Ministry of Health and Sports
The Republic of the Union of Myanmar

Strategic Directions for Financing Universal Health Coverage in Myanmar

Recommendations from National Consultations and Study Visits

National Health Plan Monitoring and Implementation Unit (NIMU)
May 2019

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Contents

Abbreviations

CSO	Civil Society Organization
DHS	Demographic and Health Survey
DP	Development Partner
EHO	Ethnic Health Organization
EPHS	Essential Package of Health Services
FCTC	(WHO) Framework Convention on Tobacco Control
GDP	Gross Domestic Product
IHME	Institute for Health Metrics and Evaluation
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MoHS	Ministry of Health and Sports
MoPF	Ministry of Planning and Finance
MoLIP	Ministry of Labor, Immigration and Population
MPLCS	Myanmar Poverty Living Conditions Survey
NCD	Non-Communicable Disease
NIMU	NHP Implementation and Monitoring Unit
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHP	National Health Plan
OOP	Out-of-Pocket
PFM	Public Financial Management
SSB	Social Security Board
TWG	Technical Working Group
UHC	Universal Health Coverage
WHO	World Health Organization

Executive summary

This paper sets the strategic directions for a health financing system that will support Myanmar's pursuit of Universal Health Coverage (UHC). It specifies health financing reforms necessary to realize the National Health Plan objective to provide the Essential Package of Health Services for the entire population. Furthermore, it identifies key decisions needed to be made in order to form a clear health financing strategy that will outline how to mobilize the resources and how to develop and implement risk pooling and purchasing mechanisms to address affordability and other substantial barriers to seeking care, especially among the poor and vulnerable.

The strategic directions were formed through a participative process involving various Myanmar health stakeholders and ASEAN countries visited by MoHS as part of a programme of study visit to inform the UHC dialogue in Myanmar. Analysis showed that low levels of health spending, a dominant out-of-pocket health spending, uncoordinated channels of health funding, and inflexible government budgeting arrangements characterize the current health financing systems. These bring about inequities and inefficiencies in resource utilization and in health service delivery. Moreover, they provide the population little financial protection from health spending.

The development of health financing strategies, policies, and systems in Myanmar should be guided by the following strategic directions for each of the three health care financing functions:

A. Strategic Directions for REVENUE RAISING

(1) Myanmar can raise resources for health in a sustainable, efficient, and equitable manner, through the following:

- Continue allocating a bigger percentage of national budget for health expenditure.
- Generate more revenues by increasing taxes for goods or products that are detrimental to health.
- Consider collecting contributions for health care from all formal sector workers.
- Improve budget utilization.

(2) Externally-sourced funds, such as donor support, should be channeled to supplement (and not replace) domestic revenues.

B. Strategic Directions for POOLING

(1) Resources for health may be channeled through two financing mechanisms

- Continued direct funding to the Ministry of Health and Sports for supply-side financing and other functions of the Ministry, and
- A pooling scheme that will manage the additional resources to reduce reliance on out-of-pocket for demand-side financing.

(2) Both financing mechanisms schemes should cover all people of Myanmar.

(3) There should only be a single pool for demand-side financing.

C Strategic Directions for PURCHASING

(1) All public funding will be channeled through the following purchasing mechanisms:

- The Ministry of Health and Sports for supply-side financing and other current functions of the Ministry, and
- A purchasing agent to manage the pooled fund for demand-side financing.

(2) The purchaser for demand-side financing should be distinct from any entity providing health services.

(3) The purchaser for demand-side financing should employ a strategic purchasing approach through:

- Buying the essential package of health services (EPHS) from any accredited health service provider, whether public or private.
- Developing payment mechanisms that are equitable, aim for cost containment, and provide motivation for quality.
- Monitoring provider performance, service utilization, and quality.

(4) Quality standards should be developed and implemented to assess health facilities.

(5) Government health care providers should be given a degree of autonomy and authority in financial management and decision-making to enable them to respond to payment incentives and deliver services more efficiently.

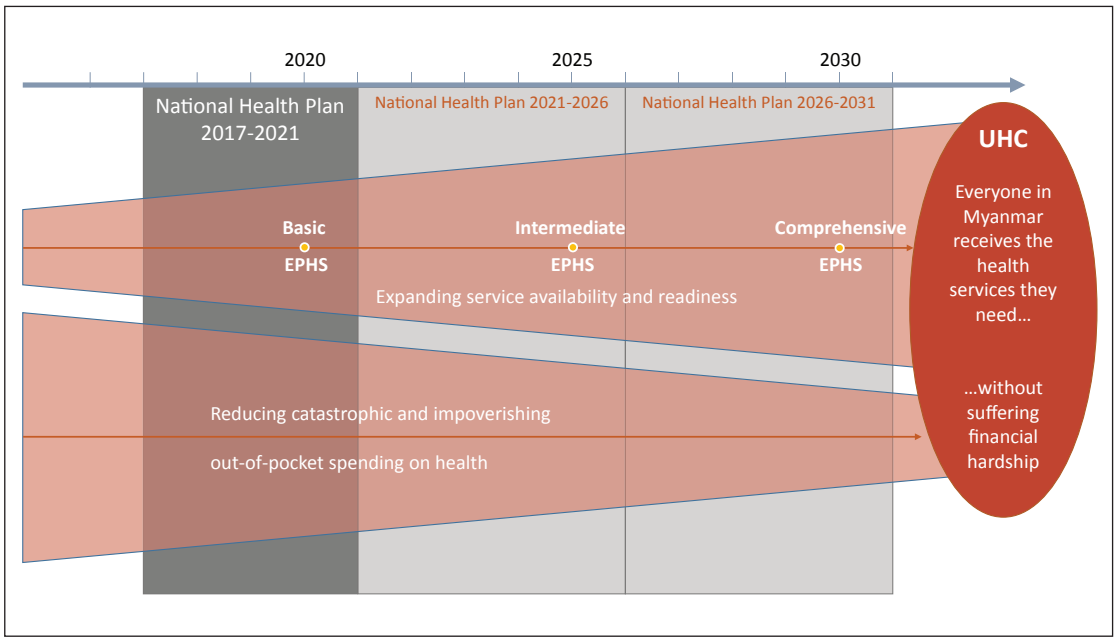
1. Introduction

This document captures main areas of discussions and agreement from a series of knowledge sharing and consultative meeting on financing UHC in Myanmar held between July and September 2019 in Nay Pyi Taw. The meeting were mainly organized by National Health Plan Implementation Monitoring Unit of Ministry of Health and Sports as part of National Health Plan Implementation and including a wide range of stakeholder: Parliamentarians, Ministry of Health and Sports, health-related ministries, academic bodies, medical and nursing councils, the private sector, Civil Society Organizations, Ethnic Health Organizations, Development Partners, Health related Local and International Non-Governmental Organizations. The knowledge sharing sessions included both technical aspects of health financing as well as international experience, especially from the ASEAN countries visited by MoHS as part of a programme of study visit to inform the UHC dialogue In Myanmar. The recommendations presented here are with the purpose of informing the UHC Bill requested by Parliament (with the name of National Health Insurance Law) and as a foundation for a national strategy that details each of the key areas of health financing: revenue raising, pooling and purchasing.

In Myanmar, political changes and economic reforms have ushered in a period of rapid growth. The Myanmar Sustainable Development Plan (MSDP) 2018-30 captures new directions in social policy to ensuring that the country's growth is inclusive, and that the government delivers on a range of social services – including health care – which Myanmar has underinvested in for decades (Teo and Cain, 2018). The country has expressed a strong commitment to achieve Universal Health Coverage, whereby all people of Myanmar by 2030 will have access to needed and quality health services without having to endure financial hardship in the process – a vision embraced globally through the Sustainable Development Goals (SDGs).

The National Health Plan 2017-21, that informed the MSDP including related national goals, lays down the groundwork for achieving UHC in three five-year phases, through the progressive rollout of an Essential Package of Health Services (EPHS). The first phase is articulated in the NHP 2017-2021, with aims to extend access to a basic EPHS for the entire population by ensuring supply-side readiness and increasing financial protection. In all phases, the NHP is guided by the principles of equity, inclusiveness, accountability, efficiency, sustainability, and quality.

Figure 1. National Health Plans and UHC



Source: National Health Plan 2017-2021, MoHS

The NHP underscores aligning health financing systems with the UHC and NHP goals. It also establishes the need to use available resources more effectively and to mobilize more resources.

Developing the Strategic Directions for Financing UHC

This paper sets forth the strategic directions for a health financing system that will support Myanmar's pursuit of Universal Health Coverage. It paves the road to forming a clear health financing strategy that will outline how resources will be mobilized to finance progress towards UHC and how risk pooling mechanisms can be developed to help improve affordability of care and address the substantial barriers to seeking care, especially among the poor and vulnerable.

The strategic directions are also an approach to ensure that NHP goals are realized within a reasonable timeline. They ensure that reforms in health financing will continue to support the realization of the NHP objective of providing EPHS for the entire population while increasing financial protection.

It is clear from laying down the strategic directions that health financing reforms require policy choices between alternatives that are contextualized and feasible for Myanmar; and, often, these need to be backed by new or revised legislation for effective implementation. Importantly, health is impacted by other sectors and, in turn, influences other sectors, requiring these choices to be made through consultation. In fact, this process needs to be a

continuous one, including the entire range of health stakeholders. This document lays down basis for such consultative and inclusive decision-making by detailing the overarching way forward for financing UHC in Myanmar.

The strategic directions also recognize that to be successful, health financing reforms should be undertaken in parallel and in coordination with other health system reforms for readiness of service delivery such as in human resources, infrastructure, medicines & equipments and budget allocation. Moreover, there are reforms that need to occur outside the health sector. For example, the alignment of public financial management rules with the health system is important to achieving broader health financing reform.

The strategic directions for financing UHC contained in this paper are the result of a series of discussions of the Ministry of Health and Sports (MoHS) together with key stakeholders including both public and non-public sectors (private sector, CSOs and EHOs) The strategic directions take into account new information, assessments, and other analyses that were not yet available during the formulation of the NHP 2017-2021. They also incorporate lessons from low- and middle-income countries that have implemented significant health financing reforms in the past two decades.

This document is structured as follows: After this introduction, the next chapter will provide a diagnosis of the health financing situation which becomes the basis for the strategic directions. The succeeding chapter will articulate the strategic directions for financing the health sector, their underlying principles and rationale. They will be presented according to each of the health financing functions, namely: revenue raising, resource pooling, and purchasing. At the end of each financing function, there will be notes on important considerations in moving ahead, some options, and some ongoing related activities that need to be seen through. A final chapter provides an indicative timeline for activities that need to be implemented and monitored, including key consultations that will define the health financing strategy in time for the next phase of the National Health Plan.

2. The Health Financing Situation in Myanmar.

This chapter reviews the health financing situation in Myanmar to highlight key issues and challenges with respect to adequate, equitable and sustainable financing for UHC in Myanmar.

How much does Myanmar spend on health?

Myanmar's total health expenditure (THE) in 2015 amounted to 3.6 trillion kyat, translating to a per capita health expenditure of 70,100 kyat or US$ 54. This represented 4.7 percent of the country's gross domestic product (GDP), which was significantly lower than the 5.9 percent average in lower middle-income countries. The per capita spending of USD 54 was also less than half of the USD 136 LMIC average (Table 1).

Table 1. Health Financing Indicators, Myanmar (2015) and Comparator Countries (2014)

	Myanmar (2015)	Cambodia	Lao PDR	Thailand	Vietnam	Lower-middle-income countries	East Asia and Pacific
GDP per capita (current US$)	1,355	1,163	2,212	5,831	2,086	2,390	4,163
Total health expenditure per capita (current US$)	54	72	57	232	127	136	281
Total health expenditure as a share of GDP (%)	4.7	6.2	3.0	4.0	6.1	5.9	7.1
Government share of total health expenditure (%)	23.0	21.7	36.7	71.6	40.0	47.3	60.2
Government health expenditure as a share of government spending (%)	8.0	6.6	4.2	15.3	8.2	9.1	11.3

Source: Myanmar, MoHS 2017; IMF World Economic Outlook, October 2018; WHO Global Health Expenditure Database.
Note: Excludes high income countries.

Significantly, the share of health in total government spending has substantially increased from less than 3 percent prior to 2011-2012 to 8 percent in 2015 (According to National Health Account and Ministrial data, General Government Health Expenditure GGHE as percentage of General Government Expenditure GGE in nominal amount increased from 1.1% in 2011 to 4.5% in 2018), and has put Myanmar closer in line with comparator countries and to the average. The rate of increase in government health expenditure was in fact faster than the rate of increase in total government spending. The recent increases in

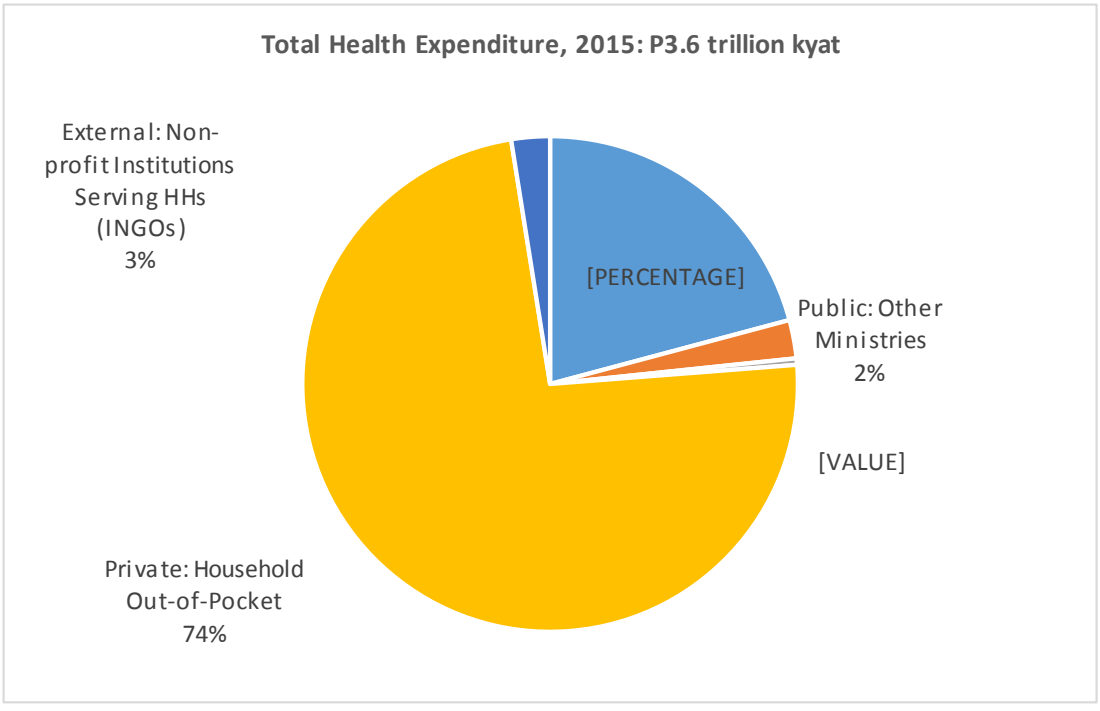
government budgets for health were allocated for construction and upgrading of hospitals and health centers, supply-side investments, medicines & medical equipments, and expansion of human resources with the separate formation of the MoHS Department of Public Health and Department of Medical Services in 2015.

The resulting government spending on health, however, was only 23 percent of Total Health Expenditure THE in 2015, just about half of the average in lower- middle-income countries where government share comprised 47.3 percent of the THE.

Who pays for health care?

The dominant source of financing was out-of-pocket spending by households, accounting for 74 percent of total health spending (Figure 2). Public health spending accounted for a total of 23 percent of the THE, and consisted largely of government budgetary expenditure on health (20.8 percent through the MOHS and 2.5 percent through other ministries), supplemented meagerly (0.42%) by health expenditure through the government's social security scheme. External sources, mostly spending through non-profit organizations, contributed about 3 percent.

Figure 2. Myanmar Health Expenditure by Financing Source, 2015

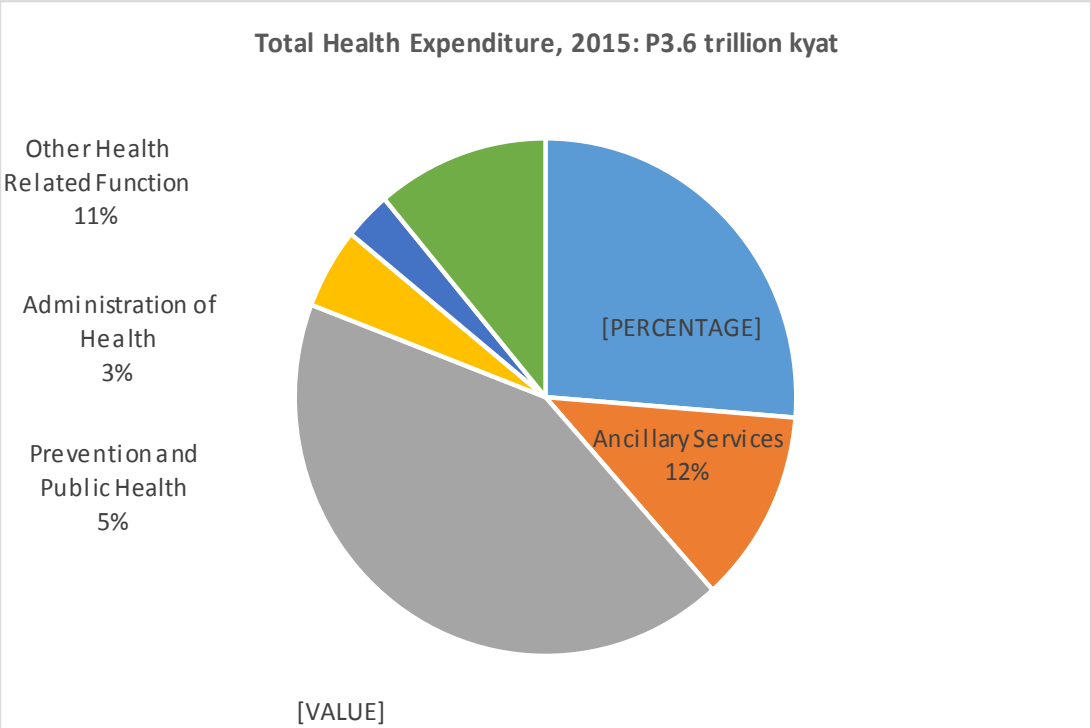


Source: Myanmar National Health Accounts, 2014-15, MoHS.

What is the spending on?

The National Health Accounts 2014-15 show that the biggest spending was on outpatient medicines, comprising 42 percent of the THE. This is followed by curative care at 26 percent. Preventive and public health care comprised only 5 percent of the spending (Figure 3).

Figure 3. Myanmar Health Expenditure by Health Care Function, 2015



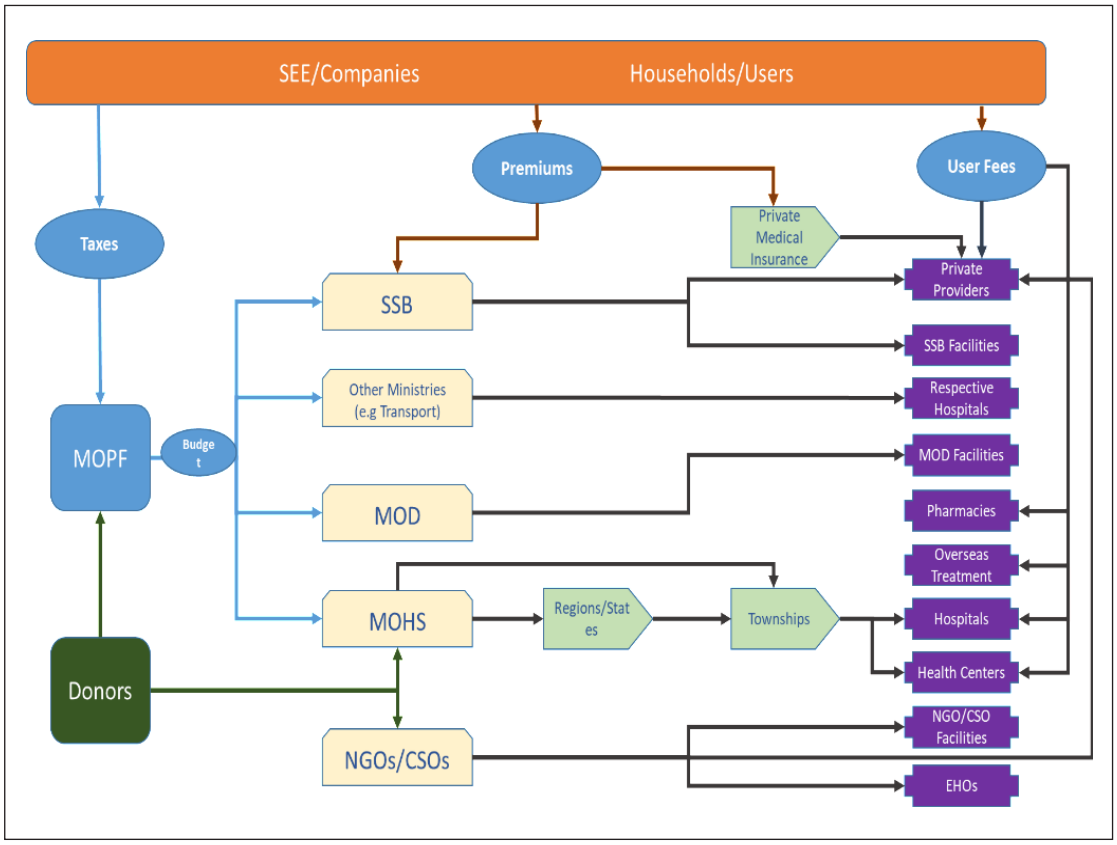
Source: Myanmar National Health Accounts, 2014-15, MoHS.

How do funds flow to providers?

Health care is mainly delivered through the network of hospitals and clinics of the MOHS. Myanmar has an estimated 1,141 public hospitals, 93 urban health centers, 348 Maternal and Child Health MCH centers, 1796 rural health centers, 9083 sub-rural health centersand 48 traditional medicine hospitals and 261 traditional medicine centers nationwide. Moreover, more than 300 private hospitals and nearly 10000 private GP clinics including EHO, CSO and NGO clinics are there also. The MOHS finances public facilities through budget line items which are generally rigid to be redistributed among different sub-line items. Although funding passes through regions and states and townships, these subnational levels have no authority to reallocate the funds (Figure 4). Other public facilities include three hospitals and close to 100 health clinics operated by the Social Security Board, funded through contributions of SSB members and their employers, and supplemented by government budget. In addition,

other ministries such as the Ministry of Transport and Ministry of Defense also fund and operate their respective facilities through budget line items, to provide services for their personnel. Under current PFM rules and regulations, other than for specific commodities linked to external funding, the MoHS cannot transfer resources to non-MoHS or non-public providers (private sector, CSOs and EHOs). It also cannot buy services from non-MoHS facilities, including SSB facilities and other government facilities.

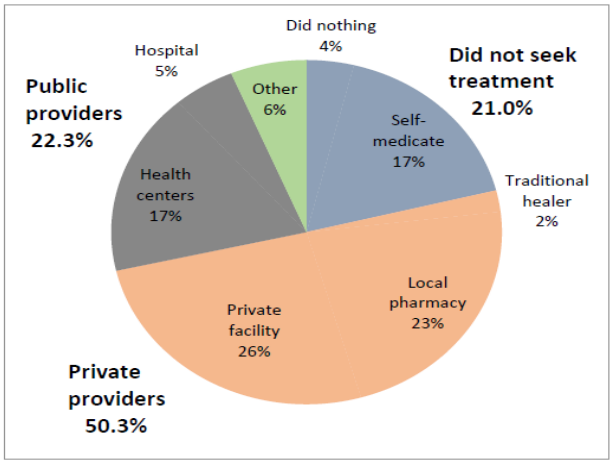
Figure 4. Flow of Health Funds in Myanmar



Source: NIMU, 2019.

It is notable that the Myanmar Poverty and Living Conditions Survey (MPLCS) found that half of those who reported ill sought care at nonpublic facilities (Figure 5), less than a fourth sought care at public facilities, while 21 percent did not seek any treatment.

Figure 5. Actions Taken when Ill/Injured



Source: World Bank 2018.

There is, therefore, a growing number of private health care facilities consisting of registered private hospitals, and an undetermined number of clinics and drug outlets. There are also facilities operated by the non-public sector (private sector, CSOs and EHOs), which are important providers because they operate in far-flung, isolated, and conflict-affected areas, but they are largely dependent on donor funding. MoHS currently has limited oversight with respect to the provider practice in the non-public sector including no data sharing agreement– on the type and quality of services, fee and other charges, appropriate and rational use of diagnostics and medicines.

Private providers are mainly paid through unregulated user fees. There may also be costs to accessing care, although unofficial and undocumented, in public facilities.

Analysis sequencing changed

The health financing situation in Myanmar is analyzed below using the **two key criteria of equity and efficiency:**

1. Equity.

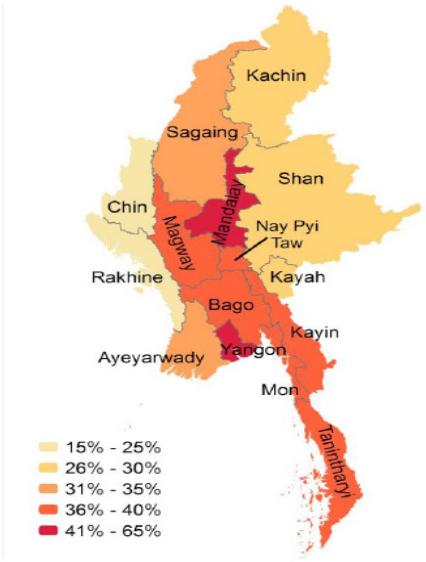
(a) **Is everyone in need of care able to access or utilize health care?**

The Myanmar Demographic and Health Survey 2015-16 data showed low coverage of health services. For example, institutional deliveries were only 37.1 percent, although pregnant women who received antenatal care by a skilled worker[1] was more encouraging at 80.7 percent. Immunization coverage[2] is also very low at only 54.8 percent.

1 With at least one ANC visit. Fifty-nine percent of these pregnant women had four or more ANC visits (recommended)
2 Basic immunization: BCG, first dose of measles, and three doses each of pentavalent and polio vaccine.

There are large disparities in coverage rates between socio-economic groups, between geographical areas, and even between sexes. For example, 82.5 percent gave birth in facilities in the richest population quintile, while it was only 16.8 percent for the poorest quintile. Institutional deliveries were highest in Yangon at 70.1 percent, and lowest in the remote Chin state at only 14.7 percent (Figure 7). They were as high as 70.1 percent in urban areas, but only 27.6 percent in rural areas. Similar disparities are observed for antenatal care although not as pronounced. It can also be noted that 57.9 percent of 12-23 month-old males have received all basic vaccination, while the rate for females is lower at 50.9 percent.

Figure 7: Institutional Deliveries by States and Regions



Source: Myanmar DHS 2015-16, MoHS and ICF

As highlighted earlier, the CSOs and EHOs provide critical care to underserved populations and the contribution would be important to include in a nation effort on UHC especially with respect to sustainable funding (currently, CSO and EHO activities are dependent larger on donor funding).

(b) **Is everyone in need of care able to access or utilize health care** without financial hardship**?**

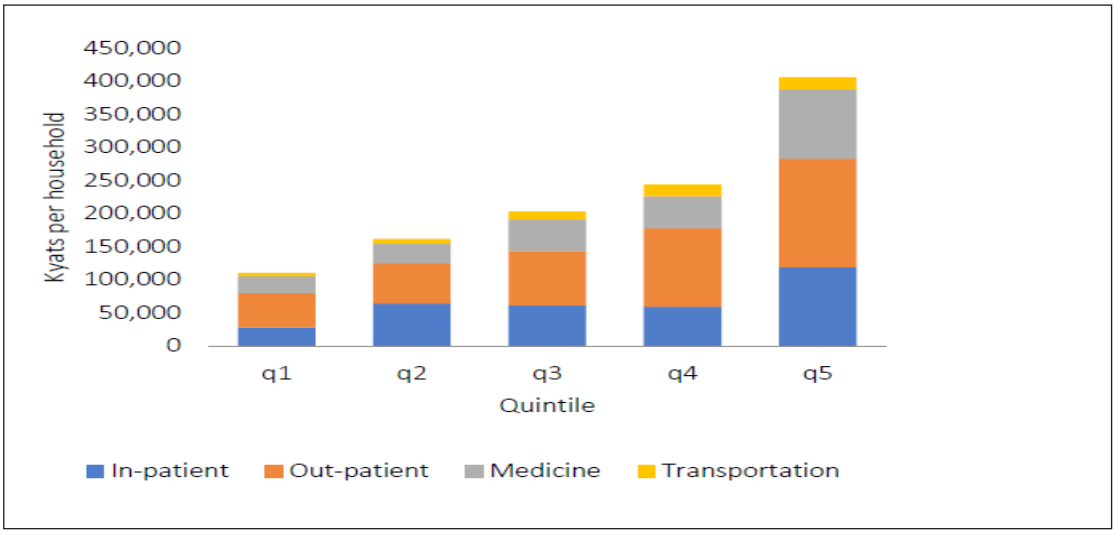
The 74 percent share of out-of-pocket spending in THE in Myanmar is among the highest in the world. The average Myanmar household is estimated to allocate 6.5 percent of its total cash spending to health. This is equivalent to about 203,000 kyat per household (or 45,000 per capita) annually.

The World Bank estimated in 2018 that approximately 16 percent of Myanmar households face catastrophic spending – that is, 10 percent of the total expenditure of the household is devoted to health. Moreover, the same estimate showed that 1.7

million people (or 3.4 percent of the population) were pushed into poverty in 2015 as a result of health spending. It is found that to cope with health spending, Myanmar households, in particular the poor ones, resort to detrimental strategies such as taking out loans, reducing other expenses (predominantly food expenses), and foregoing health care (Teo and Cain, 2018).

The cost of care is an obstacle for the poor in utilizing health care. Households below the poverty line spend about 107,000 kyats on the average for health, which is only about half that of households above the poverty line. A World Bank analysis showed that spending for inpatient, outpatient, medicine, and transportation as a total of household health spending is broadly similar across households of different income classes (Figure 8). Notably, poorer household and those in rural areas spend significantly less on every component of health, and inversely high-income households incur higher OOP spending health. The lower spending signals unmet demand for health care among the poor.

Figure 8. Annual Spending on Health by Consumption* Quintile



*Source: World Bank, 2018. *Consumption used as a proxy of income.*

2. Efficiency

(a) What are resources being spent on?

The 2015 Service Availability and Readiness Assessment (SARA) indicate that health spending is not being effectively utilized for strengthening primary services as needed for UHC. SARA examined the availability and functionality of tracer items - tracer items for general service readiness included five domains: selected essential medicines, diagnostic capacity, standard precautions for infection prevention, basic equipment at the outpatient department, and basic amenities – and findings indicated tertiary

hospitals generally fared better than facilities at the township level and below (township hospitals, rural health centers and sub rural health centers).

(b) **How are resources being spent?**

As noted above, OOP accounts for about two-thirds of total health expenditures and, in the current system, it is difficult to channel these resources in a way that would contribute to improving efficiencies.

In the public sector, government health providers are constrained by central planning, input-based budgets, and rigid budget line items. The budgets do not always correspond to the needs of the facility in service provision. This leads to poor budget execution, as service providers have very limited access to budgets allotted under the inappropriate budget lines. There is also lack of or limited communication and understanding of how to apply financial rules and regulations in a standardized manner, such as for procurement of medicines and in providing advances or reimbursement of travel costs (Teo and Cain, 2018). All these affect frontline service delivery negatively, with the limited resources not being utilized efficiently, if at all.

Further, the residual 5 percent of health spending is managed by the different government and private entities who dealt with different sets of healthcare providers. Although small in magnitude in terms of health spending, the significance of these funding sources is further undermined by inefficiencies brought about by having separate funding streams:

- Multiple administrative costs for multiple funding streams
- In having separate planning processes and accountabilities, there may be overlaps in service provision in terms of the same benefits provided to the same population. On the other end, there may be gaps in types of services provided, and in populations reached by the providers. In short, the potential of these resources to be allocated according to health needs of the entire population is not maximized.
- Having no data sharing arrangements heightens the non-integration of planning and accountabilities.

3. Strategic Directions for Health Financing

The previous chapter showed that low levels of health spending, a dominant out-of-pocket health spending, uncoordinated channels of health funding, and the top-down and inflexible government budgeting arrangements characterize the current health financing system. These bring about inequities and inefficiencies in resource utilization and in health service delivery. Moreover, they provide the population little financial protection from health spending. For adequate, equitable and sustainable financing for Myanmar's UHC effort, the development a health financing strategy needs to be guided by the following strategic directions for each of the three health care financing functions. These are also the basis for related UHC legislation as well as key areas for alignment and reinforcement by other systems components.

A. Strategic Directions for REVENUE RAISING

Myanmar needs more resources for its health sector to make substantial progress towards Universal Health Coverage (UHC) and achieve the goals of its National Health Plan. The country needs to pursue domestic, prepaid, and pooled resources for health to ensure that it is these, and not out-of-pocket payments, that will provide the necessary additional resources.

(1) **Myanmar can raise resources for health in a sustainable, efficient, and equitable manner, through the following:**

- ***Continue allocating a bigger percentage of national budget for health expenditure.*** It should be Myanmar's continuing goal to set aside a bigger percentage of its national budget for health expenditures. The continuing growth of the Myanmar economy makes it conducive for the country to commit more to health. The Myanmar Medium Term Fiscal Framework projects medium-term growth of 6.9 percent up to 2019-20. If the overall Myanmar budget will continue to grow annually, the percentage share of health can continue to go up without taking away significantly (in absolute terms) from budgets of other ministries. That is, health can get a bigger share of a bigger pie.
- ***Generate more revenues by increasing taxes for goods or products that impact public health.*** As non-communicable diseases have been figuring more prominently in the top disease burdens of the country – impacted mainly by life style choices including consumption of alcohol and tobacco as well as increased intake of salt and sugar. Tobacco use has become the number one risk factor for poor health in Myanmar by 2016 (IHME, 2017) and there is a strong investment case for Myanmar to raise tobacco taxes. An estimated 3.3 percent of GDP of the country is being lost to premature tobacco-related mortality,

tobacco-related healthcare expenditure, reduced workplace productivity and other economic losses due to smoking. On the other hand, over the course of 15 years, the return on investment from spending for tobacco control can be 225 times in terms of savings in avoided health expenditure and other economic losses avoided due to lives saved (WHO FCTC, 2018). Tobacco taxation is one of the most effective means of reducing the demand for tobacco (IARC, 2011). The increase in tobacco taxes should therefore be set at a level where it will increase prices to the point of reducing consumption, as a combined result of quitting, smoking less, and deciding not to initiate smoking. Further steps should be taken to ensure that the additional revenues from this will translate to bigger funds for health (see discussion below on Items for Consideration).

- ***Consider collecting contributions for health care.*** Formal sector contribution are easier to collected and also be collected in an equitable manner e.g. earmarked pay-roll taxes for health, like income taxes, or contributions to a health insurance pool. Collection from the informal sectors is, on the other hand, difficult and with high administrative costs.

  Some countries have realized it is more efficient for the government to subsidize the informal population than persuade them to enroll and give contributions.

  In Vietnam, the government and various projects provided subsidies to the near-poor ranging from 50 percent to 90 percent of the required contributions. While there were observed increases in coverage, anecdotal evidence shows that affordability constrains this population to enrolling into contributory schemes, no matter how large the subsidy is.

  The Philippines used a system of discretionary local government subsidies for the enrollment of the near-poor to social health insurance until 2012 before extending a full insurance subsidy to the near-poor in 2014.

  (Adapted from Somanathan, et. al, 2014; and Bredenkamp and Buisman, 2015.)

- ***Improving budget utilization.*** While this does raise new or additional resources, shifting away from top-down budgeting and improving the match between budget allocations and health needs reduces waste and underutilization of budgets – although this will require requisite service availability and readiness.

Using external funding as an interim measure. Reliance on domestic resources is key for sustainable financing of UHC. However, in the medium term, external funding for health may be used to help channel necessary investments especially for improving the readiness of the health service delivery reform. Valuable programs that are currently externally financed, should eventually be integrated into the government system and funded with domestic resources (Teo and Cain, 2018). To facilitate supplementation of resources for health sector, external funding, in the long-term, should be integrated with or use country systems in planning and fund flows.

Items for Action and for Discussion:

(1) Assessment of affordability and feasibility of contributions from various sources.

Along with revenue forecasts and spending plans in #1, an assessment should be made to provide options for designing an equitable contribution structure, regardless of who will pay the contribution. Experience of the Social Security Board in collecting contributions for social security can provide valuable insights for this.

(2) Continued advocacy for increasing tobacco taxes and consideration of earmarking this for health

There are at least two propositions in strong support of increasing tobacco taxes: higher government revenue and improvement of public health through the reduction of tobacco prevalence. These twin gains also make it justifiable to earmark the additional revenue, or at least a part of it, for the health sector. Myanmar should remember, however, a key lesson from other countries that while taxes on tobacco products have generated significant revenues, earmarking the proceeds did not necessarily result in increased resources available for health. Earmarking taxes for health might even result in non-earmarked revenues that would have gone to health to be budgeted for non-health uses. There is evidence, however, that earmarked revenues are able to augment health budgets when channeled directly into an autonomous or semiautonomous fund dedicated to specific public health or prevention activities. Moreover, other country experiences show that "hard earmarking" (where the earmark is the main or only revenue source for a particular service or program and the revenue may not be used for any other purpose) can lead to greater accountability in the use of funds for their intended purpose (Cashin e. al., 2017). Myanmar, for example, can specify to earmark the funds to a pooled fund as contributions of priority populations (to be discussed in the Strategic Directions for Pooling).

(3) Discussions with the Ministry of Planning and Finance on changes from top-down budgeting and other budget execution challenges

As the budget continues to grow, budget execution challenges have to be discussed with the MoPF to facilitate spending of funds on time and on target. Some items that need to be discussed include:

- Gaps and rigidity in the budget classification system, which either leaves some service implementers without adequate allocation or causes delays in accessing the budget allotted under irrelevant budget lines;
- Lack of or limited communication and understanding of how to apply financial rules and regulations in a standardized manner, such as for procurement of medicines and in providing advances or reimbursement for travel costs;

- Late submission and approval of revised budget estimates and consequently late release of funds, leaving service delivery units little time to spend the money before the end of the fiscal year;
- Reliance on a fully paper-based process without standardized digitization of the financial data; and
- Chronic deficit in qualified accounting staff within the spending units, especially at the state/region and township levels.

(4) Development of a medium term expenditure framework (MTEF) to support the NHP by explicitly linking planning to budgeting.

The current costing and budgeting exercises on the health sector funding requirements would be complemented with modeling of current and future revenue sources. Together, these would constitute a medium-term health spending framework, a planning tool that synchronizes resource availability with future expenditures. MTEF would also include outcome criteria for the purpose of performance monitoring. The analysis should be timed with the NHP phases, and guide the rollout of the EPHS.

MTEF can achieve its potential only if the budget actually finances the activities and services required to produce results – and this, in turn, underlines the importance of township health plans based on the health needs of the population.

Strategic Directions for POOLING

Resources for health may be channeled to two mechanisms:

(1) Continued direct funding to the Ministry of Health and Sports for supply-side financing and other functions of the Ministry, and

(2) A pooling scheme that will manage the additional resources to reduce reliance on out-of-pocket payments through demand-side financing. At least 50 percent of the population seek care in private providers, CSO and EHOs - therefore it is important to consider demand-side pool. This will enable public funds to reach areas not currently reached by MoHS facilities. Also, rather than just expand the current input-based funding, the demand-based financing will enable public money to respond better to health needs. Moreover, the pool can serve as accumulated prepaid fund protecting individuals from having to pay the full cost at the time of utilization of services. The pool, therefore, also intends to replace OOP as demand-based payer for health.

(3) Both financing mechanisms should cover all people of Myanmar. This means inclusion will not be based whether one is healthy or sick, rich or poor, productive (such as the young and/or unemployed) or non-productive (such as the old and/or unemployed).

(4) A single pool for demand-side financing. Pools not only combines funds but the risks of getting sick and incurring health spending (i.e. Risk Pooling). A single pool will create the largest possible pool and therefore provide the greatest capacity for cross-subsidies or redistribution of risks. Moreover, this arrangement will be administratively more efficient than having separate risk pools for different population groups that will require separate systems and management structures. The SSB experience with pooling is important here including consideration of the future role of the health financing function of the SSB. There are two options: to either expand population coverage of the health insurance component of the SSB; or, to include the SBB health insurance component in a new pool that has broader population coverage. Both options imply a substantive review of the current design of the health financing scheme of the SSB with associated legislative implications.

Indonesia and Vietnam have taken significant steps to integrate and harmonize multiple risk pools to achieve greater equity in coverage.

In 2014, Indonesia consolidated previously separate schemes for civil servants, private formal sector, and the poor into the national Jaminan Kesehetan Nasional (JKN). The country aims to also integrate various national and district-level insurance schemes.

Vietnam has also integrated various schemes into a single pool, but has been facing challenges of fragmentation due to the way that payments are computed differently for different population groups in each province based on previous utilization. The computation formula undermines the redistribution function of the pooling.

Adapted from Marzoeki et. al, 2014; Stott 2019; and Somanathan et. al., 2013.

Items for Action and for Discussion:

(1) Advocacy for Passing the UHC Law (National Health Insurance Law or Myanmar Universal Health Coverage Law)

Forming the pooled fund for demand-side financing can be realized more effectively and sustainably if backed by legislation. The UHC bill should include provision for the formation of the pooled fund, and the institutional arrangements for the pooling.

(2) Decision on institutional arrangements in managing the demand-side pool.

Some factors that need to be taken into consideration for the two options include:

- Transferring the health portion of the social security funds with the Social Security Board to a new pool. - This option allows undivided focus on the management of the pool for the health of the entire population, and allows the entity managing it to be accountable to the highest level of leadership in the country.
- Expanding the existing pool – The SSB already has administrative systems (e.g. finance, accounting) in for managing the fund. The SSB, however, manages

other social security benefits, and the health purchasing function may get diluted among its other functions. The purchasing functions will be discussed in more detail in the next section.

Either way, lessons should be taken from SSB's long experience in managing and implementing the social security benefits. Also, both options require legislative changes. For the first option, the 2012 SSB Law needs to be amended to specify that SSB membership could be expanded to include all segments of the population for the provision of health benefits.

Important to note here is that, by law, transition arrangement are required when shifting from one financing mechanism to another – implying that institutions and capacities shall be needed well in advance for change management as well.

(3) Discuss the role of Regions and States

In the new pooled funding and institutional set-up for demand side financing, the role of regions and states needs to be clarified.

(4) Discussions to clarify who pays for what inputs

While MoHS will be paying for supply-side inputs and the new or expanded pooled funding will be taking care of demand-side funding, there will be gray lines on which funding pays for particular inputs. When designing the benefit packages for demand-side funding, it has to be taken into account what already is being paid for by MoHS. On the other hand, it has to be considered also which mechanism will motivate better performance from the provider. For example, should salaries be covered in supply-side or in the demand-side financing? If so, how should the shift be implemented?

In the Philippines, a Health Financing Strategy for 2010-2020 envisioned reducing duplication and overlap in who pays for what. As of 2017, however, there were still a large number of programs funded by multiple sources and with possible duplication in payment. For example, PhilHealth, the national social insurance scheme, was expanding its benefit package for primary care, to include preventive medicine, but the Department of Health was not ceding responsibility for the financing of these medicines. Also, the Philippines HFS envisioned shifting of budget responsibility for personal services from the DOH and local government units to PhilHealth. This was not well understood and therefore not implemented. As a result, PhilHealth payments did not replace local government funding as intended but was supplementing them. In particular, PhilHealth payments were used to top up salaries in most localities rather than reducing the burden on payroll on LGU budgets.

Adapted from Bales et. al, 2017.

(5) Decision on Phasing for Population Coverage

As health resources are currently limited, the growth of these resources imply that coverage, especially for the demand-side financing, will have to be phased. A decision will have to be made on which population segments will be prioritized for coverage. While a method that prioritizes the poor and vulnerable is arguably the most equitable, identifying and targeting resources to them takes time and is not an easy task. Various

options for phasing have been considered, with tradeoffs on feasibility, timeliness, and equity discussed:

- *Geographic phasing* – This may be fastest to implement, but can err on subsidizing the non-poor and non-vulnerable. Such error can be mitigated by, for instance, prioritizing areas that are hard to reach, areas with the highest concentration of poor based on poverty maps, areas with worst health indicators. Another option is to prioritize areas with the most prepared facilities to deliver the Basic EPHS, to ensure the delivery of the services to the covered population.
- *Demographic phasing* – This form of phasing targets population groups that are easily identified, such as pregnant women, children below five years of age, the elderly, or the disabled. Here again, not all individuals falling into these profiles are necessarily poor nor vulnerable.
- *The poor and vulnerable* – While this may be the most equitable, identifying the poor and vulnerable is costly and complex. Other countries have developed mechanisms for identifying the poor by collecting information on socio-economic conditions of households. They have lists used for targeting social assistance that can be extended to identifying recipients of health fund contributions, making the targeting mechanism more cost-effective. It will take a country, in particular Myanmar, a number of years or even decades to come up with the mechanism. Dialogues need to be held with the Ministry of Social Welfare, Relief and Resettlement (MoSWRR), the Ministry of Union Government (General Administration Department (GAD), and other pertinent government offices to discuss whether the government has plans to establish a national mechanism to identify the poor and vulnerable, and if it has, to plot realistic timelines of implementation.

Phasing can also be combined with the government subsidizing the informal sector:

To be able to distinguish between the formal and informal sector populations, close coordination will be required with the Ministry of Labor, Immigration, and Population (MOLIP) for the population census and the database of the formal sector population. However, the informal sector comprises more than 70 percent of the population, a very large segment and may still need prioritization within this pool if resources will not allow coverage of the entire 70 percent. This method of prioritization will also err on subsidizing even those who may not be poor nor vulnerable.

As resources allow, populations outside the priority population groups may be included, or services may be expanded, or both. For example, if the poorest regions are prioritized, another set of regions may be added as more sustainable funding becomes available, until all the whole informal sector, or even the entire population, gets covered.

Population phasing can also be combined with service phasing: This is principle behind the phased roll-out of the EPHS in NHP implementation– with successive package

expanding the breadth and depth of service coverage from basic to intermediary to, ultimately, comprehensive care.

(6) Making a decision on automatic vs. active enlistment

When covering a priority population, it should be determined whether the constituents need to enlist themselves or should "automatically" become part of the pool. Experience in other countries with automatic inclusion shows that a significant portion of the subsidized population does not know that they are included and therefore do not avail of the benefits. Automatic inclusion therefore needs to be accompanied by an intensive communication effort to inform the population of their inclusion and their entitlements. Active inclusion, on the other hand, also requires a campaign to inform the population that they can be subsidized for inclusion and how they can register themselves.

For active registration, lessons from a pilot project by PSI has to be taken into consideration. In spite of a house-to-house campaign, only 67 percent of eligible beneficiaries from non-formal populations registered at assigned clinics (PSI, 2017).

Strategic Directions for PURCHASING

All public funding will be channeled through the following mechanisms:

- ***The Ministry of Health and Sports for supply-side financing and other current functions of the Ministry***, and
- ***A purchasing agent to manage the pooled fund for demand-side financing.*** This purchaser should be provided autonomy such that it can determine payment rates for services and have the flexibility to allocate funds across a range of services and providers.
- ***The purchaser for demand-side financing should be distinct from any entity providing health services.*** A purchaser provider split separates purchasing or buying health services from provision or supply of health services. This enables the purchaser to focus on how to make its funds achieve the health objectives, rather than having its objectives dictated by provider interests. Meanwhile, providers can focus how best to provide those services (CPI, 2018). If an institution is currently operating health facilities is transitioned into a purchasing entity, ownership of facilities shall need to be rearranged under the purchaser-provider split.

What is Strategic Purchasing?

Strategic purchasing aims to increase health system performance through the effective allocation of financial resources to providers. This process involves three sets of explicit decisions:

- Which interventions should be purchased in response to population needs and wishes, taking into account national health priorities and evidence on cost-effectiveness
- How they should be purchased, including contractual mechanisms and payment systems
- From whom they ought to be purchased in light of providers' relative levels of quality and efficiency

Strategic purchasing can be seen in contrast to more passive purchasing approaches – for example when a predetermined budget is followed or bills are simply reimbursed retrospectively.

(PSI 2017)

The purchaser for demand-side financing should employ a strategic purchasing approach. That is purchasing should be carried out with the aim of increasing health system responsiveness through the effective allocation of resources according to the population's needs and through motivation of health providers to improve efficiency and quality. The strategic purchaser can do this through:

(1) Buying the essential package of health services (EPHS) from any accredited facility, whether public or private. Accreditation requires the provider to fulfill certain requirements to be eligible for securing and retaining contracts to provide services. Under purchasing only those providers who achieve a minimum standard of quality, process and outcome assessed against available resources are selected. Accreditation ensures that the benefit package and its expansion are aligned with funding capacity and the service availability and readiness of providers. The purchaser will be buying services based on outputs rather by inputs. It shall do so by contracting providers that can demonstrate clearly how they can supply services that meet purchaser objectives.

The public sector alone will not be able to reach and serve the entire population of the country with the Basic EPHS. The purchasing agency should therefore also engage with and purchase services from the wide range of non-public health providers, such as ethnic health organizations (EHOs), non-government organizations (NGOs), private-for-profit providers, and consortia or networks of these providers. Collaboration across all health care providers is also essential to ensure effective referral systems, equitable coverage, to build synergies, and to avoid duplication in service delivery.

(2) ***Developing payment mechanisms that are equitable, aim for cost containment, and provide motivation for quality.*** The way that health purchasers pay health care providers to deliver services is a critical element of strategic purchasing. A payments system can be based on one or more provider payment methods and each method creates a different set of incentives and may be used appropriately in a specific context to influence equity, cost and quality of services.

Thailand case: Containment of costs by paying capitation primary care and global budget for hospital care.

Thailand tax-funded Universal Coverage (UC) scheme pays accredited providers a capitation, or a fixed amount per year for every member, to provide primary care to UC members. For public hospitals, it pays a global budget, or a fixed amount per year, based on estimates of volume and types of services that the hospital will be providing to UC members. The UC scheme is also known as the 30 Baht scheme since members are expected to make a nominal payment of 30 Baht (less than USD1) per outpatient visit and per hospital admission.

Cost-containment may be a problem if the benefit package of a scheme only covers hospital services. If primary care services are not included in the package, patients tend to go directly to a hospital or a medical specialist for a health problem that could have been dealt with at the primary care level at a much lower cost. Many countries have found that having primary health care providers act as gatekeepers to hospital care is a useful cost-containment mechanism.

(Adapted from Diane McIntrye, 2007, as sourced from Limwattananon et al., 2005; Suraratdecha et al., 2005, and Ros et al., 2000).

(3) ***Monitoring provider performance, service utilization, and quality.*** It is critical to put in place a system of monitoring provider performance, service utilization, and quality, to determine whether health system performance objectives of strategic purchasing are being met, and be able to analyze reasons and take corrective actions if they are not being met.

(4) ***Quality standards should be developed and implemented to assess health facilities and quality services.*** The possibility of establishing a third-party accreditation agency (i.e. distinct from the purchaser and the providers, may be explored. The accreditation agency shall promote adherence to standards of care across providers that will be contracted by the purchasing agency. Delegating this to a third party ensures objectivity in the assessment of performance of facilities as well as provide focused support to providers to improve on their performance.

(5) ***Public providers should be given a degree of autonomy and authority in managing their funds and making decisions (to be able to respond to incentives and deliver services efficiently).*** Unless public sector managers responsible for service delivery have legally delegated decision-making authority, public health sector providers will not be able to respond to the incentives created through the purchasing arrangements, and cannot be held fully accountable for their performance (McIntyre and Kutzin, 2016).

Items for Action and for Discussion:

(1) Building institutions and capacities for strategic purchasing (including on making decisions on provider payment mechanisms).

Overall, the responsibilities of a strategic purchaser may be categorized into four (World Bank, 2018):

- Knowing how much money the purchasing agency has and how much it spends,
- Deciding what to buy and from whom to buy
- Deciding how and how much to pay providers, and
- Knowing how the money is being used.

Myanmar has very limited experience on strategic purchasing, mainly consisting of pilot projects targeting peri-urban poor and rural poor populations living in non-conflict areas and EHO areas, implemented by PSI and CPI; and pilots with formal sector workers as implemented by SSB. Experience from other countries suggests that building the requisite systems to facilitate strategic purchasing takes many years (World Bank, 2018). Building capacities of the purchasing entity is therefore an immediate priority in the health financing reform process.

In addition to abovementioned ongoing pilots, demand-side financing in the public sector also needs be tested. Based on the NHP recommendation to establish a purchasing agency, MoHS should set aside a portion of next fiscal year's budget to pilot demand-side financing. For provider payment mechanisms, the MoHS pilots should test global budgets and capitation mechanisms.

(2) Discussions with the Ministry of Planning and Finance on related PFM considerations

The discussions in this section suggest "sufficiently flexible public financial management is a pre-condition for strategic health purchasing" (WHO). From the current state of PFM where, considerably major PFM reforms required to enable strategic purchasing and for providers to respond to the incentives created it:

- Allowing transfer of extra-budgetary funds to a semi-autonomous entity that will have different PFM rules from government ministries
- Allowing the purchasing entity to enter into contracts with any accredited provider, whether public or private
- Providing public facilities autonomy in managing their funds and other resources and making decisions.
- The NHP suggests creating a new budget line to consolidate existing, disparate operational budget lines, to enable spending more flexibility in spending by the facilities

4. Moving the Strategic Directions for Health Financing Forward: Implementing Reform Activities, Monitoring and Evaluation

Moving the strategic directions for health financing forward entails implementation of reforms in the health financing system that will support Myanmar's achievement of Universal Health Coverage.

The next step is to detail each strategic direction in a national strategy for health financing based on the legal description (Myanmar UHC Law/National Health Insurance Law). The implementation, monitoring, and evaluation of financing reforms should be therefore be incorporated in the implementation arrangements and monitoring and evaluation framework of the next National Health Plan, and schedules should be integrated with the three phases of the NHP.

Monitoring the health financing reforms should be aligned with the NHP monitoring framework and include indicators that will measure the progress towards achieving the UHC goals of financial protection, equity, efficiency, and quality. A set of suggested indicators are provided in Annex 1.

Health financing reforms should be monitored and evaluated by the NHP Implementation Monitoring Unit (NIMU), together with the Health Financing sub-group of the Health Systems Strengthening Technical Strategy Group (MHSCC) with representation from SSB, MOSWRR, MOPF, and other government agencies. NIMU is mandated to facilitate smooth implementation of the NHP, and therefore also covers corresponding health financing reforms. The NIMU reports directly to the Minister and Permanent Secretary and relevant Director Generals. The unit consists of a mixed set of skills and expertise including legal, financial management, public health, clinical, and health financing.

The scope of responsibilities in monitoring and evaluation of health financing reforms may be grouped into three:

- Facilitating the Implementation of Health Financing Activities – Along with the strategic directions set in this document, some necessary elements and considerations to move towards an actual health financing strategy were identified. These include critical decisions regarding the reform path to choose, policy changes and new legislation. The engagement among various stakeholders will have to be facilitated in order to support informed decision making. Everything is critical and

feed into each other, hence it is important that each activity is followed through and none will fall through the cracks when some activities will require special attention. Many of these activities will also facilitate decisions and provide details to be able to articulate a Health Financing Strategy in time for the second phase of the National Health Plan.

- Monitoring and coordinating for complementarity of health financing reforms with other health system reforms – Health financing functions of revenue raising, pooling, and purchasing, will have to go hand in hand with other health system functions. Health financing reforms will therefore have to be in sync with other health system reforms during the different phases of the EPHS.
- Evaluation – An evaluation needs to be undertaken for each phase, in order to examine how the strategy and reforms are working and what is being achieved. A quantitative evaluation using the monitoring indicators will be complemented with qualitative evaluations to understand the causal effects of the reforms.
- Accountability – As in the NHP, accountability isimportant to establish early on in the reform effort. CSOs have an important role to play in social accountability through community mobilization and advocacy, or by introducing checks and balances and acting as a watchdog with respect to health service planning, delivery, and monitoring, especially as it relates to the Basic EPHS to which the population will be entitled. Their capacity needs to be built to successfully carry out these functions. The Myanmar CSO informal health network that was formed during the second Myanmar CSO health forum can help civil society mobilize community and enhance public awareness around the NHP.

Table 2 in the next page summarizes the activities by phase. This is followed by a more detailed workplan for the first year, starting from the second quarter of 2019 (Table 3).

Table 2. Moving the Health Financing Strategic Directions Forward

Actions	Preparatory Phase (2019, 2020-2021)	Introduction Phase (2021-2026)	Scale-Up Phase (2026-2030)
Implementing Health Financing Activities	• Preparation of forecasts/ models of various revenue sources, and a medium-term health spending plan (health sector expenditure framework), using simulation tool • Continued advocacy communication and social mobilization (ACM) for passage of UHC bill, with provisions for establishment of pooled funds for demand-side financing, and establishment of a purchasing agency and an accreditation agency • ACM for continued increase in budget allocations for health • Lobbying for increase in tobacco taxes and earmarking for health • Continued demonstration studies to gather experience on strategic purchasing • Pilot demand-side financing in public sector using 2019-2020 budget • Discussions with Ministry of Planning and Financing on PFM reform requirements • Discussions and decisions on options for operations of pooled funding and purchasing: institutional arrangements (including the roles of regions and states), prioritization of coverage, who pays for what, provider payment mechanisms, affordability and feasibility of continued formal sector contributions • Development of Health Financing Strategy for next NHP Phase	• Establishment of purchasing agency and developing its functions and capacities • Establishment of accreditation agency and developing its capacities • Continued lobbying for budget allocations in health, and as needed, continued lobbying for increase in tobacco taxes and other revenues that may be earmarked for health • As needed, continued discussions with MoPF and other agencies on reforms and activities needed to operationalize the pooled fund and strategic purchasing arrangements • Updating of Health Sector Expenditure Framework	• Implementing reforms on purchasing according to results of evaluation of Introduction Phase, e.g., implementing provider payment reforms • Continued lobbying for budget allocations in health, and as needed, continued lobbying for increase in tobacco taxes and other revenues that may be earmarked for health • As needed, continued discussions with MoPF and other agencies on reforms and activities needed to operationalize the pooled fund and strategic purchasing arrangements • Updating of Health Sector Expenditure Framework

Actions	Preparatory Phase (2019, 2020-2021)	Introduction Phase (2021-2026)	Scale-Up Phase (2026-2030)
Monitoring complementing reforms in the Health Systems	• Supply-side readiness for Basic EPHS	• Delivery of BasicEPHS • Definition of Intermediate EPHS and setting standards • Supply-side readiness for Intermediate EPHS	• Delivery of Intermediate EPHS • Definition of Comprehensive EPHS and setting standards • Supply-side readiness for Comprehensive EPHS
Evaluation	• Quantitative evaluation • Qualitative evaluation	• Quantitative evaluation • Qualitative evaluation	• Quantitative evaluation • Qualitative evaluation
Accountability			

Table 3. Year 1 Work plan for Moving Forward Health Financing Reforms

Action	Remark	Responsible Party/ies	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Beyond Yr 1
Preparation of forecasts/models of various revenue sources, and a medium-term health spending plan		NIMU/HFS TWG	X				X
Continued advocacy for increasing tobacco taxes, and consideration of earmarking this for health		MoHS	X	X		x	
Continued advocacy for passing the UHC Law		NIMU, CSO	X	X	X	X	X
Decision on institutional arrangements in managing the demand-side pool, including the role of regions and states							
Finalize briefing papers for MOHS, MOPF, MOSWRR, SSB		NIMU, WHO	X				
Discussions/Consultations with the ministries		NIMU	X	X			
Lobby with Cabinet for Decision	Decision aimed by Q4 2019	NIMU		X	X		
Decisions on Prioritization of Coverage, and Automatic vs. Active Enrollment		NIMU, WHO					
Finalize briefing papers for MOH, MOPF, MOSWRR, SSB		NIMU	X				
Discussions/Consultations with the ministries	Concept to be already discussed with ministries, but more substantive discussions after passage of UHC Law	NIMU		X	X	X	
Lobby with Cabinet for Decision		NIMU					X
Assessment of affordability and feasibility of contributions from the formal sector		NIMU/HFS TWG, PSI	X	X	X	X	X
Build capacities for strategic purchasing							
Continue pilots of PSI, CPI, SSB		PSI, CPI, SSB	X	X	X	X	

Action	Remark	Responsible Party/ies	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Beyond Yr 1
Pilot demand-side financing in public sector using 2019-2020 budget	Preparations to being in Q2 2019	MoHS, SSB	X	X	X	X	X
Build capacity of actual strategic purchaser	After passage of UHC Law						X
Discussions on clarify who pays for what inputs (with special attention to medicines)	To start during piloting of demand-side financing, Final decision after passage of UHC Law			X	X	X	X
Decision on provider payment mechanisms	Build lessons from pilots, decision will be after institutional arrangements for strategic purchaser are agreed					X	
Discuss/lobby with Ministry of Planning and Finance the PFM considerations	Ongoing discussions with MoPF on expenditure tracking, providing more flexibility on the budget	MoHS	X	X	X	X	X
Monitor other health systems reforms (e.g. supply-side readiness, HRH reforms)		NIMU/HFS TWG	X	X	X	X	X
Preparing the Health Financing Strategy for the Next National Health Plan phase		NIMU/HFS TWG				X	X
Evaluation of health financing reforms (quantitative and qualitative), including assessment of strategies		NIMU/HFS TWG					X

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Annex 1:
Suggested Monitoring Indicators

The effectiveness of health financing reforms may be analyzed by examining the status of each health financing goal. Some suggested indicators per objective are provided below. The list of indicators should be finalized, and the baseline, target, and data source identified for each indicator. Proxy indicators can be used according to availability of data.

Objective/Goal	Indicator	Baseline	Target	Data Source
Financial Protection	% of OOP in Total Health Expenditure (THE) % of Pooled Funding in THE % of people pushed to poverty because of health spending (at poverty line of $__.day) General government expenditure on health as a % of total general government expenditure (GGHE/GGE)			
Equity	Ratio of coverage of institutional deliveries between the richest and poorest quintiles Ratio of government health expenditure between the richest and poorest states			
Effective Service Coverage	Coverage of Institutional Deliveries Coverage of Fully Immunized Children			
Allocative Efficiency	% share of primary health care in the expenditure of pooled funding for demand-side financing			
Technical Efficiency	% Share of medicines in OOP spending % of facilities that are ready to deliver basic EPHS			
Quality	Patient Satisfaction			

World Health Organization

Myanmar