MYANMAR STRATEGIC PURCHASING BRIEF SERIES – No. 9

Adding Hospital-Based Child Delivery Care Services to the Benefit Package

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INTRODUCTION – THE STRATEGIC PURCHASING BRIEF SERIES

This is the ninth in a series of briefs examining practical considerations in the design and implementation of strategic purchasing demonstration projects involving private general practitioners and private hospitals 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, case-based payments and performance-based incentives to reduce households' out-of-pocket spending and incentivize providers to deliver an essential package of primary care services and selected hospital-level child delivery care services.

CONTEXT

Provider payment mechanisms currently applied in Myanmar do not incentivize increased efficiency, improved quality of care or greater equity. The Ministry of Health and Sports (MoHS) transfers funds to public facilities through a rigid system of line-item budgets. Health services in the private sector, on the other hand, are charged directly to the patient through an unregulated fee-for-service system. With many people accessing most of their health care through the formal and informal private sector, out-of-pocket payments end up accounting for an extremely large share of total spending on health. These payments 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 pilots, 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.[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

This learning brief describes how the scope of the strategic purchasing demonstration project in Chin State was expanded to also include selected child delivery services provided by a private referral hospital.

CONNECTING GP'S WITH A PRIVATE HOSPITAL FOR SELECTED CHILD DELIVERY SERVICES

Figure 1 – Sun GP and midwife providing antenatal care services using a portable ultrasound

Issue Brief #8 – *Incentivizing Private Provision of Primary Health Care in a Remote Area – Initial Phase* described the main design features of the Chin Project, including the rationale for selecting Chin State. The brief also mentioned the participating GPs' use of "Community Life Centre" outreach backpacks donated by the Philips Foundation. These backpacks include a number of medical imaging and monitoring devices, such as a portable ultrasound, electrocardiogram, vital signs monitor, a fetal Doppler (a hand-held fetal heart rate detecting device) and a child respiratory rate monitor. These devices allow the GPs to provide antenatal care services in coordination with a private hospital based in the nearby town of Kalay and facilitate early detection and referral to that hospital of high-risk

[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.

pregnancies. To promote institutional delivery while also providing financial protection for the patient, the project's strategic purchasing arrangements were expanded to also cover child delivery care services provided by the private hospital to referred cardholders from the project.

EXPANDING STRATEGIC PURCHASING ARRANGEMENTS TO INCLUDE HOSPITAL-BASED CHILD DELIVERY CARE

1. Revising the package of services

As discussed in Issue Brief #1 – *Package of Services*, the basic package of services offered by the private GPs based in the villages already includes a range of antenatal and postnatal care services, which are essential components of child delivery care. What the basic package does not cover, however, is emergency obstetric care and care delivered during the acute phase of the postpartum period (i.e., 6 to 12 hours after childbirth). This is why the package was revised to also include hospital-based child delivery care services, in line with WHO's recommendations for intrapartum care and national guidelines for basic and advanced maternal and newborn care. Table 1 breaks down those services into five main categories.

Table 1. Hospital-based child delivery services added to the package

Category	Intervention
Hospital Admission and Discharge	✓ Complete assessment of the client's vital signs ✓ Registration into the admission file ✓ Orientation of client and her family regarding the ward, visiting hours, clients' right and responsibilities ✓ Record keeping ✓ Issue patient book and discharge
Imaging and Laboratory Examination	✓ Ultrasound examination ✓ Test for blood grouping and Rh factor ✓ Blood Test for STI, HIV, HBV, HCV ✓ Haemoglobin test ✓ Blood glucose test ✓ Urine RE/ME test ✓ Any other investigations required for complication management
Delivery and Postnatal Care	✓ Antibiotics for PPROM (Preterm Premature Rupture of the Membranes) ✓ Induction of labour (beyond 41 weeks) ✓ Labour and delivery management ✓ Active management of 3rd stage of labour ✓ Pre-referral management of labour complications ✓ Management of obstructed labour ✓ Management of eclampsia ✓ Neonatal resuscitation (institutional), emergency newborn care (EmNC) ✓ Treatment of local infections (Newborn) ✓ Kangaroo mother care ✓ Clean practices and immediate essential newborn care ✓ Postnatal preventive measures
Complication Management	✓ Intrapartum and postpartum haemorrhage ✓ Maternal complications required over 5 days of hospital stay ✓ Neonatal complications required over 5 days of hospital stay
Others	✓ Nursing care for both mother and baby by registered nurses ✓ Breastfeeding lessons

To simplify the package, maternal and neonatal complications other than postpartum haemorrhage were combined as *complications requiring over 5 days of hospital stay*.

2. Selecting the most suitable provider payment mechanism

Purchasing services from hospitals can be done using a range of provider payment mechanisms, including line-item budget, global budget, fee-for-service, payment per patient day, case-based payment, performance-based incentive, etc. Each of these mechanisms has its own strengths and weaknesses, and different mechanisms can be combined in many ways. The challenge is to define the most suitable mix in a given environment, based on the provider behaviors that need to be incentivized to achieve the health system's desired outcomes.

For this project, PSI in consultation with other stakeholders selected case-based payment as the preferred provider payment mechanism for the strategic purchasing of hospital-based child delivery services. In a case-based payment system, the purchaser reimburses a contracted hospital for each treated hospital case that falls into one of a set of defined categories of cases, such as so-called diagnosis-related-groups (DRGs). Since actual costs of treating individual cases may exceed the agreed reimbursement rate in some cases and fall below in others, this provider payment mechanism incentivizes the provider to be more efficient.[3]

To further incentivize desired provider behavior, such as quality and efficiency, PSI will also introduce performance-based incentives, which will reward the provider for the achievement of pre-defined targets. Those will be paid quarterly based on the assessment findings.

3. Securing sufficient funding for the additional services

In both the Yangon Region and the Chin State projects, benefiaries are charged a small co-payment for every clinic visit to minimize unnecessary utilization of services. For the hospital-based child delivery care that is added to the package, however, cardholders are not expected to over-utilize services. In addition, patients referred to the hospital will already incur significant travel costs, which may turn out to be prohibitive in some cases. Therefore, it was decided not to charge any co-payment for the hospital-based child delivery services.

The budget for the additional services was calculated based on the estimated number of child deliveries (both normal and obstructed, by case group) per 1,000 households per year, multiplied by a fixed reimbursement amount set for each case group. The process to calculate the actual case-based reimbursement rates will be described in Issue Brief #10. Using this approach, the risk for the purchaser to exceed the budget is rather limited.

4. Recording and analyzing data

The successful implementation of a case-based payment system relies on the availability of good data. The system can be gradually improved as more and better data becomes available. Financial and clinical data are needed to calculate the cost per patient for different types of patients, which will help define the case groups and establish the reimbursement rate for each group. Clinical data captured in the electronic medical records (EMR) will allow the purchaser to verify that the hospital correctly assigns patients to case groups. EMR data on treatment, length of stay, occurrence of complications, outcomes, etc. will also enable the purchaser to monitor quality of care. Good clinical and financial data are also important for the hospital, to track expenditures, improve quality and identify areas where efficiency can be increased.

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[3] Langenbrunner, J., Cashin, C., O'Dougherty, S., & World Bank. (2009). *Designing and Implementing Health Care Provider Payment Systems – How-To Manuals*. Washington, DC: World Bank.

Issue Brief #6 – *Improving Medical Record Keeping* described the Clinic Management Information System (CMIS) developed for and used by GP clinics participating in the Yangon Region and the Chin State demonstration projects to record clinical data. The private hospital that is being contracted for the provision of child delivery care to cardholders still relies on a paper-based system for its patients' medical records. PSI is currently working with its local digital technology partner, Koe Koe Tech, to further develop the CMIS so that it can also be adopted by the hospital, making sure it captures all the clinical information that is needed for an effective case-based payment system.

The hospital already has its own electronic system to keep track of financial data. Yet, the system needs to be further developed to allow for a more detailed cost analysis, which is needed for the case-based payment system. PSI is providing technical support to the hospital for the improvement of the system and to enable remote access to the data.

RISKS AND CHALLENGES

1. Service quality provided by the hospital

As mentioned earlier, each payment system has its own strengths and weaknesses, and the case-based payment is no exception. As the contracted hospital will be reimbursed a fixed rate defined in the case-based payment system for every treated case, there is a risk that the hospital discharges patients prematurely and/or sacrifices service quality to reduce costs. PSI will monitor this potential risk by assessing the hospital's performance using a standard checklist and by conducting client experience surveys.

2. Case upcoding by the hospital

We acknowledged that inclusion of maternal and neonatal complications in the package (and grouping of those complications under the heading *complications requiring over 5 days of hospital stay*), introduces a perverse incentive: given that the payment for cases with complications will be higher, the provider may be tempted to keep the mother admitted longer than necessary to justify upcoding. To mitigate this risk, complicated cases will be closely monitored and categories will be gradually refined as more clinical/cost data and client feedback become available during implementation.

3. Low utilization due to the COVID-19 pandemic

The utilization of hospital-based child delivery services is likely to be affected by COVID-19, especially given that it was a project clinic situated near Tedim that identified Myanmar's first confirmed COVID-19 case in March 2020. As a consequence, beneficiaries residing in the catchment area, including around Kalay, are reluctant to travel. They are also worried that they may not be able to return to their village if a lockdown is imposed during their hospital stay.

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