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MYANMAR AND INDONESIA

IMPLEMENTATION RESEARCH FOR UHC IN PRACTICE

Implementation Research for UHC in Practice

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

Part 3: Implementing IR: Lessons Learned from First Cycles

About this Series

This is the third and final technical brief in a series on Implementation Research (IR) for Universal Health Coverage (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 synthesize the Health Finance and Governance (HFG) project's experiences with and lessons learned from applying IR principles and best practices[1] to UHC activities in Myanmar and Indonesia, two countries at very different stages of rolling out UHC reforms.

[1]Based on: David H. Peters, Nhan T. Tran, and Taghreed Adam. 2013. *Implementation Research in Health: A Practical Guide*. Alliance for Health Policy and Systems Research, World Health Organization.

The first brief described laying the groundwork for this type of IR. The second brief shared the process for defining and designing IR for UHC in each country. This third brief discusses the actual cycles of learning, i.e., how findings from the IR were actually used in both countries to make stakeholders aware of implementation challenges and to identify where corrective measures were needed. Included are insights from HFG's IR partners in Myanmar (Population Service International (PSI) and the Myanmar Ministry of Health and Sports) and in Indonesia (the Center for Health Policy and Management (CHPM) at the University of Gadjah Mada and the Ministry of Health Center for Health Financing and Health Security (PPJK)).

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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

Highlights from Brief #2: Defining and Designing the IR

- IR can help stakeholders think beyond the limited duration of a particular 'project'
- A clearly designated and engaged government counterpart is critical for sustained support for the general IR process and specific activity objectives

Continuous Learning…

IR is typically organized into consecutive cycles of learning. An important feature of IR is its participatory nature. Key stakeholders contribute to defining the questions that the IR will focus on in a given cycle, as well as the research methods to be used to answer those questions. Following a data collection and analysis phase, findings are reported back to and discussed among those stakeholders, who then identify whether and which corrective measures need to be taken to improve implementation. Stakeholders then move on to the identification of questions and associated methods for the next cycle of learning.

Myanmar

Technical Brief 2 described the strategic purchasing pilot project into which the IR was incorporated to complement the pilot's impact evaluation. As a reminder, the pilot is being implemented by PSI in two peri-urban areas around the city of Yangon. In this pilot, PSI simulates the role of a purchaser. Through a mixture of capitation payments and performance-based incentives, PSI purchases an enhanced package of primary care services from a limited number of contracted general practitioners (GPs), replacing the prevailing system whereby patients pay the GP out of pocket on a fee-for-service basis.

The main goals of this pilot project are (i) to demonstrate how the engagement of private health care providers – described in Myanmar's National Health Plan 2017–2021 as an important element of the country's strategy to move towards UHC – can be operationalized and rolled out, (ii) to improve understanding of strategic purchasing – a new concept in Myanmar – among key stakeholders, and (iii) to develop the capacity and skills that are critical to effective purchasing. At the same time, the pilot project aims to challenge a number of misconceptions that are widespread within Myanmar, including the following:

- "The private sector is only used by the better-off."
- "The private sector is too expensive."
- "Private GPs do not keep records needed for strategic purchasing; it is beyond their ability."

The process

So far, two full cycles of learning have been completed in Myanmar. As discussed in Technical Brief 2, HFG helped establish the Scale-Up Management Team, in which key stakeholders (including the Ministry of Health and Sports, the Myanmar GP Society, development partners, and civil society) are represented, to:

- Stimulate reflection and discussion around the long-term strategy for the move toward strategic purchasing, which will likely need to be revised and refined along the way
- Shape a shared vision around the role of non-state actors in the move toward UHC
- Facilitate the process of building the partnerships that are critical to successful scale-up of strategic purchasing arrangements
- Help make a case for actively engaging key stakeholders from the start
- Facilitate planning and resource mobilization for subsequent scale-up

Building on the learning from the IR, this team will be well positioned to support future replication and expansion of strategic purchasing arrangements, and to formulate recommendations relating to the future take-over of the purchasing function by a designated government or semi-autonomous entity.

The management team has met three times since the launch of the pilot. Its first meeting marked the start of the first cycle of learning. The meeting was preceded by a short visit to different GP clinics involved in the pilot project to give all participants an opportunity to familiarize themselves with the project. In the afternoon, they all came together to get further information about the project objectives and its design features, to get an update on progress made and challenges encountered, and for the launch of the IR. After introducing IR to the participants – what it is, how it can help improve implementation, and how it is conducted – the group brainstormed to come up with a list of potential questions for the first cycle of learning.

At its second and third meetings, the Scale-Up Management Team reviewed the findings from the completed cycle of learning, discussed the implications of the findings in terms of necessary corrective actions, and defined priority questions and associated methods for the next cycle. Each day-long meeting started with a brief update on the status of the pilot project. PSI's research team then summarized the findings from other studies conducted as part of the pilot project – such as the quantitative baseline or midline surveys, which will both contribute to the project's evaluation – and service utilization trends extracted from the routine information system. The main findings from the analysis of primary data collected as part of IR was then shared. Lively discussions followed these different presentations. The meetings ended with a brainstorming session to come up with the broad areas and/or particular questions that the next cycle of learning should look into. This session also included initial discussions of the methods best suited to investigate those questions.

Following each meeting of the Scale-Up Management Team, a smaller group with representatives from PSI and USAID/HFG reviewed the output from the brainstorming session and finalized the list of questions and associated methods for the next cycle.

The focus

The questions that have been assessed so far, over the course of two full cycles of learning, relate primarily to three areas where implementation challenges were identified:

- **Client registration:** Not all eligible household members went through the registration process.
- **Service utilization:** Use of services by cardholders was less than expected at some but not all of the participating GP clinics.

- **Provider-purchaser interactions:** Financial incentives associated with the selected mix of provider payment mechanisms have not yet managed to trigger the desired provider behavior.

The methods

For each of the two first cycles, selected research methods involved both primary data collection – in the form of in-depth interviews with clients, providers, and staff from the implementing organization – and the analysis of secondary data sources, such as data collected for the project evaluation and routine utilization data. A local consultant hired by HFG worked closely with the research team from PSI to develop and field test the research instruments for the in-depth interviews, collect and analyze the data, and report and interpret the findings. The small group that had finalized the list of research questions provided regular feedback throughout the process.

The findings

The two first cycles of learning revealed design and implementation issues relating to selected focus areas. Some of the design issues had already been identified during the project's design phase as potential risks to watch out for.

Examples of issues with the design of the project included:

- **Misaligned financial incentives for participating GPs:**
  - The co-existence of capitation payments on behalf of cardholders and fee-for-service payments by non-cardholders resulted in differential treatment of cardholders versus non-cardholders by some participating providers.
  - The introduction of two different co-payment amounts created a perverse incentive for participating GPs to misclassify patients (a higher co-payment amount had been set for patients coming in with "general illnesses" because of the providers' fear to see a rush of clients immediately after registration; such a rush never materialized).

  - Some of the pre-conditions that make capitation work, such as the competition introduced when patients have the option to change provider if they are not satisfied with the care received, could not be met in the pilot project; as a result, providers had limited incentive to put efforts into keeping registered cardholders healthy through health promotion and prevention activities.
- **Lack of choice:** the assignment of cardholders to a particular provider had been done by the implementing organization; allowing cardholders to register with the provider of their choice appeared to be far more important to the cardholders than anticipated.

Examples of implementation issues include:

- **Inadequate communication at different levels:**
  - Incomplete or inaccurate information provided to households by the agency in charge of household selection.
  - Insufficient clarifications given to participating providers around the capitation payment method.
- **Location of providers:** Some of the participating providers appeared to be located too far from the clusters of households assigned to them; time and transportation cost involved in visiting those providers acted as a strong deterrent to seek care.
- **Definition of quality:** The meaning of quality for cardholders sometimes directly contravenes objective measures of quality, generating tension among participating providers between improving quality and ensuring patient satisfaction.

Indonesia

Technical Brief 2 described a series of consultations with Government of Indonesia stakeholders at national, provincial, and district levels which determined that the first cycle of research would focus on the effects of national health insurance scheme (Jaminan Kesehatan Nasional, JKN) financing on primary care. Five "deep dive" districts were selected in four provinces (DKI Jakarta: *Jakarta Timur City*; East Java: *Jember*; North Sumatra: *Tapanuli Selatan*; Papua: *Jayapura City and Jayawijaya*) because they met several criteria including membership in the Health Policy Network led by the local IR partner, the CHPM of Gadjah Mada University. Priority IR questions addressed how JKN policies and regulations affecting primary care were being understood and how they were being implemented in practice in the five target districts.

The process

Two cycles of IR focused on the priority questions defined through a highly participative process that helped build capacity of policymakers and managers to crystalize research questions that matter to them and to use research for decision making. Evidence that the process succeeded in developing demand for and capacity to conduct IR for UHC in Indonesia includes: (i) the IR community of practice supported by CHPM (http://indonesia-implementationresearch-uhc.net/); (ii) the request for training on IR from the research unit of the Ministry of Health and delivered by CHPM; and (iii) the training by CHPM of district representatives to support other districts to use IR to understand how JKN is being implemented on the ground.

The CHPM IR team met with district stakeholders in each district after each cycle of IR was completed to communicate findings. Following the district meetings, district stakeholders joined national-level stakeholders for "deep dive workshops" after each cycle where they learned about findings across the districts, and had the opportunity to share their experiences with national-level policymakers and managers. This process was perceived by all to be extremely valuable. National-level decision makers valued the opportunity to learn about the challenges of implementing JKN at the district level from district leaders. District leaders valued the direct learning about how JKN was being operationalized in their communities and they benefited from learning about how other districts were interpreting and operationalizing JKN policies and regulations. In addition, district leaders valued the opportunity to provide direct input to national level decision makers.

The focus

Central to the vision of JKN and the Government of Indonesia's commitment to enhance the health of all of its citizens is strengthening the role of primary care to prevent, treat, and manage health conditions. The aim of IR for UHC in Indonesia has been to enhance understanding of how JKN regulations and payment to primary care facilities are working "inside the black box" of implementation by districts and facilities. The research focused on answering questions such as how primary care facilities use JKN capitation payments; how JKN payments impact provider behavior; how JKN regulations and policies are understood

and implemented at district level, altering provision of primary care services and impacting maternal, newborn, and child health and infectious diseases.

The first cycle of IR for UHC in Indonesia focused on how JKN policies and regulations related to primary care were understood and implemented at the district level. The second cycle honed in on how the payments to individual health workers from the capitation payments to primary care facilities enhanced staff motivation.

The methods

A theory of change logic model helped policymakers and implementers identify the types of questions that were suited to IR and consider how research findings could inform revisions to implementation of JKN at the primary care level. For example, capitation payments were posited to lead to better motivated and higher numbers of staff; more medicine, equipment, and supplies; upgraded facilities; greater community outreach; and less burdensome financial management. If these improvements were occurring, the expectation was that more patients would be served with higher-quality care, which would ultimately lead to both improved population health and more efficient use of resources. IR focused on the hypothesized direct impact of capitation on staff and service delivery, with the goal of determining whether these improvements were happening and, if not, why not. By specifying a logic model, stakeholders were able to understand the types of questions IR could help answer.

CHPM trained local universities that are part of their Health Policy Network to conduct qualitative interviews and focus groups with teams at both public and private primary care facilities and hospitals and key informant interviews with District Health Officers, medical practitioners, and local government representatives. This qualitative data were complemented by analysis of secondary quantitative data. Qualitative data were coded and analyzed using NVivo.

The findings

The process of formulating research questions, engaging stakeholders, and choosing the research partner generated several lessons:

- Investing time into getting input and maintaining working relationships are critical for getting stakeholder buy-in and support.
- Bringing together a mix of stakeholders from national, provincial, and district levels revealed areas of agreement and differences in perspectives on and experiences with JKN implementation.
- Having a well-respected local partner with a research network throughout Indonesia helps create the trust, collaboration, and efficiency that contributes to success of complex IR activities. It is also important for building lasting IR competencies.
- Ensuring that IR results are communicated in language and formats that are policy-relevant and tailored to the specific priorities and concerns of key national and district stakeholders helps to facilitate uptake of the findings and follow-through on recommendations.

Cycle 1 assessed how JKN regulations on capitation fund management at the primary health center level were being interpreted and implemented. BPJS, the Indonesian entity that pays providers for services covered through the national insurance program, pays health centers a monthly per capita payment to cover a package of services to JKN members. Findings shed light on aspects of the theory of change that were not working as envisioned.

- Capitation funds had little effect on the numbers of doctors hired. One underlying reason was that regulations prevented local governments from recruiting new civil servants. In addition, the regulations mandated that staff incentive payments from capitation funds could only be distributed to civil servants and official contract workers, and could not be used to hire additional staff.
- Most doctors were not motivated by the opportunity to earn additional payment from capitation revenue. Only 25 percent of doctors reported that they were satisfied with their income after JKN, and 43 percent reported that they were not satisfied. One reason is that their workload increased under JKN and the additional payment received from capitation funds was not perceived to have compensated them for the additional effort. In addition, health workers did not perceive that the portion of capitation payments received by each individual was related to their performance. Instead, these funds were perceived as an allowance or entitlement.
- Drugs and medical supplies were reported to be more available. Respondents reported that the capitation funds made it possible to ensure that medicines and supplies were available. In addition, simplified procurement regulations streamlined purchasing.

- Utilization rate of capitation funds by facilities differed between districts. Facilities in one district only managed to use 64 percent of capitation funds in one year and 81 percent in another year because of imperfect understanding of procurement regulations. Facilities in another district failed to use between 17–18 percent of capitation funds because of challenges with procurement processes, poor experience receiving orders, and less than ideal absorption rates for outreach by primary care facilities. The other three districts reported full utilization of capitation funds.
- Capitation funds contributed to TB and HIV/AIDS services. Capitation payments were used to purchase supplies such as TB sputum pots and for transportation to pick up ARVs and TB-MDR drugs.

Cycle 2 provided additional insights into how capitation payments were being used at the primary care level and opportunities to strengthen the links between capitation and behaviors that lead to improved health service delivery. Facility-level capitation payments are determined by the number of JKN-covered people who enroll and on performance on key indicators. Doctors in private primary care facilities have discretion over how capitation funds are used, while public facilities are required to use 40 percent of the capitation for operational costs and 60 percent for health worker remuneration.

- The proportion of a doctor's income generated by capitation payments varies widely across the focus districts. In public facilities, the proportion of total income received from capitation varies from 11 percent in South Tapanuli to 67 percent in Jayapura. In addition to their civil servant salary, public providers earn income from private practice and regional government allowances. East Jakarta combines capitation payments with regional government allowances to pay significant wages, with the requirement that public providers avoid private practice.
- A doctor's income from central government salaries and regional government allowances is far greater than income from BPJS. Because income from capitation payments is a small proportion of total doctor income, the incentive effect is relatively minor.
- Assessments of doctor performance is based primarily on attendance, and secondarily on metrics of performance in some districts. In East Jakarta, the district with the most developed performance-based payment system, doctor payment is based on activities performed such as community visits, coordination meetings, and medical procedures. The least-developed payment system was found in Jayawijaya, where absence of an attendance monitoring system made it impossible to condition payment on the most basic measure of attendance.
- Health workers don't perceive the current payment system to be fair. Most of what is valued when determining performance payments are characteristics that are immutable such as education attained and position.
- Health workers would like an incentive system that is based on service delivery accomplishments. Health workers recommended basing payment on measures of health promotion, preventive service delivery, and meeting quality standards, and should be adjusted for work risk (for example, working with TB patients involves risk) and the size of the service area. In addition to financial remuneration, health workers would like to be rewarded with opportunities for training and advancement. They also recommended penalties for poor performance that could include demotions, allowance reductions, and dismissal.
- Remuneration system that assigns points for measures of performance and adjusts for risk and remoteness was recommended. Respondents would like a system that captures contribution to achieving curative, rehabilitative, and promotive and preventive services targets as specified in the Indonesian minimum service standards.

… and Problem Solving

Myanmar

Improving design and implementation

The issues revealed by the IR were discussed within the Scale-Up Management Team. Remedial actions taken to address some of them include the following:

- Contracts were terminated with one of the GPs who was providing preferential treatment to non-cardholders, as well as with another GP whose clinic was found to be excessively far from assigned cardholders.

- A single co-payment amount (rather than two different co-payment amounts) was adopted to avoid unnecessary confusion among clients and to remove the perverse incentive for providers to over-report "general illnesses."
- The capitation amount was reduced to reflect a more realistic expected utilization pattern while remaining sufficient to motivate providers to enhance preventive care and demand generation efforts.
- Community-based activities were introduced aimed at raising cardholders' awareness of their entitlements and improving their health-seeking behavior.
- A threshold service utilization level per period (i.e., a certain percentage of the expected utilization), which a participating provider needs to pass within a set period of time to remain in the pilot project, was introduced, accompanied by adequate verification procedures to deter providers from over-reporting.

Sharing lessons learned

Strategic purchasing is still in its infancy in Myanmar. While theory and global experience can inform the design of the different key components of strategic purchasing arrangements, how those arrangements perform in the local context is yet to be determined. Hence the importance of building a process of continuous learning and problem solving into strategic purchasing initiatives and sharing the lessons.

Both the design process – including the rationale behind selected design options and the trade-offs involved – and the lessons learned are being documented in a series of briefs (the Myanmar Strategic Purchasing Brief Series). Five briefs have so far been produced and disseminated widely, both within and outside Myanmar. Lessons learned in the Yangon demonstration pilot have also helped shape new strategic purchasing initiatives launched in other parts of the country.

Indonesia

Improving implementation

One of the findings in Cycle 1 was that there was uneven understanding of the regulations governing JKN. These regulations were formulated at the central level but implemented at the district level. Findings stimulated the Ministry of Health to host a meeting with 514 District Health Officers, together with the Ministry of Home Affairs, which is Indonesia's local government ministry, to explain the regulations and to understand which elements were unclear. In response to feedback from the districts, regulations were rewritten to be more user friendly and understandable by the districts.

Another result of Cycle 1 is more joint planning between the Ministry of Health and the national payer, BPJS, to address the overlaps in decision authority.

The research unit in the Ministry of Health requested training to learn how to facilitate and conduct IR to help monitor the roll-out of the country's health reforms. Accompanying this request was a policy decision by the Ministry of Health that all research they support must demonstrate policy relevance. However, institutionalizing IR is a long and complex process and this experience is only a beginning. Institutionalizing it will require commitment at the government level to establish and maintain the capacity to either implement IR directly or to contract and oversee it.

Lessons Learned: How IR facilitates dialogue and problem solving among key stakeholders

Reflecting on the experiences in advancing IR to support UHC in two very different contexts, HFG offers the following lessons learned on moving from defining and designing IR to capturing, sharing, and acting upon lessons from the cycles of learning:

- In Myanmar, IR-related meetings provided a forum for open and frank discussions among key stakeholders who otherwise rarely interact (e.g., the GP Society and Ministry of Health and Sports). They also helped improve mutual understanding and develop relationships that will be vital to the successful roll-out of strategic purchasing arrangements.
- In Indonesia, IR-related meetings at the national level provided a forum for discussion among diverse stakeholders. However, the IR implementers suggested holding pre-meetings with different groups to share findings that are controversial so that stakeholders do not respond by becoming defensive in a large group setting.
- IR-related meetings have also increased the understanding among key stakeholders of concepts that were until recently foreign and somewhat abstract (e.g., strategic purchasing or capitation in Myanmar).
- In Indonesia, IR started a conversation that was not previously occurring. Findings contradicted some stakeholders' prior expectations and misperceptions about what was happening and confirmed others' prior perceptions. This value was realized at both district and national level.
- IR was found to be a useful approach to inform strategic purchasing in both Indonesia and Myanmar. Strategic purchasing is about better aligning health care providers' incentives to the goals that the health system aims to achieve. The constant search for a combination of provider payment mechanisms that elicits the desired provider behavior is at the core of strategic purchasing. This calls for the continuous monitoring of providers' actual behavior and of how this behavior changes in response to adjustments made to the mix of provider payment mechanisms. Continuous learning – including through direct feedback from providers – and adjusting is precisely what IR does.
- The experience in Myanmar demonstrates that the scale of the project or initiative into which IR is incorporated matters little. Even if IR is built into a small pilot project involving only a limited number of providers, the richness of the findings it generates allows for valuable learning and rapid design adjustments at relatively low cost.

As Myanmar's and Indonesia's UHC strategies mature, both countries will benefit from successive rounds of IR to identify opportunities to continue to refine and strengthen them. These strategies involve many systemic changes and it is impossible to anticipate how each regulation, policy, and process will be realized on the ground. Strategic purchasing strategies, explicitly designed to change behavior, will benefit from ongoing IR to determine whether they are working as intended. IR provides governments with quick information needed to inform design corrections and process refinements so that each country's UHC strategies can be realized.

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The Health Finance and Governance (HFG) project works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. Designed to fundamentally strengthen health systems, the HFG project improves health outcomes in partner countries by expanding people's access to health care, especially to priority health services. The HFG project is a six-year (2012-2018), $209 million global project funded by the U.S. Agency for International Development under Cooperative Agreement No: AID-OAA-A-12-00080.
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