HEALTH FINANCING REVIEW
Myanmar

January and February 2012

March 13, 2011

Cover Photo: Consulting with Village Health Committee Members in the Delta Region

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List of Acronyms

AMW	Auxiliary Midwife
ANC	Ante Natal Care
AusAID	Australian International Agency for Development
CBO	Community Based Organization
CTHP	Coordinated Township Health Plan
CCS	Community Cost Sharing
CHW	Community Health Worker
CCM	Country Coordination Mechanisms
CWPG	Myanmar NGOs Contingency Plan Working Group
DFID	Department for International Development (UK)
DRF	Drug Revolving Fund
EPI	Expanded Program of Immunization
GAVI	Global Alliance for Vaccines and Immunization
GDP	Gross Domestic Product
GFATM	Global Fund to fight HIV AIDS, Tuberculosis and Malaria
GGHE	General Government expenditures on health
HA	Health Assistant
HSS	Health System Strengthening
IOM	International Office of Migration
JI-MNCH	Joint Initiative for Maternal neonatal and Child Health
MCWA	Maternal and Child Welfare Association
MMA	Myanmar Medical Association
MSF	Medecins Sans Frontiere
MRCS	Myanmar Red Cross Society
MNCH	Maternal, Neonatal and Child health
MOH	Ministry of Health
NGO	Non Government Organization
NHA	National Health Accounts
NRS	Northern Rakhine State
ODA	Overseas Development Assistance
OOP	Out of pocket payment
PvtHE	Private expenditures on health
PONREPP	Post Nargis Recovery and Emergency Response Planning
RHC	Rural Health Centre
SCF	Save the Children Fund
SRHC	Sub Rural Health centre
SEAR	South East Asia Region
THE	Total Health expenditures
TB	Tuberculosis
TMO	Township Medical Officer
VHC	Village Health Committee
WHO	World Health Organization
UNDP	United Nations Development Program
UNICEF	United Nations Childrens Fund
UNOPS	United Nations Office for Project Services

Executive Summary

Background: In Myanmar over the last 20 years, the country has been presented with significant challenges in the financing of health care, due to both low public sector and overseas development assistance investments in health, and correspondingly very high out of pocket expenditure rates, amongst the highest in the region. Given the structure of the labour market in Myanmar with a very large informal sector (> 80%), revenues through social health insurance mechanisms are also minimal (less than 1%).

In response to this problem, the Ministry of Health in 1993 developed a National Health Policy and nominated some alternative health financing mechanisms including Hospital Trust Funds (interest bearing Township Accounts for the poor), Community Cost Sharing (CCS – user fee mechanisms) and drug revolving funds (DRF). But despite these interventions, insufficient revenues have been raised to drive down OOP expenditures and reduce the burden of catastrophic payments for health on the poor. As a result, many national, international and community based organizations have designed and commenced Township based financing mechanisms to respond to the situation of low access of the poor to health care due to these financial and related demand side barriers.

Given the extent of the schemes and the diversity of context in Myanmar, it was decided to undertake a review and mapping of these Township schemes and develop some options for improving alignment of these schemes with national health objectives and strategies. This review is intended to complement a wider situation analysis of health financing and expenditures undertaken through a Universal Health Coverage document and the publication of National Health Accounts.

Methods: The review applied a range of methods including a literature review of national documentation and data bases, field visits to Township facilities and communities in the north west, central areas and Delta regions in the south, and consultations with development partners, Ministry staff, NGOs, CBOs, community members and Township health authorities. Findings were disseminated and discussed in a dissemination forum, and the findings were further informed through a "Development of Policy Options" conference implemented at the same period (development, health and education focus).

Framework for Analysis: The information is analyzed from the standpoint of the development stages of a country transition to universal coverage, which examines this transition from the initial stages of high reliance on OOP expenditures, to an intermediate stage characterized by a plethora of schemes and approaches, to a universal coverage stage characterized by higher levels of public investment and significant depth and breadth of coverage (for a nationally defined medical and social benefits package). (WHO, 2011). The basic assumption underlying such a framework is that improvement of harmonization and alignment of schemes in the intermediate period will ease the transition to universal coverage, provided the improvements in alignment are underpinned by increased public investment in health system development and operations (for both curative care and in particular preventive care).

Report Structure: This report is divided into three main sections. In the *first section*, main findings are presented from the review, including an overview of the general financing situation and the findings from

Township field studies. In the *second section*, strategy options are presented with advantages and disadvantages of each approach being summarized. In the *third section* (annexes), the various Township models are presented in more detail for reference purposes.

Main Findings: The *general health financing picture in Myanmar* is well known, and is characterized by a high rate of OOP expenditures and correspondingly low rates of public sector and ODA investment, leading to poorer access and higher rates of out of pocket and catastrophic health payments. What is less well known, is that, given the new political policy context, what the available fiscal space will be for investment in public health in the coming years

Operational financing for hospital care and public health programs is currently very weak, and contributes to higher reliance on the community for donations or to pay for their care at public health facilities through user fees. Despite these shortcomings, data is recorded in this review of high numbers of population covered through the different scheme operations implemented by Townships, NGOs and community based organizations..

There are *multiple health financing schemes* implemented in Township with specific project mandates, payment schemes, target beneficiaries and medical and social benefit packages. Coverage at this time is very limited, and Government Township financing schemes are unable to generate sufficient revenues to cover the costs of the poor. Overall, 11 types of schemes were identified and variously implemented through Townships, INGOs, NGOs, Foundations, community based organizations (CBOs) and Village Health Committees (VHCs) and are summarized in the Table below.

Table 1 A Summary of Health Financing Initiatives Reviewed

Type of Finance or Scheme	**Source of Revenue**
Village Health Committee Pre Payment Scheme	Pre Payment Schemes by Village Health Committees.
Township Micro-Protection Pre Payment Scheme	Pre Payment Schemes through Township Micro-Protection (Proposal Stage Only)
Public Sector Salaries and Operational Funding	General Government Revenue
Community Cost Sharing (CCS)	User Fee with exemptions
Drug Revolving Funds	Seed money donated by community, user fees
Township Trust Funds	Voluntary contribution by township well wisher, with revenue generated through interest bearing Township Accounts for provision of care for the poor – 1 Bed 1 Lakh)
Hospital Equity Funds	Development partner Funds to establish Hospital Health Equity Funds at Hospitals.
Emergency Referral Funds according to project Mandate (Nutrition,MCH,Child Health,3 diseases)	Development partner Funds through (3 Diseases Fund, Global Fund, JIMNCH)
Free direct health care provision by NGOs	NGO funding or community donation of funds or labour
Maternal and Child Health Voucher Schemes	To be decided (Proposal Stage Only)
Community Based Organization or Health Foundation schemes	Mix of donations and pre payment mechanisms by community members

Fund sources include the general revenues, community (pre payment or user fee), community donors (donations) and national and international NGOs and Foundations. Schemes “types” include pre payment,

donations, direct subsidized or free service provision, emergency referral schemes, and user fee with exemption schemes.

Benefit packages (which are most commonly determined by project mandates) focus variously on maternal and child health, specific communicable diseases and medical emergencies. Most systems are hospital focused and work on principles of reimbursement and cannot cover all costs in many cases. Although there was some evidence of informal payments, no formal provider payment mechanism was identified. There are various poverty identification schemes applied which are described in this report. Use of the private sector was reported to be widespread. In summary, the schemes are highly diverse in terms of benefits package, management arrangements and fund sources, but are nonetheless assisting to expand access or at the very least and reduce somewhat the burden of health expenditure on the poor.

Strategy Options: Strategy options for improvements to depth and breadth of coverage were also reviewed. There are options for moving to Township wide strategies for health protection, and potentially options for establishment of single Township Health protection Funds. However, all of these options assume substantial increases in public and / or ODA investment, as well as significant investment in system development and supply side operations and quality improvement. System developments are required to ensure adequate supply of quality services are in place, and organizational development are required to ensure that townships ("Funds Managers") have sufficient organizational capacity to manage, coordinate, operate and monitor schemes, potentially through partnerships with implementing partners (or "Funds Operators"). The definition of a health system mandate or essential medical benefits package, the development of poverty alleviation systems, and in particular, strengthening of coordinated management and planning systems are three necessary system requirements for harmonizing strategies for improving access for the poor. The capacity to generate revenues through pre payment will be very limited in the initial stages due the current social economic situation and high poverty rates.

Figure 1 Strategy Options for Improving Health Financing Performance

Development of Coordinated Planning Systems
Strengthening of Coordination mechanisms at all levels of the health system
Harmonization of health financing procedures
Deciding on a national minimum medical and social support benefits package
Sequencing Introduction of financing schemes in a Township according to development context
Development of Poverty Identification systems
Developing improved systems for provider payments (retention and motivation)
Strengthening systems for assessment of quality of care
Developing Township Funds mechanisms and governance arrangements
Improving public sector, social health insurance and ODA revenues for health
Development of national health financing strategy and improving policy processes
Responding to other demand side barriers

An important finding of this review is that there is wide variation in supply side capacity of Townships across the country, indicating that demand side health financing strategy will need to be carefully adapted to local context. That is, a careful balance will need to be set between investments in infrastructure, human resources and operational financing and investments in health financing initiatives such as health

equity funds and voucher schemes, in order to to ensure there is a good match between supply and demand.

Strategy options have been strengthened by the conducting of a Development of Policy Options conference in Myanmar in February 2012, which has highlighted poverty alleviation, social sector investment and in particular social protection as high policy priorities. The health policy forum has recommended the development of a National Health Financing Strategy by 2013. Public budget sessions have been conducted in parliament for the first time in 20 years, and the budget session have indicated significant increases in health and education budgets in the coming fiscal year. Figure 1 above outlines the strategy options which are detailed further in this report.

Conclusion: The findings of this review are consistent with those findings reached in 2008 and 2009 (DHP, 2008, DHP 2009), both of which identified the burden on the poor of high out of pocket payments, the limited reach of existing alternative schemes, the constraints of user charge systems, and the related need to drive down out of pocket payments, especially for the poor. This review has taken one step further, by mapping out the characteristics of current schemes across the country, and by suggesting strategic options for improving harmonization and alignment of schemes with a view to obtaining wider breadth and depth of coverage in the coming years.

Recent health and development policy reforms in the country provide important opportunities for analysis and discussion of the fiscal space for increased investment in health and increased investments in Township health systems. Next steps, apart from a more in depth fiscal analysis, include system preparation at the Township level in particular in order to increase capacity to manage and coordinate increased health investment and health financing schemes targeted at the poor. Given the very large ground that Myanmar is to cover in order to achieve universal health coverage, in the short to medium term, the aim is likely to be reducing OOP from the current 80% to a set target within a given number of years (to be decided), primarily through increased investments in health, and through strengthening of Township based health financing and service delivery systems. In the longer term, clearer targets will need to be set for sustainable financing of public health through general revenues, with increased ODA and technical support in the medium term to support the transition from the intermediate to the final stages of Universal Health Coverage.

Acknowledgements

Many managers, staff and community members assisted with this review. The management of the Department of Health Planning at the Ministry of Health in Nay Pi Taw, and the WHO staff in Yangon, assisted by providing technical support and guidance and support with logistics. In the field, thanks are due to Township Medical Officers, Rural Health Staff, community members, and the staff of INGOs, NGOs, CBOs and Foundations who all donated their time to assist with completing this review. Managers and staff of the country office of UNICEF and the Regional Office of WHO are also acknowledged for their technical input to this review.

1. Background

Over the last 5 years, evidence has started to emerge of financial and demand side barriers to health care access in Myanmar. Various initiatives have been developed to address these financial and demand side barriers. In recognition of the reality of health financing barriers, research has been undertaken through the Dept. Planning which has demonstrated the financial challenges associated with health services access. In the 1990s, alternative health financing models were first developed. These included Trust Funds, Drug Revolving Funds and Community Cost Sharing. Various models of "Health Foundation" are also reported to be in place with financing through local community groups. A health system strengthening strategy has been developed which proposes establishment of community based health financing schemes to expand access. Previous to that, the Division of Planning at the Dept. of Health conducted a series of research studies on barriers to access which also highlighted issues of equity of access and financial barriers to access. WHO has recently undertaken discussions with the Ministry of Health on the options for moving forward with trials of health voucher schemes for improving access to services for maternal health care. There are also wider initiatives in place to improve social protection mechanisms.

2. Scope of Work

In order to build awareness and consensus on health financing initiatives, the following tasks were undertaken:

1. Consulted with principal stakeholders in government, bilateral, international and civil society agencies on the strategic directions for health financing in Myanmar
2. Undertook a desk review on health financing barriers, initiatives and related demand side factors affecting health care access, especially for women and children.
3. Undertook a rapid assessment (in collaboration with MOH staff) of existing health financing initiatives, with the main aim being to gather evidence on best practice case studies, as well as case studies of demand side barriers to health care access

3. Objectives

The main objectives of the health financing review were:

1. To identify the current situation of health financing in Myanmar
2. To describe case studies of health financing in Myanmar (and other demand side interventions), with specific reference to how the schemes operate, what the schemes do, how much they cost and what effects they have
3. To analyse the findings, and identify potential options for strengthening of health financing strategy and procedures

4. Methods

Data collection was undertaken in the following steps.

In the first step, a desk review was undertaken. This included national documentation including recent health financing review, the National Health Accounts report from 2006/2007, and the latest national health accounts data provided through the data base of the Global Health Observatory.

In the second step, consultations were undertaken with the Department of Planning in Nay Pi Taw to clarify the study objectives and data collection methods. *In the third step*, consultations were undertaken with non government organizations to clarify how the schemes work, costs of schemes, and any evidence of effectiveness in protecting the poor (strengths and weaknesses). *In the fourth step*, field assessments were conducted in The Delta region, Rakhine State and Mandalay Division applying similar data collection tools and areas of investigation as the previous step.

In the final steps, additional inputs on health financing situation and strategy were accessed through conducting of a National Multi Sector Conference on the development of policy options for the social sectors in Nay Pi Taw in February 2012. In the same week, initial findings from this financing review were presented to a panel of health managers and development partners, and inputs were provided on strategy options.

A data collection tool was designed in order to systematically collect and categorize information (see Annex). Thematic areas included the following:

1. Demand Side Barriers
2. Background To Health Financing Scheme
3. Funding/ Revenue
4. Beneficiaries and Eligibility Criteria
5. Operational Procedures and Benefits Package
6. Management /Governance Arrangements
7. Other demand side interventions
8. Evidence of Impact, Strengths, Weaknesses and Recommendations

Field notes were collected and organized into the categories outlined in Annex 1. *Analysis* was undertaken by organizing the data collection into the following headings:

1. Background to Health Financing in Myanmar (summarizing main points from the literature review and UHC Report)
2. A selection of 3 or 4 more in depth case studies in Health Financing, organized into the main theme areas (see annexes).

In relation to point 4, the aim was to detect potential for alignment and harmonization of strategies with regards to beneficiaries, eligibility criteria, medical benefits or social support package, provider payments, other standard operating procedures and management and governance arrangements. It was expected that some analysis of potential for alignment of strategies and procedures may assist with setting future health financing options.

The review as undertaken in two teams incorporating staff of the Department of Health Planning in Nay Pi Taw and the World Health Organization in Yangon. These teams usually consulted with the relevant State/Regional director, Township medical Officer, Rural Health centre Staff and community members. Where possible, the rview team always undertook to consult with local and international NGOs, Foundations and community based organizations (refer to annex for agencies consulted).

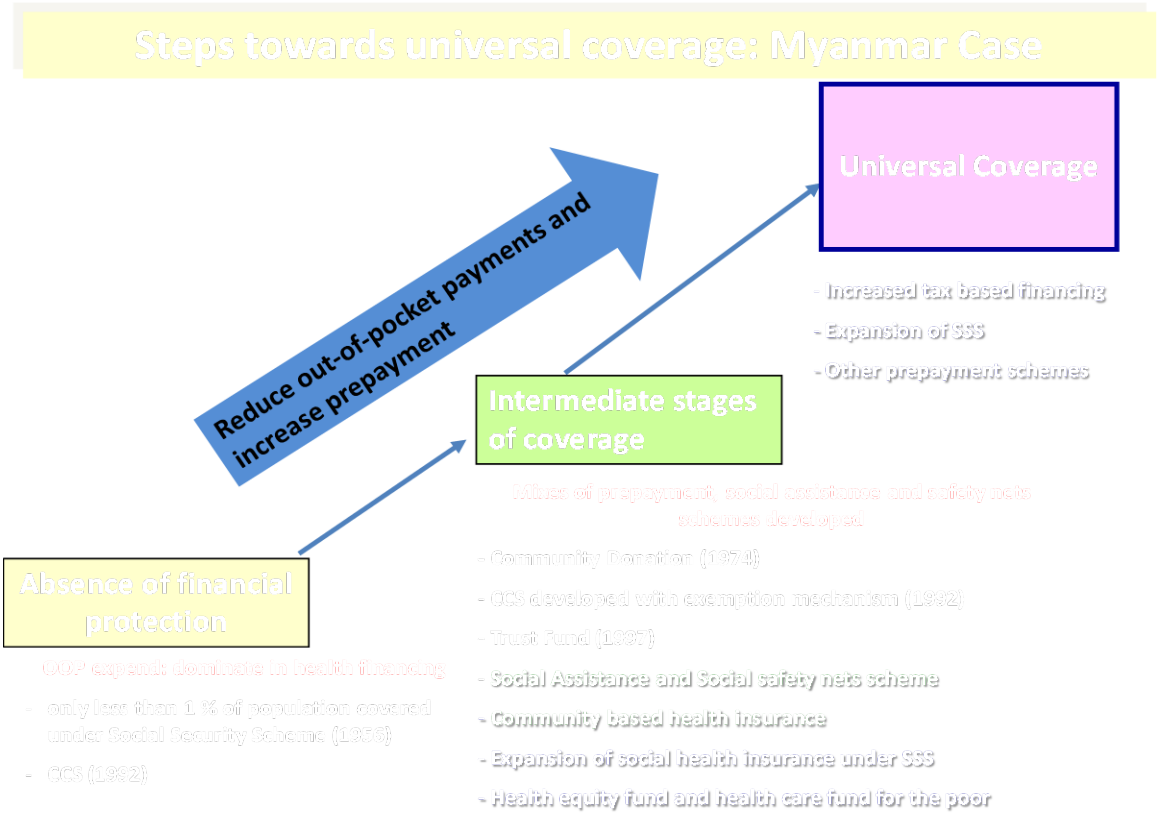
3. Target Groups and Areas

Key partners for the review were the Dept. of Planning at the MOH, the World Health Organization, development partners, Township health authorities and non government organizations. Although the review was focussed on more recent initiatives in health care financing, care was taken to adapt lessons learned from initiatives in the 1990s and earlier (Trust Funds, drug revolving funds, community cost sharing, Health Foundations) in order to inform the setting of future health Strategy options. For this reasons, main target groups for the review were non government organizations, Health Foundations and Township Health Authorities. For the field studies target areas were schemes operational in the Delta Region (Bogalay and Laputta Townships), Rakhine State (Maungdaw Township) and Mandalay Region in central Myanmar. However, models in other States and Regions were also discussed with other implementing agencies.

4. Frameworks for Description and Analysis

This description and analysis has two main points of reference. Description is informed by distinguishing concepts of breadth and depth of coverage. Whereas "depth of coverage" refers to the number of eligible benefits (or extent of health services that can be eligible for benefits) "breadth of coverage" refers to the percentage of the population covered. Analysis, particularly in terms of selection and determination of options, is guided by the overall framework for analysis of universal health coverage, contextualized for the Myanmar situation. Figure 2 below describes how Myanmar is at the "out of pocket payment" stage, and commencing early transition towards the intermediate stages of universal health coverage.

Figure 2 Steps towards Universal Health Coverage Contextualized for Myanmar (DHP, 2012)



5. Limitations of the Review

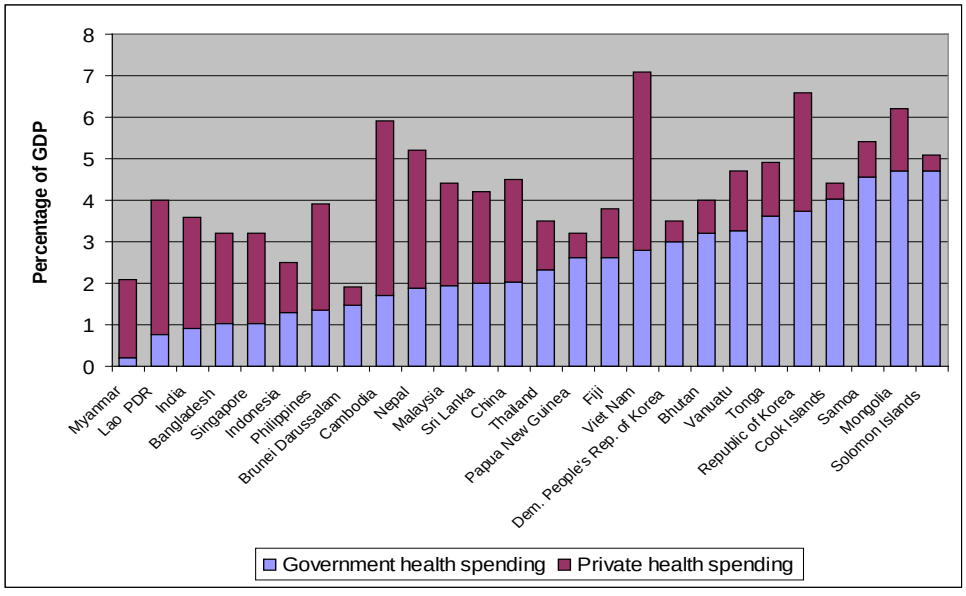
The review is a rapid assessment with a limited sample. The review is mainly focused on Township Health systems, but refers widely to national financing situation with respect to tax based financing and Overseas Development Assistance (ODA) (See Section 7.1).However, it is expected that by combining wider consultations with a limited field sample, in conjunction with a literature review, there should be sufficient information to scope out some potential options for strengthening of health financing strategy. The review also aims to identify demand side information gaps that could be addressed through programs of health systems research. It should be noted that this review was principally concerned with reviewing the current implementation status of Township Health systems with respect to health financing initiatives, with only background analysis of the macro-economic picture (see "General Health Financing Situation of Myanmar" that follows). A related "Universal Health Coverage " report will provide more detail on this aspect of the health financing situation in Myanmar.

6. Main Findings

6.1 The General Health Financing Situation of Myanmar

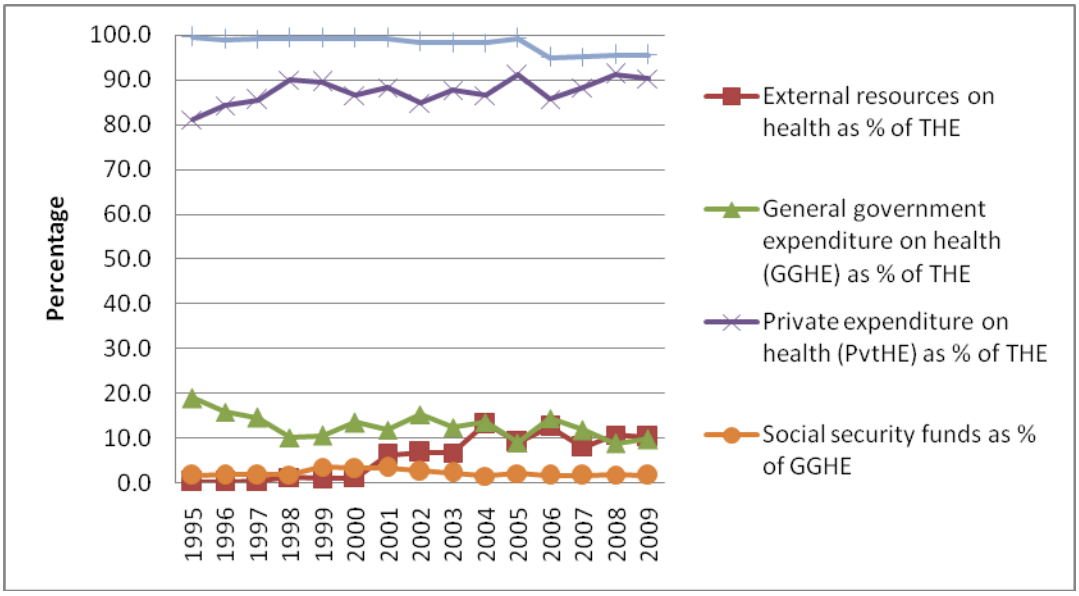
The overall finding of this situation analysis is dominated by the extent to which health service access and provision is dominated by private "out of pocket financing." In the Myanmar context, up to 80% - 90% of health service access is financed through this mechanism, with the population highly exposed to risk of catastrophic health spending, or late presentation or non access at all based on lack of affordability of the services. This rate of out of pocket expenditures is well below the above the benchmark of 30%, which is that recommended to avert catastrophic health payments by the poor. Overall, the national investment in health of 2% of GDP is well below the recommended level to maintain universal coverage of 5% of GDP. Minimal revenue (less than 1%) is being sourced through risk pooling strategies including social health insurance and voluntary health insurance. There has been a sharp decline from 18% in 1995 to 9% in 2009 in the share of government budget for health. This indicates the need for increased efficiencies in revenue collection and reprioritization of government budgets for social sector development.

Figure 3 Health Spending as a percentage of GDP from Regional Countries (DHP, 2012)



Despite this scenario, there are indications that are positive trends in expenditures in some areas. National Health Accounts (NHA) data demonstrates that between 2006 and 2007 there was a 30% increase in investment in national government spending. Although rates of Overseas Development Assistance for health (ODA) are low based on a regional comparison ($1.23 per capita), the trends are positive, with the percentage of the health sector being financed externally improving from 1% in 2000 to 10% in 2010. Nevertheless, the decline in pre payment mechanisms and risk pooling, and growth in population and the complexity of modern public health issues, demonstrates amply that these expenditure trends are not keeping pace with population health needs.

Figure 4 Analysis of Total Health Expenditures by Source 1998 – 2009 (WHO, 2012)



Regional analysis demonstrates that low social protection coverage of the population is matched by health coverage indicators which tend to lag behind regional averages. Of the limited health services research data that is available, it is evident that the poor have high health care costs for reproductive health care relative to their capacity to pay. Additionally, various reports and studies testify to the impact of catastrophic health expenditures on populations attempting to essential medical care. In response to these challenges, in 1993 the country developed a National Health Policy which recommended the exploration of alternative financing mechanisms. Subsequent to this, community cost sharing, Trust Funds and drug revolving funds were established, but the revenues have been inadequate to achieve satisfactory population. Important lessons learned from this initial period of reform is the requirement of clear Strategy and procedures, the importance for introducing systems to identify eligible populations, and the need to develop financial management capacity building and monitoring systems to support the initiatives. In recently years, arguably a second period of reform has commenced, with schemes designed for health voucher for maternal and child health services, emergency referral funds through civil society partnerships, development of financial mechanisms to decentralize pro poor funding to Townships and the establishment of hospital health equity funds. This health financing review will present some strategy options based on the findings of this review, including an analysis of these recent innovations in health care financing.

6.2 New Health and Development Policy Directions in Myanmar

Recent parliamentary session has debated sharp increases in health and education budgets in the next financial year. These debates are related to recent political and administrative reforms in the country, which have sharpened the development focus on poverty alleviation and investment in social sectors including rural development, health and education. Data on trends in budget planning for the coming fiscal years demonstrate a decrease in defense expenditures from 23.6% to 14.4% between the fiscal years of 2011 and 2012, and a complementary increase in health and education budgets from 5.4% to 7.5% in the same period (DPO, 2012).

As reported in the dissemination meeting for this review by the Ministry of Finance, tax revenues in Myanmar represent 3% of GDP, with other general revenues sourced through profits from public enterprises. Foreign direct investment in Myanmar is largely taken up by investments in the natural resource industries (electricity 40%, oil and gas 38% and mining 8%) (DPO, 2012). The absence of public health accounts data since 1988 (with the exception of publication of National Health Accounts from 2006) makes it difficult in this context to analyze the fiscal space for investment in health and related social sectors. However, trends in social sector budgeting, and the opening of public budgets sessions and public accounts in 2012 increases the likelihood that in coming years more rigorous analysis of fiscal space and options for public sector investment in health can be explored.

Other new policy directions have recently been announced. In terms of broader development policy, there is renewed emphasis on poverty alleviation and social protection, with specific reference to the need for social safety nets and quick impact interventions to cushion vulnerable populations against the effects of change. The health sector, as indicated at the recent Development of Policy Options Conference, is proposing the following main strategic directions for the coming three year period:

- Strengthening of national and sub national health planning systems
- Community system strengthening and development of decentralization policy
- Development of a health financing strategy by 2013, including a full situation analysis for universal health coverage

6.3 Health Financing Models

Five main classifications of health financing and health financing scheme have been identified in this review at Township level and below. These are:

1. Public sector and ODA investments in programs and Plans
2. Township Health System Financing Mechanisms
3. Emergency Referral Systems
4. Health Equity or Voucher Schemes
5. Pre Payment Systems (Township Micro Finance and systems various systems community pre-payments and community Health Foundation)

Although there is often overlap between these classifications (for example in some emergency referral systems there are limited systems of prepayment by community members), these classifications have been adopted for a number of reasons.

Firstly, there is in some sense a sequence in the development of these schemes, with Township Health Financing mechanisms having been established since 1993. In contrast, health equity fund/voucher and pre payment schemes are at the latter stages of the sequence, and are largely at the research and development phase.

Secondly, by classifying in this way, it is proposed to identify possible scope for harmonization and alignment of strategies and procedures within each category, as well as pointing to potential pathways for transition to more developed and comprehensive health financing mechanisms over the longer term.

Arguably, additional classifications include direct free of charge service provision by NGOs, and out of pocket payments for private and traditional sector care. In order to have a manageable scope of work, these classifications will not be examined in detail in this review. Table 2 outlines some of the types of scheme that were reviewed in this assessment.

Table 2 Details of Scheme Type Reviewed by Township

Location	Type of Scheme	Inception	Characteristics & Observations
Laputta, Bogalay, Kyaukpadaung	Trust Funds	1993	Interest bearing Accounts managed by the Township Health Committee for care of poor patients. Poverty identification by physicians/surgeons. Limited interest generated by schemes. Not utilized in Maungdaw due to difficulty with procedure
Laputta Maungdaw Kyaukpadaung	Community Cost Sharing	1993	System of user fees for laboratory, bed, and X Ray. The poor are exempted, although systems for exemption were difficult to define.
Laputta Maungdaw Kyaukpadaung	Drug Revolving Fund	1993	System for procurement of essential medicines for the poor. DRF systems are underutilized or not operational in the sites visited. In Maungdaw the Trust Fund was not utilized but the DRF was.
Laputta, Bogalay, Maungdaw Kyaukpadaung	Government Operational Budgets		Only $3000 per annum for operational budgets at Township hospital. The vast majority of the budget is for salaries. RHCs do not have operational budgets.
Mon State, Laputta, Bogalay, Dedaye, Maungdaw, Kyaukpadaung	Emergency Referral Funds	2010/2011	Funds cover emergency referral for the poor. The eligibility for the scheme depends on the project, with some focusing on the three diseases, and some on MCH (EMOC and under 5 children). Funding system is mainly based on reimbursement (with some exceptions in Laputta). Poverty identification is through VHCs and emergency classification by health staff and validation of residency by local government. Benefits usually cover medical care costs, transport and social support.
20 HSS Townships	Equity Funds	Proposal Stage Implement 2012	Early proposal development with pro poor fund established at Township level. Commencing with system of post identification of poor (i.e. identification at facility level) for emergency hospital

			treatment
1 Trial HSS Township	Voucher Schemes	Research and Development Stage	Research undertaken on health care costs and estimated costs for provision of maternal and child health care vouchers. Detailed proposal and procedures not yet developed.
Laputta, Bogalay, Mon State, Kyaukpadaung	Pre Payment Schemes	Research and Development Stage	Research and feasibility study undertaken for pre payment scheme for health care. Not yet reached proposal stage. In some locations, VHCs (Laputta, Bogalay and Mon State) or Community Based Organizations (Kyaukpadaung) collect funds from households for contributions to a village referral fund. Although fund collection is limited, in some cases it can generate sufficient interest to be sustained. In other cases, the fund collection is too limited in size. There was no evidence of pre payment schemes of any kind in Maungdaw.

General findings from this review are summarized below. For more detailed assessment of how the schemes function, the annexes provide some detailed case studies of scheme operations which were documented following field visits and consultations.

6.4 Demand Side Barriers

FINDING 1 Demand Side barriers are dominated by both cost factors and behavioral factors. All the general population is effected, though there are clearly definable groups that are at higher risk. Village Health Committees, communities and families have developed local "coping mechanisms" to manage the situation as best they can.

Demand side barriers to health care are dominated by the high costs of health care and the tradition of village based care, particularly for maternal health. In terms of cost factors village health committees and respondents identified a range of scenarios for costs of health care, and the coping mechanisms that communities apply when faced with shortage of funds for health care.

Risk Groups and their Demand Side Barriers

The Poorest of the Poor: To begin with, the incomes of communities are very low, particularly high risk groups. These high risk groups include the poorest of the poor, post disaster communities in the Delta region, and seasonal worker migrants in Mon State and refugee populations in Northern Rakhine State. In one fishing village in the Delta, it was reported that "the poorest of the poor" constituted about 15% of the population. The VHC could identify them by their "general condition", which generally referred to the quality of housing, lack of income, employment status and intermittent food insecurity. These populations are not in a position to purchase health care at all. There was also a "middle group" in the village who could manage, but were still required to seek loans, sell assets or seek assistance from the VHC for referral and health care costs. After this was the "rich group," who lived closer along the river, and of whom many were traders and boat owners with better housing. This was the group from which the poor sought loans or donations and from which the VHC often sought assistance in an emergency. In the Delta,

traditional health care could be sought from the monastery. In Northern Rakhine State, where up to 95% of the population are Bengali speaking, estimates of the very poor (that is, those who cannot pay for health care) varied in estimates from 30% to 50%.

Women of Reproductive Health Age and the Newborn: This group is at particular risk because of the need for acute in patient medical care in the time of emergency. It is this group that is the main target of the emergency referral schemes. Two main risks were identified by community members for low utilization of health facilities. These were cost factors and tradition. Consistent with recent research findings, community members indicated that the cost of a TBA delivery at the home (in cash or kind) was approximately half the cost of a delivery at a rural health centre. Most women deliver in the villages in the care of either an AMW or TBA. But cost is not the only factor. Women have always delivered in the village. The women can be surrounded by their family members. This is compared to delivering in a "strange place", where less family may be present with the mother and newborn in a location far from the village.

Emergency Medical or Surgical cases: One of the limitations of the emergency referral schemes is that eligibility criteria are limited to emergency obstetric cases and to illnesses for children under the age of 5. In other locations, schemes were established for referral for the 3 diseases, but with implementing partners indicating the need for establishment of a "comprehensive package" of services to meet the real needs of the poor. However, in some locations, up to 50% of the populations in some areas of the Delta and in NRS were identified by local managers as being too poor to afford access to health care. This being the case, in the event of medical or surgical emergency, the general population of poor residents is at risk to delayed access to essential medical care, and not only pregnant women and young children or those with communicable diseases.

Migrants: During field visits and consultations, "migrants" were also identified as a high risk group. In Mon State they can make up to 10% to 20% of the populations. They come from the dry zones in central Myanmar to work in the rubber plantations on a seasonal basis. In addition to these seasonal migrants, there are also returnees from Thailand. Aside from the issue of the costs of health care, the other main demand side barrier is the fact that, as migrants or returnees, they may not have established health or social networks from which they can gain assistance in a time of need. Being unknown to most of the community, they are less likely for example to be identified in a VHC poverty assessment. This is evidenced further by the report that 50% of malaria cases there are migrants. In the Delta region, due to very low household incomes (2000 kyats per day) and the seasonal nature of rice farming, migrants move to the salt plains in the southern part of the Delta, and its is unclear how their health and social needs may be met.

Refugee, Internally displaced or Ethnic Minority Groups: In Maungdaw Township, the presence of large numbers of refugees means these populations are at risk for poor health access and outcomes due to poverty, language barriers and traditional beliefs. In other parts of the country, the presence of over 100 minority groups mean, as well as conflict or post conflict areas, that there are likely to be demand side language and cultural barriers to care. Some respondents indicated that in many border regions, services are at this stage are undeveloped with inadequate health infrastructure, and significant and human resource numbers. In one site visited in Maungdaw, there was one midwife positioned for 20,000 population.

Coping mechanisms of the Community to Overcome Demand Side Barriers

As is evident from the narrative above, not all acute medical needs are being met by the schemes. The system and the communities are required to adapt to the project specificities (MCH or 3 diseases for example) rather than the project adapt to the system or community requirements. Additionally, the procedure for reimbursement (rather than prepayment in form or another) also puts the poor at disadvantage in some locations. At others, it was reported that system of reimbursement was satisfactory. When funds are inadequate for referral or for service purchasing, communities adopt the following coping mechanisms to deal with this situation.

1. Requesting communities to donate on a regular basis into an emergency fund held by the VHC (system of prepayment)
2. Requesting loans or donations from wealthier members of the community at the time of the referral (donation)
3. Sale of assets such as livestock
4. Paying back loans from an employer by offering labour for free for a specified period.
5. Obtaining traditional care through TBAs or the monastery

Although pre payment by household was small on most occasions (up to 2000 kyat per year per household, or 100 or 200 kyats per month), it was noteworthy to observe that the activities by the VHC in this area have the potential to improve local social networks and coping mechanisms. Not only does the VHC collect pre payments, but in an emergency, they contact wealthier members of the community for loans or donations. They also attempt to secure transport for the affected community members. In other locations, VHC systems were inactive. In areas where community based organizations and Health Foundations were more active, the principal mechanism for funding was donation or contributions, rather than a systematic approach to risk pooling through shared investments in schemes (through monthly or annual contributions for example).

Overall, project managers and communities indicated that a balance needs to be set between costs and educational (traditional) factors that constrain demand for modern health care services. But just what "health education" means in this context is less clear. Additionally, the extent to which both family and health provider behaviors influence either use or non use of facilities is a subject for more in depth social research.

6.5 Township Health Operational Budgets and Out of Pocket Expenditures

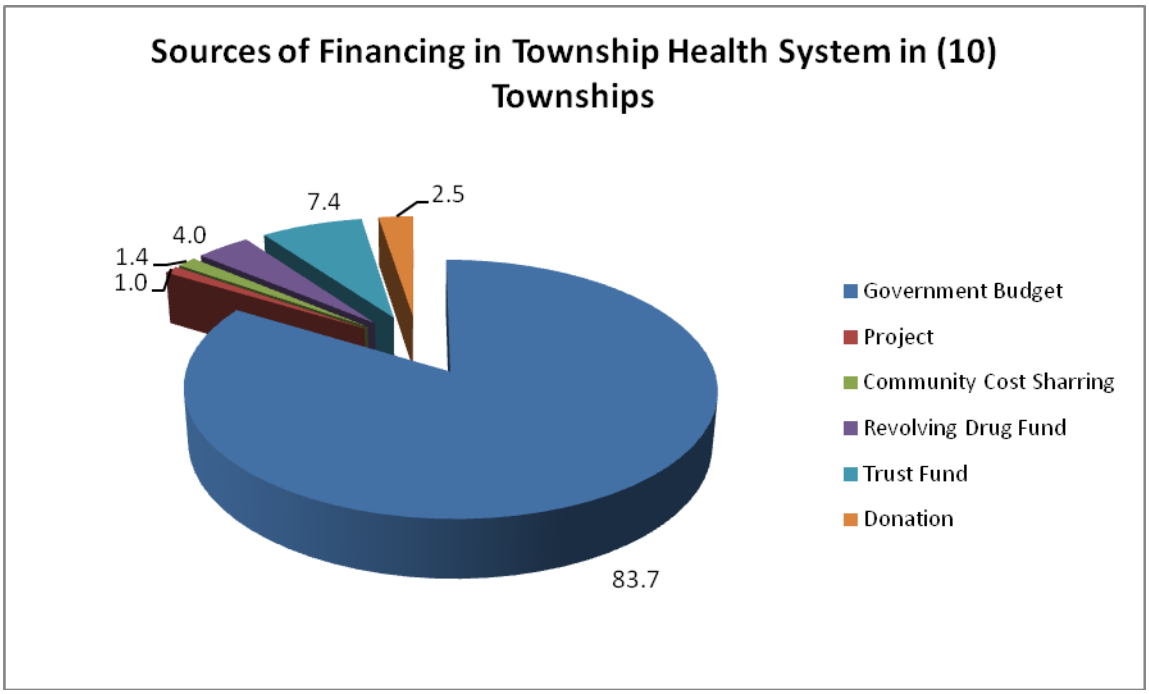
FINDING 2 Township Operations are constrained by very Low Operational Budgets and inconsistent performance of alternative financing mechanisms. This is leading to high out of pocket expenditures by community members

The very low operational financing for Township health systems is without doubt contributing to very low demand for services, as demonstrated by low hospital utilization rates and the high percentage of delivery cases not attended by a trained professional. It also contributes to very high rates of out of pocket expenditures by the public, many of whom are required to take out interest bearing loans or sell assets to finance their care. The findings of this review are consistent with those reached in recent health system assessments conducted across the country. These findings are that the current operational expenditures of

Township Health Systems are well below the required investment to meet the health needs of the population. With catchment populations of 200,000 – 300,000, Township health administrators are managing operational budgets of as low as $3,000 per annum. The vast majority of the Township Health budget (up to 90%) is expended on salaries, leaving little space for investment in basic hospital operations such as essential medicine procurements, equipment supply and food supply and running costs including electricity and communications. What budget that is available is utilized for transport, communications and administrative support.

These findings are consistent with a recent review of Township health budgets in Myanmar through the HSS program. What this review in 10 Townships found was that overall financing in township health system was financed from the government (83.7%), project source (external source) (1%) and community source (15.3%) (which includes revolving drug fund, community cost sharing scheme, trust fund and donation). (DHP, 2010).

Figure 5 Sources of Financing for Township Health Systems (DHP, 2010)



Given the very narrow national budgetary space for operations, and the limited impact of existing alternative sources of financing, then there is only one other source of funds and that is from the pockets of the populations. This is reflected in the National Health Accounts data, which demonstrates that between 80% and 90% of health care nationally is funded through out of pocket expenditures.

Reviewers observed some positive trends both in the field and during national strategy discussion in the response to this problem, both on the demand and supply side, which point to feasible options for health care financing for Township health operations. This will be discussed in the conclusion to this review.

6.6 Existing Alternative Health Financing Mechanisms

FINDING 3 Existing Alternative Financing Mechanisms do not generate sufficient revenues to meet needs. Performance of alternative schemes is inconsistent, and success is too dependent on the management capacity and commitment of the TMO.

The problem of out of pocket financing of health care was detected in the early 1990s. With the advent of the National Health Policy in 1993, alternative health financing mechanisms were established. These included interest bearing Trust Funds for the poor, community cost sharing (user fee systems) and drug revolving funds. At the sites visited, the systems were either not functioning at all or were far too limited in their capacity to generate sufficient revenues to meet the needs of the poor in very large population catchment areas.

At both sites in the Delta, the interest from Trust Funds could support the catastrophic health needs of no more than 2 or 3 patients per annum. As noted in more recent assessments, Trust Funds do no generate sufficient interest to have any significant access on improving health care access for the poor. In Maungdaw, the procedures for utilization of the fund (requiring 3 signatures from Township Health Committee members) were considered too cumbersome. In Another main constraint of the system (as is the case with referral funds described below) is the difficulty or appropriateness of health staff in identifying who is poor and who is not. Others indicated that the schemes were too "personality dependent" and relied on the management capacity and commitment of the TMO. In one location however (in Kyaukpadaung Township), Trust Funds, CCS and Drug Revolving Funds were utilized to supplement funds for the poor from Health Foundations and local Community Based Organizations.

Community cost sharing is implemented, but mechanisms for identifying who and how the poor can be exempted remains unclear. There was some limited evidence of informal charging for services in the form of consultation fees. Essential medicine costs were stated by some community members and implementing partners to be higher than recommended amounts for reimbursement to eligible beneficiaries. Others noted that there was not sufficient transparency for community members regarding user fee costs.

Drug revolving funds are underutilized. Implementation remains highly dependent upon the commitment and capacity of the TMO. Previous reviews of these schemes have identified that main constraints to successful implementation of these schemes is the lack of clear strategy and procedural detail and no systematic approach to determining eligibility for benefits (ie. poverty identification schemes).

Given the limited and inconsistent impact of these schemes, ways and means will need to be indentified on how to build revenues and link these schemes to more comprehensive systems for financial protection. Nevertheless, managers pointed out that in principle the approaches are correct, and that what was lacking was sufficient investment in these funds to make them more effective. But as to just where this additional funding would be sourced was made less clear.

6.7 Effects and Challenges of More Recent Innovations in Health care Financing

FINDING 4 Recent innovations in health financing are having some positive organizational and health effects, but are limited by project mandates, and will require constant review and revision, and much higher public sector investment, in order to meet these implementation challenges.

Emergency Referral Schemes

Innovations in health care financing, especially the emergency referral funds as implemented in the Delta, are having impact on facilitating referral of emergency cases to hospitals. Success factors seem to be an active community participation strategy modeled on the "Village Health Committee" , and a system of reimbursement of transport , social support and medical care costs by implementing partners (INGOs in this case). Nevertheless, implementation challenges are also significant. The poor are disadvantaged by the system of *reimbursement,* which in some cases reported here required the taking out of loans and selling of household assets in order to access referral and care. Additional costs were also reported to be incurred by the patients including additional essential medicine costs, *payments to providers* in the form of "gifts" [1] or "consultation fees" or "donations" for health staff and additional social support for accompanying family members. Not all were convinced that the current system of *poverty identification*, based on qualitative VHC assessment, was necessarily the best and fairest system for deciding on eligibility. VHC members and providers were of the view that the criteria for eligibility for the schemes (emergency obstetric case, child under 5) were much too narrow to meet the emergency health care needs of the poor.

Despite these implementation challenges, the referral schemes are a positive step forward in limiting the impact of catastrophic health expenditures on the poor and improving their access to hospital care. In one Township in the Delta, there were over 1,500 women and children assisted through this mechanism in a 9 month period. The role of coordinated planning and consultation mechanisms and the development of village health committees in these locations, indicates the financing strategy has been effective in supporting the development of potentially longer term *governance arrangements* to support improved health access.

Other Schemes: Voucher Schemes and Equity Funds and Pre Payment Schemes

A set of health financing initiatives are now being proposed in Myanmar. These are at the proposal and feasibility stage.

Hospital Equity Funds: Through the GAVI Health System Strengthening Initiative, a proposal is in place to fund approximately $8000 per Township annually (up to 180 Townships over a 4 year period) to provide subsidized emergency care for women (Obstetric Conditions) and children (under the age of 5). There is a funding cap of 100,000 per client. Eligibility is for the poor for maternal and child health emergency care. Poverty status will be assessed by providers and local authorities prior to referral.

Maternal and Child Health Voucher Schemes: This proposal is based on the findings of a feasibility assessment conducted by the Dept. Health Planning, WHO and HITAP. This study identified high out of

[1] Note: Community members indicated that gifts were on the basis of voluntary contribution, and were not requested by providers

pocket expenditures by families for basic maternal health care, and is proposing a s system of vouchers to provide subsidized care for basic and emergency referral MCH services.

Township Micro-Protection is a proposed Township wide system for pre payment of health care. The proposal is at a feasibility assessment stage. Feasibility findings reported at a dissemination meeting in February 2012 indicate that communities members spend approximately 30,000 Kyats per capita on health per year, but report a willingness to pay 2,200 per year for contributions. As a result, such schemes would require substantial State or ODA subsidies to be sustainable. In other locations, pre payment systems are being trialled and developed. In Mon State, with support through IOM, a Village Health Fund is established and funds are revolved through establishment of micro credit enterprises. IOM Outreach health workers are appointed to prove technical support and oversight.

6.8 Township Categories for Implementation of Health Financing Schemes

FINDING 5 There are multiple health financing schemes operating within single Townships, mostly with a project specific mandate, targeted medical benefits package, limited coverage and varying levels of coordination with the Township health system. The varying levels both of development (social, economic and organizational) and system coordination between different areas mean that health financing strategy will need to be adapted to the local context.

In a single Township, the following variety in models of health financing was located:

(a) Operational Funding for a Township Health Plan
(b) Drug Revolving Fund
(c) Hospital Equity Fund
(d) Direct Service provision for OPD by an NGO (free of charge)
(e) Emergency referral Schemes for maternal and child health
(f) Referral Schemes for management of the three diseases
(g) Free of charge nutrition care centres
(h) Out of Pocket expenditures on community cost sharing (user fee systems)
(i) Out of pocket expenditures on Private sector clinics
(j) Out of Pocket expenditures on Traditional health care
(k) Operational expenses through government revenues

There are also proposals in place for Township Health Micro-protection and maternal and child health voucher schemes.

The table below summarizes the schemes reviewed.

Table 3 Classification of Schemes According to Source, Payment Modality and Benefit Package

Type of Finance or Scheme	Source of Revenue	Purchasing	Provider payment Modality	What(Benefit package/who(Pop) Does it cover
Village Health Committee Pre Payment Scheme	*Community Risk Pooling:* Pre Payment Schemes by Village Health Committees.	Using the VHC Fund to reimburse local transport providers for service provided	Direct payment to provider of transport	***What is covered***: Emergency conditions and referral, which usually can cover transport costs only. So, and in other cases for TB and malaria referral. ***Who is covered****?* In some cases for emergency obstetric cases and under 5 children, and in other cases for TB and Malaria. Some VHCs collect donations for other emergencies.
Township Micro-Protection Pre Payment Scheme (Proposal Stage Only)	*Township Risk Pooling:* Pre Payment Schemes in communities through Township Micro-Protection	Unclear at this stage	Unclear at this stage	***What is covered****: ?* Unclear at this stage ***Who is covered****:?* Unclear at this stage
Public Sector Salaries and Operational Funding	*General Revenue*	Payments to public providers for service and operational costs to health facilities	Salaries to the health care providers and line item budget to the health facilities.	***What is covered****:* Provision of care and prevention services at the facilities and community outreach. ***Who is covered:*** For all medical, surgical and PHC care
Community Cost Sharing (CCS)	Community cost sharing	Service/user fee(bed, investigations and X Ray **)** to the health facilities for those who can afford to pay exemption systems for the poor	-	***What does it cover:*** Essential medicines and investigations ***Who is covered*** : Poor patients from the community
Drug Revolving Funds	*Seed money donated by community well wishers and revolving interests??.*	Use of CCS Funds to procure essential medicines with exemption systems for the poor	-	***What does it cover:*** Essential medicines ***Who does it cover***: Poor patients
Township Trust	***Township Risk***	Payments made	Payments to	***What does it cover:***

Funds	***Pooling/voluntary contribution by township well wisher)*** *:* Interest bearing Township Accounts for provision of care for the poor – 1 Bed 1 Lakh)	to hospital services for the cost of care (procure medicines) provided to the poor	hospital to cover costs of provision of care to the poor (requires THC endorsement)	Essential medicines and other essential medical care costs ***Who does it cover:*** Poor patients from the Township
Hospital Equity Funds	Donation from donor (GAVI) to establish Health Equity Funds at Hospitals.	Payments by GAVI to hospital. patients to cover Transportation, food, and hospital for medicines and procedures with a funding cap of 100,000 kyats per township	Fee for service	***What does it cover***: Medicines and procedures) ***Who does it cover:*** Poor mother and children needing emergency inpatient care.
Emergency Referral Funds according to project Mandate (Nutrition, MCH, Child Health, 3 Diseases)	Establishment of Emergency Referral Funds for care for the poor	Reimbursement to beneficiaries and to hospital services by implementing partner for care provided to the poor .	Usually a payment to providers for the procedures and essential medicines, and a payment to the community member (reimbursement) for transport, food and social support	***What is covered***: Emergency conditions and referral, which usually cover transport, social support, and essential medicines and procedures. ***Who is covered****?* In some cases for emergency obstetric cases and under 5 children, and in other cases for TB and Malaria, in some cases for nutrition, in some cases for any emergency.
Free health care provision by INGOs or NGOs or CBOs	Community wide free Health care through direct service provision by INGO, NGO or CBO	Block Grant by development partners to INGOs for direct service provision. Pre payments from the community for CBOs Donation of labor time by health practitioners for free provision of care by some CBOs	Salaries for health care providers and line item budget for facilities??	***What does it cover?*** This depends on the project mandate. It may include essential PHC care for all of the population. O there maybe a specific project mandate (MCH, nutrition, HIV AIDS etc) ***Who does it cover?*** Eligibility depends on the mandate – sometimes it is only the poor and sometimes not. Sometimes it is women and children, and sometimes the whole population
Maternal and	Pooling of	Reimburse the	Payments to	***What does it cover:***

Child Health Voucher Schemes (Proposal Stage Only)	MOH/DP/GAVI funds for provision of care to eligible populations (MCH and poverty status)	providers/health facilities for provision of MCH care to poor patients holding MCH vouchers.	providers for provision of agreed package of care.	Food, transportation medicines and investigations. ***Who does it cover:*** Poor mothers and pregnant women (eligible for MCH vouchers).
Community Based Organization or Health Foundation Donation schemes	Mix of donations and pre payment mechanisms by Foundation or CBO members	Funds used to purchase services for direct provision of care or for emergency transport	-	***What does it cover:*** Depends on the CBO or Foundation Mandate – most commonly care of pregnant women and emergency referral ***Who does it cover:*** Poor mothers and pregnant women or all emergencies. In some cases, direct provision of free care to the population, regardless of income status.

Most commonly, the variation in health financing model depends on the project mandate, the context of demand side barriers in each location and the leadership and management capacity of the TMO. The project mandate sets the scope for eligibility and entitlements, with some schemes focusing on maternal and child health, others on nutrition, and others on one or all of the 3 Diseases. Township financing models are universally built around the approved MOH models of Trust Fund, CCS and DRF, although the systems are not always implemented, revenue is too limited and capacity for implementation varies from Township to Township. Although it is not possible in the scope of this review to determine the proportion of OOP invested in any particular constituency, in some areas (particularly Northern Rakhine State), out of pocket expenditures through the private and traditional sectors were very common.

In terms of the health and development context, the review has observed that there is significant variation in level of social and economic development. In the context of Northern Rakhine State, due to lower levels of health infrastructure development, NGOs often provide direct services to populations for free in addition to referral of emergencies to government service networks. Also due to cultural and language differences and poverty rates, the challenges for demand side barriers, coordination and system development are significantly higher. In contrast in the Delta region, due to the significant NGO presence over the years and to the development of coordinated planning and supervision mechanisms, there are stronger organizational capacities and partnerships development which enable more scope for harmonization of systems and procedures. In Mandalay Region (Kyaukpadaung Township), there is a higher level of socio economic development, which has led to higher rates of donation, more capacity for referral, and the development of a number of Health Foundations and Community Organizations which provide subsidized care for the poor.

There are also early plans and conceptual developments in the areas of voucher schemes, hospital equity funds and Township Wide Micro-protection (ie. pre payment schemes). These schemes have the potential to be more system wide rather project based, and include systems for poverty identification (in relation to voucher and HEF schemes), potentially provider payments, a standard schedule of medical and social benefits and assessments of client satisfaction. These systems presuppose a higher level of organizational and partnership development. It is for this reason that respondents in this review highlighted the need for time and investment in capacity and partnership development so as to transition to a system of scheme management that can deliver increased depth (service package) and breadth (population) of coverage.

In summary, three categories of health financing mechanisms have been identified in the review.

Category 1 refers to the earlier level of development, whereby there are multiple project based schemes with at early stages of coordination and with high demand and supply side barriers. The application of voucher schemes and pre payment schemes will be less feasible in these contexts, as communities have lower education levels, higher poverty rates, and, most importantly, significantly lower quality and supply of public sector health care providers and delivery systems. Emergency referral (or hospital equity funds) may be the logical place to start with financing strategies here.

Category 2 refers also to multiple project based schemes but with stronger coordination systems and with some interventions to address supply and demand side barriers. This would make it more feasible to commence pre payment schemes, with targeting of the poor through hospital equity funds and/or maternal and child health voucher schemes for the primary level of care.

Category 3 is at concept or early proposal stage, and refers to Township wide schemes (or single scheme) under a Township Funds Manager with well established systems and increased breadth and depth of coverage. It may be feasible in Township with higher levels of socio economic development, and more developed health systems, to implement Township Based Micro-Protection for the majority, and consider the option of implementation of equity schemes for the poor for a transitional period.

Table 4 Three Categories of Township Health Financing Development in Myanmar

Category	Attributes	Location and Scheme Titles
Category 1 *Project based multiple schemes at an early stages of coordination with very high demand and supply side barriers*	Multiple Schemes and Funding mechanisms Project Specific Schedule of Benefits Direct Service Provision of NGOs Significant demand and supply side barriers Coordination Mechanisms at an early stage of development or not yet formalized No provider payment schemes No prepayment schemes	**Northern Rakhine State** *(a) Emergency Referral Schemes(MCH and / or 3 Diseases)* *(b) Nutrition Centres* *(c) 3 Diseases Referral Schemes* *(d) GAVI HSS Equity Fund* *(e) Free Direct service provision by NGO (OPD services)*
Category 2 *Project Based multiple schemes but with stronger coordination systems and with interventions to address supply and demand side barriers*	Multiple Schemes and Funding Mechanisms Project Specific Schedule of Benefits Service delivery through government systems Demand and Supply side barriers significant but more capacity to address Early Establishment of Coordination mechanisms under leadership of Township Health Authority or Local Government (Laputta) Early attempts at harmonization of procedures Commencing project based or community systems for poverty identification No provider payments schemes Limited village based pre payment schemes at project sites	**Dedaye, Bogalay and Laputta and Mon State (IOM), Kyaukpadaung** *(a) Emergency Referral Schemes (MCH and / or 3 Diseases)* *(b) Pre Payment Schemes at Village level (through VHCs)* *(c) Trust Funds, CCS, Drug Revolving Funds*
Category 3 *Township wide schemes (or single scheme) under a Township Funds Manager with well established systems and increased breadth and depth of coverage*	Reduced number of Schemes with one main funding and governance mechanism Well Established Planning and Coordination System System defined wider schedule of benefits System defined method for poverty identification System of provider payments System for assessment of quality/patient satisfaction Commencement of Township wide prepayment schemes	**Not yet implemented (a-c)** At proposal or concept stage *(a) Township Micro-Protection* *(b) MCH Voucher Schemes* *(c) Health Equity Funds* *(d) Trust Fund, CCS, DRF* *Potentially with single Funds management mechanisms and oversight through THC Funds Committee with implementing partner Fund Operator*

FINDING 6: There are feasible policies and strategy options for improving health financing performance, but this will require significant investment in public sector health systems development and will involve strategy decision making on approaches to this system development

If the three categories described earlier can be viewed as a transition, then significant system developments will be required to make this transition towards schemes with greater depth and breadth of coverage. These system developments will include the following:

1. A Common Schedule of Benefits
2. A Common Poverty Identification Mechanism
3. System of Provider Payments
4. Quality Assessment Mechanism
5. A Common Governance mechanisms (a Common Strategy and a Common Management or oversight mechanism, and potentially a Common Funds Mechanism)
6. An improved national and sub national planning system with significantly higher levels of public sector financing and Overseas Development Assistance

In practical terms this means transitioning from a stage of existing Township Financing Schemes and Emergency referral funds towards more comprehensive financing systems with a common governance mechanism, clear target population, larger investment pool, and a wider benefits package. Currently, multiple schemes operate within single Townships, but have demonstrated potential for higher harmonization and efficiency of operations in terms of management, procedures and benefits.

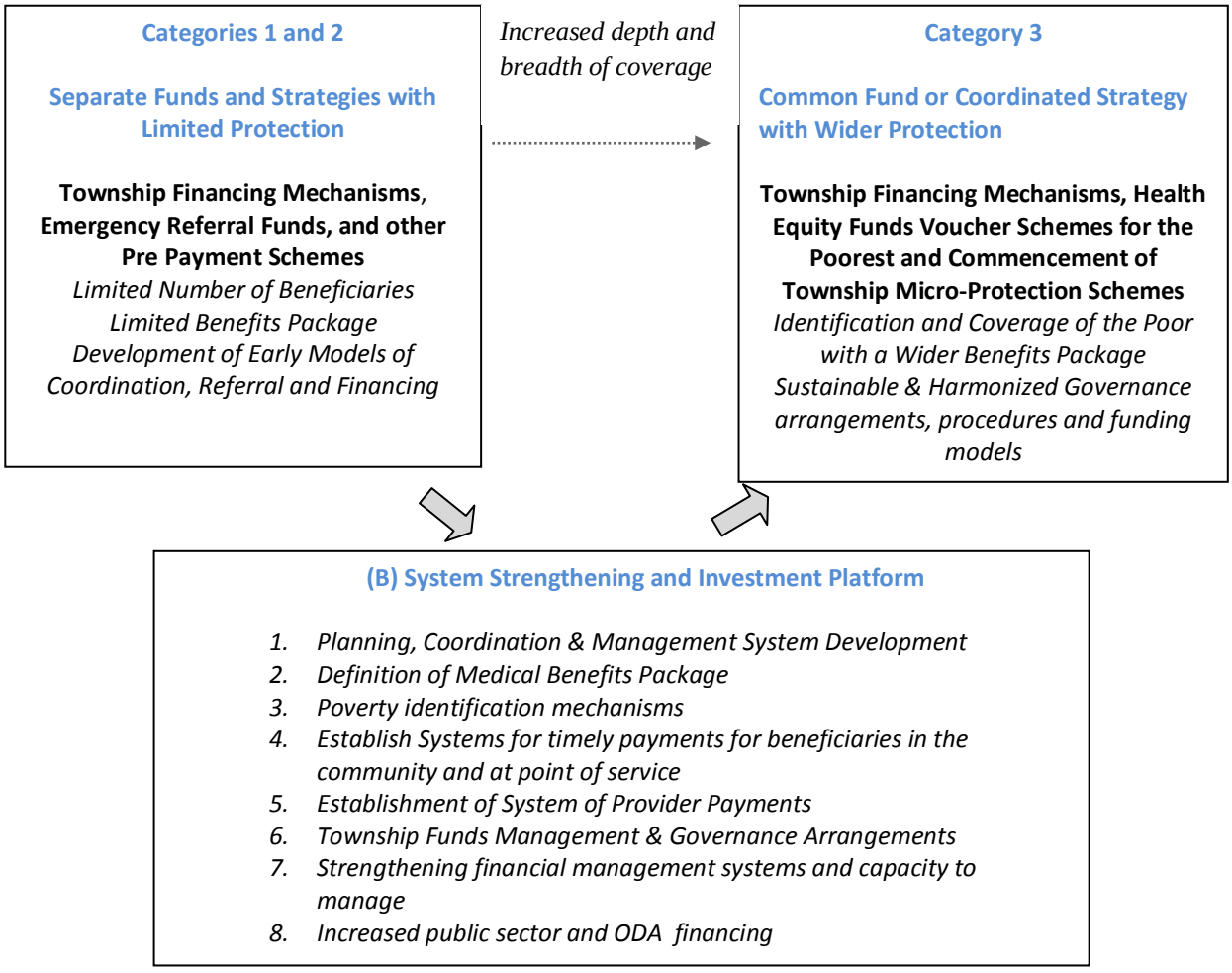
To obtain wider coverage for the poor, what is evident from this review is that pre identification of the poor, a wider benefits package, provider payments and timely provision of funds *in the community and at the point of service* are all critical factors in ensuring that the poor can access health care, especially for catastrophic health events. Health Equity Funds and Voucher schemes are designed for these purposes, in so far as they exempt the poor from payment at the point of care, and can be designed to ensure some form of provider payment. Pre payment mechanisms contribute to ensuring that there is timely provision of care in the community and at the point of service, and offer more prospects for sustainability. Adequately financed operational health plans ensure supply side investments are adequately in place to meet the health needs of populations.

This review has found that there are clearly a number of procedural areas and governance arrangements that could be harmonized and aligned into a national strategy at a later date, provided time and resources are invested in the required system , organizational and human resource developments.

In practical terms, this will mean research, design and test of more comprehensive models in Townships that are at the midway point through category 2. A well established coordination mechanism should be in place, with investment in demand side initiatives and improved supply side quality of services. It may well be the case that Townships at the level of Category 2 may need 1 or 2 years to strengthen these aspects of the system before transitioning to Category 3. For Townships at Category 1, steps should commence as soon as possible, but bearing in mind due to the organizational and social context that it will take longer to transition towards a wider protection organizational framework and delivery system.

To make the transition from Category 1-2 to category 3, the idea will be to obtain greater breadth of coverage (in terms of population covered) and depth of coverage (in terms of number of medical benefits and social support package). But to make the transition, investment will be required in system development and national and ODA investment to ensure that the transition is sufficiently resourced to be scaled up, particularly in relation to supply side investments.

Figure 6 Required System Developments and Investments for Transition to Schemes with Greater Depth and Breadth of Coverage (intermediate Stage of UHC)



7. Strategy Options for Improving Health Financing Performance

Main strategy and procedural options for consideration in undertaking these transitions from category 1 onwards are suggested below.

In considering these options, it is important to note that not all strategy options can be implemented in the short term, while others can. Generally speaking, a selection from options 1 – 4, and 10-11 could be implemented within a shorter time frame, and guide consideration of longer term strategy options (5 – 9).

1. ***Planning System:*** Is there a Coordinated Township Health Plan? Is the plan addressing supply and demand side gaps? Is there a National Health Plan Mandate and Strategy for social protection?

It is difficult to envisage Township or Nationwide financing schemes in the absence of a coordinated planning system that identifies community health needs and the collaborative management and service delivery activities that will need to be undertaken to reach them. In order to harmonize health financing schemes, it will first be necessary to harmonize health assessments and priority activities so that financing is directed at those most in a need with a consistent strategy that can be evaluated. This is a main point also in terms of efficiency gains and aid effectiveness, by promoting an approach to health service delivery based on a shared planning approach. Strategy options to consider include the following:

(a) Strengthening national health planning and costing processes (including NHA), including identifying a national health system mandate and strategy for social protection (expanding health care access for the poor)
(b) Scale up of coordinated township health planning system, including costing of activities, identification of funding gaps, and identification of funding from all sources (including health financing initiatives)
(c) Smaller scale micro-planning targeted at high risk groups including the rural poor, remote areas, internally displaced or refugee populations, the urban poor, migrant populations and ethnic minorities
(d) Combination of the above options

2. ***Coordination Mechanism:*** Has a Township Health Coordination mechanism been established under the direction of the TMO with participation of local government and implementing partners? Are there national level processes for coordination of national strategy on health care financing?

As a corollary to coordinated planning, coordination mechanisms, under the leadership of the Township Health Authority and at each level of the health system, will need to be strengthened in order that different stakeholders (local government, INGO, national NGO, BHS) can share information on strategies and activities, and problem solve issues of implementation. By working to a Coordinated Plan, it should become more possible to work towards a Health System Mandate (systems goals and strategies) rather than a Project Mandate (project goals and strategies). This applies even more importantly to the development of National Health Planning and State /Regional Planning processes. Options to consider include the following:

(a) Strengthening of national health coordination mechanisms such as the CCM (TB , Malaria, HIV AIDS) and Health Sector Coordination Committee (HSS)
(b) At State and Regional levels, and Township levels, establishment of coordination mechanisms to oversee coordinated plans and health financing initiatives from a range of sources

3. ***Harmonization of Health Financing Procedures:*** Are coordination forums being used to strategize ways to harmonize scheme management and implementation?

Harmonization of procedures is a major step towards attaining higher coverage for health financing schemes. It ensures that there are clear expectations for staff and community members on procedures and entitlements, and should pave the way for development of Township wide financing schemes. Strategy options for harmonization include the following:

(a) Planning and Coordination systems
(b) Poverty Identification Systems
(c) Medical Benefits Package
(d) Referral Mechanisms
(e) Provider payments system
(f) Pre Payment Mechanisms
(g) Governance Arrangements and Funds mechanisms

4. ***Medical and Social Support Benefits Package:*** Is the medical benefits package for beneficiaries consistent and/or complementary across the Township? What should be the scope of this medical benefits package?

Defining a Township wide or National medical Benefits package would ensure that there is consistency in approach, and will assist implementers and community members to have a clear expectation of their responsibilities and eligibility to entitlements. This also applies to other social support entitlements. There will need to be consistent standards and procedures across the Township for benefits for beneficiaries with respect to transport, accompanying person's costs, food entitlements and other benefits. Options for an essential Medical and social benefits package include:

(a) Essential obstetric care
(b) Under 5 Child Care
(c) Communicable disease prevention and control (TB, Malaria, HIV)
(d) All OPD
(e) All emergency care
(f) Social support (home based care, transport, food and accommodation, accompanying family costs)

The advantage of a more comprehensive package is that it will be more responsive to community health needs. The advantage of the MCH package only is that services will be more targeted to areas of greatest need in the context of resource scarcity.

5. ***Which Health Financing Model should be selected?*** What are the options for introducing health financing schemes, and how could their introduction be sequenced across a Township and across the country?

Given the fact that Townships have varying levels of socio economic and health system development, this review has found that health financing strategies will need to be adapted to the local area context in the short to medium term, with the aim for consistent standards and entitlements as the country transitions closer to universal health coverage. It would not be feasible for example to implement MCH voucher schemes in communities where there is one midwife for every 20,000 to 30,000 population or where there is no midwife at all. Similarly, Township Based Micro-Protection may be less feasible in Townships where the poverty line is too high (Category 1). However, in Townships where the level of both socio economic and health system development is higher (Category 2 & 3), these options would be more feasible. But the question is, would targeting of the poor with voucher schemes and health equity funds in these Townships impact on the successful scale up of Township based Micro-Protection? (ie. poorer communities will not make prepayments as they are already protected). Alternatively, could HEF and voucher schemes be considered as transitional schemes as public sector investment and pre payment systems are gradually scaled up?

This review has found that Hospital Equity Funds for the poor (alternatively referred to as Emergency Referral Funds) could be implemented in most categories as they provide protection for some of the poor at the point of service. Options for sequencing the introduction of health financing schemes in townships can therefore be summarized as the following:

(1) *Single schemes strategies* can be introduced in Townships according to the level of socio-economic and health system development. For example, Township Based Micro-Protection in more developed Townships, Hospital Equity Fund schemes (including existing health financing mechanisms) and primary care MCH vouchers in less developed Townships.

(2) *Multiple scheme strategy* can be introduced in Townships. Township Based Micro-Protection could be introduced gradually to all Townships (commencing with pilots). In the same Townships, HEF schemes for hospitals (including existing health financing mechanisms) and vouchers for primary care MCH could be introduced as a transitional measure targeting the poorest of the poor only (lowest socio economic quintile). This is based on the premise that it may take longer to scale up public investment and prepayment schemes such as Township Based Micro-Protection, which will require that in this transitional period the poor are protected through alternative schemes.

(3) *Supply Focus and Removal of CCS (user fees)*: In category 3 Townships (those with lower level of health system development and lower socio economic status), the main financing strategy should be on health system development, particularly in regard to infrastructure, human resource placement and retention, and procurement and logistic systems. In these areas, removal of user fees could be considered, alongside introduction of health equity funds to reduce the impact on the poor of catastrophic health expenditures.

The advantage of the first option is less organizational complexity and ease of management. The disadvantage is lower social protection for the poor in a transitional period (the length of time of which is difficult to assess).

The advantage of the second option is higher protection of the poor in the transitional period. The disadvantage is that management will be more complex, and will require a wider range of implementing partners (CBOs and NGOs) in order to implement.

The third option is context specific. It will require the identification of "high risk Townships" according to a set of socio economic and health indicators.

Whichever approach is adopted, the main strategy will need to be underpinned by increased public investment in health care. In order that the poor are reached with at least a basic package of both curative and preventive services, this increased public sector funding will need to be decentralized to Township level, to ensure the operational funds are available for extending services to hard to reach populations.

6. Poverty Identification Mechanisms: Are there consistent standards for poverty identification?

There are alternative mechanisms for identifying who is eligible for entitlements. In this review, poverty identification by providers is often undertaken. Generally speaking, this approach is not recommended internationally because of the risk of stigma or misclassification. Options to consider are as follows:

(a) Pre identification (i.e) before arrival at facility through household questionnaires
(b) Pre identification through participatory community appraisal (wealth ranking)
(c) Pre identification according to health worker or local government recommendation
(d) Post identification (after arrival at facility) of the poor can be provided by a third party agency applying a consistent method of data collection on income and / or assets.
(e) Post Identification by resident health staff.
(f) A combination of pre and post identification systems
(g) A systematic effort nationwide to undertake poverty assessment through local government channels or through a system of social welfare registration

The comparative advantage of option (a) (survey) is more rigour in the assessment method and reduced risk of misclassification of the poor.

The comparative advantage of option (b) (community appraisal) is ease of management and reduced administrative costs, although the risks of misclassification of the poor may be higher (particularly in relation to migrant or highly marginalized populations).

Option (c) (health staff classification) is more manageable, but there can be risks of misclassification and potentially stigma for the poor.

Utilizing a combination of pre and post identification of the poor can be effective (option f), as it reduces the risk that the poor will be missed or misclassified.

Regardless of the option exercised, the method should be consistent across the Township (and eventually the nation) using standard data collection tools and income/assets criteria. Once again, this is to ensure

clear expectations from the provider and the community on entitlements and eligibility, and reduce the risks of misclassification.

7. ***System of Provider Payments:*** Have policies and procedures been put in place for regulation of provider payments?

Throughout this review, respondents have highlighted the major role that staff motivation and remuneration plays in ensuring quality of care for the poor. Notwithstanding high levels of commitment of health providers to care for the poor, it nonetheless remains the case that health financing schemes are considered non sustainable in the absence of either substantially increased salary systems or without a system of provider payments. In the absence of such systems, rules and procedures for regulation of payment, informal payments and increased private practice will become the rule instead. This area of system development is critical for Townships who are considering transition to Category 3 (systems with wider depth and breadth of coverage). Options for improving the situation of provider payments include the following:

(a) Increasing government salary rates through Civil Service Salary Reform
(b) Payment to providers according to diagnostic category (fee for service)
(c) Performance Based payments or ”Block Grants” according to agreed coverage targets (performance contracting either with facilities or with individuals)
(d) Defining rules and regulations governing informal fees and private sector practice for government employees (in the context of introduction of system of provider payments)
(e) Payment of remote area allowances for basic health staff
(f) Any combination of the above options

Ignoring these Strategy options may result in reduced motivation of health staff, and potentially a decline in the quality of health provider behaviors. It may also increase the phenomenon of “double job holding”, informal payments and public sector drift into the private sector, which is a pattern observable in many regional countries. On the other hand introducing provider payments systems poses challenges for public sector reform and for sustainability if highly dependent on development partner funds.

8. ***Quality of care*:** Are there systems for assessment of patient satisfaction or with quality assessment of services? Are the community members and other investors in health insurance receiving value for money for their investment?

Currently implementing partners are investing in emergency referral and other subsidized forms of care but there is lack of clarity on what the quality of care has been, particularly from the perspective of the clients. In line with global strategies of “patient centred” and “responsive” health care systems, and more accountable and transparent management systems, the strategy option could be considered for institutionalizing systems of client satisfaction with services and quality assessment. Procedural options include exit interviews, complaints mechanisms, facility accreditation systems and community follow up of discharged patients. This strategy option should be considered with systems of provider payments, and in particular during transition to category 3 when the investments may be much higher.

There are few disadvantages to this approach. The main one is the additional administrative cost associated with system development and implementation. The main advantage is improving the extent to

which health systems are responsive to community needs and expectations and meet a minimum set of quality standards.

9. ***Township Health Financing Funds Mechanisms and Governance Arrangements:*** If there are a number of funding mechanisms, what opportunities are there for pooling the funds or if not, at the very least, linking the strategies or developing a common Governance arrangement (i.e. with a single Funds operator) ?

The review has found that there are a wide variety of funding sources for health financing initiatives, each with their own procedures, benefits package and administrative network. Sometimes implementing partners provide subsidized care in parallel with government services. In one case, single implementing staff far outweigh in numbers BHS staff. There are also multiple administrations for management of financing schemes. This raises questions about efficiency, aid effectiveness and sustainability. Options could be explored for funds pooling, or at least, linking of the strategy under a single governance arrangement. There are many options for undertaking this approach.

(a) The Ministry of Finance has established a funds flow from the MOH directly to the Township for pro poor financing. These same mechanisms could be utilized for other funding sources. The prospects for direct financing of Townships through other development partner sources (eg. proposed MDG Fund of 2013) increase the likelihood of this option.
(b) Implementing partners, in collaboration with TMO through the Township coordination mechanism, could agree on common strategies, procedures and systems for health financing, and regulate and monitor this through the Township Coordination mechanism (Category 2)
(c) A Funds Management Committee (represented by THC, community members and TMO) provides oversight for the pro poor funds. An implementing partner (or "Township Funds Operator") would be required to work with the Funds Management Committee for implementation of poverty identification, provider payment and patient satisfaction systems (Category 3). This requires a higher level of organizational development and strategy decision making.
(d) To support a Township Health Financing Governance mechanism, local implementing partners (CBOs or NGOs or Foundations) should partner with the Funds Manager with roles in community advocacy for referral, pre payment systems, poverty identification, and community and health facility liaison.

There are many advantages and disadvantages to governance arrangements which will require detailed design. However, some basic minimum requirements would be a Funds mechanisms in the Township and an implementing partner (3rd party arrangement) to assist the Funds Manager to implement at the community level. The implementing partner could be external (NGO, CBO or Foundation) or be internal (local government, health system and community networks of VHC and CHWs).

10. ***Tax based Financing, Social Health Insurance and Overseas Development Assistance (ODA):*** Are national government and ODA targets for health sufficient to manage a staged scale up of health financing schemes into a national strategy with wide coverage for the poor and a standard package of medical and social benefits? What are the targets for expected coverage through Social Health Insurance?

In order to ease the burden on the population for out of pocket expenditures, there are three main sources of funds available. These are tax based financing, ODA and national pre payment schemes (social health insurance). As noted in the main report, the share of national budget allocated to health has declined in recent years, although, as noted in the earlier sections of this report, recent reforms may see a change to this situation. Options for improving tax based financing of health include the following:

(a) Setting national health financing targets for health, particularly with respect to the percentage of government budget allocated to health, and advocate for political commitment to agreed budgetary targets
(b) Improve allocative efficiencies and aid effectiveness through (a) development, costing and financing of needs based Coordinated Health Plans and coordination mechanisms at all levels of the system (b) Costing and financing of funding gaps in a multiyear National Health Plan
(c) Consider the policy option of imposition of duties and tariffs on the alcohol and tobacco industries and earmarking the revenues for health
(d) Transitioning from a model of historical budgeting to implementation of funding models based on needs, activities and/or results (capitation based funding, activity budgeting, performance based funding)
(e) The setting of ODA targets for investment in health that is more in line with levels of investment in countries with a similar level of development.
(f) Revitalization and expansion of social health insurance systems to expand breadth and depth of coverage for eligible employees, with greater buy in from private sector investors

11. ***Development of National Health Financing Strategy and Strengthening of Processes for Strategy Development:*** Is their sufficient evaluative evidence from scheme operations and on demand and supply side barriers to inform the development of a national health financing strategy? What should be the timeline for development of such a strategy? How will policy dialogue take place to ensure all the policy actors, and technical and contextual issues are adequately represented and reflected in health financing strategy and strategy development?

The process for deciding on a strategy will be important to determining the quality of the strategy and its implementation. If there is sufficient evidence on effectiveness of strategies, evidence on the monitoring of revenue raising from the variety of sources including government, ODA, communities and through SHI, then clearly policy makers and planners will be in a stronger position to guide the design and scale up of a health financing strategy. Options for strengthening strategy processes and the quality of strategy development include the following:

(a) Setting a health financing research agenda and implementing it over a set timeframe
(b) Strengthening of technical cooperation capacity and collaborations with a wider regional network to ensure lessons learned from neighboring countries are built into the development of Myanmar Health Financing Strategy.
(c) Establishment or utilization of a national health policy forum on health financing, chaired by government, with participation of the main policy actors in the process
(d) Reference to a National Health Plan that sets a health system mandate for breadth and depth of coverage, and the main strategies by which this mandate will be exercised

(e) Publication and dissemination of NHA data and health financing research in regular strategy forums
(f) Conduct analysis of the available fiscal space for investment in health, and put in place mechanisms for consultations with parliament and the Ministry of Finance for setting of budgetary targets for health
(g) National stakeholders, including health planners and managers, development partners, and national and international NGOs, should strengthen coordination mechanisms and partnerships to ensure that capacity is developed to sustain the introduction of innovative health financing policies and mechanisms

12. ***Responding to Other Demand Side Barriers***: The review has noted that financial barriers are by no means the most important barriers to access to health care in some locations. How can policies options be exercised to respond to these barriers?

High risk groups for access to health care identified in this review include the very poor, remote area residents, the urban poor, refugees, and those communities with different language and cultural practices from the mainstream health care providers. Although these issues are too large for the scope of this review, it is very important to note that improving access will not necessarily be resolved through supply side investment and health financing initiatives. Other national lessons (picked up in this review) and international lessons would demonstrate there are viable strategic options to address these demand side barriers which include the following:

(a) Promotion of local employment strategies for AMWs, CHWs and midwives
(b) Strengthening of community participation mechanisms such as Village Health Committees
(c) Placement of local language "patient attendants" in health facilities to provide interpretation and social support for ethnic patients and their families
(d) Including in health financing packages adequate remuneration for social support to ensure that families can be in attendance with patients in hospitals
(e) Activating local community facilitation and income generation models, and other participatory methods for involvement in health
(f) Development of language and context specific communication media and materials

8. Conclusions and Next Steps for Consideration of Strategy Options

Respondents in this review pointed out that strengthening coordination (a necessary condition for harmonized health financing and governance arrangements) takes time in order to build trust, confidence and organizational capacity for coordination. What this review has found is that different areas of the country are at different stages of socio-economic development, with varying exposures to coordinated planning and management systems and implementation of health financing mechanisms.

This being the case, it is more likely that scale up of innovations in health financing should proceed according to the capacity of Townships in various areas of the country to manage and be supported in this effort, rather than on at this stage a national developed guideline or strategy with simultaneous "single model" nationwide implementation.

In the meantime, investments will be required in proposal design, technical assistance and health systems research in order to evaluate and refine those Townships in Category 2 and commence detailed designs of the feasibility of Category 3 (some of which are already underway for Township Micro-protection and Health Voucher schemes). Meanwhile, for Townships in Category 1, significant investment will be required in the development of coordinated planning and management systems, with investment in supply side human resources, infrastructure and operational funding, with some attention given to harmonizing agency efforts for emergency referral schemes and hospital equity funds.

Myanmar is now at the early stages from transition from the initial phase of health financing (high reliance on out of pocket payments) towards the intermediate stages of universal health coverage (implementation of pro poor health financing schemes including equity funds and systems of pre payment).

There is an array of health financing schemes being implemented through various agencies including Township Health authorities, UN agencies and non government organizations and communities. This review has found that the social and economic context varies significantly from Township to Township, as does the extent to which the coordination system for health has been developed and the extent to which supply and demand side barriers contribute to poor health access. Given these systems weaknesses and under investments, NGO projects step into this gap and sometimes provide direct services to the people. Alternatively, schemes operate according to a project mandate rather than to health system mandate. The schedule of benefits varies according to these project mandates, and is often too limited in depth and breadth of coverage.

In the short to medium term, some steps can be undertaken to harmonize and align existing schemes within Townships through a coordinated planning and management system. Areas for harmonization and alignment include the following:

- Systems for pre payment through village health committees,
- Systems for poverty identification,
- A definition of a medical benefits package,
- Consistency in entitlements of beneficiaries.
- Coordinated planning and management systems

Category 1 Townships in particular may require support for supply side investments and strengthening of coordinated planning and management systems. International lessons demonstrate that if this harmonization can take place, then the transition to wider schemes will be easier and more rapid.

In the longer term, in order to transition to more comprehensive schemes with increased depth and breadth of coverage, investment in system developments are required in the areas of coordinated management and planning systems, financial management capacity building, poverty identification, provider payment systems and assessment of patient satisfaction with services (which presupposes more investment in supply side quality of health care). This will require investment in HSS (particularly on the supply side through increased tax based financing and ODA) and test and development of schemes with greater depth and breadth of coverage, such as MCH voucher schemes, Hospital Equity Funds, and Township Micro-Protection. It is on the basis of these lessons learned that consideration could be given to development of a national health financing strategy in the coming 1 -2 years.

Annex 1: Examples of Health Financing Schemes Across the Country

(a) Laputta Township Health System Model – Trust Funds and Community Cost Sharing

Demand Side Barriers: In the Nargis affected areas, much of the population is still in the recovery phase of operations, so communities are reestablishing livelihoods. Although only 15% of the population is exempted from hospital service payments, the District Medical Superintendant estimated that 50% of the population is not in a position to afford health care services. In some cases, there are no funds from existing sources to cover the needs of the poor. In these circumstances, the hospital procures essential drugs on loan from a private pharmacy, and writes letters to the District Administrator to make repayments. If the poor do not have money they cannot come. Some who can afford it bypass the facility for services in Yangon.

Photo: Meeting with Village Health Committee in the Delta Region

The other main demand side barrier is distance. The newly constructed two hundred bedded hospital is a long distance from the main riverside town. The town administration has been resited on high ground post Nargis disaster which is where the hospital is now located.

Background To Health Financing Scheme: There are two health financing schemes in operation. These are the Trust Funds and Community Cost Sharing scheme. The Revolving Drug Fund is not operational On the supply side, the government provides a salary and operations budget (details below).

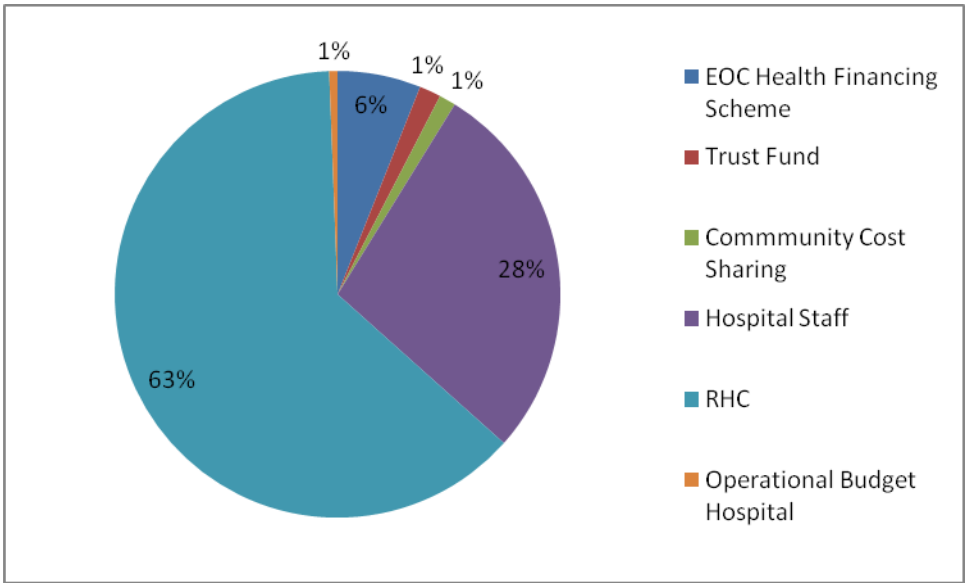
Funding/ Revenue: The Trust Fund only manages to provide $250 US revenue per month, which is likely to meet the catastrophic health needs of only 2 or 3 patients. Community Cost Sharing generates more funds. 50% of the proceeds are deposited into the "OA" Government account at Township level for

procurement of essential medicines and consumables. The remaining 50% is deposited in to the "MD" account and refunded to Treasury. The Trust Fund and CCS fall well short of meeting the needs of the population.

Table 5 Finance Per Annum by Funding Source Laputta Township (excluding out of pocket expenditures)

Finance Per Annum by Source	
EOC Health Financing Scheme	$ 10,000.00
Trust Fund	$ 2,600.00
Community Cost Sharing	$ 2,000.00
Hospital Staff	$ 46,000.00
RHC	$ 104,000.00
Operational Budget Hospital	$ 1,000.00
TOTAL FINANCE	$ 165,600.00
Population	500,000
Finance Per Capita	$ 0.33

Figure 7 Laputta Township Health Financing by Source (%) (excluding out of pocket expenditures)



Funding falls well short of needs. The TMO indicated that if there was a sufficient fund to support health care services for the poor, and the hospital advertised that services would be free, then the utilization rate would increase rapidly. Currently the bed utilization rate is 39%.

Beneficiaries and Eligibility Criteria : In relation to community cost sharing, eligibility for exemption for the poor is assessed by the physicians and surgeons on duty.

Operational Procedures and Benefits Package; There are operational procedures for community costs sharing with respect to set fee rates for X ray, laboratory and bed utilization.

Management /Governance Arrangements: There is a hospital supervisory committee that takes responsibility for oversight of the Trust Fund and CCS.

Other demand side interventions: No other demand side interventions were described. As stated above, if services were available with adequate drug supply free of charge, the MS indicated that if the services were advertised utilization would rise rapidly.

Evidence of Impact, Strengths, Weaknesses and Recommendations: The current funds schemes are far too limited in scope to meet the health needs of the population of 300,000, most of who are classified as poor. The fact that these systems are reliant on poverty identification by the physicians and surgeons on duty indicates quite clearly that there is lack of system and procedural and governance arrangements to support this initiative (which has been documented in previous assessments of these schemes). However, the staff indicated that Trust Funds have potential because of their potential for sustaining of financing (rather than being dependent on external finance).

(b) The Mon State Model

The International Migration Organization is an inter government mental organization with a mandate on health care for migrants (specifically the health aspects of migration). The organization is operational in a range of areas including 3 diseases management in Mon State, maternal neonatal and child health in Bogalay Township and health programs in support of the response to the cyclone Giri emergency in Rakhine State.

Demand Side Barriers The most established health financing strategy is in Mon State. Mon State has high rates of migration for the rubber plantations. Populations leave the dry region areas on a seasonal basis and come to Mon State. Also, there is in and out migration in to Thailand for work opportunities. It is estimated that migrants constitute up to 10% to 20% of the Mon State Population. 50% of the malaria cases are migrants. The percentage is less for TB patients. Many of the HIV cases are returnees from border areas with Thailand.

*Background To Health Financing Scheme: T*he program supports health care services for migrant populations for improved health care access for health services for TB, Malaria and HIV AIDS (through the 3 Diseases, and now Global Fund Support). The scheme has been established in 76 villages in 6 Townships.

The model uses a community based approach for vulnerable group identification and referral. A Township based Community Project Assistant is appointed to be responsible for 3-5 villages. The role includes facilitating the development of "Village Mobility Work Groups" and assisting these groups to develop project activity proposals to improve health care access.

A Village Health Fund is established and funds are revolved through establishment of micro credit enterprises. IOM Outreach health workers are appointed to prove technical support and oversight.

Funding/ Revenue; Funding to IOM is provided through the Global Fund. The local fund holder is the village mobility working group (VMWG). There is a $500 seed grant for micro credit to participating villages. Funding has been sustained in 20 villages to date through use of interest gained from micro credit enterprises (low interest loans). However, the outreach health worker continues to provide technical

support to these villages. A Bank Account is established jointly in the name of the VHWG, HA and outreach health worker. Withdrawals are made monthly and expenditure reports are also made monthly.

Beneficiaries and Eligibility Criteria : *Operational Procedures and Benefits Package*; The benefit package is limited to the three diseases only. benefits to clients include transport, meal (migrants and poor) allowance, accommodation, and cost of referral. Servicesd covered include TB and malaria diagnosis, OI diagnosis and treatment, referral. IOM identifies the need for a more comprehensive package of services including CDC, MNCH, disaster risk reduction, education support and water and sanitation.

Management /Governance Arrangements: A procedure manual for development and operations of the scheme is available. Main content areas include: background to 3 diseases, objective, activities, how to make a budget proposal, care and support guidelines, eligibility criteria and type of support provided. There are no set criteria for membership of the Village Mobility Work Group (VMWG). The VMWG membership consists of the village leader or elder, religious leader, ex school teacher and the migrants themselves. Sometimes employers are involved. However, there are no set criteria for group membership – it is based on willingness to participate as facilitated by the community project assistant. IOM conducts monthly coordination meetings with Township Health authorities to oversee implementation.

Evidence of Impact, Strengths, Weaknesses and Recommendations: Main challenges include the need for extensive capacity building effort for management, proposal development, bookkeeping and reporting at the village level. An end of project evaluation (with 55 respondents in 5 Townships) indicated that in 42% of cases, despite the fact that all were beneficiaries of IOM financial support, additional costs were expended on accompanying family members and on medicines outside the essential drug list.

(c) The Laputta Township Model for Emergency Referral

In Laputta Township (pop 500,000) there are 15 rural health centres, 60 sub centres and 651 villages. Merlin is a non government organization that has been active in Primary Health care since the pre Nargis period. This NGO supports a village based "bottom up" referral fund for poor mothers and under 5 children.

Demand Side Barriers. The main demand side barriers in the Township relate to poverty and local knowledge and beliefs. In the village visited, in the previous year there has been 9 deliveries, 6 of which were at home (the other 3 being emergency referrals). Main reasons provided for delivery at home were cost and because the women did not wish to travel from the village to a strange location.

The financial aspect of demand side barriers was dominant in villager accounts of utilization of hospital services. In one case, a community member accessed the referral fund for referral. Surgery was required (Cesarian section). The family borrowed from their aunty (160,000). Merlin supported 92,000 for drugs. An additional 150,000 (at 8% interest) was required to cover additional medical costs. Overall, 170,000 was used on the day of the emergency for surgery, and 100,000 for the fee for consultation. Additional costs were needed for accommodation and nutrition for 4 relatives.

In one other case, another emergency obstetric case received 20,000 for transport and 120,000 for reimbursement of medical care costs. But the actual costs were 400,000. So the family made their way by selling piglets and chickens and by taking out a loan which was intended to be paid back in 3 months.

Photo: Village Health Committee Members Delta Region

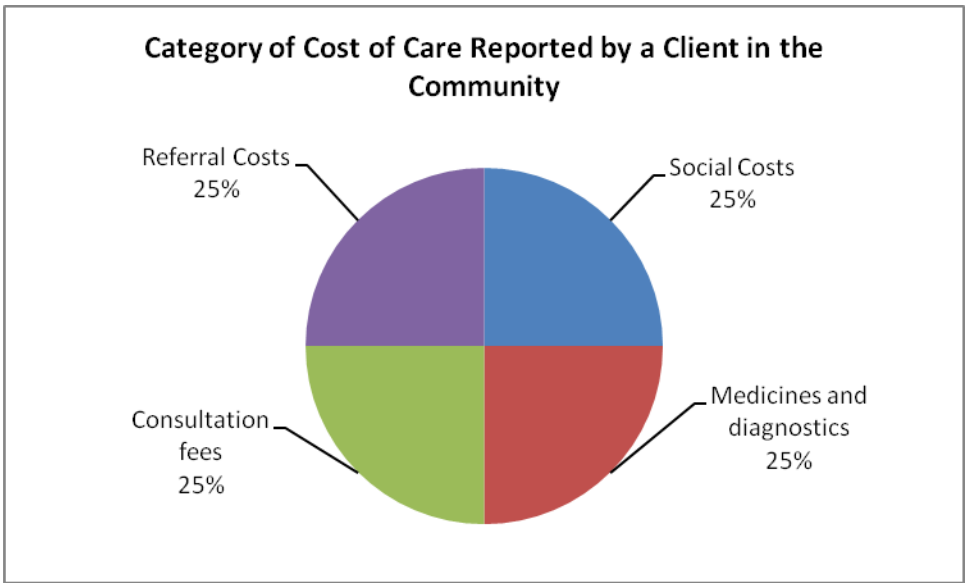
The impact of this on families is that, although the funds are of assistance, they are inadequate to cover real costs. As a result the following options are exercised:

- before undertaking the referral, the families try to borrow in the village to take money with them
- It is possible to borrow from employers or richer residents and pay them back with labour (forgoing salary)
- Sale of assets

Funding/ Revenue; Revenue is sourced from community contributions at the village level. In the village visited, the VHC is able to collect 250 kyats monthly from as many households as possible. Currently, the fund is at 165,000. The fund is not able to revolve (in the form of interest payments or micro finance loans) as the funds are too small in size. The fund supports emergency transport costs for referral only. In the previous year there had been three emergency referrals from the village. Families are expected to pay back the amounts after 3 months (making it an interest free loan for referral). At the hospital, Merlin reimburses up to 100,000 for medical care costs. Part of these funds go to the patient for transport and food and accompanying person, and part of the fund goes to the hospital for payment according to the intervention (categories of intervention are included in the guideline). Documents are completed when referred and forwarded to the Merlin Office.

There are a range of categories of cost, but only revenue for some categories. For example, the VHC supports referrals, and Merlin medical care costs. Provider payments are not included. Although Merlin supports social costs (ie. accompanying person), additional family members also attend. In some cases

therefore, families remain unprotected and there are still significant out of pocket expenditures (requiring sale of assets and interest bearing loans). The figure below gives the breakdown of costs by category reported by one community member for a cesarian section.



Beneficiaries and Eligibility Criteria : *Operational Procedures and Benefits Package*; At the village level, the Chair of the VHC decides how much to provide each family by assessing the situation. However, funds are mainly kept for women and children under the age of 5. The main beneficiaries are the poor. This population in the Delta area makes up to 50% - 60% of the population, who are earning $1 - $3 per day. One respondent indicated the families earn 2,500 kyats at a mximum per day in rural areas, and 3000 in the urban areas. The scheme does not cover the urban poor. According to Merlin, 40% are still required to pay additional medical costs on top of the Merlin benefits provided. Between November 2010 and January 2012, over 1,100 clients have benefited from the scheme.

Management /Governance Arrangements: The scheme at the local level is overseen by a Village Health Committee. This committee is made up of the CHW, AMW, chairman (local government) and other community members. The chair maintains bookkeeping operations including funds status, meeting minutes and activity reports of referred patients. The members are volunteers only. Most of the community understands the benefits of the Fund and value their contributions. Not many community members are unable to- contribute to the scheme. Aside from funds collection and emergency referral, the VHC has other health roles including health education, under 5 care, health campaigns and monitoring of water and sanitation. The VHC is supported by a CHW and AMW (ANC, delivery, folate, community mobilization, and health education).

Three documents are required for entry into the scheme at the hospital. These are the referral slip, the VHC letter confirming the patient undertook the travel and the receipt for boat rental. the emergency department confirms this is an emergency and provides a stamp. the patient can then collect three days finance in advance (for boat rental and food costs). On production of the discharge slip, a second installment is provided based on the agreed cost of the intervention.

These steps are documented in a standard operational procedure document.

The scheme took some time to establish, but now there has been sufficient trust, confidence and capacity for the scheme to function successfully at the hospital and in the community.

What has assisted to facilitate this process is coordinated planning and regular coordination meetings with the Township health authority and other NGOs. The District Administrator now chairs a quarterly coordination meeting. This has also assisted greatly to enhance the local government's knowledge on health issues.

Evidence of Impact, Strengths, Weaknesses and Recommendations: The main issue with the scheme are as follows:

- Lack of definition of a national medical benefits package
- Lack of parameters for assessment of poverty
- Additional patient charges including provider payments and additional medicines

National strategy and guidelines are required in these areas.

(d) The Dedaye Township Model

Background: The Joint Initiative for maternal, neonatal and child health (JIMNCH) is funded through UNOPS in 5 Townships with 5 implementing partners. The International Relief Committee provides technical support for this initiative in Dedaye Township. The program has been operational for 6-7 months.

Demand Side Barriers. Incomes are estimated at 360,000 kyats per year. So the amin barrier is poverty. At the moment, the focus is on the poor and hard to reach, but more emphasis is needed on migration (particularly seasonal migration).

Funding/ Revenue: Funding is through UNOPS (JIMNCH). A ceiling of 140,000 kyats is set for each case

Beneficiaries and Eligibility Criteria: *Operational Procedures and Benefits Package*; The beneficiaries are the very poor, under 5 children and emergency cases. In order to be eligible, clients must be classified as poor and as an emergency case. A letter is required confirming the case is an emergency (letter from midwife). A letter is also required from the local authority indicating the person is poor. Costs covered are for transport, food and medical costs.

Management /Governance Arrangements: There is a Coordinated Township health plan. To support implementation, coordination meetings are conducted at Township and RHC level. Management is through project staff, a VHV committee and CHW participation. Monthly meetings are conducted for the purpose of reinforcing referral protocol and assisting with identifying the poor. Once the patient is identified, classified and referred (and has necessary documents) all patient costs (up to the ceiling are reimbursed.

Evidence of Impact, Strengths, Weaknesses and Recommendations: One of the strengths of the program is that the NGO is an independent agency. During supervision, the NGO has a list of patients, with their name age and address etc. So it is easy to validate if procedures are being followed.

There are several main challenges with this program that will require attention in the future.

Firstly, the system for poverty assessment is not sufficiently systematic. Now it relies on the opinion of the midwife and the local authority. There is risk of bias and misclassification with this, so a better system should be developed. The risk of bias may particularly apply to the situation of migrants, who the local community may not know well.

Secondly, due to the referral scheme, the work burden is increasing for the Township health staff but there is no system of provider payments.

Thirdly, health financing is a HSS initiative which requires long term system development. Currently funding for HSS .

(e) The Bogalay Township Model

Demand Side Barriers: The main demand side barriers in Bogale were cost for transport, care and social support and the traditional practice of seeking maternal care in the village setting. Key informants at Township and at the community level indicated that 50% - 60% of the population required some form of financial support to access health care. They were considered to be just too poor. In one village, the VHC indicated that the village could be categorized into the rich group, who are mostly the traders along the riverside, the "middle group" who are likely to own some land and have some income, the very poor group, who were estimate to make up 15% of the population. They live in a cluster of houses together and experience food insecurity due to lack of income.

Photo: Coordination Meeting Bogalay Township

Traditional birth attendants were very active in the villages visited. The poor in particular use their services because they and village based and they are less expensive. At the RHC, deliveries cost 10,000 – 15,000 and at home in the care of the TBA about half that amount (5000 – 10000) in kind or cash. Community members reported that they preferred to deliver in the village because of less cost and because there was no need to go to a "strange place." Also, it is the tradition (i.e "normal) for the mothers to deliver in the village.

Funding/ Revenue: The main schemes in operation are the Township Trust Fund, the NGO supported emergency referral funds and VHC supported prepayment schemes. At the Township level, only 120,000 kyats interest is available per year to support poor patients. 800,000 per year is available for electricity and communications, 60,000 for uniforms, 300,000 for transport, and 200,000 for fuel. Altogether this is a 1.3 million kyat operational budget for a hospital catchment of 300,000. The NGO supported scheme (through IOM and UNOPS) expended 17,682,545 kyats in the period January to September 2011 to support the emergency referral of 1156 emergency obstetric cases, 403 under 5 children and 154 other cases. As indicated by the NHA data, it is the patients however who contribute the most significantly to health sector investments through their out of pocket payments for essential medicines, social support and "gifts" for providers.

Beneficiaries and Eligibility Criteria: *Operational Procedures and Benefits Package*: For the emergency referral schemes, the main beneficiaries are mothers with obstetric emergencies and children under the age of 5. At the VHC level, the VHC members (Red Cross, MCWA, Elders, AMW, CHW, community members) go house to house and collect 100 kyats. They use this fund for emergency cases other then obstetric and under 5 cases. The VHC reported that it was difficult to collect money from the community members for the following reasons:

1. It is sometimes difficult to collect money from people who are not sick
2. Others say the families should help themselves
3. It is the tradition for community support for religious institutions only

For the mothers and children, the IOM scheme is used. This is reported by villages to cover transportation, medical costs, food costs and support for 1 attendant. Funds are reimbursed by IOM following approval by the Medical Superintendant and Local Authority.

Due to the reimbursement issue, at the community level, the VHC and persons concerned still need to mobilize a loan locally to be able to go. They usually come to the VHC members to ask for help and then the VHC request support from wealthier community members. Sometimes this loan does not have to be paid back. At one other village, a 45 year old multi gravida mobilized funds for hospitalization through an 8% interest loan from a nearby village and through sale of pigs and chickens. Half of the funds were reimbursed through IOM. Additional funds were required for medicines, extra family in attendance and for "gifts" for hospital staff.

Strictly speaking , eligibility criteria for the ION scheme include poverty assessment by the VHC and referral letter from the local health staff.

Management /Governance Arrangements: In on village, the VHC was reactivated in 2010 post Nargis. Prior to Nargis there was no support. The VHCs in the two villages visited had wide representation of community members, local government and health workers (CHW, AMW). Although VHCs could not raise a large fund, it was evident that the structure had leadership and could problem solve barriers to referral at the local community level. This problem solving was undertaken through local social networks for transport and raising of loans. At the RHC level, there are systems of monthly meetings with CHWs to streamline the system. At the Township level, a Township coordination meeting is conducted with local government, health staff and with participating NGOs. During attendance at one of these meetings, it was quite apparent the forum is effective in coordinating strategies and procedures, and on keeping the Township health authority and local government informed of the local health situation. As well as these coordination mechanisms, the Township has a coordinated Township health Plan.

Evidence of Impact, Strengths, Weaknesses and Recommendations: The Referral Scheme has clearly got off to a strong start, with over 1500 referred in a nine month period. This referral system is reinforced by a community mechanism that is functioning (the VHC model) and the network of RHC facilities. The system is further reinforced by the coordinated planning system as well as by the functioning of Township level coordination mechanisms.

There are significant challenges to implementation which were detected in the consultations and are as follows:

1. The system of payment by reimbursement means that the poor still sometimes need to sell assets or take out loans
2. The reimbursement does not always meet the costs for medical care, "gifts" and social support
3. The system is not sufficiently comprehensive and does not cover all medical emergencies
4. The system of poverty identification, according to some, may not always favor the poorest.

(f) Maungdaw Township Models, Rakhine State

Background: Consultations with managers at the State level indicated that after 1988 and the closure of the socialist model, there have been significant pressures on the health sector, particularly in relation to infrastructure, essential medicines and health human resources. As a result, out of pocket expenditures by the population continue to rise, and health financing has become a major issue. Current government schemes across Rakhine State include Trust Funds, community cost sharing and drug revolving funds. Implementation across the State is mixed. The functioning of the systems is completely dependent on the managerial capacity and commitment of the TMO. When they do function, they cannot completely cover the needs of the poor population, as their needs of the poor are particular in each case. The volume of funds is also insufficient to meet the needs of the people.

This means these new financing mechanisms being implemented by INGOs are important. But it is not exactly clear what each scheme is doing and how each mechanism works. Although there are State and township level coordination meetings, they are usually issue specific and irregular.

In Maungdaw Township, the population is over 550,000, with a very high rate of deliveries by TBAs in households ((home delivery by health staff is 31.8%). There were 20 maternal deaths reported in 2011 (2 in the hospital). This distance is also wide across the Township (50 miles to the north and 50 miles to the south). Aside from the Township hospital there are 4 Station hospitals, but only two of which are reported

to be working well. There are 5 health INGOs assisting in the Township. There are significant supply side barriers relating to the level of health infrastructure, low staff to population ratios, very low operational budgets, and no ambulance transport.

Photo: Meeting with Village Representatives in Maungdaw Township Rakhine State

Demand Side Barriers. The State level indicated that poverty rates vary from Township to Township. These rates could be 20% in some Townships and up to 50% in others. The recent MICS survey confirmed the relationship between socio economic status and health and this should be referred to. Rakhine has the second highest poverty rates in the country (with Chin State being number 1). In Maungdaw Township, the TMO indicated that 30%-40% of the patients who present at the hospital do not have the ability to cover their medical care costs. The Township health staff indicated that demand side barriers were a mix of poverty factors, transport issues and cultural factors (language and beliefs). There are three main languages – Bengali, Rakhine and Myanmar, all the vast majority of the population speaks Bengali. The system of "Village Health Committee" is less developed, and there are no Muslim AMWs. There is a system of CHWs however.

In fact, there are demand side barriers that are quite specific to this Township. The population is 95% Muslim and Bengali. Here are some of the demand side barriers that are specific to this area:

- There are no Muslim AMWs in the whole Township. This is because the adequate literacy levels cannot be attained.
- It is very difficult to place a Rakhine or Myanmar health staff in the communities, as there are very poor living conditions and too many cultural barriers to be located there.
- Language is a significant barrier, with lack of sufficient interpretation services at health facilities

- There are significant cultural and gender barriers to care, with limitations of female school attendance and completion, and lack of freedom of movement of women movement outside the home and village.
- Poverty is a major determinant of access, and accounts for the very high consultation rates at NGO services (where services are free) compared to the public facilities where services can come at a cost.
- There are delays to population referral to Sittwe that can be up to three days according to one informant due to requirements for local authority permission to travel.
- There are very high levels of food insecurity in the area, with very high numbers treated for malnutrition by an NGO (ACF). There is income poverty, with many households having only their labor to sell at 2000 kyats per day.

There are significant supply side barriers which without doubt affect the strength of demand. These include low operational budgets, and very low health staff to population ratios. In one sub RHC visited, there is only 1 midwife for 20-30,000 people. INGO staff significantly outnumbers BHS staff in the Township. In one site visited by the review team, the midwife had a catchment area of 20,000. She manages 5 to 6 deliveries per month, which are all in the home. TBAs in contrast deliver up to 40 infants per month. Although there are 70 BHS staff for the whole Township, some NGOs in the area have between 100 to 200 staff.

During this field visit, community members also expressed their preference for private sector attendance in the town because there was not much waiting time. Consultation fees are generally 1500-2000 in addition to medicine costs. At these private clinics, according to one informant, half the staff are public staff working after hours and half are non public. MSF services are also utilized extensively.

Funding/ Revenue; At the Township, The Revolving Drug Fund generates 200-300,000 per month. The Trust fund has a 600,000 balance, but it is not used. The procedures are considered too difficult, particularly in getting the three required signatures from the Township Health Committee. CCS schemes are implemented, with approximately 30% exemption rates. In terms of government budget, for electricity there is an annual budget of 40,000 kyats. So electricity runs on donations and the DRF. There is no vehicle, no motorcycle, and no supervision and training budgets. A Coordinated Township Health Plan and assessment has just been completed through GAVI HSS but funding has not arrived as yet. This will include a budget (at the Township only) for operations and for health financing. The 5 INGOs finance the patients directly for food and transport, and they also finance the hospital for medicines, procedures and other costs (including electricity).

Beneficiaries and Eligibility Criteria : *Operational Procedures and Benefits Package*; There are a mix of models in Maungdaw Township. Overall the model is characterized by multiple schemes that are project based. Most of the schemes are targeted at the Township Hospital, although they also operate at several station hospitals. According to the project mandate, the agencies focus on nutrition, OPD, MCH and the three diseases. There is variation in the medical benefits provided, with some schemes used for HIV, TB and malaria and others for emergency obstetric care and under 5 children. All are based on systems of reimbursement, which cover medical care, food and transport and 1 accompanying patient. Payments are made directly to beneficiaries (food and transport) and to hospitals (medical costs, medicines,

investigations). There were also reports that inpatient care was becoming more expensive due to high medicine costs, procedures and additional infusions.

Management /Governance Arrangements: The INGOs not only assist with referrals. More widely, they assist with direct patient care (consultations) for OPD and nutrition. There is no system of provider payments, although it was reported that donations are requested from discharged patients. Many informants indicated that without a system of provider payments, financing schemes will not be sustainable. Most do not utilize poverty identify mechanisms, except for UNDP, which uses community based "wealth ranking" to assess eligibility for loans, grants and health and social sector benefits. GAVI HSS will manage a Hospital equity Fund through a "Funds Management Committee" consisting of THC, TMO, accountant and community representatives (MOF decree). Poverty identification will be by local government and health providers. In terms of coordination, there are one on one meetings by the TMO when issues arise with agencies. UNHCR facilitates an inter agency health committee meeting. GAVI HSS proposes to strengthen the Township Coordination system. This was also stated as an intention by the Health Director of Rakhine State. Malteser locates Bengali speaking "patient attendants" at the hospital to facilitate communications with the hospital staff.

Evidence of Impact, Strengths, Weaknesses and Recommendations: There is a high volume of patients that are processed through the various INGO referral schemes. Malteser supports 80-100 MCH patient referrals per years, with the GAVI HSS program proposing to support a similar number through a hospital equity fund. MSF Holland through the clinic system had over 1,300 referrals in 2011 and over 180,000 OPD consultations (free service provision). The table below provides more details on subsidized health care in North Rakhine State (NRS).

Table 6 Examples of Agency Support in Maungdaw Township and NRS

Agency	Type and numbers of Support
Malteser	DOTS Nutrition centres 80-100 patients referral per year for MCH in Mgd
MSF Holland	1,300 Hospital referrals & 180, 000 OPD consultations.
Myanmar Red Cross Society	7275 beneficiaries for MCH and under 5 care
GAVI HSS	Approx. 80 patients for emergency referral in 2012
WFP-UNHCR	1255 mothers and children for "blanket" feeding program
ACF	17326 admission in North Rakhine State for treatment of malnutrition

(g) The Kyaukpadaung Township Model, Mandalay Region

Background: Kyaukpadaung Township is located in Mandalay region. Compared to many other Townships, this one is relatively better off socio economically. There is a population of 300,000, with health infrastructure including a 50 bedded hospital, 2 station hospitals, and 5 RHCs. The site is of particular interest due to the role of community based organizations and Health Foundations providing subsidized health care to the population either directly or through the Township Health System. In this review, 11 Foundations and CBOs were consulted with in the Township. A sample of the CBOs, their role and function, period of implementation, and some details on beneficiaries, is included in the table below.

Table 7 Background and Main Activities of CBOs and Health Foundations in Kyaukpadaung Township

Name	Main Activities	Start date	Beneficiaries and Costs	Fund Source
CBO 1	Funeral services Ambulance Services Free services at Sangha Hospital		All households in the village	Prepayments by the community
CBO 2	Funeral Services Social Activities in health, wealth and religious affairs	2010	Delivery support for poor mothers Support for hospitalization	Donations from the community
CBO 3	Free of Charge Clinics Referrals Blood Donations Funeral Services			Donations monthly fro members
Foundation 1	Deliveries for poor mothers Some supply side investments for the hospital	2010	20,000 for poor mothers to offset costs of hospitalization.	Donations from the community
UNDP	Reproductive health activities Water and Sanitation Dengue control Snake Bite prevention Micro enterprises and community development	1990s	Assists with loans and grants to populations in 76 villages in 2011 Assist communities with poverty identification (wealth ranging) to determine eligibility for loans and grants).	UNDP
CBO 4	PLHA Care and Support for OI and ART treatment	2010	Assist with covering costs for referral for ART and OI with funds from Global Fund	Global Fund
CBO 5	Support for referral and care of poor pregnant women	2006	Collects 100 Kyat per day from market sellers (up to 50) with fund now expanded to 100 Lakh. TMO refers to Foundation who makes 20,000 payment to beneficiaries for costs of care.	Donations from market sellers
CBO 6	Free of Charge Clinics Ambulance Transport Flood Relief	2011	Funds collected from well wisher donors with 400 members. Staff donate their labor for free clinics. FOC clinics see 120 patients per day)	Donations from members. members hold a "Muditar card" and monthly payments are made according to the card.

Main characteristics of the CBOs and Foundation activities are as follows:

- Generally they are small in terms of service coverage and revenue generation (CBOs in particular). The Foundations have a wider network of donors and community well wishers. In fact one attempts to cover the whole Township (Sakawame Foundation).
- There is a limited services package according to the project mandate
- Some are not registered with the Ministry of Home Affairs
- Most of the Foundations and CBOs are urban based, leaving it unclear as to the extent to which these organizations can permeate to the rural regions.
- Innovative mechanisms for fund collection, pre payments and sustainability are implemented (see more below).

Demand Side Barriers. The demand side barriers, from a health financing perspective, were similar to others sites. UNDP provides some information on how wealth ranking is conducted, with wealth classifications in 5 groups from A to E with a being wealthy, b, middle, c poor, d very poor and e poorest of the poor. This poorest of the poor group is estimated by those concerned with wealth ranking to between 10% and 20%, which would be in total 30,000 in population of the Township. The TMO estimates that he exempts 10% from costs at the hospital. The UNDP wealth ranking criteriafor "the poorest of the poor" include the following:

- No assets
- Low Education
- Large number of dependents (ie. numbers below 5 and in the older age groups)
- Disabled
- Chronic diseases
- No income

At the RHC level, most sub centres are distant from the RHC. These sub centres do not have delivery rooms and mothers prefer to deliver in homes. There are 3 to 4 deliveries per month at the RHC. Women prefer to deliver at home due to the beliefs of elders. Most of the women do have ANC but do not agree to deliver at facilities.

One women interviewed in the hospital had had 5 deliveries, and 3 infants had already died following TBA delivery. She delivered in the hospital this time supported through the support of Sagawame Foundation.

Funding/ Revenue: Most of the Foundation and CBO systems are built around the concept of donation. Pre payment is viewed by the staff as difficult, even in this Township which is considered to be better off socio economically. According to one staff member, the previous TMO tried pre payment system for 15 years without success – people are not concentrated on their daily living needs and health and safety according to him were lower priorities for the populations.

Staff at the RHC refers patients to the Foundation to assist with costs of referral to the Township.

At the Township, the Trust Fund, DRF and CCS systems are all utilized. The TMO uses these funds to complement funds from CBOs and Foundations. This strategy has resulted in higher hospital utilization rates. The majority of the hospital infrastructure is funded through local donation (OPD, hospital wards).

Beneficiaries and Eligibility Criteria: *Operational Procedures and Benefits Package*; These are dependent on the mandate of the Foundation of CBO (refer to Table above). Some Foundations focus on Delivery and snakebite for the poor only for example, while others cover the costs of the whole population (free of charge clinics). Trust Funds and DRF are used for the poor, with exemptions for CCS. Exemptions are assessed by the health staff.

Members of Review Team with Township Medical Officer at Kyaukpadaung Township

Management /Governance Arrangements: Each of the Foundations and CBOs have their own unique governance mechanisms. Some select committee members from the pool of local donors. One CBO selected representatives from the local area urban blocks. Nearly all time provided by health staff or CBO staff is voluntary. The TMO usually meets the representatives of Foundations on a one off basis every three months. Township wide meetings have not previously been convened.

Evidence of Impact, Strengths, Weaknesses and Recommendations: Generally speaking, the hospital is well utilized with high bed utilization rates. At the time of the review, most beds were utilized. According to the TMO, 10% of beds are occupied by patients who required financial assistance. The Table above demonstrates that the various Foundations and CBOs are providing increasing coverage of care for the population, although it is not clear to what extent this support permeates into the villages and more remote areas.

Annex 2 The National Civil Society Sector in Myanmar and its Potential Role in Financing

The Development of the National NGO Sector in Myanmar Since 2004, national NGOs in Myanmar have become more active. They commenced sharing updates of their activities with UN agencies. In 2007, local NGOs started forming their own thematic groups in health, education and women's and youth matters. International NGOs became very active in the post Nargis emergency and recovery efforts and the requested that national NGOs become more involved. After that, weekly meetings were then conducted with INGOs. There are now 101 National NGOs in Myanmar, although not all are officially registered. There are 17 national Health NGOs. Main interest and expertise of the health NGOs include WASH, the 3 diseases, medical services and disaster response. The future for national NGOs is to build their capacity down to village level, and to strengthen governance structures and capacity, particularly in areas such as project management, human resource development and financial management. The National NGO sector considers it should be more considered by Ministries and the development partner community and the contribution it can make to broader development.

Out of the Nargis experience, a "contingency plan" was developed by NGOs. That is, what happens if there is another disaster? The UN inter-agency plan becomes activated if there are an estimated 50,000 population affected. But the national NGOs considered the figure should be 10,000. So they formed their own ***"Myanmar NGOs Contingency Plan Working Group."*** membership of this group is involved with projects in the areas of emergency preparedness, emergency health preparedness and public health interventions, health education and VHW training.

The National NGO sector was recently active in the response to the Giri Disaster in Rakhine State, and provided funds for referral of patients. This mostly covered transport costs, social support, and the costs for emergency medical supplies. The national NGOs indicated in consultations the urgent need for national coordination mechanisms with the civil society sector and with development partners at all levels of the system. There also should be closer links with local community based organizations. In Myanmar for a very long time there have traditionally been local community networks through the Abbot, the Headmaster and the Local Authority. The Monastery is also active in providing traditional health care services.

The Myanmar Medical Association, established since 1949, has been active in the post Nargis areas and in Rakhine State. It has 15,000 members and 70% are in the community practicing as GPs. Currently the group managers 14 health projects in such areas as Malaria, HIV, TB Dots, youth development programs and male involvement in reproductive health. The MMA is also active in managing a maternity homes in Rakhine State and operates some referral schemes for high risk patients, and covers costs such as transport, consultation costs, food, accommodation and medical care. MMA is a project sub recipient and has a health project department, program management structures and employs financial management assistants.

Both the Health Assistant Association and Myanmar Red Cross have networks of members (Health Association) and Volunteers (MRC) across the country.

The Border Area Association is active in provision of mobile medical clinics in border areas including provision of surgical services, particularly for cataract interventions. There are difficulty in sustaining these operations.

The Role Foundations and Community Based Organizations are widely discussed in the sections above. These organizations have potentially a significant role as implementing partners for Township health authorities in support of health financing systems implementation – particularly advocacy, referral, social networking, poverty identification and patient satisfaction assessment. The limitations of these organizations are the following:

- They are very new with limited experience in project and funds management
- They are not registered with the Ministry of Home Affairs
- They often have a very limited program reach

The distinct advantage of these organizations however is that they are from the local area, they know the communities very well, and have the capacity to advocate, assess community needs and poverty levels, organize referral and conduct local fund raising.

International NGOs are playing an increasing role in health delivery and systems development. Some of these INGOs were towards a humanitarian mandate, while others are more developmentally orientated. The review has observed that many provide direct service provision to communities in Northern Rakhine State and other areas across the country, while others, particularly in the Delta, are commencing to work closer with Township Health Authorities on system development (coordinate planning, financing, and community participation systems). Clearly, in order to support health financing systems development, the role of INGOs may transition in the near future towards technical assistance and support roles and away from the direct service provision role (depending on the context). There may also be a position for INGOs to partner with National NGOs, Foundations and CBOs to support implementation of health financing initiatives.

Annex 3 List of Consultations and Field Visits Health Financing Review

Date and Time	Activity	Responsible Person, Agency
16-1-2012	Official visit to WHO for administrative procedure	WHO Country Office
17-1-2012	Travel to nay Pi Taw	
18-1-2012 (13:30-15:30 Hr)	Preliminary discussion on Health Financing Review	Dr. Phone Myint Dr. San San Aye Department of Health Planning
19-1-2012	Preparation of draft protocol	
20-1-2012	Presentation and review of protocol with Dr Phone Myint and Dr San San Aye Travel back to Yangon	Dr. Phone Myint Dr. San San Aye Department of Health Planning
21-1-2012 (Saturday)	Lit Review Health Financing	
22-1-2012 (Sunday)	Discussions on financing scheme conducted by other INGOs, NGOs: World Vision IOM, Relief International, MMA, MRCS, MNGO-CPWG	National and International NGOs and Professional Associations
23-1-2012 to 27-1-2012	Consult with medical Superintendant Laputta District Hospital	Patient Referral Fund Manager Township Medical Officers
24-1-2012	Field Visit to Village in Laputta Team Meeting with Merlin project Managers	Village Health Committee CHW/AMW Community members Merlin Project Staff Referral Program Manager Community members
25-1-2012	Travel to Bogalay Township. Meet with TMO	
26-1-2012	Travel to RHC and Village 1 and Village 2 Attend Township Health coordination Meeting Interview with TMO	Meet with RHC Staff Meet with VHC, AMWs and CHW at two villages TMO, NGOs, Local Authority, WHO (approx 30 participants)
27-1-2012	Travel Back to Yangon	
30-1-2012	Travel to Sittwe	State Health Director and

Date and Time	Activity	Responsible Person, Agency
	State Health Dept	Deputy Director
31-1-2012	Travel to Maungdaw Meeting with TMO	TMO
1-2-2012	Meeting with ACF Meeting with UNDP Meeting with Malteser Meeting with MSF Holland meeting with UNICEF Meeting with GAVI HSS officer	NGOs and UN Agencies
2-2-2012	Meeting with UNHCR Meeting with Village community members at sub centre near Maungdaw	UN and community members
3-2-2012	Travel to Sittwe	
4-2-2012	Travel to Yangon	
6-2-2012	Meeting with AusAID Meeting with DFID	Bilateral Agency Staff
7-2-2012	Meeting with MSF Meeting with UNICEF Team	NGO and UN staf
8-2-2012	Meeting with Save the Children Travel to NPT	NGO Staff
9-2-2012		
10-2-2012	Travel to Kyaukpadaung Township Meet with TMO	TMO
11-2-2012	Meeting with Health Foundations and CBOs (8) in Kyaukpadaung Township Mandalay Division	NGOs and CBOs and Foundations (8)
12-2-2012	Travel to RHC at Kyaukpadaung Township Travel back to Nay Pi Taw	Health Staff
13-2-2012	Report writing and preparation for Policy Options Conference	-
14-2-2012	Report writing and preparation for Policy Options Conference	-
15-2-2012	Development of Strategy Conference	Government and Development partners
16-2-2012	Development of Policy Options Conference Health Financing dissemination meeting with government, NGOs and development partners Travel back to Yangon	Government and Development partners
17-2-2012	Return Travel	

Annex 4 Health Financing Schemes Question Guideline

	Response	Notes
DEMAND SIDE BARRIERS		
1. What are the main demand side barriers to health care access? (social, economic, geographic other)		
2. What is the expected size of the population effected and their location?		
BACKGROUND TO HEALTH FINANCING SCHEME		
3. Name of Scheme		
4. Name of Funds Operator		
5. Geographic Area of Operation		
6. Estimated % Population Cover		
FUNDING/ REVENUE		
7. Source of Revenue		
8. Revenue per Year		
9. Other		
BENEFICIARIES AND ELIGIBILITY CRITERIA		
10. Who are the Main Beneficiaries?		
11. Number of Beneficiaries per year		

12. What is the Eligibility Criteria for entry into the scheme?		
13. How is eligibility assessed? 14. Is there a Poverty Identification mechanisms or Method? Please describe?		
OPERATIONAL PROCEDURES AND BENEFITS PACKAGE		
15. Is there an operational procedures manual? What are main content areas? Describe……..		
16. What is the schedule or list of benefits for the client?		
17. Is there any system of prepayment? Describe……..		
18. Is there a system of provider payments or other benefit? Describe…….		
19. Other		
20. MANAGEMENT /GOVERNANCE ARRANGEMENTS		
21. Is there a Governing Body/Management mechanism Describe……		
22. Are there any Evaluation / Reporting processes		
23. Is there a Representation process (health authority , local government, clients) Describe……		
24. Is there a complaints mechanism in place or		

system to assess client satisfaction Describe……		
25. Are there 3rd Party mechanisms for poverty ID or assessment of complaints or client satisfaction with services?		
OTHER DEMAND SIDE INTERVENTIONS		
26. What other demand side interventions have been implemented? (communication strategy, local employment strategy, management mechanisms, participation mechanisms) Describe……		
EVIDENCE OF EFFECTIVENESS, STRENGTHS AND WEAKNESSES AND RECOMMENDATIONS		
27. Is there Evaluation evidence? What does it indicate?		
28. What are the Strengths of the Scheme or demand side intervention?		
29. What are the weaknesses of the Weaknesses of the Scheme or demand side intervention? Describe……		
30. What are your recommendations for Health Financing Schemes/Strategy		
31. Any Other Issues ?		

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