



MYANMAR STRATEGIC PURCHASING BRIEF SERIES – No. 3

## Targeting Poor Households

November 2017

### INTRODUCTION – THE STRATEGIC PURCHASING BRIEF SERIES

This is the third in a series of briefs examining practical considerations in the design and implementation of a strategic purchasing pilot project among private general practitioners (GPs) in Myanmar. This pilot aims to start developing the important functions of, and provide valuable lessons around, contracting of health providers and purchasing that will contribute to the broader health financing agenda. More specifically, it is introducing a blended payment system that mixes capitation payments and performance based incentives to reduce households' out-of-pocket spending and to incentivize providers to deliver an essential package of primary care services.

### CONTEXT

Many people in Myanmar access most of their health care through the formal and informal private sector and payment for this care comes mostly out of the patient's pocket. This can cause a significant financial burden to poor and vulnerable populations and lead to a chronic under-use of basic health services.

In response to this challenge, and in support of the Government of Myanmar's long term universal health coverage goal, Population Services International (PSI)/Myanmar has established a pilot project to demonstrate the capacity of private GPs in its Sun Quality Health (SQH) network to offer a basic package of primary care services to poor and vulnerable households. In this pilot, PSI is 'simulating' the role of a purchaser, but expects this role to be taken over at some point by a national purchaser, as outlined in the National Health Plan (2017-2021). In the long run, the role of PSI is likely to evolve into that of an intermediary organization (for more information on this, see "[Intermediaries: The Missing Link in Improving Mixed Market Health Systems?](#) Results for Development Institute, July 2016"). This intermediary role could include supporting the formation of networks of providers that are easier to integrate into payment systems, and helping these providers meet minimum requirements through quality improvement and management capacity development. Eventually, the



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'package' of services to be purchased from GPs, even if limited, will need to be streamlined with the basic Essential Package of Health Services that is currently being developed at the national level.

Under the pilot, a total of 2,506 low income households in two townships<sup>1</sup> in Yangon region, Shwepyithar and Darbein, have been registered, screened and issued with health cards which entitle them to a defined benefit package provided by five selected members of the SQH network. The pilot specifically aims to demonstrate an increase in the range of services offered by private providers, a decrease in out-of-pocket payment by the registered households, and a decrease in the time to seek treatment from the start of signs and symptoms.

## OBJECTIVE

This brief aims to describe the process that the pilot project followed to identify low income individuals and enroll them into the project, from the initial identification of clusters of poor dwellings to the eventual issuance of health cards to registered members of poor households.

The brief discusses the rationale behind the selected approach, indicating both its strengths and limitations, and highlighting some of the trade-offs that were involved. The brief also shares the main challenges encountered and how the project tried to overcome those challenges. The identification and enrolment process described in this brief is expected to evolve over time as the project expands, and as feedback is received from providers, beneficiaries and other stakeholders.

## TO TARGET OR NOT TO TARGET

There were extensive discussions during the project's design phase on whether to target poor households. At that time, Myanmar did not have a health financing strategy. As such, the question of whether a national mechanism to target the poor would be established had yet to be debated.

The design team initially considered two different models for the pilot: a first model in which everyone in a delimited geographical area gets a health card, and a second one in which a health card is only given to a fixed number of individuals identified as poor. Both models are described in Box 1. The option to test both models concurrently was also explored.

### Box 1 – The two models considered during the design phase

#### Model 1 – Everyone gets a health card

This first model would be implemented in an area with 2-3 SQH clinics serving between 2,000 and 3,000 households. All the households living in that area would be asked to register with one of the clinics by a certain date on a first-come-first-serve basis. All the members of the households in the area would receive a health card that entitles them, for a set period of time, to the services and interventions included in the package, to be delivered by the clinic with which they registered.

#### Model 2 – Only the poor get a health card

Poor households would be identified and targeted by the project to receive a health card that entitles them to the services and interventions included in the package. An effective targeting approach would need to be developed, since there is no nationally accepted system in place. Non-poor patients would continue to pay out of their pocket, even for services and interventions included in the package.

In both models, there would be a maximum of around 1,000 households per clinic. Patients would continue to pay out-of-pocket for services and interventions that are not included in the package or for services and interventions delivered by a health care provider other than the clinic with which they registered. Each SQH clinic would be paid a capitation amount for each individual that is registered with the clinic. On top of that, the clinic would receive performance-based incentives linked to selected indicators. Patients who did not receive a card, would continue to pay on a fee-for-service basis for services and interventions included in the package.

<sup>1</sup> Townships in Myanmar are somewhat comparable to what many other countries call districts. On average, a Township has a population of around 150,000.

After careful consideration, it became clear that Model 1 would not be feasible for at least three reasons:

- Identifying a small enough, clearly delineated, geographical area where everyone could be covered proved to be extremely challenging
- The population size in neighborhoods that could potentially qualify was found to be far larger than expected<sup>2</sup>
- Trying to cover an entire population in an area where some public-sector doctors were found to be running a dual practice was likely to lead to conflict, as the project would potentially impinge on their business

The final design of the pilot project was therefore based on Model 2, despite the potentially perverse incentives it was likely to create for participating providers – incentives that arise when a provider is being pre-paid, through capitation, for poor (card-holding) patients, while continuing to charge non-poor (non-card-holding) patients on a fee-for-service basis.

### TO TARGET, BUT HOW?

Once the decision was made to go with Model 2, the next step was to develop a suitable targeting approach to identify and register poor households. The first approach that was considered was developed with input from members of the World Bank's Poverty Team. While sound from a methodological point of view, this approach was found to be infeasible given available time and budget. An alternative approach that was faster and less costly was therefore developed and adopted. The steps involved in each of the two approaches are described in Annex 1.

The approach that the design team eventually adopted relied heavily on an assessment of the visual appearance of dwellings, first by local authorities and then by an external agency recruited by PSI. The following three categories of dwellings were defined:

- Category 1 (poorest) – the dwelling is in the deteriorating condition; there is no proper roof and there are no proper walls; the dwelling is covered in unconventional but easily available materials
- Category 2 (poorer) - the dwelling is small with a proper roof and proper walls, but it is made of cheap locally-made materials; the household has no access to basic utilities such as electricity and it does not possess its own water source
- Category 3 (poor) - The dwelling is small but neat and made of durable materials such as zinc roof and wooden walls. The household has access to some basic utilities, but it does not have convenient access to higher amenities (e.g. motorbike) and businesses (e.g. retail shop).

Local authorities, with support from the PSI-appointed field team, identified a total of 2,797 poor dwellings. The external agency visited all these dwellings and rejected 291 of them, which did not meet the inclusion criteria and were deemed to belong to better-off households. For cost saving purposes, the external agency was also used for conducting the household survey that determined baseline health data as well as the data needed to calculate the socio-economic status of beneficiaries.

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<sup>2</sup> Interestingly, several neighborhoods that could potentially qualify had the expected low number of private clinics; the only reason why these clinics were able to cover a large population was that actual service utilization was well below optimal. If these providers were to deliver optimal care, they would be unable to cope with the demand.

## FROM IDENTIFICATION TO REGISTRATION

The identification of eligible households was only the first step in the registration process. As shown in Box 2, eligible household members received a voucher from the inspection team to visit the SQH clinic to which they had been assigned to undergo a free medical screening. The screening served three purposes:

- Provide an incentive to identified individuals to come to the clinic and meet the provider.
- Identify higher-risk groups (e.g. pregnant women, children under the age of five, people with high blood pressure).
- Enable biometric data collection in the form of a photograph for the health card and an iris scan that generates a unique patient identification number and acts as a means to verify the identity of a cardholder.<sup>3</sup>

It was important that all individuals come to the clinic for screening, since it was rare to find all household members present at the moment of the initial household registration. Therefore, the screening also acted as a means of verifying the individual's existence, and an opportunity for the collection of biometric data. Screened individuals were then issued a health card, granting them free access, apart from a nominal user fee, to all services included in the benefit package (see Issue [Brief #1](#)).

### Box 2 – The registration process

Step 1 – Identification of poor households (see Annex 1)

PSI-appointed field team works with local authorities to identify households meeting inclusion criteria.

Step 2 – Issuance of voucher

External agency visits households identified in Step 1, confirms whether the inclusion criteria were met, and issues a voucher that lists all household members by name.

Step 3 – Medical screening and biometric data collection

Members of households with vouchers visit the clinic for medical screening and for biometric data collection.

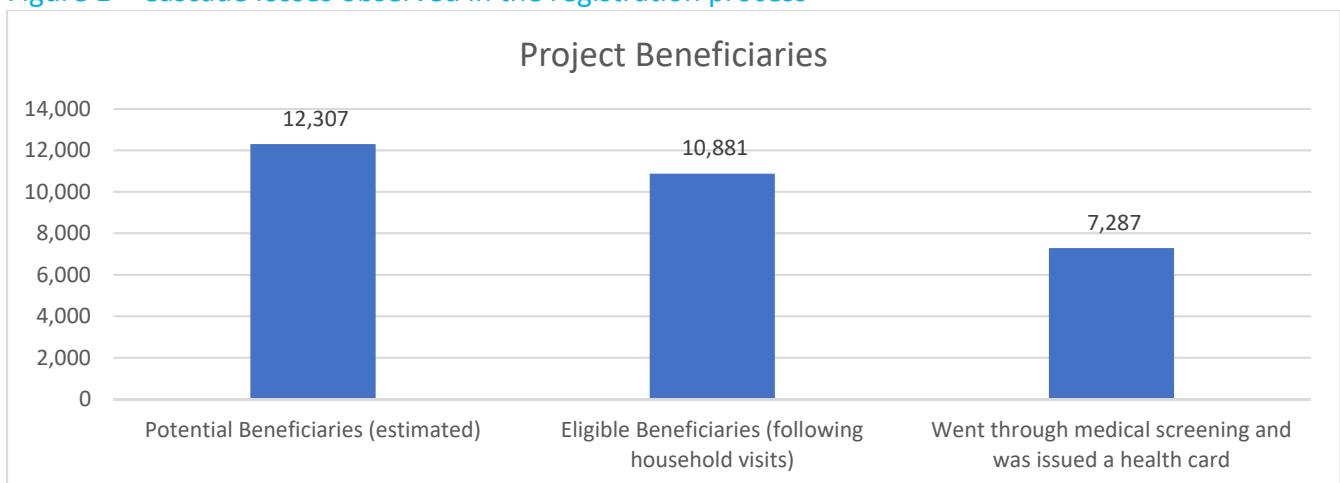
Step 4 – Issuance of health card

PSI issues a health card to each screened individual and adds the individual to the provider's list, which is used to determine the monthly capitation payment (see Issue [Brief #2](#)).

## CHALLENGES

Eligible individuals were lost at each step of the registration process (see Figure 1).

Figure 1 – Cascade losses observed in the registration process



<sup>3</sup> A secondary objective was to assess the potential scalability of patient identification using iris recognition technology.

With support from USAID’s Health Finance and Governance (HFG) project, implementation research (IR) was built into the pilot project. Key stakeholders<sup>4</sup> met in June 2017 to identify IR questions for the first cycle of learning. Some of the questions focused on the observed losses at the different stages of the registration process (see Figure 1). For example:

- Why do only about two-thirds of eligible beneficiaries go to the clinic for screening?
- Why do, in some eligible households, only some members go for screening while other members do not?

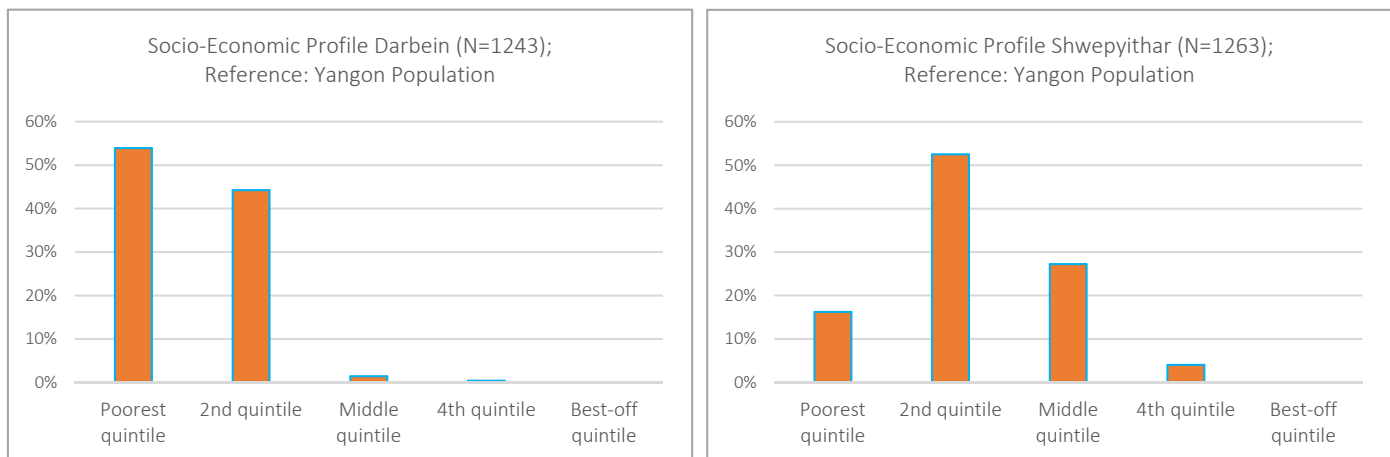
Findings revealed a number of issues that could relatively easily be addressed, including the following:

- The external agency in charge of household selection provided incomplete information to many households, especially with respect to the steps involved in the registration process
- The limited duration of the screening period prevented many individuals working outside the Township to register. In particular, some factory workers did not get enough time to go to the clinic for screening
- The long distance between the houses of beneficiaries and the assigned clinic
- Some eligible individuals were unwilling to have their picture taken as part of the registration process

### EFFECTIVENESS OF THE TARGETING

The Equity Tool was used for an *ex-post* assessment of the effectiveness of the targeting. The tool was used to assess the socio-economic profile of identified households.<sup>5</sup> The results are displayed for each of the two project areas in Figure 2. Targeting was clearly effective in Darbein, with more than 98% of the identified households falling into the two lowest socio-economic quintiles. Figure 2 suggests that targeting was slightly less effective in Shwepyithar (around two-thirds of identified households fall into the two lowest quintiles). One possible explanation for this difference is that Shwepyithar attracts large groups of migrant workers, who were considered non-eligible for the pilot – it was felt that the project would not be able to guarantee continued access to the package of services for the entire duration of the project to a transient population. Another possible explanation is that there are just fewer people in the bottom socio-economic quintiles relative to the more rural Darbein. The IR findings also revealed that there could have been some selection bias or favouritism by the local authorities from Shwepyithar during the poor household identification process.

Figure 2 – Socio-economic profile of cardholders in the two project areas of Darbein and Shwepyithar



<sup>4</sup> Including: The Ministry of Health and Sports, the GP society, participating GPs, civil society organizations, development partners, PSI and HFG.

<sup>5</sup> Maternal and Child Survival Project (2017). [Are We Reaching the Worst-off? How the Myanmar Census Helped to Answer this Question](#). Washington, DC: USAID/MCSP.

## IMPLICATIONS FOR PROJECT PLANNING AND IMPLEMENTATION

While the targeting approach for beneficiaries proved to be generally effective, the project team found that in the more urban site of Shwepyithar where there is more competition among providers, the beneficiaries selected were not necessarily those geographically closest to the providers who had already been pre-selected to join the scheme. It soon also became clear that despite the low cost of the services offered in the basic package by the providers, travel costs still put up a major barrier to access for many of the beneficiaries. As a result, the project has begun seeking out other providers closer to the target groups, and in future will aim to identify target communities first, and providers second.

Other important lessons learned around this process included the need to better train those in charge of beneficiary selection in educating households around both the steps involved in the registration process and the overall rights conferred by the health card. The clinic opening times for registration and health screening purposes also need to be better suited for those household members who work long hours away from home.

Finally, the project will need to determine whether this targeting approach can be scaled up easily to other sites, and whether it is effective in settings that are more rural than the current sites in and around Yangon.

### **Myanmar Strategic Purchasing Brief Series:**

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## ANNEX 1 – STEPS INVOLVED IN THE TWO TARGETING APPROACHES CONSIDERED

### Approach A – easier-to-implement approach (adopted)

Step A1: PSI team - Identify clusters of poor households (with input from SQH providers)

Step A2: PSI team - Visit identified clusters to take pictures of the dwellings

Step A3: PSI team - Develop three categories of poor dwellings based on their external appearance (see Figure 3)

Step A4: PSI team - Identify project areas by the smallest administrative unit ('wards' in urban areas, and 'villages' in rural areas) and sensitize local authorities about the project and its objectives

Step A5: Local authorities - Identify the poor dwellings in their respective areas based on proposed categorization

Step A6: Agents locally recruited by PSI - Get list of poor dwellings identified by local authorities; take pictures of each dwelling on the list and pin its location on a map

Step A7: PSI team - Screen the photos to review the list of poor dwellings

Step A8: External agency - Visit each dwelling on the reviewed list, check whether the dwelling should figure on the list (based on agreed categorization), and conduct baseline survey; include questions to construct asset index in the survey questionnaire

Step A9: PSI team - *A posteriori* application of the Equity Tool to measure the socio-economic profile of selected households and compare it to that of the general Yangon population

### Approach B – more sophisticated approach (not adopted)

Step B1: Review the questionnaire used in the World Bank-supported Myanmar Poverty and Living Conditions Survey (MPLCS) and identify candidate questions for the identification of urban poor

Step B2: Using MPLCS data, conduct regression analysis to identify the questions that are significantly associated with urban poverty

Step B3: Establish community committees (if none already exists) that may include, for example, community leaders, religious leaders, civil society organizations, local authorities from each catchment area. Work with community committees to validate and possibly shorten the question set; conduct another regression analysis to determine weights for the final selection of questions

Step B4: Prepare the list of households to be interviewed

- a) Identify the catchment area of each SQH provider by the smallest administrative level (e.g. ward, village)
- b) Check if community committees already have a preliminary list of poor households, established based on community opinion and/or other information; if so, include the households on the list in the survey
- c) If community committees do not have such list of poor households yet, or if the list is insufficient, work with the SQH providers to identify additional poor households that should also be included in the survey
- d) If the lists from both the community committees and SQH providers are insufficient, conduct an on-the-ground mapping exercise to identify areas with a high concentration of what seems to be poor households

Step B5: Survey the poor households identified in Step 4 and rank them according to their SES status. The total number of households included in the survey should be at least 150% of the target (i.e., of the expected total number of households who will be issued a health card)

Step B6: Identify lower number of households (e.g. 80% of the target) who become automatically eligible for enrollment into the program

**Step B7:** Work with the community committees to identify, from the list, the rest of the households that will be enrolled (e.g. the remaining 20%) as well as 10% to be kept as reserve; some selection criteria may be specified (e.g. households should figure among the poorest x% in the list)

**Step B8:** Using the MPLCS, assess in which national / urban socio-economic quintile selected households fall, to make sure all selected households fall into the two lowest quintiles

**Step B9:** Inform the community committees of the final selection and proceed with the registration process

Figure 3 – Categorization of households based on physical appearance of dwellings

