Path to Universal Health Coverage
Myanmar
Total population - 52 million
Life expectancy at birth m/f - 65/69
Poverty (WB 2015) - 38% rural
  14.5% urban

First elections in Myanmar in 2010
Civilian government 2011
## Health Expenditures among WHO SEA Region

<table>
<thead>
<tr>
<th>Country</th>
<th>THE as % of GDP</th>
<th>GGHE as % of THE</th>
<th>GGHE as % of GGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>2.8</td>
<td>3.7</td>
<td>39.0</td>
</tr>
<tr>
<td>Bhutan</td>
<td>6.9</td>
<td>4.3</td>
<td>79.3</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>4.5</td>
<td>7.1</td>
<td>48.6</td>
</tr>
<tr>
<td>India</td>
<td>4.3</td>
<td>3.7</td>
<td>26.0</td>
</tr>
<tr>
<td>Indonesia</td>
<td>2.0</td>
<td>2.8</td>
<td>36.1</td>
</tr>
<tr>
<td>Maldives</td>
<td>7.0</td>
<td>6.2</td>
<td>58.0</td>
</tr>
<tr>
<td>Myanmar</td>
<td>2.1</td>
<td>2.0</td>
<td>13.5</td>
</tr>
<tr>
<td>Nepal</td>
<td>5.4</td>
<td>5.1</td>
<td>24.6</td>
</tr>
<tr>
<td>Srilanka</td>
<td>3.7</td>
<td>3.5</td>
<td>48.4</td>
</tr>
<tr>
<td>Thailand</td>
<td>3.4</td>
<td>3.9</td>
<td>56.1</td>
</tr>
<tr>
<td>Timor</td>
<td>8.0</td>
<td>5.7</td>
<td>78.9</td>
</tr>
</tbody>
</table>

Public vs OOP health spending, 2011

Out of Pocket Health Spending

Public spending on health share of GDP (%) vs OOP share of total health spending (%)

Indonesia, Myanmar, Fiji, Japan, Cambodia, Thailand, China, Sri Lanka, Philippines, Korea, Lao PDR, Malaysia, PNG, Vietnam

Fr Presentation by San San Aye – National dialogue on social protection policy options and scenarios, 2014, NayPyiTaw
A recent study in Myanmar shows that health expenses are the second greatest cause of catastrophic expense (after natural disasters).

Of households that reported to have visited a health facility (public or private) in the last 12 months, nearly one-third took loans and more than 15 percent sold assets to cover their medical expenses.

[Source: Myanmar Poverty and Living Conditions Survey 2014-15].
## UHC Indicators

<table>
<thead>
<tr>
<th>WHO target indicators</th>
<th>Myanmar’s situations</th>
</tr>
</thead>
<tbody>
<tr>
<td>• OOP spending should not exceed 30-40 % of THE</td>
<td>• OOP Expenditure as % of THE: &gt;80%</td>
</tr>
<tr>
<td>• THE should be at least 4-5 % of GDP</td>
<td>• THE as % of GDP: 2%</td>
</tr>
<tr>
<td>• Over 90 % of the population is covered by prepayment and risk-pooling scheme</td>
<td>• GGHE: 20 % SSB: &lt;1%</td>
</tr>
<tr>
<td>• Close to 100 % coverage of vulnerable populations with social assistance and safety-net program</td>
<td>• Supply Side Financing ???</td>
</tr>
<tr>
<td></td>
<td>• Demand Side Financing ???</td>
</tr>
</tbody>
</table>
UHC

- means that all individuals and communities receive the health services they need without suffering financial hardship.

- It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

- UHC enables everyone to access the services that address the most important causes of disease and death, and ensures that the quality of those services is good enough to improve the health of the people who receive them.
National Health Plan Myanmar 2017 – 2021

Goals of NHP (2017-2021)

• Universal Health Coverage (UHC), all people having access to needed health services without experiencing financial hardship, has become a global priority as defined in the SDG’s.

• Myanmar political leadership also has expressed a strong commitment to accelerating progress towards UHC.

• The NHP aims to strengthen the country’s health system and pave the way towards UHC, choosing a path that is explicitly pro-poor.

• The main goal of NHP 2017-2021 is to extend access to the Basic Essential Package of Health Services (EPHS) to the entire population while increasing financial protection.
Annual Operation Plan (AOP) 2017-2018

- Strengthening systems to support operationalization of the NHP
- Operationalizing at the Local Level
- Developing a Supportive Environment
- Monitoring & Evaluation

- A total of 116 activities and tasks to be accomplished under those 4 main areas
The National Health Plan 2017-2021 and Universal Health Coverage

National Health Plan 2017-2021
- Basic EPHS
- Reducing catastrophic and impoverishing out-of-pocket spending on health

National Health Plan 2021-2026
- Intermediate EPHS
- Expanding service availability and readiness

National Health Plan 2026-2031
- Comprehensive EPHS
- Everyone in Myanmar receives the health services they need...
  - ...without suffering financial hardship
## Outline of all inclusive NHP development process

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 - Oct, 2016</td>
<td>Launching for NHP (2016-2021) road map to all stakeholders</td>
<td>Grand Amara Hotel, NPT</td>
</tr>
<tr>
<td>20, 21 - Oct, 2016</td>
<td>Workshop # 1 for all inclusive NHP formulation process with all stakeholders</td>
<td>Amara Hotel, NPT</td>
</tr>
<tr>
<td>2,3 - Nov, 2016</td>
<td>Workshop with UN/INGOs for effective health collaboration to support NHP planning process</td>
<td>Horizon Lake View Hotel</td>
</tr>
<tr>
<td>10,11 - Nov, 2016</td>
<td>EPHS workshop to identify basic EPHS with all national program managers</td>
<td>Kimpinski Hotel, NPT</td>
</tr>
</tbody>
</table>
# Outline of all inclusive NHP development process

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>21,22 - Nov, 2016</td>
<td>CSOs Health consultation meeting for all inclusive NHP formulation and way to UHC</td>
<td>Sky Star Hotel, Yangon</td>
</tr>
<tr>
<td>23 - Nov, 2016</td>
<td>EHOs meeting for all inclusive NHP formulation process and way to UHC</td>
<td>Kayin State</td>
</tr>
<tr>
<td>28,29,30 - Nov, 2016</td>
<td>Workshop #2 and #3 to finalize NHP (2016-2021) planning process with all stakeholders</td>
<td>Horizon Lake view Hotel, NPT</td>
</tr>
<tr>
<td>29 Nov, 2016</td>
<td>Half day workshop with national health program Managers</td>
<td>Horizon Lake view Hotel, NPT</td>
</tr>
<tr>
<td>1,2 - Dec, 2016</td>
<td>Myanmar’s Way to UHC 2030 Panel Discussion</td>
<td>Park Royal Hotel, NPT</td>
</tr>
</tbody>
</table>
Outline of all inclusive NHP development process

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Place</th>
</tr>
</thead>
<tbody>
<tr>
<td>7- Dec, 2016</td>
<td>Sharing the draft NHP to all stakeholders for comments/suggestions</td>
<td></td>
</tr>
<tr>
<td>12 - Dec 2016</td>
<td>Workshop # 4 to finalize the draft NHP (2016-2021)</td>
<td>NPT</td>
</tr>
<tr>
<td>15, Dec 2016</td>
<td>Dissemination of NHP (2016-2021) framework to all stakeholders</td>
<td>NPT</td>
</tr>
</tbody>
</table>
National Health Plan

Goals

- The National Health Plan (NHP) aims to strengthen the country’s health system and pave the way towards UHC, choosing a path that is explicitly pro-poor.

- To extend access to Basic EPHS to entire population equitably in line with Myanmar UHC strategies while increasing financial protection.
  - *Basic EPHS emphasizes critical role of primary health care*

- Strengthening the health system to support effective delivery of quality services.

- Enhance responsiveness and accountability.
  - *Basic EPHS clarifies entitlements and manage expectations*
National Health Plan

Goals

- Introduce Inclusive Township Health Planning to ensure inclusiveness of all partners

- NHP also aims to promote further alignment at several levels:
  - Among programs (e.g. by encouraging more integrated training, joint supportive supervision, better aligned referral mechanisms, a more streamlined health information system..)
  - Among development partners, through stronger oversight and coordination
  - Among the different types of providers, through the engagement of EHOs, NGOs, private-for-profit..
  - Among implementing agencies by ensuring that projects and initiatives contribute to the achievements of the NHP goals
Conceptual Framework

National
State/Region

Township
and Below

Basic EPHS
COMMUNITIES
Conceptual Framework

National
State/Region

Township
and Below

Service Availability and Readiness

GVT
EHO
NGO
GP

Minimum Standards of Care

Basic EPHS

COMMUNITIES
Conceptual Framework

National
State/Region

Township
and Below

Inclusive Township
Health Plan

Service Availability and Readiness

GVT
EHO
NGO
GP

Minimum Standards of Care

Basic EPHS

Communities
Conceptual Framework

National State/Region

Township and Below

Geographical Prioritization

Systems Building
- Human Resources
- Infrastructure
- Service Delivery
- Health Financing

Inclusive Township Health Plan

Service Availability and Readiness
- GVT
- EHO
- NGO
- GP

Minimum Standards of Care

Basic EPHS

Communities
Conceptual Framework

Guiding Principles (Equity, Inclusiveness, Accountability, Efficiency, Sustainability, Quality)

National
State/Region

Township
and Below

Geographical
Prioritization

Systems Building

Service Prioritization

Human Resources
Infrastructure
Service Delivery
Health Financing

Inclusive Township
Health Plan

Service Availability and Readiness

Minimum Standards
of Care

Basic EPHS

Supportive Environment (policies, regulations, ethics, research, oversight...)

COMMUNITIES
Operational plan 2017–18
Some of the immediate next steps (1/2)

- Finalization of the Basic EPHS – including detailed breakdown by level of the system
- Costing of the NHP
- Development of the NHP M&E framework
- Prioritization of Townships where investments in improving service availability and readiness are to be made
- Development of a Health Financing Strategy
- Achievement of alignment between development assistance and the NHP
Operational plan 2017–18
Some of the immediate next steps (2/2)

- Preparation of a ‘national’ approach for the assessment of service coverage at Township level
- Development of a ‘national’ approach to the elaboration of an Inclusive Township Health Plan
- Identification of most urgent efforts needed to strengthen the health system and further develop the enabling environment
- Institutionalization of implementation research
Unfortunate reality

Health Care Needs

Available Resources

Fr Thant Sin Htoo
If you have limited resources, what do you spend them on?
Prioritization of Health Services and Interventions
Essential Package of Health Services (EPHS)

MoHS launched an inclusive exercise to define the EPHS in February 2015. With technical inputs from the different programs, health services and interventions were prioritized based on following criteria:

- **Burden of disease / epidemiological relevance**
- **Cost-effectiveness of services and interventions**
- **Societal values and priorities**
- **Affordability and fiscal space**
- **Feasibility and supply side readiness**
- **Equity** – (services and interventions that disproportionately benefit the poor and vulnerable)
Essential Package of Health Services (EPHS)

Based on this prioritization, essential services and interventions will be included in a basic package, an intermediate package or a comprehensive package, to be made available to the entire population by 2020, 2025 and 2030, respectively.

The NHP 2017-2021 will focus on ensuring everyone can access the Basic EPHS by 2020.
The Basic EPHS has a strong focus on Primary Health Care services and interventions delivered at Township level and below.
If you have limited resources, where do you expand service readiness first?

In areas that are already well covered?

Or in areas that are poorly covered?

GVT  NGO
EHO  GP

NGO
Geographical Prioritization
The NHP will be operationalized nationwide to deliver the Basic EPHS based on existing capacity but for investments in the expansion of service readiness, Townships with the greatest needs will be prioritized.
prioritization should therefore be based on **objective criteria**
using the best available data
Initially, prioritization of Townships will be based on two indices:

The **Health Input Scoring Index (HISI)**

and

The **Health Output Scoring Index (HOSI)**
The Health Input Scoring Index (HISI) combines information on

Health Access Points

and

Health Workforce Conditions

in both public and private sectors
Figure 10 – Functioning Health Facilities (Health Access Point) Scoring among States and Regions 2017-2021

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Figure 9 – Health Workforce Scoring among States and Region (as of 2016 November 30)
Key Assumptions

The optimum is defined as:

- one standard access point for an area with 2.5km radius (not considering terrain) and a population of 3,500 individuals
- one standard health workforce for an area with 1 km radius and a population of 450 individuals

Interpretation: composite score = 0: access is optimal
- composite score > 0: access is above optimum
- composite score < 0: access is below optimum

Initial assumption: existing public sector access points are all functional. In reality, …
<table>
<thead>
<tr>
<th>States &amp; Region</th>
<th>Total Number of Public Health Facilities (Excluding Hospitals)</th>
<th>Standard infrastructure</th>
<th>Substandard infrastructure</th>
<th>Need Renovation and no infrastructure</th>
<th>Hard to access</th>
<th>Non functioning Access Point %</th>
</tr>
</thead>
<tbody>
<tr>
<td>KACHIN</td>
<td>379</td>
<td>45</td>
<td>257</td>
<td>42</td>
<td>35</td>
<td>20.3%</td>
</tr>
<tr>
<td>KAYAH</td>
<td>151</td>
<td>62</td>
<td>15</td>
<td>64</td>
<td>10</td>
<td>49.0%</td>
</tr>
<tr>
<td>KAYIN</td>
<td>334</td>
<td>44</td>
<td>156</td>
<td>95</td>
<td>39</td>
<td>40.1%</td>
</tr>
<tr>
<td>CHIN</td>
<td>406</td>
<td>35</td>
<td>191</td>
<td>180</td>
<td>0</td>
<td>44.3%</td>
</tr>
<tr>
<td>MON</td>
<td>389</td>
<td>46</td>
<td>152</td>
<td>174</td>
<td>17</td>
<td>49.1%</td>
</tr>
<tr>
<td>RAKHINE</td>
<td>739</td>
<td>124</td>
<td>461</td>
<td>154</td>
<td>0</td>
<td>20.8%</td>
</tr>
<tr>
<td>SHAN N</td>
<td>454</td>
<td>21</td>
<td>48</td>
<td>336</td>
<td>49</td>
<td>84.8%</td>
</tr>
<tr>
<td>SHAN E</td>
<td>172</td>
<td>53</td>
<td>0</td>
<td>111</td>
<td>8</td>
<td>69.2%</td>
</tr>
<tr>
<td>SHAN S</td>
<td>473</td>
<td>58</td>
<td>343</td>
<td>72</td>
<td>0</td>
<td>15.2%</td>
</tr>
<tr>
<td>YANGON</td>
<td>587</td>
<td>140</td>
<td>440</td>
<td>268</td>
<td>10</td>
<td>47.4%</td>
</tr>
<tr>
<td>MDY</td>
<td>945</td>
<td>625</td>
<td>174</td>
<td>145</td>
<td>1</td>
<td>15.4%</td>
</tr>
<tr>
<td>AYEYAR</td>
<td>1542</td>
<td>157</td>
<td>348</td>
<td>1037</td>
<td>0</td>
<td>67.3%</td>
</tr>
<tr>
<td>SAGAING</td>
<td>1417</td>
<td>368</td>
<td>734</td>
<td>213</td>
<td>102</td>
<td>22.2%</td>
</tr>
<tr>
<td>TANIN</td>
<td>306</td>
<td>52</td>
<td>94</td>
<td>93</td>
<td>67</td>
<td>52.3%</td>
</tr>
<tr>
<td>MAGWAY</td>
<td>1095</td>
<td>197</td>
<td>0</td>
<td>898</td>
<td>0</td>
<td>82.0%</td>
</tr>
<tr>
<td>BAGO</td>
<td>1076</td>
<td>140</td>
<td>429</td>
<td>487</td>
<td>20</td>
<td>47.1%</td>
</tr>
<tr>
<td>NPT</td>
<td>199</td>
<td>45</td>
<td>20</td>
<td>112</td>
<td>22</td>
<td>67.3%</td>
</tr>
</tbody>
</table>
The Health Output Scoring Index (HOSI) combines information on

**EPI coverage (public health),**

**TB New Case Detection Rate (disease control)**

and

**Hospital Bed Occupancy Rate (medical care)**
Construction of HOSI

Geometric mean for the fraction of 3 health indicators of medical care, public health and disease control, for states and regions as well as for each township

Composite score with a value between 0 and 1

Interpretation:  composite score = 0: worst health output
composite score = 1: worst health output
HOSI

Health Output Scoring among States and Region (As of 2016 November 30)

Fr Thant Sin Htoo
for the calculation of both indices, assumptions can be changed to look at different scenarios
both indices will be gradually improved, as more and better data becomes available
What does UHC mean for Myanmar?

✓ Myanmar is on the road to universal health coverage, with a commitment to provide families with access to a package of essential quality health services by 2030.

✓ Guiding Myanmar’s path to UHC is the National Health Plan 2017-2021 for the next five years.

✓ Subsequent National Health Plans (2021-2026) and (2026-2031) will build on the current National Health Plan to reach the long-term goal of UHC.

✓ It is the result of an inclusive and collaborative process that sought to include all stakeholders.

✓ Providing a package of essential health services and improving access for all is the cornerstone of this plan.
Important first steps are already being taken:

- This includes strengthening the primary health care system.
- Developing strategies to improve financing;
- Strengthening communities, who have an important role to play in ensuring health access.
- They can generate demand for services and hold services and finances accountable.
- To implement the NHP, annual operational plans will be developed including concrete steps needed to make universal health coverage a reality.
Figure 3 – Government spending on health as a percentage of total government expenditure

Source: MoHS
Figure 4 – Rate of increase in number of health facilities

Source: MoHS
But the focus in the first year has been on Investment & Service Delivery Plan.
Step by step starting from selected townships -

In each selected Township (and in addition to routine investment budget):

- Medical equipment for Township hospitals (already procured)
- One ambulance for each Township Hospital (already procured)
- One Type C lab for each Township Hospital (still to be procured)
- 1 set of RHC + connected sub-RHCs (to be reconstructed on existing sites)
- Equipment + drugs/medical supplies kits for re-constructed RHC and sub-RHCs
- Renovation of 5 sets of RHC + connected sub-RHCs

Estimated cost: around US$ 500,000 per township, or US$ 38 million for the 76 selected Townships (i.e., ~ 5% of the 2017-’18 government budget for health)
Investments to expand Townships’ capacity by improving service availability and readiness will be gradually phased in.

**Year 1**
2017-18
76 Townships

Phasing of Townships
Investments to expand Townships’ capacity by improving service availability and readiness will be gradually phased in.

Year 2
2018-19
76 + 82 Townships

Phasing of Townships
Investments to expand Townships’ capacity by improving service availability and readiness will be gradually phased in.

**Year 3**

**2019-20**

76 + 82 + 83 Townships

**Phasing of Townships**

*Fr Thant Sin Htoo*
Investments to expand Townships’ capacity by improving service availability and readiness will be gradually phased in.

Year 4
2020-21
76 + 82 + 83 + 89 Townships = 330

Phasing of Townships

Fr Thant Sin Htoo
Health System Challenges
Human resource

• Current Issues
  • shortages of human resources for Health
  • inappropriate balance and mix of skills
  • inequitable distribution (largely concentrated in urban area)
  • difficulties in rural retention
• well below WHO minimum recommended threshold (2.28/1000 population) (1.49 health workers/1,000 people as of Nov, 2016)
• Lack of accreditation system for educational programs and institutions
• Lack of clear recruitment and deployment policies
• Limited clarity around roles and responsibilities of different health care providers at all levels of the system
• In-service training are the joint responsibility of the Department of Public Health and the Department of Medical Services.
• Currently, in-service training tends to be project-oriented
Infrastructure

- no clear nationwide infrastructure investment plan
- mismatch between health administrative maps and catchment areas of health facilities
- Design of health facilities can vary depending on the funding source
  - not all health facilities have critical amenities such as clean water, sanitation, electricity, warehousing facilities, staff housing and communication facilities
- restrictions imposed by financial rules and regulations have led to delays in the tendering process
- lack of enough operational budget for maintenance
Service delivery

- relies on a mix of public, private for-profit, private not-for-profit and EHO providers
- Township/station hospitals and below have received less attention over the past few decades
- This underinvestment lead to shortcomings in service availability, readiness and coverage, especially in rural areas.
- limited public sector service delivery in both conflict-affected and post-conflict affected areas.
- recognized that the public sector will not be able to reach the entire population by itself
- other actors, such as private for profit providers, NGOs and EHOs, are also involved in service delivery
• Existing procurement and supply chain system - highly fragmented along vertical programs and funding sources
• Poor alignment between the Government of Myanmar’s Public Financial Management (PFM) system and the financing objectives related to health service delivery at the primary health care level
  (bottlenecks throughout the budget cycle)
• A disconnect between planning and budgeting functions and cycles
• Budget allocation – mostly historical and delinked to actual needs
• Budget is structured around line items that largely focus on inputs and are disconnected from programs or outputs
Health financing

- allocates 4.2 percent of its total budget on health, which is extremely low by global and regional standards
- However health budget increased almost ten-folds in absolute amount from 2011-2017
- mainly used to finance delivery of health care and expansion of service coverage with a focus on free medical care in hospital settings
The road toward UHC
UHC giant

David and Goliath
Described as the “single most powerful concept that public health has to offer” by the World Health Organization, universal health coverage is critical to Myanmar’s development and economic growth.

Thank You