

USAID-BCG PROJECT IN INDONESIA

Institutional assessment of private sector health providers in TB care

District field research approach: Clinic

USAID and BCG Indonesia

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1 Topics covered in district interviews with facilities

Phase 2 of the private provider review will map the most critical private facilities - private hospitals, clinics, labs, and pharmacies - in each selected district and focus on understanding **current market** and **policy incentives** for private health care facilities and how different policies or interventions might affect those incentives at an institutional level. It will provide information to support the implementation of future initiatives to increase uptake and improve the quality of TB care, especially opportunities to use JKN as a lever to change behaviors of private sector providers.

More specifically, the interviews with private hospitals, clinics, labs, pharmacies, and local health care organizations across the seven districts will help us understand:

- **Who are the major private actors currently operating at a national level and in the selected districts?**
 - What's their size, capabilities, resources, services offered, and geographical reach?
 - What are the relationships between institutions in each district?
 - This landscaping would include data such as market share, commercial or more informal relationships between different types of institutions that might affect TB-related solutions, the TB services they provide, and the typical profile of their clients, with recommendations for their proposed role in improving private sector TB engagement in the district.
- **Are current market incentives driving providers towards or away from the provision of quality TB care? How?**
 - Understand attitudes among private providers toward participation in district-based PPM and how they envision engaging with Puskesmas and Dinas Kesehatan in their district
- **Other than private hospitals, labs, pharmacies, and physicians, are there any other local organizations or stakeholders (outside the public sector) that are contributing or could potentially contribute toward the TB care-seeking and treatment ecosystem in each district, and what are their capacities?**
- **What is the business case of providing TB-related diagnostics and drugs in the private sector?**
 - What are the incentives and disincentives, both commercial and non-commercial?
 - How does this change when taking into account other health conditions (e.g., HIV, diabetes)?
- **What opportunities exist to engage these identified actors in JKN?**
 - What has already motivated their participation in JKN or what incentives would motivate them to participate?
 - What concerns do they have about participation in JKN?
- **How would private hospitals, clinics, labs and pharmacies respond to any potential fee-for-service components of JKN or other interventions aimed at them, and would they pass those incentives on to their providers?**

The outcomes will be used to:

- Recommend a set of concrete, specific next steps for each district to advance its process of engaging private providers and institutions in TB care and prevention.
- Socialize findings with Dinas Kesehatan and other stakeholders to inform the national dialogue on district-based PPM for TB in Indonesia

2 Phase 2b approach to qualitative research and insight generation

Overview

For Phase 2b district research with private sector hospitals, clinics, pharmacies and labs, we will employ a multi-step process to generate insights. This process has been adapted from BCG best practices for qualitative interviews.

At a high-level, there are six key steps in this process:

1. Pre-planning
2. Pre-research hypothesis generation
3. Interview guide development and pre-work
4. Interview conducting*
5. Insights capture and hypothesis refinement*
6. Synthesis

*Note that steps four and five are iterative in that they will inform each other through the process.

Each step of the process will be explained in more detail in the following sections. To bring the process to life, we will use hospitals as an example, but the process will be similar for pharmacies.

Step 1: Pre-planning (In-process)

The team has engaged in pre-planning to set the objectives of the district research, determine the number and type of hospital interview participants, develop the selection methodology and the location of the interviews.

For hospitals, the key research objectives are to understand the sphere of influence of hospitals in TB care; identify strengths, weaknesses and opportunities of institutional relationship between hospitals and other TB care providers; and highlight institutional incentives / disincentives to provide high quality, effective TB treatment, including via participation in district PPM. For each district, we are targeting interviews with 4-5 directors / managers of private hospitals. In order to be able to see meaningful distinctions in behaviors and incentives for hospitals, we are seeking a balanced set of hospitals based on characteristics such as:

- Class & size:
 - Mix of different hospitals including Type (A/B/C/D) and/or
 - # of beds and outpatients and/or
 - # of reported TB cases
- TB-service capabilities:
 - Mix of facilities with in-house labs w/ and w/out advanced TB diagnostic tools (GeneXpert, DST, Culture) and w/ and w/out in-house pharmacy disbursing TB drugs (FDC vs loose)
 - Aim to include all facilities with GeneXpert if possible
- BPJS-K enrollment: Mix of BPJS-K-affiliated and non-BPJS-K affiliated
- Business model: Mix of chain and non-chain facilities
- Clientele served: Mix of higher and lower socioeconomic status clientele (proxy by % of BPJS patients or affluence level of neighborhood)

We are now in the process of selecting facilities with input from NTP, CTB, and district Dinkes to ensure feasibility (i.e. ability to secure interviews) as well as to identify those hospitals they see as the technical and moral leader in TB. (See Section 3 for details on facility selection).

We have determined that the location of the interviews with hospitals will be at the hospitals themselves as confirmed in the introduction meetings with Dinkes.

Step 2: Pre-research hypothesis generation (*In-process*)

Prior to conducting research in the districts, we have developed informed conjectures about how private sector hospitals may be performing currently in diagnosing, treating, and reporting TB and their relationships with other facilities and providers and the rationale for this behavior. This is critical to perform prior to developing the interview guide as well as conducting the research in order to ensure that the research is structured and delivered in a way that can meet the research objectives and enable the team to identify the most effective levers and incentives to affect change. (See Section 4 for specific ingoing hypotheses). These hypotheses have been informed by existing literature and research, findings from past efforts and perspectives of experts in the field (including hypotheses shared by Dinkes in introduction meetings). In generating these hypotheses, we have also considered relevant 'root causes'.

Step 3: Interview guide development and pre-work (*In-process*)

The team is developing an interview guide to help direct the interview discussion, ensuring that the questions are targeted and tie back to the pre-research hypotheses and the overarching project objectives. (See Section 5 for draft interview guide for hospitals).

Step 4: Interview conducting

For each of the districts, the interviews with hospital directors / managers will take place in stages over the course of one to two weeks as opposed to all of the interviews for hospitals being conducted in one condensed, standalone time period (note that for most districts it will take up to 8 days to complete all interviews for that district including hospitals, clinics, labs, pharmacies, Dinkes and professional associations). This staged approach is deliberate in order to enable the team to reflect, adjust and refine in between interviews. Specifically, the initial set of interviews will be used as exploratory interviews to test (i.e. prove/disprove) initial hypotheses and understand the range of responses from participants. Once initial patterns emerge, the team will use the interviews to a) continue to validate patterns and probe deeper on understanding the "why", b) to probe in-depth on specific concepts emerging as critical and / or c) to close any remaining gaps in information.

This evolution will occur in two ways: a) over the course of the research in each district as well as b) over the course of the district research process across districts. This ongoing refinement will be informed by the insight capturing step as outlined in the next section.

Step 5: Insights capture and hypothesis refinement

The team will capture insights in two ways: during the interview and after the interview. During the interview, the team will capture key notes to supplement the audio recording. Key insights of the interviews will be typed up, synthesized and shared with the broader team on a weekly basis. The relevant part of the audio recording will be listened to in order to ensure key points are captured and interpreted accurately. At the end of each day, the team will collectively discuss key themes from the discussion, compare notes, test and determine the following areas:

- Are the interviews providing the type of insight we need? If not, what needs to be adjusted?
- What are we learning to prove or disprove our hypotheses?
- What are the key themes and takeaways related to our project objectives?

In doing so, the team will refine and focus the pre-research hypotheses as the evidence accumulates. One example of the refinement of hypotheses will include determining the typologies / archetypes of hospital characteristics that can help explain behaviors. While the team will be refining hypotheses throughout the district research, we plan to have an updated view of the hypotheses at the mid-point of the project.

Step 6: Synthesis

After the district research is conducted, the team will synthesize the findings. The team will identify key themes from the research including:

- Areas of convergence & divergence across interview findings (also highlighting the findings that were expected and unexpected and why)
- Areas of most importance to answer the overarching project questions
- Insights on the rationale for why challenges are occurring
- Develop the landscape mapping and key themes, observations and recommendations

3 Methodology for facilities selection

To determine how to impact the behavior of private sector providers with different profiles, the interviews will include a mix of facility typologies in each selected district. Figure 1 below attempts to capture the variation of facility typologies selected for district interviews.

Due to data limitations, especially for private clinics, pharmacies, and labs, facility selection will not be a solely data-driven approach. We will supplement this with feedback from the district-level CTB team (for North Jakarta, Medan, and Tulungagung) and District Health Offices (DHO). Local knowledge of the CTB team and DHO in each district will help identify facilities that are considered the technical leaders in providing TB care, while ensuring feasibility to secure interviews with the respective facilities.

The initial list of identified facilities will be re-calibrated with underlying data whenever possible to ensure a balanced set of facilities to interview in each selected district.

Dimension	Hospital (n=4-5 per district)	Clinic (n=4-5 per district)	Pharmacy (n=8-10 per district)	Lab (n=4-6 per district)
Size	Mix of size, based on - Type (A/B/C/D), and/or # of beds and outpatients, and/or # of reported TB case	Mix of size of clinics ¹ , based on - Type (<u>pratama</u> and <u>utama</u>), and/or # of doctors and/or # of patients	Mix of size, based on # of pharmacists, or # of TB drugs sold, or # of TB cases referred	Mix of size, based on # of TB diagnostics performed, or # of laboratory technicians
TB care service capabilities	Mix of lab w/ and w/out advanced TB diagnostic tools (<u>GeneXpert</u> , DST, Culture) and in-house pharmacy disbursing TB drugs (<u>FDC</u> vs loose) Include all facilities with <u>GeneXpert</u> if possible	Mix of lab w/ and w/out advanced TB diagnostic tools (<u>GeneXpert</u> , DST, Culture) and in-house pharmacy disbursing TB drugs (<u>FDC</u> vs loose) Include all facilities with <u>GeneXpert</u> if possible	Mix of pharmacy selling more <u>FDC</u> and selling more loose-drugs	Mix of lab w/ and w/out advanced TB diagnostic tools (<u>GeneXpert</u> , DST, Culture) Include facilities with <u>GeneXpert</u> if possible
BPJS-K affiliation	Mix of <u>BPJS-K</u> -affiliated and non <u>BPJS-K</u> affiliated			Not applicable (Not affiliated with <u>BPJS</u> , except for preventive diagnosis, e.g. cervical cancer pap smear)
Business model	Mix of chain and non chain facilities			
Clientele served	Mix of higher and lower SES clientele (proxy by % of <u>BPJS</u> patients or affluence level of neighborhood)			
Qual. assessment	Technical leaders in TB, level of engagement or participation of facilities in PPM, ability to secure interviews			

Figure 1. Variation of facility typologies for district interview

4 Key hypotheses to be tested in the interviews for clinics

We have structured the interview guide in 9 sections. Each section has the objectives articulated, which is to test the relevant pre-research hypotheses on how private facilities are performing and why.

Additionally, the team will also test a set of hypotheses around potential archetypes that may enable NTP and its partners to implement change more effectively and understand how each of those archetypes would behave in response to TB care improvement initiatives. These initial hypotheses include:

- Chain clinics, may be an important opportunity for impact in any change initiative due to sheer number of facilities within the network, assuming there is a strong central command model
- Clinics with large capitation, and especially those equipped with in-house pharmacies, may be a prime / priority candidate for PKM to have a formal referral / MoU with in order to minimize numbers of loss-to-follow-up
- Clinics set up inside big facilities/factories, especially those involving occupational hazard (e.g. chemical / biological / physical hazards), may be an important lever to not only provide medical treatment but also provide educational seminar on TB- (and non-TB-) related diseases
- Clinics who are part of a group with other business, e.g. for hospital -> Rumah Sakit Mitra Keluarga owned by the largest Pharmaceuticals company in Southeast Asia Kalbe Farma, are likely to present both challenges (e.g. they may prefer their own drugs to government-funded FDCs in their clinics) and opportunities (e.g. ability to better monitor care over the patient pathway)
- Clinics that are part of a strong broader network of care (e.g. referral agreements with labs and pharmacies, with Puskesmas or community health organizations or professional health associations as well as commercial service providers such as sample transporters) vs. those that act independently may be more effective and efficient in delivering convenient, consistent care because they have institutions that can help supplement care delivery or reinforce behaviors of the providers and patients

5 Interview guide and questionnaires: for Clinics

The team will develop a data template that will be sent to the facilities for completion before the interview (see Section 6 for data request) in order to minimize the number of data-intensive questions that could interrupt the discussion flow. The collected data will provide a basis for understanding the characteristics of each facility, enabling the interview questions and discussion to be tailored according to the facility's profile. However, in the event that the pre-interview data request is not filled prior to the interview (or not fully completed), this information will be gathered during the interview. The interview guide will enable the team to explore qualitative elements on the topics targeted in the data request in order to understand the 'whys' behind any figures.

5.1 Introduction and context (~ 5 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
To be shared with interviewee after introductions to BCG team • Project objective: Understand who are the key private sector actors and how they are currently operating in delivering TB care, understanding the institutional relationships in private sector TB	• Share objectives and get early buy-in (i.e., what's in it for them)

care, and to establish a strong basis for follow-up support from NTP Indonesia and a USAID/Indonesia project • Interview objective: Understand the sphere of influence of clinics in TB care; identify strengths, weaknesses and opportunities of institutional relationships between facilities and other TB care providers; and identify the institutional incentives / disincentives to providing high quality, effective TB treatment • Protection of interviewee: Results will be anonymized and reported in aggregate. The raw data will not contain identifiers of either individual respondents or individual facilities. • Overview of interview, including: • Format • Topics covered • Anonymity to promote openness	• To encourage candidness in answers
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5.2 Background & profile of facility (~15-20 min if template not yet populated)

<u>Interview Questions / Guidelines</u> To be collected prior to the interview in template provided (see Section 6 for complete view; will be pre-populated with existing data before sending to participant) Business performance and high-level business model • Over the past few years, has business been steady, struggling, or growing / expanding? What factors may have driven this performance? • Do you have a strategy for increasing your market share? What is it? • What is the socio-economic status of your customers? (e.g., % low income with disposable income <IDR 2,000,000 / month), % medium income between IDR 2,000,000 – 5,000,000 / month, % high income > IDR 5,000,000 / month)? Do they primarily come to the facility for primary, secondary, or tertiary care? Are you trying to change or influence this? How and why? • Given your facility's therapeutic and business priorities, how much of a business case is there for providing and improving TB care (low, medium, high)? Which aspects of TB care are most important to your facility (diagnostic capabilities, availability of drugs, quality of treatment and on-going care, reporting)? Why?	<u>Objectives</u> • Understand characteristics of the clinic to inform potential archetypes of different facility types • Develop recommendations tailored to specific archetype / typology of institutions
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5.3 High quality TB care: Successful detection & diagnosis (~15 min)

<u>Interview Questions / Guidelines</u> Availability of diagnostic tools • Who in the clinic (i.e. which position / role) decides which diagnostic capabilities to own? • What are the methods and tools your facility uses to diagnose DS-TB? How does the facility diagnose MDR-TB? Have you increased /	<u>Objectives</u> • To understand facility's current level and quality of TB care capabilities and to identify gaps as potential target areas for
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decreased your TB diagnostic tools in the last few years? Which ones specifically? • If indicated no X-ray or sputum smear in in-house lab in data request, why not? • GeneXpert: - If indicated GeneXpert in data request, did you acquire it from a private supplier or from the public sector? - Do you procure the cartridges from private or public sources? • Do you think your diagnostic tools are sufficient for the current demand in TB care? Why or why not? • Have you considered providing / proposing more advanced diagnostic tools? If not, why and what is the challenge? - What are the financial and non-financial considerations? - What # of patients per tool is necessary / desirable to acquire more advanced diagnostic tools in-house (e.g. for it to make economic sense to purchase GeneXpert)? - Would you be interested in hosting a public sector Xpert machine if, in return, you had to limit your client test fee and report the outcomes to the public sector? • What would incentivize you to provide more advanced diagnostic tools? Which one is most attractive? Why? - More suitable or competitive pricing model (e.g., Cost per Reportable Result vs. procuring the diagnostic equipment, discounted price from group purchase, etc) - Volume guarantee from referral network - Fee-for-service (BPJS) for diagnostic method / tools—which one and why? - Any others? - How do you ensure physicians' compliance to monitor patient treatment completion? (if they are the ones responsible for doing so)? - If not, who is in charge and who do you think is better positioned for the role and why? - Are there any consequence if facility / PIC does not follow up with patients and ensure treatment completion?	improvement; to be able to identify if any patterns exist between level of capability and their behaviors
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5.4 Up-referral and Cross-referrals (~10 min)

<u>Interview Questions / Guidelines</u> Up referral and Cross-referrals • For general medical issues, in what circumstances would you refer patients out for services, and where? (which lab, pharmacy,	<u>Objectives</u> • Understanding incentives / disincentives for down-referral of
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specialist, PHC clinic or hospital?) Does this differ for TB, e.g., referring out for diagnostic or pharmacy services, or for follow-up care? If clients are referred in, where do they mostly come from (lab, pharmacy, specialist, PHC clinic; overall, more from public or private), and why? How many clients are referred in a year? Do you have preferred referral relationships? Does this differ for TB vs other conditions?	clients / patients as basis for encouraging ideal behaviors in delivering TB care Gauging the extent of facility's current referral networks and understanding the merits of appropriate facilities in providing different aspects of TB care for different TB patients
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5.5 High quality TB care: Successful treatment (and completion) (~25 min)

<u>Interview Questions / Guidelines</u> TB drug provision and treatment capabilities - If previously indicated “no in-house pharmacy” in data request, why not? (<i>For facilities without in-house pharmacy, jump to “system of monitoring” question</i>) - If your facility has an in-house pharmacy, who in the clinic decides which drugs (FDC vs. loose, first-line vs. second-line) to stock or procure? - Why do you stock public / private TB drugs? (For facilities stocking $\leq 100\%$ private drugs), would you be willing to stock public TB drugs (or increase current supply of public drugs)? Why/why not? - What would incentivize you to stock and prescribe government-funded TB drugs based on TB care guideline in your hospital? - Reduce requirement and financial burden to access government-funded FDCs? How and by how much if financial? - Direct or indirect financial incentives for correct prescription? How much and how to claim? - Any others? - What are the mechanisms in place to ensure that pharmacists don't sell TB drugs without prescription? If no mechanisms are currently in place, what would be required to ensure compliance? - Do TB care doctors / physicians have a preference for prescribing loose TB drugs over FDCs? If yes, what % of them and what are potential reasons (e.g. habit, belief of higher efficacy)? Does the clinic have any authority to influence the doctors' preference? Treatment completion - Does the institution have an incentive for monitoring and promoting the continuity of long-term and follow-up care in general (not just	<u>Objectives</u> - To understand facility's current level and quality of TB care capabilities and to identify gaps as potential target areas for improvement; to be able to identify if any patterns exist between level of capability and their behaviors - Understand economics behind providing TB care capabilities to identify compelling financial levers for incentivizing facilities to improve services - Uncover potential non-financial means to encourage ideal behaviors and incentivize facility to provide high quality TB care - Identify facilities with high TB care capability as potential “role model”
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for TB)? Is that a monetary or reputational incentive? - Is there any system to promote this monitoring of follow-up care? Is this used for TB (e.g. patient adherence to 6 months treatment regimen, check-ups, follow-up for missed prescription refills or check-ups)? What are some key challenges? - How do you ensure physicians' compliance to monitor patient treatment completion? (if they are the ones responsible for doing so)? - If not, who is in charge and who do you think is better positioned for the role and why? - Are there any consequence if facility / PIC does not follow up with patients and ensure treatment completion? - Are there consequences / penalties for the facility / physicians / other staff in charge for not monitoring TB treatment completion? - What would incentivize the clinic to encourage doctors to monitor and remind patients about on-going treatment? Which one is most attractive? Why? - Financial payments from BPJS-K for each completed treatment of patients (milestones)? Other rewards? - Accelerated annual licensing renewal or ease of licensing renewal - Auto-reminder, e.g., application to send automatic SMS to patients - Any others? HR policies and physician profile - Are TB diagnosis and treatment functions limited to certain individuals in your hospital, or spread widely across all physicians in the hospital? What are the main considerations in hiring such people? Are they TB certified? - What proportion of the physicians in your facility are specialists (including internists) vs. what proportion are GPs without internist? - Are there differences in the quality of care they provide / compliance to facility's policies? How? - If indicated there are TB certified / specialist staff, what support (e.g. paid leave, non-financial rewards, etc.) does the facility provide to encourage doctors to obtain the certification? - What motivates the clinic to provide training and support to ensure that doctors are TB-trained or TB-certified? Which one is most important? Why? - Financial reward? How much? - Ease of clinic / doctor licensing renewal - Earned reputation e.g., as TB care top provider / other non-monetary rewards (what are they?) - Better access to training (free training, shortened training) - Any others? - If you indicated that you don't not have any TB certified / specialist	in future support initiatives - Understand facility's motivations for investing in TB staff and TB care certification - Understand the levers facilities have based on the motivations and allegiances of TB care providers
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staff, have you tried to encourage training? If not, what has prevented you from providing support for it (time away from practice, lack of accessible programing, lack of need)? Compensation • Are doctors / physicians paid a salary or commission or both? Are they paid additional amounts based on either BPJS-K or other income? - Are there differences in the quality of care provided / compliance to facility's policies for different payment schemes? How? • If previously indicated presence of dual practice doctors, where else do they practice? What types of other facilities? • What proportion of their incomes come from respective sources? Is it more economically desirable for physicians to practice partly in a hospital vs. in a standalone PHC clinic? Or to practice in multiple clinics / hospitals? • How many doctors / physicians working at your hospital are also working at (or operating) private clinics? - Do they refer patients from the facility to the clinics? - Do you see this as an issue impacting health outcomes of patients? If yes, what actions have you taken to monitor and manage this?	
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5.6 Operational DOTS corner (~ 15 min)

<u>Interview Questions / Guidelines</u> What is the facility's current DOTS unit functionality? • Do you have a DOTS unit in this facility? Why or why not? • Which functions of a DOTS unit do you have? - Does your facility have centralized TB reporting? - Does your facility report TB data to the public sector? ▪ For all or some providers / clients in the facility? ▪ If partial, why? ▪ How (electronic or paper; collected or sent)? - Does your facility stock and prescribe public sector TB drugs? ▪ If yes, how much (100%, 50-99%, <50%)? • If you don't have any of the above functions, why not? • What are the benefits to your facility of having a DOTS unit? (i.e. enables treatment of more patients, better reputation, improves quality of TB care for patients, easier to renew / obtain license) • What challenges do you face in complying with DOTS requirements? What is the facility's current TB case and treatment reporting capabilities? • Do you report all TB cases? Who is responsible for reporting TB cases?	<u>Objectives</u> • Understanding current DOTS capabilities and identifying any breakdown in the system • Uncovering reasons or burdens behind non-compliance as basis for future interventions to strengthen efficacy of DOTS in private institutional TB care
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- Are there any consequences when the facility / responsible person (or group of people) do not do so? If yes, what are they? • Do you report treatment outcomes to the government? Who is responsible for reporting TB cases? - Are there any consequences when the facility / responsible person (or group of people) fail to do so? If yes, what are they? • As administrator / manager / owner: do you enforce reporting requirements for any conditions? For TB? If yes, how often? If not, why not, and what are your ideas about how to do so and whether it might work? (lack of clear consequences for non-compliance, lack of clear / guaranteed benefits, not comfortable, high cost burden, high administrative burden, etc.)? - For chain facilities, do you believe that having a chain business model enables you to enforce better – why or why not? • What incentives would be effective for your clinic to establish systems to facilitate or check that your physicians comply with reporting guidelines? Which one is most attractive? Why? - Streamline reporting process (e.g., WiFi TB application for CTB districts, integrated reporting between internal and external systems) - Referral guarantee if meeting certain thresholds - Direct or indirect financial payments for each validated report - Any others?	
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5.7 BPJS-K enrollment (~ 15 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
• (From data template or previous section's answer on BPJS-K enrollment) If your facility is enrolled in BPJS-K, why did you join? Do you think it has been or has not been beneficial to participate? What benefits have you seen specifically or why has it not been beneficial? How has your financial position, level of care, etc. changed since you joined? • If not enrolled with BPJS-K, why not? What incentives or changes in the BPJS-K system would encourage you to join? • In which of the following areas do you experience challenges in providing TB care under the BPJS-K program? What changes would you like to see? - Areas to explore: Compliance with service and facility standards, reporting requirements, increasing resource and cost burden, economics of treating a patients using BPJS vs. using private insurance vs. paying out of pocket (including reimbursement coverage and value, reimbursement process /	• Understanding facility's incentives / disincentives for enrolling in BPJS-K program • Gauging economic attractiveness of BPJS-K programs and understanding challenges to lay groundwork for better TB care in BPJS-K with increasing network of clients / patients

timeline, value of fee-for-service scheme, if applicable) • Deep Dive: What is the challenge with the existing capitation model in providing quality TB care? – Does the capitation model cover your cost of providing TB care? – Which services in the TB cascade (from diagnosis to treatment) should be assigned to your type of facility and trigger a payment to you by BPJS-K? Who should be compensated for the other steps?	
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5.8 Relationships with other institutions / care providers and PPM (~15 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
<u>Relationship with other institutions</u> • When providing any medical services, what other institutions do you engage with (E.g., other providers such as Puskesmas, clinics, hospitals, labs, pharmacies, Professional Assoc., Community Health Org, DinKes)? • With whom? What is the nature of the engagement? (one-way / mutual referral, reporting, formal / contractual or informal, etc) • Why did you choose these partners? What criteria do you use to select? How do you prioritize? • Who makes the decision on who to partner with? • How does this relate to your future growth strategies for the hospital or chain? • When providing TB care, what other institutions do you engage with (E.g., other providers such as Puskesmas, clinics, hospitals, labs, pharmacies, Professional Assoc., Community Health Org, DinKes)? • With whom? What is the nature of the engagement? (one-way / mutual referral, reporting, formal / contractual or informal, etc) • Why did you choose these partners? What criteria do you use to select? How do you prioritize? • Who makes the decision on who to partner with? • If you do not engage with any of the above institutions, why not? Do you see any of the institutions as playing a potential role to complement or support the role of your facility? If so, how? • Do you agree that uncomplicated TB patients are more effectively cared for in primary care either in the private sector or in Puskesmas? Why or why not? • Do you think it is valuable for primary care providers to be the “first point of contact” for patients with any condition, before those patients come to hospitals? Why or why not? How about for patients with possible TB symptoms? • What role do you think professional associations (e.g., IAI,	• Gauging the extent of facility’s current relationship networks as basis for achieving ideal linkages in TB care ecosystem • Understanding the merits of appropriate facilities in providing different aspects of TB care for different TB patients • To identify facilities with large relationship networks as possible target of future impactful initiatives • Understanding facility’s linkages with PPM and public sector as well as professional associations & community organizations

ASKLIN, IDI, ARSSI, etc) or community organizations should play in supporting TB care / improving linkages between facilities?

PPM / Partnership or linkage with Public Sector

- How often does this institution interact with either the DHO or PKM? For what purposes (licensing, trainings, reporting, other)?
- How has the hospital interacted with the public sector related to TB care?
 - What was the last time that somebody from DHO or PKM visited or called the facility for TB monitoring or reporting?
 - Are you aware of the district-based PPM TB programming /other partnership with public or other private sectors in TB?? What is your understanding of this? {if no, clarify that it involves the public sector reaching out to the private providers for TB notification and quality of care, including use of public TB drugs}
 - Are you part of the district's PPM network / other network with public or other private sectors in TB?? Why did you agree to be part of the network?
 - Has anybody approached / engaged the facility to participate in PPM TB initiatives / other partnership initiatives with public or other private sectors in TB??
 - If yes, who approached you (Dinkes, community organizations, etc)? In which activities did you participate? Would you participate again? Why or why not?
 - If you did not participate, why not? Any feedback?
 - How effective do you perceive the network to be? Has it addressed the needs of private sector? Which needs specifically (funding, knowledge support, etc)? If not, what additional efforts would address the unmet needs better?
 - Explore relationships with NTP, Dinas Kesehatan, Puskesmas/other public primary care (if not covered yet)
- Would you be open to further PPM efforts / interaction with public sector regarding TB?
 - Would you like to be involved (if not yet) or more involved (if previously already) in strategy formulation / implementation of efforts to improve TB care or improve linkages between different facilities that offer TB services? Why or why not? In what type of roles or opportunities? (e.g., be invited to planning meetings / establish and join a referral network)
 - Do you think the relationship between the private and public sector needs to be improved? If yes, what do you think can be improved in the relationship between the private and public sector? What specific initiatives / actions would be

- required to do so? - What is the best way for the government to continuously engage the private sector?	
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5.9 Commercial networks (~10 minutes)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
- Do you also work with other commercial providers E.g., do you have any commercial arrangements for sample transportation, drug procurement, drug delivery / distribution co., medical equipment providers (Abbot, Roche, etc)? - When do you typically use these providers? Who are the main companies? - Generally when you work with commercial providers: - What is the structure of the agreement? Exclusive or non-exclusive? Bi-lateral vs. multi-party agreement? What are the specific financial mechanisms: Kick-back, referral fee, discount? How much? What is the payment term? What are your obligations in the agreement? Duration of agreement? Do you typically cover the costs or pass on to the patient (for deliveries or sample transport)? - Do drug reps influence you in any way, whether related to TB or not? How? Why? - Do you believe that engaging commercial providers and other partnerships better equip the facility to treat patients overall? Why or why not? - What specific partnerships / engagement have the highest impact on TB patients / TB care? What drives the impact? (e.g. drug delivery company increases convenience for patients in accessing TB drugs to maximize chances of completing full regimen)?	- Understanding size of facility's commercial network to determine potential levers of support in delivering TB care; understanding whether commercial & non-commercial network enables the facility to deliver higher quality care / stronger influence in TB care ecosystem - To identify facilities with large commercial networks as possible target of future impactful initiatives

6 Data template and request

Clinic name, district:	<i>[example]</i> Clinic Semper Medika, Kota Jakarta Utara
Classification (Pratama/Utama):	Pratama
BPJS-K?:	Enrolled in BPJS-K
# of branches:	~32
Location of branches (districts, provinces):	To be filled
# of branches affiliated with BPJS:	To be filled

Is the clinic a PMDT ¹ site?	To be filled
Does the clinic have a pulmonology unit?	Yes
In-house lab?	Yes
In-house pharmacy?	Yes

DATA (UNIT)	2015	2016	2017	2018
# of outpatients	To be filled	To be filled	To be filled	To be filled
% of patients who are BPJS-K				
% of patients who are non-BPJS-K who pay out-of-pocket				
# of TB patients				
% DS-TB				
% MDR				
% of TB patients who are BPJS-K				
% of TB patients who are non-BPJS-K who pay out-of-pocket				
# of beds	To be filled	To be filled	To be filled	To be filled
Area of district (catchment area) (km ²)	To be filled	To be filled	To be filled	To be filled
Population of district (catchment area) (#)	To be filled	To be filled	To be filled	To be filled
# of total doctors	To be filled	To be filled	To be filled	To be filled
# pulmonary specialist	To be filled	To be filled	To be filled	To be filled
# TB-certified	To be filled	To be filled	To be filled	To be filled
# other specialists	To be filled	To be filled	To be filled	To be filled
% of total doctors who are dual-practice ²				
# of consulting doctors / physicians (non-permanent staff)				
# of non-doctor employees	To be filled	To be filled	To be filled	To be filled
# nurses	To be filled	To be filled	To be filled	To be filled
# admin staff	To be filled	To be filled	To be filled	To be filled

¹ Programmatic Management of Drug Resistant TBC

² Dual-practice physicians refers to physicians who work at multiple locations

# others	To be filled	To be filled	To be filled	To be filled
Estimated % of total income from DS-TB				
Estimated % of DS-TB income from BPJS				
Estimated % of total income from MDR-TB				
Estimated % of MDR-TB income from BPJS				
# of TB cases diagnosed				
% DS-TB				
% MDR-TB				
% comorbid TB+HIV				
% comorbid TB+Diabetes				
% comorbid TB+others				
# of TB cases reported				
# DS-TB				
# MDR-TB				
# comorbid TB+HIV				
# comorbid TB+Diabetes				
# comorbid TB+others				
<u>For in-house pharmacy</u>				
Approximate % of TB drugs stocked from government				
Approximate % of TB drugs stocked from private sector suppliers				

<u>For in-house lab</u>							
DATA (UNIT)	Microscopes for Smear Microscopy	CXR	Labs with IGRA	GeneXpert (or other molecular diagnostics)	Labs with Culture	X-Ray	Labs capable of TB DST ³
Number of tools (#)							
Price per test (IDR)							
Pathologists / analysts with capability (#)							

³ Drug susceptibility test

USAID-BCG PROJECT IN INDONESIA

Institutional assessment of private sector health providers in TB care

District field research approach: Community Health
Organization

USAID and BCG Indonesia

5/30/2018

Contents

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1 Topics covered in interviews with Community Organizations

Phase 2 of the private provider review will map the most critical private facilities - private hospitals, clinics, labs, and pharmacies – in each selected district and focus on understanding **current market** and **policy incentives** for private health care facilities and how different policies or interventions might affect those incentives at an institutional level. It will provide information to support the implementation of future initiatives to increase uptake and improve the quality of TB care, especially opportunities to use JKN as a lever to change behaviors of private sector providers.

More specifically, the interviews with Community Organizations across the seven districts will help us understand:

- **For each district, which community organizations are stronger and weaker, which have an interest in health and in TB, and which individuals from these organizations have the greatest potential to be key opinion leaders for future initiatives?**
- **Are there any opportunities for community organizations, as institutions, to interact with private facilities?**
 - How do community organization, as institutions, view their role or function vis-à-vis private facilities?
 - How often do community organizations interact with private facilities? For what purposes?
 - How have community organizations interacted with private facilities related to TB care?
 - What is the community organization's ideal, expected interaction with private facilities?
- **What are the challenges faced by community organizations in implementing current initiatives to drive providers towards the provision of quality TB care? How?**
 - Understand how community organizations envision engaging with private facilities in their district, and the attitudes among private providers toward participation in community organizations programming

The outcomes will be used to:

- Recommend a set of concrete, specific next steps for each district to advance its process of engaging private providers and institutions in TB care and prevention
- Socialize findings with Dinas Kesehatan and other stakeholders to inform the national dialogue on district-based PPM for TB in Indonesia

2 Phase 2b approach to qualitative research and insight generation

Overview

For Phase 2b district research with private sector hospitals, clinics, pharmacies, labs, Professional Association, DHO and community health organization, we will employ a multi-step process to generate insights. This process has been adapted from BCG best practices for qualitative interviews.

At a high-level, there are six key steps in this process:

1. Pre-planning
2. Ideas generation from private facilities interviews
3. Interview guide development and pre-work
4. Interview conducting*
5. Insights capture and hypothesis refinement*
6. Synthesis

*Note that steps four and five are iterative in that they will inform each other through the process. Each step of the process will be explained in more detail in the following sections. To bring the process to life, we will use community health organization as an example. Please refer to the Hospital interview guide for the approach regarding private facilities.

Step 1: Pre-planning (*In-process*)

The team has engaged with DHO, and in some cases the PHO (e.g. East Java, North Jakarta, Makassar), of each of all seven districts included in this assessment during facilities selection process. DHO helped the team select organization to ensure feasibility (i.e. ability to secure interviews) as well as to identify community health organizations they see as the active, moral leader in TB. DHO has also introduced us to the district head or the representatives of community health organizations for interviews.

Step 2: Ideas generation from private facilities interviews (*In-process*)

Prior to conducting the community organizations interviews, the team would have conducted a few interviews to develop informed conjectures about private sector facilities' current interaction with community organizations and possible areas for improvements (see Section 3 for ideas generation from private facilities interviews).

Community organizations interviews are planned to be an exploratory session for the team to learn community organizations' views of ideal interaction with private facilities. The ideas captured through private facility interviews will be raised to heads of relevant community organizations or representative towards the end of the interview and discussed to enable the team to test and identify the most effective, practical levers and incentives to affect change.

Step 3: Interview guide development and pre-work (*In-process*)

The team is developing an interview guide to help direct the interview discussion, ensuring that the questions are targeted and tie back to the overarching project objectives. (See Section 4 for draft interview guide for community organizations).

Step 4: Interview conducting

For each of the districts, the interviews with community organizations will take place after the team has conducted a few private facility interviews over the course of one to two weeks as opposed to being conducted early (note that for most districts it will take up to 8 days to complete all interviews for that district including hospitals, clinics, labs, pharmacies, Dinkes and community organizations). This approach is deliberate in order to enable the team to collate inputs from facilities to bring into the community organizations interview.

Whenever possible, the team will run a Focus Group Discussion with Community Health Organizations, as long as they are not determined to be competing with each other. The team will also make sure that the ongoing refinement will be informed by the insights captured over the course of the research in each district across districts.

Step 5: Insights capture and hypothesis refinement

The team will capture insights in two ways: during the interview and after the interview. During the interview, the team will capture key notes to supplement the audio recording. Key insights of the interviews will be typed up, synthesized and shared with the broader team on a weekly basis. The relevant part of the audio recording will be listened to in order to ensure key points are captured and interpreted

accurately. At the end of each day, the team will collectively discuss key themes from the discussion, compare notes, test and determine the following areas:

- Are the interviews providing the type of insight we need? If not, what needs to be adjusted?
- What are the key themes and takeaways related to our project objectives?
- What are we learning to ensure feasibility of emerging recommendation?

In doing so, the team will refine and focus the pre-research hypotheses as the evidence accumulates. While the team will be refining hypotheses throughout the district research, we plan to have an updated view of the hypotheses at the mid-point of the project.

Step 6: Synthesis

After the district research is conducted, the team will synthesize the findings. The team will identify key themes from the research including:

- Areas of convergence & divergence across interview findings (also highlighting the findings that were expected and unexpected and why)
- Areas of most importance to answer the overarching project questions
- Insights on the rationale for why challenges are occurring
- Develop the landscape mapping and key themes, observations and recommendations

3 Testing of ideas & hypotheses generated from Community Health Organization interview

Towards the end of the community organizations interviews, we plan to share the emerging set of ideas and / or lessons learned from private facilities interviews in order to compare whether this perspective coincides with community organizations' own views about their relationship with private providers and their role in the TB care ecosystem. This will also enable the team to diagnose the efficacy of current initiatives and incentives / disincentives, determine areas of alignment or potential disconnects, identify weaknesses and untapped opportunities for future interventions.

This set of ideas will be informed by the following pre-research hypotheses that have been identified to help define the role of Community Health Organizations in the TB care ecosystem. These hypotheses, which will continue to be refined and validated during the initial set of exploratory interviews:

- Members of community organizations, having close interaction with TB suspects and patients are key to case identification and can help identify and suggest solutions for problems in the continuum of care, specifically for private provider clients
- Community organizations that are part of a larger network of facilities or those with strong ties to facilities (e.g. AISYIYAH is part of Muhammadiyah Foundation that also owns hospitals under the same name Rumah Sakit Muhammadiyah) have access to a wider range of TB care services giving them a larger sphere of influence for future interventions
- Member of community organization acting as TB-patients supervisor (e.g. ensuring patients to take drugs in timely manner, escorting patients to collect next set of medications at PHCs or Hospitals) may help private facilities temporarily reduce the administrative burden of treatment adherence and provide education to patients and their families / networks to maximize chances for completion of care (e.g. on the importance of adhering to full drug regimen or the risks and implications of dropping out)

- Community organizations can extend hospitals' / clinics' / labs' outreach by utilizing community organizations' members for specific functions (e.g. to deliver the clients' sputum sample to private facilities lab for testing) – reducing facilities' customer acquisition cost (e.g. marketing) for TB diagnosis services

4 Interview guide and questionnaires: for Community Organizations

We have structured the interview guide in 5 sections. Each section has the objectives articulated, which is to understand community organizations' role, business case for participating in the private sector TB care ecosystem and views of ideal relationships with private providers and other key stakeholders (public sector, associations and other community organizations).

4.1 Introduction and context (~ 5 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
To be shared with interviewee after introductions to BCG team • Project objective: Understand who are the key private sector actors and how they are currently operating in delivering TB care, understanding the institutional relationships in private sector TB care, and to establish a strong basis for follow-up support from NTP Indonesia and a USAID/Indonesia project • Interview objective: Understand the sphere of influence of community organizations in TB care; identify strengths, weaknesses and opportunities of institutional relationships with facilities and other TB care providers; and identify the institutional incentives / disincentives to supporting high quality, effective TB treatment • Protection of interviewee: Results will be anonymized and reported in aggregate. The raw data will not contain identifiers of either individual respondents or individual facilities. • Overview of interview, including: - Format - Topics covered - Anonymity to promote openness	• Share objectives and get early buy-in (i.e., what's in it for them) • To encourage candidness in answers

4.2 Background & profile of community organizations (~20 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
Background and profile of community health organization • When and why was the institution established? What is the main mission? Is the organization part of a larger network? If yes, what other institutions are part of the network? What is the nature of the relationship? • What is the organizational structure of the organization? Who leads the organization? How is he / she appointed? Is there a board? • How many members are currently in the organization in this district	• Understand characteristics of community organization to gauge sphere of influence for different stages of TB care and geographic reach

(permanent and temporary)? What are the characteristics of your constituents and how are they recruited? - What is required to become a member? Who decides? Why do they choose to join? - What % of members are active (attend meetings at least once a month, lead initiatives / programs, etc.)? What are the characteristics of active members? - What % of members belong to multiple organizations? • Does the organization have representatives or offices in the district / provincial / national level? • What is the source of your funding (donations from members, donations from institutions, etc.)? • Are there any full-time, paid staff in the district organization? How many? • How does the organization make decisions? - Are key decisions on agenda and resource allocation centralized or decentralized (e.g. decided on the national level and socialized to the province and districts or made with input from all levels)? - Are key decisions made through consensus or majority vote or others? • How do teams across districts interact? How often do they meet? Key priorities and initiatives • What are the other health conditions that the organization addresses, if applicable? • Given various priorities, how much of a business case is there for improving TB care in the private sector in the district? Which aspects of TB care are most important to your district (diagnostic capabilities, availability of drugs, quality of treatment and on-going care, reporting)? Why? • How many TB-related initiative have been launched over the past year and other than the district-based PPM, which one is your organization prioritizing? How does your organization prioritize these initiatives and why?	• Understand key priorities and success factors of past initiatives as basis for future programs
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4.3 Relationships with other healthcare providers (~20 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
• How often does your organization interact with private facilities (not just for TB)? For what purposes? • In the context of TB care, which institutions do you engage with (E.g., Puskesmas, private providers such as clinics, hospitals, labs, pharmacies, other Professional Assoc., Community Health Org.)? - With whom? For what purpose? - What is the nature of the engagement? (one-way / mutual referral, reporting, formal / contractual or informal, etc)	• Understanding current interactions between community organizations and private facilities

How many times in a year? - Why did you choose to interact with these partners? How do you prioritize? - Who makes the decision on who to engage with? • If your organization does not engage with any of the above institutions, why not? Do you see any of the institutions as playing a potential role to complement or support the role of your organization's mission? If so, how? • Have there been other conditions or priorities that you have worked on (e.g. diabetes, HIV) in which you have effectively engaged private facilities? If yes, what did you do to achieve this engagement? What incentives did you provide, if any? Ideal relationship with private healthcare providers • What's your view of the ideal institutional relationship between your organization and private sector providers (E.g. clinics, hospitals, labs, pharmacies) both in the context of TB and non-TB care? - What is the purpose for this relationship? - What should the nature of the engagement be? (one-way / mutual referral, reporting, formal / contractual or informal, etc) - What is the organization's role or function to establish or improve this relationship? • If such relationship or linkages between the organization and facilities or between the facilities are not happening today, why not?	• Understanding the ideal institutional relationships between community organization and private providers in TB care to identify gaps and opportunities to improve linkages
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4.4 Relationship with the public sector and role in PPM (~20 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
Interaction with public sector and role in PPM • Generally, how often does your organization interact with each of the public sector entities (DHO, PKM, other relevant ones, etc.)? For what purposes? - Which parties do you interact with the most and why? - How do you interact with these organizations (e.g. implementation support, educational and socialization, etc)? • Are you aware of the district-based PPM TB programming /other partnership with public or other private sectors in TB?? What is your understanding of this? {if no, clarify that it involves the public sector reaching out to the private providers for TB notification and quality of care, including use of public TB drugs} - Has anybody approached / engaged the organization to participate in private provider engagement for TB? - If yes, who approached you (Dinkes, other professional associations, etc)? - Is your organization part of the district's PPM network/	• To understand community organizations' current level of engagement with public sector and to identify the progress and challenges of the district-based PPM roll-out

network with public or other private sectors in TB? In what role? If so, why did your organization agree to be part of the network? - If your organization did not participate, why not? Any feedback? - How effective does your organization perceive the network to be? Has it addressed the needs of private sector? Which needs specifically (funding, knowledge support, etc)? If not, what additional efforts would address the unmet needs better? • Explore relationships with NTP, Dinas Kesehatan, Puskesmas/other public primary care (if not covered yet) Would you be open to further PPM efforts/ other partnership with public or other private sectors in TB? • Would your organization like to be involved (if not yet) or more involved (if previously already) in strategy formulation / implementation of efforts to improve TB care or improve linkages between different facilities that offer TB services? Why or why not? In what type of roles or opportunities? (e.g., be invited to planning meetings / establish and join a referral network) • Do you think the relationship between the private and public sector needs to be improved? Specifically between organizations and the public sector? If yes, what do you think can be improved in the relationship between the private and public sector, and between community organizations and the public sector? What specific initiatives / actions would be required to do so? • What is the best way for the government to continuously engage the private sector and organizations? • Which other community organizations (other than your own) are currently strong in TB, or in private provider engagement (or both)? • Which other community organizations could be strong in these roles? Why?	
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4.5 Testing of ideas & hypotheses generated from private facilities interview (~20 min)

<u>Ideas and hypotheses generated from private facilities interview</u> <u>Initial hypotheses include:</u> • Members of community organizations, having close interaction with TB suspects and patients are key to case identification and can help identify and suggest solutions for problems in the continuum of care, specifically for private provider clients • Community organizations that are part of a larger network of facilities or those with strong ties to facilities (e.g. AISYIYAH is part of Muhammadiyah Foundation that also owns hospitals)	<u>Objectives</u> • Share and discuss the emerging set of ideas and / or lessons learned from private facilities interviews in order to compare whether this perspective coincides
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under the same name Rumah Sakit Muhammadiyah) have access to a wider range of TB care services giving them a larger sphere of influence for future interventions • Member of community organization acting as TB-patients supervisor (e.g. ensuring patients to take drugs in timely manner, escorting patients to collect next set of medications at PHCs or Hospitals) may help private facilities temporarily reduce the administrative burden of treatment adherence and provide education to patients and their families / networks to maximize chances for completion of care (e.g. on the importance of adhering to full drug regimen or the risks and implications of dropping out) • Community organizations can extend hospitals' / clinics' / labs' outreach by utilizing community organizations' members for specific functions (e.g. to deliver the clients' sputum sample to private facilities lab for testing) – reducing facilities' customer acquisition cost (e.g. marketing) for TB diagnosis services	with community organizations' own views about their relationship with private providers and their role in the TB care ecosystem.
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USAID-BCG PROJECT IN INDONESIA

Institutional assessment of private sector health providers in TB care

District field research approach:
District Health Office

USAID and BCG Indonesia

5/30/2018

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1 Topics covered in interviews with District Health Office (DHO)

Phase 2 of the private provider review will map the most critical private facilities - private hospitals, clinics, labs, and pharmacies – in each selected district and focus on understanding **current market** and **policy incentives** for private health care facilities and how different policies or interventions might affect those incentives at an institutional level. It will provide information to support the implementation of future initiatives to increase uptake and improve the quality of TB care, especially opportunities to use JKN as a lever to change behaviors of private sector providers.

More specifically, the interviews with DHOs across the seven districts will help us understand:

- **Which DHOs are more or less sympathetic to the need to engage private providers, and the need to provide certain public sector inputs to ensure high quality private sector TB care**
- **Are DHOs aware of the financial and business pressures and market incentives on private healthcare facilities?**
 - And do they understand how that should influence their own interactions with the private sector (e.g., ensuring that regulations and/or quality schemes and trainings minimize financial impacts)?
 - If not, how to increase that understanding?
- **How should the public sector interact with private facilities?**
 - How often does the DHO or their constituents (e.g. Puskesmas) interact with private facilities? For what purposes (licensing, trainings, reporting, other)?
 - How has the public sector interacted with private facilities related to TB care?
 - What is the public sector's ideal, expected interaction with private facilities?
 - Understand how DHO (and Puskesmas) envision engaging with private facilities in their district, and the attitudes among private providers toward participation in district-based PPM
- **Other than private hospitals, labs, pharmacies, and physicians, are there any other local organizations or stakeholders (outside the public sector) that are contributing or could potentially contribute toward the TB care-seeking and treatment ecosystem in each district, and what are their capacities? How should they interact with public sector?**
- **How should private sector institutions interact with each other and what should the DHO's role be in improving linkages between facilities?**
- **What opportunities exist to engage private facilities in JKN?**
 - What has already motivated their participation in JKN or what incentives would motivate them to participate?
 - What concerns do they have about participation in JKN?
- **How would private hospitals, clinics, labs and pharmacies respond to any potential fee-for-service components of JKN or other interventions aimed at them, and would they pass those incentives on to their providers?**

The outcomes will be used to:

- Recommend a set of concrete, specific next steps for each district to advance its process of engaging private providers and institutions in TB care and prevention.
- Socialize findings with Dinas Kesehatan and other stakeholders to inform the national dialogue on district-based PPM for TB in Indonesia.

2 Phase 2b approach to qualitative research and insight generation

Overview

For Phase 2b district research with private sector hospitals, clinics, pharmacies, labs, Professional Association, DHO and community health organization, we will employ a multi-step process to generate insights. This process has been adapted from BCG best practices for qualitative interviews.

At a high-level, there are six key steps in this process:

1. Pre-planning
2. Ideas generation from private facilities interviews
3. Interview guide development and pre-work
4. Interview conducting*
5. Insights capture and hypothesis refinement*
6. Synthesis

*Note that steps four and five are iterative in that they will inform each other through the process. Each step of the process will be explained in more detail in the following sections. To bring the process to life, we will use DHOs as an example. Please refer to the Hospital interview guide for the approach regarding private facilities.

Step 1: Pre-planning (*In-process*)

The team has engaged with DHO, and in some cases the PHO (East Java, North Jakarta and Makassar), of each of all seven districts included in this assessment during facilities and other stakeholders (professional associations and community organizations) selection process. DHO helped the team select facilities and stakeholders to ensure feasibility (i.e. ability to secure interviews) as well as to identify private facilities and other stakeholders they see as the technical and moral leader in TB. Through this introduction, our team has established a channel of communication and is in process of securing interviews with selected facilities and stakeholders.

Step 2: Ideas generation from private facilities interviews (*In-process*)

Prior to conducting the DHO interviews, the team would have conducted a few interviews with private facilities to develop informed conjectures about private sector facilities' current interaction with DHO (and Puskesmas) and private facilities' views of what the ideal interaction with public sector and other private sector institutions should be (see Section 3 for ideas generation from private facilities interviews).

DHO interviews are planned to be an exploratory session for the team to learn DHO's views of ideal interaction with private facilities. The ideas captured through private facility interviews will be raised to DHO towards the end of the interview and discussed to enable the team to test and identify the most effective, practical levers and incentives to affect change.

Step 3: Interview guide development and pre-work (*In-process*)

The team is developing an interview guide to help direct the interview discussion, ensuring that the questions are targeted and tie back to the overarching project objectives. (See Section 4 for draft interview guide for DHOs).

Step 4: Interview conducting

For each of the districts, the interviews with DHO will take place after the team has conducted a few private facility interviews over the course of one to two weeks as opposed to being conducted early (note

that for most districts it will take up to 8 days to complete all interviews for that district including hospitals, clinics, labs, pharmacies, professional associations and community organizations). This approach is deliberate in order to enable the team to collate inputs from facilities to bring into the DHO interview.

The team will also make sure that the ongoing refinement will be informed by the insight captured over the course of the research in each district across districts.

Step 5: Insights capture and hypothesis refinement

The team will capture insights in two ways: during the interview and after the interview. During the interview, the team will capture key notes to supplement the audio recording. Key insights of the interviews will be typed up, synthesized and shared with the broader team on a weekly basis. The relevant part of the audio recording will be listened to in order to ensure key points are captured and interpreted accurately. At the end of each day, the team will collectively discuss key themes from the discussion, compare notes, test and determine the following areas:

- Are the interviews providing the type of insight we need? If not, what needs to be adjusted?
- What are the key themes and takeaways related to our project objectives?
- What are we learning to ensure feasibility of emerging recommendation?

In doing so, the team will refine and focus the pre-research hypotheses as the evidence accumulates. While the team will be refining hypotheses throughout the district research, we plan to have an updated view of the hypotheses at the mid-point of the project.

Step 6: Synthesis

After the district research is conducted, the team will synthesize the findings. The team will identify key themes from the research including:

- Areas of convergence & divergence across interview findings (also highlighting the findings that were expected and unexpected and why)
- Areas of most importance to answer the overarching project questions
- Insights on the rationale for why challenges are occurring
- Develop the landscape mapping and key themes, observations and recommendations

3 Testing of ideas & hypotheses generated from District Health Office interview

Towards the end of the DHO interview, the team will share the emerging set of ideas and / or lessons learned from private facilities interviews in order to discuss the understanding of a) DHO's current role and function, b) the ideal interaction between public and private sector, c) the ideal institutional interaction between private sector actors, and d) DHO's role in improving those linkages between facilities – all of which are informed by existing literature and research, findings from past efforts and perspectives of experts in the field.

The initial list is based on the team's ingoing hypotheses, which will be refined and added to with the ideas from the interviews. The initial hypotheses include but are not limited to:

- DHOs vary in their willingness to provide indiscriminating levels of support (e.g. subsidy for sputum cup, N95 respirator masks, etc) to private and public sector facilities, which are both upheld and adhere to the same regulatory standards, and conscious engagement by associations and other actors may be needed to improve this situation in certain districts

- DHO is pivotal in ensuring that reporting procedures / processes are streamlined at all levels to encourage compliance with requirements, including the case notification via WiFi TB and SITT, integrated case reporting between data systems (e.g. between BPJS-K case reporting system and SITT / SITB), and automated transmission of test results (e.g. from GeneXpert machines directly to DHO)
- DHO could help extend favorable public sector access to and mechanisms for TB care to the private sector in order to increase incentives for facilities to improve TB care capabilities in-house, e.g. negotiating / facilitating the placement of public sector GeneXperts (and/or cartridges) as incentives for private sector facilities
- DHO could coordinate and facilitate new arrangements between commercial network providers they have engaged with from past or current initiatives (e.g. to procure FDC drugs or GeneXpert, etc) and private facilities, e.g. enabling group purchase discount, etc. to improve access to tools to improve TB care capabilities
- DHO may be critical in playing an intervening role to keep private clinics with low capitation in business (e.g. provide direct financial assistance such as direct subsidies, push for capitation rate increase, normalize number of registered patients across clinics, limit number or locations of licensed outlets to discourage over-competition, facilitate networking arrangements, etc.) to ensure continuity of care for patients

4 Interview guide and questionnaires: for DHO

We have structured the interview guide in 6 sections. Each section has the objectives articulated, which is to understand DHOs' role and function, their view of the ideal interaction with the private sector and between institution, and the business case in incentivizing private facilities in TB care.

4.1 Introduction and context (~ 5 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
To be shared with interviewee after introductions to BCG team • Project objective: Understand who are the key private sector actors and how they are currently operating in delivering TB care, understanding the institutional relationships in private sector TB care, and to establish a strong basis for follow-up support from NTP Indonesia and a USAID/Indonesia project • Interview objective: Understand DHO's views of a) DHO's current role and function, b) the ideal interaction with private sector, c) the ideal interaction between private sector institutions, and d) DHO's role in improving linkages between facilities • Protection of interviewee: Results will be anonymized and reported in aggregate. The raw data will not contain identifiers of either individual respondents or individual DHOs. • Overview of interview, including: • Format • Topics covered • Anonymity to promote openness	• Share objectives and get early buy-in (i.e., what's in it for them) • Encourage candidness in answers

4.2 Key priorities and initiatives (~20 mins)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
Key priorities and recent initiatives - Given the district's various priorities, how much interest is there in engaging with private health providers and facilities, in general, for all health areas? Is this a priority? Why or why not? - Is there interest in improving TB care in the private sector in the district? Is this a priority? Why or why not? Which aspects of TB care in the private sector are most important to your district (diagnostic capabilities, availability of drugs, quality of treatment and on-going care, reporting)? Why? - Has the DHO launched district-based PPM? Is it a priority? Why or why not? - How much influence does the TB officer in the DHO have in influencing the health agenda of the district? Why? What is his/her view on the private sector providers? - What key challenges do you still face in implementing your agenda in engaging private providers in quality TB care?	- Understand importance of TB care in the district and TB-related past initiatives to provide context for incentives to help engage private sector institutions - Understand key success factors of DHO's initiatives in the respective district

4.3 Role and relationship with private sector: PPM and commercial network (~30 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
Role and interaction with private sector - What do you see as the DHO's role in relation to private healthcare facilities? {Probe if necessary: regulation; facilitation of networking; capacity building; none} - Generally, how often do you interact with each of the private facility type (hospitals, labs, pharmacies, clinics)? For what purposes (licensing, trainings, reporting, other)? <i>Will not spend too much time on licensing as it has been covered in Phase 1</i> - Which type of facilities and / or specific facilities do you interact with the most and why? - How do you interact with these facilities? - Are these interactions productive? Why or why not? - How have DHO interacted with the private sector related to TB care? - Do DHOs or PKM staff currently visit or call private facilities for TB monitoring or reporting? If yes, how often, and for what purpose? - If the district has launched district PPM: As DHO, you have two roles in district PPM. The first is that the district TB wasor has to personally monitor and interact directly with private hospitals. The second task is for the DHO to convince PKM TB focal points to reach out to GPs. Which	To understand DHO's current level of engagement with private facilities and to identify the progress and challenges of the district-based PPM roll-out

task is more or less challenging? Why? What could be improved in this scheme? • Do professional associations help in this work? How? How could they help more? • How aware are the private facilities of the district-based PPM TB programming? Do they have a good understanding of this? • What proportion of the district's private hospitals are engaged as part of the district's PPM network? What proportion of GP clinics? • What characteristics or are the types of facilities that generally participate in the district-based PPM vs those that don't participate? • How effective do you perceive the network to be? Has it addressed the needs of private sector? Which needs specifically (notification, tracing loss-to-follow-up, supply of public sector drugs to private facilities, knowledge support, etc)? If not, what additional efforts would address the unmet needs better? • Have there been other conditions or priorities that you have worked on (e.g. diabetes, HIV) in which you have effectively engaged the private sector? If yes, what did you do to achieve this engagement? What incentives did you provide, if any? • Do you think the relationship between the public and private sector needs to be improved? If yes, what do you think can be improved in the relationship between the public and private sector? What specific initiatives / actions would be required to do so? • What is the best way for the government to continuously engage the private sector? <u>Commercial networks</u> • <i>[Ask few times in case DHO have commercial contracts of their own]</i> Does DHO work with commercial providers E.g., do you have any commercial arrangements with drug delivery / distribution co., medical equipment providers (Abbot, Roche, etc) to provide directly or facilitate provision of TB care? • If yes, could DHO facilitate arrangement to private sector facilities? E.g. for private facilities and offer services at lower rate from group purchase or providing access to e-catalogue if not yet? • Are there any areas of commercial networks that would be helpful to expand in order to enable delivery of effective TB care?	• To understand DHO's commercial networks to leverage for private facilities
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4.4 Institutional relationship and DHO's role in improving inter-facility linkages (~20 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
<u>Cross-referrals and relationship between private sector institutions</u>	• Understanding the ideal

- For TB care, what's your view of the ideal institutional relationships in private sector (E.g., between clinics, hospitals, labs, pharmacies, Professional Assoc., Community Health Org, DinKes)? - Which types of private facilities should do TB diagnosis? And TB treatment? - Which types of private facilities have the capacity to do TB diagnosis? And TB treatment? - Which facilities should be responsible for reporting? - What should DHO's role or function be to establish or improve these capacities and any necessary referral relationships? - If such relationship or linkages between facilities are not happening today, why not? - What role do you think professional associations (e.g., IAI, ASKLIN, IDI, ARSSI, etc) should play in supporting TB care / improving linkages between facilities? - Which associations does DHO see as particularly active and influential? Why? - What else is needed / what might need to change in order for the associations to play a more effective role? - What role do you think community organizations (AISYIYAH, LKNU, etc) should play in supporting TB care / improving linkages between facilities? - Which organizations does DHO see as particularly active and influential? Why? - What else is needed / what might need to change in order for the organizations to play a more effective role?	institutional relationship among private sector care providers to offer different aspects of TB care for different TB patients Understanding DHO's ideal role and function to establish or improve linkages between facilities
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4.5 BPJS-K enrollment (~ 15 min)

<u>Interview Questions / Guidelines</u> - How successful do you think the public sector (i.e. government) BPJS-K program is, e.g. INA CBG for hospital and capitation model for clinics? What additional inputs from DHO are needed to be more effective with engaging the clinics and incentivizing behavior? - Outside of the BPJS-K agreement with labs on chronic disease (hypertension and diabetes), are there other BPJS-K model that work for standalone laboratories? What is needed to be more effective with engaging the laboratories and incentivizing behaviour change? - In which of the following areas would you foresee challenges for private facilities in providing TB care under such BPJS-K program? - Areas to explore: Compliance with service and facility standards, reporting requirements, increasing resource and cost burden, economics of treating a patients using BPJS vs. using private insurance vs. paying out of pocket (including reimbursement coverage and value, reimbursement process / timeline, value of fee-for-service scheme, if applicable)	<u>Objectives</u> - Understanding DHO's view on BPJS-K program for private facilities - Understanding challenges and alternatives to current BPJS-K program / model
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• Are there alternative claim or payment system that have been discussed (e.g. fee-for-service and unbundling scheme for TB)? Any other?	
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4.6 Testing of ideas & hypotheses generated from private facilities interview

<u>Ideas and hypotheses generated from private facilities interview</u> • DHOs vary in their willingness to provide indiscriminating levels of support (e.g. subsidy for sputum cup, N95 respirator masks, etc) to private and public sector facilities, which are both upheld and adhere to the same regulatory standards, and conscious engagement by associations and other actors may be needed to improve this situation in certain districts • DHO is pivotal in ensuring that reporting procedures / processes are streamlined at all levels to encourage compliance with requirements, including the case notification via WiFi TB and SITT, integrated case reporting between data systems (e.g. between BPJS-K case reporting system and SITT / SITB), and automated transmission of test results (e.g. from GeneXpert machines directly to DHO) • DHO could help extend favorable public sector access to and mechanisms for TB care to the private sector in order to increase incentives for facilities to improve TB care capabilities in-house, e.g. negotiating / facilitating the placement of public sector GeneXperts (and/or cartridges) as incentives for private sector facilities • DHO could coordinate and facilitate new arrangements between commercial network providers they have engaged with from past or current initiatives (e.g. to procure FDC drugs or GeneXpert, etc) and private facilities, e.g. enabling group purchase discount, etc. to improve access to tools to improve TB care capabilities • DHO may be critical in playing an intervening role to keep private clinics with low capitation in business (e.g. provide direct financial assistance such as direct subsidies, push for capitation rate increase, normalize number of registered patients across clinics, limit number or locations of licensed outlets to discourage over-competition, facilitate networking arrangements, etc.) to ensure continuity of care for patients	<u>Objectives</u> • Share and discuss the emerging set of ideas and / or lessons learned from private facilities interviews in order to understand a) DHO's current role and function, b) the ideal interaction between public and private sector, c) the ideal institutional interaction between private sector actors, and d) DHO's role in improving those linkages between facilities
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USAID-BCG PROJECT IN INDONESIA

Institutional assessment of private sector health providers in TB care

District field research approach: Hospital

USAID and BCG Indonesia

5/30/2018

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1 Topics covered in district interviews with facilities

Phase 2 of the private provider review will map the most critical private facilities - private hospitals, clinics, labs, and pharmacies - in each selected district and focus on understanding **current market** and **policy incentives** for private health care facilities and how different policies or interventions might affect those incentives at an institutional level. It will provide information to support the implementation of future initiatives to increase uptake and improve the quality of TB care, especially opportunities to use JKN as a lever to change behaviors of private sector providers.

More specifically, the interviews with private hospitals, clinics, labs, pharmacies, and local health care organizations across the seven districts will help us understand:

- **Who are the major private actors currently operating at a national level and in the selected districts?**
 - What's their size, capabilities, resources, services offered, and geographical reach?
 - What are the relationships between institutions in each district?
 - This landscaping would include data such as market share, commercial or more informal relationships between different types of institutions that might affect TB-related solutions, the TB services they provide, and the typical profile of their clients, with recommendations for their proposed role in improving private sector TB engagement in the district.
- **Are current market incentives driving providers towards or away from the provision of quality TB care? How?**
 - Understand attitudes among private providers toward participation in district-based PPM and how they envision engaging with Puskesmas and Dinas Kesehatan in their district
- **Other than private hospitals, labs, pharmacies, and physicians, are there any other local organizations or stakeholders (outside the public sector) that are contributing or could potentially contribute toward the TB care-seeking and treatment ecosystem in each district, and what are their capacities?**
- **What is the business case of providing TB-related diagnostics and drugs in the private sector?**
 - What are the incentives and disincentives, both commercial and non-commercial?
 - How does this change when taking into account other health conditions (e.g., HIV, diabetes)?
- **What opportunities exist to engage these identified actors in JKN?**
 - What has already motivated their participation in JKN or what incentives would motivate them to participate?
 - What concerns do they have about participation in JKN?
- **How would private hospitals, clinics, labs and pharmacies respond to any potential fee-for-service components of JKN or other interventions aimed at them, and would they pass those incentives on to their providers?**

The outcomes will be used to:

- Recommend a set of concrete, specific next steps for each district to advance its process of engaging private providers and institutions in TB care and prevention.
- Socialize findings with Dinas Kesehatan and other stakeholders to inform the national dialogue on district-based PPM for TB in Indonesia

2 Phase 2b approach to qualitative research and insight generation

Overview

For Phase 2b district research with private sector hospitals, clinics, pharmacies and labs, we will employ a multi-step process to generate insights. This process has been adapted from BCG best practices for qualitative interviews.

At a high-level, there are six key steps in this process:

1. Pre-planning
2. Pre-research hypothesis generation
3. Interview guide development and pre-work
4. Interview conducting*
5. Insights capture and hypothesis refinement*
6. Synthesis

*Note that steps four and five are iterative in that they will inform each other through the process.

Each step of the process will be explained in more detail in the following sections. To bring the process to life, we will use hospitals as an example.

Step 1: Pre-planning (*In-process*)

The team has engaged in pre-planning to set the objectives of the district research, determine the number and type of hospital interview participants, develop the selection methodology and the location of the interviews.

For hospitals, the key research objectives are to understand the sphere of influence of hospitals in TB care; identify strengths, weaknesses and opportunities of institutional relationship between hospitals and other TB care providers; and highlight institutional incentives / disincentives to provide high quality, effective TB treatment, including via participation in district PPM. For each district, we are targeting interviews with 4-5 directors / managers of private hospitals. In order to be able to see meaningful distinctions in behaviors and incentives for hospitals, we are seeking a balanced set of hospitals based on characteristics such as:

- Class & size:
 - o Mix of different hospitals including Type (A/B/C/D) and/or
 - o # of beds and outpatients and/or
 - o # of reported TB cases
- TB-service capabilities:
 - o Mix of facilities with in-house labs w/ and w/out advanced TB diagnostic tools (GeneXpert, DST, Culture) and w/ and w/out in-house pharmacy disbursing TB drugs (FDC vs loose)
 - o Aim to include all facilities with GeneXpert if possible
- BPJS-K enrollment: Mix of BPJS-K-affiliated and non-BPJS-K affiliated
- Business model: Mix of chain and non-chain facilities
- Clientele served: Mix of higher and lower socioeconomic status clientele (proxy by % of BPJS patients or affluence level of neighborhood)

We are now in the process of selecting facilities with input from NTP, CTB, and district Dinkes to ensure feasibility (i.e. ability to secure interviews) as well as to identify those hospitals they see as the technical and moral leader in TB. (See Section 3 for details on facility selection).

We have determined that the location of the interviews with hospitals will be at the hospitals themselves as confirmed in the introduction meetings with Dinkes.

Step 2: Pre-research hypothesis generation (*In-process*)

Prior to conducting research in the districts, we have developed informed conjectures about how private sector hospitals may be performing currently in diagnosing, treating, and reporting TB and their relationships with other facilities and providers and the rationale for this behavior. This is critical to perform prior to developing the interview guide as well as conducting the research in order to ensure that the research is structured and delivered in a way that can meet the research objectives and enable the team to identify the most effective levers and incentives to affect change. (See Section 4 for specific ingoing hypotheses). These hypotheses have been informed by existing literature and research, findings from past efforts and perspectives of experts in the field (including hypotheses shared by Dinkes in introduction meetings). In generating these hypotheses, we have also considered relevant 'root causes'.

Step 3: Interview guide development and pre-work (*In-process*)

The team is developing an interview guide to help direct the interview discussion, ensuring that the questions are targeted and tie back to the pre-research hypotheses and the overarching project objectives. (See Section 5 for draft interview guide for hospitals).

Step 4: Interview conducting

For each of the districts, the interviews with hospital directors / managers will take place in stages over the course of one to two weeks as opposed to all of the interviews for hospitals being conducted in one condensed, standalone time period (note that for most districts it will take up to 8 days to complete all interviews for that district including hospitals, clinics, labs, pharmacies, Dinkes and professional associations). This staged approach is deliberate in order to enable the team to reflect, adjust and refine in between interviews. Specifically, the initial set of interviews will be used as exploratory interviews to test (i.e. prove/disprove) initial hypotheses and understand the range of responses from participants. Once initial patterns emerge, the team will use the interviews to a) continue to validate patterns and probe deeper on understanding the "why", b) to probe in-depth on specific concepts emerging as critical and / or c) to close any remaining gaps in information.

This evolution will occur in two ways: a) over the course of the research in each district as well as b) over the course of the district research process across districts. This ongoing refinement will be informed by the insight capturing step as outlined in the next section.

Step 5: Insights capture and hypothesis refinement

The team will capture insights in two ways: during the interview and after the interview. During the interview, the team will capture key notes to supplement the audio recording. Key insights of the interviews will be typed up and shared with the broader team, and the relevant part of the audio recording will be listened to, to ensure key points are captured. After each interview (or at the end of each day if interviews are scheduled back-to-back), the team will discuss key themes from the discussion, compare notes, and type up the notes to be shared with the team, in parallel the team will collectively test and determine the following areas:

- Are the interviews providing the type of insight we need? If not, what needs to be adjusted?
- What are we learning to prove or disprove our hypotheses?
- What are the key themes and takeaways related to our project objectives?

In doing so, the team will refine and focus the pre-research hypotheses as the evidence accumulates. One example of the refinement of hypotheses will include determining the typologies / archetypes of hospital characteristics that can help explain behaviors. While the team will be refining hypotheses throughout the district research, we plan to have an updated view of the hypotheses at the mid-point of the project.

Step 6: Synthesis

After the district research is conducted, the team will synthesize the findings. The team will identify key themes from the research including:

- Areas of convergence & divergence across interview findings (also highlighting the findings that were expected and unexpected and why)
- Areas of most importance to answer the overarching project questions
- Insights on the rationale for why challenges are occurring
- Develop the landscape mapping and key themes, observations and recommendations

3 Methodology for facilities selection

To determine how to impact the behavior of private sector providers with different profiles, the interviews will include a mix of facility typologies in each selected district. Figure 1 below attempts to capture the variation of facility typologies selected for district interviews.

Due to data limitations, especially for private clinics, pharmacies, and labs, facility selection will not be a solely data-driven approach. We will supplement this with feedback from the district-level CTB team (for North Jakarta, Medan, and Tulungagung) and District Health Offices (DHO). Local knowledge of the CTB team and DHO in each district will help identify facilities that are considered the technical leaders in providing TB care, while ensuring feasibility to secure interviews with the respective facilities.

The initial list of identified facilities will be re-calibrated with underlying data whenever possible to ensure a balanced set of facilities to interview in each selected district.

Dimension	Hospital (n=4-5 per district)	Clinic (n=4-5 per district)	Pharmacy (n=8-10 per district)	Lab (n=4-6 per district)
Size	Mix of size, based on - Type (A/B/C/D), and/or # of beds and outpatients, and/or # of reported TB case	Mix of size of clinics ¹ , based on - Type (<u>pratama</u> and <u>utama</u>), and/or # of doctors and/or # of patients	Mix of size, based on # of pharmacists, or # of TB drugs sold, or # of TB cases referred	Mix of size, based on # of TB diagnostics performed, or # of laboratory technicians
TB care service capabilities	Mix of lab w/ and w/out advanced TB diagnostic tools (<u>GeneXpert</u> , DST, Culture) and in-house pharmacy disbursing TB drugs (<u>FDC</u> vs loose) Include all facilities with <u>GeneXpert</u> if possible	Mix of lab w/ and w/out advanced TB diagnostic tools (<u>GeneXpert</u> , DST, Culture) and in-house pharmacy disbursing TB drugs (<u>FDC</u> vs loose) Include all facilities with <u>GeneXpert</u> if possible	Mix of pharmacy selling more <u>FDC</u> and selling more loose-drugs	Mix of lab w/ and w/out advanced TB diagnostic tools (<u>GeneXpert</u> , DST, Culture) Include facilities with <u>GeneXpert</u> if possible
BPJS-K affiliation	Mix of <u>BPJS-K</u> -affiliated and non <u>BPJS-K</u> affiliated			Not applicable (Not affiliated with <u>BPJS</u> , except for preventive diagnosis, e.g. cervical cancer pap smear)
Business model	Mix of chain and non chain facilities			
Clientele served	Mix of higher and lower SES clientele (proxy by % of <u>BPJS</u> patients or affluence level of neighborhood)			
Qual. assessment	Technical leaders in TB, level of engagement or participation of facilities in PPM, ability to secure interviews			

Figure 1. Variation of facility typologies for district interview

4 Key hypotheses to be tested in the interviews for hospitals

We have structured the interview guide in 9 sections. Each section has the objectives articulated, which is to test the relevant pre-research hypotheses on how private facilities are performing and why.

Additionally, the team will also test a set of hypotheses around potential archetypes that may enable NTP and its partners to implement change more effectively and understand how each of those archetypes would behave in response to TB care improvement initiatives. These initial hypotheses include:

- Chain hospitals, e.g. Rumah Sakit Hermina, may be an important opportunity for impact in any change initiative due to sheer number of facilities within the network, assuming there is a strong central command model
- Large hospital groups with feeder clinics, e.g. Rumah Sakit Siloam and Klinik Siloam, have a large sphere of influence and are less likely to be worried about potentially losing clients from down-referrals, as financial incentives are still captured in the broader hospital-clinic network
- Hospitals who are part of a group with other business, e.g. Rumah Sakit Mitra Keluarga owned by the largest Pharmaceuticals company in Southeast Asia Kalbe Farma, are likely to present both challenges (e.g. they may prefer their own drugs to government-funded FDCs in their hospitals) and opportunities (e.g. ability to better monitor care over the patient pathway)
- Hospitals that are part of a strong broader network of care (e.g. referral agreements with labs and pharmacies, with Puskesmas or community health organizations or professional health associations as well as commercial service providers such as sample transporters) vs. those that act independently may be more effective and efficient in delivering convenient, consistent care because they have institutions that can help supplement care delivery or reinforce behaviors of the providers and patients
- Hospitals serving a high percentage of clientele with lower socioeconomic status may be more reliant on BPJS-K reimbursement in order to cover their cost (given the lower ability of patients to pay) and are vital to drive positive changes for TB care especially in rural, less affluent areas

5 Interview guide and questionnaires: for Hospitals

The team will develop a data template that will be sent to the facilities for completion before the interview (see Section 6 for data request) in order to minimize the number of data-intensive questions that could interrupt the discussion flow. The collected data will provide a basis for understanding the characteristics of each facility, enabling the interview questions and discussion to be tailored according to the facility's profile. However, in the event that the pre-interview data request is not filled prior to the interview (or not fully completed), this information will be gathered during the interview. The interview guide will enable the team to explore qualitative elements on the topics targeted in the data request in order to understand the 'whys' behind any figures.

5.1 Introduction and context (~ 5 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
To be shared with interviewee after introductions to BCG team • Project objective: Understand who are the key private sector actors and how they are currently operating in delivering TB care, understanding the institutional relationships in private sector TB care, and to establish a strong basis for follow-up support from NTP Indonesia and a USAID/Indonesia project • Interview objective: Understand the sphere of influence of hospitals in TB care; identify strengths, weaknesses and opportunities of institutional relationships between facilities and other TB care providers; and identify the institutional incentives / disincentives to providing high quality, effective TB treatment • Protection of interviewee: Results will be anonymized and reported in aggregate. The raw data will not contain identifiers of either individual respondents or individual facilities. • Overview of interview, including: • Format • Topics covered • Anonymity to promote openness	• Share objectives and get early buy-in (i.e., what's in it for them) • To encourage candidness in answers

5.2 Background & profile of facility (~15-20 min if template not yet populated)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
To be collected prior to the interview in template provided (see Section 6 for complete view; will be pre-populated with existing data before sending to participant) Business performance and high-level business model • Over the past few years, has business been steady, struggling, or growing / expanding? What factors may have driven this performance? • Do you have a strategy for increasing your market share? What is it? • What is the socio-economic status of your customers? (e.g., % low income with disposable income <IDR 2,000,000 / month, % medium income between IDR 2,000,000 – 5,000,000 / month, % high income > IDR 5,000,000 / month)? Do they primarily come to the facility for primary, secondary, or tertiary care? Are you trying to change or influence this? How and why? • Given your facility's therapeutic and business priorities, how much of a business case is there for providing and improving TB care (low, medium, high)? Which aspects of TB care are most important to your facility (diagnostic capabilities, availability of drugs, quality of treatment and on-going care, reporting)? Why?	• Understand characteristics of the hospital to inform potential archetypes of different facility types • Develop recommendations tailored to specific archetype / typology of institutions

5.3 High quality TB care: Successful detection & diagnosis (~15 min)

<u>Interview Questions / Guidelines</u> Availability of diagnostic tools • Who in the hospital (i.e. which position / role) decides which diagnostic capabilities to own? • What are the methods and tools your facility uses to diagnose DS-TB? How does the facility diagnose MDR-TB? Have you increased / decreased your TB diagnostic tools in the last few years? Which ones specifically? • If indicated no X-ray or sputum smear in in-house lab in data request, why not? • GeneXpert: - If indicated GeneXpert in data request, did you acquire it from a private supplier or from the public sector? - Do you procure the cartridges from private or public sources? • Do you think your diagnostic tools are sufficient for the current demand in TB care? Why or why not? • Have you considered providing / proposing more advanced diagnostic tools? If not, why and what is the challenge? - What are the financial and non-financial considerations? - What # of patients per tool is necessary / desirable to acquire more advanced diagnostic tools in-house (e.g. for it to make economic sense to purchase GeneXpert)? - Would you be interested in hosting a public sector Xpert machine if, in return, you had to limit your client test fee and report the outcomes to the public sector? • What would incentivize you to provide more advanced diagnostic tools? Which one is most attractive? Why? - More suitable or competitive pricing model (e.g., Cost per Reportable Result vs. procuring the diagnostic equipment, discounted price from group purchase, etc) - Volume guarantee from referral network - Fee-for-service (BPJS) for diagnostic method / tools— which one and why? - Any others? - How do you ensure physicians' compliance to monitor patient treatment completion? (if they are the ones responsible for doing so)? - If not, who is in charge and who do you think is better positioned for the role and why? - Are there any consequence if facility / PIC does not follow up with patients and ensure treatment completion?	<u>Objectives</u> • To understand facility's current level and quality of TB care capabilities and to identify gaps as potential target areas for improvement; to be able to identify if any patterns exist between level of capability and their behaviors
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5.4 Down-referral to PHC and cross-referrals (~10 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
Down referrals • What % of uncomplicated DS-TB (without co-morbidity) cases are down-referred to primary care providers after diagnosis? • What prevents hospital from down-referring them? And when do you down-refer a client vs. keeping him / her in your facility? • What % of DS-TB patients, if any, are unwilling to be down-referred to primary care providers? • What would incentivize you to down refer (more) uncomplicated DS-TB, without co-morbidity, clients to primary care? Which one is most attractive? Why? • Compensation for “lost” customer, resource provided for paper work? • Direct / indirect financial payments per referral reported? How much and what is the claim process? • Accelerated or ease of doctor / hospital licensing renewal? • Any others? • Are there consequences for the facility / physicians for not down-referring (for hospitals) / referring (for clinics)? What are they? Cross-referrals • For general medical issues, in what circumstances would you refer patients out for services, and where? (which lab, pharmacy, specialist, PHC clinic or hospital?) Does this differ for TB, e.g., referring out for diagnostic or pharmacy services, or for follow-up care? • If clients are referred in, where do they mostly come from (lab, pharmacy, specialist, PHC clinic or hospital; overall, more from public or private), and why? How many clients are referred in a year? Do you have preferred referral relationships? Does this differ for TB vs other conditions? • For hospitals with feeder clinics (e.g., Siloam): How different is your engagement with facilities in your network from the engagement with external/non-Group institutions?	• Understanding incentives / disincentives for down-referral of clients / patients as basis for encouraging ideal behaviors in delivering TB care • Gauging the extent of facility’s current referral networks and understanding the merits of appropriate facilities in providing different aspects of TB care for different TB patients

5.5 High quality TB care: Successful treatment (and completion) (~25 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
TB drug provision and treatment capabilities • If previously indicated “no in-house pharmacy” in data request, why not? (<i>For facilities without in-house pharmacy, jump to “system of monitoring” question</i>) • If your facility has an in-house pharmacy, who in the hospital decides which drugs (FDC vs. loose, first-line vs. second-line) to	• To understand facility’s current level and quality of TB care capabilities and to identify gaps as potential target areas for improvement; to be able

stock or procure? • Why do you stock public / private TB drugs? • (For facilities stocking $\leq 100\%$ private drugs), would you be willing to stock public TB drugs (or increase current supply of public drugs)? Why/why not? • What would incentivize you to stock and prescribe government-funded TB drugs based on TB care guideline in your hospital? - Reduce requirement and financial burden to access government-funded FDCs? How and by how much if financial? - Direct or indirect financial incentives for correct prescription? How much and how to claim? - Any others? • Do TB care doctors / physicians have a preference for prescribing loose TB drugs over FDCs? If yes, what % of them and what are potential reasons (e.g. habit, belief of higher efficacy)? Does the hospital have any authority to influence the doctors' preference? Treatment completion • Does the institution have an incentive for monitoring and promoting the continuity of long-term and follow-up care in general (not just for TB)? Is that a monetary or reputational incentive? • Is there any system to promote this monitoring of follow-up care? Is this used for TB (e.g. patient adherence to 6 months treatment regimen, check-ups, follow-up for missed prescription refills or check-ups)? What are some key challenges? - How do you ensure physicians' compliance to monitor patient treatment completion? (if they are the ones responsible for doing so)? - If not, who is in charge and who do you think is better positioned for the role and why? - Are there any consequence if facility / PIC does not follow up with patients and ensure treatment completion? • Are there consequences / penalties for the facility / physicians / other staff in charge for not monitoring TB treatment completion? • What would incentivize the hospital to encourage doctors to monitor and remind patients about on-going treatment? Which one is most attractive? Why? - Financial payments from BPJS-K for each completed treatment of patients (milestones)? Other rewards? - Accelerated annual licensing renewal or ease of licensing renewal - Auto-reminder, e.g., application to send automatic SMS to patients - Any others? HR policies and physician profile	to identify if any patterns exist between level of capability and their behaviors • Understand economics behind providing TB care capabilities to identify compelling financial levers for incentivizing facilities to improve services • Uncover potential non-financial means to encourage ideal behaviors and incentivize facility to provide high quality TB care • Identify facilities with high TB care capability as potential "role model" in future support initiatives • Understand facility's motivations for investing in TB staff and TB care
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• Are TB diagnosis and treatment functions limited to certain individuals in your hospital, or spread widely across all physicians in the hospital? What are the main considerations in hiring such people? Are they TB certified? • What proportion of the physicians in your facility are specialists (including internists and hospitalists) vs. what proportion are GPs without internist or hospital qualifications? - Are there differences in the quality of care they provide / compliance to facility's policies? How? • If indicated there are TB certified / specialist staff, what support (e.g. paid leave, non-financial rewards, etc.) does the facility provide to encourage doctors to obtain the certification? • What motivates the hospital to provide training and support to ensure that doctors are TB-trained or TB-certified? Which one is most important? Why? - Financial reward? How much? - Ease of hospital / doctor licensing renewal - Earned reputation e.g., as TB care top provider / other non-monetary rewards (what are they?) - Better access to training (free training, shortened training) - Any others? • If you indicated that you don't not have any TB certified / specialist staff, have you tried to encourage training? If not, what has prevented you from providing support for it (time away from practice, lack of accessible programing, lack of need)? Compensation • Are doctors / physicians paid a salary or commission or both? Are they paid additional amounts based on either BPJS-K or other income? - Are there differences in the quality of care provided / compliance to facility's policies for different payment schemes? How? • If previously indicated presence of dual practice doctors, where else do they practice? What types of other facilities? • What proportion of their incomes come from respective sources? Is it more economically desirable for physicians to practice partly in a hospital vs. in a standalone PHC clinic? Or to practice in multiple hospitals? • How many doctors / physicians working at your hospital are also working at (or operating) private clinics? - Do they refer patients from the facility to the clinics? - Do you see this as an issue impacting health outcomes of patients? If yes, what actions have you taken to monitor and manage this?	certification • Understand the levers facilities have based on the motivations and allegiances of TB care providers
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5.6 Operational DOTS corner (~ 15 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
What is the facility's current DOTS unit functionality? • Do you have a DOTS unit in this facility? Why or why not? • Which functions of a DOTS unit do you have? - Does your facility have centralized TB reporting? - Does your facility report TB data to the public sector? ▪ For all or some providers / clients in the facility? ▪ If partial, why? ▪ How (electronic or paper; collected or sent)? - Does your facility stock and prescribe public sector TB drugs? ▪ If yes, how much (100%, 50-99%, <50%)? • If you don't have any of the above functions, why not? • What are the benefits to your facility of having a DOTS unit? (i.e. enables treatment of more patients, better reputation, improves quality of TB care for patients, easier to renew / obtain license) • What challenges do you face in complying with DOTS requirements? What is the facility's current TB case and treatment reporting capabilities? • Do you report all TB cases? Who is responsible for reporting TB cases? - Are there any consequences when the facility / responsible person (or group of people) do not do so? If yes, what are they? • Do you report treatment outcomes to the government? Who is responsible for reporting TB cases? - Are there any consequences when the facility / responsible person (or group of people) fail to do so? If yes, what are they? • As administrator / manager / owner: do you enforce reporting requirements for any conditions? For TB? If yes, how often? If not, why not, and what are your ideas about how to do so and whether it might work? (lack of clear consequences for non-compliance, lack of clear / guaranteed benefits, not comfortable, high cost burden, high administrative burden, etc.)? - For chain facilities, do you believe that having a chain business model enables you to enforce better – why or why not? • What incentives would be effective for your hospital to establish systems to facilitate or check that your physicians comply with reporting guidelines? Which one is most attractive? Why? - Streamline reporting process (e.g., WiFi TB application for CTB districts, integrated reporting between internal and external systems) - Referral guarantee if meeting certain thresholds - Direct or indirect financial payments for each validated report	• Understanding current DOTS capabilities and identifying any breakdown in the system • Uncovering reasons or burdens behind non-compliance as basis for future interventions to strengthen efficacy of DOTS in private institutional TB care

- Any others?	
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5.7 BPJS-K enrollment (~ 15 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
• (From data template or previous section's answer on BPJS-K enrollment) If your facility is enrolled in BPJS-K, why did you join? Do you think it has been or has not been beneficial to participate? What benefits have you seen specifically or why has it not been beneficial? How has your financial position, level of care, etc. changed since you joined? • If not enrolled with BPJS-K, why not? What incentives or changes in the BPJS-K system would encourage you to join? • In which of the following areas do you experience challenges in providing TB care under the BPJS-K program? What changes would you like to see? - Areas to explore: Compliance with service and facility standards, reporting requirements, increasing resource and cost burden, economics of treating a patients using BPJS vs. using private insurance vs. paying out of pocket (including reimbursement coverage and value, reimbursement process / timeline, value of fee-for-service scheme, if applicable) • Deep Dive: Do you see any challenges with the existing INA CBG system in enabling you to manage the economics of delivering quality TB care? (Enable open response, then ask the following): - What is the current reimbursement rate for DS-TB and MDR-TB? Is this sufficient / too low? Does it cover all TB related care? - How long is the payment claim process? Is it different for DS-TB or MDR-TB vs. other TB? Has it been a deterrence? - Would you prefer a fee-for-service and unbundling scheme for TB services? Would it incentivize the hospital to increase their service quantity as well as quality? How? - Which service/product would you prefer to be unbundled and why? - Do you currently screen for cough in the outpatient department, then send the coughers for TB testing? If not, what would it take to incentivize such an action?	• Understanding facility's incentives / disincentives for enrolling in BPJS-K program • Gauging economic attractiveness of BPJS-K programs and understanding challenges to lay groundwork for better TB care in BPJS-K with increasing network of clients / patients

5.8 Relationships with other institutions / care providers and PPM (~15 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
<u>Relationship with other institutions</u> • When providing any medical services, what other institutions do you engage with (E.g., other providers such as Puskesmas, clinics,	• Gauging the extent of facility's current

hospitals, labs, pharmacies, Professional Assoc., Community Health Org, DinKes)? • With whom? What is the nature of the engagement? (one-way / mutual referral, reporting, formal / contractual or informal, etc) • Why did you choose these partners? What criteria do you use to select? How do you prioritize? • Who makes the decision on who to partner with? • How does this relate to your future growth strategies for the hospital or chain? • When providing TB care, what other institutions do you engage with (E.g., other providers such as Puskesmas, clinics, hospitals, labs, pharmacies, Professional Assoc., Community Health Org, DinKes)? • With whom? What is the nature of the engagement? (one-way / mutual referral, reporting, formal / contractual or informal, etc) • Why did you choose these partners? What criteria do you use to select? How do you prioritize? • Who makes the decision on who to partner with? • If you do not engage with any of the above institutions, why not? Do you see any of the institutions as playing a potential role to complement or support the role of your facility? If so, how? • Do you agree that uncomplicated TB patients are more effectively cared for in primary care either in the private sector or in Puskesmas? Why or why not? • Do you think it is valuable for primary care providers to be the “first point of contact” for patients with any condition, before those patients come to hospitals? Why or why not? How about for patients with possible TB symptoms? • What role do you think professional associations (e.g., IAI, ASKLIN, IDI, ARSSI, etc) or community organizations should play in supporting TB care / improving linkages between facilities? PPM / Partnership or linkage with Public Sector • How often does this institution interact with either the DHO or PKM? For what purposes (licensing, trainings, reporting, other)? • How has the hospital interacted with the public sector related to TB care? • What was the last time that somebody from DHO or PKM visited or called the facility for TB monitoring or reporting? • Are you aware of the district-based PPM TB programming /other partnership with public or other private sectors in TB? What is your understanding of this? {if no, clarify that it involves the public sector reaching out to the private	relationship networks as basis for achieving ideal linkages in TB care ecosystem • Understanding the merits of appropriate facilities in providing different aspects of TB care for different TB patients • To identify facilities with large relationship networks as possible target of future impactful initiatives • Understanding facility’s linkages with PPM and public sector as well as professional associations & community organizations
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providers for TB notification and quality of care, including use of public TB drugs} • Are you part of the district's PPM network / other network with public or other private sectors in TB? Why did you agree to be part of the network? • Has anybody approached / engaged the facility to participate in PPM TB initiatives / other partnership initiatives with public or other private sectors in TB? - If yes, who approached you (Dinkes, community organizations, etc)? In which activities did you participate? Would you participate again? Why or why not? - If you did not participate, why not? Any feedback? • How effective do you perceive the network to be? Has it addressed the needs of private sector? Which needs specifically (funding, knowledge support, etc)? If not, what additional efforts would address the unmet needs better? • Explore relationships with NTP, Dinas Kesehatan, Puskesmas/other public primary care (if not covered yet)	
• Would you be open to further PPM efforts / interaction with public sector regarding TB • Would you like to be involved (if not yet) or more involved (if previously already) in strategy formulation / implementation of efforts to improve TB care or improve linkages between different facilities that offer TB services? Why or why not? In what type of roles or opportunities? (e.g., be invited to planning meetings / establish and join a referral network) • Do you think the relationship between the private and public sector needs to be improved? If yes, what do you think can be improved in the relationship between the private and public sector? What specific initiatives / actions would be required to do so? • What is the best way for the government to continuously engage the private sector?	

5.9 Commercial networks (~10 minutes)

<u>Interview Questions / Guidelines</u> • Do you also work with other commercial providers E.g., do you have any commercial arrangements for sample transportation, drug procurement, drug delivery / distribution co., medical equipment providers (Abbot, Roche, etc)? • When do you typically use these providers? Who are the main companies? • Generally when you work with commercial providers:	<u>Objectives</u> • Understanding size of facility's commercial network to determine potential levers of support in delivering TB care; understanding whether commercial &
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- What is the structure of the agreement? Exclusive or non-exclusive? Bi-lateral vs. multi-party agreement? What are the specific financial mechanisms: Kick-back, referral fee, discount? How much? What is the payment term? What are your obligations in the agreement? Duration of agreement? Do you typically cover the costs or pass on to the patient (for deliveries or sample transport)? • Do drug reps influence you in any way, whether related to TB or not? How? Why? • Do you believe that engaging commercial providers and other partnerships better equip the facility to treat patients overall? Why or why not? • What specific partnerships / engagement have the highest impact on TB patients / TB care? What drives the impact? (e.g. drug delivery company increases convenience for patients in accessing TB drugs to maximize chances of completing full regimen)?	non-commercial network enables the facility to deliver higher quality care / stronger influence in TB care ecosystem • To identify facilities with large commercial networks as possible target of future impactful initiatives
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6 Data template and request

Hospital name, district:	[example] Rumah Sakit Siloam Karawaci, Kabupaten Tangerang
Classification (A/B/C/D):	Class A
BPJS-K?:	Enrolled in BPJS-K
# of branches:	~32
Location of branches (districts, provinces):	To be filled
# of branches affiliated with BPJS:	To be filled
Is the hospital a PMDT ¹ site?	To be filled
Does the hospital have a pulmonology unit?	Yes
In-house lab?	Yes
In-house pharmacy?	Yes

DATA (UNIT)	2015	2016	2017	2018
# of outpatients	To be filled	To be filled	To be filled	To be filled
% of patients who are BPJS-K				
% of patients who are non-BPJS-K who pay out-of-pocket				

¹ Programmatic Management of Drug Resistant TBC

# of TB patients				
% DS-TB				
% MDR				
% of TB patients who are BPJS-K				
% of TB patients who are non-BPJS-K who pay out-of-pocket				
# of beds	To be filled	To be filled	To be filled	To be filled
Area of district (catchment area) (km ²)	To be filled	To be filled	To be filled	To be filled
Population of district (catchment area) (#)	To be filled	To be filled	To be filled	To be filled
# of total doctors	To be filled	To be filled	To be filled	To be filled
# pulmonary specialist	To be filled	To be filled	To be filled	To be filled
# TB-certified	To be filled	To be filled	To be filled	To be filled
# other specialists	To be filled	To be filled	To be filled	To be filled
% of total doctors who are dual-practice ²				
# of consulting doctors / physicians (non-permanent staff)				
# of non-doctor employees	To be filled	To be filled	To be filled	To be filled
# nurses	To be filled	To be filled	To be filled	To be filled
# admin staff	To be filled	To be filled	To be filled	To be filled
# others	To be filled	To be filled	To be filled	To be filled
Estimated % of total income from DS-TB				
Estimated % of DS-TB income from BPJS				
Estimated % of total income from MDR-TB				
Estimated % of MDR-TB income from BPJS				
# of TB cases diagnosed				
% DS-TB				
% MDR-TB				

² Dual-practice physicians refers to physicians who work at multiple locations

% comorbid TB+HIV				
% comorbid TB+Diabetes				
% comorbid TB+others				
# of TB cases reported				
# DS-TB				
# MDR-TB				
# comorbid TB+HIV				
# comorbid TB+Diabetes				
# comorbid TB+others				
<u>For in-house pharmacy</u>				
Approximate % of TB drugs stocked from government				
Approximate % of TB drugs stocked from private sector suppliers				

<u>For in-house lab</u>							
DATA (UNIT)	Microscopes for Smear Microscopy	CXR	Labs with IGRA	GeneXpert (or other molecular diagnostics)	Labs with Culture	X-Ray	Labs capable of TB DST ³
Number of tools (#)							
Price per test (IDR)							
Pathologists / analysts with capability (#)							

³ Drug susceptibility test

USAID-BCG PROJECT IN INDONESIA

Institutional assessment of private sector health providers in TB care

District field research approach: Laboratory

USAID and BCG Indonesia

5/30/2018

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1 Topics covered in district interviews with facilities

Phase 2 of the private provider review will map the most critical private facilities - private hospitals, clinics, labs, and pharmacies - in each selected district and focus on understanding **current market** and **policy incentives** for private health care facilities and how different policies or interventions might affect those incentives at an institutional level. It will provide information to support the implementation of future initiatives to increase uptake and improve the quality of TB care, especially opportunities to use JKN as a lever to change behaviors of private sector providers.

More specifically, the interviews with private hospitals, clinics, labs, pharmacies, and local health care organizations across the seven districts will help us understand:

- **Who are the major private actors currently operating at a national level and in the selected districts?**
 - What's their size, capabilities, resources, services offered, and geographical reach?
 - What are the relationships between institutions in each district?
 - This landscaping would include data such as market share, commercial or more informal relationships between different types of institutions that might affect TB-related solutions, the TB services they provide, and the typical profile of their clients, with recommendations for their proposed role in improving private sector TB engagement in the district.
- **Are current market incentives driving providers towards or away from the provision of quality TB care? How?**
 - Understand attitudes among private providers toward participation in district-based PPM and how they envision engaging with Puskesmas and Dinas Kesehatan in their district
- **Other than private hospitals, labs, pharmacies, and physicians, are there any other local organizations or stakeholders (outside the public sector) that are contributing or could potentially contribute toward the TB care-seeking and treatment ecosystem in each district, and what are their capacities?**
- **What is the business case of providing TB-related diagnostics and drugs in the private sector?**
 - What are the incentives and disincentives, both commercial and non-commercial?
 - How does this change when taking into account other health conditions (e.g., HIV, diabetes)?
- **What opportunities exist to engage these identified actors in JKN?**
 - What has already motivated their participation in JKN or what incentives would motivate them to participate?
 - What concerns do they have about participation in JKN?
- **How would private hospitals, clinics, labs and pharmacies respond to any potential fee-for-service components of JKN or other interventions aimed at them, and would they pass those incentives on to their providers?**

The outcomes will be used to:

- Recommend a set of concrete, specific next steps for each district to advance its process of engaging private providers and institutions in TB care and prevention.
- Socialize findings with Dinas Kesehatan and other stakeholders to inform the national dialogue on district-based PPM for TB in Indonesia

2 Phase 2b approach to qualitative research and insight generation

Overview

For Phase 2b district research with private sector hospitals, clinics, pharmacies and labs, we will employ a multi-step process to generate insights. This process has been adapted from BCG best practices for qualitative interviews.

At a high-level, there are six key steps in this process:

1. Pre-planning
2. Pre-research hypothesis generation
3. Interview guide development and pre-work
4. Interview conducting*
5. Insights capture and hypothesis refinement*
6. Synthesis

*Note that steps four and five are iterative in that they will inform each other through the process. Each step of the process will be explained in more detail in the following sections. To bring the process to life, we will use hospitals as an example, but the process will be similar for pharmacies

Step 1: Pre-planning (In-process)

The team has engaged in pre-planning to set the objectives of the district research, determine the number and type of hospital interview participants, develop the selection methodology and the location of the interviews.

For hospitals, the key research objectives are to understand the sphere of influence of hospitals in TB care; identify strengths, weaknesses and opportunities of institutional relationship between hospitals and other TB care providers; and highlight institutional incentives / disincentives to provide high quality, effective TB treatment, including via participation in district PPM. For each district, we are targeting interviews with 4-5 directors / managers of private hospitals. In order to be able to see meaningful distinctions in behaviors and incentives for hospitals, we are seeking a balanced set of hospitals based on characteristics such as:

- Class & size:
 - o Mix of different hospitals including Type (A/B/C/D) and/or
 - o # of beds and outpatients and/or
 - o # of reported TB cases
- TB-service capabilities:
 - o Mix of facilities with in-house labs w/ and w/out advanced TB diagnostic tools (GeneXpert, DST, Culture) and w/ and w/out in-house pharmacy disbursing TB drugs (FDC vs loose)
 - o Aim to include all facilities with GeneXpert if possible
- BPJS-K enrollment: Mix of BPJS-K-affiliated and non-BPJS-K affiliated
- Business model: Mix of chain and non-chain facilities
- Clientele served: Mix of higher and lower socioeconomic status clientele (proxy by % of BPJS patients or affluence level of neighborhood)

We are now in the process of selecting facilities with input from NTP, CTB, and district Dinkes to ensure feasibility (i.e. ability to secure interviews) as well as to identify those hospitals they see as the technical and moral leader in TB. (See Section 3 for details on facility selection).

We have determined that the location of the interviews with hospitals will be at the hospitals themselves as confirmed in the introduction meetings with Dinkes.

Step 2: Pre-research hypothesis generation (*In-process*)

Prior to conducting research in the districts, we have developed informed conjectures about how private sector hospitals may be performing currently in diagnosing, treating, and reporting TB and their relationships with other facilities and providers and the rationale for this behavior. This is critical to perform prior to developing the interview guide as well as conducting the research in order to ensure that the research is structured and delivered in a way that can meet the research objectives and enable the team to identify the most effective levers and incentives to affect change. (See Section 4 for specific ingoing hypotheses). These hypotheses have been informed by existing literature and research, findings from past efforts and perspectives of experts in the field (including hypotheses shared by Dinkes in introduction meetings). In generating these hypotheses, we have also considered relevant 'root causes'.

Step 3: Interview guide development and pre-work (*In-process*)

The team is developing an interview guide to help direct the interview discussion, ensuring that the questions are targeted and tie back to the pre-research hypotheses and the overarching project objectives. (See Section 5 for draft interview guide for hospitals).

Step 4: Interview conducting

For each of the districts, the interviews with hospital directors / managers will take place in stages over the course of one to two weeks as opposed to all of the interviews for hospitals being conducted in one condensed, standalone time period (note that for most districts it will take up to 8 days to complete all interviews for that district including hospitals, clinics, labs, pharmacies, Dinkes and professional associations). This staged approach is deliberate in order to enable the team to reflect, adjust and refine in between interviews. Specifically, the initial set of interviews will be used as exploratory interviews to test (i.e. prove/disprove) initial hypotheses and understand the range of responses from participants. Once initial patterns emerge, the team will use the interviews to a) continue to validate patterns and probe deeper on understanding the "why", b) to probe in-depth on specific concepts emerging as critical and / or c) to close any remaining gaps in information.

This evolution will occur in two ways: a) over the course of the research in each district as well as b) over the course of the district research process across districts. This ongoing refinement will be informed by the insight capturing step as outlined in the next section.

Step 5: Insights capture and hypothesis refinement

The team will capture insights in two ways: during the interview and after the interview. During the interview, the team will capture key notes to supplement the audio recording. Key insights of the interviews will be typed up, synthesized and shared with the broader team on a weekly basis. The relevant part of the audio recording will be listened to in order to ensure key points are captured and interpreted accurately. At the end of each day, the team will collectively discuss key themes from the discussion, compare notes, test and determine the following areas:

- Are the interviews providing the type of insight we need? If not, what needs to be adjusted?
- What are we learning to prove or disprove our hypotheses?
- What are the key themes and takeaways related to our project objectives?

In doing so, the team will refine and focus the pre-research hypotheses as the evidence accumulates. One example of the refinement of hypotheses will include determining the typologies / archetypes of hospital

characteristics that can help explain behaviors. While the team will be refining hypotheses throughout the district research, we plan to have an updated view of the hypotheses at the mid-point of the project.

Step 6: Synthesis

After the district research is conducted, the team will synthesize the findings. The team will identify key themes from the research including:

- Areas of convergence & divergence across interview findings (also highlighting the findings that were expected and unexpected and why)
- Areas of most importance to answer the overarching project questions
- Insights on the rationale for why challenges are occurring
- Develop the landscape mapping and key themes, observations and recommendations

3 Methodology for facilities selection

To determine how to impact the behavior of private sector providers with different profiles, the interviews will include a mix of facility typologies in each selected district. Figure 1 below attempts to capture the variation of facility typologies selected for district interviews.

Due to data limitations, especially for private clinics, pharmacies, and labs, facility selection will not be a solely data-driven approach. We will supplement this with feedback from the district-level CTB team (for North Jakarta, Medan, and Tulungagung) and District Health Offices (DHO). Local knowledge of the CTB team and DHO in each district will help identify facilities that are considered the technical leaders in providing TB care, while ensuring feasibility to secure interviews with the respective facilities.

The initial list of identified facilities will be re-calibrated with underlying data whenever possible to ensure a balanced set of facilities to interview in each selected district.

Dimension	Hospital (n=4-5 per district)	Clinic (n=4-5 per district)	Pharmacy (n=8-10 per district)	Lab (n=4-6 per district)
Size	Mix of size, based on • Type (A/B/C/D), and/or • # of beds and outpatients, and/or • # of reported TB case	Mix of size of clinics ¹ , based on • Type (<u>pratama</u> and <u>utama</u>), and/or • # of doctors and/or • # of patients	Mix of size, based on • # of pharmacists, or • # of TB drugs sold, or • # of TB cases referred	Mix of size, based on • # of TB diagnostics performed, or • # of laboratory technicians
TB care service capabilities	Mix of lab w/ and w/out advanced TB diagnostic tools (<u>GeneXpert</u> , <u>DST</u> , <u>Culture</u>) and in-house pharmacy disbursing TB drugs (<u>FDC</u> vs loose) Include all facilities with <u>GeneXpert</u> if possible	Mix of lab w/ and w/out advanced TB diagnostic tools (<u>GeneXpert</u> , <u>DST</u> , <u>Culture</u>) and in-house pharmacy disbursing TB drugs (<u>FDC</u> vs loose) Include all facilities with <u>GeneXpert</u> if possible	Mix of pharmacy selling more <u>FDC</u> and selling more loose-drugs	Mix of lab w/ and w/out advanced TB diagnostic tools (<u>GeneXpert</u> , <u>DST</u> , <u>Culture</u>) Include facilities with <u>GeneXpert</u> if possible
BPJS-K affiliation	Mix of <u>BPJS-K</u> -affiliated and non <u>BPJS-K</u> affiliated			Not applicable (Not affiliated with <u>BPJS</u> , except for preventive diagnosis, e.g. cervical cancer pap smear)
Business model	Mix of chain and non chain facilities			
Clientele served	Mix of higher and lower SES clientele (proxy by % of <u>BPJS</u> patients or affluence level of neighborhood)			
Qual. assessment	Technical leaders in TB, level of engagement or participation of facilities in PPM, ability to secure interviews			

Figure 1. Variation of facility typologies for district interview

4 Key hypotheses to be tested in the interviews for laboratories

We have structured the interview guide in 6 sections. Each section has the objectives articulated, which is to test the relevant pre-research hypotheses on how private facilities are performing and why.

The following pre-research hypotheses have been identified for private laboratories to help define potential archetypes that may enable NTP and its partners to implement change more effectively and explain how each of those archetypes would behave in response to TB care improvement initiatives. These hypotheses, which will continue to be refined and validated during the initial set of exploratory interviews, include:

- Large laboratory chains in Indonesia, e.g. Prodia (with ~130 clinical laboratories and ~114 Point of Care outlets operated in doctor's offices) or Pramita, provide an important opportunity for impact in any change initiative due to the sheer number of facilities within the network, and the chain's greater interest in branding themselves as high quality, assuming there is a strong central command model
- Such chains may be oriented more towards a richer clientele, and towards expensive tests that brand them as being distinct from the public sector and smaller labs
- Chains may already profit from their own testing approaches (such as in-house PCR) that are hard to displace with more quality assured approaches such as GeneXpert. However, they may be open to arguments in which lower, concessionary pricing drives higher volumes of testing and thus, potentially, higher overall profit despite lower mark-up
- Small-scale lab operations, especially in rural, less affluent areas, are less equipped or are less knowledgeable about proper TB care protocols
 - These labs are less likely to employ TB-trained pathologists or on-duty doctors, and may lack clear protocols in ensuring infection control in patient areas or for directing those with TB symptoms towards TB testing, limiting TB detection opportunity
 - These labs may also lack referral networks (i.e. no formal agreement) with PHCs or Hospitals, and therefore have limited ability to link into efficient TB patient pathways that would minimize patient inconvenience and loss to follow-up
- Sub-scale TB-burden or challenging economics don't justify the investment and operation of TB diagnostic tools (e.g. GeneXpert), especially for laboratories whose profit comes mostly from non-TB diagnosis / tests
- Incentivizing labs to join BPJS-K network, through which free TB-related diagnosis tests could be offered to the masses, is critical for providing increased access for those in need, especially in less affluent areas, given that labs are often an entry point for many patients
- Labs offering home sample collection services to stay-at-home customers can lower the barriers for clients who may not have taken the tests in-person otherwise (due to negative connotation or stigma from contracting TB disease)

5 Interview guide and questionnaires: for Laboratories

The team will develop a data template that will be sent to the facilities for completion before the interview (see Section 6 for data request) in order to minimize the number of data-intensive questions that could interrupt the discussion flow. The collected data will provide a basis for understanding the characteristics of each facility, enabling the interview questions and discussion to be tailored according to the facility's profile. However, in the event that the pre-interview data request is not filled prior to the interview (or not fully completed), this information will be gathered during the interview. The interview guide will enable

the team to explore qualitative elements on the topics targeted in the data request in order to understand the ‘whys’ behind any figures.

5.1 Introduction and context (~ 5 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
To be shared with interviewee after introductions to BCG team • Project objective: Understand who are the key private sector actors and how they are currently operating in delivering TB care, understanding the institutional relationships in private sector TB care, and to establish a strong basis for follow-up support from NTP Indonesia and a USAID/Indonesia project • Interview objective: Understand the sphere of influence of laboratories in TB care; identify strengths, weaknesses and opportunities of institutional relationships between facilities and other TB care providers; and identify the institutional incentives / disincentives to providing high quality, effective TB treatment • Protection of interviewee: Results will be anonymized and reported in aggregate. The raw data will not contain identifiers of either individual respondents or individual facilities. • Overview of interview, including: • Format • Topics covered • Anonymity to promote openness	• Share objectives and get early buy-in (i.e., what’s in it for them) • To encourage candidness in answers

5.2 Background & profile of facility (~15-20 min if template not yet populated)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
To be collected prior to the interview in template provided (see Section 6 for complete view; will be pre-populated with existing data before sending to participant) Business performance and high-level business model • Over the past few years, has business been steady, struggling, or growing / expanding? What factors may have driven this performance? • Do you have a strategy for increasing your revenue? What is it? • Who are your typical customers? What’s the proportion and characteristics for each? - Where do they come from? (walk-in customers, referrals from hospitals, other labs, pharmacy, clinics, stand-alone physicians, other laboratories), Overall, more from public or private facilities, and why? How many clients are referred in a year? Do you have preferred referral relationships? Does this differ for TB vs other conditions? - What percentage come with a prescription for a lab test, vs what proportion come complaining of certain symptoms and	• Understand characteristics of the laboratory to inform potential archetypes of different facility types • Develop recommendations tailored to specific archetype / typology of institutions

wanting the lab to determine which test to do? - For walk-ins: What is the socio-economic status of your customers? (e.g., % low income with disposable income <IDR 2,000,000 / month), % medium income between IDR 2,000,000 – 5,000,000 / month, % high income > IDR 5,000,000 / month)? Do they come for primary vs. secondary vs. tertiary care? - For hospital referrals: are they mostly public or private? Are they typically class A/B/C/D hospitals? - For clinic referrals: are they mostly public or private? Are they typically Clinic “Pratama” or “Utama”? - Which customer segment is most profitable? Why? - Are you trying to change or influence your customer profile / mix? How and why? • What tests (for all medical conditions) do you run the most? Are there variations in the types of tests run for / requested for by each of your different customer types (if applicable)? - What percentage of your business (volume and / or sales) comes from TB tests? • What do you think differentiates your facility from other labs? What is your comparative advantage? • Is the organization part of a larger network? If yes, who is part of your network (e.g. hospitals, community organizations, etc.)? What is the nature of the relationship? • (Ask separately for each diagnostic tool) Given your facility’s therapeutic and business priorities, how much of a business case is there for providing and improving TB tests such as chest Xray, sputum smear, and GeneXpert (low, medium, high)? Which aspects of TB care are most important to your facility (other than diagnosis, if applicable)? Why? • If chain, what decisions / activities are typically centralized vs. decentralized? If centralized or have branches in different cities or districts, who makes the decision (e.g. national head branch or more regional level)?	
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5.3 High quality TB care: Successful detection, diagnosis, and reporting (~45 min)

<u>Interview Questions / Guidelines</u> Availability of diagnostic tools and other add-on services • Who in the laboratory (i.e. which position / role) decides which diagnostic capabilities to own? If chain, is this decision centralized from the head branch / regional or made in each branch? • What are the methods and tools your facility uses to diagnose DS-TB? E.g. CXR, sputum smear, GeneXpert. - If TB testing is offered, where do most of clients come from (e.g. referral from clinics, hospitals vs. non-referral patients)?	<u>Objectives</u> • To understand facility’s current level and quality of TB care capabilities and to identify gaps as potential target areas for improvement; to be able to identify if any patterns exist between level of capability and
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• If indicated no X-ray or sputum smear in the data request, why not? • GeneXpert: - Are you aware of GeneXpert? - Do you know that it is used to diagnose TB? Do you know what else it is used for (e.g. rapid flu testing, risk factors for thrombosis, MRSA surveillance, etc)? Which are those uses are more or less important to you? - If indicated GeneXpert in data request, did you procure it from a private supplier or was it provided by the public sector? If provided by the public sector, under what agreement (in terms of who supplies cartridges, at what cost, the price that you can charge for the test, what reporting is necessary, and who pays for maintenance)? - Do you procure the cartridges from private or public sources, or are they supplied for free by the public sector? • Have you increased / decreased your TB diagnostic tools in the last few years? Which ones specifically? • Have you considered providing / proposing more advanced diagnostic tools? If not, why and what is the challenge? - What are the financial and non-financial considerations? - What # of patients per tool is necessary / desirable to acquire more advanced diagnostic tools in-house (e.g. for it to make economic sense to purchase GeneXpert)? - Would you be interested in hosting a public sector Xpert machine if, in return, you had to limit your client test fee and report the outcomes to the public sector? • What would incentivize you to provide more advanced diagnostic tools? Which one is most attractive? Why? - More suitable or competitive pricing model (e.g., Cost per Reportable Result vs. procuring the diagnostic equipment, discounted price from group purchase, etc) - Volume guarantee from referral network - Fee-for-service (BPJS) for diagnostic method / tools—which one and why? - Any others? • Does your facility offer other add-on services (e.g. home collection services for stay-at-home customers, pick-up services for other health facilities)? If yes, what's the benefit to your institution? How do the economics work? Are they favourable / unfavourable? • Does your laboratory have any programs or tools to facilitate your lab technicians or staff to ensure clients / patients receive proper follow up care for any conditions (not just TB) (e.g. ensuring referred patients visit hospital or clinic to evaluate test results and receive proper diagnosis)? Who is responsible? • What are some of the regulatory requirements regarding your test quality that you would have to meet? Are there penalties or consequences for non-participation or incompliance?	their behaviors • Understanding current
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What is the facility's current TB case reporting capabilities? • Does your laboratory have any programs to report data on certain diagnostic categories to the public sector (not just for TB)? - Are there any incentives for the patient or your lab employees (clinical pathologists, admin, phlebotomists, etc) to participate in these programs? - Are there any consequences when the facility / responsible person (or group of people) do not do so? If yes, what are they? • As administrator / manager / owner: do you enforce reporting requirements for any conditions? For TB? If yes, how often? If not, why not, and what are your ideas about how to do so and whether it might work? (lack of clear consequences for non-compliance, lack of clear / guaranteed benefits, not comfortable, high cost burden, high administrative burden, etc.)? - For chain facilities, is reporting centralized or decentralized? Is it enforced by the head branch or do each branches enforce its lab technician's or other employees' compliance with reporting requirements? Do you believe that having a chain business model enables you to enforce better – why or why not? • What incentives would be effective for your facility to establish systems to facilitate or check that your technicians / physicians comply with reporting guidelines? Which one is most attractive? Why? - Streamline reporting process (e.g. integrated reporting between internal and external systems) - Referral guarantee if meeting certain thresholds - Financial payments for each validated report (in what format?) - Any others? HR policies and pathologists profile • How many staff in total do you employ in this facility or in the whole chain? How many pathologists and on-duty doctors? • If clinical pathologists or on-duty doctors indicated previously, Do you consider your lab staff to be proficient in TB techniques such as ordering and interpreting TB tests, reading CXR, and conducting smear microscopy and GeneXpert? Why or why not? Is the facility motivated to improve this? Why or why not? How? • What motivates your lab to provide training and support to ensure that pathologists / physicians are TB-trained? Which one is most important? Why? - Financial reward? How much? - Ease of laboratory licensing / registration renewal - Earned reputation e.g., as TB care top provider / other non-monetary rewards (what are they?)	reporting practice and identifying any breakdown in the system • Uncovering reasons or burdens behind non-compliance as basis for future interventions to strengthen / incentivize reporting practice in laboratories • Understand facility's motivations for investing in TB staff and TB care education • Understand the levers facilities have based on the motivations and allegiances of TB care providers
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- Better access to training (free training, shortened training) - Any others? • If chain, is training provided centrally or at the regional or district level?	
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5.4 Cross-referrals and relationships with other institutions / care providers and PPM (~15 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
<u>Cross-referrals</u> • For general medical issues, in what circumstances would you refer patients out for services, and where? E.g., • For patients sent with a physician's prescription for a test, do you always send them back to that physician, or sometimes retain them in care or send them elsewhere for care? • For clients who come in with symptoms but no prescription for a test, do you retain them in care or refer them to a physician elsewhere? • Does these behaviours differ for TB? <u>Relationship with other institutions</u> • Other than for referrals, when providing any medical services, what other institutions do you engage with (E.g., other providers such as Puskesmas, clinics, hospitals, other labs, pharmacies, Professional Assoc., Community Health Org, DinKes)? • With whom? What is the nature of the engagement? (reporting, formal / contractual or informal, etc) • Why did you choose these partners? What criteria do you use to select? How do you prioritize? • Who makes the decision on who to partner with? • How does this relate to your future growth strategies for the laboratory or chain? • Other than for referrals, when providing TB care, what other institutions do you engage with? • With whom? What is the nature of the engagement? (reporting, formal / contractual or informal, etc) • Why did you choose these partners? What criteria do you use to select? How do you prioritize? • Who makes the decision on who to partner with? • If you do not engage with any of the above institutions, why not? Do you see any of the institutions as playing a potential role to complement or support the role of your facility? If so, how? • What role do you think professional associations (e.g., IAI, ASKLIN, IDI, ARSSI, etc) should play in supporting TB testing in labs / improving linkages between facilities? What about the role for community organizations?	• Gauging the extent of facility's current referral networks and understanding the merits of appropriate facilities in providing different aspects of TB care for different TB patients • Gauging the extent of facility's current relationship networks as basis for achieving ideal linkages in TB care ecosystem • Understanding the merits of appropriate facilities in providing different aspects of TB care for different TB patients • To identify facilities with large relationship networks as possible target of future impactful initiatives • Understanding facility's linkages with PPM and public sector as well as professional associations

PPM / Partnership or linkage with Public Sector • How often does this institution interact with either the DHO or PKM? For what purposes (licensing, trainings, reporting, other)? • Does licensing put any quality or performance pressure on you, or is it just paperwork? What kind of quality or performance pressure? • How has the hospital interacted with the public sector related to TB care? • What was the last time that somebody from DHO or PKM visited or called the facility for TB monitoring or reporting? • Are you aware of the district-based PPM TB programming /other partnership with public or other private sectors in TB? What is your understanding of this? {if no, clarify that it involves the public sector reaching out to the private providers for TB notification and quality of care, including use of public TB drugs} • Are you part of the district's PPM network / other network with public or other private sectors in TB? Why did you agree to be part of the network? • Has anybody approached / engaged the facility to participate in PPM TB initiatives / other partnership initiatives with public or other private sectors in TB? - If yes, who approached you (Dinkes, community organizations, etc)? In which activities did you participate? Would you participate again? Why or why not? - If you did not participate, why not? Any feedback? • How effective do you perceive the network to be? Has it addressed the needs of private sector? Which needs specifically (funding, knowledge support, etc)? If not, what additional efforts would address the unmet needs better? • Explore relationships with NTP, Dinas Kesehatan, Puskesmas/other public primary care (if not covered yet) • Would you be open to further PPM efforts / interactions with the public sector on TB? • Would you like to be involved (if not yet) or more involved (if previously already) in strategy formulation / implementation of efforts to improve TB care or improve linkages between different facilities that offer TB services? Why or why not? In what type of roles or opportunities? (e.g., be invited to planning meetings / establish and join a referral network) • Do you think the relationship between the private and public sector needs to be improved? If yes, what do you think can be improved in the relationship between the private and	& community organizations
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public sector? What specific initiatives / actions would be required to do so? • What is the best way for the government to continuously engage the private sector?	
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5.5 Commercial networks (~10 minutes)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
• Do you also work with other commercial providers E.g., do you have any commercial arrangements for sample transportation, reagent procurement, reagent delivery / distribution co., medical equipment providers (Abbot, Roche, etc)? • When do you typically use these providers? Who are the main companies? • If chain: Are any of these arrangements made centrally or regionally or are they all sourced, facilitated and managed by your institution locally? • Generally when you work with commercial providers: - What is the structure of the agreement? Exclusive or non-exclusive? Bi-lateral vs. multi-party agreement? - What are the specific financial mechanisms: Kick-back, referral fee, discount? How much? What is the payment term? - What are your obligations in the agreement? - Duration of agreement? - Do you typically cover the costs or pass on to the patient (for deliveries or sample transport)? • Do you believe that engaging commercial providers and other partnerships better equip the pharmacies to treat patients overall? Why or why not? • What specific partnerships / engagement have the highest impact on TB patients / TB care? What drives the impact? (e.g. drug delivery company increases convenience for patients in accessing TB drugs to maximize chances of completing full regimen)?	• Understanding size of facility's commercial network to determine potential levers of support in delivering TB care; understanding whether commercial & non-commercial network enables the facility to deliver higher quality care / stronger influence in TB care ecosystem • To identify facilities with large commercial networks as possible target of future impactful initiatives

5.6 BPJS-K enrollment (~ 15 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
• Has the laboratory had any experience with BPJS-K programs (e.g. providing testing for BPJS-K chronic diseases such as Hypertension and Diabetes)? If yes, did you find it beneficial, why? If not, are you aware of these programs? If yes, why did you not participate? • Would you be interested in enrolling in the current BPJS-K program (PROLANIS or other BPJS-K program for lab)? Why or why not? - If not, what would have to change for you to be willing to enroll (increased reimbursement rates, reimbursements for	• Understanding facility's view on a potential BPJS-K program for laboratories • Understanding challenges to lay BPJS groundwork for

more tests, increase of patients)? - In which of the following areas would you foresee challenges in providing TB care under such BPJS-K program? - Areas to explore: Compliance with service and facility standards, reporting requirements, increasing resource and cost burden, economics of treating a patients using BPJS vs. using private insurance vs. paying out of pocket (including reimbursement coverage and value, reimbursement process / timeline, value of fee-for-service scheme, if applicable)	laboratories and gauging cost and benefit of such BPJS-K programs
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6 Data template and request

Laboratory name, district:	<i>[example]</i> Lab Prodia, Kab Tangerang
# of branches:	~130
Location of branches (districts, provinces):	To be filled
# of branches that have PMDT sites:	

DATA (UNIT)		2015	2017
# of TB diagnosis / year			
# of DS-TB			
# of MDR-TB			
# of visitors / year			
% of patients who pay out of pocket vs. private insurance vs. outsourcing			
Area of district (catchment area) (km ²)	To be filled		
Population of district (catchment area) (#)	To be filled		
# of TB tests / year			
# Smears (and # positive)			
# Xpert (and # of TB+Xpert test)			
# CXR			
# Culture			
# IGRA			
# Others			

# of doctors						
# of pathologists						
% of total doctors / pathologists who are dual-practice ¹ (if applicable)						
# of consulting doctors / pathologists (non-permanent staff) (if applicable)						
# lab technician						
# Lung specialist (if applicable)						
# Other specialist (if applicable)						
# Other staffs						
Estimated % of total income from DS-TB						
<i>Estimated % of DS-TB income from BPJS</i>						
Estimated % of total income from MDR-TB						
<i>Estimated % of MDR-TB income from BPJS</i>						
# of TB cases reported						
# DS-TB						
# MDR-TB						
<i>(Optional) # comorbid TB+HIV</i>						
<i>(Optional) # comorbid TB+Diabetes</i>						
<i>(Optional) # comorbid TB+others</i>						
DATA (UNIT)	Microscopes for Smear Microscopy	CXR	Labs with IGRA	GeneXpert (or other molecular diagnostics)	Labs with Culture	Labs capable of TB DST²
Number of tools (#)						
Price per test (IDR)						
Pathologists /						

¹ Dual-practice physicians refers to physicians who work at multiple locations

² Drug susceptibility test

analysts with capability (#)						
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USAID-BCG PROJECT IN INDONESIA

Institutional assessment of private sector health providers in TB care

District field research approach: Pharmacy

USAID and BCG Indonesia

5/30/2018

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1 Topics covered in district interviews with facilities

Phase 2 of the private provider review will map the most critical private facilities - private hospitals, clinics, labs, and pharmacies - in each selected district and focus on understanding **current market** and **policy incentives** for private health care facilities and how different policies or interventions might affect those incentives at an institutional level. It will provide information to support the implementation of future initiatives to increase uptake and improve the quality of TB care, especially opportunities to use JKN as a lever to change behaviors of private sector providers.

More specifically, the interviews with private hospitals, clinics, labs, pharmacies, and local health care organizations across the seven districts will help us understand:

- **Who are the major private actors currently operating at a national level and in the selected districts?**
 - What's their size, capabilities, resources, services offered, and geographical reach?
 - What are the relationships between institutions in each district?
 - This landscaping would include data such as market share, commercial or more informal relationships between different types of institutions that might affect TB-related solutions, the TB services they provide, and the typical profile of their clients, with recommendations for their proposed role in improving private sector TB engagement in the district.
- **Are current market incentives driving providers towards or away from the provision of quality TB care? How?**
 - Understand attitudes among private providers toward participation in district-based PPM and how they envision engaging with Puskesmas and Dinas Kesehatan in their district
- **Other than private hospitals, labs, pharmacies, and physicians, are there any other local organizations or stakeholders (outside the public sector) that are contributing or could potentially contribute toward the TB care-seeking and treatment ecosystem in each district, and what are their capacities?**
- **What is the business case of providing TB-related diagnostics and drugs in the private sector?**
 - What are the incentives and disincentives, both commercial and non-commercial?
 - How does this change when taking into account other health conditions (e.g., HIV, diabetes)?
- **What opportunities exist to engage these identified actors in JKN?**
 - What has already motivated their participation in JKN or what incentives would motivate them to participate?
 - What concerns do they have about participation in JKN?
- **How would private hospitals, clinics, labs and pharmacies respond to any potential fee-for-service components of JKN or other interventions aimed at them, and would they pass those incentives on to their providers?**

The outcomes will be used to:

- Recommend a set of concrete, specific next steps for each district to advance its process of engaging private providers and institutions in TB care and prevention.
- Socialize findings with Dinas Kesehatan and other stakeholders to inform the national dialogue on district-based PPM for TB in Indonesia

2 Phase 2b approach to qualitative research and insight generation

Overview

For Phase 2b district research with private sector hospitals, clinics, pharmacies and labs, we will employ a multi-step process to generate insights. This process has been adapted from BCG best practices for qualitative interviews.

At a high-level, there are six key steps in this process:

1. Pre-planning
2. Pre-research hypothesis generation
3. Interview guide development and pre-work
4. Interview conducting*
5. Insights capture and hypothesis refinement*
6. Synthesis

*Note that steps four and five are iterative in that they will inform each other through the process. Each step of the process will be explained in more detail in the following sections. To bring the process to life, we will use hospitals as an example, but the process will be similar for pharmacies.

Step 1: Pre-planning (In-process)

The team has engaged in pre-planning to set the objectives of the district research, determine the number and type of hospital interview participants, develop the selection methodology and the location of the interviews.

For hospitals, the key research objectives are to understand the sphere of influence of hospitals in TB care; identify strengths, weaknesses and opportunities of institutional relationship between hospitals and other TB care providers; and highlight institutional incentives / disincentives to provide high quality, effective TB treatment, including via participation in district PPM. For each district, we are targeting interviews with 4-5 directors / managers of private hospitals. In order to be able to see meaningful distinctions in behaviors and incentives for hospitals, we are seeking a balanced set of hospitals based on characteristics such as:

- Class & size:
 - o Mix of different hospitals including Type (A/B/C/D) and/or
 - o # of beds and outpatients and/or
 - o # of reported TB cases
- TB-service capabilities:
 - o Mix of facilities with in-house labs w/ and w/out advanced TB diagnostic tools (GeneXpert, DST, Culture) and w/ and w/out in-house pharmacy disbursing TB drugs (FDC vs loose)
 - o Aim to include all facilities with GeneXpert if possible
- BPJS-K enrollment: Mix of BPJS-K-affiliated and non-BPJS-K affiliated
- Business model: Mix of chain and non-chain facilities
- Clientele served: Mix of higher and lower socioeconomic status clientele (proxy by % of BPJS patients or affluence level of neighborhood)

We are now in the process of selecting facilities with input from NTP, CTB, and district Dinkes to ensure feasibility (i.e. ability to secure interviews) as well as to identify those hospitals they see as the technical and moral leader in TB. (See Section 3 for details on facility selection).

We have determined that the location of the interviews with hospitals will be at the hospitals themselves as confirmed in the introduction meetings with Dinkes.

Step 2: Pre-research hypothesis generation (*In-process*)

Prior to conducting research in the districts, we have developed informed conjectures about how private sector hospitals may be performing currently in diagnosing, treating, and reporting TB and their relationships with other facilities and providers and the rationale for this behavior. This is critical to perform prior to developing the interview guide as well as conducting the research in order to ensure that the research is structured and delivered in a way that can meet the research objectives and enable the team to identify the most effective levers and incentives to affect change. (See Section 4 for specific ingoing hypotheses). These hypotheses have been informed by existing literature and research, findings from past efforts and perspectives of experts in the field (including hypotheses shared by Dinkes in introduction meetings). In generating these hypotheses, we have also considered relevant 'root causes'.

Step 3: Interview guide development and pre-work (*In-process*)

The team is developing an interview guide to help direct the interview discussion, ensuring that the questions are targeted and tie back to the pre-research hypotheses and the overarching project objectives. (See Section 5 for draft interview guide for hospitals).

Step 4: Interview conducting

For each of the districts, the interviews with hospital directors / managers will take place in stages over the course of one to two weeks as opposed to all of the interviews for hospitals being conducted in one condensed, standalone time period (note that for most districts it will take up to 8 days to complete all interviews for that district including hospitals, clinics, labs, pharmacies, Dinkes and professional associations). This staged approach is deliberate in order to enable the team to reflect, adjust and refine in between interviews. Specifically, the initial set of interviews will be used as exploratory interviews to test (i.e. prove/disprove) initial hypotheses and understand the range of responses from participants. Once initial patterns emerge, the team will use the interviews to a) continue to validate patterns and probe deeper on understanding the "why", b) to probe in-depth on specific concepts emerging as critical and / or c) to close any remaining gaps in information.

This evolution will occur in two ways: a) over the course of the research in each district as well as b) over the course of the district research process across districts. This ongoing refinement will be informed by the insight capturing step as outlined in the next section.

Step 5: Insights capture and hypothesis refinement

The team will capture insights in two ways: during the interview and after the interview. During the interview, the team will capture key notes to supplement the audio recording. Key insights of the interviews will be typed up, synthesized and shared with the broader team on a weekly basis. The relevant part of the audio recording will be listened to in order to ensure key points are captured and interpreted accurately. At the end of each day, the team will collectively discuss key themes from the discussion, compare notes, test and determine the following areas:

- Are the interviews providing the type of insight we need? If not, what needs to be adjusted?
- What are we learning to prove or disprove our hypotheses?
- What are the key themes and takeaways related to our project objectives?

In doing so, the team will refine and focus the pre-research hypotheses as the evidence accumulates. One example of the refinement of hypotheses will include determining the typologies / archetypes of hospital characteristics that can help explain behaviors. While the team will be refining hypotheses throughout the district research, we plan to have an updated view of the hypotheses at the mid-point of the project.

Step 6: Synthesis

After the district research is conducted, the team will synthesize the findings. The team will identify key themes from the research including:

- Areas of convergence & divergence across interview findings (also highlighting the findings that were expected and unexpected and why)
- Areas of most importance to answer the overarching project questions
- Insights on the rationale for why challenges are occurring
- Develop the landscape mapping and key themes, observations and recommendations

3 Methodology for facilities selection

To determine how to impact the behavior of private sector providers with different profiles, the interviews will include a mix of facility typologies in each selected district. Figure 1 below attempts to capture the variation of facility typologies selected for district interviews.

Due to data limitations, especially for private clinics, pharmacies, and labs, facility selection will not be a solely data-driven approach. We will supplement this with feedback from the district-level CTB team (for North Jakarta, Medan, and Tulungagung) and District Health Offices (DHO). Local knowledge of the CTB team and DHO in each district will help identify facilities that are considered the technical leaders in providing TB care, while ensuring feasibility to secure interviews with the respective facilities.

The initial list of identified facilities will be re-calibrated with underlying data whenever possible to ensure a balanced set of facilities to interview in each selected district.

Dimension	Hospital (n=4-5 per district)	Clinic (n=4-5 per district)	Pharmacy (n=8-10 per district)	Lab (n=4-6 per district)
Size	Mix of size, based on - Type (A/B/C/D), and/or # of beds and outpatients, and/or # of reported TB case	Mix of size of clinics ¹ , based on - Type (<u>pratama</u> and <u>utama</u>), and/or # of doctors and/or # of patients	Mix of size, based on # of pharmacists, or # of TB drugs sold, or # of TB cases referred	Mix of size, based on # of TB diagnostics performed, or # of laboratory technicians
TB care service capabilities	Mix of lab w/ and w/out advanced TB diagnostic tools (<u>GeneXpert</u> , <u>DST</u> , <u>Culture</u>) and in-house pharmacy disbursing TB drugs (<u>FDC</u> vs loose) Include all facilities with <u>GeneXpert</u> if possible	Mix of lab w/ and w/out advanced TB diagnostic tools (<u>GeneXpert</u> , <u>DST</u> , <u>Culture</u>) and in-house pharmacy disbursing TB drugs (<u>FDC</u> vs loose) Include all facilities with <u>GeneXpert</u> if possible	Mix of pharmacy selling more <u>FDC</u> and selling more loose-drugs	Mix of lab w/ and w/out advanced TB diagnostic tools (<u>GeneXpert</u> , <u>DST</u> , <u>Culture</u>) Include facilities with <u>GeneXpert</u> if possible
BPJS-K affiliation	Mix of <u>BPJS-K</u> -affiliated and non <u>BPJS-K</u> affiliated			Not applicable (Not affiliated with <u>BPJS</u> , except for preventive diagnosis, e.g. cervical cancer pap smear)
Business model	Mix of chain and non chain facilities			
Clientele served	Mix of higher and lower SES clientele (proxy by % of <u>BPJS</u> patients or affluence level of neighborhood)			
Qual. assessment	Technical leaders in TB, level of engagement or participation of facilities in PPM, ability to secure interviews			

Figure 1. Variation of facility typologies for district interview

4 Key hypotheses to be tested in the interviews for pharmacies

We have structured the interview guide in 6 sections. Each section has the objectives articulated, which is to test the relevant pre-research hypotheses on how private facilities are performing and why.

The following pre-research hypotheses have been identified for private pharmacies. These hypotheses help to define potential archetypes that may enable NTP and its partners to implement change more effectively and explain how each of those archetypes would behave in response to TB care improvement initiatives. These hypotheses will continue to be refined and validated during the initial set of exploratory interviews. The initial set of hypotheses include:

- There may not be significant demand for TB drugs in standalone pharmacies, given the preference of diagnosed patients to acquire drugs in a one-stop-shop manner, where they receive initial diagnosis when possible (e.g. in-house pharmacies of diagnosing hospitals)
- Standalone pharmacy chains e.g. K-24, provide an important opportunity for impact in any change initiative due to the sheer number of facilities within the network, and the ability to mark quality care with a brand or visual identity across these facilities, assuming there is a strong central command model
- Standalone pharmacy chains might be more willing to take on non-profit driven activities (such as treatment monitoring) if there is reputational benefit
- Pharmacy chains are more likely (than individual pharmacies) to adhere to regulations such as dispensing antibiotics only with a prescription
- Pharmacies in close proximity to other TB care providers (e.g. lung specialist hospitals / clinics) provide an opportunity to increase stock of TB drugs and enforce guidelines for quality prescriptions, especially within areas of likely high TB prevalence such as those that are poor and/or crowded
- Pharmacy installations within shopping malls, offices, airports etc. typically opt for a more “convenience store”-like business model, focusing on higher margin consumer goods and are most likely not as involved or influential in TB care
- Pharmacies located in areas with a lower concentration of hospitals, labs, or clinics play a pivotal role as a more convenient distribution channel to facilitate access to TB (FDC) drugs for the surrounding patients
- Pharmacies are currently not incentivized to be guided by BPJS-K policies since there is limited financial relationship between them (only BPJS-K Rujuk Balik). However, if BPJS-K Rujuk Balik is extended to cover TB, there might be an opportunity to better engage pharmacy
- Lack of client loyalty to a particular pharmacy diminishes standalone pharmacies’ ability to monitor and ensure treatment completion relative to hospital / clinic in-house pharmacies, particularly those with a DOTS corner. Hospital/clinic might be in a better position to be responsible for patients monitoring
- Different types of pharmacies have more or less stable connections to surrounding GPs and hospitals
 - Such connections, when present, are an opportunity to introduce interventions that strengthen referral of symptomatic TB patients, act as a check on non-standard prescribing for TB, and/or assist with case holding
- Pharmacies are less influenced in their practices by the pharmacy association, and more influenced by drug sales reps. Drug reps from certain companies might be effective in conveying TB messages and programs

- Pharmacies lack incentives or knowledge for referring symptomatic TB patients to PHC or private physicians for diagnosis and treatment; a lack of supervision and mechanism to prevent drugs disbursement to TB-symptomatics without prescription exacerbates tendency to not refer
- Pharmacies that are part of a broader network of care (e.g. home delivery services; referral agreements with hospitals, clinics, labs, community organizations, etc) may be more effective and efficient in delivering convenient, consistent care than those that act independently because they can use institutions in their network to supplement care delivery or reinforce behaviors of the providers and patients

5 Interview guide and questionnaires: for Pharmacies

The team will develop a data template that will be sent to the facilities for completion before the interview (see Section 6 for data request) in order to minimize the number of data-intensive questions that could interrupt the discussion flow. The collected data will provide a basis for understanding the characteristics of each facility, enabling the interview questions and discussion to be tailored according to the facility's profile. However, in the event that the pre-interview data request is not filled prior to the interview (or not fully completed), this information will be gathered during the interview. The interview guide will enable the team to explore qualitative elements on the topics targeted in the data request in order to understand the 'whys' behind any figures.

5.1 Introduction and context (~ 5 min)

Interview Questions / Guidelines	Objectives
To be shared with interviewee after introductions to BCG team • Project objective: Understand who are the key private sector actors and how they are currently operating in delivering TB care, understanding the institutional relationships in private sector TB care, and to establish a strong basis for follow-up support from NTP Indonesia and a USAID/Indonesia project • Interview objective: Understand the sphere of influence of pharmacies in TB care; identify strengths, weaknesses and opportunities of institutional relationships between facilities and other TB care providers; and identify the institutional incentives / disincentives to providing high quality, effective TB treatment • Protection of interviewee: Results will be anonymized and reported in aggregate. The raw data will not contain identifiers of either individual respondents or individual facilities. • Overview of interview, including: - Format - Topics covered - Anonymity to promote openness	• Share objectives and get early buy-in (i.e., what's in it for them) • To encourage candidness in answers

5.2 Background & profile of facility (~15-20 min/less if data request template has been populated)

Interview Questions / Guidelines	Objectives
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To be collected prior to the interview in template provided (see Section 4 for complete view; will be pre-populated with existing data before sending to participant) Business performance and high-level business model (additional questions to be asked during interview) - Over the past few years, has business been steady, struggling, or growing / expanding? What factors may have driven this performance? - Do you have a strategy for increasing your revenues? What is it? - Who are your typical customers? What's the proportion and characteristics for each? - Where do they come from? (walk-in customers, patients with prescriptions from hospitals / clinics / stand-alone physicians, referrals from laboratories / other pharmacies, more from public or private), and why? How many clients are referred in a year? Do you have preferred referral relationships? Why? Does this differ for TB vs other conditions? - What is the socio-economic status of your customers? (e.g., % low income with disposable income <IDR 2,000,000 / month), % medium income between IDR 2,000,000 – 5,000,000 / month, % high income > IDR 5,000,000 / month)? - For hospital referrals: are they mostly public or private? Are they typically class A/B/C/D hospitals? - For clinic referrals: are they mostly public or private? Are they typically Clinic “Pratama” or “Utama”? - Are you trying to change or influence your customer profile mix? How and why? - What classes of drugs (for all medical conditions) (e.g. antibiotics, anti-hypertensives, etc.) do you sell in the highest volumes? Are there variations in the types for each of your different customer types (if applicable)? Which customer segment is most profitable? Why? - What percentage of your volume and / or sales do TB drugs represent? - Do you fill prescriptions for TB comorbid with HIV, diabetes, or both? If yes, what is the estimated % out of all TB drugs? - What do you think differentiates your facility from other pharmacies (private and public)? What is your comparative advantage? - Given your facility's therapeutic and business priorities, how much of a business case is there for providing and improving TB care (low, medium, high)? Which aspects of TB care are most important to your facility (ensuring availability of drugs, improving referral of symptomatics for quality diagnosis; quality of treatment and on-going care)? Why?	- Understand characteristics of the pharmacy to build archetypes of different facility types - Develop recommendations tailored to specific archetype / typology of institutions
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If the facility is part of a chain, what decisions / activities are typically centralized vs. decentralized? If there are branches in different cities or districts, who makes the decision (e.g. national head branch or more regional level)?	
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5.3 Access to public sector FDCs and experience with BPJS-K (~ 10-20 min)

<u>Interview Questions / Guidelines</u> Procurement policies - Do you stock TB drugs? Why or why not? - What is the current demand for TB drugs in your pharmacy (i.e. how many people come in every month to fill a prescription or wishing to purchase TB drugs)? Which ones (FDCs or loose drugs)? What proportion of each? Is this mostly with prescriptions or not? Do clients prefer FDCs or individual drugs for TB? Why? - For TB, do doctors prefer to prescribe FDCs or individual drugs? Why? - Do you currently stock any government drugs for any condition? Why did you decide to? - Do your clients prefer cheaper generic drugs or more expensive branded drugs? Why? - Presumably your clients currently buy TB drugs at market price. Would your clients accept TB drugs at lower prices (or for free) if those drugs were generic, government-procured drugs? Why or why not? - Who in the pharmacy decides what drugs to stock and procure? - If chain, is this decision centralized / decentralized? What are the mechanisms (e.g. each branch forecasts requirements depending on local needs to stock or procurements at the central office is distributed to branches)? - If previously indicated in data request that FDC is zero or a small proportion (<50%) of TB drugs stock, why (e.g. lack of access, lack of patient demand, lack of financial returns, etc.)? - In relation to procuring drugs from government, what additional steps or requirements are needed and what additional financial or non-financial resources are required to procure government FDC drugs? What are they? How much? - Is it easier or more difficult to procure and stock FDCs or single TB drugs? Why? - What would incentivize you to stock or increase stock of TB FDC drugs based on TB care guidelines in your pharmacy? - Reduce requirement and financial burden to access government-funded FDCs - Direct or indirect financial incentives for use of FDC drugs. How much and how to claim? - Any others? - How often do stock-outs occur with TB drugs? Which ones typically	<u>Objectives</u> - Understand current mixture of TB drugs and procurement policies in the pharmacy - Uncovering financial and non-financial reasons or burdens behind non-compliance as basis for future interventions and to increase use of FDC drugs in private institutional TB care
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run out first / the most? Why? What do you do in the event of a stock-out? - How do you typically set prices for TB drugs (loose, FDCs; first line, second line)? Experience with BPJS-K programs - Do you participate in the BPJS-K Rujuk Balik program or any other BPJS-K programs? Why or why not? - If no experience yet, why have you not joined? What financial (e.g. full reimbursement) or non-financial (e.g. patient referrals from other BPJS-K affiliated facilities) incentives would encourage you to join? - If a participant, why did you join? Do you think that the reimbursements for the drugs are sufficient (e.g. covers all your costs for procurement, dispensing, etc.)? Why or why not? - Is it easier or better to get a BPJS-K reimbursement or incentive, or just to get paid directly by the patient? Why? - Do BPJS-K patients know they are entitled to free drugs? - How does BPJS-K reimbursement compare to being reimbursed by private insurance? - If a participant, what benefits have you seen since you joined (e.g. easier procurement process, more patients purchasing from the pharmacy)? - If a participant, what challenges did you face when meeting the application requirements? Were there additional resources (e.g. financial, employees) that you needed to comply? - Deep Dive: For those who are in program Rujuk Balik or similar programs, what are the challenges with the existing Fee for Service (FFS) system? Do you think the system is suitable / can be applied for TB private drugs? Why or why not? Areas to explore: - E-Catalogue pricing rate / reimbursement period / admin / availability / etc - Compliance with service and facility standard - Inventory standards - Reporting requirements	- Understanding facility's incentives / disincentives for potentially becoming part of BPJS-K-related networks - Gauging economic attractiveness of BPJS-K programs and understanding challenges to lay groundwork for better TB care in BPJS-K with increasing network of clients / patients
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5.4 High quality TB treatment (successful detection and treatment) (~20min)

<u>Interview Questions / Guidelines</u> What is the pharmacy's current capabilities in providing TB care? TB symptoms detection and treatment capabilities? - Does anyone in your pharmacy know what symptoms are associated with TB? Who? Are they motivated to ask the necessary questions and refer those clients for TB testing? Why or why not? - If some staff know how to screen for TB symptoms, did you hire them with that knowledge already or did you facilitate / provide the training? Why? What would motivate you, as an institution, to promote TB education of at least some of your providers?	<u>Objectives</u> To understand facility's current level and quality of TB care capabilities and to identify gaps as potential target areas for improvement; to be able to identify if any patterns exist between level of capability and
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- If chain, is training provided centrally or at the regional or district level? • As administrator / manager / owner: How do you incentivize pharmacists to follow proper dispensing guidelines (e.g. don't dispense drugs requiring prescriptions without it, check accuracy of prescription, properly relay dosage and regimen to patients, etc)? • If chain: Are these processes / standards typically determined centrally or locally in branches? • We understand that it is common to sell TB drugs without a prescription, how often do your pharmacists sell TB drugs without a prescription? • Do you know the correct dosing for TB drugs? • How often do pharmacists double check drug dosages for drugs in general (not specific to TB)? • Do you ever see TB prescriptions that are incorrect? What action do you take? - Do pharmacists check TB drugs dosage or regimen (e.g. either checking if dosage is correct for patient's weight or double checking with prescribing doctor / physician) before disbursing drugs to TB patients? On-going care and reporting • Does your pharmacy have any programs to monitor patients or promote follow-up care for any conditions (not just for TB)? - Are there any incentives for the patient or the pharmacist or the business to participate in these programs? - Are these programs used for TB (e.g. patient adherence to 6 months treatment regimen, follow-up for missed prescription refills)? - What are some key challenges? - How do you ensure pharmacists' compliance to monitor patient treatment completion (if they are the ones responsible for doing so)? - If not, who is in charge and who do you think is better positioned for the role and why? - Are there any consequences if facility / PIC does not follow up with patients and ensure treatment completion? • What would incentivize the pharmacy to encourage pharmacists / other staff to monitor and remind patients about on-going treatment? Which one is most attractive? Why? - Financial payments for each completed treatment of patients (milestones)? Other rewards? - Accelerated annual licensing renewal or ease of licensing renewal - Auto-reminder, e.g., application to send automatic SMS to patients	their behaviors • Understand economics behind providing TB care capabilities to identify compelling financial levers for incentivizing facilities to improve services • Uncover potential non-financial means to encourage ideal behaviors and incentivize facility to provide high quality TB care • Identify facilities with high TB care capability as potential "role model" in future support initiatives
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- Any others? • As administrator / manager / owner: do you enforce reporting requirements for any conditions? If yes, how often? If not, why not (lack of clear consequences for non-compliance, lack of clear / guaranteed benefits, not comfortable, high cost burden, high administrative burden, etc.)? - For chain facilities, is reporting centralized or decentralized? Is it enforced by the head branch or do each branches enforce its pharmacist's compliance with reporting requirements? Do you believe that having a chain business model enables you to enforce better – why or why not? • What additional resources (e.g. additional admin employee, reporting system) would the pharmacy need to report TB cases / treatment outcomes to DHO? What would incentivize the pharmacy to report all TB cases / treatment outcomes to DHO / build systems to facilitate pharmacists' compliance? Which one is most attractive? Why? - Streamline reporting process (e.g., WiFi TB application for CTB districts, integrated reporting between internal and external systems) - Referral guarantee if meeting certain thresholds - Direct or indirect financial payments for each validated report - Any others?	
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5.5 Relationships with other institutions / care providers and referral networks (~10-20 mins)

<u>Interview Questions / Guidelines</u> Relationship with other institutions • When providing treatment for any medical conditions, what other institutions do you engage with (E.g., other providers such as Puskesmas, clinics, hospitals, labs, other pharmacies, Professional Assoc., Community Health Org, DinKes)? - With whom? What is the nature of the engagement? (one-way / mutual referral, reporting, formal / contractual or informal, etc) - Why did you choose these partners? What criteria do you use to select? How do you prioritize? - Who makes the decision on who to partner with? - How does this relate to your future growth strategies for the pharmacy or chain? • When providing TB care, what other institutions do you engage with (E.g., other providers such as Puskesmas, clinics, hospitals, labs, other pharmacies, Professional Assoc., Community Health Org, DinKes)?	<u>Objectives</u> • Gauging the extent of facility's current referral networks and understanding the merits of appropriate facilities in providing different aspects of TB care for different TB patients • Understanding incentives / disincentives for referral of clients / patients as basis for achieving ideal linkages in TB care ecosystem • Understanding facility's linkages with PPM and
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- With whom? What is the nature of the engagement? (one-way / mutual referral, reporting, formal / contractual or informal, etc) - Why did you choose these partners? What criteria do you use to select? How do you prioritize? - Who makes the decision on who to partner with? • If you do not engage with any of the above institutions, why not? Do you see any of the institutions as playing a potential role to complement or support the role of your facility? If so, how? • What role do you think professional associations (e.g., IAI, ASKLIN, IDI, ARSSI, etc) should play in supporting TB care / improving linkages between facilities? What about the role of community organizations? - How have professional associations interacted with members or the facility related to TB care? - How effective are professional associations in meeting the needs of the facility and its staff, specifically in understanding and representing the interests of the facility and its owners, for example in providing necessary training or related to negotiating with the government on licensing requirements, other regulatory requirements, and BPJS rates? - What are the challenges? What can be improved? • Does the pharmacy association influence you in any way, whether related to TB or not? How? Why? Referral networks • For general medical issues, in what circumstances would you refer patients out for services, and where? Which lab, other pharmacy, specialist, PHC clinic or hospital? How many clients are referred out in a month? Do you have preferred referral relationships? Why? Does this differ for TB, e.g., referring symptomatic TB clients out for diagnostic or for follow-up care? • What % of people with TB symptoms such as persistent cough are referred out to other providers rather than being sold drugs directly? Increased /decreased recently? By how many? - If they are referred out, where are they referred to and why? Do you have referral agreements with them? What is the nature (exclusive vs. non-exclusive, kick-back / referral mechanism, obligations, durations, etc)? Who decides? - What prevents the pharmacy from referring them (e.g. when do you refer a client vs. keeping him / her in your facility)? What do you think it costs for the pharmacy to refer a client instead of prescribing drugs immediately (e.g. lost revenues, other referral costs)? - How many patients are referred back for future purchase of drugs / prescription fulfilment? • What incentives would increase your willingness to refer clients to	public sector as well as professional associations & community organizations
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other providers (e.g. hospitals, PHCs, labs, etc.) Which one is most attractive?

- Guarantee of future purchase of drugs after referee received proper diagnosis
 - Direct financial or non-financial reward for referral
 - Expedited licensing or discounted cost
- If symptomatic TB clients are referred out, is it the pharmacy's policy to follow-up with treatment outcomes?

PPM / Partnership or linkage with Public Sector

- How often does this institution interact with either the DHO or PKM ? For what purposes (licensing, trainings, reporting, other)?
- How has the pharmacy interacted with the public sector related to TB care?
 - What was the last time that somebody from DHO or PKM visited or called the facility for TB monitoring or reporting?
 - Are you aware of the district-based PPM TB programming /other partnership with public or other private sectors in TB? What is your understanding of this? {if no, clarify that it involves the public sector reaching out to the private providers for TB notification and quality of care, including use of public TB drugs}
 - Are you part of the district's PPM network / other network with public or other private sectors in TB? Why did you agree to be part of the network?
 - Has anybody approached / engaged the facility to participate in PPM TB initiatives / other partnership initiatives with public or other private sectors in TB?
 - If yes, who approached you (Dinkes, community organizations, etc)? In which activities did you participate? Would you participate again? Why or why not?
 - If you did not participate, why not? Any feedback?
 - How effective do you perceive the network to be? Has it addressed the needs of private sector? Which needs specifically (funding, knowledge support, etc)? If not, what additional efforts would address the unmet needs better?
 - Explore relationships with NTP, Dinas Kesehatan, Puskesmas/other public primary care (if not covered yet)
- Would you be open to further PPM efforts / interactions with public sector around TB care?
 - Would you like to be involved (if not yet) or more involved (if previously already) in strategy formulation / implementation of efforts to improve TB care or improve linkages between different facilities that offer TB services?

Why or why not? In what type of roles or opportunities? (e.g., be invited to planning meetings / establish and join a referral network) - Do you think the relationship between the private and public sector needs to be improved? If yes, what do you think can be improved in the relationship between the private and public sector? What specific initiatives / actions would be required to do so? - What is the best way for the government to continuously engage the private sector?	
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5.6 Commercial networks (~10-20 minutes)

<u>Interview Questions / Guidelines</u> • Do you also work with other commercial providers? E.g., do you have any commercial arrangements for, drug procurement, drug delivery / distribution co., pharmaceutical companies (Bayer, Pfizer), etc.? - When do you typically use these providers? Who are the main companies? - If chain: Are any of these arrangements made centrally or regionally or are they all sourced, facilitated and managed by your institution locally? - Generally when you work with commercial providers: - What is the structure of the agreement? Exclusive or non-exclusive? Bi-lateral vs. multi-party agreement? - What are the specific financial mechanisms: Kick-back, referral fee, discount? How much? What is the payment term? - What are your obligations in the agreement? - Duration of agreement? - Do you typically cover the costs or pass on to the patient (for deliveries or sample transport)? • Do drug reps influence you in any way, whether related to TB or not? How? Why? • Does your facility use an e-catalogue? Why or why not? If yes, what is it used for? Is it used for TB? If yes, what aspects of TB care specifically? • Do you believe that engaging commercial providers and other partnerships better equip the pharmacies to treat patients overall? Why or why not? • What specific partnerships / engagement have the highest impact on TB patients / TB care? What drives the impact (e.g. pharmacies offering home delivery services increases patient's access to TB drugs and minimizes chances for patient missing a dosage or not completing full drug regimen)?	<u>Objectives</u> • Understanding size of facility's commercial network to determine potential levers of support in delivering TB care; understanding whether commercial & non-commercial network enables the facility to deliver higher quality care / stronger influence in TB care ecosystem • To identify facilities with large commercial networks as possible target of future impactful initiatives
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6 Data template and request

Pharmacy name:	<i>[example]</i> Apotek Keshia Farma, Medan
# of branches:	
Location of branches (district, province):	
# of branches participating in BPJS-K programs (e.g. Rujuk Balik):	

DATA (UNIT)		2015	2017
# of visitors / year			
% of visitors who use BPJS-K benefits at the pharmacy			
% of visitors who pay out-of-pocket			
# of distinct clients purchasing TB drugs / year			
# DS-TB / year			
# MDR / year			
# of TB patients who use BPJS-K benefits			
# of TB patients who pay out-of-pocket			
Area of district (catchment area) (km ²)	To be filled		
Population of district (catchment area) (#)	To be filled		
Estimated sales volume of drugs (IDR) / year			
Estimated % of sales volume from drugs for DS-TB treatment			
Estimated % of BPJS from DS-TB drugs sales			
Estimated % of sales volume from drugs for MDR-TB treatment			
Estimated % of BPJS from MDR-			

<i>TB drugs sales</i>			
# of pharmacists			
# TB educated / trained (if applicable)			
Approximate % of TB drugs stocked from public sources			
Approximate % of TB drugs stocked from private sources			
# of TB cases notified to public sector			
# DS-TB			
# MDR-TB			

USAID-BCG PROJECT IN INDONESIA

Institutional assessment of private sector health providers in TB care

District field research approach: Professional
Association

USAID and BCG Indonesia

5/30/2018

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1 Topics covered in interviews with Professional Associations

Phase 2 of the private provider review will map the most critical private facilities - private hospitals, clinics, labs, and pharmacies – in each selected district and focus on understanding **current market** and **policy incentives** for private health care facilities and how different policies or interventions might affect those incentives at an institutional level. It will provide information to support the implementation of future initiatives to increase uptake and improve the quality of TB care, especially opportunities to use JKN as a lever to change behaviors of private sector providers.

More specifically, the interviews with Professional Associations across the seven districts will help us understand:

- **For each district, which professional associations are stronger and weaker, and which individuals from the associations have the greatest potential to be key opinion leaders for future initiatives?**
- **Are there any opportunities for professional associations, as institutions, to interact with members and their respective private facilities?**
 - How effective are professional associations in meeting the needs of its members and in understanding and representing the interests of private facilities and their owners, for example in providing necessary training or related to negotiating with the government on licensing requirements, other regulatory requirements, and BPJS rates?
 - How do professional associations, as institutions, view their role or function vis-à-vis private facilities? What is the professional association's ideal, expected interaction with private facilities?
 - How often do professional associations interact with its members and their private facilities? For what purposes?
 - How have professional associations interacted with members or their private facilities related to TB care? How often and for what purposes? What do they see their roles to be?
- **What are the challenges faced by professional associations in facilitating or advocating for improved TB care? How?**
 - How do current support or interactions between associations and its members and facilities differ from what associations envision?
 - What current roadblocks do professional associations face in interacting with and providing support for TB care improvement initiatives within the private sector?
 - Understand how professional associations envision improving engagement with members and their private facilities in their district, and current success of their programming involving the private sector providers
- **Other than private hospitals, clinics, labs, pharmacies, and physicians, are there any other local organizations or stakeholders (outside the public sector) that are contributing or could potentially contribute toward the TB care-seeking and treatment ecosystem in each district, and what are their capacities? How should professional associations interact with them?**

The outcomes will be used to:

- Recommend a set of concrete, specific next steps for each district to advance its process of engaging private providers and institutions in TB care and prevention
- Socialize findings with Dinas Kesehatan and other stakeholders to inform the national dialogue on district-based PPM for TB in Indonesia

2 Phase 2b approach to qualitative research and insight generation

Overview

For Phase 2b district research with private sector hospitals, clinics, pharmacies, labs, Professional Association, DHO and community health organization, we will employ a multi-step process to generate insights. This process has been adapted from BCG best practices for qualitative interviews.

At a high-level, there are six key steps in this process:

1. Pre-planning
2. Ideas generation from private facilities interviews
3. Interview guide development and pre-work
4. Interview conducting*
5. Insights capture and hypothesis refinement*
6. Synthesis

*Note that steps four and five are iterative in that they will inform each other through the process. Each step of the process will be explained in more detail in the following sections. To bring the process to life, we will use professional associations as an example. Please refer to the Hospital interview guide for the approach regarding private facilities.

Step 1: Pre-planning (*In-process*)

The team has engaged with DHO, and in some cases the PHO (e.g. East Java, North Jakarta, Makassar), of each of all seven districts included in this assessment during facilities selection process. DHO helped the team select associations to ensure feasibility (i.e. ability to secure interviews) as well as to identify professional associations they see as the active, moral leader in TB. DHO has also introduced us to the district head or the district representatives of professional organizations in each district for interviews. Dr. Carmelia Basri has also introduced the team with the heads of the Coalition Organization of Indonesian Professionals (KOPI) in Jakarta.

Step 2: Ideas generation from private facilities interviews (*In-process*)

Prior to conducting the professional association interviews, the team would have conducted a few interviews to develop informed conjectures about private sector facilities' current interaction with professional associations and possible areas for improvements (see Section 3 for ideas generation from private facilities interviews).

Professional association interviews are planned to be an exploratory session for the team to learn professional associations' views of ideal interaction with private facilities. The ideas captured through private facility interviews will be raised to heads of relevant professional associations or representative towards the end of the interview and discussed to enable the team to test and identify the most effective, practical levers and incentives to affect change.

Step 3: Interview guide development and pre-work (*In-process*)

The team is developing an interview guide to help direct the interview discussion, ensuring that the questions are targeted and tie back to the overarching project objectives. (See Section 4 for draft interview guide for professional associations).

Step 4: Interview conducting

For each of the districts, the interviews with professional associations will take place after the team has conducted a few private facility interviews over the course of one to two weeks as opposed to being conducted early (note that for most districts it will take up to 8 days to complete all interviews for that district including hospitals, clinics, labs, pharmacies, Dinkes and community organizations). This approach is deliberate in order to enable the team to collate inputs from facilities to bring into the professional associations interview.

The team will group interviews into focus-group discussions to capture a more holistic view of current relationships and facilitate brainstorming on possible new initiatives to improve TB care. The interviews will be divided into the following groups: 1) doctors / physicians associations (e.g. PDPI and PAPDI), 2) hospitals / clinics associations (e.g. PKFI/ASKLIN and ARSSI), 3) pharmacists associations (e.g. IAI), and 4) laboratory associations (e.g. ILKI).

The team will also make sure that the ongoing refinement will be informed by the insights captured over the course of the research in each district across districts.

Step 5: Insights capture and hypothesis refinement

The team will capture insights in two ways: during the interview and after the interview. During the interview, the team will capture key notes to supplement the audio recording. Key insights of the interviews will be typed up, synthesized and shared with the broader team on a weekly basis. The relevant part of the audio recording will be listened to in order to ensure key points are captured and interpreted accurately. At the end of each day, the team will collectively discuss key themes from the discussion, compare notes, test and determine the following areas:

- Are the interviews providing the type of insight we need? If not, what needs to be adjusted?
- What are the key themes and takeaways related to our project objectives?
- What are we learning to ensure feasibility of emerging recommendation?

In doing so, the team will refine and focus the pre-research hypotheses as the evidence accumulates. While the team will be refining hypotheses throughout the district research, we plan to have an updated view of the hypotheses at the mid-point of the project.

Step 6: Synthesis

After the district research is conducted, the team will synthesize the findings. The team will identify key themes from the research including:

- Areas of convergence & divergence across interview findings (also highlighting the findings that were expected and unexpected and why)
- Areas of most importance to answer the overarching project questions
- Insights on the rationale for why challenges are occurring
- Develop the landscape mapping and key themes, observations and recommendations

3 Testing of ideas and hypotheses generated from Professional Association interview

Towards the end of the professional associations' interviews, the team will share the emerging set of ideas and / or lessons learned from private facilities interviews in order to compare whether this perspective coincides with professional associations' own views about their relationship with private providers and their role in the TB care ecosystem. This will also enable the team to diagnose the efficacy of current

initiatives and incentives / disincentives, determine areas of alignment or potential disconnects, identify weaknesses and untapped opportunities for future interventions.

See below for initial hypotheses (to be refined with findings during interviews with private facilities) that may serve as a starting point of discussion for NTP and its partners to implement change more effectively and inform how different associations would play a role in TB care improvement initiatives. These will continue to be refined and validated during later set of exploratory interviews. The initial set includes:

- Professional associations are integral channels to socialize and reinforce TB care improvement initiatives, including public sector PPM initiatives, and potentially play the following roles:
 - Doctors / physician / specialist (e.g. PDPI) organizations relay vital information on current best practices and enforce proper procedures for the provision of quality diagnosis and treatment of TB clients / patients in respective facilities
 - Pharmacist associations (e.g. IAI) increase awareness of proper TB treatment regimens and advocate the efficacy and use of FDC drugs over loose drugs alternatives
 - Laboratory associations (e.g. ILKI) provide learning about TB diagnostic tools and enforce procedures for diagnosis and referrals post-diagnosis
- Professional associations should understand and represent the interests of private facilities and their owners, for example related to negotiating with the government on licensing requirements, other regulatory requirements, and BPJS rates, but currently lack the power and organization to be very effective in this function
- Professional associations provide a potential forum for educational / training programs for care provider members, which may reduce the financial burden of individual private facilities to provide training to care providers, while increasing knowledge of and capability in TB care
- Professional associations increase the likelihood of non-network facilities participation in BPJS-K given that interactions with BPJS-K facilities can help in overcoming pre-existing reservations. Higher participation in BPJS-network increases potential impact of future interventions in TB care through this channel
- The newly-formed coalition uniting multiple professional associations (i.e. KOPI TB) will be more effective in engaging and leverage professional associations than previously possible with individual associations alone. This is due to many factors, including:
 - Coalition facilitates members of professional associations to identify and promote quality-assured referral pathways (e.g, hospitals not currently stocking HIV drugs are aware of and can easily coordinate with reputable pharmacies that stock HIV drugs needed to treat comorbid TB+HIV) which increases continuity of care and minimize patient drop-offs
 - The coalition enables the provision of more comprehensive, consistent care to TB clients / patients because facilities have increased access to opportunities for partnerships to close gaps in care capabilities or untapped market niches

4 Interview guide and questionnaires: for Professional Associations

We have structured the interview guide in 5 sections. Each section has the objectives articulated, which is to understand professional association's role, business case for participating in the private sector TB care ecosystem and views of ideal relationships with private providers and other key stakeholders (public sector, associations and other community organizations).

4.1 Introduction and context (~ 5 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
To be shared with interviewee after introductions to BCG team • Project objective: Understand who are the key private sector actors and how they are currently operating in delivering TB care, understanding the institutional relationships in private sector TB care, and to establish a strong basis for follow-up support from NTP Indonesia and a USAID/Indonesia project • Interview objective: Understand the sphere of influence of professional associations in TB care; identify strengths, weaknesses and opportunities of institutional relationships with facilities and other TB care providers; and identify the institutional incentives / disincentives to supporting high quality, effective TB treatment • Protection of interviewee: Results will be anonymized and reported in aggregate. The raw data will not contain identifiers of either individual respondents or individual facilities. • Overview of interview, including: - Format - Topics covered - Anonymity to promote openness	• Share objectives and get early buy-in (i.e., what's in it for them) • To encourage candidness in answers

4.2 Background & profile of professional associations (~20 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
Background and profile of association • When and why was the institution established? What is the main mission? What are the main activities of the association (in general, not specific to TB)? • What is the total budget of the association in this district? What is the source of your funding (donations from members, donations from institutions, etc)? • Does the association in this district have any paid staff? How many? • How many members are currently in the association? What are the characteristics of your constituents (mainly from private / public facilities, etc)? Are there different groups? If yes, what are they? What are the different characteristics? - What is required to become a member? Who decides? Why do they choose to join? - What % of members are active (attend meetings at least once a month, lead initiatives / programs, etc.)? What are the characteristics of active members? - What % of members belong to multiple organizations? - What % of members belong to institutions that are part of the BPJS-K networks? ▪ If 0%, why are some reasons they have not joined the BPJS-K network (e.g. reduced profitability,	• Understand characteristics of professional association to gauge sphere of influence for different stages of TB care and geographic reach

change in characteristics of patients, etc.)? • What is the organizational structure of the association? Who leads the association? How is he / she appointed? Is there a board? How do they make decisions (e.g. consensus, majority vote, etc.)? • Does the association have representatives or offices in the district / provincial / national level? Are key decisions on agenda and resource allocation centralized or decentralized (e.g. decided on the national level and socialized to the province and districts or made with input from all levels)? How often do you meet? - What is the relationship with offices in other districts? Do you work together in initiatives? What kind? How often do you meet? • Is your association currently part of any coalitions of multiple professional associations? If yes, which ones? Why did you join? If not, would you be willing to partake in a coalition with other associations (e.g. KOPI TB)? Key priorities and initiatives • Given various priorities, how much weight is given for improving TB care in the private sector in the district? Is there a business case for addressing or improving TB care? Which aspects of TB care are most important to your district (diagnostic capabilities, availability of drugs, quality of treatment and on-going care, reporting)? Why? • How many TB-related initiative have been launched over the past year which one are you prioritizing? How do you prioritize these initiatives and why? Do they require money or are they based on volunteering? • Are private providers engaged in your programs? If yes, which ones specifically? If not, why do you think they are not? What can be improved? • Do the activities of the association work to promote the business viability of private healthcare facilities? How? - Have you ever been engaged by the public sector on initiatives targeting private sector providers / facilities (e.g. helping distribute supplies such as sputum cups or N95 respirator masks)? If yes, which ones? What was the nature of it? • Or do they constrain the business opportunities of private healthcare facilities? How?	• Understand key priorities and success factors of past initiatives as basis for future programs
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4.3 Relationships with other healthcare providers (~20 min)

<u>Interview Questions / Guidelines</u>	<u>Objectives</u>
• Which types of facilities are most influential in providing TB care in your district (e.g. have the most TB patients, have the most extensive TB care capabilities, role models in providing high quality care for example, most accurate diagnostics)? - Do you think these roles should change? Which ones and	Understanding current interactions between associations and private facilities

how? • In the context of TB care, which institutions does the association engage with (E.g., Puskesmas, private providers such as clinics, hospitals, labs, pharmacies, other Professional Assoc., Community Health Org.)? - With whom? For what purpose? - What is the nature of the engagement? (coordinate on programming, enforcing government regulations, etc) How many times in a year? - Why did you engage these partners? What criteria do you use to select? How do you prioritize? - Who makes the decision on who to partner with? • If you do not engage with any of the above institutions, why not? Do you see any of the institutions as playing a potential role to complement or support the role of your association's mission? If so, how? • How often do professional associations interact with private facilities related to TB care? For what purposes (provide training, discussion forum for new government regulation, lobbying, etc.)? • What are the mechanisms you have used to implement initiatives? • Do you have influential members who act as champions or role models for quality TB care? Who are they? What motivates them to take on that role? • Have there been other conditions or priorities that you have worked on (e.g. diabetes, HIV) in which you have effectively engaged the private sector in improving the quality of care? If yes, what did you do to achieve this engagement? What incentives did you provide, if any? • If linkages between the association and facilities or between the facilities (through members) are not happening today, why not? • Do you see any of the institutions as playing a potential role to complement or support the role of in TB care? If so, which institution and how? • Other than private hospitals, labs, pharmacies, and physicians, are there any other local organizations or stakeholders (outside the public sector) that are contributing or could potentially contribute toward the TB care-seeking and treatment ecosystem in the district, and what are their capacities? How should professional associations interact with them?	• Identify gaps in current institutional relationships between associations with private providers in TB care as opportunities to improve linkages
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4.4 Relationship with the public sector and role in PPM (~20 min)

<u>Interview Questions / Guidelines</u> Interaction with public sector and PPM • Generally, how often does your association interact with each of the public sector entities (DHO, PKM, other relevant ones, etc.)? For	<u>Objectives</u> • To understand professional
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what purposes (licensing, trainings, reporting, other)? - Which parties do you interact with the most and why? - Has the public sector engaged the association to implement policies / socialize initiatives among members? If yes, which ones? - Have these interactions been positive / negative? Why? • How have you interacted with the public sector related to TB care? - When was the last time that somebody from DHO or PKM engaged the association relating to TB care (monitoring, new initiatives, etc)? • Are you aware of the district-based PPM TB programming/ /other partnership with public or other private sectors in TB? What is your understanding of this? {if no, clarify that it involves the public sector reaching out to the private providers for TB notification and quality of care, including use of public TB drugs} - Are you aware of the designated roles of associations / organizations, private facilities, and the government? If not all, which ones are you not aware of? - Are you part of the district's PPM network/ network with public or other private sectors in TB? Why did the association agree to be part of the network? - What % of your members are part of the PPM network/ /other network with public or other private sectors in TB? What are some of the reasons they joined or didn't join? Does this differ with different types of members (if applicable), or between members and non-members? - Has anybody approached / engaged the association to participate in TB initiatives led by the public sector? - o If yes, who approached you (Dinkes, community organizations, etc)? In which activities did you participate? Would you participate again? Why or why not? - o If you did not participate, why not? Any feedback? - How effective do you perceive the network to be? Has it addressed the needs of private sector or associations? Which needs specifically (funding, knowledge support, etc)? If not, what additional efforts would address the unmet needs better? - Explore relationships with NTP, Dinas Kesehatan, Puskesmas/other public primary care (if not covered yet) Would you be open to further PPM efforts/ other partnership with public or other private sectors in TB? • Would the association like to be involved (if not yet) or more involved (if previously already) in strategy formulation / implementation of efforts to improve TB care or improve linkages between different facilities that offer TB services? Why or why not? In what type of roles or opportunities? (e.g., be invited to planning	association's current level of engagement with public sector and to identify the progress and challenges of the district-based PPM roll-out
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meetings / establish and join a referral network) • Do you think the relationship between the private and public sector needs to be improved? Specifically between associations and the public sector? If yes, what do you think can be improved in the relationship between the private and public sector and between associations and the public sector? What specific initiatives / actions would be required to do so? • What is the best way for the government to continuously engage the private sector and associations? • Which other professional associations (other than your own) are currently strong in TB, or in private provider engagement (or both)? • Which other professional associations could be strong in these roles? Why?	
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4.5 Testing of ideas & hypotheses generated from private facilities interview (~20 min)

<u>Ideas and hypotheses generated from private facilities interview</u> <u>Initial list includes:</u>	<u>Objectives</u>
• Professional associations are integral channels to socialize and reinforce TB care improvement initiatives, including public sector PPM initiatives, and potentially play the following roles: - Doctors / physician / specialist (e.g. PDPI) organizations relay vital information on current best practices and enforce proper procedures for the provision of quality diagnosis and treatment of TB clients / patients in respective facilities - Pharmacist associations (e.g. IAI) increase awareness of proper TB treatment regimens and advocate the efficacy and use of FDC drugs over loose drugs alternatives - Laboratory associations (e.g. ILKI) provide learning about TB diagnostic tools and enforce procedures for diagnosis and referrals post-diagnosis • Professional associations should understand and represent the interests of private facilities and their owners, for example related to negotiating with the government on licensing requirements, other regulatory requirements, and BPJS rates, but currently lack the power and organization to be very effective in this function • Professional associations provide a potential forum for educational / training programs for care provider members, which may reduce the financial burden of individual private facilities to provide training to care providers, while increasing knowledge of and capability in TB care • Professional associations increase the likelihood of non-network facilities participation in BPJS-K given that interactions with BPJS-K facilities can help in overcoming pre-existing reservations. Higher participation in BPJS-network increases potential impact of future interventions in TB care through this channel • The newly-formed coalition uniting multiple professional	• Share and discuss the emerging set of ideas and / or lessons learned from private facilities interviews in order to compare whether this perspective coincides with professional associations' own views about their relationship with private providers and their role in the TB care ecosystem.

associations (i.e. KOPI TB) will be more effective in engaging and leverage professional associations than previously possible with individual associations alone. This is due to many factors, including:

- Coalition facilitates members of professional associations to identify and promote quality-assured referral pathways (e.g, hospitals not currently stocking HIV drugs are aware of and can easily coordinate with reputable pharmacies that stock HIV drugs needed to treat comorbid TB+HIV) which increases continuity of care and minimize patient drop-offs
- The coalition enables the provision of more comprehensive, consistent care to TB clients / patients because facilities have increased access to opportunities for partnerships to close gaps in care capabilities or untapped market niches