



**CLOSING THE GAP**

Expanding access to  
social services

**POLICIES FOR SHARED PROSPERITY IN MYANMAR**



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## CLOSING THE GAP: Expanding access to social services

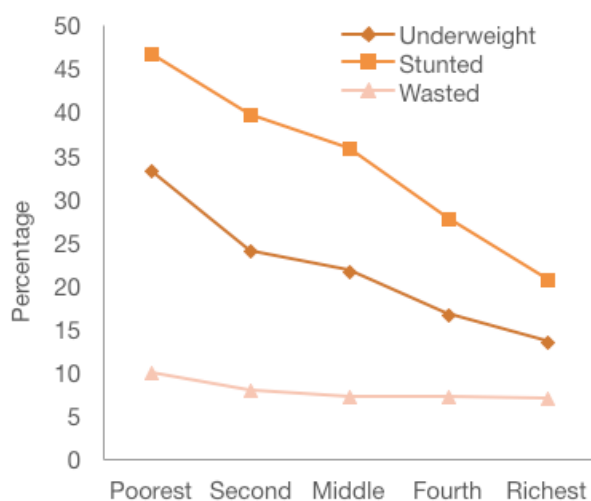
Myanmar has an important opportunity to improve the health status and education outcomes of its people after decades of underspending and institutional neglect in the social sectors. Low access to health, education and social protection services has severely worsened human development outcomes, which ranked among the lowest in the region. Since 2011, there has been a sea change in public policy with rapidly rising social spending to expand access to services and protect families from poverty. The payoffs are immense – in Myanmar, an additional year of schooling is estimated to be associated with 6.7 percent higher income (World Bank, 2014a), which will be compounded with better health and social protection. Although significant progress has been made recently, immense challenges and opportunities remain. Policies to close the gap in access to social services are fundamental to inclusive growth in Myanmar.

### CONTEXT AND OPPORTUNITIES FOR CHANGE

There are big opportunities to improve human development outcomes in Myanmar, including by addressing disparities across socio-economic groups (figure 1). Only 29 percent of children from households in the poorest quintile were enrolled in secondary school, compared with 80 percent of those from the richest quintile. Women in the poorest quintile have the lowest percentage of births delivered by skilled attendants, receiving post-natal care and practicing exclusive breastfeeding of under 6-month olds. Furthermore, 33 percent of children from households in the poorest wealth quintile were underweight compared with 14 percent of children from the richest quintile.



Figure 1: Nutrition outcomes across income groups



Source: UNICEF and MNPED (2010)

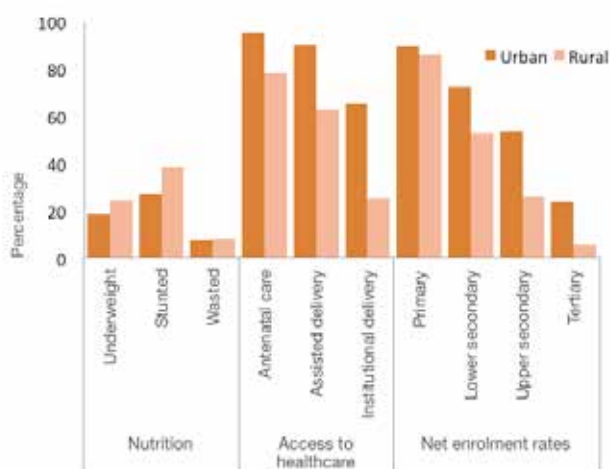
**Gaps in access to education between poor and richer households are more significant than the differential access between boys and girls.** There is some evidence of gender gaps at a State/Region level, with lower enrollment and attainment for girls relative to boys in Rakhine and greater dropout rates for boys over girls in those parts of the country where labor market opportunities are drawing children from work. Greater analysis is needed to explore the sub-national patterns and to devise appropriate policy responses.





**There are also opportunities to address big disparities across geographical areas. Health status and education outcomes fare worse in rural areas than in urban areas** (figure 2). Within rural areas, net primary enrollment rate in 2009/10 ranged from 96 percent in Kayah to 69 percent in Rakhine. The highest pass rate in the 2010 final examination was 45 percent in Mon, whereas the lowest was 17 percent in Chin. Exclusive breastfeeding up to the age of six months ranges from 1.3 per cent in Rakhine to 40.6 percent in Kachin.

Figure 2: Urban and rural health and education indicators



Source: Nutrition and access to health care: UNICEF and MNPED (2010). Net enrollment rates: staff calculations using 2009/10 MICS data

**Closing gaps in access to services will mean tackling difficult terrain, conflict in border areas, and cultural diversity and local norms.** These are compounded by systems challenges, namely limited and fragmented financing, weak human resources, basic physical infrastructure, and scant data. Remote/hard-to-reach areas face huge difficulties in deploying and retaining qualified teachers, doctors and basic health staff. Approximately a third of primary school teachers nationwide have been teaching for less than 2 years and they will require more support in terms of training and mentoring.

**In areas affected by conflict, where government presence has been historically limited, social service delivery will need to be harmonized with existing service delivery mechanisms and aligned with the peace process.** Services in these areas are delivered by ethnic authorities associated with armed groups that administer these territories. The New Mon State Party, for example, has 142 schools and over 13,000 students. Community based organizations and ethnic health groups deliver prevention and primary health care in conflict-affected areas of Eastern Myanmar. One household survey found that in some of those areas 70 percent of its respondents used ethnic-led health services whereas only 8 percent relied on government health services within the last 12 months.

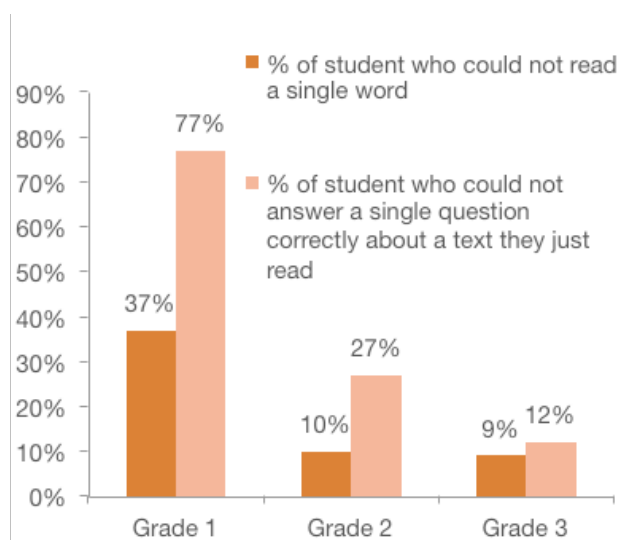
**Recent shifts in the Union Budget have created an opening to further reverse low public spending on health and education and to reduce the financial burden on households.** In 2009, households bore 63 and 82 percent of total education and health costs respectively through direct out-of-pocket payments, one of the highest in the world. This either prevented poor people from accessing healthcare because they could not afford it, or led to further impoverishment as they had to sell assets to access services. In a survey in 2009, almost a third of respondents noted that out-of-pocket costs were unaffordable.

**The Union Budget can also help to significantly improve the quality of education and health services.** Very basic school facilities have made learning conditions difficult, as demonstrated by Early Grade Reading Assessment (EGRA) results (figure 3). At the point of health service delivery, quality is severely affected by a shortage of critical inputs. A recent nationally-representative survey of health facilities found that only 26 percent of them had essential medicines, 41 percent basic amenities, and 57 percent the capacity to provide basic obstetric care.



**There is also an opening to establish an effective social protection system to help the poor and vulnerable to access services.** They currently have limited mechanisms and programs to reduce the exposure to risks and to expand their ability to cope with ill-health and other shocks, such as the recent floods. Social assistance spending in Myanmar continues to be extremely low, with only 0.02 percent of GDP, compared to an average of 1.1 percent of GDP among low-income countries. In addition, social assistance programs reach only 0.1 percent of the population, compared to 39 percent among East Asian and Pacific countries.

Fig 3: Early Grade Reading Assessment (EGRA) Results, Yangon Region (2014)



Source: World Bank Myanmar Early Grade Reading Assessment (EGRA) for the Yangon Region , 2014



## RECENT DEVELOPMENTS

**Several reforms have been initiated to improve service delivery, increase utilization and reduce out-of-pocket spending in the health sector.** These include: the provision of free essential drugs at township hospitals and below; and free services for pregnant women and children under five. In addition, the Ministry of Health implemented a pilot scheme to incentivize poor women to seek antenatal visits, safe delivery, and postnatal care by paying for transportation, food and lodging.

In the education sector also, policies were adopted to encourage children to attend school and reduce dropout rates. Primary and secondary school fees have been eliminated, free textbooks are now provided to all students, and over 70,000 contracted teachers have been recruited. In addition, since 2014 a stipends program for poor and vulnerable students has been introduced (grades 5-11) in 8 townships across 4 States and Regions, reaching 36,800 students in the first year. The aim is to reach 184,000 recipients by 2017/2018.

**policy  
changes are  
delivering  
results**

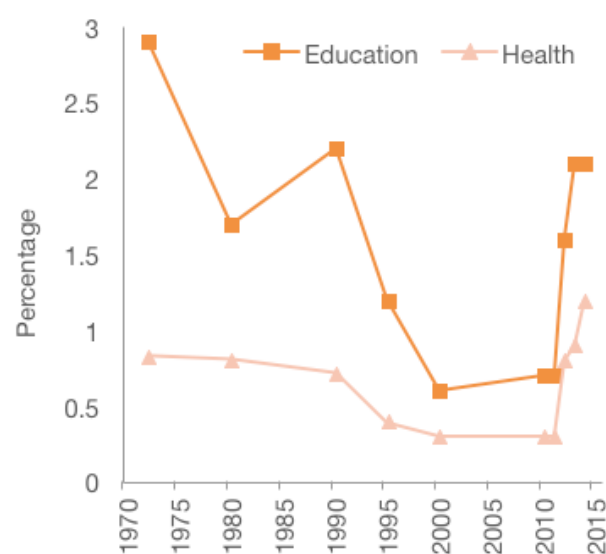




**These policies were implemented through a dramatic increase in public spending.** Health spending has increased from 0.2 percent of GDP in 2009 to over 1 percent of GDP in 2014. This is equivalent to a nine fold increase in nominal terms between 2009 and 2013. Education spending has increased from 0.7 percent of GDP in 2011 to an estimated 2 percent of GDP in 2014. Furthermore, a promising reform of decentralization has started, through facility grants provided directly to schools, hospitals, and health centers that are at the frontline of service delivery.

**These policy changes are already delivering results.** Out-of-pocket spending as a share of total spending is estimated to have dropped from 63 percent in 2010 to 30 percent in 2015 for education and from 82 percent to 54 percent for health over the same period. Anecdotal evidence suggests that the stipends program so far has encouraged parents to get more involved in their children's education, to improve attendance, and to cover education costs such as stationary, uniforms, and transport with the stipend.

Fig 4: Government expenditure on health and education (% of GDP)



Source: World Bank (1985), World Bank (1995) and World Development Indicators, Ministry of Education and Ministry of Health

## Thailand

### **Thailand's road to Universal Health Coverage (UHC) may provide valuable lessons for Myanmar.**

Thailand's decades of health infrastructure development and experimenting with different financial risk protection schemes alone did not deliver UHC. In 2001, however, Thailand launched an ambitious reform known as the Universal Coverage Scheme (UCS). Within one year of its launch, the UCS covered 47 million people: 75% of the Thai population, including 18 million people previously uninsured. This rapid coverage was supported by the readiness of the services, which was enabled by earlier investments in health infrastructure. The other 25% of the population were government employees, private-sector employees, and others who were covered under existing schemes.

Public health spending in Thailand increased from 5 percent of the budget in 1985 to 17 percent in 2015, which is one of the highest in the world. In addition to reprioritization across the budget, efficiency gains in health spending were achieved through better procurement of essential drugs and medical services. Further fiscal space was afforded through a 2% additional surcharge on tobacco and alcohol excise tax, which is used for campaigning on various health risks including tobacco, alcohol, HIV/AIDS, non-communicable diseases and road safety.

Whilst Thailand's starting point in 2001 was different from that of Myanmar today, the basic ingredients to success in Thailand are relevant: high-level political leadership and commitment to UHC; evidence-based policy making; and a fiscal framework that ensured financial affordability and sustainability. All of these can be applied to Myanmar today (World Bank 2015).





## Vietnam

**In Vietnam, the government invested early in tackling socio-economic and geographic disparities in access to education services, which had some similarities to Myanmar's situation today.** In terms of net participation rates in education there was significant progress between 1994 and 2003, going from 91 percent to 98 percent in primary education, 42 percent to 81 percent in lower secondary, and 13 percent to 37 percent in upper secondary. Nonetheless, geographically disadvantaged areas, which included ethnic minority groups, had lower access to education services. To address this, the government provided more resources to remote areas (e.g. for higher teacher salaries), introduced safety nets in vulnerable provinces, and had targeted fiscal transfers for less developed regions.

**Vietnam's dramatic improvements in education outcomes relied on evidence-based policies.** This involved heavy investment in data collection, which helped improve the prioritization of government spending and education quality. Vietnam also introduced poverty-targeted cash transfers (stipends) to enable children from poor households and those living in remote areas to complete schooling. Between 1998 and 2002, the benefit incidence from government spending in education increased for the poor and near poor from 51 percent to 54 percent in primary education, from 32 percent to 43 percent in lower secondary, and from 15 percent to 25 percent in upper secondary. The government introduced tests to monitor education outcomes and adopted minimum quality standards, which further informed budget allocations. International benchmarking tools show that literacy and numeracy among Vietnam's students and adult workforce is widespread, and higher than in a number of richer countries. This in turn has enabled Vietnam to produce a strong, productive workforce, which has contributed to its development success over the past two decades.

## Philippines

**The Philippines may offer good lessons in rapidly scaling up social protection services from a low base.** In 2007/08, the Philippines had high unemployment and rising poverty and inequality linked in part to the international commodity price and global financial crises. Spending on social protection was only 0.4 percent of GDP in 2007, with the social assistance budget at just 0.05 percent of GDP, a little over Myanmar today. Existing social protection programs were fragmented, poorly targeted and prone to leakage.

In 2008 the government launched a pilot Conditional Cash Transfer (CCT) program to cover 6,000 households. Within two years, the program was rolled out to a million households. Spending on social assistance increased to 0.35 percent of GDP. By 2014 the program reached nearly 4 million poor households and serves as the backbone of a modern and consolidated social protection system.

The CCT program in the Philippines became a platform to develop delivery systems that have already proven effective in reaching those in need, responding to disasters, and addressing human development constraints. It was the foundation for establishing the National Household Targeting System for Poverty Reduction, known as Listahanan. This established the framework for channeling resources under the National Community Development Program, and in response to natural disasters. The evidence shows that these initiatives have promoted inclusion by enabling poor and vulnerable households to invest in their children's health and education, and enabled faster response to natural disasters.





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#### POLICY OPTIONS

**Spending better:** The recent increase in social sector spending in Myanmar could yield the greatest benefit if spending is focused on cost-effective interventions, aligned with priority issues, and focused on lagging geographic areas and specific groups. In health this might mean allocating more for prevention and public health, which could help reduce the risks of infection and negative effects on others. In education, the data suggests that improving the quality of basic education is a priority; given the young teaching force, more attention seems warranted for in-service teacher training and mentoring programs. For example, Indonesia's in-service teacher training used clusters for professional development, which proved to be an effective means of supporting a large number of teachers with consistent, quality professional development activities.

Improved targeting of public resources is another dimension of better quality spending. This includes prioritizing lagging rural areas. Today more public resources go to urban areas, even though the majority of the population, in particular the poor, live in rural areas.<sup>1</sup> For example, urban health facilities, such as teaching hospitals and state/region hospitals, accounted for about 70 percent of total public spending on health in 2013/14. As Thailand demonstrates, achieving UHC required a strong rural health network that is adequately resourced to deliver essential services.

Better targeting of resources could be facilitated by making better use of data from the census and household poverty surveys.<sup>2</sup> In particular this could help to ensure that budgets are linked to addressing problems that are more prevalent among the poor, such as malnutrition, and to programs that promote equitable and affordable access to services, such as stipends and maternal health vouchers, which have been initiated or piloted in Myanmar.

Improving spending quality might also mean incentivizing education and health service providers so that they work on delivering sector outcomes. One option for this could be through strategic purchasing, which are explicitly aimed at controlling costs or increasing utilization of particular services. Salaries or line budget items do not necessarily incentivize quality or cost savings. For example, primary care providers are increasingly paid through capitation, which leads to greater attention to prevention and health promotion, as there is an incentive to keep the population healthy. Capitation gives predictability and flexibility to use funds for providers and helps to contain costs, but performance could be further incentivized to facilities, e.g. through bonuses for delivering specific high priority interventions, such as women giving birth in health centers or hospitals.

Finally, there may also be scope for increased spending efficiency. For example, in education, the current 92 titles of textbooks used throughout the school system are of such poor quality that they have to be replaced every year, compared to other countries where a textbook

<sup>1</sup> For further details please see the Policy Note on "Growing together: Reducing rural poverty in Myanmar."

<sup>2</sup> Please see Policy Note on "Growing together: Reducing rural poverty in Myanmar."





can easily be used for three years. Another example is the high level of spending on pharmaceuticals in Myanmar. This could be a result of prescription behaviors of doctors and/or the procurement system, which does not support the use of generic drugs. With the expansion of Information and Communication Technologies (ICT), Myanmar could also increase savings by making better use of ICT to deliver training and information. Similarly, the use of the expanding financial services and telecommunications network could greatly improve systems for payment of salaries for front line staff as well as social protection benefits, while also promoting financial inclusion.

**Pooling resources:** In health, pooling of resources could enable financial risk protection. Larger pools of funds allow for greater cross-subsidization between rich and poor, between young and old, and between healthy and sick. It could also allow for better purchasing of health services (i.e. bigger pool gives greater purchasing power) and translate to greater savings from reduced management and administration. Today Myanmar has fragmented and uncoordinated pools financed by the government (i.e. Social Security Board, Ministry of Health) and by households, not to mention many parallel pools of external aid. Moving towards fewer and bigger pools is common in many countries aiming for UHC, such as Indonesia and the Philippines.

Social protection programs can also provide a common platform for pooling development partner (DP) funds to respond to disaster. This is demonstrated by Ethiopia's Productive Safety Net Program (PSNP) which ensures

financial commitments from donors are in place before any crises occurs, reducing emergency response time from eight to two months. In the Philippines, the government used its existing cash transfer program by channeling donor funds for emergency response when Cyclone Haiyan hit.

**Spending more:** Health sector needs are massive relative to current levels of public service delivery. The fiscal space needed for higher spending on social sectors could come from various sources. Increased efficiency within the sector as highlighted above is one of them. A second source could be reprioritization across the budget. For example in Thailand, providing universal access to health was, in large part, financed by a gradual decline in military spending. A third source could be through mobilization of new resources by improving tax administration and reforming tax policies. For example, a number of countries are reforming the structure of tobacco taxes in order to raise additional government revenues. China and the Philippines are recent examples from the region.

**Harmonizing and converging:** In areas affected by conflict, especially in the Southeast part of Myanmar, social services are delivered and financed in parallel to national government systems. Rather than efforts to replace and compete with existing service delivery arrangements, more alignment and synergies through coordination and cooperation are needed to provide inclusive access to services in all areas.



*The table below proposes short-term (within 1 year) and long-term (within 3-5 years) policy options for the next five years (2016-2020) to help deliver on the above four objectives of spending better, pooling resources, spending more, and harmonizing and converging.*

OBJECTIVES	SHORT-TERM OPTIONS	LONG-TERM OPTIONS
Spending better	<p>Expand coverage of stipend programs to disadvantaged children. International evidence suggests that stipend programs can have a large and immediate impact on drop-out rates.</p> <p>Establish a common platform to use results of the 2014 census to identify geographic areas with greater development needs to ensure equitable distribution and inclusion.</p>	<p>Develop a more sophisticated “targeting system” that relies on household characteristics to identify the poor and vulnerable.</p> <p>Implement performance monitoring system of providers (e.g. student learning outcomes), holding them accountable for quality and access of services, particularly among the poor and vulnerable..</p>
Pooling resources	<p>Increase pooling or alignment of resources to ensure sustainable financing for social protection programs and for delivering an essential package of health and nutrition services for everyone living in the country.</p>	<p>Develop a system for financial risk protection, which prioritizes the poor and the near poor.</p>
Spending more	<p>Based on a prior analysis of fiscal affordability, further increase the grants currently provided to schools and health facilities to ensure more flexible and transparent funds to the frontlines of service delivery in education and health and to reduce out-of-pocket spending.</p>	<p>Regularly review social sector expenditure to continuously promote alignment of government spending on health, education, and social protection with social sector needs.</p>
Harmonizing and converging		<p>Harmonize financing and delivery of social services in conflict affected areas, in line with the Nationwide Ceasefire Agreement, which calls for Government and ethnic cooperation on health and education.</p>



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**“This Policy Note is part of a series entitled All Aboard! Policies for shared prosperity in Myanmar”**



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