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OPTIMIZING NATIONAL HEALTH INSURANCE MEMBERSHIP REDISTRIBUTION TO REMEDIATE THE DELIVERY OF HEALTHCARE SERVICE IN THE BANGLI REGENCY

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ABSTRACT

The recent collaboration between the Indonesia Social Security Administrative Body (SSAB) and the Ministry of Health emanated the notion to optimize the National Health Insurance (NHI) membership redistribution program. This latest scheme aims to enable health access comprehensively and improve the healthcare service quality through equal member distribution in the primary care health facilities (PCHF). This was a descriptive study using an evaluation approach, summative, and observational design. A Context, Input, Process, and Product (CIPP) evaluation model was followed to assess the membership transfer redistribution scheme. Data were collected from February to March 2022 through observation, interview, and documentation techniques. Subsequently, the data were then analyzed using the CIPP Evaluation Model and Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis with Focus Group Discussion (FGD). Based on the CIPP evaluation, five and eight PCHFs were executing outstanding (>14,893 or 80.79%) and good level of transferring and receiving scheme practices (11,123 – 14,892 or 60%-79%), respectively. Thus, it could be argued that the membership transferring redistribution procedure has been delivered adequately. Regardless, we still encourage efforts to foster the monitoring and evaluation process. Further, future studies are suggested to include additional evaluation elements to provide a more thorough finding and allow constant membership redistribution program improvement, acquiring the program end goals to the fullest extent.

Keywords: Health Insurance, Redistribution, Remediate, Healthcare

1. INTRODUCTION

1.1. BACKGROUND

The redistribution program is an innovative agenda introduced by the Indonesia Social Security Administrative Body (SSAB) or *Badan Penyelenggara Jaminan Sosial* (shortened as *BPJS* in Bahasa Indonesia) and the Ministry of Health to habilitate the national healthcare system with its primary intention to enable equal health access and enhance healthcare quality. The establishment of this

program manifests vital health system reformation points elaborated on Article Number 7 Paragraph 4 in Presidential Regulation Number 82 of 2018 on Health Insurance which has encountered several revisions with the last amended version drafted in the Presidential Regulation Number 64 of 2020 on the Second Revision of Presidential Regulation Number 82 of 2018 on Health Insurance. It pinpoints the redistribution needs and its corroborating circumstances, as it declared: "due to the unevenness number of participants registered at a Primary Care Health Facilities (PCHF or *Fasilitas Kesehatan Tingkat Pertama*, abbreviated as FKTP in Bahasa Indonesia), SSAB for Health could redistribute them to another PCHF by carefully considering the number of registered participants, the availability of doctors, health workers other than doctors, and its facilities" Endartiwi and Setianingrum (2019). Responding to this mandate, SSAB for Health subsequently released the SSAB for Health Regulation Number 4 of 2019 concerning the Transfer of National Insurance Participants at the PCHF SSAB (2021).

The total population of Bangli Regency in 2022 was 254,890 people, where 226,569 of them have subscribed to the National Health Insurance (NHI) membership scheme. In that case, several health facilities have been established as PCHF. It is comprised of 12 Public Health Centers (PHCs) (five equipped with inpatient care facilities and seven with standard health care service), 12 primary clinics, 69 clinics handled by the independent physician practice (44 general practitioners, 12 dentists, and 13 specialist medical practitioners), 61 health facilities run by the independent midwife practice, and 15 clinics run by the independent general nurse practitioner (Division of Health Services and Resources of Bangli Local Health Department, 2022). However, data from the SSAB of Bangli Regency later revealed the lop-sided NHI membership distribution with the physician ratio in each PCHF from the year 2018-2021. There was a 30 to 35% gap between the number of NHI members registered in public-owned health facilities (PHC) and the other PCHF. A higher number of NHI participants was generally registered in PHCs SSAB of Bangli Regency (2022).

The membership transferring procedure sequence of SSAB for Health's member redistribution in PCHF begins with the establishment of the transferring and receiving PCHF that was conducted by carefully considering: 1) physician ratio, 2) member number limit, 3) credentialing achievements, 4) back-referral program, 5) Performance-Based Capitation, 6) compliance, 7) referral ratio, 8) the availability in targeted PCHF, 9) declaration of support from the Local Government/Health Department, 10) the map of targeted members jointly designed with the Regional Government and 11) coordination with the Regional Government and/or Health Facilities Association. The subsequent procedure conducted is the membership transferring process that would be terminated by the monitoring activity (monthly), evaluation (once in three months and at a minimum twice a year), and remediation actions if required SSAB (2021).

SSAB (2022) reported that Performance-Based Capitation Coverage, an NHI performance indicator coverage employed in Bangli Regency, was 90% in 2021. This figure signified a number of unabsorbed budgets of IDR 1.1 billion. Further, the referral ratio of PCHF in 2021 was 19.60%. Referring to the SSAB referral ratio standard of 15% of the total sick or healthy patient visitation, this number was pretty high. Additionally, the compliance coverage was only 87.93%, while SSAB for Health set a solid 100% coverage in this evaluation standard SSAB (2022).

Phase 1 of SSAB for Health member redistribution in PCHF was directed in August 2022. The mapping model of the PCHF that would transfer and accept 4,000 NHI members was previously prepared with strict performance-based indicators

Bangli Regency Local Health Department (2022). The transferring PCHF was PHC of Susut I, PHC of Bangli Utara, PHC of Tembuku I, and PHC of Tembuku II. These NHI members would be redistributed to the following PCHF: (1) Primary Clinic of Bangli Medika Canti and (2) Independent Physician Practice Clinic of dr. Ida Bagus Udayana Hanggara Bangli Regency Local Health Department (2022).

2. OPTIMIZATION OF NHI MEMBERSHIP REDISTRIBUTION

2.1. DEFINING THE NHI MEMBERSHIP REDISTRIBUTION

The NHI membership redistribution is the effort to enable equal distribution of the number of the registered members in all health facilities that cooperate with SSAB in a geographical area according to predetermined indicators of health services Hendrawan et al. (2021).

Mukti (2021) mentioned that NHI member redistribution should have been done comprehensively through related stakeholder coordination, thorough analysis of the PCHF that would transfer and accept, the fixed establishment of members that would be transferred, and the transfer mechanism to achieve the redistribution goals effectively.

The redistribution scheme will affect the member's health access and the physician's workload, which sequentially influences the quality of healthcare services. Four aspects that determine the proportion suitability of the number of registered members per physician are: 1) capacity calculation (including service time per patient, number of physicians, and ideal population), 2) formularies and facility resources, 3) analysis of utilization rate and physician productivity, and 4) ideal patient panel calculation based on the number of active physician practices Otang and Arfandi (2018).

2.2. THE PROGRAM OPTIMIZATION

In the recent paper, the term evaluation and supervision shares an identical definition. Evaluation or supervision aspires to construct knowledge and make decisions or initiate proper efforts to improve the program process or outcomes. Its findings would be a crucial basis for program optimization. Several benefits from the program evaluation and supervision could be exemplified in several forms: (1) program termination, (2) program revision, (3) program continuation, and (4) program dissemination Laily (2021).

2.3. THE CIPP EVALUATION MODEL

The CIPP evaluation model assesses the element of Context, Input, Process, and Product of an activity, providing rational judgments about its significance. CIPP is the literal abbreviation of its own elements: context (C), input (I), process (P), and product (P) evaluation Gunadi (2014). These are linear backbone elements. Thus, the evaluation process using this model should have been executed from the context to input, then to the process, and lastly to the product evaluation. CIPP evaluation was initially developed by Daniel L. Stufflebeam and has been broadly adopted worldwide to asses miscellaneous subjects and services, such as education, housing, community engagement and development, transportation, and military personnel evaluation Arikunto (2008).

3. STUDY METHOD

This was a descriptive study employing an evaluation approach, summative design, and observational method. This study was conducted in Bangli Regency, Bali, Indonesia, with a total region of 520,81 km^2. Eight health facilities were set as transferring PCHFs (PHC of Susut I, PHC of Susut II, PHC of Bangli Utara, PHC of Tembuku I, PHC of Kintamani I, PHC of Kintamani II, PHC of Kintamani IV, and PHC of Kintamani V) and the other five health facilities were established as the receiving PCHFs (Independent Physician Practice Clinic of dr. Ida Bagus Udayana Hanggara, Primary Clinic of BMC, Primary Clinic of Bangli Husada Sejahtera, Primary Clinic of Windusara, and Primary Clinic of Kesuma Husada). These health facilities were selected according to the mapping model developed by SSAB of Bangli Regency and the Local Health Department. Forty-two participants were recruited from these first level health facilities.

3.1. THE DATA TABULATION AND STUDY INSTRUMENT

The study data collection technique included:

1) **Observation:** technique involves systematic watching and recording activities of the visible elements of particular study objects or features appearing due to phenomena.
2) **Interview:** conducted by using a questionnaire that is complete and systematically organized to gather the study data Sugiono (2010)
3) **Documentation:** Arikunto. (2008) defined documentation as a technique to compile information about the study variables through field notes, transcriptions, textbooks, newspapers, magazines, modules, minutes of meetings, agenda, etc.
4) **Focus Group Discussion (FGD):** Participants were also requested to participate in FGD sessions. The FGD participants were selected using a purposive sampling technique and represented the transferring PCHFs, receiving PCHFs, Local Health Department of Bangli Regency, SSAB of Bangli Regency, NHI members, and local authority figures. Researchers also partook in the FGD sessions as the representative from the Ministry of Health of the Republic of Indonesia, simultaneously delivering a monitoring and evaluation of NHI Membership Redistribution in Bangli Regency. This FGD sessions expected to generate complete and yield multiple perspectives in addressing the study objectives.

3.2. DATA ANALYSIS

The CIPP evaluation model need to follow the linear evaluation process on the four major components in the model, as follows Arikunto. (2008):

1) Context Evaluation (context) provides information for the needs, asset issues, and opportunities for the decision-making process, designating the goals and priorities, and assisting the group to make broader decisions, priorities, and outcomes.
2) Input Evaluation (input) offers the examination of the approach alternatives, program implementation plan, resources provision, adequate funding needs and physical requirements for achieving the desired goals.

3) Process Evaluation (process) evaluates the implementation strategy plans to provide information necessary for the program execution, assesses the program performances, and interprets the outcomes.
4) Product Evaluation (product) identifies and assesses the short and long-term outcomes to emphasize the intended major and end program goals. It also measures the extent of progress that has been made in meeting the pre-established goals.
5) After the CIPP evaluation, a SWOT analysis with the Focus Group Discussion (FGD) was subsequently performed.

4. RESULT AND DISCUSSION

4.1. CONTEXT EVALUATION (C) OF THE NHI MEMBERSHIP REDISTRIBUTION PROGRAM

Table 1

Table 1 Findings from the Evaluation on the Program Context Component

		Variable			
No	**Health Facility**	**Program Goal**	**Program Target**	**Juridical Basis**	**Total Variable Sum**
1	Health Facility 1	100	80	60	240
2	Health Facility 2	80	80	60	220
3	Health Facility 3	80	80	80	240
4	Health Facility 4	80	80	80	240
5	Health Facility 5	100	100	60	260
6	Health Facility 6	100	80	80	260
7	Health Facility 7	80	80	80	240
8	Health Facility 8	60	80	80	220
9	Health Facility 9	100	100	80	280
10	Health Facility 10	80	80	80	240
11	Health Facility 11	80	60	80	220
12	Health Facility 12	80	80	80	240
13	Health Facility 13	100	80	80	260
	Score Total	1120	1060	980	3160
	Assessment Category	Very Good	Very Good	Good	Very Good

Range	Interval	Variable Interval	Variable Value Sum Interval
Very Good	80% - 100%	>1028	>3082
Good	60% - 79%	768-1027	2302 - 3081
Moderate	40% - 59%	508-767	1522 - 2301
Poor	20% - 39%	261-507	781 - 1521
Very Poor	0 - 19%	260	780

Source Primary Analysis

Table 1. shows that the context component evaluation of NHI membership redistribution program in Bangli Regency was in the very good category.

4.2. INPUT EVALUATION (I) OF THE NHI MEMBERSHIP REDISTRIBUTION PROGRAM

Table 2

Table 2 Findings from the Evaluation on the Program Input Component

		Variable				
No	**Health Facility**	**Participation**	**Redistribution Program Financing**	**Redistribution Flow**	**Human Resources in the Redistribution Program**	**Total Variable Sum**
1	Health Facility 1	150	120	120	120	510
2	Health Facility 2	120	120	120	90	450
3	Health Facility 3	120	120	120	60	420
4	Health Facility 4	120	120	120	120	480
5	Health Facility 5	150	120	150	60	480
6	Health Facility 6	150	120	120	30	420
7	Health Facility 7	120	120	120	60	420
8	Health Facility 8	120	120	120	120	480
9	Health Facility 9	150	120	120	90	480
10	Health Facility 10	120	120	120	120	480
11	Health Facility 11	120	120	90	120	450
12	Health Facility 12	120	120	90	120	450
13	Health Facility 13	150	120	120	120	510
	Score Total	1710	1560	1530	1230	6030
	Assessment Category		Very Good	Very Good	Good	Very Good

Range	Interval	Variable Interval	Variable Value Sum Interval
Very Good	80% - 100%	>1542	>6163
Good	60% - 79%	1152-1541	4603 - 6162
Moderate	40% - 59%	762-1151	3043 - 4602
Poor	20% - 39%	391-761	1561 - 3042
Very Poor	0 - 19%	390	1560

Source Primary Analysis

Table 2 reveals that two input variables were in the very good category: (1) cross-program and cross-sectoral participation and (2) program financing. Further, the other variables: NHI membership redistribution flow and human resources were classified into the good category. Hence, the input evaluation showed the

overall input variable of the NHI membership redistribution program in Bangli Regency was in a good category.

4.3. PROCESS EVALUATION (P) OF THE NHI MEMBERSHIP REDISTRIBUTION PROGRAM

Table 3

Table 3 Findings from the Evaluation on the Program Process Component

		Variable			
No	**Health Facility**	**Planning**	**Implementation**	**Monitoring, Evaluation, and Remediation Action**	**Total Variable Sum**
1	Health Facility 1	120	120	120	360
2	Health Facility 2	120	120	90	330
3	Health Facility 3	120	120	150	390
4	Health Facility 4	120	90	120	330
5	Health Facility 5	120	120	120	360
6	Health Facility 6	120	60	120	300
7	Health Facility 7	120	60	120	300
8	Health Facility 8	120	120	120	360
9	Health Facility 9	120	120	150	390
10	Health Facility 10	120	120	120	360
11	Health Facility 11	120	90	120	330
12	Health Facility 12	120	120	120	360
13	Health Facility 13	120	120	120	360
	Score Total	1560	1380	1590	4530
	Assessment Category	Very Good	Very Good	Good	Very Good

Range	Interval	Variable Interval	Variable Value Sum Interval
Very Good	80% - 100%	>1542	>4623
Good	60% - 79%	1152-1541	3453 - 4622
Moderate	40% - 59%	762-1151	2283 - 3452
Poor	20% - 39%	391-761	1171 - 2282
Very Poor	0 - 19%	390	1170

Source Primary Analysis

Table 3 shows that the variable of (1) planning and (2) monitoring, evaluation, and remediation action were in desirable conditions, a very good category. The variable of NHI membership redistribution implementation was in a good category. The complaint management, as a part of the redistribution implementation variable, was still inadequate, however, participants specified that this component was in relatively acceptable condition. Thus, the process evaluation confirmed the overall process variable of the NHI membership redistribution program in Bangli Regency was in the good category.

4.4. PRODUCT EVALUATION OF (P) OF THE NHI MEMBERSHIP REDISTRIBUTION PROGRAM

Table 4

Table 4 Findings from Evaluation on the Program Product Component

No	Health Facility	Variable	Total Variable Sum
		Finding	
1	Health Facility 1	80	80
2	Health Facility 2	60	60
3	Health Facility 3	80	80
4	Health Facility 4	80	80
5	Health Facility 5	100	100
6	Health Facility 6	80	80
7	Health Facility 7	60	60
8	Health Facility 8	60	60
9	Health Facility 9	100	100
10	Health Facility 10	80	80
11	Health Facility 11	80	80
12	Health Facility 12	80	80
13	Health Facility 13	100	100
Score Total		1040	1040
Assessment Category		**Very Good**	**Very Good**

Range	Interval	Variable Interval	Variable Value Sum Interval
Very Good	80% - 100%	>1028	>1028
Good	60% - 79%	768-1027	768-1027
Moderate	40% - 59%	508-767	508-767
Poor	20% - 39%	261-507	261-507
Very Poor	0 - 19%	260	260

Source Primary Analysis

4.5. THE CONTEXT, INPUT, PROCESS, & PRODUCT (CIPP) EVALUATION OF NHI MEMBERSHIP PROGRAM REDISTRIBUTION

The CIPP Model evaluation revealed that the membership transferring redistribution program has been delivered adequately. This program was initiated by creating the mapping model for the PCHF that transferred and received the membership. Eight and five transferring and receiving PCHFs were set, respectively. Improvement is required in several evaluation components in moderate category to achieve desired end product and goals, as shown in Table 5.

Table 1 CIPP Evaluation Model on NHI Membership Redistribution Program in Bangli Regency in 2023.

Table 5

Table 5 Findings from Program Evaluation on the Context, Input, Process, & Product (CIPP) Components

No	Assessment Component and Variable	Health Facility													Score Total	Assessment Category
		1	2	3	4	5	6	7	8	9	10	11	12	13		
Context																
1	Goals	100	80	80	80	100	100	80	60	100	80	80	80	100	1120	Very Good
2	Targets	80	80	80	80	100	80	80	80	100	80	60	80	80	1060	Very Good
3	Juridical Basis	60	60	80	80	60	80	80	80	80	80	80	80	80	980	Good
Context Total Score		240	220	240	240	260	260	240	220	280	240	220	240	260	**3160**	**Very Good**
Input																
1	Program Financing Participation	150	120	120	120	150	150	120	120	150	120	120	120	150	1710	Very Good
2	Redistribution	120	120	120	120	120	120	120	120	120	120	120	120	120	1560	Very Good
3	Redistribution Flow	120	120	120	120	150	120	120	120	120	120	90	90	120	1530	Good
4	Human Resources	120	90	60	120	60	30	60	120	90	120	120	120	120	1230	Good
Input Total Score		510	450	420	480	480	420	420	480	480	480	450	450	510	**6030**	**Good**
Process																
1	Planning	120	120	120	120	120	120	120	120	120	120	120	120	120	1560	Very Good
2	Implementation	120	120	120	90	120	60	60	120	120	120	90	120	120	1380	Good
3	Monitoring, Evaluation, and Remediation Action	120	90	150	120	120	120	120	120	150	120	120	120	120	1590	Very Good
Process Total Score		360	330	390	330	360	300	300	360	390	360	330	360	360	**4530**	**Good**
Product																
1	Outcomes	80	60	80	80	100	80	60	60	100	80	80	80	100	1040	Very Good
Product Total Score		80	60	80	80	100	80	60	60	100	80	80	80	100	**1040**	**Very Good**
CIPP Total Score		1190	1060	1130	1130	1200	1060	1020	1120	1250	1160	1080	1130	1230	**14760**	**Baik**

Assessment Category	Very Good	Good	Good	Good	Very Good	Good	Good	Good	Very Good	Very Good	Good	Good	Very Good	

Range	Interval	Variable Interval	Variable Value Sum Interval
Very Good	80% - 100%	>1147	>14893
Good	60% - 79%	857-1146	11123 - 14892
Moderate	40% - 59%	567-856	7353 - 11122
Poor	20% - 39%	291-566	3771 - 7352
Very Poor	0 - 19%	290	3770

Source Primary Analysis

Overall CIPP evaluation classified five and eight PCHFs in very good and good categories, respectively. These findings also showed that the higher category was associated with better and more proportionate NHI membership redistribution. CIPP provided a comprehensive evaluation of the redistribution program because it assessed all program components, the context, input, process, and product, identifying the intercorrelation between the component as a system Gunadi. (2014).

4.6. FOCUS GROUP DISCUSSION (FGD)

To achieve high-quality and equal healthcare access in Bangli Regency, the NHI membership distribution impartiality is clearly required. It begins by generating even membership distribution at the PCHF level which could be achieved by delivering specific efforts at three different levels: the coordinator (Local Health Department, SSAB for Health), the executor (PCHF that transferred and received the NHI members), and the target (NHI members). The Focus Group Discussion (FGD) sessions were conducted separately, engaging the transferring and receiving PCHFs, the cross-sectoral institutions in Bangli Regency, the cross-sectoral institution in Bali Province, the Ministry of Health, SSAB of Bali Regency, and the Bangli Regency Regent. Balitbang. (2016), Dewi (2019), Notoadmojo (2003)

4.7. NHI MEMBERSHIP REDISTRIBUTION STRATEGIES

The program strategy was situated in the second SWOT quadrant, which signified the strong program position but with potential threats. It subsequently developed into the ST strategies:

1) Effectively delegate the works to put the NHI membership redistribution conceptualization in adequate practices from the local level to the program target.
2) Establish cross-sector and program partnerships or engagements. Also, it is important to cultivate the organizational commitment in understanding the NHI membership redistribution program implementation.
3) Improve and sustain improvement efforts toward the comprehensive, high-quality and health care access through cross-sector and program engagements.
4) Engage key local and national stakeholders through advocacy efforts to prepare technical policy guidelines as the legal foundation for the NHI membership redistribution implementation.

5) Setting-up monitoring and evaluation with tight standards by proposing members' satisfaction as the front-line component as they are an important NHI beneficiary.

5. CONCLUSION AND RECOMMENDATION

5.1. CONCLUSION

1) CIPP Evaluation Model revealed that NHI Membership Redistribution Program in Bangli Regency has been aligning with the standard operational procedure mandated in the Regulation of SSAB for Health Number 4 of 2019 on The Flow of NHI Membership Transfer at the Primary Care Health Facility. Regular evaluation is required to improve the working performance in the evaluation component. It could be conducted every three months by the Local Health Department and SSAB to ensure the attainment of desired end products and goals.
2) Three recommendation models for the NHI Membership Redistribution Program in Bangli Regency were organized based on findings from the FGD sessions. These models also could be proposed as the basic framework for the redistribution program at the national level. Here are three recommendation models for the program.

- **The Coordinator Level**

Meticulous and detailed strategies are the central elements that piloted this recommendation model. Profound and persistent advocacy endeavors with the regional authorities and the regional legislative councils are critical to facilitate the issuance of technical program implementation policies, address financing needs, and enable cross-sectoral or cross programs coordination. Information dissemination and more intensive education efforts targeting the public is the further action required to introduce the membership redistribution program. The successful redistribution program would occur if NHI members notice the upgraded quality and discern the health access improvement in PCHF who received the membership after the transfer procedure. Post-Transfer Accompaniment could be an alternative to evaluate and observe the implementation of NHI membership redistribution.

- **The Executor Level**

The health facility's performance, both in the transferring or receiving PCHFs, will be observed through the performance-based capitation indicator. The decision for the NHI redistribution membership is designated based on findings from the assessment of this indicator. This level serves a crucial part in successful redistribution program implementation.

- **The Target Level**

NHI Members, as the target of the NHI Membership Redistribution Program, are granted the power and right to transfer their membership according to the PCHF mapping model provided by the SSAB and Local Health Department. The transferring process should be done on one own's initiative. The members are suggested to transfer their membership through the NHI WhatsApp Contact and NHI Mobile Application. Three months after the transfer process, they could revisit their PCHF choices. The crucial idea in this model is the presence of NHI members that would become the evaluation means to assess the health facility's performance.

Their satisfaction with the health service provision under the PCHF who received their membership would be the fundamental element at this level.

5.2. RECOMMENDATION

1) For the Local Health Department of Bangli Regency

As a local health stakeholder, the Local Health Department of Bangli Regency suggested organizing a more selective and practical transferring and receiving PCHF mapping model by precisely referring to the performance indicator. Additionally, the local health department also bears a critical role in emanating new program policies at the local level to complement or foster program implementation, such as the regional or regent regulations. Further, the local health department could be more proactive in proposing policies to the national level stakeholders or policymakers, especially to the Ministry of Health of the Republic of Indonesia, driving more tailored policies release that support program implementation with more imperative references and rationales.

2) For the SSAB for Health

To sufficiently implement the NHI membership redistribution program, official policies and the implementation-technical guidelines are urgently required. In addition, the establishment of teams that are particularly in charge of periodic supervision and evaluation presents significant benefits as they would catch discrepancies between the expected outcomes and actual implementation, minimizing program implementation missteps.

3) NHI Members

The PCHF transfer only could be conducted according to the mapping model provided by the SSAB for Health. NHI members are suggested to independently transfer their membership through the NHI Mobile Application or Pandawa NHI WhatsApp Contact. NHI members shall ensure the sufficient fulfillment of their promulgated membership duty. NHI members are also expected to use their opportunity to proactively assess the provision of healthcare service provided in the PCHF that received their transferred membership, especially in the first three months after the transferring procedure.

CONFLICT OF INTERESTS

None.

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None.

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