



MYANMAR STRATEGIC PURCHASING BRIEF SERIES – No. 5

Continuous Learning and Problem Solving

February 2018

INTRODUCTION – THE STRATEGIC PURCHASING BRIEF SERIES

This is the fifth in a series of briefs examining practical considerations in the design and implementation of a strategic purchasing pilot project among private general practitioners (GPs) in Myanmar. This pilot aims to start developing the important functions of, and provide valuable lessons around, contracting of health providers and purchasing that will contribute to the broader health financing agenda. More specifically, it is introducing a blended payment system that mixes capitation payments and performance-based incentives to reduce households' out-of-pocket spending and incentivize providers to deliver an essential package of primary care services.

CONTEXT

Many people in Myanmar access most of their health care through the formal and informal private sector and payment for this care comes mostly out of the patient's pocket. This can cause a significant financial burden to poor and vulnerable populations and lead to a chronic under-use of basic health services.

In response to this challenge, and in support of the Government of Myanmar's long term universal health coverage goal, Population Services International (PSI)/Myanmar has established a pilot project to demonstrate the capacity of private GPs in its Sun Quality Health (SQH) network to offer a basic package of primary care services to poor and vulnerable households. In this pilot, PSI is "simulating" the role of a purchaser, but expects this role to be taken over at some point by a national purchaser, as outlined in the National Health Plan (2017-2021). In the long run, the role of PSI is likely to evolve into that of an intermediary.¹ This intermediary role could include supporting the formation of networks of providers that are easier to integrate into health financing programs, and helping these providers meet minimum requirements through quality improvement and development of management capacity. Eventually, the package of services to be purchased from GPs, even if limited, will need to be streamlined with the basic Essential Package of Health Services that is currently being developed at the national level.

¹ Results for Development Institute (2016). [Intermediaries: The Missing Link in Improving Mixed Market Health Systems?](#) Washington, DC: R4D.

Under the pilot, 2,506 low income households in two townships² in Yangon region, Shwepyithar and Darbein, have been registered, screened and issued with health cards which entitle them to a defined benefit package provided by five selected members of the SQH network. The pilot specifically aims to demonstrate an increase in the range of services offered by private providers, a decrease in out-of-pocket payment by the registered households, and a decrease in the time to seek treatment from the onset of health symptoms.

OBJECTIVE

This brief aims to describe the process of continuous learning and problem solving that was built into the pilot and how it has already helped identify and address implementation challenges. This brief also demonstrates the essence of strategic purchasing: understanding whether the incentives associated with selected mix of provider payment mechanisms lead to the desired change in provider behaviour and, where they do not, adjusting the mix to tweak the incentives as necessary.

BUILDING CONTINUOUS LEARNING AND PROBLEM SOLVING INTO THE PILOT

No matter how much effort goes into the design of an initiative (e.g. a policy or a pilot project), no matter how much the design draws upon best practice or how much it has been subjected to the scrutiny of experts, there will always be implementation challenges. Things will never go exactly as planned. Factors that were not taken into consideration may disrupt some of the activities, assumptions on which the design was based may turn out to be incorrect, or actions may have unintended consequences that could not have been foreseen.

While this is absolutely normal, it also highlights the importance of being able to identify and address implementation challenges early on. For that, there needs to be a conscious effort to build continuous learning and problem solving, also referred to as implementation research, into the initiative. For the strategic purchasing pilot, USAID's Health Finance and Governance (HFG) project and PSI have been working closely together since the pilot's early design phase to do just that. Readers who are not familiar with implementation research are referred to Box 1, which summarizes its key features and lists the kinds of questions it aims to answer. Implementation research typically involves subsequent cycles of learning, each covering a period of three to four months.

Box 1 – What is implementation research and why do we need it?

Implementation research "...aims to understand not only what is and isn't working, but also how and why implementation is going right or wrong, and testing approaches to improve it..."³ It benefits both policymakers and implementers as a way to quickly identify and respond to implementation challenges by helping answer questions such as:

- ◆ Is the initiative being implemented as planned?
- ◆ What factors are hampering smooth implementation?
- ◆ Does the initiative translate into the expected changes in the system?
- ◆ Are there unintended consequences associated with the initiative (either positive or negative)?
- ◆ What actions should be taken to improve current implementation?
- ◆ How can the initiative be scaled up or sustained?

Implementation research has the following key features:

- ◆ It addresses the "know-do gap"
- ◆ It is conducted in the real-world context
- ◆ It generates real-time evidence/learning
- ◆ It focuses on questions of interest to implementers, to those who influence implementation, and to those affected by implementation
- ◆ It is highly collaborative and multi-disciplinary
- ◆ It involves a wide range of methods and approaches
- ◆ It is built into programs (as opposed to being carried out after the fact)

² Townships in Myanmar are somewhat comparable to what many other countries call districts. On average, a Township has a population of around 150,000.

³ Peters, D.H., Tran, N.T., Adam, T. (2013). *Implementation Research in Health: A Practical Guide*. Geneva: Alliance for Health Policy and Systems Research, World Health Organization.

An important feature of implementation research is its participatory nature. Key stakeholders contribute to defining the questions that the implementation research will focus on in a given cycle, and the research methods that will be used to answer those questions. While answering the questions may require primary data collection, it can also draw on existing information, which may have been gathered for other reasons (e.g. data collected as part of the project evaluation, utilization data, etc.). At the end of each cycle, the findings are shared with those stakeholders who together discuss whether and what corrective measures need to be taken to improve implementation.

Stakeholders then move on to the identification of questions for the next cycle of learning. So far, two cycles of learning have been completed in the pilot. Stakeholders include representatives from: the Ministry of Health and Sports; the Yangon Regional Health Authorities; the GP Society, which is a part of the Myanmar Medical Association; PSI, as implementing agency carrying out the pilot; participating GPs; the 3MDG Fund, which provides a large share of the funding for the pilot; and HFG, which helps with the implementation research. Together, these stakeholders form the Project Scale-Up Management Team.

IDENTIFYING AND UNDERSTANDING IMPLEMENTATION CHALLENGES

The Scale-Up Management Team has met three times since the launch of the pilot. Its first meeting, which marked the start of the first cycle of learning, was in June 2017. At its second and third meetings, in September 2017 and February 2018, respectively, the team reviewed the findings from the completed cycle of learning, discussed their implications, and defined priority questions for the next cycle.

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

- ◆ client registration: not all eligible household members went through the registration process;
- ◆ service utilisation: use of services by cardholders was lower 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 behaviour.

The assessment involved both primary data collection – in the form of in-depth interviews with clients, providers and members of the implementing agency – and a review of other data sources.

The main findings can be summarized as follows:

- ◆ **Some providers are located too far from the clients they serve.** The proximity of services appeared to be even more important to beneficiaries than the design team had anticipated. Even seemingly short distances can act as a barrier, especially where there are many alternative providers to choose from. Cardholders will continue to access low cost, low quality, informal health providers if these are located close by, particularly for illnesses that are perceived as non-severe. Moreover, in Shwepyitha township, there are charity clinics, both mobile and non-mobile, where cardholders can access health care services free of charge. An important factor affecting cardholders' health seeking behaviour is the cost of transportation from their home to the provider and back. As a result, there may be a trade-off between identifying and enrolling the providers who meet the most eligibility criteria, and ensuring they are conveniently

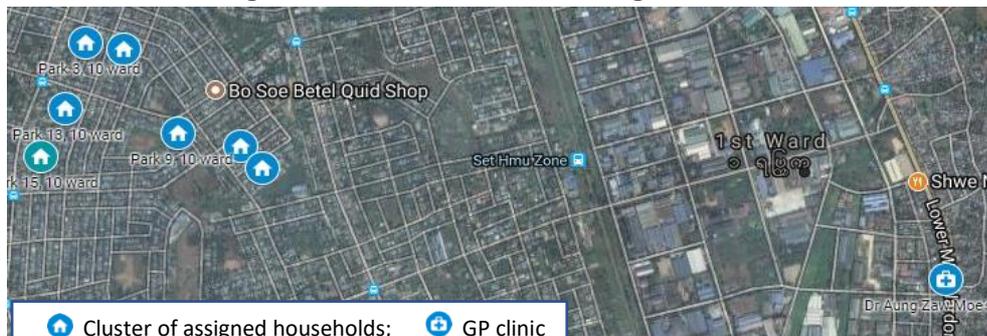


Figure 1 - Distance between one of the GPs and his assigned beneficiaries

Box 2 – Provider eligibility criteria used in the pilot

- ◆ Existing SQH member, not a government employee
- ◆ At least 5 years of experience as a full-time GP at the existing clinic
- ◆ Registered clinic (including for specialized services) at the health department
- ◆ Acceptable clinic infrastructure and privacy for clients
- ◆ Easy access for beneficiaries, in terms of clinic location (ward) and operating time
- ◆ Provision of 5 or more of PSI's franchise programmes or equivalent
- ◆ Capacity to manage at least 20 visits per operating day
- ◆ Committed to practice two or more years at the existing clinic or at a nearby location
- ◆ Willing to receive additional clinical and business management trainings
- ◆ Proven record of good communication and reputation in the community
- ◆ Demonstrated enthusiasm to participate in the pilot

located. The criteria that were initially used to identify eligible providers for participation in the pilot are listed in Box 2. Proximity was initially defined as being located in the same ward as the beneficiaries registered with the provider (Figure 1 shows the distance between one of the participating GPs and the clusters of households assigned to him); the findings call for redefining acceptable proximity as being located within the same neighbourhood. Note that some participating providers were well located, and it is telling that the provider with the largest absolute number of client visits generated is located in Darbein, where distances are smaller and where there is likely to be far less competition from other providers.

- ◆ **The demand for health services relating to “general illnesses”** (see [Issue Brief #1](#)) is much higher than anticipated, relative to that for specific services explicitly listed in the package. The inclusion of such “general illnesses” appears to be a major

attracting factor for patients to use services. It is also possible that providers over-report general illnesses in order to ask the patient to pay a higher co-payment (1,000 Kyats instead of 500 Kyats).

- ◆ **The perception of quality by clients sometimes directly contravenes objective measures of quality.** Clients can perceive they are receiving poor quality care if they do not receive the typical and yet usually medically unnecessary drug cocktails (Figure 2), intravenous infusions or vitamin injections that many providers give (and charge for) routinely. How to manage this dissonance in a program that aims to improve quality of care, but that also needs clients to feel satisfied in order to succeed, is a delicate balancing act. Interestingly, quantitative findings suggest high satisfaction with the care received. This contradiction may point to some form of response bias.

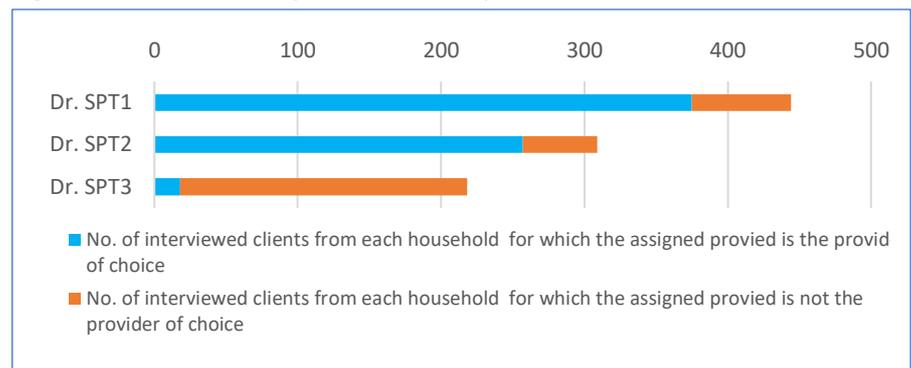
Figure 2 – A typical drug cocktail often dispensed to clients



- ◆ **In some cases, the provider's attitude towards cardholders and non-cardholders differed.** In-depth interviews with clients revealed cases where a participating GP would be rude towards cardholders and provide preferential treatment to non-cardholders who continue to pay for the services out of their pocket on a fee-for-service basis. This led some cardholders to conceal their beneficiary status and to pay the full fee for the services.
- ◆ **Choice of provider matters.** Clients consistently report the importance of being able to choose their health provider. Due to its small scale, however, the pilot was not able to offer much choice. Yet, as illustrated in Figure 3, the pilot did a relatively good job at accommodating client preferences at least in some cases – Figure 3 shows that for more than 80% of the clients assigned to either SPT 1 or SPT 2, these providers were the provider of choice. In other cases, the mismatch between assigned provider

and provider of choice was quite pronounced – SPT3 in Figure 3 was the provider of choice for only 8% of assigned households. Note that SPT3 was also the provider shown in Figure 1

Figure 3 – Stated client preferences for provider of choice



◆ **The provider’s fear to see a rush of clients immediately after registration never materialized.**

This fear was among the reasons

that led to the introduction of co-payments in the first place. The utilization figures show that what happened was quite the opposite, with relatively few cardholders showing up. For one of the providers, for example, the actual number of visits was less than 10% of the number that was expected based on the modelling used to calculate the capitation amount. This was in part due to the poor understanding among clients of the management of chronic illnesses such as hypertension and diabetes (see Box 4).

Box 3 – What makes capitation work?

Capitation is one of the possible provider payment mechanisms. In this mechanism, a fixed amount of money (a capitation payment) is pre-paid by the purchaser (in this pilot, simulated by PSI) to the provider for each individual registered with that provider. In exchange of the payment, the provider agrees to manage the health care needs of that individual within the scope of an agreed package of services and over an agreed period of time. The payment is therefore unrelated to the actual service utilization by that individual ([see Issue Brief #2](#)).

As with any provider payment mechanism, capitation introduces both “good” and “bad” incentives for the provider. Capitation provides positive incentives for the provider to:

- ◆ Carefully use inputs
- ◆ Deliver good service quality to attract clients to register with him/her (if there is competition)
- ◆ Provide preventive and promotive care

Negative (or perverse) incentives for the provider include:

- ◆ The provision of sub-standard services
- ◆ The under-provision of care
- ◆ Over-referral of patients
- ◆ Avoiding that sick and costly patients register with him/her
- ◆ Avoid services with no short-term payoff (e.g. smoking cessation)

Some of the preconditions for capitation to work include the following:

- ◆ Individuals should be able to choose which provider to register with
- ◆ There should be enough providers to choose from (competition)
- ◆ Individuals should be allowed to switch to another provider at the end of the period covered by the capitation payment if not satisfied with the care received
- ◆ Individuals should be able to provide feedback on satisfaction level of the chosen provider

◆ **The financial incentives introduced through the selected mix of payment mechanisms did not automatically result in the expected changes in provider behaviour.**

The capitation payment alone did not increase the provision of preventive services nor did it encourage providers to actively create demand for their services in the community (e.g. for non-communicable disease screening services included in the package). This is largely due to the fact that some of the pre-conditions that make capitation work (see Box 3) cannot be met in this pilot, namely: clients were not asked to choose their preferred provider but were assigned to a particular provider; even if they had been asked to choose, the options would have been limited given the scale of the pilot; likewise, options for clients to switch to another provider if not satisfied with the care received are limited. In the absence of these pre-conditions, providers have little incentive to put more energy into preventive activities or to generate additional demand for their services, as this would reduce their short-term profits. Moreover, some of the participating providers still do not fully

understand capitation: they fail to think in terms of average utilization and cost over all registered clients and instead look at the number and cost of individual patients' visits.

The performance-based incentives selected by the design team (see Issue Brief #4)⁴ are designed to counterbalance some of the weaknesses associated with capitation. Given that these incentives were only introduced recently, it is too early to notice their effects on provider behaviour. However, since PSI set immunization coverage for children under two as a key quality indicator, two out of four providers applied a significant effort to document the immunization status of all children under two from their assigned households. As a result, 76% of children were reported as having complete immunization by one provider in Shwepyithar and 71% by the Darbein provider. However, the other two providers in Shwepyithar did not report any data (yet).

THE IMPLICATIONS FOR PROJECT PLANNING AND IMPLEMENTATION

During the pilot's design phase, the design team held a brainstorming session to identify potential risks associated with selected design options (see Issue Brief #4). The findings from the implementation research indicate that some of those risks did indeed materialize and that corrective measures need to be taken.

One of the challenges that the first two cycles of learning investigated is the relatively low service utilization by cardholders from most, but not all, of the participating providers. In-depth interviews with clients revealed some of the important contributing factors such as lack of choice of assigned provider, the distance to the clinic, discrimination between cardholders and non-cardholders and failure to encourage patients with chronic health conditions to seek continuous care to manage their health (see Box 4).

For some of the participating providers, all these factors could be ruled out. Yet, service utilization at these providers was still relatively low. As described below, one further reason was that the number of expected visits was overestimated at the beginning of the pilot.

Other areas of learning worth highlighting include:

- ◆ **Changing client expectations will take time.** It will require long term behavioural change and communication efforts to get clients to both understand what is an acceptable level of care, and also to understand their rights under the project. What can be done in the meantime is unclear. Participating providers currently bear the financial risk associated with the delivery of unnecessary care (for example typical drug cocktails, intravenous infusions or vitamin injections) in the sense that they cannot charge the patient extra for these services. Yet, motivated by a desire to be well-perceived by their clients, some providers seem to be willing to offer them.

Box 4 – Management of chronic illnesses

One particular cause of the relatively low use of services is the poor understanding among clients of the management of chronic illnesses such as hypertension and diabetes. These two diseases require daily medication and constant monitoring, and together were expected to generate around half of all client visits, not least because the project agreed to cover the cost of a good proportion of the associated daily drug requirements. Lessons from other work by PSI on hypertension has shown that diagnosed hypertensive clients who need to pay for their drugs out of their own pockets will usually only take them until they have stabilized and normalized their blood pressure, usually after a month or so of treatment. The design team had assumed that a combination of free screening at the beginning of the pilot, education by the provider and the access to free medication would be enough to overcome the under-consumption of services related to these conditions. To date that has not happened, and this under-utilization will need to be addressed in the next stages of the pilot.

⁴ Selected incentives relate to the friendliness of the provider, the full immunization of children under the age of two, and the achievement of service delivery standards.

- ◆ **Performance-based incentives**, which are meant to compensate for some of the weaknesses of capitation, will need to be closely monitored. Following the introduction of these incentives, initial findings are promising with a considerable increase in vaccination coverage among children under two being observed among some providers.
- ◆ **Incentivising providers to generate demand in their communities:** Provider payment mechanisms will need to be continuously revisited to further incentivise participating GPs to conduct preventive activities or generate additional demand for their services given that some of the pre-conditions that make capitation work are currently not met in the pilot.
- ◆ **Revisiting the level of expected service utilisation:** Some of the abovementioned findings raise the question of what the expected service utilization should be. [Issue Brief #2](#) described how the initial capitation amount was calculated. Due to the lack of reliable local data, the calculations had to rely heavily on assumptions around optimal service uptake with the intention to minimize financial risk to providers. These assumptions related, for example, to the expected number of episodes of illness, considering a rather generic demographic and epidemiological profile of the beneficiary population, and to the expected number of visits per episode based on standard treatment guidelines. Many of the assumed values turned out to be highly overestimated, resulting in a generous capitation amount, and unrealistic expectations on providers around what levels of service utilisation would occur. While a capitation amount that is higher than is justified based on utilization rates translates into inefficient use of resources, the generous payment has been critical in getting the first batch of GPs to sign up, especially given their fear of being inundated by poor beneficiaries as the pilot began. One year into the pilot, it is now possible to revisit some of these assumptions using data generated through the pilot (e.g. client characteristics; results of screening for hypertension and diabetes) to come up with more realistic estimates of expected service utilization per person per year.

Several corrective measures have already been taken in response to the lessons learned, including the following:

- ◆ **Single co-payment:** the adoption, in November 2017, of a single co-payment amount of 500 Kyat (rather than two different co-payment amounts) to avoid unnecessary confusion among clients and to remove the perverse incentive for providers to over-report “general illnesses”.
- ◆ **Reduced capitation:** The reduction, in November 2017, of the capitation amount by 22%. The goal of the reduction was not to have the amount reflect the current utilization rate, which is known to be too low, but rather to have it reflect a more realistic expected utilisation pattern (with the average number of visits per person per year for the core package – See [Issue Brief #1](#) – reduced from 4.4 to 3.4). It is important that the amount remains sufficient to motivate providers to enhance preventive care and demand generation efforts.
- ◆ **Contract termination:** The termination, in December 2017, of the contract with one of the GPs who was providing preferential treatment to non-cardholders, as well as the termination, in February 2018, of the contract with another GP, whose clinic was found to be excessively far from assigned beneficiaries.
- ◆ **Community Mobilization Events:** The organization, in October and November 2017, of community mobilization events aimed at raising cardholders’ awareness of the package of services they are entitled to. Field coordinators of PSI/Myanmar visited the cardholders’ households to explain their entitlements.

Despite their being to the relative detriment of the providers, these changes were surprisingly well received by participating GPs. This gives the project continuing hope that the remaining GPs have entered into this project with good intentions and a desire to help make it work.

Additional measures that the design team is considering include the following:

- ◆ **The unpacking of the category “general illnesses”**, which is presently a black box. It is likely that many consultations that are currently recorded under general illnesses relate to services that are included in the Basic Essential Package of Health Services being finalised by the Ministry of Health and Sports. Taking these services out of the category “general illnesses” and recording them more explicitly will help show greater alignment of the pilot with national policy. Examples include the separation of fever and non-fever related categories, and better categorisation of illnesses related to ear, nose and throat, respiratory system, digestive system, etc. This will be facilitated by the introduction of electronic medical records (EMR) based on ICD-10 categories, which are currently being piloted in a number of SQH clinics.
- ◆ **The introduction of a threshold service utilisation level per period** (i.e., a certain percentage of the expected utilisation) that a participating provider needs to pass within a set period of time to remain in the pilot. This would need to be accompanied by adequate verification procedures to deter providers from over-reporting. The minimum utilisation level will also need to be based on realistic expectations of what the acceptable level of utilisation should be.



Figure 4 - Women waiting for cervical cancer screening at one participating clinic

- ◆ **The design of effective accompanying community-based activities**, such as targeted client education, to improve health seeking behaviour. PSI, in close collaboration with participating providers, will test various low intensity approaches to see what works best and how. Effective approaches to improve health seeking behaviour will subsequently be integrated into the system by ensuring that their realisation is incentivised by the mix of provider payment arrangements, i.e., it should be in the financial interest of the provider to carry them out. These approaches will likely include screening campaigns, clearer explanations of patient rights, and educating clients that generic drugs are still quality drugs.

- ◆ **The promotion of peer-learning among participating providers.** Successful initiatives implemented by participating GPs should be shared with others. One of the providers, for example, already managed to run an effective campaign for cervical cancer screening in the community (see Figure 4). Other initiatives might include helping providers better understand the objectives of the project and the nature of capitation payments through peer support.
- ◆ **Better mapping of project areas** – to help understand the market, to locate alternative service providers that may be working in the area, and to identify potential referral facilities.

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.



Myanmar Strategic Purchasing Brief Series:

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