The government, in the 2022 budget pledged spending on HRD, an amount close to 7 million, which also emphasises the level of commitment by the government to improve the HR in healthcare.

Theme 3: Legislation in the Health Sector

3.0. Background and Context

This chapter analyses qualitative data obtained through a focus group discussion (Group 3 of the Health Forum) of healthcare legislation relevant to North Region Health Sector. The data has been extracted from recorded discussions lasting for over 90 minutes, and although participants addressed wide-ranging issues, this section reports the key themes that the participants identified during the discussions. The participants explored two research questions under a broad theme of legislation. They expressed their opinions, views, and ideas on the minimum requirements for medical services. They also discussed urgent laws that should be enacted to improve health services in the Maldives. What follows from here are the main points identified by the participants on the two questions.

3.1. The Minimum Legislative Requirements

Participants reported a number of issues related to the quality of health services in the Northern Region, ranging from a lack of equipment/facilities (e.g., CT scanner, MRI equipment) as well as shortages of human resources, with much focus on management of healthcare professionals. From the human resource management (HRM) perspective, it was discussed that healthcare professionals' retention must be linked with the regulatory mechanism through comprehensive legislation. However, the details of how this can be prescribed in law needs further elaboration and discussion because employee retention is an HRM issue (see Theme 2, Chapter 3) rather than something that can be achieved through legislation.

That said, from the discussions, it was evident that one key government policy that should be bolstered in the healthcare sector is the compulsory service (*'Bond')* legislation (Act No. 29/76) [Law on compulsory service period attached to government-sponsored learning and training]. The compulsory service *(bond)* is a mechanism through which government mandates the government-sponsored graduates to serve in the regional and atoll hospitals for a specified period. Still, the MoH faces many challenges in implementing the compulsory service period, under the legislation. Not only is it an aged legislation, but it also may not be fit-for purpose, according to the participants and may not cater for the needs of the current healthcare conditions. In the extant literature, such practices are considered as one of the 'fragmented' (The World Bank, 2020) legislations aiming at encouraging trained healthcare professionals to serve in remote/rural areas of the country. The question remains whether this legislation can enhance the effectiveness of implementing retention practices for healthcare professionals.

The retention theme continued during the group discussion leading to other HR issues such as strengthening the performance appraisal system, identifying motivational strategies to encourage doctors, nurses and other healthcare workers to work at regional and atoll hospitals and health centres in remote islands.

Suggestions were made to use a point-based system for awarding scholarships based on the agreement to serve at the atoll and regional hospitals. However, there was detailed discussion as to how these HR issues can be addressed in law through which the retention issues of healthcare professional can be resolved.

Another minimum legislative requirement identified by the research participants was specifying employer and employee responsibilities in the health sector. Within employer (government) responsibilities, there was a suggestion to write Standard Operational Procedures (SOPs) and to specify how to ensure implementation of these SOPs. Again, there is a lack of details on what areas of healthcare provision should these SOPs cover because there cannot be a general SOP that can be applied to all medical procedures and practices. For example, in the UK, there are SOPs for the general practice of Covid-19. In the guidance provided by the National Health Services (NHS, 2020), a detailed SOP has been prescribed on lateral flow antigen testing. Similarly, Gandy (2019) identified several other areas with SOPs, including dietetic and nutritional professional practices. Therefore, a more detailed discussion will be required to find out what medical and healthcare areas need SOPs to be legislated to provide quality healthcare services in the regional and atoll hospitals. As for employee rights, the existing Employment Act 2008 (Act No. 2/2008) must be consulted for what has been legislated and to what extent the provisions of the Act addressed the healthcare providers' needs.

3.2. An Urgent Piece of Legislation

The second question that was posed to the focused group discussion was "What would be one piece of legislation that is urgently needed to improve the healthcare system in the Maldives?" After a lengthy discussion, the participants came to a consensus that there should be Occupational Health and Safety legislation with a focus on safety in the workplace in general, in particular health professionals working at health centres, atoll and regional hospitals. Some initial work has been done in this particular area and the government of Maldives has been receiving consultancy from the WHO beginning in 2008 (Saiyed, 2008). In this legislation, participants wish to include a number of areas with many responsibilities bestowed upon the employer. According to the qualitative data from the discussions, employers must ensure a safe work environment for their employees by providing the necessary tools/equipment. In this Occupational Health Safety legislation, it must be made mandatory for employers to provide regular health check-ups for health professionals who are classified as working in high-risk areas such as X-ray and Radiology departments. To prevent from flu-like diseases, the legislation must give provisions for ensuring health workers' safety by providing vaccines as stipulated by WHO.

Another important area that needs a specific mention in the Occupational Health Safety legislation is mandating healthcare providers to have indemnity insurance for their employees. The power to regulate

such insurance policy must be given to the health services regulatory body through an amendment of the existing Care Profession Act (Law number: 13/2015). The indemnity insurance clauses must state the compensation mechanism and should define a no-fault compensation mechanism. Lastly, there should be a clause about whistleblowing and conditions and protections within the legislation to whistle-blowers. Despite these details, there was no discussion as to how to begin to develop a Parliamentary Bill on these areas and the advantages of having a separate piece of legislation instead of bringing amendments to the existing relevant legislation.

3.3. Conclusion and Recommendations: Healthcare Legislation

This chapter has reported a summary of the discussions of Group 3 of the Health Forum lasting for over 90 minutes of sharing ideas, views and opinions by the participants representing a diverse healthcare stakeholder group from the North Region. The outcome of the discussions suggests that there is still support for a piece of legislation that was introduced in 1976, (Law on compulsory service period attached to government-sponsored learning and training) as a mechanism to sharpen the quality of existing healthcare provision between Greater 'Male' area and atolls or alleviating the healthcare services quality differences between urban and rural divide. However, one can question how to legislate employee retention strategies in the health sector, but rather this issue must be resolved through the implementation of effective strategic HRM strategies such as performance management, provision of training and compensation contingent on performance. The analysis of the discussion has found a need for an Occupational Health and Safety legislation with the necessary considerations such as regulating employer responsibilities (also identified in Theme 2: Human Resources), identifying indemnity mechanisms and focusing on health and safety measures within healthcare organisations.

Key recommendations:

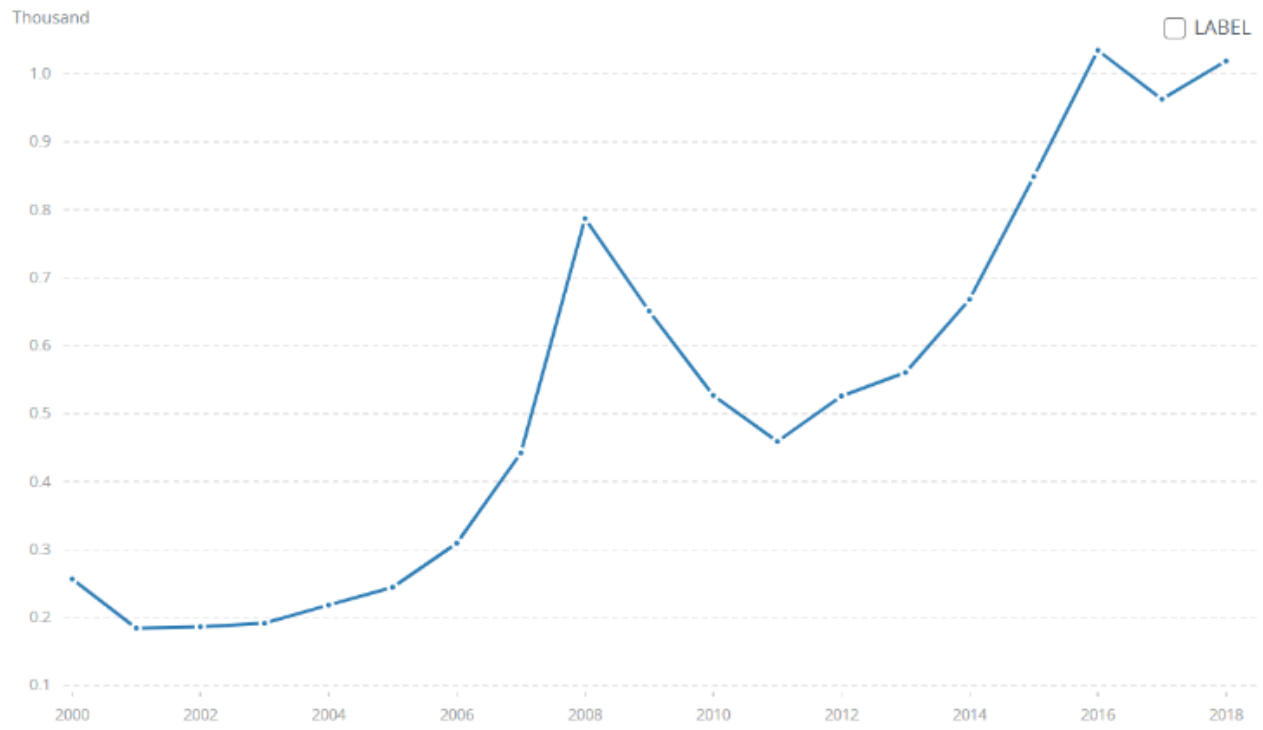
- Consider new legislation on Occupational Health and Safety legislation to cover use of equipment, workers' safety in high-risk areas and to cover localised aspects of working in the various healthcare facilities in the region.
- Amend the Care Profession Act (13/2015) to ensure indemnity for employees
- Review Compulsory service – (service bond) to work in the atoll health facilities and the bond's implementation and effectiveness.
- Consult Employment Act 2008 to review and add more clarity to employer/employee roles
- Review SoPs for various healthcare services in the atolls.
- Strengthen the performance appraisal system of healthcare workers
- Find ways to motivate the workforce and attract quality recruits: scholarships

Theme 4: Affordability and National Health Insurance schemes

4.0 Background and context

The Maldives currently has universal health insurance that covers a plethora of primary services. The introduction of a universal health insurance scheme Aasandha in January 2012, covering all inpatient and outpatient treatments, including consultation and medicine, within the overall cap of MVR 100,000 per person per year and the entire population is automatically enrolled without a premium contribution to the scheme. The scheme achieved the important milestone of access to health insurance coverage of the entire population, and drastically decreased out-of-pocket expenditures on services.

Out of pocket expenditure on health as a % of current health expenditure (Source: World Bank open data)



Domestic general government health expenditure per capita (Source: World Bank open data, 2021)

While the scheme drastically decreased out of pocket health expenditures, it simultaneously increased the domestic health expenditure by the government, as shown in the above graph. According to World Health Organization (WHO), 9% of the Maldives' GDP goes toward healthcare. The country spends a higher percentage of its GDP on healthcare than any country in Southeast Asia, where the average expenditure for the region is 3.46%.

In 2014, the scheme evolved into Husnuvaa Aasandha, abolishing the cap of MVR 100,000 and providing unlimited healthcare for all medical services.

Husnuvaa Aasandha

The scheme is governed privately by Aasandha Company Limited but regulated under the National Social Protection Agency (NSPA), and provides curative services to the whole population, and is fully financed by the Government of Maldives.

The scheme includes inpatient and outpatients and medication, diagnostics and surgical interventions, transportation fees of emergency cases, annual check-ups for those above 30 and below 18 years of age, medical cover for terminally ill patients and those with special needs, and medical cover during pregnancy.

The only pre-requisite of the scheme is to be a citizen of the Maldives, so every Maldivian with a valid National Identification card has access to unlimited health care 'for all medical services prescribed and recommended by medical doctors, without paying any fee'. The scheme however excludes certain services, for example, private room fees for admitted patients, cosmetic treatments and surgeries, assistive devices for patients with disabilities, nutrition and other food supplements (refer to Scheme Exclusion for the full list of services excluded from the scheme).

Limitations of Husnuvaa Aasandha

While the scheme attains a high coverage of the population, only selected private health service providers are registered in the scheme (refer to the full list of Husnuvaa Aasandha empanelled facilities). In addition, the scheme does not cover expatriates and dependents residing in the Maldives, which is a high proportion of the total population (approximately 70,000 expatriates reside in the Maldives according to the 2016 statistics).

One of the major deficiencies of the scheme, according to the Maldives Health Master Plan (2016 – 2025), is that 'currently, beneficiaries tend to over-utilize services due mainly to poor information and the perception of the Husnuvaa Aasandha being a "unlimited pre-paid scheme", which results in inefficient use of resources, especially with the absence of gate-keepers in the system. Despite the SHI, direct out-of-pocket expenditures were high (49%) in 2011-12, of which almost 53% was spent at public providers and 47% at private providers. A law on SHI in Maldives was enacted in 2011, however the SHI system in place is not consistent with the law.'

Since the introduction of the schemes, government spending on healthcare has more than doubled during the years 2013-2017, resulting from inefficiencies in medicine procurement and supply chain systems, limited regulatory and diligent oversight, etc., which adds to the inherent costs of the three-tiered health service system in the Maldives.

Forum Discussions

Given the limitations in access to affordable health care in the Maldives and inefficient uses of the schemes, Group 4 discussions were centred around the following questions:

- What benefits do the national health insurance schemes provides for the users?
- What are the challenges in delivering/receiving National Health Insurance Scheme?

- To what extent is healthcare services affordable to patients?

4.1 Benefits of the National Health Insurance Scheme

The group discussed the overall benefits of Universal Health Insurance, which ensures access quality health services, protecting them from public health risks, illness-related impoverishments due to increased out-of-pocket payments for healthcare, and loss of income when household members fall sick. In the Maldives, with the aim of promoting affordable and accessible health care for all Maldivian nations, Husnuvaa Aasandha insurance scheme which evolved from previous Aasandha scheme in 2014, providing healthcare without a ceiling for all Maldivian nationals with a valid national Identity Card. The group recognized that the universality of the scheme is an important element that has contributed to the improved livelihoods resulting from decreased out-of-pocket health expenditure in the Northern Atolls in the Maldives.

Box 1: Benefits of the National Health Insurance Scheme

The scheme covers the following:

- Both inpatient and outpatient treatments and medication
- Diagnostics and surgical interventions
- All transportation fees of emergency cases
- Annual medical check-up for those above the age of 30 and below the age of 18
- Medical cover for terminally ill patients and those with special needs
- Medical cover during pregnancy

Emergency Evacuation -Aasandha emergency evacuation involves coordinating with local health centres in arranging transfer of patients requiring urgent medical service/treatment to the closest health centre where the treatment is available.

- The mode of transfer (whether to use air or sea transport)
- Services can get it from all public health facilities and empanelled private health facilities.
- **Overseas Treatments-** Aasandha provides cover for medical treatment overseas, only for those treatments and services unavailable within Maldives.
- **Customer Service Centre**

- Customer Service Centre (CSC) operates a 24/7 call centre with a dedicated hotline 1400 and a customer service front office to cater for customer needs.

Source: Husnuvaa Aasandha

Socioeconomic benefits of universal health coverage

The group highlighted the socioeconomic benefits of the universal health insurance scheme. For a country with increasing out-of-pocket health expenditure, universal health coverage has resulted in drastic improvement in livelihoods especially for the middle to low-income groups. Similar to many developing countries in the region, increased economic growth, coupled with the movement for democracy in the early 2000s, contributed to the full implementation of a Universal Health Care scheme in the Maldives. Although the benefits of the schemes have not been extensively studied in the Maldives, the Group discussed the following as benefits of universal coverage for the entire population:

- reductions in inequalities by increased cross subsidization and consolidation of other services
- increased efficiencies and decreased bureaucracies from a unified health system financed through taxation only (although the costs related are higher and this increases room for misuse of funds)
- Pooling of risks resulting in savings to the schemes

4.2 Challenges in delivering and receiving health care in the Maldives

Although health service coverage is universal in the Maldives, the quality of the health services and accessibility related to the dispersed island population remains a challenge in the Maldives. Given these inherent features, health service provision in the Maldives is Maldives has a "tier-based" healthcare system. Every inhabited island, even the most sparsely populated, has a primary care facility. Every inhabited atoll, or island chain, has a secondary care facility. Larger urban areas also have tertiary care centres.

The health posts and health centres offer primary health services, including medical examinations, investigations, immunization, antenatal care, drugs etc, but the delivery of these services is continuously challenged due to inadequate human resources, disruptions to medical supplies and poor management. In addition, given the size of the island populations, there are often insufficient demand for services that compromise the skills and efficient service delivery of health care professionals in the islands. The second tier is the regional level and atoll hospitals provides primary and curative health care in atolls. Often, specialty treatments are limited in the regional and atoll hospitals. The third tier is the Tertiary Hospital

in Male', which is also the only referral centre for all medical services where all emergencies and serious cases are referred and administered.

The group noted that geographical dispersion is the main challenge in providing equitable and quality health services in the Maldives. The costs are further exacerbated by disruptions to service deliveries due to lengthy hiring processes of medical staff, difficulties in retaining skilled medical staff in regional and island service centres, challenges in logistics management of medical equipment and medicine. The public pharmacies in smaller islands with health posts often lack basic medicines and antibiotics, and this is not a service private sector is attracted to due to diseconomies of scale. Due to the high operational costs, monitoring, evaluation and training of health care providers are often a challenge in the primary and secondary tiers.

Associated with challenges in health service delivery due geographically dispersion, are the difficulties in access and high costs of transportation to access tertiary care situated only in greater Male' region. Often the mode of transportation is sea or air, which are largely dependent on the weather patterns and availability of seats. Together with the accommodation and transportation required for the duration, those residing in the smaller islands are still faced with increased out-of-pocket health expenditures.

The group noted that these constraints are worsened by heavy reliance by the public on the island councils to arrange hospital appointments, transportation and other arrangements through Husnuvaa Aasandha because of the lack of general awareness about the scheme. This particular constraint is worsened due to increased use of political influence in service delivery. Due to this, in serious cases, equitable availability of transfer services for patients to tertiary facilities in Male' vary.

A major challenge identified by the group is the gaps in the existing regulatory framework of the Public Health Act and the Health Services Act. Defining the regulations under the two Acts for medical negligence is a key challenge in health service delivery. This also contributes to the overall lack of trust in health care.

All the constraints in access and service delivery adds to increased costs of health services in the Maldives, which are covered universally financed by the government of Maldives through tax financing. This expansion without necessary governance structure that separates the functions of healthcare providers and purchasers, has undermined the quality of health services at the primary and secondary health centres, which in turn diverts healthcare seekers abroad or to tertiary hospitals, further increasing the financial burdens of the scheme.

Sustainability of Husnuvaa Aasandha

As discussed above, the evolution of the national scheme to one that is uncapped and unlimited coverage has resulted in systematic abuse of the scheme, monopolized suppliers in the health equipment and service value chain, leading to inefficiencies and higher costs. The group noted that the role of private insurance providers has minimized since the adoption of the new scheme, further lessening the scope for diversifying the sources of financing universal health coverage in the Maldives. The group noted that while universal health coverage is important for the overall health service and growth of the nation, an efficient source of financing the scheme with a stronger governance structure overseeing the existing loopholes is required for the long-term sustainability of the scheme.

Key Recommendations

Diversifying sources of revenue for universal health coverage (explicit budget earmarks and other financial commitments)

Implementing rigorous governance and monitoring mechanisms on health insurance spending

Robust investments in institutional capacity of health service providers

Investments in technology and increase innovation in health service provision

Introduction of nation-wide telemedicine

4.3 The extent to which healthcare services are affordable to patients

By design, the national health insurance scheme in the Maldives is accessible to ALL Maldivian nationals without discrimination of gender, age, residency. The universal health coverage here means that all Maldivians are able to obtain health services de factor without any financial hardship. This implies that health services are accessible and affordable, and the scheme is equal to all citizens.

In the Maldives, given the above constraints, many factors inhibit affordability of health services, especially for those residing in the islands other than where secondary and tertiary health centres are located.

Physical accessibility: Secondary and tertiary health services are still not within reach for a large part of the population (namely those residing in smaller islands).

Financial affordability: Related to physical accessibility, costs of transportation and accommodation to and from the secondary and tertiary health care centres (and the indirect costs of loss of working days) are still out of pocket expenses not covered by Husnuvaa Aasandha. This implies that health services, especially specialty services, are not affordable universally to all in the Maldives.

Acceptability: The constraints and hurdles faced by those residing is smaller islands along with issues of trust in the current health service system, have led to increased tendency for Maldivians to seek medical services outside of Maldives, even for services available in greater Male' region. This again increase the costs of health care and out-of-pocket expenses, especially when they are not covered by Husnuvaa Aasandha.

Service availability: Although the Maldives health sector have achieved commendable strides during past two decades, the country has a long way to go achieve quality health service provision for all. Many specialty services including mental health services are not available universally in the Maldives. Therefore, a larger part of Husnuvaa Aasandha is for specialty health services outside the Maldives, incurring huge costs to the scheme and the patient.

4.4 Conclusion and Recommendations: Affordability of Healthcare

1. Increased uniformity of services across regional hospitals to reduce the burden on tertiary health service centres
2. Increasing equity in the current Aasandha scheme by providing the same level of service for all with no exception
3. Increasing monitoring and oversight of cost approvals (for services, medical equipment and medicine)
4. Empowering and improving the skills of health service providers in the primary and secondary hospitals and health centres.
5. Risk pooling and consolidating services to decrease costs of service delivery
6. Introducing specialist camps throughout the country – and making regional hubs of excellence
7. Establish services focused on tourism sectors - decompression chambers
8. Introducing services for those with special needs and coverage of their medical accessories and medicine
9. Introduction of mental health centres and rehabilitation centres in regional and atoll hospitals.

Theme 5: Equity of Healthcare Access

5.0 Background and Context

Theme 5 of the health forum focussed on equity of healthcare access. Equity in this report encapsulates fairness and a feeling of unity in the provision of healthcare to ensure a just treatment, as opposed to the more simplistic idea of equality, which relates to similarity or identical opportunities, capacity or status when receiving healthcare (Leeder, 2003). An exploration of equity, therefore, will uncover amongst other things, unjust differences of level of access to healthcare as a result of societal status or income (Walker and Peterson, 2018). The five northern atolls when compared to the capital, Male', show a significantly higher level of poverty in terms of relative earning of low poverty line (MRf 74/individual / day). While Male' has about 2% living below the low poverty line, in the northern atolls an approximate average of 10% of the population live below the low poverty line (NBS, 2018). Our forum's discussion attempted to find evidence of inequity in healthcare for the northern 7 atolls within this context. The main research question for the theme by Group 5 was:

What issues of equity (if any) of healthcare access exist in healthcare services in the 7 atolls?

Two more specific questions were used, during the theme discussion to sharpen the focus and these were:

1. Does inequity exist in the health system?
2. In what areas, if any, does inequity of healthcare access currently exist?

In addressing equity, where possible we tried to compare the service between the Northern atolls and Male', the capital. The data collected composed of group notes made by the group's note-taker, the groups' presentation (PowerPoint) delivered to the main audience during the forum and the audio and video recordings of the groups' discussion in Zoom. The PowerPoint consisted a summary of the issues emerged from the group discussion.

We reviewed a range of literature during the planning of and analysis of equity-related themes in the forum. This set of literature includes grey literature such as the Maldives Health Masterplan 2016-2025 (MoH, 2014); the Maldives Healthcare Quality Standards of 2018 (Srivastava and Prakash, 2018); Research work by Leeder (2003); Walker and Peterson (2018) Zeeniya (2019); data available in World Health Organisation's Health Equity Assessment Toolkit (HEAT, 2020); datasets from Aasandha's Statistical Year Book, 2020 and Household Income and Expenditure Survey, 2019 (NBS, 2021); and other relevant datasets from NBS (2018 and 2020).

Analysis / Discussion

Following the discussion and while preparing the slides for the forum presentation, participants categorised the discussion points into key issues. Further collating of the issues by the MaldivesResearch team identified 3 broad equity-related themes in the region: 1) availability of services and resources; 2) quality of doctors; and 3) political influences in service provision.

After the evidence was analysed, data was verified for accuracy and reliability through three processes:

- consulting Group 5 participants again to see if they recognised the identified emerging themes from the discussions and if they were in line with the situation in the atolls based on their experiences
- consulting the relevant authorities, health service providers for comments on the themes and for any further insights they could provide
- consulting the relevant literature for common and contrasting ideas in relation to the three equity-related themes identified.

5.1 Availability of Services and Resources in the Region

Availability of services and resources in the northern atolls was the theme discussed the most in-depth in Group 5's discussions. Earlier in the discussion, one Haa Dhaal (HDh) participant stated that the two regional hospitals in the north operate as the only sources of specialist healthcare service for many patients but, unlike in the capital, the population from the local islands have only one choice (the nearest regional hospital) where there may be a shortage of highly qualified specialists/consultants and therefore, the local population do not have the choice of finding an alternative healthcare service if needed/desired

Financial support through Aasandha is available with equitable access throughout the atolls, according to the participants. Our analysis of official Aasandha and population statistics shows that 91% of the registered population in the 7 northern atolls accessed Aasandha while in the capital, it was 89%; hence equity of access does not indicate major issues for this region. Our data is derived from analysis of raw data from Aasandha's Statistical Yearbook, 2020 and Household Income and Expenditure Survey, 2019 (NBS, 2021) HDh atoll shows the highest use of Aasandha in terms of number of individual access in the region while Lhaviyani represented the lowest use in terms of numbers (Table 1). While level of access appears to be high, the discussion focussed on the potential lower quality of service in the region compared to the capital.

Male'	**61,192**	**89%**
Northern Atolls	**126,733**	**91%**
North Thiladhunmathi (HA)	**21,255**	**90%**
South Thiladhunmathi (HDh)	**25,100**	**91%**
North Miladhunmadulu (Sh)	**16,879**	**91%**
South Miladhunmadulu (N)	**15,363**	**90%**
North Maalhosmadulu (R)	**22,095**	**92%**
South Maalhosmadulu (B)	**13,749**	**93%**
Faadhippolhu (Lh)	**12,292**	**92%**
Southern Atolls	**161,818**	**92%**

Table 1: Population accessing Aasandha - analysis of data obtained from Aasandha Stats, 2019, 2020 and NBS, 2021)

One disruption to service is patient treatment at island level needing to be approved by the atoll hospital and the associated delays or official approval not forthcoming for various reasons. According to the forum participants, in antenatal care, midwife-visits to a given island average less than once a month,

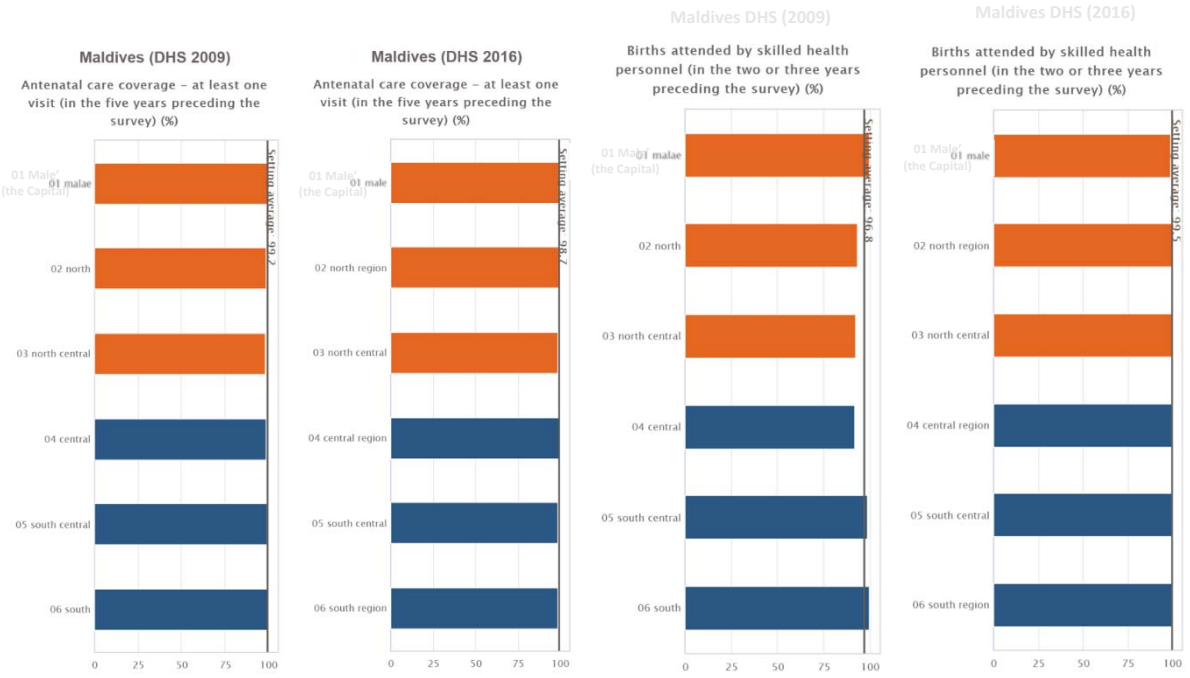


Figure 1: Data analysis from data obtained from WHO Heat Equity Monitor Database, 2020; and from WGHO, HEAT, 2021)

which means patients need to visit the atoll hospital by sea. Analysis of relevant equity-related Demographic Household Data (DHS) from the WHO (HEAT, 2020) shows some important trends worth exploring (Figure 1).

The northern atolls enjoyed improvements between 2009 and 2016 to national average levels in terms of the proportion of the relevant population receiving the services from at least one antenatal care visit (98.7%, 2016) and skilled health personnel during births (99.5%, 2016). However, there are concerns as the proportion of the relevant population receiving at least 4 visits in the previous 5 years has decreased from around 84% (2009) to about 70% (2016), well below the national average of 81.6% (Figure 2). This drop in service level has equity-related impacts for the population in the region and these figures resonate with the concerns raised by the forum participants, as described above.

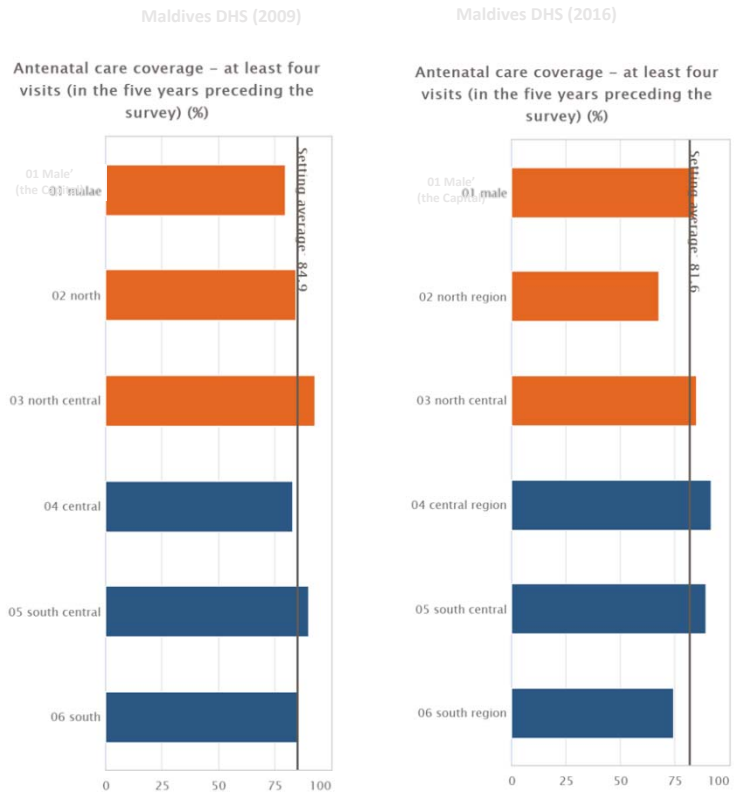


Figure 2: Data analysis from data obtained from WHO Heat Equity Monitor Database, 2020; and from WGHO, HEAT, 2021)

Other issues relate to health diagnosis-related services. Sometimes ultrasound scan machines at atoll hospitals or regional hospitals are out of order forcing patients to go to the capital. At island level, appointments may sometimes take 2 weeks. Regarding appointments, equity issues arise when people tend to operate outside the appointment guidelines. There is a set number of appointments each day but where some hospitals such as Kulhuduffushi Regional Hospital receive extra requests for consultations, it arranges extra appointments/memos for those extra visits from other islands/atolls and inform the doctors. Those patients usually arrive via ferries. Public information dissemination of how these systems work needs to be more effective.

These issues suggest that for some patients, it may be more beneficial cost-wise to go direct to Male' early on when treatment is needed, bypassing the local service. At the same time, there is an emerging trend in some atolls, where patients are opting for intra-atoll healthcare services, instead of travelling to the capital. Naifaru is an example, residents hire expensive and long speed boat trips to go to HDh Kulhudhuffushi for medical treatment because of the difficulties and expenses associated with a Male' trip; it also suggests that patients may not be receiving the expected standard of local healthcare in Naifaru; an issue, according to participants that is prevalent across Lh atoll.

The descriptions of the services by participants from HDh and Lhaviyani (Lh) atolls suggest that the regional population in the north may still see a need to go to Male' for basic healthcare services and therefore, there may not be a decline in the number of the local population opting to go to the capital for healthcare treatment. This is despite services being offered locally to provide a relatively equal service of access but with concerns of inequity. It seems that in some atolls, there are healthcare facilities and hospitals but without a sufficient quality of service. Another inference may be that the local populations need to have fuller information about the range of services available at island, atoll and regional level to make better informed decisions about obtaining healthcare locally.

In some aspects, healthcare services in HDh Atoll are slightly different from Lh Atoll. HDh Kulhudhuffushi hospital (HDh) advises each local health centre to refer patients elsewhere if patient's hospitalisation duration may be longer than the service hours/day for the health centre, with an indication for the reason for the referral. The hospital does not find it difficult to use Aasandha's services and receive patients from other islands, nor to refer patients to Male'. In the local region, there are 12 islands and it is not feasible to arrange monthly specialist visits to the islands. However, they assess the need for outreach specialist visits and arrange them if needed. For example, in 2020, 16 outreach visits had been arranged by Nov 2020. Any issues in some atolls may be managerial: discrepancy between what healthcare the public expects to receive and what the system provides but this may not be true for all atolls.

Baa Atoll participants recognised that the government has allocated specific levels of service to be provided. This allocation depends on whether the service provider is an island health centre, an atoll hospital or a regional hospital. Therefore, levels of service received by the public at these providers will be different and not seen as 'equal'. Participant from Aasandha confirmed that these different standards of service depend-on the size of the population. However, at some health centres basic healthcare facilities are not available and this is an issue, for example there have been requests for cases where a lack of everyday dressing or injection supply necessary for birth deliveries have resulted in some patients being transferred to another island. The issue here is then unavailability of expected services for the healthcare provider (e.g.: health centre or atoll hospital) resulting in inequity of access to basic services by some parts of the population. Participants feel that there is a role for healthcare managers at island levels to play in resolving these issues. Some regular complaints include some island health centres not having sufficient budget, or not having sufficient daily or weekly access to consumables delivered by the atoll hospital or regional hospital causing disruption to service. As per Aasandha procedures, it is not possible to finance the transfer of patients simply because the health centre does not have the expected service or consumables. Referring or redirection can be funded only in emergency cases or if there is threat to life. This issue leads to many public complaints against Aasandha. Although Aasandha is not designed to be responsible for transferring patients arising from a lack of availability of healthcare on one island. Aasandha operates as a financial guarantee for the health care services for eligible patients from the public. Availability of basic health service is an equity-related issue in some islands. It is worthwhile noting that provision of "a basic package of essential services" "free to all" in the public is recognised as a strategic plan in the nation's Masterplan 2016-2025 (MoH, 2014:42). The publication of performance within the sector against such strategic plans and indicators is vital to measure equity-related performances.

The issue of medical consumables in some healthcare provider has become so serious that the patient has in some case had to purchase the syringe from the pharmacy prior to doing a blood test. To achieve equity, each centre or hospital's budget need to ensure the availability of all basic consumables to the same level as in the population of Male' - such level of scarcity of consumables is not evident in the capital. As a response to this issue, Aasandha started financing consumables for patients and now the problem is some health centres have started directing the cost of all of their consumables to each patient's application for treatment under the Aasandha scheme. This can be regarded as misuse of Aasandha. Healthcare providers redirecting the cost of everyday and emergency consumables to Aasandha as a result of budget distribution issues within the atolls can be seen as poor healthcare service at those health centres and hospitals.

With consumables sometimes, there is a delay in the supplier, the State Trading Organisation's (STO) delivery of the consumables to the health centres as they prioritise hospitals. So sometimes in HDh Atoll,

the hospital provides consumables to the health centres from their own stock and even vice versa. With syringes, in this atoll, this issue was a concern in the past but not anymore. Now they are obtained through Aasandha scheme, which confirms the earlier point about service providers redirecting costs to Aasandha issue raised by Aasandha member) from STO. Experience in Lh and HDh atolls suggests that in these atolls, the patients still have to go to pharmacies and collect the syringes. It transpires from the discussion that there is a difference between some atolls or between the atolls and the capital in this procedure, causing unnecessary inconvenience and delays in service in some parts of the region.

Other issues noted related services and resources included the unavailability of medicine in the islands. Although STO pharmacies operate on every island, the level and distribution of medicine stockists across the pharmacies in the islands and atolls may need further investigation and the issue could be one to do with the distribution chain and logistics. Everyday medicines such as antibiotics, medicines for Intensive Care Units or even Paracetamol are in shortage and it may take unreasonable amount of time before doctors' prescribed medicine are available from the pharmacies. This observation is also supported by existing research (Zeeniya, 2019). In one extreme case, due to non-availability of medicines, family members had to travel to another atoll to obtain emergency pre-birth injections and subsequently there was an unfortunate loss of an infant's life. The issue of medicines shortage may be widespread in the region and may include medicines not covered by Aasandha. Local pharmacists need to update their stocks or databases to synchronise with medication available with Aasandha and some complaints around unviability arises from this issue. The issue gets exacerbated because some doctors would prescribe only specific brands of medicine even when alternatives are available and what they prescribe is not always available resulting in the ordering of the medicine from Male' or the patient being referred to another region for treatment resulting in avoidable and unnecessary costs.

Participants felt Teleconsultation could be a good approach to service and it has been introduced as a response to Covid-19 in the atolls throughout the country. The scheme allows islanders to consult healthcare services in Male' without the need to travel. There appears to be plans to continue the initiative for a limited period and see how well it works. Some of the issues include the medication prescribed by the Male'-based teleconsultants appears to be what is available in Male' rather than in the islands, where the patients are based. This leaves the inconvenience of the patient having to arrange a way of obtaining the medicine from Male' and therefore the scheme is not fully realised as a viable solution for those based in the Northern atolls. A past initiative in 2012 to introduce telemedicine (a potentially more holistic practice than teleconsultations; WHO, 2010) including HDh did not work effectively because of difficulties in securing online consultants in Male'. Currently what is provided currently is Teleconsultation rather than Telemedicine. This scheme started during the Covid-19 pandemic, although a simpler approach is described by the HDh representative as more effective than the previous initiative. The reason is the

focus on arranging appointment for patients and ensuring that it takes place without fail at the appointed time. However, one issue that remains unsolved is that even though islanders can use online consultations provided by Male'-based healthcare providers, some of the local pharmacies do not seem to accept the prescriptions from online consultations.

Summary: Availability of Services and Resources.

The way to improve the services in the region is to ensure that the regional hospitals have the same level and quality of service as the major hospitals in Male' – that is to convert them to tertiary hospitals with full service including equipment, staffing, e.g.: specialists for common conditions and diseases such as cardiovascular diseases; surgeons for routine surgeries. Otherwise, at some stage of treatment, patients would need referring to Male' again. This is particularly relevant because the Maldives Health Master Plan 2016-2025 details an outcome to measure the percentage of population living "within 30-minute travel time to a referral hospital as an indicator for level of "access to specialty care" (MoH, 2014:52). It is not clear how performance against such outcomes is measured and disseminated to the public.

Despite the above argument for easy access to referral hospitals, participants recognised that highly specialist services may need to be reserved for national level hospitals in Male' to make economic and logistical sense. They also stressed that it is important to raise wider public awareness through better information dissemination regarding how services are designed to operate at different healthcare service providers and how an equitable service is prioritised.

5.2 Access to High Quality Doctors in the Region

The issue of service users' choice of service/hospitals in the atolls discussed in the previous topic (2.1) in this theme is connected to the quality of stationed doctors, consultants and as exemplified in the provision of basic services such as ultra-sound scans in pregnancies. More detailed analysis of HR issues is presented in Theme 2 above (Human Resources). In pregnancies, the quality of reports on scans provided by island-based consultants are identified by participants as not always of sufficient quality, resulting in the patients being referred to the capital, Male'. The patients in these situations experience extra costs, anxiety, travel-related inconveniences and unnecessarily delayed service not experienced by the residents of the capital.

The population from the local islands have only one choice (the nearest regional hospital), where there is usually a shortage of highly qualified specialists/consultants. In Lh Atoll, one participant suggested that island healthcare centres have only one doctor on duty in any 24 hours but should have at least two to be regarded as an adequate service. More island hospitals need specialist practitioners to avoid having to go to Male' or bigger hospitals for equity between the atolls and Male'. This issue of limited skilled health

personnel is recognised in the Maldives Health Masterplan 2016-2025, although at national level, doctors/population ratio is considered high at 1:609. To achieve this ratio in the northern atolls, the atolls should have between 22 and 40 doctors per atoll depending on the most recent registered population sizes in atolls as a guide (NBS, 2020). Alternative to stationed doctors could be regular healthcare visits to local populations, a service that has been in place in the Maldives since the 1970s. However, forum members feel that currently this service is almost non-existent in many islands in the region. This is an issue because in the Maldives Healthcare Quality Standards of 2018 (Srivastava and Prakash, 2018), there is a quality standard for establishing procedures for Home visits (Standard 16), including 3 home visits for pregnant women (Standard 11) and as part of out-reach services (Standard 24) by public health workers and other relevant healthcare workers. Therefore, a question arises as to how some islands in the region do not appear to benefit from home visits or out-reach healthcare visits when there are already established healthcare quality standards to ensure this service and in particular, when the Health Master Plan (MoH, 2014) specifies a vision to promote an outreach programme service targeting small atolls (Output 9). An immediate review of how well the Health Masterplan (2016-2025) has been implemented in the region needs to be carried out and publicised.

Some of the prescription and medicine availability issues discussed in section 1 above may be related to an absence of the Ministry's treatment guidelines for doctors although the necessary work for this may be underway. This is particularly relevant when there is a high turnover of doctor – a particular issue in the atolls in comparison to the capital, according to the participants. Atoll-based doctors would benefit from an induction or orientation program that covers prescribed medicines and stocks in local islands. Recently, a new policy has come into effect on doctors using generic functions to prevent the prescription of a particular brand of medicine (MoH, 2020). There is evidence of pharmacists practice changing even though some doctors continue to prescribe branded medicine. Pharmacists have begun to dispense the available medicine (of any brand) for the prescribed medicine. Participants believe this is the result of the new policy and that this practice by pharmacists would begin to address issues of medicine non-availability in local islands.

Summary: Quality of Medical Doctors

It appears that there is variability of access to outreach healthcare visits across the region. There is a need to review both the implementation of Standards, 11, 16 and 24 specified in the Maldives Healthcare Quality Standards 2018 as well as how Output 9 in the Masterplan has progressed in the seven Northern atolls. Progress has been made in improving access to medicine across the atolls due to the implementation of generic (as opposed to branded) medicine. However, the practice amongst some doctors, especially newly recruited doctors need investigation.

5.3 Political Influences in Service Provision.

Participants raised the issue or political influence disrupting equitable access to Aasandha, for example ineligible patients receiving financial support. The discussion revealed examples of incidents taking place at island health centres - not only in the process of referring to Aasandha but also in how the service is provided, for instance expediting some patients' pre-arranged referrals through political influence. Other examples include rejected Aasandha referrals later reviewed due to political connections and pressure. In healthcare queuing system when consulting doctors, very often some influential members of the public are allowed to bypass the queue system and receive service faster than others by passing procedures for issuing consultation memos.

It was felt that staff providing services may have to take some responsibility in inequality of service arising from nepotism, cronyism or political influence. It was recognised in the discussion that there is political influence affecting equality of service. A solution may be individual staff to be vigilant against such political influence and oppose such attempts to gain unfair advantage in receiving healthcare service at the expense of other members of the public. Individual responsibility and self-awareness could play a part too. A challenge is that those staff who oppose such political powers may face risk of job losses. However, there is no evidence of action (disciplinary or otherwise) taken against staff for following or declining political or undue requests in healthcare provision. If they do challenge such requests, it creates tension in work relations. Participants agree this issue is more to do with some influential people in society with access to knowledge about the established procedure for reviewing healthcare decisions while some in the public may not be aware of these procedures. Making sure that every single citizen has the required information about the established system for service is critical for equity. Healthcare professionals and organisations have a duty to relay this information to service users as a part of their regular daily practice. There is also a related issue of managers in healthcare provider organisations not being aware of the agreed procedure for frontline service provision and the implications for equitable healthcare provision when professional decisions are compromised for political reasons or for personal gain. In some cases, even though even if a given service is available locally in the atolls, some patients use political influence to get their case reviewed and be referred to the capital – this leads to a waste of local healthcare resources.

The practices mentioned above result in parts of the public who are not informed on bureaucratic procedures or who do not have close contacts at service providers being left disadvantaged in receiving services. Therefore, misuse of political positions is a cause of inequality.

To address the issues of equity, there is a need for those responsible for services to enforce and apply the relevant legislation and challenge unethical actions that contravene the law and legislation together with reducing possibilities for political intervention and influence in service provision. This can be achieved by holding individuals to account. However, there is a challenge that some staff have fears of

repercussion at work such as losing their jobs if they do not succumb to political requests within the system. Participants from all the atolls unanimously agreed that there is a need for individual and managerial responsibility and accountability. The system needs personnel who can enforce legislation and uphold the rules of law. Both service providers and service users need to collaborate in providing fair and equitable services free from political influence and interference.

Summary: 2.3 Political Influences in Service Provision

Political or undue influence is prevalent throughout the way Aasandha is managed and delivered to the public affecting equity of healthcare. It seems both management staff and frontline staff must address this issue in order to provide equitable service in the 7 atolls. A fundamental and related issue appears to be unequal access to information about Aasandha's procedures and processes. Better quality of information provision may begin to address the issue.

5.4 Conclusion and Recommendations: Equity of Healthcare Access

Based on the evidence from the forum and the subsequent analysis of relevant data, the forum concludes that:

- There is considerable amount of inequity in the health region
- Inequity exists in the North region in access to medicine, quality doctors, service providers, access to outreach health visits and the way Aasandha is implemented.

Forum participants noted that overall and in principle, equity in healthcare is enhanced through use of referring patients to different islands within the region depending on the service required. However, this process needs to be significantly improved and wider and more effective implementation of teleconsultations may be part of an improvement plan. The outreach access to healthcare, including antenatal visits need to be reviewed in order to identify islands and atolls where the service is failing to reach the expected standards. Aasandha service has been a welcome introduction; however, its implementation is a significant inequity issue arising from political and unfair influences, which make it difficult to deliver an equitable healthcare service in the region.

Based on the analysis of discussion during the forum and the subsequent analysis of relevant data, the forum makes the following five recommendations regarding addressing equity in healthcare in the Northern atolls:

1. Determine ways to Increase incentives for local doctors to work in the region.
2. Review the recruitment of doctors especially how some doctors with evidently poor basic medical knowledge get stationed in smaller islands in the region. The aim of this investigation would

be to ensure that agreed minimum unnegotiable standards are met by all doctors in the region and the planned budget needs to prioritise to ensure standard of doctors do not affect equity of service to all residents in the region.

3. Investigate how widespread is any unequal distribution of medicines and consequences to patients (including fatalities, increased risks to life) and take necessary procurement-related or procedural/logistical remedial action.
4. Carry out an immediate investigation into whether services provided by specific islands are affected by undue political influence; if they are, redress the issue to ensure all islands receive equitable service irrespective of any perceived local political alignment
5. Regularise evaluation of localised equity in healthcare using established equitable outcomes and measures in the Health Masterplan 2016-2025 (MoH, 2014); place of residence (capital versus rural) / regions as a factor in healthcare equity (WHO, 2006) and WHO's recommendations regarding localised medicine equity in the Maldives (WHO, 2020). Both the Masterplan and WHO recommendations emphasise on outcomes such as doctor-population ratio, access to neonatal care, and availability and distribution of services at local levels, not just at a national level.

Recommendations for Policy and Practice

The analysis of the overall recommendations allowed the forum to arrive at the following set of recommendations for healthcare policymakers and practitioners to consider under the 5 themes of trust, HR, legislation, affordability of healthcare and equity in healthcare. These recommendations are cross analysed across the recommendations within each of the theme to identify priority action, as highlighted throughout the recommendations below.

1. Trust

The following 10 recommendations could increase the level of trust and transparency in the service.

1. **PRIORITY ACTION:** Strengthen performance monitoring of public health sector as a priority (Trust, HR and Legislation). Related to this point there is a need to begin publishing performance related data and conduct assessment of affordability costs (see also, HR section below).
2. **PRIORITY ACTION:** Implement frameworks to pave the way for the roles of the healthcare provider and the regulator to be discharged by two independent bodies. The present administrative arrangement does not ensure independence between these two roles.
3. Introduce mechanisms to receive concerns and complaints (by both public and employees in the organisation) with a guaranteed feedback duration on the issues raised.
4. Introduce greater transparency on incidents of medical negligence and how these are reported to the public.
5. Introduce mandatory biennial refresher trainings for medical professional on "code of conduct" and legislation, for instance the Healthcare Act. There is a perception that medical professionals lack knowledge of the obligations and protections imposed on them by these guidelines.
6. The concerned authorities need to establish why still a larger population of the patients seeking medical treatment choose to travel abroad while treatments are available in the country. Discussions in Group 4 of the forum (Healthcare Affordability) suggest that the reasons could be increased costs and low quality of healthcare at primary and secondary healthcare centres but further research could explore these two factors.
7. Since travelling to an appointment is a challenge via sea transport and is subject to weather conditions for services in atolls, consider introducing measures to ensure patients' appointments will not be cancelled in cases where late arrivals are caused by adverse weather conditions. Such cases could be put on the queue for the following day or ask doctors for attendance for a delayed appointment and compensate the doctors for out of office hour services. This level of service would be welcome and increase the amount of trust in healthcare.
8. Conduct public awareness raising activities on available treatments and surgeries in the region and the country. Inform the public on the health care model implemented (general practitioner

model) in island health centres. Currently, there is a mistrust of the doctors in islands on their competence.

9. Distribute information on Aasandha scheme and NSPA, scheme limitation, fairness and coverage. There is a perception of inequality between cost coverage for treatment within and outside country - potentially due to lack of information amongst the public on the scheme. There is also a strong perception in the public that medical services abroad (for the same treatment) are superior compared to the in-country treatment and getting an appointment for a specialist is much easier if patients travel abroad for treatment. This perception has created a strong desire for the patient or patient representative to push for qualifications for Aasandha through any means possible, such as through networking and personal approach to medical professions to create a case for going abroad for treatments available within the country.
10. Publicise the availability of and greater push for usage of online consultation and implementation of specific days to be reserved for appointments for patients travelling from nearby islands to atoll or reginal hospitals. This service was also discussed as length as an important issue in Theme 5, Equity.

2. Human Resources

Seven of the recommendations would enhance the Human Resources for Healthcare (HRH)

1. **PRIORITY ACTION:** Identify creative ways to motivate the workforce and attract quality recruits; one way identified in the forum was to introduce study scholarships the completion of which will require graduates to work in the region's healthcare facilities. This was seen as a priority action as motivating the workforce and attracting highly qualified personnel were identified through the discussions in 3 of the forum's 5 themes: equity, human resources and legislation.
2. **PRIORITY ACTION:** There is an indication of a greater trust towards local doctors compared to expatriate doctors. Policy direction on increasing local capacity is required. There is no human resource health plan available at policy level, identifying at the very minimum, the local or region-specific needs. This topic of local doctors was identified in three themes of Trust, Human Resources and Equity and therefore, should be seen as a priority.
3. **PRIORITY ACTION:** Each regional hospital needs to be developed to a level that can cater for the islands around it, resourced with specialist doctors. Strengthen the referral system within and between the islands and the processes to deliver a service that is not discriminatory towards patients coming from other islands. This action is also a priority as it addresses issues of trust, HR and equity.
4. Strengthen the performance appraisal system of healthcare workers. This recommendation arose from discussions of issues in the themes of HR and legislation.

5. Revise recruitment processes to hire dedicated, experienced and well-harnessed doctors with MBBS qualifications. Each medical facility should have at least have one medical doctor, and nurses with varying speciality experience. During the hiring process, HR managers should cater for the identified speciality gaps in the HRH. Recruitment of doctors to the atolls was identified as an issue of equitable healthcare service. Review the recruitment of doctors, especially how some doctors with evidently poor basic medical knowledge are stationed in smaller islands in the region. The aim of this investigation should be to ensure that agreed minimum unnegotiable standards are met by all doctors in the region and the planned budget needs to prioritise to ensure standard of doctors do not affect equity of service to all residents in the region.
6. Arrange specialized mobile clinics at specified frequencies (for instance every quarter) in areas where certain ailments are persistent.
7. Modifying the tertiary education curriculum relevant to the medical field, especially planning for nurses to specialize in certain areas that are highly essential, and multi-disciplinary within the medical faculty.

3. Legislation

1. Consider new legislation on Occupational Health and Safety legislation to cover use of equipment, workers' safety in high-risk areas and to cover localised aspects of working in the various healthcare facilities in the region.
2. Amend the Care Profession Act (13/2015) to ensure indemnity for employees
3. Review Compulsory service – (service bond) to work in the atoll health facilities and the bond's implementation and effectiveness.
4. Consult Employment Act 2008 to review and add more clarity to employer/employee roles
5. Review Standard Operational Procedures for various healthcare services in the atolls.

4. Affordability of Healthcare

1. **PRIORITY ACTION:** In all 5 group discussions of the forum's focus areas of trust, HR, legislation, affordability of healthcare and equity, there was a unanimous agreement that an increase in uniformity of services across regional hospitals is a priority and is needed to reduce the burden on tertiary health service centres.
2. Increasing equity in the current Aasandha scheme by providing the same level of service for all with no exception
3. Increasing monitoring and oversight of cost approvals (for services, medical equipment and medicine)

4. Empowering and improving the skills of health service providers in the primary and secondary hospitals and health centres.
5. Risk pooling and consolidating services to decrease costs of service delivery
6. Introducing specialist camps throughout the country – and making regional hubs of excellence
7. Establish services focused on tourism sectors - decompression chambers
8. Introducing services for those with special needs and coverage of their medical accessories and medicine
9. Introduction of mental health centres and rehabilitation centres in regional and atoll hospitals.

5. Equity

The analysis of forum's data led to 6 recommendations to address inequity in the system.

1. **PRIORITY ACTION:** Investigate how widespread is any unequal distribution of medicines and consequences to patients (including fatalities, increased risks to life) and take necessary procurement-related or procedural/logistical remedial action. An effective mechanism needs to be provided to implement and monitor stocking and refilling of essential medicines. If mechanisms already exist, feedback should be taken from all pharmacies, hospitals and health centres to find out the challenges in the maintenance of adequate medical stocks and take the necessary remedial action. This issue of the availability of medication was a recurring priority theme in aspects of Trust, Affordability and Equity.
2. **PRIORITY ACTION:** Carry out an immediate investigation into whether services provided by specific islands are affected by undue political influence; if they are, redress the issue to ensure all islands receive equitable service irrespective of any perceived local political alignment. Part of the remedial action may be implementing measures to eliminate some patients' use of political influence or high-status positions to bypass procedures and guidelines to obtain medical services at the expense of other patient's entitlement. This issue of undue political action was seen to detract from levels of trust and equity in the system and therefore, it was seen as a priority action.
3. **PRIORITY ACTION:** Arising from the discussions throughout the forum, there appears to be a priority need to establish a reliable and timely transport mechanism to be made available between the islands. Such as system should have a general service and a separate emergency service, and modify policies for the local councils to be responsible and involved in ensuring that the transport system is functioning.
4. Determine ways to increase incentives for local doctors to work in the region (Themes: Trust and Equity)

5. Many health centres in islands lack basic medical tests such as complete blood count and this often forces people to make journeys that could have been avoided to nearby health facilities for very basic needs that could have been avoided. The cost of supporting such trips via Aasandha versus such tests being available in the islands needs to be established. (Themes: Trust and Equity)
6. Regularise evaluation of localised equity in healthcare using established equitable outcomes and measures in the Health Masterplan 2016-2025 (MoH, 2014); place of residence (capital versus rural) / regions as a factor in healthcare equity (WHO, 2006) and WHO's recommendations regarding localised medicine equity in the Maldives (WHO, 2020). Both the Masterplan and WHO recommendations emphasise on outcomes such as doctor-population ratio, access to neonatal care, and availability and distribution of services at local levels, not just at a national level.

Further research may be needed to see whether the above recommendations can be applied to the southern atolls too. Some recommendations related to aspects such as the management of Aasandha could apply to the whole nation but wider research focussing on collecting quantitative data to substantiate the findings of the Health Forum further may be the next step forward.

The Maldives healthcare system as a whole, like the rest of the world, has experienced an unprecedented amount of exposure to public users as a result of the Covid-19 pandemic (Sodiq, 2021). Therefore, the health forum, from a public policy review perspective regards the Healthcare system is presented with an important opportunity to review the service in the northern atolls as well as in the nation. Given that forum took place in the first year of the pandemic, the qualitative data and the recommendations that have surfaced as described above could be a useful set of evaluative resources to start from in achieving a more equitable healthcare system.

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