MYANMAR STRATEGIC PURCHASING BRIEF SERIES – No. 8

Incentivizing Private Provision of Primary Health Care in a Remote Area – Initial Phase

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INTRODUCTION – THE STRATEGIC PURCHASING BRIEF SERIES

This is the eighth in a series of briefs examining practical considerations in the design and implementation of strategic purchasing demonstration projects involving private general practitioners in Myanmar. These projects aim to start developing the important functions required for effective strategic purchasing, and generate valuable lessons that will help shape Myanmar's broader health financing arrangements. More specifically, the projects are introducing a blended payment system that combines capitation payments and performance-based incentives to reduce households' out-of-pocket spending and 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. Private healthcare providers charge for their services on a fee-for-service basis that is unregulated, and payment 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) has established two demonstration projects, one in Yangon Region and one in Chin State, to demonstrate the capacity of private providers in its Sun Quality Health network to offer a basic package of primary care services to poor and vulnerable households. Design of the Yangon project started in 2016, while that of the Chin project was initiated in 2017. In these projects, 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 (NHP). In the long run, the role of PSI is likely

to evolve into that of an intermediary.[1] This intermediary role could include supporting the formation of networks of providers that are easier to integrate into health financing programs, and helping these providers meet minimum requirements through quality improvement and development of management capacity. Eventually, the package of services to be purchased from providers, even if limited, will need to be streamlined with the basic Essential Package of Health Services that has been developed at the national level.

Under the two demonstration projects, over 4,500 low-income households from two townships[2] in Yangon Region and one township in Chin State have been registered, screened and issued with health cards. The health card entitles beneficiaries to a defined benefit package provided by selected members of the Sun Quality Health network. The projects specifically aim 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 onset of health symptoms.

OBJECTIVE

The first seven issues of the Myanmar Strategic Purchasing Brief Series describe how strategic purchasing arrangements in an urban setting enable existing capacity in the private sector to be harnessed to deliver an essential package of services to vulnerable populations. This brief instead describes how strategic purchasing is used to motivate private providers to establish entirely new capacity in underserved remote areas and looks at some of the challenges that have been experienced so far along the way.

Many people in rural Myanmar do not have access to quality primary health care services. Even where public facilities have been established in remote areas, there are many vacant posts, despite the fact that a special hardship allowance is provided to civil servants assigned to these areas. As a result, there is chronic underutilization of health services leading to poor health indicators.

Formal private providers have few incentives to establish their practice beyond the larger towns. The project therefore set out to demonstrate whether a provider contracting mechanism that guaranteed a minimum level of income could motivate private providers to set up services in an underserved area and provide basic primary health care to the community. Over time, the project aims to improve health indicators by ensuring improved access to quality health services with financial protection, and to assess whether strategic purchasing from private providers is a cost-effective way to extend access to the basic EPHS in areas that are currently not covered by government facilities. Evidence from this particular project may be able to contribute to future resource allocation plans by the government.

SELECTION OF CHIN STATE

Chin State in western Myanmar (population 478,801 in the 2014 census) is a mountainous region with a poor transportation system that limits economic development. These and other factors make it one of the least developed areas of the country, with around 73% of the population living below the national poverty line. Chin State experiences some of the worst mortality rates in the country. Infant and under-five mortality rates are about twice the country average, at 75 and 104 deaths per 1,000 live births[3] respectively, while the maternal mortality ratio is nearly three times higher than the country average, at 147 deaths per 100,000 live births.[4]

[1] Results for Development Institute (2016). Intermediaries: The Missing Link in Improving Mixed Market Health Systems? Washington, DC: R4D.
[2] Townships in Myanmar are comparable to what many other countries call districts. On average, a Township has a population of around 150,000.
[3] Myanmar Demographic and Health Survey, 2015-16
[4] Maternal Death Surveillance Response 2017

HEALTH AREA FOCUS, TOWNSHIP SELECTION AND BENEFICIARY ENROLLMENT

PSI invited key stakeholders, including representatives from the Central Ministry of Health and Sports (MoHS), Chin State Health Department, the private sector, donors and implementing partners to a co-creation workshop to jointly design the project. This workshop was held in Kalay, a medium sized city close to Northern Chin State in order to maximize engagement from local stakeholders. During the workshop, the group decided to ensure a broad package of primary health care services would be provided, while paying particular attention to maternal and child health services. These included institutional delivery at health care facilities (since around 85% of deliveries are happening at home, usually without a skilled birth attendant present) as well as the provision of quality antenatal and postnatal care.

Tedim township in the northern part of the State was selected from among the nine possible townships in Chin State, as it contains several large villages with a population greater than 1,000 people, as well as two private hospitals (one in Tedim town, and one in nearby Kalay) that are already affiliated with PSI's Sun Quality Health (SQH) program. Further site selection considerations included:

- The fact that the nearest public facility did not have a health assistant assigned to it, in order to avoid duplication
- The relative proximity to the secondary and tertiary referral hospitals
- The number of beneficiaries that could be enrolled within available budget
- The number of providers that could be recruited to serve these beneficiaries and ensure geographic proximity
- The feasibility for each provider to cover at least 1,000 beneficiaries, in order to achieve a minimum level of risk pooling and generate enough income to keep the provider motivated.

Why conduct a Co-Creation Workshop?

While being time consuming, the project co-creation workshop brought together technical resource people and a range of local stakeholders to ensure that the final design would accommodate local priorities while being aligned with the NHP. It meant that new and potentially complicated concepts around health financing – such as the use of capitation payments, and the planned engagement with the private sector, could be discussed and shared in advance with local authorities, and it cleared the path to rapid endorsement of the workplan when submitted to the central MoHS for approval.

Further engagement with the Chin State Health Department and the Tedim Health Authority led to three villages being selected in two sites: Zozang and Zonuamzang – Site One with approximately 2,000 people, and Kaptel – Site Two with approximately 3,000 people.

Unlike the targeting approach applied in the Yangon demonstration project (see Issue Brief #3 – Targeting Poor Households), it was decided that every individual in the selected villages would be entitled to enrollment given the high poverty headcount ratio in Chin State, and following an initial field assessment confirming that the majority of households from these selected villages were likely to be poor.

PROVIDER RECRUITMENT

Because the Sagaing Region town of Kalay is located close to the Chin State border and has a large number of ethnic Chin migrants, PSI had initially hoped to identify and recruit at least two private general practitioners working in Kalay with a valid medical license who could each speak the local Chin language. However, only one doctor who could speak the local language applied, and even then, there were many delays as he felt uncertain about making the commitment to operate a clinic in a remote area. He was finally convinced to sign the contract with the encouragement and support from the head of one of the hospitals affiliated with PSI's SQH network.

For the second provider, PSI consulted with the local community and received the suggestion that the village had at least one person who could act as a translator. PSI agreed to hire that person as translator and clinic

assistant to the doctor who was eventually recruited. To date, client satisfaction surveys and field monitoring visits indicate that this approach has worked well. At each site, the local community was willing to contribute to the success of the project – for example by helping identify a house within the village that the doctor could take over as a clinic, and helping out with simple construction and improvements.

The Sun Quality Health Network

This network of private general practitioners consists of about 1,300 members located in over 203 townships in urban and peri-urban parts of the country. PSI provides capacity building and training for members, supply chain and commodity support, marketing and community mobilization, monitoring and evaluation, while members provide a range of primary health care services to the community. The network service offering includes maternal and child health, reproductive health, communicable diseases (including prevention, detection and treatment of HIV, tuberculosis and malaria) and non-communicable diseases (hypertension, diabetes, cervical cancer prevention).

PREPARATION FOR SUPPLY-SIDE READINESS

Technical Training: To improve the technical capacity of recruited providers to deliver quality care, PSI's Continuing Medical Education Team provided intensive training, focusing on services included in the package (described in the next section). The different training modules were developed in line with national and international guidelines and covered the knowledge, skills, abilities, and traits needed to successfully and effectively deliver high-quality services.

Supply of Medicines and Commodities: Other than the contractually agreed payments described in the next section, PSI did not extend any financial assistance to the recruited providers for the establishment of their clinics. However, as part of PSI's regular support to SQH network members, the providers did receive job-aids, Information, Education and Communication materials and some medicines, including free anti-TB and anti-malaria drugs from the national programs and subsidized contraceptives from PSI. The providers were expected to purchase all the other drugs and supplies needed to deliver the agreed package of services themselves. PSI encouraged them to opt for generic drugs approved by the Myanmar Food and Drug Administration, as per the essential medicine list.

Electronic Medical Records (EMR): PSI gave recruited providers a mobile device and access to PSI's EMR App – the Sun Clinic Management Information System (CMIS) – to facilitate effective record keeping and allow easy monitoring of service utilization. More on this below.

Clinic Establishment and Community Introduction: Since the providers were new to their assigned villages, PSI's field staff assisted them with their move (for example, helping them find accommodation, establish the clinic, and hire a clinic assistant) and introduced them to village authorities and the local community to facilitate engagement and improve community awareness of service availability.

DEFINING THE PACKAGE OF SERVICES AND PROVIDER PAYMENT MECHANISM

The project used an inclusive process involving local authorities and the community to define a package of services that included maternal and reproductive health, under-five child health, communicable diseases, non-communicable diseases and a wider set of 'general illnesses', in line with the primary health care approach set out in more detail in Issue Brief #1 – Package of Services.

As in the Yangon demonstration project, participating providers agreed to be paid a combination of capitation payments and performance-based incentives. The capitation value was set following the approach outlined in Issue Brief #2 – Calculating a Capitation Payment, and performance-based incentives were established as described in Issue Brief #4 – Introducing Performance-Based Incentives. PSI worked with existing mobile banking services to ensure that all payments would be made electronically from the beginning of the project.

In consultation with providers, the project introduced a small co-payment that would be incurred by the cardholder for each visit to the GP clinic. The co-payments are intended to incentivize providers to remain client focused and offer quality services, while discouraging clients from consuming unnecessary care. PSI set the co-payment rate at 200 Kyats per visit (about 15 US cents), significantly lower than the rate used in Yangon (around 500 kyats per visit), based on a lower perceived ability to pay in Chin State. PSI estimated that the co-payments would represent around 10% of the provider's total earnings.

PSI recruited and trained local people to act as field coordinators to help ensure that beneficiaries would clearly understand the registration process, their eligibility to access the package of services under the scheme, and the need to pay a small co-payment for each visit. All communication materials developed by PSI discussing these subjects were translated into the local Chin language.

BARRIERS AND CHALLENGES EXPERIENCED

Area Selection for Project Implementation: To meet the complex set of considerations for village and township selection described above, the project team had to conduct an intensive area mapping exercise in collaboration with the providers who were being considered for recruitment and local authorities. This process took a considerable amount of time, leading to delays to the start of the project.

Lack of Caregivers in Households during Farming Season: It was found that in the farming season, parents frequently left their households and went to their farms for extended periods of time, leaving older children at home to care for their younger siblings. Our field team reported that it was challenging to communicate with these older children about the registration process and the benefits of accessing health services. Typically, the older child felt their main role was to keep a younger child from crying, rather than looking after the actual health of their siblings, and very few of them knew how to recognize medical symptoms in a way that would encourage them to seek access to services when needed.

Influence of Village Authorities: At the time of registration, there appeared to be a local dispute between the head of the village and some of the villagers at one of the sites. Around 200 people from this village did not come forward for registration, despite having been sensitized about the benefits, since they thought this project was being organized by the village head.

Affordability of Co-payment: Providers reported that some households could not even afford to pay the 200 Kyat co-payment. However, they might instead bring a handful of chillies, or a pack of vegetables from their farms as an alternative. In all cases, the providers seemed to be comfortable accepting this alternative to payment, and in general were ready to waive co-payment fees for other households if needed as it was not considered a big amount.

Provider's Concern on Co-payment: At the same time, one of the providers was concerned that the beneficiaries would perceive he was not a qualified provider as the 200 Kyat co-payment was much lower than the amount that villagers in the area were accustomed to paying to unqualified 'quack' providers, who typically charge between 3,000 and 5,000 Kyats per consultation.

Non-Insured Patients Coming From Outside the Coverage Area: Both providers agreed to receive patients who were willing to travel relatively long distances from other villages that had not been recruited into the project. In theory, the providers were free to set a consultation fee based on market rates, but they reported that patients would often arrive with only 200 Kyats and expect to be served at that price. Up to this point, the providers did not consider this a big burden on their time and income, but this will need to be monitored.

Religious Beliefs around Family Planning: Around 85% of the population in Chin State self-reported as Christian in the 2014 census. The majority of these are thought to be members of churches which discourage the use of contraception, and both the providers and field coordinators report that it has been challenging even to give basic health talks about contraceptive choices, let alone actually promoting method use.

Technology: As mentioned above, providers were supported to use an electronic medical record (EMR) system rather than a paper-based system (see Issue Brief #6 – Improving Medical Record Keeping) to register new clients and report each clinical visit using the ICD10 disease classification system. The EMR is in the form of an Android App, which is designed to operate off-line given the rather unstable mobile network. However, while all providers have managed to upload data successfully each month, they found this to be quite time consuming. Because paper records were not used at any time by these providers, there was no counterfactual to determine if this was easier or harder than using manual record keeping.

OUTCOMES IN THE INITIAL PHASE OF THE PROJECT

Despite some initial delays, the project is now functioning effectively. Some early results include:

1. **Beneficiary Registration:** The first provider, a medical doctor who can speak the local language was assigned to the Site One (Zozang and Zonuamzang) and beneficiary registration started in May 2018. After six months, 1,657 individuals (about 83% of the total resident population) had been enrolled as beneficiaries. The second provider, also a medical doctor, was recruited in July 2018 and assigned to the Site Two (Kaptel) in August 2018. Within six months, 2,816 individuals (about 88% of the total resident population) were enrolled in that site.

   In both sites, PSI coordinated with village authorities and religious leaders to enhance and promote the registration. PSI also hired young people of the village as part-time staff to communicate with the households about the benefits of the project and the registration procedure. PSI found that residents were very motivated to register, and the proportion of eligible beneficiaries who had registered within six months of the start of the each project site was higher overall in Chin state (at 86%) relative to Yangon (66%) at the equivalent stage. An assessment of the socio-economic profile of the beneficiaries shows that 97% of them fall into the poorest two wealth quintiles, relative to the population of Chin state.

2. **Service Delivery:** The community was also very motivated to take advantage of the health services offered in the benefit package. Within six months of implementation in each project site, attendance at clinics was higher than that experienced in Yangon, with 47% of registered beneficiaries in Site One and 67% of registered beneficiaries in Site Two having visited their assigned clinics at least once. There were 1,610 clinic visits in Site One, covering around 1,957 services, and 3,971 clinic visits in Site Two, covering 4,074 services.

3. **Public-Private Partnership in Provision of Maternal and Child Health Care:** The Philips Foundation, working in partnership with the in-country commercial arm of the health technology company Philips, has supported the project by donating two "Community Life Centre" outreach backpacks for early risk identification and referral in pregnancy. The outreach backpacks include a number of medical imaging and monitoring devices, including a portable ultrasound, electrocardiogram, vital signs monitor, a fetal Doppler (a hand-held fetal heart rate detecting device) and child respiratory rate monitor.

   Philips handed over the outreach kits to the two GPs and provided device training in February 2019, at which time the GPs received clinical training on ultrasound scanning and result reading from Wesley Private Hospital, which is affiliated with PSI's Sun Quality Health program.

Philips CLC Outreach Backpack

Since staff at the public sector rural health center and rural health sub-centers in the project sites were also providing antenatal care, the project worked in close partnership with the local health authority to offer joined-up antenatal care between midwives and the newly established providers, with the antenatal care services taking place at the public facilities rather than at the new clinics. Up to October 2020, the midwives and the new providers jointly delivered 221 ultrasound examinations for pregnant women, leading to four at-risk cases being referred to the Kalay General Hospital for consideration for caesarean delivery. Three of these women ended up receiving a caesarean delivery at the hospital, which dramatically reduced their risk of an adverse event during childbirth.

PRELIMINARY CONCLUSIONS

Early results suggest that strategic purchasing arrangements can be effectively deployed in remote areas and are popular with the local communities. They have the potential to form part of a future contracting-in strategy for MoHS, or even State- or Township-level Health Authorities who wish to address problems with health workforce retention. The project has successfully deployed new technology in remote areas that could form the basis for a future telemedicine project. PSI will continue to implement and monitor performance. Findings will be captured in a follow up learning brief in this series. PSI also plans to conduct a detailed economic analysis to determine the cost-effectiveness of this approach.

Myanmar Strategic Purchasing Brief Series:

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