

Health Care Financing Methods and Access to Health Care in Myanmar

(San San Aye, Soe Tun, Kyaw Swar Min, Htwe Htwe Myint, Htay Htay Win, Kyawt Kay Khine, Department of Health Planning, Ministry of Health)

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Abstract

Access to affordable and effective health care is a major problem in low and middle income countries and out of pocket expenditure for health care a major cause of impoverishment. Placing health equity as the central goal of health system requires substantial and coordinated reorientation through re-framing of policy and institutional transformation.

The study assessed the health care financing methods with the view to explore feasibility of introducing appropriate prepayment scheme in Myanmar. It composed of three main components: (a) literature review on health care financing in developing countries and previous studies in Myanmar, (b) in-depth interview for perception on different methods of health care financing experienced and still experience in Myanmar and (c) compilation of secondary data on government health expenditures from the departments and household health expenditure survey.

In most nations, private sector financing plays a major role in funding health care but it is overlooked in policy discussions because the Ministry of Health and Ministry of Finance focus on government spending for health care. Worldwide, 1.3 billion people do not have access to effective and affordable health care.

Methods of health care financing experienced in Myanmar were varied from the time period. During the period of 1948 to 1962, Myanmar followed the National Health Services (NHS) which was provided mainly by the general government tax revenue. Government taxation was also the major source of finance for health sector during 1962 to 1974. The other source of finance for health sector at that time was the international assistance. The private sector started to grow that period and regulated doctors provided the health care services in inpatient delivery homes. A new constitution was adopted in 1974 and afterwards health care services were provided according to the National Development Plan. Another source of financing for that time was donation, not only the buildings of the station hospital but also some of the buildings for the central hospital. Community Cost Sharing Scheme was developed in 1992 with the objective of affordable people who need to pay some share for curative health care services but exemption for the poor. Trust fund was another source of finance for health care and the interest of the trust fund would be used for the poor. However, assessment has been required for actual situation: is the interest for the Trust Fund sufficient for all poor patients?

In regards with health expenditures, the per capita health expenditures for sample households was (49,743) kyat in 2007. There was increasing trend of government health expenditures since 1988-89 to 2006-07 (464.1 million kyat to 24178.6 million kyat) but the per capita government health expenditure is still low which was only (427.8) kyat in 2006-2007. The financial burden for health care in the study area revealed that 20 to 30 percent of total households in the sample area suffered catastrophic payment for health. It could not be considered small and mechanism for preventing catastrophic payment for health should be explored.

Hence it is imperative that need to find alternative health financing mechanisms: health insurance is one such alternative. Health insurance protects people against catastrophic financial burden resulting from unexpected illness or injury and an efficient system ensures the pooling of resources to cover risks. Although it is the ideal condition, there are so many issues challenging to initiate new system: political commitment, quality of health care services, providers' payment, administrative structure, fund management system, donor's backing, community awareness and community demands.

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1. Introduction

The states in most developing countries have been trying to fulfill health care needs of their poor population with available budgetary support for health care services. Adequate and sustainable financial support is a vital requirement for providing health services with the objective of raising the health status of the people. Universal coverage, which is one of the objectives of all health care systems, implies *equity of access* and *financial risk protection*. It is also based on the notion of equity in financing, i.e. that people contribute on the basis of ability to pay rather than according to whether they fall ill. It is also important that available financial resources are spent efficiently.

With growing population, advancing health care technologies and rising costs consequent to inflation, even sustaining the existing level of health service provision requires more financial resources. Expanding health services to attain universal coverage will inevitably require increasing health expenditure further.

The most common ways of financing health care are tax-funding, social health insurance, private health insurance, community-based health insurance and out-of-pocket spending (OOPS). Tax-based financing: the money to pay for health services comes from general government revenue (sale taxes, income taxes, import/export taxes, etc.) Everyone is automatically included and has access to these facilities. Social health insurance: members pay a contribution based on their income to a health insurance agency which purchases health services from either public or private facilities. The payment is proportional to income, so that within the pool of SHI members, the better-off subsidize lower income groups. Also, the healthy and young subsidize the sick and elderly. To avoid a high-risk pool, SHI is usually compulsory. Private health insurance: people buy health insurance for themselves from private, for-profit insurance companies. These companies pay providers for health services for their members and charge premiums from their members according to their health risk status. As a consequence, the poor can usually not afford private health insurance. Community-based health insurance (CBHI): local insurance schemes raise money from their members to pay for their health services. CBHIs show both characteristics of private health insurance and social health insurance, as they are usually voluntary, premiums are not risk-rated and schemes are often self managed. However, in poor communities CBHI rarely raise enough funds to provide adequately for health services. Out-of-pocket spending (OOPS): OOPS is not a health financing scheme in itself but rather the way money is spent on health in the absence of a system. Here, people buy health services straight from health providers and pay the full price for the services. OOPS is very problematic as it causes people to fall into poverty because of medical expenses. This is called catastrophic expenditures because health services can be extremely expensive and because illnesses are unplanned, people cannot save (enough) money individually for health services. Wherever OOPS occurs, it should be replaced by prepayment mechanism.

In Myanmar, the National Health Committee has laid down the National Health Policy in 1993. Among fifteen guidelines, one guideline stated "To explore and develop

alternative health care financing system" which is directly concerned with health care financing reforms in Myanmar. Following the policy guideline, a number of financing reform activities had been undertaken in the health sector since 1993. However, much of the payment made by the households in time of illness is out of pocket in nature with potential for catastrophic spending.

Myanmar Health Care System evolves with changing political and administrative structure and relative roles played by the key health providers are also changing although the Ministry of Health remains the major provider of comprehensive health care. It has a pluralistic mix of public and private system both in the financing and provision. The private, for profit, sector is mainly providing ambulatory care though some providing institutional care has developed in Yangon, Mandalay and some large cities in recent years. In exploring and implementing alternative means for financing health in conformity with the national health policy, user fees have been collected in government hospitals from those who can afford for medicine, rooms, laboratory, imaging and other investigation services on cost sharing basis. A health system where individuals have to pay out of their own pockets for a substantial part of the cost of health services at the moment of seeking treatment clearly restricts access to only those who can afford it. So that indigents are not denied access to health services, exemption mechanism is in place with establishment of trust funds in these hospitals.

Although social security scheme is in place since 1956 in Myanmar, covering only government employees and private employees, the coverage is still low only less than one percent (0.89 %) of the total population in 2006. It is a compulsory insurance and irrespective of the nature of work in which the eligible workers are engaged whether it be permanent or temporary, manual or other-wise, and irrespective of the amount and form of their remuneration.

The way a health system is financed and organized is a key determinant of population health and well-being. Yet in many of the poorest countries, available funds are still insufficient to ensure equitable access to basic and essential services. In addition, health financing in many setting relies heavily on out-of-pocket payments made directly by patients to providers. Lack of ability to pay prevents some people from seeking or continuing care, while some of those who do seek care incur catastrophic financial burdens, and some are pushed into poverty as a result.

Access to affordable and effective health care is a major problem in low and middle income countries and out of pocket expenditure for health care a major cause of impoverishment. One way to facilitate access and overcome catastrophic expenditure is through a prepayment mechanism, whereby risks are shared and financial inputs pooled by way of contributions.

There is a need to develop the health system looking for equitable utilization of health care services including curative services. Placing health equity as the central goal of health system requires substantial and coordinated reorientation through re-framing of policy and institutional transformation. This in turn requires active management of the policy development and implementation process and needs to be based on the wider political and policy commitment to social equity through which such action is enabled. A comprehensive study on health financing situation in the country answering policy relevant questions on introduction of health insurance system in the country is necessary.

2. Objectives

The general objective is to explore existing experiences on health care financing methods with the view to look for feasibility of introducing prepayment financing method in Myanmar. The specific objectives are:

- 2.1. To describe existing experiences on health care financing methods in developing countries and in Myanmar
- 2.2. To explore the existing health care expenditures and look for mechanisms for ensuring access to health care by poor (people especially who are financially vulnerable)

3. Methodology

The study composed of three main parts for assessing the health care financing methods with the view to look for the feasibility of introducing appropriate prepayment scheme in Myanmar using both qualitative and quantitative research methods.

The first part of the study was literature review for accessing the health care financing methods in developing countries and previous studies related to health care financing methods in Myanmar.

The second part of the study tried to find out the different methods of health care financing experienced and still experience in Myanmar, strength and weakness of each method and opinions for improving health care financing system by conducting in-depth interview. Total of six senior officials from the Ministry of Health who are experts in the field of health economics and health care financing were interviewed. Six In Depth Interview (IDI) sessions were conducted for reviewing expert opinions relating to information on previous experiences and current experiences on health care financing methods, condition of out-of-pocket payment, ways to introduce prepayment system and universal coverage of health care. The health care expenditures in terms of government health expenditures, health care expenditures by departments, by region, by function and by type of hospital and existence and utilization of trust funds were reviewed by available data and information from respective departments under Ministry of Health.

The third part of the study was household interview on health care expenditures, health care seeking pattern and financial burden for receiving health care services. The study was conducted in three States and Divisions and planned to cover (450) households using pre-tested structured questionnaire. A total of (476) households: (175) from urban and (301) from rural were included in household interview.

3.1. Developing data collection tools

A discussion guide on In Depth Interview (IDI) for experts in the field of health economics and health care financing was developed. A structured questionnaire was developed to assess the household health expenditures, financial burden for health care and health care seeking pattern.

3.2. Pre-testing data collection tools

The discussion guide was pre-tested in the Department of Health Planning (DHP). The structured questionnaire was pre-tested in Pyinmanar Township and modified as required.

3.3. Selection of Interviewers and Supervisors for Training

Interviews were done by the researcher and two research assistants, acting as facilitators and note-takers for In Depth Interviews (IDI). Research assistants were given 2 days training on use of the discussion guide, interview skills, note-taking, recording, transcribing and principles and procedure of qualitative data analysis.

The staffs from the department of health planning were recruited as interviewers for the structured interview survey. The central supervision team consists of officials from the Department of Health Planning. The Township Medical Officer acted as the field supervisors for their respective townships for arrangement of survey area.

3.4. Ethical consideration

Informed consent was obtained from the experts and interviewees.

3.5. Data management

3.5.1. For Qualitative Assessment

For IDI, researcher acting as interviewer and one research assistant tape recorded the conversations. Then, research assistant completed the transcripts and researcher translated and assessed the main points from the discussions.

3.5.2. For Quantitative Assessment

3.5.2.1. Government Health Expenditures

Research assistants collected the secondary data on government health expenditures by departments under the Ministry of Health. Researcher entered the data and described the data by using Microsoft Excel.

3.5.2.2. Household Health Expenditure Survey

Interviewers performed daily check on the questionnaires for missing, inconsistent data and take actions accordingly. Central supervisors rechecked, signed in the same evening and collected systematically and send the questionnaires to the data manager.

Data manager cleaned the data while entering data into the computer using Epi Data program and prepare data for easy analysis.

3.6. Data Analysis

3.6.1. For Qualitative Assessment

The qualitative data were synthesized into perception on different methods of health care financing, perception on Social Security Scheme, impact of out-of-pocket payment and how to improve it, how to introduce prepayment system for risk pooling and universal coverage for health care.

3.6.2. For Quantitative Assessment

The followings were explored.

- (a) Government Health Expenditures by department, by function, by region, by type of hospital in 2005-06
- (b) Existence and Utilization of Trust Fund for the year 2007
- (c) Household Health Expenditures by region for the year 2007
- (d) Sources of Finance for Health Care Services by region for the year 2007
- (e) Financial burden for health care services by region for the year 2007
- (f) Health care seeking pattern by region for the year 2007

4. Findings and Discussions

4.1. Health Care Financing in Developing Countries and Experiences in Myanmar

4.1.1. Health Care Financing in Developing Countries

Globally there exists an enormous mismatch between countries' health financing needs and their current health spending. Developing countries account for 84 percent of global population and 90 percent of the global disease burden, but only 12 percent of global health spending. The poorest countries bear an even higher share of the burden of disease and injury, yet they have the fewest resources for financing health services. The underlying population and epidemiological dynamics will have profound effects on the economies and future health needs of all countries.¹ As documented by the World Health Organization (WHO, 2000), low and middle-income countries merely account for 18 percent of world income and 11 percent of global health spending, yet bear 93 percent of the world's disease burden. Obviously, poor health drastically impedes the social and economic development of a country: beyond directly affecting people's well-being (reduced life expectancy, high infant mortality, spread of infectious diseases etc.) poor health also lowers the productivity of labor and menaces the entire economy. (WHO, 2001)

There are several methods of financing health care, each of which has its own strengths and weaknesses. The method that a nation chooses to employ depends greatly on its history, culture, and current institutions and on the trade-offs in objectives that the nation is willing to make. In most nations, private sector financing plays a major role in

¹ Pablo Gottret, George Scieber, Health Financing Revisited, A Practitioner's Guide, World Bank, 2006

funding health care. Private financing refers to funds paid directly to health care providers from private sources, including direct household expenditures such as out-of-pocket payments, expenditures through private insurance plans, employers' direct payments for health services, and charitable contributions. Often the importance of private financing is overlooked in policy discussions, however, because the Ministry of Health and the Ministry of Finance focus on government spending for health care.² Policy goals of efficiency, equity, and sustainability will often require public policy to set the rules for private funding of health services. In establishing and managing a health care system, the government or the market has very few effective instruments by which to influence the system's performance and outcome. Financing is the principal instrument with which to determine resource flows, distribution of resources, and incentive structures for health providers. Health care financing policy determines who will have access to basic health care, what services are offered, and their quality. Thus, it is a major determinant of whether a society provides equal access to basic health care for its people.

Health care financing continues to be a key challenge in many low- and middle-income countries. Despite various efforts to improve the health situation in the developing world, many emerging economies are still far from achieving "universal health coverage". Worldwide, 1.3 billion people do not have access to effective and affordable health care, including drugs, surgeries, and other medical interventions.³ To a large extent, health problems of low- and middle-income countries stem from financial and institutional deficiencies. According to estimates of the Commission on Macroeconomics and Health (WHO, 2001), around USD 34 per year are needed to cover all essential interventions of an individual. On average, this amount is only reached by about 15 percent of all low-income countries, merely looking at private expenditure on health this number even drops to a little over 6 percent. The situation is worrisome as regards public provision of health care. Universal health coverage would require public spending of around 12 percent of GNP in low-income countries to meet the international development goals. Such spending is far from being realized; i.e., only one low-income country (East Timor) has public spending exceeding 5 percent of GNP. In order to achieve greater health coverage, it thus seems indispensable to pool resources by bundling available funds and spreading the risk of illness and health care financing. Low- and middle-income countries rarely have the financial means and institutional capacity to offer state-based social insurance to their citizens. A large percentage of health spending consequently comes directly out of patient's pockets. According to WHO (2003) data, out of pocket payments (OPP) account for 1/3 of total health care spending in 2/3 of all low-income countries. Catastrophic health cost (i.e., payments exceeding 40 percent of a household's capacity to pay) occur in many countries and drastically increase the risk of impoverishment; especially considering the impact of indirect costs of health expenditure, i.e., loss of productive capital associated with illness. In view of these perils, a main focus of the current debate on health reform consequently emphasizes the need "to

² William Hsiao, K.T.Li, *Health Care Financing in Developing Nations*, Harvard University School of Public Health, 2000

³ Denis Drechsler and Johannes P. Jutting, *OECD Development Centre, Private Health Insurance in Low- and Middle-Income Countries, Scope, Limitations, and Policy Responses*, Draft Version, World Bank, 2005

move away from excessive reliance on out-of-pocket payment as a source of health financing”.

Given the limitation of a public health care system, private health insurance (PHI) offers a potential alternative to insure against the cost of illness. As indicated by the WHO (2000), private schemes can serve as “a preparatory process of consolidating small pools into larger ones” to eventually achieve universal coverage. Such development would indeed correspond to the experience of many industrialized countries, where universal social insurance emerged out of private risk sharing programs. There is nevertheless essential to note that low- and middle-income countries compose a very heterogeneous group. Particularly striking is the large disparity of expenditure for insurance premiums among individual countries, reaching from per capita values of USD 1064 in Barbados to USD 3 in Bangladesh.

Universal coverage of health care means that everyone in the population has access to appropriate promotive, preventive, curative and rehabilitative health care when they need it and at an affordable cost. Universal coverage thus implies *equity of access* and *financial risk protection*. It is also based on the notion of equity in financing, i.e. that people contribute on the basis of ability to pay rather than according to whether they fall ill. This implies that a major source of health funding needs to come from prepaid and pooled contributions rather than from fees or charges levied once a person falls ill and access services. Universal coverage requires choices to be made in each of the three components of a health financing system; *revenue collection*: financial contributions to the health system have to be collected equitably and efficiently; *pooling*: contributions are pooled so that the costs of health care shared by all and not borne by individuals at the time they fall ill (this requires a certain level of solidarity in the society); and *purchasing*: the contributions are used to buy or provide appropriate and effective health interventions.⁴

Prepayment schemes aim to improve the poor’s financial accessibility to care by making it possible for people to enroll at the time that they have cash available and, consequently, pay very little when they need to use health care services. Nevertheless, the poorest households may not be able to afford the annual enrollment fee.⁵

Community health insurance is an important intermediate step in the evolution of an equitable health financing mechanism. According to the World Health Organization, greater than 80 percent of total expenditure on health in India is private (figure for 1999-2001, WHO 2004) and most of this flows directly from households to the private-for-profit health care sector. Most studies of health care spending have found that out-of-pocket spending in India is actually progressive, or equity neutral; as a proportion of non-food expenditure, richer Indians spend marginally more than poorer Indians on health care. However, because the poor lack the resources to pay for health care, they are far more likely to avoid going for care, or to become indebted or impoverished trying to pay for it. In recent years, community health insurance (CHI) has emerged as a possible means of: (1) improving access to health care among the poor; and (2) protecting the poor from indebtedness and impoverishment resulting from medical

⁴ Technical Briefs for Policy-Makers, Achieving Universal Health Coverage: Developing the Health Financing System, Number 1, 2005

⁵ Prepayment for Health Services in Rwanda: Results and Recommendation for Policy Directions and Implementation, 1999

expenditures. There are total of 12 schemes where health insurance has been operationalised. The community health insurance programmes in India offer valuable lessons for the policy-makers and the practitioners of health care. While many state that the poor in India cannot understand the complexities of health insurance and will not accept any insurance product. It is clear that what is required is a good product.⁶

Community-based health insurance schemes allow many people's resources to be pooled to cover the costs of unpredictable health-related events. They protect individuals and households from the risk of catastrophic medical expenses in exchange for regular payments of premiums. Prepayment can facilitate access to expensive medical care, because it spreads costs overtime and prevents people having to pay at the time of treatment. By pooling resources, health insurance schemes can improve equity of an access to health care and can offer financial protection.⁷

Scarce economic resources, low or modest economic growth, constraints on the public sector and low organizational capacity explain why the design of adequate health financing systems in developing countries, especially low income ones, remains cumbersome and the subject of significant debate. Earlier on, cost-recovery for health care via user fees was established in many developing countries usually as a response to serve constraints on government finance. However, most studies alert decision-makers to the negative effects of user fees on the demand for care, especially that of poorest households. Alternative health financing systems exist, de-linking utilization from direct payment, and thereby protecting the population, especially the most vulnerable groups, from having to resort to various coping mechanisms. Financing is based either on general tax revenues and/or social health insurance contributions. Risk-pooling is a core characteristic of these systems, enabling health services to be provided according to people's need rather than to their individual capacity to pay for health services. There may be various forms of community financing: a scheme can involve the direct payment of health services or health service inputs such as drugs, the payment of user fees for services organized via the scheme, or community based health insurance. Community based health insurance is a common denominator for voluntary health insurance schemes that are labeled alternatively as mutual health insurance schemes, and medical aid societies or medical aid schemes. The common characteristics, however, are that they are run on a non-profit basis and they apply the basic principles of social health insurance.⁸

The difficulty that low- and middle-income countries have in providing for health care needs of their populations remains a major problem. Moreover, the so-called "health care financing gap" has been spotlighted by the MDGs, as have the escalating burden of ill-health related to the AIDS epidemic, particularly in Africa and Asia, and growing prevalence of non-communicable diseases in some low- and middle-income countries. In the 1980s and 1990s, cost-recovery or cost-sharing systems that called for contributions from users of public sector facilities, primarily through direct out-of-pocket payments or user fees, were much in the public eye. However, in recent years, the consensus has grown that prepayment health care financing, whereby people contribute regularly to the

⁶ Community Health Insurance in India: An Overview, 2004

⁷ Reduction of catastrophic health care expenditures by a community-based health insurance scheme in Gujarat, India: current experiences and challenges, WHO Bulletin 2002;80:613-621

⁸ Community based health insurance schemes in developing countries: facts, problems and perspectives, WHO 2003

cost of health care through tax payments and/or health insurance contributions, provides greater financial protection to households than – and is, therefore, preferable to – out-of-pocket health care financing.⁹

4.1.2. Previous studies on health care financing methods in Myanmar

In Myanmar, the National Health Committee has laid down the National Health Policy in 1993. Among fifteen guidelines, one guideline stated "To explore and develop alternative health care financing system" which is directly concerned with health care financing reforms in Myanmar.¹⁰ Again, one of the objectives of current National Health Plan¹¹ is to develop the health system in line with the changing political, economic and social system of the country. Following these policy guidelines, a number of financing reform activities have been undertaken in health sector since 1993. Generally six different types of financing reforms can be classified as: (1) introducing of paying wards or rooms in public hospitals; (2) introducing of user charges for Government Drug Supplies from Central Medicine Store Depot (CMSD); (3) introducing user fees for diagnostic services such as laboratory, X-ray, ECG; (4) Community Cost Sharing (CCS) for essential drugs; (5) introducing private service by in service staff at public hospitals; (6) establishment of Trust Funds.¹²

In line with new health policy the paying wards or rooms are opened at government hospitals and charges are set according to quality and quantity of facilities provided. A rule has been set for utilization of revenue collected at paying wards. According to the rule, collected revenues have to be used in four equal ways (i.e. 25 percent each)¹³: (1) retain as government revenue; (2) maintenance fund for the hospital; (3) fund for procurement of drugs at the hospital; and (4) fund for welfare of hospital staff. This is a unique characteristic of new system of alternative financing in health sector of Myanmar. Now most of the large hospitals including specialist hospitals, general hospitals and divisional and district hospitals have opened the paying or private rooms.

In regard with the drug supply, in the past all government health institutions were providing free medical care including free supply of drugs. Starting from 1994 Department of Health introduced a user charges system for selected items of drugs. Firstly 20 items of drugs and later additional 23 items are included to charge at factory price of Myanmar Pharmaceutical Factory. This is the cost recovery scheme for selected items of drugs supplied at public hospitals. Exemption can be made for those who can not afford, by the decision of respective medical superintendent or township medical officer. All revenue except a small margin added for overhead charges of drug stores, are credited to government accounts. The revenue collected from selling drugs supplied by Central Medicine Store Depot (CMSD) in 1999 was kyat 19.9 million.

⁹ Learning from Experience: Health care financing in low- and middle-income countries, Global Forum for Health Research, 2007

¹⁰ Health in Myanmar, Ministry of Health, 2007

¹¹ National Health Plan (2006-2011), Ministry of Health, 2006

¹² U Aung Kyaing, Health Sector Reforms: Emphasis on Health Financing Reforms in Myanmar, 2000

¹³ Amendment of the rule in 2007 denoted that only three groups: 50 % going to government revenue, and 25 % each is going to maintenance fund for hospital and fund for procurement of drugs at the hospital

Starting from 1993, the user fee system was imposed for some diagnostic services such as laboratory tests, radiography services and ECG etc. The income from this system follows the rules of allocation of 25 percent each into four as mentioned earlier. Income from various user fees for diagnostic services using machines at Yangon General Hospital (YGH) in 1997 was kyat 28 million and it equals to 90 percent of recurrent budget of YGH in that year.

Myanmar Essential Drugs Project (MEDP) was implemented in 1989 and all essential drugs are provided free of charge at four pilot townships till 1993. Later MEDP introduced cost sharing system for essential drugs. Price of essential drugs is set based on the market price. Following the concepts and principles of essential drug the basic health division of Department of Health introduced the drug financing for essential drugs using Community Cost Sharing (CCS) system in additional townships with the assistance of Nippon Foundation in 1994. Up to 1999, CCS for essential drugs was operating in 54 townships by MEDP and 72 townships by basic health division.

Community Cost Sharing (CCS) approach in Myanmar started in 1989 when the WHO introduced the Essential Drugs (ED) Programme. The government provided funds and technical assistance to assist the ED project in nine pilot townships for four years. Since then the developments of the project began and has been followed by various CCS projects, namely the Community Health Management and Financing (CHMF) project funded by the Nippon Foundation; the Myanmar Essential Drug Project (MEDP) funded by WHO; the Human Development Initiative-Extension (HDI-E) project funded by UNDP; the Central Medicine Store Depot (CMSD) funded by the government.¹⁴

Regarding to HDI-E project, improving rural community access to Primary Health Care aims to enhance accessibility of health care services and healthy lifestyle for the most vulnerable and disadvantaged in selected eleven townships. The project interventions are designed to address the issues of accessibility, availability and affordability of health care and healthy lifestyle for the poor and disadvantaged rural population through appropriate technologies including prevention and self care, improvement of health care facilities and services, and community participation and empowerment.¹⁵

Trust funds for drugs are established in some hospitals by the donation of well wishers. Trust funds are kept normally as saving accounts at banks and the annual interests earned from that account can be utilized according to the rules set by trust fund management committee or hospital management committee. Normally certain amount from earned interests is put into main trust fund account in order to increase the fund. One of the main objectives of trust funds is to finance the cost for waiving poor patients who can not pay for the costs of care at public hospitals. A trust fund with large amount by collective donations was established in Yangon General Hospital initiated by Chairman of National Health Committee in 1997. In 1999, a total of 139 hospitals in all states and division have trust funds with total value of kyat 135.7 million.

There is no comprehensive health insurance system in Myanmar. A social security system was established since 1956 under Ministry of Labour according to Social Security Act 1954. This system covers social services including health care for insured workers.

¹⁴ Siripen Supakankunti, Comparative Analysis of Various Community Cost Sharing implemented in Myanmar, 1998

¹⁵ Manisri Puntularp, Economic Concepts and Advocacy for Community Cost Sharing in Myanmar, 1998

Benefits provided by the scheme are free medical care during illness, payment of seventy five percent salary during maternity leave, full salary for one year for severely injured worker, cash payments for death and injury and survivors' pension. Three sources of financing to the scheme are contributions from employees, employers and government.

Based on Myanmar National Accounts (1998-2001) total expenditures on health at current prices were estimated to be increasing from twenty nine thousand million kyat in 1998 to seventy three thousand million kyat in 2001. They are found to be increasing along with growth in Gross Domestic Product (GDP) and total health expenditures as a percentage of Gross Domestic Product was also increasing from (1.8) percent in 1998 to (2.1) percent in 2001. Out of three financing sources namely public, private and external, private sector was the major source of health finance for almost (90) percent of total health expenditures for each year although there are some increases in the public finance during the period. Private financing is almost exclusively from household out of pocket spending.¹⁶

4.2. Different methods of health care financing experienced in the past and still experience in Myanmar

This part of the study tried to find out the different methods of health care financing experienced in the past and still experience in Myanmar, strength and weakness of each method and opinions for improving Health Care Financing System by conducting in-depth interview.

4.2.1. Knowledge, Perception/ Views/ Opinions on Health Care Financing Methods in Myanmar

All respondents explained about the health care financing methods that had been used in the past and methods still in use. All of them described the changes after independence 1948 to 1962, 1962 to 1974, 1974 to 1988 and 1988 onwards.

1948 - 1962

According to the history, Myanmar followed the British National Health Services (NHS) since 1948 to 1962. All types of health care services were provided mainly by general government tax revenue.

“Followed the British National Health Service was not only in Myanmar but also in other countries: Bangladesh, Nepal, India, Pakistan and Srilanka provided health care services by using general government tax, the difference only the name: some called health and family welfare, MCH services, Rural and Urban Health Services and so on. All the institutional care including inpatient and OPD services and all the outreach services were free of charge.”

(Expert from DHP)

There were free health care services including curative services after independence and all the expenditures were born by government through general taxation.

¹⁶ National Health Accounts, Myanmar (1998-2001), Ministry of Health, 2006

“Regarding health care financing, there were two portions at the time of after independence. The first one was the government fund which was covered for the whole country and the other was the local fund which was managed by respective township authority.”

(Expert from DHP)

“There was only (20) million population in 1948, and government provided health care services freely through general taxation but with the population growth the government couldn’t afford all the health care services especially curative services in later period. Therefore try to find out the alternative health care financing methods.....”

(Expert from DOH)

Social Security Scheme was started to implement in 1956 according to 1954 Social Security Act. It composed of social health insurance services and which was implemented by the Ministry of Labor. It is the only prepaid system in providing health care services.

1962 – 1974

Government taxation was the major source of finance for health sector as well as all the government sectors in this period. The other source of finance for health sector at that time was the international assistance: WHO, UNICEF as like in present time. They supported especially disease control activities: TB campaign, Malaria campaign. WHO mainly supported the technical assistance, fellowships, consultants and training component. UNICEF mainly supported the supplies and equipment.

Private sector started to grow in that period and the health care services were provided in inpatient delivery home like AYE Clinic, MYA Clinic and many delivery homes. They provided surgery, delivery and other curative health care services. These services were provided by retired practitioners and public sector practitioners in their private time.

“There was one special allowance provided to Township Health Officers and doctors who worked in the public health activities: getting extra (100) kyats than other doctors in public sector.”

(Expert from DHP)

There were only two central hospitals: Rangoon General Hospital (YGH) and Mandalay General Hospital (MGH) in 1962. There were only district health system in the periphery and no State and Divisional level. The organizational structure of health department had three levels consisting of Head Quarter Office of the Director of Health Services (DHS) in Rangoon, Civil Surgeon Offices at District towns and Township Medical Offices at Township Hospitals.

In 1965 under the Revolutionary Council Government, the new divisional level health departments were established in six administrative divisions according to six military commands of that time. They were Yangon Division (Yangon), Central Division (consists of Bago and Rakhine), South Western Division (Ayeyarwady), South Eastern Division (consists of Mon, Tanitharyi and Kayin), North Western Division (consists of Mandalay, Magway, Sagaing, Chin and Kachin) and Eastern Division (Shan North, South and East). Civil Surgeons became Township Medical Officer Grade 1 and district level was abolished. Therefore, the administration level was changing to central, divisional

and township. There was a relationship between administration and financing. In 1972 in line with new administrative system of the Government, the Department of Health was reorganized and all fourteen states and divisions opened divisional health offices.

Myanmar started to practice Socialist System in 1962. During the period of 1962 to 1974, all the sectors including health sector were owned by government. There was very limited private sector in that period and all the private sector especially mission hospitals were not practiced as a private and changing the ownership from the private to government.

“All the mission hospitals were run by their own donation as a non-profit before changing in to public. It was one of the financing methods in health care system.”

(Expert from DHP)

“Essential Drugs were available freely up to the RHC level till 1974. There was not necessary to pay any cost in hospitalizations. If additional drugs were required these were also available in government BPI drug store.”

(Expert from DOH)

1974 – 1988

A new constitution was adopted in 1974 and afterwards health care services were provided according to the National Development Plan. There was much relation between financing and planning. In accordance with People’s Health Plan (1978-1990) there was an annual increase of (10) Station Hospitals and (25) Rural Health Centers. Some of the buildings for Station Hospitals were built up voluntarily by the community. Apart from this aspect the financing pattern was not much changed.

“Not only the Station Hospitals were donated by the community but also some of the building was donated to Central Hospital for example ‘Daw Pu Ward’ in Rangoon General Hospital (RGH). There was a private ward in the government hospitals and patients need to pay room charges, consultant fees, nurse fees and others.”

(Expert from DOH)

In regards with the source of financing there was not only government source but also private and external sources. Most of the public health activities were funded by UN agencies. Government source of financing was coming from taxation and it was again depends upon size of population.

“We have very limited knowledge on how to collect government tax exactly. It was sufficient in the earlier part but not enough in the later part. It could be said because at first all the hospitals and RHCs received enough supplies from CMSD but in the later period it was not sufficient for the whole population in the township.”

(Expert from DOH)

The international assistance was another source of financing if the government revenue to health was not adequate but it had limitation according to their preferences.

“Most of the international assistance was going to preventive aspect rather than curative aspect.”

(Expert from DHP)

1988 to up till now

Since the time of gaining independence, Government has practiced a tradition for providing free medical care. According to Myanmar's socio-cultural system, donations in cash as well as in kind are generously made for construction of new hospitals, and supply of medicines. Growing population together with border area development and extensive coverage of health care delivery to the population demands more and more expenditures to use in public health. In such a situation and with the emergence of market-oriented economic system in Myanmar, health care cost is highly considered not only the sole responsibility of the government but also the coordinated effort or shared responsibility of the community and also the willing contribution of the non-governmental organization. The Ministry of Health in the implementation of the national health plan in accordance with the health policy guidelines, encourages to explore alternative mechanisms for health care financing. Some example are introducing of paying wards, cost sharing schemes in laboratory and x-ray services and other medical checkups, drug store for community cost sharing. The cost recovery schemes with the provision of essential drugs are also implemented. Such exploration on alternative ways of health financing is being experimented to be in conformity with the changing socio-economic conditions of Myanmar.

“According to changing economic pattern, expenditures for the health sector was not enough only with the government taxation and tried to find out the alternative health care financing methods.”

(Expert from DHP)

Community Cost Sharing Scheme (CCS) was developed in 1992 according to recommendation made by 11th meeting of National Health Committee and people who can afford has to pay the cost for curative health care services. Although the CCS scheme was developed and practiced in the country, people who couldn't afford to pay curative health care services have a chance to get free health care services. According to CCS scheme the cost for laboratory, radio imaging, private room, drug, medical equipment, physician and nurse fees were paid by the patient who can afford. It was only up to 2001, afterwards physician and nurse fees are not necessary to pay according to the decision made by 31st meeting of National Health Committee held in 2001.

The revenue for CCS scheme was divided in four portions (25 percent each): (i) going to government revenue, (ii) maintenance, (iii) drug and medical equipment replenishment, (iv) staff welfare. Starting from 2007 this revenue is divided into only three portions (i) 50 percent going to government revenue, (ii) 25 percent is for drug and medical equipment replenishment, (iii) 25 percent is for maintenance. The percentage going to government revenue is used for human resources and capital assets for high technology medical equipment.

“The concept of Community Cost Sharing Scheme is very perfect: people who can afford have to pay for the health care services but who cannot afford couldn't need to pay anything but in practice there is some difficulty.”

(Expert from DOH)

“In Cambodia, there is a list of poor in every village and they have a chance to get exemption for health care services not depending on their income but in India, health care cost is depended on the income. In India, someone who was hospitalized they have

to fill up the form including their income. There is a bank account section in the hospital and the hospital staff doesn't need to collect the finance directly."

(Expert from DHP)

"There was absence of clear policy, guidelines and procedures for operating CCS scheme at all levels. And also absence of formal authorization of full cost sharing at all levels. There was lack of well-designed exemption mechanism that includes guidelines and procedures."

(Expert from DOH)

"Although the CCS scheme is practiced in the hospitals, in case of emergencies (e.g. cases of road traffic accidents and outbreak cases) whether the patients are affordable or not, the hospitals provide free of charge for all services. It is one of the strengths of our country."

(Expert from DOH)

There is another alternative health care financing method: Revolving Drug Fund (RDF) which was started in 1990 and run by Myanmar Essential Drug Program (MEDP). Nine townships in Bago Division were started as pilot townships. The funding was coming from WHO, UNICEF and Sasakawa Foundation and those funding was running as a seed fund. According to success of the pilot townships the program was expanded to 100 townships in 1995. The policy guideline for RDF was getting from 18th Meeting of the National Health Committee and afterwards RDF covers the whole townships.

"RDF is not profit oriented and costing is depended upon First In First Out (FIFO) and Last In Last Out (LIFO). There would be needed to do re-cost based on drug price according to consignment."

(Expert from DOH)

"Revolving Drug Fund is affected by exchange rate, for example at the time of starting MEDP, the exchange rate was 100 kyat but the value of seed money become drop with changing the price of exchange rate."

(Expert from DOH)

"There is a rule and regulation for this system including voucher system, daily account, monthly account but there is some difficulties in the township level because there is no additional staff for accounting system."

(Expert from DOH)

"Although there is no additional finance staff in township level, the system is very successful in some township due to the interest of TMOs. In those successful townships, there would be sufficient amount and qualified essential drugs up to the Rural Health Center level."

(Expert from DOH)

There is lack of unified mechanism within the DOH to formalize and coordinate the various cost sharing projects. And poor financial management capability of the health services at the township, district levels and even in the states and divisional level. There was poor quality and high cost of locally available drugs.

"These are the issues at the township level: insufficient supply of drugs from CMSD and Nippon Foundation, most commonly used drugs are not available (e.g. Antibiotics), drugs are supplied nearly expired, the costs of supplied drugs are very high."

(Expert from DOH)

“Drugs for malaria and TB, Iron tablet and anti-helminthic drug, these four items of drugs are not included in RDF. Those drugs have to pay free of charge according to National Health Policy.”

(Expert from DHP)

Another source of financing for health is hospital fund collected by donation from each wards and managed by Hospital Management Committee.

Development of Trust Fund is another option of health care financing method in Myanmar Health Care System. The policy for Trust Fund is ONE BED ONE LAKH (100,000 Kyat). Only the interest for that fund has been used for the patient who couldn't afford the cost for hospitalization.

“Trust Fund is more or less dead money and there should be increased turn over. The interest becomes increase if the fund is not dead. Most of the TMOs are not familiar to operate financial account and even though they have to use the interest of Trust Fund to poor but they haven't used it.”

(Expert from DOH)

“Fund management is very important in Trust Fund. Systematic utilization is necessary. Fund raising is still weak. Assessment has been required for actual situation. Is the interest for Trust Fund sufficient for all unaffordable patients? How to define unaffordable patient?”

(Expert from DHP)

It is very important to develop skilled manpower for accounting to thoroughly implement the system. The additional training on accounting system is required to provide TMOs and DMOs who are actual implementers of health care financing scheme.

There is a thousand million kyat allocated annually from government taxation. Although the allocated money is too much, the amount of drug is not sufficient because of buying the drug with foreign exchange (FE).

“The drug price was significantly high in 1995. If we have to buy drug with foreign currency, the amount of drug can be available more.”

(Expert from DOH)

The amount of drug provided from CMSD becomes lesser than before. CMSD provided only essential drug. Some of the decentralized townships have to buy the drug from the companies with RDF and donation. Replenishment of essential drug is based on demand (morbidity based).

“In the past, the drugs and equipment supplies from government even to the RHC was 8 to 10 cartons while it was only 2 cartons right now. Drugs and equipment supplies to hospitals were enough in previous time and the operation theater was well equipped at that time compare to private specialist clinic. At that time, some of the operations could be done in the government hospital out of office hour as for a private case.”

(Expert from DOH)

Apart from alternative health care financing mechanisms, Ministry of Health has continued to receive allocation from government budget as well as external aids such as WHO, UNICEF and etc. Social Security Board under the Ministry of Labor is sole system like health insurance system in the country but the coverage is low. The other source of financing for health system is the community contribution. In Myanmar custom, most of the people are used to contribute donation in cash and kinds and labor

(volunteer work). The exact amount for community contribution has not been calculated yet in terms of monetary value because there is still a weak system for recording all community donations. For example, community has actively participated in the NIDs through their labor as well as contribution in cold chain system. Some of the hospitals were built with 50 percent from government revenue and another 50 percent from community contribution. There should be separate definition for the private contribution and community contribution. Some donate privately and some donate as a group. Community contribution has two aspects; some are going to hospital care and other are going to public health activities. The source of funding for community contribution is coming from private households but it can reduce the Out of Pocket (OOP) expenditure at the time of seeking treatment and it can also meet the equity issue by subsidizing poor by rich.

Health card was tested as alternative health care financing method in Myanmar. It was something like community cost sharing system but it was prepaid system for getting drug supply depends on the episode of illness. But there is no sustainability and the mechanism was abolished after the project period.

“There were so many reasons for abolishing the mechanism and one of the reasons was Myanmar Traditional Custom. Many people think about that if they buy these health cards, one or more of their family members will become ill.”

(Expert from DOH)

In regards with the government budget, government expenditure on health is increasing from 1886.3 kyat in million in 1991-92 to 23441.4 kyat in million in 2005-06. At the same time Total Health Expenditure as a percentage of Gross Domestic Product is also increasing trend, 1.8 % in 1999 to 2.8 % in 2003 but it is not too much and needed to be increased more. According to report on Commission on Macroeconomic on Health, this percentage should be increased additional 1 % in every year up to 2015. Not only increased amount of government health expenditure is important for health development but also efficient utilization is also essential. Allocation of scarce resources is so important for efficiency. According to Myanmar National Health Accounts (1998-2001) report, service of curative and rehabilitative care as a percent of government health expenditure was 29.57 % while as of prevention and public health services was 9.45 % in 2001. In the aspect of sources of financing for health, total public source was 9.3 percent in 1998 and 11.2 percent in 2001 while the total private source was 89.5 percent and 87.7 percent in the respective years. Almost all of the total private source was coming from the Out of Pocket payment. The Out of Pocket payment is still increased and there might be financial catastrophic especially for the poor.

“Although the government encouraged to build up the Trust Fund for the poor, there need to be thorough analysis for how much extent of the fund prevent the catastrophic payment for the poor. There should be development of the new system to prevent the catastrophic spending especially for poor and the system should also need to be sustainable.”

(Expert from DHP)

4.2.2. Perception on Social Security Scheme in the country and how to improve it

Social Security Scheme is the sole scheme functioning as a social health insurance in Myanmar Health Care System.

The Social Security Board is one of the directorates, boards and committees under the Ministry of Labor. The Social Security Act was enacted in 1954 and came into force in Yangon area on 1st January 1956. The Social Security Scheme was a pilot scheme and gradually extended to other areas of the country. The objectives of the scheme are to improve the health of the insured workers, to enhance their working ability and to boost productivity, to provide effective benefits in times of social contingencies such as sickness, maternity, employment injury, unemployment, old age and death etc, to support the insured workers and their family members for living when the former are unable to work, to make the Social Security Scheme concern the entire people. The Social Security Scheme has been implemented based on social insurance system comprising employers, employees and the State. The Social Security Board collects contributions from establishments covered by the Act and provides free medical care and cash benefits to insured workers in time of social contingencies such as sickness, maternity, death and employment injury. In the areas to which the Social Security Act applies, public industrial and transport establishments, ports, mines, oil fields, cooperative enterprises, private enterprises employing five or more workers and any other establishments as may be notified by the State are covered by the Act. Nowadays, the Social Security Act comes into force in 108 townships in 13 States and Divisions and the number of insured workers covered by the scheme in March 2006 was 494,385 in public, cooperative and private sectors.¹⁷

“Social Security Scheme in the country is not only health but also including other benefit packages. The payment mechanism is well established. Let say, if the total premium is 100, all the benefit packages are using only 70 and they can save 30. Therefore the scheme is still sustained. In regards with eligibility, there should be including family member and so the coverage will become more. The scheme should be modified. The contribution of premium rate may be needed more because of including dependents will be made more service requirements.”

(Expert from DHP)

“The Scheme should be expended including all civil servants. Benefit packages should be modified. Some of the cash benefits are not in line with current value. The scheme should be modified in terms of human resources, technology and infrastructure.”

(Expert from DOH)

The coverage of the scheme is too low only (0.89) percent of the total population in 2006. The provider payment is only salary and there is no additional incentive for the provider and the quality of services become weak. Every payment mechanism has strengths and weaknesses. But on the other hand, the scheme is good in cost containment.

Eligibility population of SSB is fluctuation because of private enterprises and some of the enterprises are opened and closed off and on. The benefit package for the scheme is good, in case of hospitalization patient get free health care services as well as

¹⁷ Presentation on Implementation of the Social Security Scheme in Myanmar, Report of the Workshop on Exploring Mechanisms for Financing Health in Myanmar, Department of Health Planning, 2006

reimbursement of drug cost and other cost including patient attendant cost and transportation cost.

4.2.3. Impact of Out of Pocket Payment and how to prevent it

The impact of Out of Pocket Payment is worse than before. This is because of changing system and the adaptation of the people become change in both sites: provider and consumer perspectives. There was free of charge at the time of seeking treatment in the earlier time. Health care services were fully financed by government health expenditure through government taxation but it was no longer existing as in other developing countries and tried to find out for the alternative sources of financing for health care services. On the other hand, the investment to become a medical profession is too expensive and there is too much competition in this field from the provider perspective. Therefore their attitudes become change and they want to get back money to overcome their investment to become a specialized profession and at the same time providing services with compassion (Saytanar in Myanmar words) in the private sector. Although it is still happened in the private sector, the provider payment in the public sector is solely salary, no additional extra fees but they still providing the services with compassion. Those are the factors from provider point of view. The other perspective is the consumer (patient) point of view. In Myanmar custom, if one of the family member suffers one kind of diseases, they want to cure him or her whether they can afford or not. If they cannot afford the cost of treatment they try to find out the cost by selling their assets, borrowing money from their relatives or their friends. Another factor is advanced technology. There was only X-ray in the previous time but now existence of MRI, CT scan and so on. Most of the rural people they didn't have a complete information. They collect the money by many ways and go to the city for curing their patient. Their money is almost finished after giving the cost of MRI. They think that it will cure the disease but in reality it is only one kind of investigation not for curing the diseases. Therefore, counseling should be done in each and every step of managing the case.

“One example of case, patient with Liver Cancer who was the son of health staff and taking treatment at the Specialist Clinic spent more than 500,000 kyat within 4-5 days of hospitalization. It was almost catastrophic and whether the patient will be cure is uncertain. Health care market is different from other markets and there would be more chance to get market failure mostly due to incomplete information. For that reason, gate keepers are necessary to perform counseling.”

(Expert from DOH)

“The costs for curative services are so expensive, for example the cost for Hepatitis B positive to negative was 600,000 kyat. Most of the people in Myanmar want to spend for the costs whether they can afford or not. But in the real situation most of them are in the condition beyond their affordability. Let say, they saved 500,000 kyat but the cost for the treatment will be needed to spend 1,000,000 kyat, they want to spend even they couldn't afford if the disease will be cured. Although they want to spend, there is uncertainty for curing the disease. Another issue is the costs for investigation which is very expensive in this era. This will be solved by alternatives like voluntary organization and well wishers as one of the alternative options.”

(Expert from DHP)

The cost of treatment is higher than previous time. The price of drug especially Antibiotic is also higher than before. The other factor is Myanmar custom, if one of the family members suffered one kind of disease, they want to get seeking treatment to him or her whether they can afford or not. Some people they need to sell their house and taking treatment to their family member.

“In the average the cost of hospitalization for once is 50,000 kyat and in case of LSCS it costs more than 100,000 kyat. In some area, the delivery cost even with Midwife may be around 10,000 kyat.”

(Expert from DOH)

Although it is happened in the real situation, some of the patients who is totally unaffordable they have to get free of charge for taking treatment.

“There are more than 200 patients waiting for one famous specialist in one of the Specialist Clinics in one evening. The consultation fee for each patient is 4,000 kyat. Most of the patients they are willing to pay their finance as well as their waiting time. The price for drug in there is also twice higher than market price. There may be questionable, how many patients have to pay catastrophic for their seeking treatment?”

(Expert from DOH)

The extent of catastrophic payment may be more or less existed. Some have to spend their saving and some have to sell their assets depend on their situation.

“Someone who needs to sell their asset which is essential things for their regular income (productive assets) like their lands, machines and etc suffered more than someone who needs to sell their saving assets.”

(Expert from DHP)

It can be said that there is existence of catastrophic payment at the time of seeking treatment and need to develop appropriate method for prepayment system. This catastrophic payment may be depended on type of illness either acute or chronic and severity of diseases. Patients who needed to pay catastrophic payment may not be a small group it means the large group of patients needed to pay catastrophic payment at the time of seeking treatment. It can be also expressed that the Out of Pocket Payment at the time of seeking treatment is increasing. In theory, it can be prevented by development of prepayment scheme.

4.2.4. How to introduce Prepayment System for risk pooling

In regards with health care financing methods in recent health care system, it would be necessary to find one of the appropriate health care financing methods to prevent catastrophic payment. In theory, development of prepayment system is most appropriate for solving catastrophic payment at time of seeking treatment. It also needs to pool the fund and so it might be fair among the members because sharing the risks but the main constraint is how to introduce the scheme.

“This is the right time to introduce the one of the prepayment schemes to prevent catastrophic payment at the time of seeking treatment. Community Based Health Insurance Scheme is most appropriate and starting with pilot township and then expand phase by phase.”

(Expert from DOH)

The most important issue is political commitment. The other constraints are community awareness, quality of services, administrative structure, financial investment, accounting system and management system. Seed money as financial investment will be needed to introduce new scheme for reducing the burden of all the members of society who are willing to participate in the new scheme. Each and every member has to pay regular amount to pool the fund for sustainability. Co-payment system should be used to reduce moral hazard. The scheme should be developed by level wise: Township Hospital, Station Hospital, RHCs and Sub-center level and also consider for referral system up to secondary health care, not including tertiary health care.

It is necessary to develop appropriate prepayment system if the portion of Out of Pocket Payment is high in the health care financing system. There are many options for prepayment system: social health insurance, community based health insurance, private health insurance. The social health insurance is a compulsory, not a voluntary and there is needed to contribute by the government. There should be increased formal sector workers also and so increased amount of premium and sharing among many people. In Myanmar situation, the formal sector is only growing in the urban area which is only 30 percent of population residing. In rural area, most of the people are working in the informal sector and collection of premium (contribution) will become a problem.

“According to the current situation in Myanmar, it should be started with pilot but one problem is voluntary and if the people don’t want to enter the scheme how can conduct the scheme for covering the health care for insured personnel. The pooling should be increased and so it can share the risk among many people. There is some kind of backing system for running the health insurance scheme especially for community health insurance. Donors are necessary to back-up for running the scheme.”

(Expert from DHP)

The development of the scheme is more or less difficult because of necessary to set up the systematic organization for fund management. In Myanmar, Community Based Health Insurance Scheme is most appropriate for pilot testing and will expand phase by phase but the following factors are necessary to consider: political commitment, community awareness, community demand, quality services, provider incentives, organizational set up, capacity building for managing the fund and donor backing.

Another option is revitalization of Myanmar Insurance Scheme. The current situation of Myanmar Insurance is almost defunct for health sector.

“All the government staff should be involved in voluntary insurance scheme and start with the pilot ministry: Ministry of Health. It is necessary to calculate unit cost for each disease (Diagnostic Related Group –DRG). After that how many percentage of salary either 5 % or 10 % collect as a premium will be decided. The expansion of other ministries would be in the next phase. If this option will be tried to develop, it may need strong political commitment.”

(Expert from DOH)

4.2.5. Universal Coverage for Health Care

Every one should have a chance to access health care services even though whatever they are. The accessibility includes not only physical but also financial. The extent of health care services would be primary and secondary health care services.

In May 2005, the 192 members of WHO endorsed a resolution entitled “Sustainable health financing, universal coverage and social insurance” (WHA58.33). It urged countries to develop their financing systems to ensure that their populations have access to needed services without the risk of financial catastrophe, and urged the secretariat to support countries to do this.¹⁸

“Universal coverage for Primary Health Care means essential services for health. There are eight elements now nine elements among which MCH services and provision of Essential Drugs are very important. Health Education and Sanitation activities are provided for a certain extent but considering for Essential Drugs is expressing as an example. According to the norms, the basic needs for essential drug alone is one US \$ per capita. Right now in Myanmar is 20 cents and calculating with the current population it would be around US\$ 10 million. Therefore there should be at least US\$ 10 million cost of essential drugs distributed within the country either produced from BPI or imported. Another issue is distribution issue. The real situation in the government hospitals and clinics are insufficient availability of essential drugs for basic needs.”

(Expert from DHP)

Universal coverage can be done only in the situation where the fund is available. Actually, Primary Health Care (PHC) should be available free of charge but some of the elements are not available free of charge in the real situation. Disease control activities, immunization, health education, water and sanitation available free of charge but not including essential drugs component.

“Primary Health Care should be provided free of charge for universal coverage which is adopted by all the members countries of WHO but there is separated to two portion in real practice. One is selected PHC and other is comprehensive PHC. Finally, it can be said that the universal coverage of PHC has not been achievable yet.”

(Expert from DHP)

Secondary Health Care is situated only in the urban area and very limited in rural area. This is the physical accessibility but in the aspect of financial accessibility there can be said that the people who can afford to pay are accessible to secondary health care services. Universal coverage for secondary health care is still far away. Development of the prepayment scheme is one of the solutions for universal coverage of secondary health care but everyone should have an ability to pay for the new scheme as an advanced payment. The scheme should be mobilized to enter not only poor people but also rich people and so there could be sharing the risks among rich and poor. Myanmar has experienced to develop and run trust fund for providing Secondary Health Care in the hospitals. Based on this idea, the new scheme should be introduced by their willingness, not by compulsory. Donation is one of the traditions of Myanmar custom and only thing

¹⁸ Mapping of available tools and guidelines to strengthen health financing systems, Department of Health Systems Financing (HSF), WHO, 2007

is necessary to explain about the scheme broadly for community awareness. It should be introduced as demand driven.

“Community itself know their needs and want to develop community financing for subsidizing among healthy and unhealthy, rich and poor, elderly and young. This is one kind of donation. It is very important and community must aware about these ideas.”

(Expert from DOH)

In the rural area CMSD provide 30 items of essential drugs but it is not free of charge, it is also included in Community Cost Sharing Scheme and it is not enough for all the community. This is in the primary level. In the secondary level, all the cost for health care providers are free of charge but cost of investigation, drugs and equipments are necessary to pay. The interest of the trust fund in the hospital should be used for the patients who could not afford to pay but it is not sufficient for all the poor people in real situation.

Government contribution through general taxation is one of the options for achieving universal coverage. Ear marked tax should be provided to health sector also. Development of prepayment scheme will be more or less difficult to introduce because of the community awareness and their traditional belief: something bad things will be happened if they contribute to the prepayment scheme for health care.

4.2.6. General Comments

In conclusion, prevention and promotion measures are very important for overall development of health. At the same time care (curative measures) also supports preventive and promotive measures. This can be seen especially in communicable diseases. The curative care for communicable diseases could prevent the community for morbidity of diseases and this can also lead to increase life expectancy and reduction of mortality. In the aspect of health care financing, it can be said that there is under finance for health care services. This is indicated by Total Health Expenditure (THE) as a percentage of Gross Domestic Products (GDP). The way how to increase THE from all the sectors should be considered. The government contribution should be increased but government expenditure alone will not be possible. International assistance and community contribution should be considered. And at the same time, Social Security Scheme should be encouraged for increase coverage.

“Many people ask about development of health insurance system (when will be started, how to introduce, and so on) in Myanmar Health Care System. It couldn't be developed by our-selves alone. Community itself needs to demand.”

(Expert from DHP)

Some of the countries noticed about for development of health insurance scheme and government itself realize for development of the scheme. This is one aspect and another aspect is community, community itself wants to develop for the scheme.

4.3. Exploring Myanmar Health System and existing health care expenditures, existence and utilization of Trust Fund in Myanmar

Ministry of Health is the main organization of health care provision. Department of Health one of 7 departments under the Ministry of Health plays a major role in providing comprehensive health care throughout the country including remote and hard to reach border areas. Some ministries are also providing health care, mainly curative, for their employees and their families. They include Ministries of Defense, Railways, Mines, Industry I, Industry II, Energy, Home and Transport. Ministry of Labour has set up two general hospitals, one in Yangon and the other in Mandalay, and one TB hospital in Hlaingtharyar (Yangon) to render services to those entitled under the social security scheme. Ministry of Industry (1) is running a Myanmar Pharmaceutical Factory and producing medicines and therapeutic agents to meet the domestic needs.

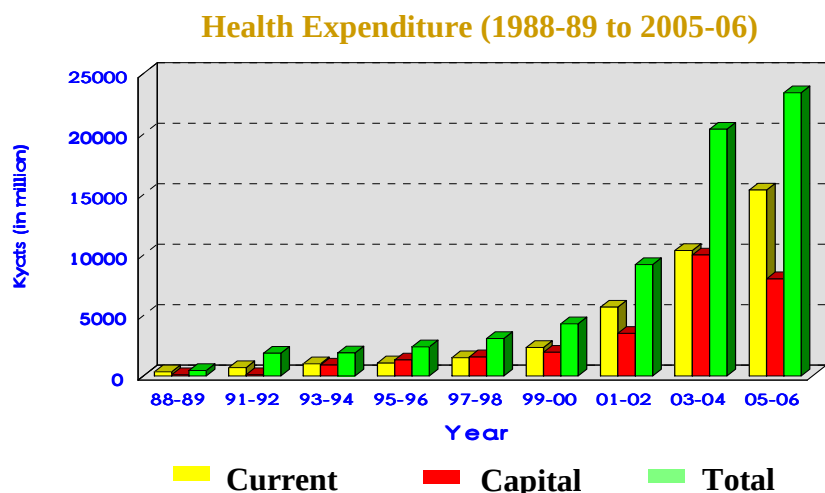
One unique and important feature of Myanmar health system is the existence of traditional medicine along with allopathic medicine. Traditional medicine has been in existence since time immemorial and except for its waning period during colonial administration when allopathic medical practices had been introduced and flourishing it is well accepted and utilized by the people throughout the history. With encouragement of the State scientific ways of assessing the efficacy of therapeutic agents, nurturing of famous and rare medicinal plants, exploring, sustaining and propagation of treatises and practices can be accomplished. There are a total of 14 traditional hospitals run by the State in the country. Traditional medical practitioners have been trained at an Institute of Traditional Medicine and with the establishment of a new University of Traditional Medicine conferring a bachelor degree more competent practitioners can now be trained and utilized. As in the allopathic medicine there are quite a number of private traditional practitioners and they are licensed and regulated in accordance with the provisions of related laws.

In line with the National Health Policy NGOs such as Myanmar Maternal and Child Welfare Association, Myanmar Red Cross Society, Myanmar Medical Association are also taking some share of service provision and their roles are also becoming important as the needs for collaboration in health become more prominent. Sectoral collaboration and community participation is strong in Myanmar health system thanks to the establishment of the National Health Committee in 1989. Recognizing the growing importance of the needs to involve all relevant sectors at all administrative levels and to mobilize the community more effectively in health activities health committees have been established in various administrative levels down to the wards and village tracts. These committees at each level are headed by the chairman or responsible person of the organs of power concern and include heads of related government departments and representatives from the social organizations as members. Heads of the health departments are designated as secretaries of the committees.¹⁹

The Government has been providing budgetary allocation for public health services and free medical care since the country regained independence in 1948. According to religious and social customs Myanmar people are eager to provide assistance for social works. Individually or along with fellow members they are

¹⁹ Health in Myanmar 2007, Ministry of Health

contributing in cash, labour or in kind for developing health infrastructure and procuring medicine and equipment. The extent and proportion contributed by the community in the national health expenditure could be more accurately estimated with availability of data and development of a system for recording and registration.²⁰



Government has increased health spending on both current and capital yearly. Total government health expenditure increased from kyat 464.1million in 1988-89 to kyat 23411.8 million in 2005-2006.¹⁹ This total government health expenditure include health expenditure of Ministry of Health plus health expenditure of other ministries.

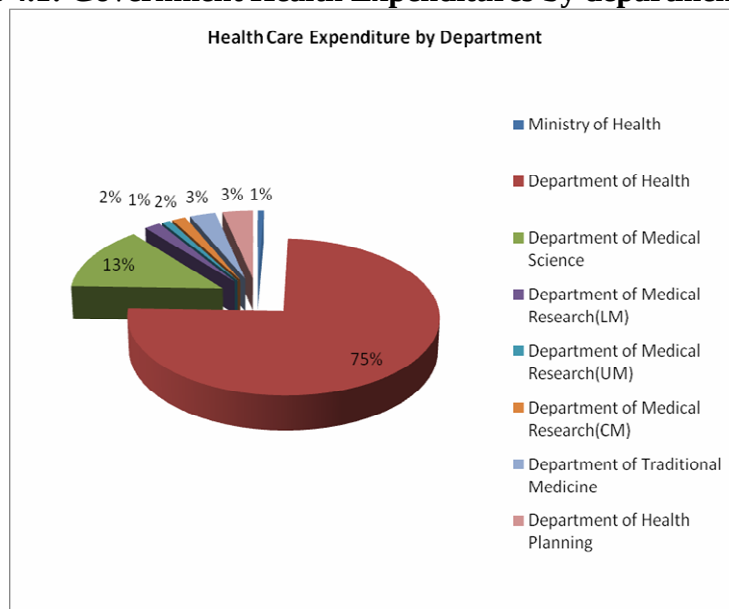
Government Health Expenditures within the Ministry of Health was allocated among departments as follows.

Table 4.1: Government Health Expenditures by Department in 2005-06

Kyat in million					
Sr. No.	Department	Current	Capital	Total	Percentage
1.	Ministry's Office, MOH	113	26	139	0.7
2.	Department of Health	10763	4115	14879	74.8
3.	Department of Medical Science	965	1726	2691	13.5
4.	Department of Medical Research(Lower Myanmar)	208	160	368	1.9
5.	Department of Medical Research (Upper Myanmar)	82	112	194	1.0
6.	Department of Medical Research(Central Myanmar)	35	286	321	1.6
7.	Department of Traditional Medicine	286	311	596	3.0
8.	Department of Health Planning	637	65	702	3.5
	Total	13089	6801	19890	100

²⁰ National Health Plan (2006-2011), Ministry of Health

Figure 4.1: Government Health Expenditures by department in 2005-2006



Department of Health provides all health care services and so, it was allocated most, (74.8) percent of government health expenditures. Department of Medical Science produces all types of health work force for human resources for health and was allocated second priority, (13.5) percentage.

Department of Health is a main department for service provision and the following figure expressed allocated budget to that department by functions.

Figure 4.2: Government Health Expenditures of Department of Health by functions in 2005-06

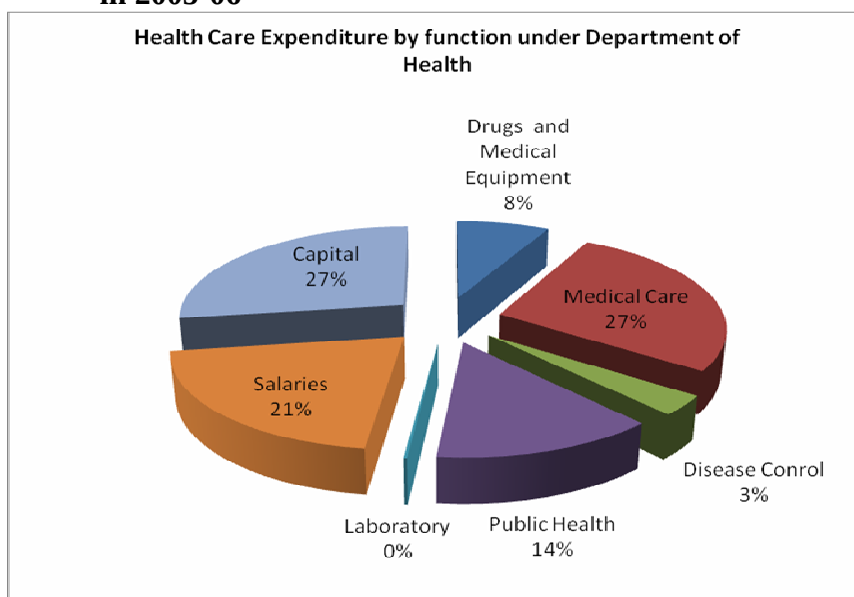


Table 4.2: Government Health Expenditure by functions in 2005-06

Functions	Health Expenditures (Kyat in million)	Percentage
Drugs and Medical Equipment	1150	7.73
Medical Care	4025	27.05
Disease Control	499	3.35
Public Health	2027	13.62
Laboratory	33	0.22
Salaries	3078	20.69
Capital	4067	27.33
Total	14879	100.00

Capital expenditures used 28 percent and which was the highest quota among other categories. Medical care expenditure percentage was the second highest, 27 percent. 20.69 percent of expenditures was used for salaries. Expenditures for public health and disease control were only 13.62 and 3.35 respectively. Expenditures for drugs and medical equipment was only 8 percent. Laboratory expenditures was too low which was allocated under 1 percent of all the government expenditures of the Department of Health.

Furthermore, health care expenditure was mentioned by region and this can be expressed distribution of expenditures within the country. There are total of 14 States and Divisions in Myanmar. The following table expressed the distribution of health care expenditure under Department of Health by region in 2005-06. This expenditure was only government health expenditures not included private sector.

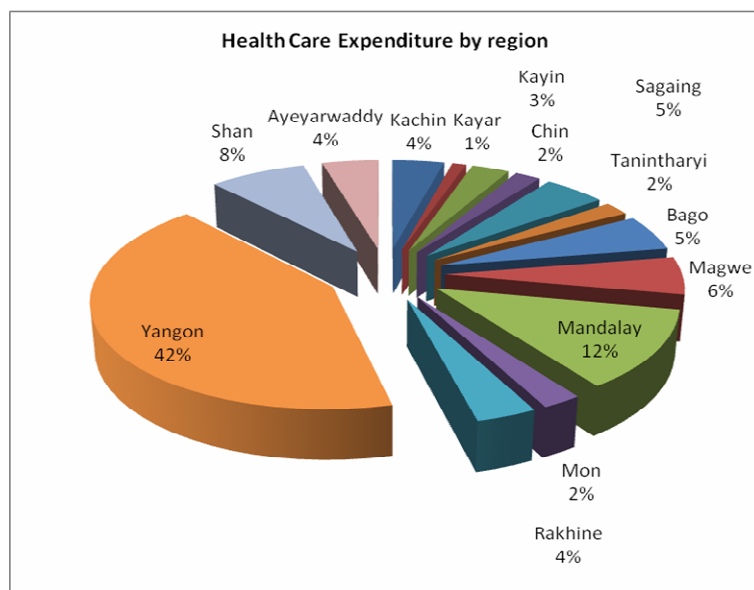
Figure 4.3: Health Care Expenditure by region in 2005-06

Table 4.3: Health Care Expenditures by region in 2005-06

Kyat in million

Sr. No.	State/ Division	Current	Capital	Total
1	Kachin	246.88	353.40	600.28
2	Kayar	111.50	49.77	161.27
3	Kayin	153.31	283.72	437.02
4	Chin	173.22	124.44	297.65
5	Sagaing	503.72	219.01	722.73
6	Tanintharyi	181.18	120.45	301.64
7	Bago	520.64	280.73	801.37
8	Magwe	501.73	348.42	850.15
9	Mandalay	995.50	800.38	1795.87
10	Mon	234.94	114.48	349.42
11	Rakhine	307.61	228.96	536.57
12	Yangon	5558.85	693.86	6252.71
13	Shan	709.79	408.15	1117.94
14	Ayeyarwaddy	564.45	89.59	654.04
Total		10763.30	4115.38	14878.68

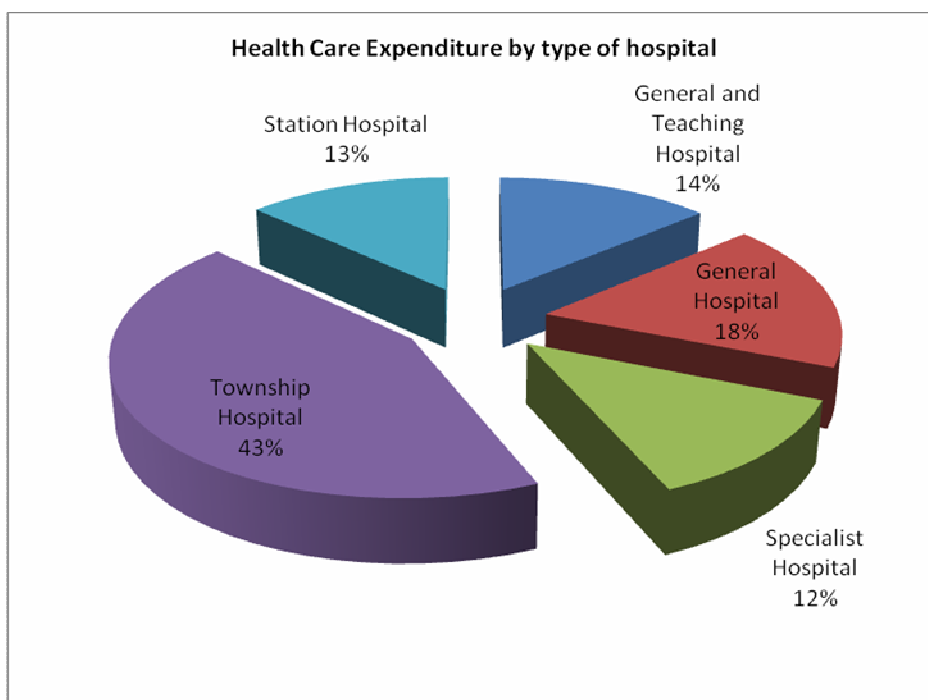
Yangon is located as a city of the country and populated area. All the health care facilities: primary, secondary and tertiary health care facilities were situated in there. Therefore Yangon Division was utilized most among the 14 regions. The second was Mandalay Division which is situated in upper part of Myanmar and health care facilities were upgraded nearly as Yangon and so the community in upper part of the country could access the tertiary care facilities in Mandalay.

There are general and teaching hospitals, general hospitals, specialist hospitals, township hospitals and station hospitals providing health care services in the country. The followings were the distribution of health care expenditures according to type of hospitals.

Table 4.4: Health care expenditures by type of hospitals in 2005-06

Kyat in million

Sr. No.	Type of Hospital	Current	Capital	Total
1	General and Teaching Hospital	685.9	386.5	1072.4
2	General Hospital	861.7	535.0	1396.7
3	Specialist Hospital	585.6	382.2	967.8
4	Township Hospital	1435.9	1996.9	3432.8
5	Station Hospital	453.3	567.5	1020.8
	Total	4022.4	3868.1	7890.5

Figure 4.4: Health Care Expenditure by type of hospital in 2005-06

Township hospitals used most of the finance among all types of hospital. It means the health system is based on township health system and which can cover not only urban area but also rural area where (70) percent of the population residing.

According to religious and social customs Myanmar people are eager to provide assistance for social works. Individually or along with fellow members they are contributing in cash, labor or in kind for developing health infrastructure and procuring medicine and equipment. The extent and proportion contributed by the community in the national health expenditure could be more accurately estimated with availability of data and development of a system for recording and registration. Although all the community contribution has not been collected yet, the data for existence of trust fund and utilization of trust fund were available in the hospitals.

The existence of trust fund of all over the country in 2007 was more than three thousand kyat in million and utilization of this fund in 2007 was more than two hundred million kyat (6.96 percent of the total fund) which was eligible for the poor.²¹

Table 4.5: Existence and Utilization of Trust Fund in the hospitals by region in 2007

Level	Existence	Kyat in million
		Utilization
Central Level Hospitals	572.29	142.80 (24.95%)
States and Divisional Level Hospitals		
Kachin	13.94	0.03 (0.22%)
Kayar	15.34	0.12 (0.78%)
Kayin	94.04	1.51 (1.61%)
Chin	32.06	0.71 (2.21%)
Sagaing	385.98	43.86 (11.36%)
Tanintharyi	100.47	2.67 (2.66%)
Bago	250.69	5.55 (2.21%)
Magwe	104.62	2.25 (2.15%)
Mandalay	842.38	4.00 (0.47%)
Mon	89.06	3.51 (3.94%)
Rakhine	131.62	9.58 (7.28%)
Yangon	188.05	5.47 (2.91%)
Shan	321.42	6.97 (2.17%)
Ayeyarwaddy	213.92	4.42 (2.07%)
Total	3355.86	233.44 (6.96%)

²¹ Third Quarterly Report for the year 2007, Ministry of Health, 2008 January, Naypyitaw, Myanmar

4.4. Household Survey on Health Care Expenditures, Sources of Finance for Health Care Services, Financial Burden for receiving health care services

The survey was conducted in Yangon Division, Mandalay Division and Mon State out of fourteen States and Divisions. A total sample size of (476) households were interviewed by pretested set questionnaire.

Table 4.6: Total Sample Size

States/ Divisions	Urban	Rural	Total
Yangon	60	100	160
Mandalay	60	101	161
Mon	55	100	155
Total	175	301	476

4.4.1. Exploring the household health expenditures and per capita health expenditures

Household health expenditures during last year included cost of medicine, cost for health care products including spectacles, dentures, BP cuff and glucometer, cost for nursing care, cost for OPD treatment and cost for inpatients care for the whole family for last year.

**Table 4.7: Average Household Health Expenditures for three regions
(Mean $\pm$ Standard Error)**

Average Total Health Expenditures	Yangon	Mandalay	Mon
Urban Mean $\pm$ Standard Error	577327.5 $\pm$ 167301.2	209787.3 $\pm$ 44837.8	278260.3 $\pm$ 53706.5
Rural Mean $\pm$ Standard Error	180182.2 $\pm$ 47257.2	195439.0 $\pm$ 35454.9	127793.6 $\pm$ 17515.3
The whole Area Mean $\pm$ Standard Error	331593.9 $\pm$ 71501.8	200786.2 $\pm$ 27738.8	181185.0 $\pm$ 22798.7

Table 4.8: Average Household Health Expenditures for three regions (Median)

Average Total Health Expenditures	Yangon	Mandalay	Mon
Urban Median (Range)	219000 (8400-9484000)	69300 (240-1800000)	134000 (6000-2221000)
Rural Median (Range)	52200 (0-4210000)	78000 (1800-2004000)	64000 (1200-1015200)
The whole Area Median (Range)	96600 (0-9484000)	73500 (240-2004000)	84000 (1200-2221000)

The total population in sampled area was (2281) in total (476) households. The total household health expenditures for all (476) households for the year 2007 was 113,465,280 kyat (113.465 million kyat). Therefore the per capita health expenditure for sample households was 49,743.6 kyat. This is the per capita health expenditure from the household and almost all are out of pocket in nature.

The per capita health expenditure on the government health expenditure for 2006-2007 was only 427.8 kyat.¹⁹ It can be said that although there was increasing trend of government health expenditures since 1988-89 to 2005-2006, the per capita health expenditure on government health expenditure is still low. This indicated that in terms of sources of financing, out of pocket expenditure on health from the household is still high.

Table 4.9: Per capita health expenditures by region

Per capita health expenditures	Yangon	Mandalay	Mon
Urban	115088	39583	52956
Rural	41873	41038	27721
Whole region	72480	40459	37445

Per capita health expenditure in each state and division by urban rural area was calculated by total health expenditures in sampled households and total population of sampled households in the respective area. The overall per capita health expenditures was nearly 50,000 kyat for all three areas. Among them as of Yangon division was more than 72,000 kyat which was highest compared to other two regions. This value was more than 110,000 kyat in Yangon urban area.

4.4.2. Sources of financing for costs of Out-patient and In-patient care

Source of financing for health care cost is one of the important indicators for financial burden of the family. Financing sources may be multiple. Not all the patients were using their current family income. There were combination of sources of finance including current family income, saving, sale of assets and some families needed to find the health care expenditures from the other sources.

The total patients for three regions were (585) and (215) from urban area, (370) from rural area which was 37 percent and 63 percent respectively.

Table 4.10: Sources of financing for costs of out-patient care for family members of sample households in selected townships of Yangon Division

Sources	Yangon Division			
	Urban (65 patients)		Rural (94 patients)	
	Number	%	Number	%
Current family income	61	93.8	78	83
Savings	30	46.2	16	17
Sale of assets	1	1.5	2	2.1
Relatives or Friends	3	4.6	17	18.1
Borrowing from others with interest	-	-	-	-

In Yangon urban area 93.8 percent which was 61 patients out of 65 patients were paid their health care cost by current family income. That figure in rural area was 83 percent which was 78 patients out of 94 patients. 46.2 percent which was 30 patients out of 65 patients in Yangon urban area was using saving for their out-patient health care costs. In rural area 17 percent which was 16 patients out of 94 patients were paid their out-patient health care costs from saving. There was 1.5 percent which was 1 patient out of 65 patients in Yangon urban area needed to use their out-patient health care costs by sale of assets. As of in rural area was 2.1 percent which was 2 patients out of 94 patients needed to pay by sale of assets. 3 patients out of 65 patients (4.6 percent) needed to pay their out-patient health care by financing from their relatives and friends.

Table 4.11: Sources of financing for costs of out-patient care for family members of sample households in selected townships of Mandalay Division

Sources	Mandalay Division			
	Urban (73 patients)		Rural (135 patients)	
	Number	%	Number	%
Current family income	68	93.2	113	83.7
Savings	2	2.7	13	9.6
Sale of assets	1	1.4	3	2.2
Relatives or Friends	1	1.4	9	6.7
Borrowing from others with interest	-	-	6	4.4

In Mandalay urban area, 68 patients out of 73 patients (93.2 percent), 2 patients out of 73 patients (2.7 percent), 1 patient out of 73 patients (1.4 percent) and 1 patient out of 73 patients (1.4 percent) were using their out-patient health care costs from current family income, savings, sale of assets and relatives or friends respectively. In rural area 113 patients out of 135 patients (83.7 percent), 13 patients out of 135 patients (9.6 percent), 3 patients out of 135 patients (2.2 percent), 9 patients out of 135 patients (6.7 percent) and 6 patients out of 135 patients (4.4 percent) needed to pay their out-patient health care costs from current family income, savings, sale of assets, relatives or friends and borrowing from others with interest respectively. Even for the out-patient health care costs, the family member in rural area needed to get the finance from borrowing from others with interest.

Table 4.12: Sources of financing for costs of out-patient care for family members of sample households in selected townships of Mon State

Sources	Mon State			
	Urban (53 patients)		Rural (112 patients)	
	Number	%	Number	%
Current family income	45	84.9	98	87.5
Savings	14	26.4	14	12.5
Sale of assets	4	7.5	1	0.9
Relatives or Friends	8	15.1	7	6.3
Borrowing from others with interest	-	-	-	-

There were 45 patients out of 53 patients, 14 patients out of 53 patients, 4 patients out of 53 patients and 8 patients out of 53 patients needed to pay their out-patient health care costs from current family income, savings, sale of assets and relatives or friends respectively in urban area. In rural area 98 patients, 14 patients, 1 patient and 7 patients out of 112 patients were paid their out-patient health care costs from current family income, saving, sale of assets and relatives or friends respectively.

Table 4.13: Sources of financing for costs of in-patient care for family members of sample households in selected townships of Yangon Division

Sources	Yangon Division			
	Urban (13 patients)		Rural (13 patients)	
	Number	%	Number	%
Current family income	10	76.9	8	61.5
Savings	13	100	5	38.5
Sale of assets	4	30.8	6	46.2
Relatives or Friends	3	23.1	5	38.5
Borrowing from others with interest	-	-	-	-

In Yangon urban area 10 patients out of 13 patients were using current family income while all patients were needed to finance from saving for their in-patient health care costs. In rural area, 4 patients out of 13 patients and 3 patients out of 13 patients needed to get their in-patient health care costs from sale of assets and relatives or friends respectively. In rural area 61.5 percent, 38.5 percent, 46.2 percent and 38.5 percent were financing their in-patient health care costs from current family income, saving, sale of assets and relatives or friends respectively.

Table 4.14: Sources of financing for costs of in-patient care for family members of sample households in selected townships of Mandalay Division

Sources	Mandalay Division			
	Urban (5 patients)		Rural (13 patients)	
	Number	%	Number	%
Current family income	4	80.0	8	61.5
Savings	1	20.0	3	23.1
Sale of assets	-	-	4	30.8
Relatives or Friends	-	-	4	30.8
Borrowing from others with interest	-	-	4	30.8

In Mandalay urban area, 4 patients out of 5 patients (80 percent) and 1 patient out of 5 patients (20 percent) were using their in-patient health care costs from current family income and saving respectively. In rural area, 8 patients out of 13 patients (61.5 percent), 3 patients out of 13 patients (23.1 percent) were needed to pay their in-patient health care costs from current family income and savings respectively while 4 patients out of 13 patients (30.8 percent) were needed to pay their in-patient health care costs from sale of assets, relatives or friends and borrowing from others with interest.

Table 4.15: Sources of financing for costs of in-patient care for family members of sample households in selected townships of Mon State

Sources	Mon State			
	Urban (6 patients)		Rural (3 patients)	
	Number	%	Number	%
Current family income	2	33.3	2	66.7
Savings	6	100	2	66.7
Sale of assets	1	16.7	2	66.7
Relatives or Friends	1	16.7	-	-
Borrowing from others with interest	-	-	-	-

In Mon urban area, 2 patients out of 6 patients were using current family income and all the patients were using saving for their in-patient health care costs while 1 patient out of 6 patients (16.7 percent) were using sale of assets and relatives or friends for in-patient health care costs. In rural area 2 patients out of 3 patients (66.7 percent) were using current family income, savings and sale of assets for their in-patient health care costs.

4.4.3. Financial burden for receiving health care services

Health care finance in low-income countries is still characterized by the dominance of out-of-pocket payments and the relative lack of prepayment mechanisms, such as tax and health insurance. Households without full health insurance coverage face a risk of incurring large medical care expenditures should they fall ill. This uninsured risk reduces welfare. Further, should a household member fall ill, the out-of-pocket purchase of medical care would disrupt the material living standards of the household. If the health care expenses are large relative to the resources available to the household, this disruption to living standards may be considered catastrophic. One conception of fairness in health finance is that households should be protected against such catastrophic medical expenses.²²

²² World Health Report 2000, World Health Organization, 2000

A popular approach has been to define medical spending as “catastrophic” if it exceeds some fraction of household income or total expenditure in a given period, usually one year (Berki 1986; Russell 2004; Wagstaff and van Doorslaer 2003; Wyszewianski 1986; Xu et al. 2003).

The two key variables underlying the approach are total household out-of-pocket (OOP) payments for health care and a measure of household resources. Measures of the incidence and intensity of catastrophic payments can be defined analogous to those for poverty. The incidence of catastrophic payments can be estimated from the fraction of a sample with health care costs as a share of total (or nonfood) expenditure exceeding the chosen threshold.²³

World Health Organization researchers have used 40 percent (Xu et al. 2003) when “capacity to pay” (roughly, nonfood expenditure) is used as the denominator.

The study tried to find out the nature of the financial burden for receiving health care services based on costs for Out-patient and In-patient care for the whole families as a numerator and nonfood expenditures of the whole family as a denominator for one year period. If the share of the total health expenditures for household out of non-food expenditures of household was more than **(40) percent** there could be said for financial burden for health.

The following table expressed the percentage of household which had catastrophic payment for health.

Table 4.16: Exploring the financial burden by region (based on costs for OPD and In-patient care for the whole families)

Households (%)	Yangon	Mandalay	Mon
Urban	34.4	23.3	36.4
Rural	28.3	31.7	21.0

The financial burden for health was still high even only based on costs of seeking treatment taken by family members. In Yangon, 21 households (34.4%) out of 61 households in urban area and 28 households (28.3%) out of 99 households in rural area were still suffered catastrophic payment for health. In Mandalay, 14 households (23.3%) out of 60 households in urban area and 32 households (31.7%) out of 101 households in rural area: in Mon state, 20 households (36.4%) out of 55 households in urban area and 21 households (21%) out of 100 households in rural area were also suffered catastrophic payment for health. In the overall 136 households (28.6%) out of 476 households still suffered catastrophic payment for health even calculated only with costs for Out-patient and In-patient care.

²³ Catastrophic Payments for Health Care,
(<http://siteresources.worldbank.org/INTPAH/Resources/Publications/HealthEquityCh18.pdf>)

4.4.4. Health care seeking pattern in the community

The health care seeking pattern in the sample area indicated the preference of their choices for seeking health care. The health care seeking pattern for in-patient care was only two sectors: the private and the public health facilities while those for out-patient care was not only private and public health facilities but also other facilities such as traditional hospital/clinic, non-profit hospital/clinic and self care by buying from the drug stores.

Health care seeking pattern of Yangon Division revealed that most of the household members going to private sector for their out-patient care: 80 percent and 66 percent in urban and rural area. In rural area 25.5 percent of the household members treated their illness by their selves and buying the drugs from the drug stores.

Table 4.17: Exploring health care seeking pattern for out-patient care in sample area of Yangon Division

Health care seeking pattern	Yangon Division			
	Urban (65)		Rural (94)	
	No.	%	No.	%
Public Sector	5	7.7	6	6.4
Private Sector	52	80	62	66.0
Traditional Medicine	2	3.1	-	-
Non-profit	-	-	2	2.1
Self care/ Drug store	6	9.2	24	25.5

There were few percentage 3.1 percent in urban area and 2.1 percent in rural area receiving out-patient care from traditional medicine and non-profit health facility respectively.

Table 4.18: Exploring health care seeking pattern for out-patient care in sample area of Mandalay Division

Health care seeking pattern	Mandalay Division			
	Urban (73)		Rural (135)	
	No.	%	No.	%
Public Sector	2	2.7	10	7.4
Private Sector	49	67.1	93	68.9
Traditional Medicine	3	4.1	9	6.7
Non-profit	-	-	1	0.7
Self care/ Drug store	19	26.0	22	16.3

In Mandalay, household members also going to the private sector: 67.1 percent in urban area and 68.9 percent in rural area. Only 2 household members out of 73 household members in urban area and 10 out of 135 household members in rural area were going to public sector for their out-patient health care. 3 out of 73 in urban area and 9 out of 135 in rural area were receiving their out-patient health care from traditional medicine practitioners. Only 1 person out of 135 household members in rural area received out-patient health care from non-profit. The second most health care seeking pattern in Mandalay Division was self care/ drug store: 26 percent in urban area and 16.3 percent in rural area.

Table 4.19: Exploring health care seeking pattern for out-patient care in sample area of Mon State

Health care seeking pattern	Mon State			
	Urban (53)		Rural (112)	
	No.	%	No.	%
Public Sector	1	1.9	5	4.5
Private Sector	43	81.1	85	75.9
Traditional Medicine	1	1.9	2	1.8
Non-profit	4	7.5	-	-
Self care/ Drug store	4	7.5	20	17.9

Only 1 out of 53 in urban area and 5 out of 112 household members in rural area were seeking their out-patient health care from the public sector. Most of the household members were going to private sector for seeking their out-patient health care: 81.1 percent in urban area and 75.9 percent in rural area. Only 1 out of 53 in urban and only 2 out of 112 household members in rural were going to traditional medicine practitioners for seeking their out-patient health care. 4 out of 53 household members in urban area took their out-patient health care from non-profit practitioners. 4 out of 53 in urban and 20 out of 112 household members in rural obtained their out-patient care from self care/ drug store.

Table 4.20: Exploring health care seeking pattern for out-patient care

Health care seeking pattern	Total out-patient	
	Number	Percent
Public Sector	29	5.5
Private Sector	384	72.2
Traditional Medicine Hospital/ Clinic	17	3.2
Non-profit Hospital/ Clinic	7	1.3
Self care/ Drug store	95	17.9
Total	532	100

For overall, 384 household members (72.2 percent) out of 532 household members received their health care services from the private sector. Nearly 18 percent of the household members received their health care by self care or buying from drug store by their selves. 29 household members out of 532 (only 5.5 percent) were going to private sector. 17 out of 532 household members (only 3.2 percent) got their out-patient health care from traditional hospital/ clinic. Only 7 out of 532 household members (1.3 percent) received their out-patient care from non-profit hospital/ clinic.

Table 4.21: Exploring health care seeking pattern for in-patient care in sample area of Yangon Division

Health care seeking pattern	Yangon Division			
	Urban (13)		Rural (13)	
	No.	%	No.	%
Public Sector	10	76.9	13	100
Private Sector	3	23.1	-	-

Total 10 out of 13 household members were seeking their in-patient care from the public sector and only 3 out of 13 seeking from the private sector in Yangon urban area. In rural area a total of 13 household members received their in-patient care from the public sector only.

Table 4.22: Exploring health care seeking pattern for in-patient care in sample area of Mandalay Division

Health care seeking pattern	Mandalay Division			
	Urban (5)		Rural (13)	
	No.	%	No.	%
Public Sector	2	40	8	61.5
Private Sector	3	60	5	38.5

In Mandalay, 2 out of 5 and 3 out of 5 household members in urban area were going to receive their in-patient care from the public and private sector respectively. In rural area most of the household members 8 out of 13 (61.5 percent) were going to the public sector while only 5 out of 13 (38.5 percent) were going to the private sector for receiving their in-patient health care.

Table 4.23: Exploring health care seeking pattern for in-patient care in sample area of Mon State

Health care seeking pattern	Mon State			
	Urban (6)		Rural (3)	
	No.	%	No.	%
Public Sector	3	50	2	66.7
Private Sector	3	50	1	33.3

In Mon State, 50 percent of household members from urban area were going to public sector and private sector to seek their in-patient health care. In rural area 2 out of 3 and 1 out of 3 household members received their in-patient care from the public sector and private sector respectively.

Table 4.24: Exploring health care seeking pattern for in-patient care

Health care seeking pattern	Total in-patient	
	Number	Percent
Public Sector	38	71.7
Private Sector	15	28.3
Total	53	100

Here again, the health care seeking pattern for in-patient care was different from out-patient care, 72 % of in-patient going to public sector while only 28 % going to the private sector. There was no household member going to private for non-profit sector for receiving in-patient health care in the sample area.

5. Conclusions and Recommendations

Efficient and effective health care is determined by the way the financing of health care system is structured and organized. The health financing system in Myanmar is dependent on government budgetary allocations, private financing and external sources. The total health expenditures as a percentage of GDP was 2.1 percent in 2001. The role of private financing has increased significantly in recent years. It is estimated that total private sources in the total health expenditures was 87.7 percent in 2001 (Myanmar National Health Accounts, 1998-2001). Almost all private sources are coming from out-of pocket payment. However, the importance of private financing is overlooked in policy discussions because the Ministry of Health and the Ministry of Finance focus on government spending for health care. Policy goals of efficiency, equity, and sustainability will often require public policy to set the rules for private funding of health services. In recent times, health care has become almost unaffordable due to development of new technologies and more costly interventions are in part to blame for health care becoming more expensive and it has given rise to serious equity issues. Hence it is imperative that need to find alternative health financing mechanisms: health insurance is one such alternative. Health insurance protects people against catastrophic financial burden resulting from unexpected illness or injury and an efficient system ensures the pooling of resources to cover risks. Although it is the ideal condition, there are so many issues challenging to initiate new system: political commitment, quality of health care services, providers' payment, administrative structure, fund management system, donor's backing, community awareness and community demands.

The Government has been providing budgetary allocation for public health services and free medical care since the country regained independence. All types of health services were provided mainly by general government tax revenue at that time.

Growing population together with border area development and extensive coverage of health care delivery to the population demands more and more expenditures to use in the public health. In such a situation and with the emergence of market-oriented economic system in Myanmar, health care cost is considered not only the sole responsibility of the government but also the coordinated effort or shared responsibility of the community and also the willing contribution of the non-governmental organization.

The study also attempted to reveal the universal coverage for health care which means not only physical but also financial accessibility. Government contribution through general taxation is one of the options for achieving universal coverage. Ear marked tax should be provided. The another aspect is community itself know their needs and wants to develop community financing for subsidizing among healthy and unhealthy, rich and poor, young and elderly.

One of the strengths in Myanmar health care financing system is development of the Trust Fund from community donation. The source of funding for community contribution is coming from private households but it can reduce the Out of Pocket (OOP) expenditure at the time of seeking treatment and it can also meet the equity issue by subsidizing poor by rich.

In regards with existing health care expenditures, the per capita government health expenditures in 2006-2007 was (427.8) kyat. Although the increasing trend of government health expenditures since 1988 to 2006 (464.1 million kyat to 24178.6 million kyat), the per capita government health expenditure is still low. The government health expenditures also expressed as by departments, by functions, by regions, and by types of hospitals. The study also tried to find out the household health expenditures in the sample area. It was explored in total household health expenditures, per capita health expenditures, sources of financing for costs of out-patients and in-patients and financial burden for health care services. The per capita health expenditures for sample households was (49,743) kyat in 2007. The sources of finance for out-patient costs mostly came from current family income but some percentage need to use from other sources like: savings, sale of assets, from relatives or friends and borrowing from others with interest which was even for out-patient costs. The financial burden for health calculated as a share of the total health expenditures for household out of non-food expenditures of household which exceed more than 40 percent that could be said for catastrophic payment for health. In the study area, more than 30 percent of households in Yangon urban, Mon urban, Mandalay rural areas and more than 20 percent of households in Yangon rural, Mandalay urban and Mon rural areas had suffered catastrophic payment for health. It could not be considered small and mechanism for preventing catastrophic payment for health should be explored.

The study also revealed the health care seeking pattern in the community for knowing their preference of choice for seeking health care. (72.2) percent of the people going to private sector for their out-patient care while (71.7) percent are going to public sector for their in-patient care.

One of the weak points of the study is estimation of household health expenditures for one year period. In the household questionnaire, recalling one year for inpatient health care for the household members but only one month for the outpatient health care because of the memory recall period. These outpatient health care costs could be estimated to one year by applying how many times within one year and assumed to be

same costs as last episode of illness. The study also couldn't tackle the issues on critical reviewing for utilization of the trust fund, community perspectives on community financing based on willingness and ability to pay, traditional belief and awareness. Hence, further studies such as Community perspectives for development of Community Based Health Insurance (CBHI) Scheme, Pilot study on CBHI with the initial investment from the donors, Utilization of trust fund which is enough for all the poor in the hospitals and etc. will be carried out for additional improvement of fairness in financing for health care services.

Predictable and sustainable health financing is an essential component for achieving important population health goals. Appropriately arranged health care financing (HCF) helps government mobilize adequate financial resources for health, allocate them equitably, and use them efficiently and effectively. Pro-poor health financing policies promote universal access to the most needed health services. They also contribute to social protection and strengthen the social safety nets in rapidly changing socioeconomic environments. In the broad context, effective health care financing contributes to the overall social and economic development process.

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