SOCIAL HEALTH PROTECTION NETWORK

Institutional frameworks in the area of health financing systems

MYANMAR Summary

February 2023

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CONTENTS

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1. BACKGROUND

1.1. Introduction

The P4H Network develops innovative collaborations in its role as an honest broker, whose mission is to promote, develop and strengthen exchange and collaboration for social health protection and health financing. In this context, a consultant, Virgile Pace, was engaged by the P4H Network Coordination Desk to review the institutional frameworks of ten countries. Virgile worked in countries where the P4H Network was engaged and collaborated with several members of P4H and P4H country focal persons (P4H-CFPs). The summaries Virgile produced were first intended to help familiarize P4H-CFPs with the countries and regions where they work to thus enhance their agency in facilitating their work with national stakeholders. The summaries will also be helpful to anyone interested in institutional frameworks related to SHP and HF in general and in the context of the selected countries.

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2. ANALYSIS

In Myanmar, the coup d'état in February 2021 has put in hold all the plans that involve direct engagement with the *de facto* authorities.

Situation, as of February 2022, is the following:

2.1. Constitutional/Legal/Governance Challenges

- There is no article in the 2008 Constitution relating to health financing. However, the Constitution includes several articles relating to health in general: article 367 states that every citizen "shall…have the right to healthcare"; other articles call for the Union to "earnestly strive to improve education and health of the people," "care for mothers and children," and enact laws enabling people to "participate in matters relating to their education and health". In a very significant way, the Constitution restricts political and fiscal control of Government activities at the State level, which limits the Ministry of Health (MoH)'s ability to decentralize control of operations to these levels.
- The lack of a strong legal framework hinders major health financing reforms at the national level. A strong institutional, legal and regulatory framework needs to be developed, based on a comprehensive review of existing policies and legislations, to support the implementation of the National Health Plan (NHP) and more broadly the country's move towards Universal Health Coverage (UHC).

- Enforcement of legal and regulatory instruments is still a concern in Myanmar. For example, from the social protection perspective[1], though the legal and policy framework has experienced substantial development, the enforcement of those instruments remains limited[2]. As a result, most social protection programmes have limited coverage and workers, and their families effectively benefit from little protection[3].
- It is thus of the utmost importance to develop modern public health and social protection legal frameworks comprising of implementing measures (regulatory dimension) to pave the way for a truly and efficient social health insurance system that would support the UHC objectives of effective coverage and financial protection[4].
- Legislative measures help to concretize explicit health service guarantees to the population and provide a legal basis for collection of contributions. Legal frameworks are indispensable since they enshrine the rights of the population to receive services as defined by law or in policy. The institutionalization of a social health insurance system supported by robust legislations is expected to strengthen institutions, increase funding, improve access and financial protection, and increase patient empowerment.

2.2. Political and Socio-Economic Challenges

- Low levels of health spending is a recurring problem in Myanmar. Current expenditure on health (CHE) as a share of gross domestic product (GDP) has increased notably between 2011- 2015, but then remained stable. Health is not being properly prioritized and domestic Government health spending does not increase as fast as total Government spending.
- Out-Of-Pocket (OOP) spendings remain high, and the dominant source of financing for health[5]. It is a major cause of catastrophic expenditure by households, increasing poverty and compromising progress towards UHC. In addition, it prevents households from seeking necessary health care[6].

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[1] Myanmar social protection includes policies, legal instruments and programmes for individuals and households that prevent and alleviate economic and social vulnerabilities, promote access to essential services and infrastructure and economic opportunity, and facilitate the ability to better manage and cope with shocks that arise from humanitarian emergencies and/or sudden loss of income.

[2] The Social Security Law 2012 was enacted as Law No.15 of the Union Parliament on 31 August 2012. The Social Security Law 2012 became effective on 1st April 2014 under Presidential Order 25/2014.

[3] The Social Security Board (SSB) of the Ministry of Labour, Employment and Social Security is implementing social protection through laws and bylaws for workers who are contributing to the productivity of the country, in particular: mandatory social security schemes for certain workers; and voluntary insurance under the social security schemes for all workers entitling them to benefits according to law.

[4] Essential medicines are currently provided at no cost, as are services to children under five at public hospitals and dispensaries; vouchers are provided for neo-natal, delivery and post-natal care.

[5] A recent nationally representative survey found that OOP spending comprises roughly 75 percent of total health spending.

[6] By bringing quality services closer to communities, health seeking behaviour can be improved: households need to spend less on transportation and spending on medicines outside the public facility can be reduced.

- Vulnerable groups, such as households with a household head with a low-level of education, households with children under the age of 5 years or disabled persons, and low-income households should be prioritized by policymakers to improve access to essential health care[7].
- Supply side investments in Myanmar are now critical to bringing down OOP spending. They should be done particularly in primary care facilities, human resources, and essential medicines. Due consideration should be given to options that could be put in place as temporary measures to reduce OOP spending until more robust risk pooling mechanisms are developed. These measures include definition of a catastrophic package, or extension and harmonization of existing mechanisms to cover referral costs.
- Besides, given that majority of OOP expenditures are spent on drugs, further work needs to be done on better understanding prescription behaviour, drug pricing, and health-seeking behaviour, which may require a comprehensive assessment of the pharmaceutical sector with a review of policies and regulations.
- Effectively managing the transition from externally financed to domestically financed health programs is a key challenge. From the financial perspective, this implies mobilizing replacement domestic financing for programs that are financed primarily by external funds. This should ideally be channelled through prepayment and pooling mechanisms, to ensure greater efficiency and equity. From the programmatic perspective, it is critical to ensure that Governments have the institutional capacity to deliver these services effectively. This is all the more complicate as many externally financed programs run in parallel to Government systems, with separate procurement, financial management, human resource management, and reporting modalities. Achieving better alignment across externally financed programs and integrating them into the Government system is critical to their sustainability.
- Health systems strengthening efforts in Myanmar have to be organized around four pillars: human resources, infrastructure, service delivery and health financing.

2.3. Financial Challenges

- Providing sustainable financing with strong Government oversight is key to strengthening governance of the health sector.
- From a financial perspective, Myanmar has to tackle two critical issues: first, it needs to prepare itself for the so-called health financing transition: as the country gets richer, external assistance for health will gradually decrease; and second, it needs to address current fragmentation in health financing, which creates considerable inefficiencies. All this supposes to develop a clear health financing strategy is a priority.

[7] Geographical location, gender of the household head, total number of household members, number of children under 5, and number of disabled persons in the household are statistically significantly associated with catastrophic health care expenditures.

Revenue Raising

- Resource mobilization is core to any health financing strategy. Mobilizing additional resources for health is a core challenge for Myanmar since it is clear that achieving the NHP goals will not be possible with the current level of Government spending on health[8].
- How revenues are raised[9] is a critical question since it has significant implications for efficiency and equity. How much can the Government's current budget allocation to health be increased[10], what other sources of additional funding can be sought[11], what share goes to the Basic Essential Public Health Services (EPHS)[12] and how much can the share be increased, how much external financing for health can be augmented are also critical issues in the Myanmar's current financial and operational context.
- Resources for health may be used through two financing mechanisms that should cover all the population: (i) Continued direct funding to the MoHS for supply-side financing and other functions of the Ministry; and (ii) A pooling scheme that will manage the additional resources to reduce reliance on OOP payments through demand-side financing.
- Government should focus on increasing fiscal space for health and rethinking the internal allocation of the health budget. If the Basic EPHS is to be made accessible to everyone, investments in service readiness, especially at Township level and below, and funding for the actual delivery of services and interventions included in the EPHS will need to increase, along with the financing of broader health systems strengthening efforts. Funding from sources other than general revenue, mainly development assistance, will need to be mobilized to help finance the expansion of the Basic EPHS.
- Weak tax infrastructure is still challenging in Myanmar[13]. Increasing domestic revenue mobilisation through a fair, efficient and transparent taxation system is a priority. Increasing tax revenue requires a reformed and professional tax administration with high levels of integrity and clear powers to assess and collect tax as well as to manage tax exemptions. This requires a legal framework that encourages taxpayers to meet their tax obligations, as well as the extensive use of modern technology to make it easy for taxpayers to file tax returns and pay tax online.

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[8] Whether sufficient financial resources can be mobilized to achieve those goals will largely depend on the country's expected economic growth. Fiscal space may grow thanks to a conducive macroeconomic environment.

[9] e.g. the sources of funds, structure of payments or contribution methods, and collection arrangements.

[10] 3.6% in 2020.

[11] e.g. earmarked funding for health. Currently, public funding for health consists of general Government revenues, which are channelled through the budgets of MoHS, other ministries and departments, and to the social security scheme. Health sector-specific resources actually include social security contributions, currently collected by the Social Security Board (SSB). Revenues from these contributions will increase as SSB further expands coverage of the formal sector to public sector workers and to dependents of those who contribute. Private funding is mostly OOP payments made by households.

[12] e.g. supply-side readiness, services delivery, systems building.

[13] Myanmar's tax revenue amounts to approximately 8% of GDP in 2020, which is the lowest in the ASEAN region.

- MoHS should thus explore increasing health sector-specific resources through taxes that are earmarked for health. From this point of view, it is urgent to carry out simulations and projections of both the public health and financial impacts of various types of sin taxes (on alcohol, tobacco products, sugar drinks)[14].
- While mobilizing additional resources for health is important, equally critical is to increase the efficiency of existing Government spending on health by addressing some of the main sources of inefficiency [15]. For example, funding from other sources than governmental, including from development partners (DPs), is largely channelled through parallel systems. In addition to making oversight and coordination challenging, this results in inefficiencies, and it does not contribute to strengthening the government's institutional capacity.

Pooling[16]

- Prepaid and pooled funds for health remain relatively small and fragmented in Myanmar, limiting the redistributive capacity of the health financing system. The *de facto* pool for most of the population is the Government health budget. However, Myanmar's current level of public spending on health is insufficient to cover the basic health needs of its population.
- There are also smaller and less diverse pooled funds for health in Myanmar than in other countries in the Region with comparable revenues. These include the Social Health Insurance (SHI) scheme managed by the Social Security Board (SSB)[17], and voluntary private health insurance schemes.
- Expanding general Government revenue for health and channelling the funds to a semi-autonomous agency for pooling and purchasing is an option that the country could consider[18]. This would be consistent with the vision of the NHP to establish a public purchasing entity in the medium term.
- Several countries with fragmented pooling arrangements and low coverage for poor and vulnerable groups (Philippines for example) have chosen policy reforms that aim to increase equity of coverage by introducing tax financed schemes (with different contribution rates based on ability to pay). Contributions for the poor and other vulnerable groups are covered by the state through tax financing. Funds from social health insurance (SHI) contributions thus complement tax financing via the Government budget.

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[14] In cooperation with the Ministry of Planning and Finance (MoPF).

[15] They include (not exhaustive): the inappropriate or ineffective use of medicines; medical errors and sub-optimal quality of care; unnecessary hospital admissions; inappropriate or costly staff mix; unmotivated workers leading to low productivity; waste, corruption and fraud.

[16] Pooling is the accumulation of funds for health care on behalf of a population before they get sick. The main rationale for pooling of funds is that health care costs are unpredictable.

[17] Decision on institutional arrangements in managing the demand-side pool has to be made. Two options are possible: (i) Transferring the health portion of the social security funds with the Social Security Board (SSB) to a new pool; and (ii) Expanding the existing pool with the SSB (it already has administrative systems e.g. finance, accounting; however, it manages other social security benefits, and the health purchasing function may get diluted among its other functions). Both options require legislative changes.

[18] Another approach is to begin consolidating disparate health coverage schemes and offer a standardized benefits package according to the population's epidemiological profile and costs of care.

- Establishing a consolidated pool made of the existing pooled funds is another option[19]. The risk, however, is that benefits will accrue mostly to urban areas and to higher-income households, where service availability and utilization are generally higher.
- The health financing strategy will need to provide clear directions in terms of the development of effective risk pooling mechanisms (for example on whether a mechanism to target the poor needs to be established or not, and what should be done to ensure that the informal - non-poor - sector can access services without experiencing financial hardship).
- Regardless of how fund pools are arranged and governed, the most critical challenge in Myanmar now is to reduce its reliance on OOP spending, and to increase the share of prepaid and pooled funds.
- In addition, temporary measures to reduce financial barriers to access health services should be considered. These measures may include Health Equity Funds, Hospital Trust Funds, maternal voucher schemes and the reimbursement of emergency referral costs.

Purchasing[20]

- Strategic purchasing[21] can be instrumental in incentivizing provider behaviours that can result in improved quality of care[22]. However, in-country experience in strategic purchasing is limited in Myanmar.
- It is of the utmost importance to develop suitable institutional arrangements that enable the smooth and efficient operation of the purchasing function. The functions of a purchaser will need to be developed, including the accreditation of providers, the contracting of providers and the definition of the most appropriate provider payment mechanisms.
- It is becoming critical to build institutional capacity to ensure that the institutions concerned can be effective in purchasing services by contracting competent public and private providers and in ensuring health care providers are acting in the interests of social security members.
- A key issue is whether providers are also responsible for service provision, and if so, whether they have been granted some form of management authority and a purchaser-provider split created[23]. In Myanmar, public hospitals and health centers have minimal decision-making authority. And centralized human resource planning and public financial management limit provider autonomy and accountability.

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[19] This would involve discussions between MoHS and the Social Security Board to align administration and governance, benefits packages, contribution rates, and payment methods.

[20] Purchasing is the process of allocating prepaid resources from pooled funds to providers for service benefits. Closely linked to purchasing are decisions on benefits (what services, and at what level of cost coverage) and provider payment methods. The way purchasing arrangements are set up will have significant implications for provider behaviour and efficiency.

[21] e.g. performance-based payment mechanisms.

[22] more rational prescribing for example.

[23] Unless public sector managers responsible for service delivery have legally delegated decision-making authority, public sector health providers will not be able to respond to the incentives created through the purchasing arrangements and cannot be held fully accountable for their performance.

- MoHS [24] 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. The MoHS cannot transfer resources to non-MoHS or non-public providers[25] and cannot buy services from non-MoHS facilities, including Social Security Board (SSB) facilities and other government facilities.
- An efficient measure to align revenue and expenditure is to ensure that the purchasing entity has a sustainable source of revenue and has a system that will enable it to manage and track expenditures. On the revenue side, regulation of purchasers' budgets is critical to ensure financial adequacy. This often involves official approval by parliament of a purchaser's budget in cases where the purchaser is a public organization, often with an annual spending ceiling. Where there are multiple purchasers, it is important to set the rules for the distribution of funds among purchasers[26]. On the expenditure side, a robust tracking system will enable the purchaser to understand its expenditure patterns[27] so that adjustments can be made to improve efficiency and equity of spending over time.

Financial Rules and Regulation/Budget

- Budget allocation criteria hinders the ability of the Government health budget to be distributed in a way that effectively responds to health needs[28]. Issues to be tackled are mainly the lack of strategic planning linked to budgeting, the top-down nature of the budget preparation process, and the absence of a needs-based formula to allocate funds to subnational governments and service delivery units.
- Poor budget execution[29] is symptomatic of broader challenges in the public financial management (PFM) system, from budget formulation to execution and monitoring. Existing PFM system and processes actually jeopardize rather than enable effective service delivery and there are bottlenecks throughout the budget cycle[30].

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[24] After the coup, the Ministry of Health and Sports (MoHS) became the Ministry of Health (MoH).

[25] private sector, Civil Society Organizations - CSOs and Ethnic Health Organizations – EHOs.

[26] When developing its health financing strategy, Myanmar will need to discuss what sources of revenue the purchasing entity can or should draw on, and decide on a process for formulating, debating, and approving the budget. Defining the institutional structure of the purchasing entity - national or at the state/region level – will be also critical since it will have implications on how revenue projections are developed and how money is distributed.

[27] e.g. service volumes, unit prices, utilization patterns.

[28] Myanmar's budget cycle focuses almost exclusively on financial controls, while key planning tools are almost entirely absent. Within its budget ceiling, MoHS allocates funds to central departments, states/regions, and townships using methods that do not adequately allow for redistribution of funds across administrative lines to meet changing health needs. Township Medical Officers for example hold no responsibility for managing the budget, contracting, and procurement of infrastructure projects and equipment.

[29] e.g. underspending, overspending, and poor budget accuracy.

[30] Budget is not allocated within MoHS based on a clear and transparent formula. It is prepared with little consultation with implementers at lower levels and is delinked from actual needs. Communication from central level to the lower levels about available annual budget envelope for coming fiscal year tends to be unclear. And the budget is structured around line items that largely focus on inputs and are disconnected from programs or outputs.

- Core objectives to improve PFM are the following: To ensure that the allocation of the health budget among and within different departments of MoHS follow clear guidelines; To communicate the estimated annual budget and budgeting instructions to all levels of the health system at the start of the annual planning process; To synchronize planning calendar and processes with both planning cycle and budgeting cycle, so that central level budgeting considers the costed plans that come from townships and from states and regions; To create a new budget line to consolidate existing, disparate operational budget lines, to enable more flexibility in spending by health facilities; and to adopt new Procurement Guidelines for efficient budget execution.

2.4. Collaborative Challenges

Poor Coordination

Poor coordination across various health programs and actors should be pointed out in Myanmar.

- Engaging health providers outside MoHS is crucial: they have an important role to play in the country's move towards UHC since a considerable segment of the population currently seeks care outside the public sector[31]. All these providers can actually contribute to ensuring that the whole population can access EPHS without suffering financial hardship. Enhanced collaboration across all health care providers is also essential to ensure an equitable coverage, to build synergies and avoid duplication in service delivery.
- Health financing reforms should be undertaken in parallel and in coordination with other health system reforms for readiness of service delivery such as in infrastructure, medicines and equipment, budget allocation and human resources. Besides, there are reforms that need to occur outside the health sector, for example the alignment of public financial management rules with the health system.

Managing Development

Managing development assistance for health and ensuring its alignment with national goals and priorities continue to pose a huge challenge in Myanmar.

- Development assistance for health[32] represents around 60% of total financing for public health. Most development assistance is still off-budget and is managed and/or implemented by UN agencies, NGOs, CSOs, and National Professional Associations[33]. Stronger coordination has been hampered by various factors such as the absence of a clear Government strategy for external aid, the weak capacity within

[31] This can be from a range of health care providers such as private-for-profit General Practitioners clinics, Ethnic Health Organizations (EHOs) or Non-Governmental Organizations (NGOs).

[32] It focuses largely on public health, mainly control of communicable diseases and strengthening delivery of maternal, new-born, and child health services.

[33] The largest providers of development assistance are Global Fund for AIDS, Tuberculosis, and Malaria (GFATM), pooled funds of bilateral aid from seven countries managed by UNOPS (3MDG Fund), Global Alliance for Vaccines Initiative, the World Bank Group, and Japan International Cooperation Agency (JICA).

the MoHS) to coordinate Development Partners (DPs), the multitude of parallel financing and implementation arrangements, and the inadequacy of existing coordination mechanisms, in particular the Myanmar Health Sector Coordinating Committee (MHSCC). The implementation of the National Health Plan - NHP (2017-2021) has provided an opportunity to better align development assistance, but efforts remain to be done.

- Coordination mechanisms to jointly monitor and discuss progress for developing the health financing strategy should be strengthened. Efforts should focus on areas where fragmentation is the greatest, which includes financial management, procurement, supply chain, and information systems. Collaboration with parliamentarians and civil society should be enhanced to support the development of the health financing strategy.

Coup d'État

The coup d'état on the 1st of February 2021, staged by the military, has forced DPs and other international actors to suspend their activities directly supporting the current *de facto* Government and its initiatives.

- P4H network in particular, along with its partner organizations, was required to re-strategize its operations. The implications range from shifting of focus of support from state actors to non-state actors, suspension of select activities furthering the nascent UHC journey in Myanmar, adaptation of activities to be relevant to the conflict-affected and fragile setting (CAFS) and to the emerging need to identify opportunities to streamline financial protection in new programs and/or new geographical areas via innovative thinking and creative program designs.
- Opportunities of collaboration for international partners include broadened and deepened engagement with the non-government actors[34] in health financing to strengthen networks through active facilitation and joint programming. DPs should also develop products and capacity as well as promote learning, knowledge generation and exchange. To attain these objectives, DPs have to closely monitor the operational space in the unfolding context, through dialogue and exchange with in-country partners working on health financing.
- Regarding population coverage, a decision has to be made on which population segments will be prioritized for coverage. To be able to distinguish between the formal and informal sector populations, close coordination is required with the Ministry of Labour, Immigration, and Population (MoLIP).
- Partnerships with the private sector, NGOs, CSOs, EHOs, and DPs around issues such as planning, and management of the health workforce have to be strengthened.

[34] Include actors such as the UN bodies, bi-lateral and multi-lateral DPs, international NGOs, civil society, community-based groups and the private sector.

2.5. Human Resources Challenges

- Lack of internal capacities within ministries and weak infrastructures hinders the enforcement and effective implementation of the legal and regulatory framework for health financing.
- Parallel and poorly coordinated implementation arrangements have added to the burden of already capacity-stretched health managers and staff and put in place competing processes and varied incentive structures.
- Conducting a skill needs assessment[35] at the different levels of the health system is a priority. The very purpose is to identify areas where task shifting should be considered[36].
- All health workers involved in the delivery of health promotion, prevention and treatment services must be fully recognized and institutionalized within the health system to ensure efficient use of resources, necessary oversight and quality service provision. This implies inclusion in national level policy frameworks, plans and budgets at all levels and integration into Human Resources for Health (HRH) plans for necessary oversight. In addition, integrated data and reporting should be developed since they support performance management and inform decision making.
- Decision-making with respect to the deployment of human resources should be gradually decentralized to States and Regions. It should be based on the local needs with a focus on the delivery of the Basic EPHS at Township level and below.

2.6. Health Information Challenges

- The absence of a robust national database still hamper the possibility to carry out a broad assessment of equity in financing[37]. Without precise data to calculate the benefit incidence or financing burden of each financing source, it is difficult to quantitatively assess whether health financing is progressive or regressive in aggregate[38].
- Data collection mechanisms should be strengthened to allow for the generation of all indicators included in the NHP's M&E framework. MoHS, ideally through the entity responsible for Health Information System (HIS) should lead compilation of health facility and administrative data and coordinate data quality assessment. The Central Statistical Office is responsible for collection of civil registration and vital statistics (CRVS) data and should work more closely with the entity responsible for HIS on health surveys and the Department for Medical research (DMR).

[35] On the form of an Institutional Capacity Assessment (ICA).

[36] Job descriptions will then be revised accordingly. Accompanying training materials should also be developed to upgrade health workers' skills and prepare them for their new roles.

[37] Can be done by determining the percentage share of total health expenditure funded by each financing mechanism, and by considering whether that funding source is likely to be progressive or regressive.

[38] However, as threequarters of the sources of funds for health come from a source that is regressive (OOP payments = 74 percent), it is most likely that health financing is, on balance, regressive.

- There also needs to be an independent assessment of the quality of data generated from health facilities and administrative sources, ad hoc surveys, and other data sources. This could be done by DMR in collaboration with the entity responsible for HIS within MoHS and NIMU, and possibly the University of Public Health.
- It is also critical to develop appropriate channels for strategic information to reach the National Health Plan Monitoring and Implementation Unit (NIMU) in a timely manner. Efforts have already been done to institutionalize implementation research and establish a continuous feedback loop. Routine analysis of HIS data should be carried out by the entity responsible for HIS within MoHS. Other analyses and reviews should be coordinated by NIMU in close collaboration with the entity responsible for HIS within MoHS, DPs and the Central Statistical Office.
- With regard to strategic purchasing, robust cost data is needed to help the purchaser determine reasonable payment rates. So far, due to the budget structure, very little information is available on the cost of delivering each type of service or intervention. There is no program budgeting *per se* for specific groups of activities related to objectives[39]. This makes it difficult for MoHS - and in the future, the purchasing entity - to understand service costs and set payment rates based on cost information.

3. WHAT IS NEEDED?

3.1. Strengthening policy frameworks by

Adopting conducive policies and strategic plans

- A strong legal framework has to be developed to support the country's move towards UHC. This framework needs to be based on a comprehensive review of existing policies and legislations. Several comprehensive national policies have to be drafted or reviewed through a broad-based multi-stakeholder process (not exhaustive): National health policy; National drug policy; Population policy; HIS policy; Human resources for health; Taxes on tobacco and other products that are harmful to health ("sin taxes").
- A clear health financing strategy has to be developed to outline how resources will be mobilized to finance progress towards UHC and how risk pooling mechanisms will be developed. The health financing strategy should determine whether a mechanism to target the poor needs to be established or not, and what will be done to ensure that the informal (non-poor) sector can access services without experiencing financial hardship.
- Reform is also needed regarding provider payments. Issues to be tackled include: The way provider payment systems work together within the country's overall payment system architecture; The capacity of the purchaser to design and manage payment systems of varying complexity; The autonomy, flexibility, and capacity of providers to respond to payment incentives; The alignment with

[39] While some implementing institutions include subdivisions into disease programs and health facilities.

other health financing functions, such as pooling of funds and defining benefits or essential services packages.

- Regarding anti-corruption legislation, enforcement measures and policies, including strengthening grievance and whistle blower mechanisms, should be developed to enhance integrity and accountability across Myanmar public health sector.

Elaborating costing frameworks

- A costing framework has already been developed for the NHP. It included the cost associated with the improvement of supply-side readiness, and that associated with the actual delivery of services and interventions included in the basic EPHS. It also included a rough estimate of the cost associated with the various health systems strengthening activities that needed to be implemented.
- A costing methodology should now be developed to acquire cost estimates for the implementation of the entire Sector Plan with a given time frame. The costing exercise requires detailed descriptions of activities or projects so as to identify the type of inputs or resources required to implement each activity[40].
- The second step is to develop a financing or resource mobilisation strategy for the sector. This step includes making a systematic projection of domestic resources available for the sector in the next three to five years[41]. Additional sources of financing should be sought using the costed Sector Plan as a device for resource mobilisation. This exercise normally requires extensive consultation with multiple stakeholders including relevant Government Entities, DPs, private sector, NGOS and INGOs.
- M&E strategies and associated budgets should be clearly specified in the costed sectoral plans.

Promoting equity in health system financing[42]

- There should be equity in access to health services: everyone who needs services should get them, not only those who can pay for them. The level of inequality in Myanmar is not considered high from a regional or global perspective. However, it will be important to monitor progress on inequality indicators and other proxy measures for equity of access to services, including health care, to ensure that these services are reaching the poor and other vulnerable groups. In doing so, all the dimensions of equity should be considered e.g. equity in health outcomes, equity in utilization, equity in access or equity in financial contribution.

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[40] Unit-Cost approach is the most preferred method. For this approach, each project should be subdivided into components or subcomponents and inputs required for each target are given realistic cost estimates.

[41] Normally, a macroeconomic model is used to estimate the availability of public expenditure for the sector in a given time frame. Funding gaps are then calculated by reviewing the differences between the project costs and the availability of different sources of funding between public finance, Official Development Assistance (ODA), and private sector.

[42] It is generally accepted that the burden of health financing should be distributed according to an individual's ability to pay, that is, the burden should increase as household income increases.

- Discussions on how to expand coverage for the poor and other vulnerable groups have led to more realistic consideration of equity. However, enrollment of those in the informal sector or the self-employed is still a major challenge because mandatory enrollment is not easily enforceable.
- In the public sector, shortages in medicines and commodities, poor availability of basic amenities, and low diagnostic capacity have led to ineffective and inefficient service delivery. This, in turn, contributes to low coverage rates and poor health outcomes. There are vast disparities in health outcomes and coverage across geographic areas and across social groups. In addition, conflict and security concerns exacerbate inequity of access to care.

Ensuring financial sustainability and the efficient use of resources

- The national immunization program is in its early transition phases, with much work to be done to ensure financial and programmatic sustainability. While the government has started financing traditional vaccines and has met co-financing obligations for new vaccines, future commitments for Government financing of vaccine procurement remains uncertain.
- Implementation of SHI has forced more careful and rational planning regarding the imperative of equating SHI revenues with SHI expenditures. Accurate estimates of the benefits package and of costs determine the financial sustainability and survival of SHI.
- Anchoring spending decisions against expected tax receipts is important for fiscal sustainability. In terms of composition of general government revenue, tax revenues account for approximately 60 percent of Union government receipts and are more stable and better correlated with economic activity than are nontax revenues.
- Rigid financial rules and regulations, restrictions on international procurement, and cumbersome manual information systems have become serious impediments to effective delivery and getting value for money. Revising public financial management systems is a priority for the Government.

Improving data availability to inform policy and decision making

- In order to enable Myanmar transition toward an inclusive digital economy and to expand connectivity and access to online services, it is necessary to support innovation and data literacy while ensuring security and online privacy, This requires strengthening the legal and institutional basis to promote innovation.
- With regard to development assistance, innovative tools have already been developed, such as the Mohinga Aid Information Management System (AIMS)[43]. Accurate data on development assistance is actually essential to enable the Government to make informed decisions regarding the allocation of domestic resources and to ensure that development assistance aligns with Myanmar's priorities.

[43] The Mohinga' AIMS is a simple, open and modern cloud-based web-application. It is the officially designated platform for storing and analysing all development assistance information.

3.2. Strengthening legal and regulatory frameworks by

Adopting robust legislations

- Myanmar has engaged in recent year in a number of important legal reforms. The rule of law is the fundamental principle which underpins democratic governance[44]. In Myanmar, weaknesses in the rule of law place a heavy burden upon people, particularly those who are poor and vulnerable, and present institutional barriers to achieving durable peace, stability and other goals of sustainable development.
- It is now necessary to review health sector laws and regulations to identify constraints and opportunities and to develop and operationalize health-financing functions, in particular strategic purchasing and pooling. This may imply: Reviewing the current legal aid system and developing a legal aid policy that expands coverage of eligible beneficiaries; Improving and legalizing citizens' access to health information and broadening the accessibility of information on budgets, legislation, strategies plans, policies, statistics and other key health information held by public authorities; Increasing transparency, predictability and accountability of government processes for health financing.
- The Myanmar UHC Law has already been drafted (Bill on Health Insurance) but still needs to be passed. The Law should provide for a Healthcare Fund Management Agency which sets up the necessary infrastructures, human resources and medical facilities for the provision of healthcare services to the public. The Healthcare Fund Management Agency will be in charge of undertaking management of the Universal Healthcare Coverage Fund in accordance with the guideline of the central committee[45].
- The Universal Health Coverage Fund aims at providing universal healthcare services to all regardless of income range, social status or locations[46]. Raising and utilization of funds shall be in accordance with the rules and regulations of the Central Committee.

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[44] A Joint Coordination Body for Rule of Law Centres and the Justice Sector (JCB-RoLJ) has been established. The JCB-RoLJ seeks to ensure the coordination and effective implementation of initiatives related to rule of law and justice sector affairs in Myanmar. With regard to development assistance, the JCB-RoLJ provides a convening function, bringing together Government Entities, DPs and other relevant stakeholders to ensure support to the sector is provided in a transparent and coordinated manner.

[45] Other duties include: Reporting to Healthcare Central Committee and its sub-Committees; Evaluating the effectiveness and cost of the healthcare facilities listed in the Law; Paying healthcare expenses approved by the central committee to the eligible healthcare centres; Validating the documents that are submitted in order to get the reimbursement of healthcare expenses applied by healthcare centres, and reimburse if applicable; Timely releasing the required information to the public regarding issues on matters related to the healthcare centres including the transformation of centres; Reviewing the quality of healthcare centres of the health departments based on the standards of the Healthcare Quality Audit Agency, and reporting back to the Agency and the Central Committee if necessary; Officially disclosing the properties owned and annual budget managed by the agency; Hiring medical experts and organizations, if necessary, for technical matters required by the agency for a short or long term; Developing and submitting an annual budget report in a timely manner to the Central Committee at a designated time.

[46] The Fund shall be established by the following contributions: (i) Annual health insurance premiums for the poor, non-incomer dependents and vulnerable populations that will be paid annually by the State with approval from the Union Government and the Healthcare Central Committee; (ii) Individual health insurance premiums for vulnerable populations that will be paid annually by development partners under an agreement between the Healthcare Central Committee and development partners supported by foreign assistance; (iii) Individual health insurance premiums for salary-workers which are paid annually by Social Security Board under an agreement between the Healthcare Central Committee and the National Social Security Board; (iv) Individual health insurance premiums for government employees which will be paid annually by the Ministry of Planning And

- The Law will also establish a Healthcare Quality Audit Agency which will check and evaluate whether health care centres have the specified qualifications to pay for the purchase of the affordable health care policy contract specified by the Healthcare Fund Management Agency[47]. A Healthcare Central Committee will be established to supervise the tasks of MoHS, Healthcare Fund Management Agency and Healthcare Quality Audit Agency.
- The UHC Law includes provision for the formation of the pooled fund, and the institutional arrangements for the pooling. It will stipulate the "purchaser-provider split": a different financing structure for both the purchaser and providers will be established. The purchaser needs a sustainable source of revenue and autonomy to determine payment rates for services, and the flexibility to allocate funds across a range of services and providers. Providers should be able to better respond to changing needs and deliver the requisite services[48].
- Social Security Law (2012) is now the central piece of legislation offering social security benefits in Myanmar[49]. Revising laws in a coherent manner to ensure proper coordination between social protection and health policies over the long term is needed. For SHI, legislation can be blocked or may be difficult to pass if there is a lack of consensus among key stakeholders. Facilitating national debate and consensus on financing health care and allocating resources, especially where legislation is required to authorize mandatory contributions, is critical.
- Establishing a legal framework to ensure that people have access to services of the highest quality, and as affordably as possible, is the priority. Formal recognition of Ethnic Community-based Organizations (ECBHOs)[50] as health providers is critical from this point of view. ECBHOs are actually crucial partners for achieving UHC, due to their unique resources, experience, and territorial access.

Adopting implementing/regulatory measures

- Regulation of private health care is needed to improve hospital care.

Finance under an agreement between the Government of the Union of Myanmar and the Healthcare Central Committee; (v) Targeted additional tax on products that may be harmful to health which will be collected annually by the Ministry of Planning And Finance for the fund; (vi) Interest through the deposit of fund in the bank; (vii) Donations in cash and materials for the fund from abroad and the country; (viii) Fines and contributions collected under this law; (ix) Contributions prescribed by the Central Committee from time to time.

[47] People who are entitled to health care services under the Social Security Law (SSL) could access health care services under the UHC Law with the coordination and agreement between Healthcare Fund Management Agency and Social Security Board (SSB)

[48] They need a degree of autonomy and authority in managing their funds and making decisions.

[49] A number of policies, strategies and legislations which are outside the scope of the Ministry of Labour provide also social protection entitlements.

[50] Mistrust between ECBHOs and the MoH stems from decades of civil war. ECBHOs' experiences working in conflict areas, and reporting on human rights violations, have generated deep scepticism of the central Government and military.

- Mandatory SHI needs to be enforced[51]. If passing a law and creating an organization to collect premiums should be relatively easy, enforcing collection of premiums is still challenging.
- Successful implementation of the NHP requires a robust regulatory framework made of well-functioning institutions, strengthened MoHS leadership and oversight, enhanced accountability at all levels, and strong evidence-based processes that can guide decision making and improved ethics. Creating or increasing community engagement is key to success[52].
- Implementing provider payment reforms is still critical. MoPF and other agencies should focus on reforms and activities needed to operationalize the pooled fund and the strategic purchasing arrangements, which includes the establishment of the purchasing agency and developing its functions and capacities.
- Updating the Health Sector Expenditure Framework is also a priority. Developing templates to facilitate mapping of existing resource allocation processes e.g. existing flows, allocation criteria/formulas used, equity of current approaches, is core to improving health financing.

3.3. Strengthening institutional frameworks by

Creating supportive environments

- Building institutional capacity is required to ensure that institutions concerned by health financing can be effective in carrying out their key tasks, e.g. enforcing premium collection from the formal sector, purchasing services by contracting competent public and private providers, and ensuring health care providers are acting in the interests of social security members.
- A dedicated unit will be established within the MoHS, with a clear mandate to facilitate smooth implementation of the NHP[53]: the NHP Implementation Monitoring Unit (NIMU). NIMU will have a mixed set of skills and expertise including legal, financial management, public health, clinical, health financing.
- Myanmar's budget cycle focuses almost exclusively on financial controls. It is necessary to develop key planning tools for health financing. These should include medium-term expenditure frameworks, and multiyear budgets[54]

[51] Implementation of SHI has succeeded in raising more revenues for health in addition to existing revenues raised by general taxation.

[52] The introduction and strengthening of accountability mechanisms, including social accountability, will help give communities a voice, which in turn will enhance responsiveness of the system.

[53] NHP was meant to provide a framework that would enhance the effective and efficient implementation of programs within the national health system, especially at township level and below.

[54] While the government of Myanmar has a Medium-Term Fiscal Framework (MTFF), it does not have a Medium-Term Expenditure Framework (MTEF). The MTFF helps aggregate total fiscal space available to determine resource availability but does not help determine and plan for future expenditure allocation, as an MTEF would.

Advocating for new investments

- Decades of underinvestment in Myanmar's health system has led to substantial inefficiencies in the health system: poor service readiness and availability, ineffective coverage, low quality care and poor health outcomes. Further investments in basic health service inputs and health systems will help to eliminate the inefficiency that comes from low expenditures on health.
- Extending the Basic EPHS to the entire population will require substantial investments by the MoHS in supply-side readiness at Township level and below and in strengthening the health system at all levels. It will also require active engagements of health providers outside the public sector, including private-for-profit general practitioners clinics, EHOs and NGOs. Likewise, underinvestment in the MoHS procurement and supply chain management system has translated into limited management capacity, infrastructure, and technology.
- Developing an integrated infrastructure investment plan, which will be based on updated, cost-effective and standardized designs of health facilities, is a priority. Health facilities need to be constructed, rehabilitated and/or equipped, considering the local context. Investments should be prioritized at Township level, as part of the Inclusive Township Health Plan. It should also be aligned with the human resources deployment plan to avoid empty facilities[55].

Establishing close monitoring and accountability for results

- A strong M&E framework is needed to track and measure progress in the implementation of the NHP and for health financing[56]. Efforts will need to be made to explicitly address equity under its various forms in implementation of the NHP. M&E should include the regular collection of data on specified indicators and the tracking of the disbursement of funds. The integration of Sustainable Development Goals (SDG) indicators into project and programmatic indicators are encouraged.
- Objectives are to reduce excessive and duplicative reporting requirements, serve as a general reference and provide guidance for standard indicators and definitions. Enhancing efficiency of data collection investments and availability and quality of data on results is also critical. A strong M&E framework should also improve transparency and accountability.
- At the national level, M&E will be overseen by NIMU. At state and region level, the state/regional Health Authorities will be in charge of M&E. They will provide regular feedback to Townships. The

[55] Accountability in the execution of contracts related to the construction or rehabilitation of health facilities should be enhanced. Equipment specifications will be standardized. Restrictions to international procurement of equipment and drugs/supplies will be removed. Funding for maintenance will be made available to health facilities.

[56] A strong M&E framework usually includes the following components: Ex-ante evaluation to analyse the potential costs and benefits, and to assess the value and relevance of the program; Mid-term evaluations conducted as part of the implementation cycle used to evaluate the progress and performance of implementation, and to propose adjustments in the design and implementation where necessary; Final evaluations conducted immediately after completion used to assess the end results and the preparation of final reports; Impact evaluations conducted at an appropriate time within three years following the completion of an initiative to assess its efficiency, effectiveness, sustainability and impact against a set of clearly specified targets.

M&E framework should also include provisions for the monitoring of the performance of DPs and implementing partners[57].

- Joint Annual Reviews will be organised by NIMU to assess progress made. These reviews will involve representatives from key MoHS departments/divisions, representatives from state/regional Health Authorities, and representatives from other key ministries such as MoPF. They will also involve other key stakeholders, such as DPs and civil society. The Joint Annual Reviews will help identify areas where corrective measures need to be taken.
- Improving accountability between contributing members and the SHI system, especially if benefit entitlements have not been honoured, is needed as leakage of SHI funds are recurrent due to corruption. Likewise, purchasing contracts should aim to fulfil the objectives of transparency and accountability, value-for-money, and be quality-assured. A key task will be to start building the capacity of the purchasing entity, to ensure that it has the capability to manage and enforce contracts, to attain its objectives.

Aligning overall health system and health financing reforms

- It is necessary to promote further alignment at several levels: Among programs, by encouraging more integrated training, joint supportive supervision, better aligned referral mechanisms, a more streamlined health information system; Among DPs, through stronger oversight and coordination; Among the different types of providers, through the engagement of EHOs, NGOs, private-for-profit providers; Among implementing agencies by ensuring that projects and initiatives contribute to the achievement of the NHP goals.
- The Government encourages the delivery of development assistance through Programme Based Approaches (PBA) and/or Multi Donor Trust Fund (MDTF) mechanisms. Such forms of assistance enable the efficient delivery of a comprehensive and coordinated set of activities directly aligned with national, sub-national and sector level development priorities.

Transferring powers and resources to local authorities (decentralization)[58]

- Health sector in Myanmar remains a highly centralized one. The 2008 Constitution provides the central Government an exclusive legislative power over health policy-making. The state/region governments

[57] An overall monitoring and evaluation framework has been established to inform the smooth implementation of the Development Assistance Policy (DAP): the DAP Joint Monitoring and Accountability Framework. It is intended to provide a set of clear and monitorable indicators that will contribute to the adherence to the DAP.

[58] Decentralization is a process by which political, administrative and fiscal authority, responsibilities and functions are transferred from the central government to the state/region governments. There are at least three aspects of decentralization: devolution, deconcentration and delegation. Devolution is the transfer of authority and responsibility from central government ministries to lower-level, autonomous units of government through statutory or constitutional provisions that allocate formal powers and functions. Deconcentration is the transfer of authority and responsibility from central government ministries in the country's capital city to field offices of those ministries at a variety of levels (region/state or local). Delegation is the transfer of authority and responsibility from central government ministries to organizations not directly under the control of those

have no jurisdiction, but only coordination role, over state/region health departments. As a result, there is a lack of incentive and a poor line of accountability. Communities are not part of decision-making about strengthening or improving health facilities and services and regarding health financing.

- Despite having a bicameral parliament (or *Hluttaw*), Myanmar is still a centralized country with a *de facto* unitary form of government. The ethnic nationalities are calling for constitutional reform to build a federal union of Myanmar, wherein political control, fiscal authority and administrative responsibilities are decentralized, and the states/region governments will have more autonomy in all three areas. Ideally, development of a national health policy and system should be according to the framework of a Federal Union[59].
- Three critical challenges have emerged recently in this regard: (i) the challenge of a highly centralized management of health system and the opportunity to decentralize it so that concerns at the state/region level are addressed with efficiency; (ii) the challenge of inadequate budget and finance for healthcare and the need to grant state/region governments budgetary authority, e.g. capacity to seek funding, propose revenue options and decide on how and where the funds will be spent; and (iii) the challenge of lack of incentives from the central government to address local needs and concerns, and the opportunity to develop local community commitments especially in terms of empowerment of state/region and local authority in dealing with issues unique to their localities.
- The overall decentralization of the health system - decision-making authority, developing resources and public financing, and management of health programs and facilities - would address both the issue of accountability and the need for efficiency. From the budget perspective, budget execution (drawing rights) is decentralized only to Township Medical Officers. There is no fund flow to health facilities below the Township level. Likewise, discussing the role of regions and states in the new pooled funding and institutional set-up for demand side financing is critical to clarify the role of regions and states. This may imply to develop a framework for policy implementation to determine which actions are to be taken across departments and programs at the different levels, e.g. national, state/region and Township.

Developing Public-Private Partnerships (PPP) and "contractual arrangements"

- Private sector participation in health financing is still limited but could play an increased role in the future. The Government is currently developing a PPP policy that seeks to develop a consistent approach to project identification, development, procurement and management and to clarify the

ministries, for example, non-governmental organizations, and/or autonomous region/state and township governments. In Myanmar, devolution should be sought rather than deconcentration or delegation.

[59] The task is not easy. It supposes to amend the Constitution. Constitutionally, actually, the state/region governments must have explicit grants of authority to shape discussions of health policy, finance and administration. It means that the health system would be decentralized within a framework that clarifies and details the responsibilities and functions of each government level and agency. And, the design of such policy framework would encompass delineation on which functions and responsibilities should be decentralized to state/region level, and which would remain centralized.

roles and responsibilities for Government bodies at each stage in the process[60]. From this point of view, a sound legal and regulatory framework would be important to maximize benefits and minimize fiscal and delivery risks of PPPs.

- DPs are encouraged to support the development of the private sector, in line with the Private Sector Development Framework and Action Plan established by the Government. They should seek to prioritise local procurement and innovative partnerships with the private sector wherever possible in order to maximise the impact and sustainability of development assistance.

[60] Countries tend to use PPPs for two major reasons: (i) To enhance efficiency of project execution and as alternative forms of financing. The general expectation is that the private sector can execute projects more efficiently than the public sector, and thus PPPs in general are expected to increase capital expenditure efficiency; and (ii) To ease fiscal constraints while ensuring adequate investment in essential infrastructure.