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Implementation Research for UHC in Practice

A Series of Technical Briefs Based on Lessons Learned from the Field in Myanmar and Indonesia

Part 2: Defining and Designing the IR

About this Series

This is the second in a three-part series of technical briefs on Implementation Research for Universal Health Coverage (IR for UHC) in practice. The series aims to make IR more tangible and accessible to a wide audience of donors, researchers, and country stakeholders implementing reforms to achieve UHC, and to stimulate the use of IR findings to strengthen UHC reform policies and implementation. The three briefs seek to provide a near real-time synthesis of the Health Finance and Governance (HFG) project's experiences with and lessons learned from applying IR

principles and best practices¹ to UHC activities in Myanmar and Indonesia, two countries at very different stages of rolling out UHC reforms.

The first brief described laying the groundwork for this type of IR. This second brief shares the process for defining and designing IR for UHC in each country to ensure real-time use of findings to improve implementation. Included are insights from HFG's IR partners in Myanmar (Population Services International and the Myanmar Ministry of Health and Sports) and in Indonesia (the Center for Health Policy and Management at the University of Gadjah Mada).

¹ Using as reference: David H. Peters, and Nhan T. Tran, Taghreed Adam, *Implementation Research in Health: A Practical Guide*. (Alliance for Health Policy and Systems Research, World Health Organization, 2013).

Highlights from Brief #1: Laying the Groundwork for IR for UHC

- IR is well suited to the complexity of UHC initiatives on stakeholder engagement and actionable learning in real time
- IR should be an ongoing stakeholder-driven process, not a time-limited research project
- Laying the groundwork for IR for UHC has four steps: gaining buy-in and trust, engaging diverse stakeholders, narrowing the focus, and ensuring local partner leadership
<https://www.hfgproject.org/ir-uhc-part-1-laying-groundwork/>

Country Contexts

Myanmar and Indonesia are at different stages of rolling out UHC reforms, and are undergoing different political and economic transitions.

Myanmar: A shifting political landscape offers promise but requires patience

Myanmar is a complex, challenging, and rapidly changing environment. After many decades of military rule, the first freely elected government took office in April 2016.

To provide guidance to the incoming government, the winning party's National Health Network prepared a "Program of Health Reforms – A Roadmap Towards Universal Health Coverage in Myanmar (2016–2030)." The program recommends that IR be institutionalized to support implementation of the reforms. In his inaugural speech, the new Minister of Health and Sports, H.E. Dr. Myint Htwe, explicitly highlighted the importance of IR twice. Nine months later, in December 2016, the Ministry of Health and Sports (MoHS) officially disseminated the new National Health Plan (NHP) 2017–2021. The NHP's main goal is to extend access to a basic Essential Package of Health Services (EPHS) to the entire population by 2020 while increasing financial protection. In early 2017, MoHS also established the NHP Implementation Monitoring Unit (NIMU), which will help orchestrate and track progress in the

execution of the NHP. IR is an important part of the NHP's monitoring and evaluation framework.²

A new and promising opportunity: Building IR into the country's first strategic purchasing pilot

Population Services International (PSI) runs Sun Quality Health (SQH), a large social franchise network in Myanmar. SQH aims to improve and standardize quality of care among private General Practitioners (GPs). In early 2017, PSI started piloting a new method to pay SHQ GPs to deliver an enhanced package of primary care services. The package mirrors, to the extent possible, the services and interventions included in the basic EPHS for UHC being developed by MoHS. This demonstration project involves a limited number of Yangon Region-based GPs who are in the SQH network. With financial support from development partners, PSI is purchasing this package of services from participating providers using a combination of capitation payments and performance-based incentives, replacing the current system in which patients are charged on a fee-for-service basis.

Relevance for UHC

The new government recognizes the need to engage and oversee private service providers to ensure that the entire population can access the basic EPHS without suffering financial hardship. This need was explicitly highlighted in the Program of Health Reforms prepared by the National Health Network and in the Minister of Health and Sport's inaugural speech. It is now also reflected in the NHP 2017–2021 that was officially launched by the State Counsellor, Aung San Suu Kyi, on March 31, 2017.

The PSI demonstration project contributes to building a platform for addressing this need. It fits perfectly into the broader strategy to engage non-MoHS health providers, as described in the NHP.

² Efforts initiated in 2015 to build IR into the implementation of the World Bank-supported Essential Health Services Access Project (EHSAP) – described in the first brief of this series – did not come to fruition. Even though two local organizations associated with MoHS, the University of Public Health (UoPH) and the Department of Medical Research (DMR), were keen to collaborate on the IR, official approval from the central level of MoHS could not be obtained. An alternative entry point for UHC-related IR was identified.

Indonesia: Making progress toward UHC, but facing many challenges

Indonesia is in its fourth year of a five-year roadmap to roll out its ambitious national health insurance scheme, known as Jaminan Kesehatan Nasional (JKN), as a central part of its strategy to achieve UHC. JKN aims to integrate the numerous district-level insurance schemes and cover the country's population of over 250 million by 2019. President Joko Widodo has remained committed to pursuing UHC as part of his administration's goals of increasing equity and reducing poverty in Indonesia.

Despite the political commitment, however, implementation of JKN has faced a range of complex challenges, some in line with any ambitious health reform and some unique to Indonesia's decentralized health system and political and economic context. The challenges have included ensuring adequate infrastructure and quality of service delivery, enrolling and collecting premiums from the informal sector, paying providers effectively, and communicating and clarifying how the new sets of regulations will work for government institutions, providers, and beneficiaries alike.

In this context, IR can be a useful mechanism for understanding the underlying obstacles to implementing the JKN insurance scheme, and to translating national JKN policy into implementation actions at the decentralized level. In particular, the Indonesian Ministry of Health is looking to implementation research to engage multiple stakeholders at national and district levels in the challenging task of strengthening of primary care as the gatekeeper of JKN.

Moving from Groundwork to Design

Myanmar:

Demonstration project offers a logical role for IR

PSI's initial intention was to attach a strong evaluation component to this experiment, which would allow testing a limited number of relatively broad hypotheses. HFG is now collaborating with PSI to build IR into the demonstration project. Given that this is meant to be a demonstration project and that PSI is venturing into uncharted territory (at least for Myanmar), it is critical to build in a continuous feedback loop that can help elucidate what works as planned and what does not, and why, and that allows timely corrective measures to be taken to put implementation back on track. IR will also inform future roll-out to other health care providers (not only GPs, but also potentially NGOs and ethnic health organizations) and possible absorption of the purchasing function by a government entity or a semi-autonomous body. Moreover, building IR into this demonstration project will provide valuable lessons that will help institutionalize IR as part of the broader monitoring of NHP implementation. The NHP Implementation Monitoring Unit, established under the Minister's Office to track the execution of the NHP, will be actively involved in the IR.

Design of IR strengthened the design of the demonstration project

The process of designing IR can force a more critical review of the project or reform to be implemented. For example, IR requires a causal model of how the different components of the project are expected to help realize the project's objectives. The development of such a causal model for PSI-Myanmar's demonstration project raised questions about some of the design choices that had been made, which in turn led to improvements in the design of the demonstration project.

Implementation of the demonstration project, whereby capitation payments start flowing to selected GP clinics, started in early 2017. Many critical preparatory steps that directly impact implementation needed to be accomplished prior to that. These include, for example: the selection of the project sites in Yangon Region; the selection of GP clinics that are part of the SQH network and that are willing to participate in the demonstration project; the definition of the actual benefit package; the design and testing of the information system (e.g., what information will

participating GPs need to and be willing to share and how); the determination of the payment arrangements (i.e., the capitation amount and the performance-based incentives); the design of a mechanism to identify and possibly target the poor; the actual identification, recruitment, and registration of card-holders, and so forth. Each of these steps required a considerable amount of information on the context. IR contributed to a better understanding of relevant contextual factors and how they influence the choices that were made. In addition to making implementation more effective, this understanding will also help strengthen the future design of a scaled-up program. Understanding the rationale behind decisions made during the demonstration phase and its design will prevent having to reinvent the wheel and/or repeat the same mistakes during subsequent scale-up.

...and vice versa: The project design process can help shape IR

Some of the tasks that need to be carried out during the design phase of a demonstration project help define and narrow down the focus of IR. A good example is the determination of the provider payment arrangements in the Myanmar pilot. While capitation payments will offer multiple advantages over the existing system, in which patients are charged on a fee-for-service basis, they come with their own limitations. This is precisely why in this demonstration project capitation payments are combined with performance-based incentives: to the extent possible, the latter are to compensate for the weaknesses of the former. The starting point for the development of the performance-based incentive system was therefore to think carefully about what those weaknesses are. Where do capitation payments fail to introduce (sufficient) incentives to motivate desired behaviors, and where do they actually introduce perverse incentives? The next step was to assess whether and how performance-based incentives can help better align the incentives. This exercise resulted in a long list of anticipated changes in the behavior of service providers, some but not all of which are expected to be influenced by performance-based incentives. Whether or not these anticipated changes are observed in reality is an important question that IR can help investigate. The findings can then guide periodic revisions to the payment arrangements.

Structuring IR to be used and institutionalized by adopting a long-term perspective from the start

This demonstration project has a duration of 12 to 18 months. Yet, it represents only a first step in the long process of engaging private providers in the delivery of the EPHS. Rather than focusing solely on this demonstration project, HFG is facilitating the adoption of a long-term perspective from the start. To do so, it supports the development of a scale-up plan and the establishment of an accompanying Scale-Up Task Force. Having a dedicated team with a clear plan in place will contribute to securing buy-in from the different stakeholders and to getting them to agree on next steps and on their respective roles and responsibilities. The members of the Scale-Up Task Force represent the different key stakeholders, including, among others, MoHS, the Myanmar GP society, development partners, and civil society. This team oversees the IR: it is involved in defining relevant IR questions, identifying suitable research methods to investigate those questions, and acting on IR findings. Moving forward, it will be well positioned to learn from the demonstration phase and support replication and expansion. It will also be able to formulate recommendations relating to the future take-over of the purchasing function by a government or semi-autonomous entity.

Indonesia: Shaping research design through consensus while facilitating a learning culture

Building on the groundwork

As described in the first brief, the time taken to lay the groundwork for IR for UHC in Indonesia was well spent in terms of putting the key elements of the IR in place: a primary Government of Indonesia (GOI) counterpart to own the IR, participants in a multi-stakeholder technical working group to shape the IR, a local research partner to carry out the IR, a topic reflecting shared concerns around JKN implementation, and target districts for the IR fieldwork.

Involving the IR implementers

The Ministry of Health (MOH) Center for Health Financing & Health Security (PPJK) agreed to serve as the main GOI counterpart for the activity as the IR aligned with their growing role as policy advisor on JKN. As the 'owner' of the IR, they established and convened an IR for UHC technical working group (TWG) consisting of multiple stakeholders engaged in ensuring the successful implementation of JKN: seven departments within the MOH, the Ministries of Finance and National Development Planning, the new single-payer Health Insurance Agency BPJS, and USAID.

Selecting a local IR partner

Through a competitive bidding process, HFG selected a local partner to lead the implementation of the IR for UHC work: the Center for Health Policy and Management (CHPM) at the University of Gadjah Mada. As one of the leading health policy research institutions in Indonesia, CHPM brought to the IR activity significant expertise, credibility, convening power, and a nationwide network of university partners.

Choosing an IR focus

After a series of consultations to engage the GOI stakeholders, presenting the benefits of IR generally and the goals of the IR for UHC activity specifically, the stakeholders agreed that the first cycle of IR should focus on the effects of JKN financing on primary care. This had been identified in HFG's original landscape study as an area in need of further study. It was also in line with stakeholders' interest in strengthening the "gatekeeper" function of primary care under JKN. This topic was specific enough to begin defining the study, yet broad enough to allow room for national- and district-level stakeholders to provide input into the specific research questions and instrument design.

Selecting target districts

For the first cycle of IR, consultations among USAID, HFG, PPJK, and CHPM led to the selection of five districts in four provinces (DKI Jakarta: *East Jakarta*; East Java: *Jember*; North Sumatera: *Tapanuli Selatan*; Papua: *Jayapura* and *Jayawijaya*) that met the following criteria:

- USAID and MOH priority districts for reproductive, maternal, neonatal, and child health, tuberculosis, and HIV
- Strong local political commitment to IR

- Mix of urban and rural areas
- Presence of financially autonomous (BLUD) and non-autonomous (non-BLUD) primary care facilities
- Part of CHPM's Indonesia Health Policy Network



Multi-stage process to build consensus on the IR topic

Once the key IR elements were in place, continual engagement of national and local stakeholders was necessary to promote strong local ownership of the activity, to deepen understanding of and commitment to the IR process, and to understand stakeholder concerns over JKN implementation at the primary care level.

The following multi-stage approach was used to achieve consensus on the topic for the first cycle of IR:

- **Consultations:** CHPM consulted with multiple stakeholders at the national, provincial, and district levels to gauge their main concerns around how JKN has been impacting primary care.



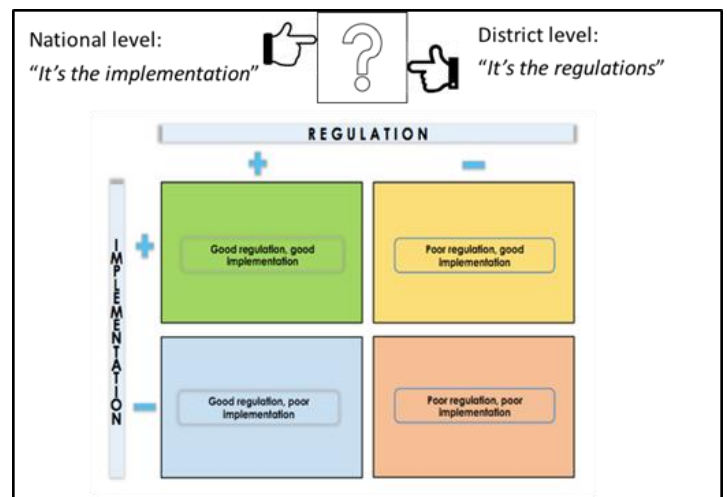
This resulted in a list of prioritized JKN implementation concerns for each of the different stakeholder groups.

- Problem Statements:** HFG and CHPM used this list of prioritized issues to develop five problem statements that best reflected stakeholders' overlapping areas of concern. As part of the preparation for an IR for UHC launch workshop, CHPM sent this list of problem statements to the different stakeholders, asking them to think about the underlying causes that might be contributing these problems.
- Multi-level Stakeholder Launch Workshop:** The Ministry of Health's PPJK and CHPM co-hosted a two-day launch workshop for the activity in Jakarta, with representatives from USAID, HFG, national-level ministries, provincial- and district-level organizations, and local university partners in the five selected districts. The aim of the workshop was to bring together national- and district-level stakeholders and to engage them in reaching consensus on the specific topic for the first cycle of IR.
- Root Cause Analyses:** CHPM facilitators worked with groups representing each district and the national level to select two of the five problem statements they felt were most urgent and then to conduct a root cause analysis of these two problems using fishbone diagrams. As the groups presented their root cause analyses, a clear picture emerged of national- and district-level understanding of factors impeding JKN implementation at the primary care level, and where their views overlapped.



Consensus Building Around Priority IR Topic:

HFG and CHPM analyzed the participants' root cause analyses to identify the most frequent and pressing underlying causes. The dominant theme that emerged was confusion over how JKN regulations, particularly those pertaining to capitation financing of primary care centers, were being understood and implemented at the district level. CHPM then led participants through a synthesis of the group work, highlighting the need to clarify where implementation challenges were a result of unclear or poorly conceived policy versus weak implementation. The workshop discussion culminated in consensus on the need to understand this issue more deeply as it pertained to the financing and delivery of primary care under JKN.



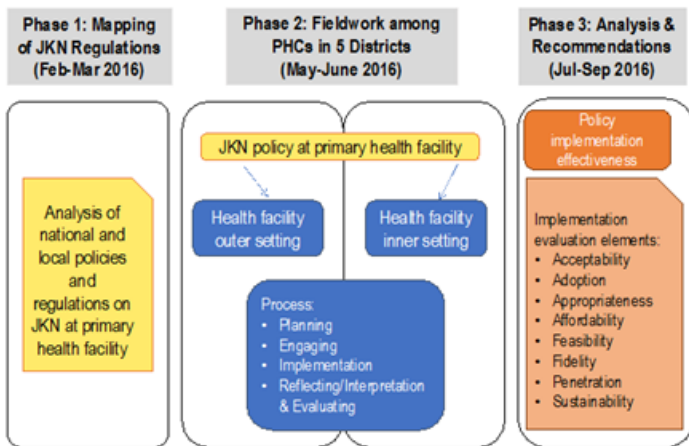
Moving from IR topic to strategy and design

Building on stakeholder inputs and consensus for the first cycle of IR, HFG and CHPM developed a three-phased approach to exploring how JKN regulations on primary care are being implemented at the primary care level.

Phase 1 involved an analysis and mapping of the various policies and regulations affecting primary care with the aim of identifying where the regulations are unclear and/or conflicting. **Phase 2** comprised a primarily qualitative exploration of how these policies and regulations on primary care are being implemented in practice in the five target districts, using recognized IR

domains and outcome variables as a framework.³ **Phase 3** consisted of analysis of the desk research and field data, followed by a process to develop actionable recommendations in collaboration with national and district stakeholders, with the aim of strengthening JKN policy on primary care and the conditions for their effective implementation.

IR Cycle 1 Phases & Framework



The three-phased approach to the IR had several benefits. First, it ensured that the research team had deep understanding of the JKN policy and regulations and insight into potential implementation challenges. Second, it allowed for stakeholder involvement throughout the IR process as they provided feedback on draft instruments and interim findings. Third, this approach allowed for triangulation of rich data from desk research, facility administrative records, interviews with national and district government and health officials, and focus group discussions with health care providers.

Lessons Learned

Reflecting on the experiences in advancing IR to support UHC in two very different contexts, HFG offers the following lessons learned on moving from laying the groundwork to defining and designing IR:

IR timeline

- As with laying the groundwork (Technical Brief 1), investing time into engaging stakeholders and getting their input into the IR focus and design is critical to maintaining meaningful buy-in and support.
- Patience and flexibility are needed as key stakeholders, priorities, and the pace of UHC reforms will likely change.
- IR can help stakeholders think beyond the limited duration of a particular 'project.'

Partners and Collaboration

- A clearly designated and engaged government counterpart - such as the NHP Implementation Monitoring Unit in Myanmar - is critical for sustained support for the general IR process and specific activity objectives.
- A well-respected local IR partner with a strong research network - such as the Center for Health Policy and Management in Indonesia - helps create the trust, collaboration, and efficiency necessary for a complex IR activity to succeed.
- Consultation and/or collaboration with other implementing partners on the ground can help to inform and advance an IR activity.
- It is necessary to engage with all stakeholders, whose input is vital for effective implementation (including, for example, private sector providers).
- IR can be a useful mechanism to bridge the gap between different perspectives. In the decentralized system of Indonesia, IR brought together key stakeholders from national and district levels; in Myanmar, IR will bring together private providers and public policymakers. In both cases, frank and open discussions help to highlight differences in perspectives on and experiences with policy and implementation challenges in moving toward UHC.

³ Damschroder LJ, DC Aron, RE Keith, et al., Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science, *Implementation Science* 4 (Aug. 7, 2009):50, DOI: 10.1186/1748-5908-4-50



Planning and Process

- The consultative process of defining and designing the IR is at least as important as the design itself.
- IR should be designed to be institutionalized; its structure should set in place new relationships and habits of collective learning and action, and a sense of the outcomes for the IR (what specific policies or programs might be strengthened and in what ways?) should be built into the planning and design process.
- Linking the IR to a concrete policy-making event, such as the formulation of a health financing strategy in the case of Myanmar or the review of JKN regulations on primary care in Indonesia, can lend greater urgency and significance to the activity.
- Using a multi-stage, iterative approach to engage stakeholders at multiple levels is effective for building consensus around the specific focus of the IR.
- A systematic and multi-faceted consultation strategy - using seminars, meetings, and web-based information - targeted to various levels of policymakers and implementers helps to increase stakeholder ownership of the IR.
- Investing time into ensuring that stakeholder concerns and priorities are fully understood by the research team and incorporated into the research training, is critical to ensuring depth and relevance in the research results.

Design

- Given the complexity of UHC initiatives, a multi-phased, mixed-method approach to IR for UHC may yield deeper insights and more targeted recommendations on how to strengthen both policy and implementation.
- A phased approach to IR for UHC also allows for incorporation of learning from one phase to another.
- In addition to meeting robust standards for research methodology, data collection strategies, instrument development, and analysis plans, IR design must be sure to capture rich data on the context in which UHC reforms are occurring. In Indonesia, the mapping of JKN regulations on primary care, analysis of district and facility health performance, and consultations with diverse GOI officials provided important context for fieldwork and analysis.⁴
- Qualitative research is particularly important for IR given its focus on underlying motivations and behaviors and complex real-world contexts.

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⁴ The Consolidated Framework for Implementation Research can provide useful constructs, domains, and outcome variables for studying implementation. See <http://cfirguide.org/>

A flagship project of USAID's Office of Health Systems, the Health Finance and Governance (HFG) project supports its partners in low- and middle-income countries to strengthen the health finance and governance functions of their health systems, expanding access to life-saving health services. The HFG project is a six-year (2012-2018), \$209 million global health project. The project builds on the achievements of the Health Systems 20/20 project. To learn more, please visit www.hfgproject.org.

The HFG project is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc.



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