



National Health Network

Programme of Health Reforms

A Roadmap Towards Universal Health Coverage in Myanmar (2016-2030)

Version 1.0

March 2016

ACKNOWLEDGEMENTS

The authors would like to thank Dr Tin Myo Win, members of the NLD National Health Network and members of the National Health Governance Core Group for initiating and facilitating the process of developing this Program of Health Reforms. Their sincere gratitude goes to all the participants who attended the different workshops and meetings for generating ideas and providing valuable inputs for the Program. These include representatives from development partners, from civil society and from Ethnic Health Organizations, as well as independent experts and academics. The authors would also like to thank the regional and global experts who provided useful thoughts and inputs during the side-meetings organized at the Prince Mahidol Award Conference 2016. Finally, the authors would like to thank the different agencies and individuals that were consulted whilst preparing this report for the valuable information they shared.

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ACRONYMS

AMW	Auxiliary Midwife
BEmOC	Basic Emergency Obstetric Care
CD	Communicable Disease
CHW	Community Health Worker
CPE	Continuing Professional Education
CSO	Civil Society Organisation
DHPRDM	Department of Health Professional Resource Development and Management
DMR	Department of Medical Research
DoMS	Department of Medical Services
DP	Development Partner
DoPH	Department of Public Health
EHO	Ethnic Health Organisation
EPHS	Essential Package of Health Services
FDA	Food and Drugs Administration
GAVI	Global Alliance for Vaccines and Immunisation
GFATM	Global Fund to fight Aids, Tuberculosis and Malaria
GP	General Practitioners
HEF	Health Equity Fund
HITAP	Health Intervention and Technology Assessment Programme
HRO	Health Reforms Office
HSS	Health Systems Strengthening
HTA	Health Technology Assessment
HTF	Hospital Trust Fund
ICT	Information Communication and Technology
MHAA	Myanmar Health Assistants Association
MHSCC	Myanmar Health Sector Coordination Committee
MAMS	Myanmar Academy for Medical Science
MMA	Myanmar Medical Association
MMC	Myanmar Medical Council
MMCWA	Myanmar Maternal and Child Welfare Association

MNMA	Myanmar Nurse and Midwife Association
MNMC	Myanmar Nurse and Midwife Council
MoH	Ministry of Health
MoPF	Ministry of Planning and Finance
MoLIP	Ministry of Labour, Immigration and Population
MPLCS	Myanmar Poverty Living Conditions Survey
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NHA	National Health Accounts
NICE	National Institute for Clinical Excellence
NLD	National League for Democracy
OOP	Out-of-Pocket
OPD	Outpatient Department
PER	Public Expenditure Review
PFM	Public Financial Management
PHC	Primary Health Care
PMAC	Prince Mahidol Award Conference
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SSB	Social Security Board
TB	Tuberculosis
TMO	Township Medical Officer
TRIPS	Trade Related Aspects of Intellectual Property Rights
UHC	Universal Health Coverage

INTRODUCTION

The Myanmar health system faces numerous challenges

There have been recent efforts to reverse decades of institutional neglect in the health sector. Thanks to efforts to tackle the spread of the three main communicable diseases – malaria, tuberculosis, and HIV/AIDS –, for example, the country was able to largely meet the targets associated with Millennium Development Goal 6. Several policies were introduced in 2013 and 2014 to improve service delivery, increase service utilisation and reduce households' out-of-pocket spending for health^{1*}. The introduction of these policies was accompanied by a rise in public spending on health from 0.2 per cent of GDP in 2009 (the lowest in the world) to slightly over 1 per cent in 2014.

Despite these efforts, the health status of the Myanmar population remains poor. Myanmar has the lowest life expectancy at birth among ASEAN countries. Based on preliminary estimates from the 2014 census, the maternal mortality ratio (MMR) is 282 deaths per 100,000 live births, compared to 161 in Cambodia and only 20 in Thailand, and the under-five child mortality rate (U5MR) is 72 deaths per 1,000 live births, compared to 29 in Cambodia and 12 in Thailand. Malnutrition is highly prevalent, with more than one third of the children under the age of five stunted. Both HIV prevalence and TB incidence are second highest among ASEAN countries. The burden of disease from non-communicable diseases (NCDs) is increasing at alarming rates; it is estimated to already account for more than 40 per cent of all deaths. Diabetes and hypertension are particularly prevalent.

Hidden behind the national averages are wide geographic, ethnic and socio-economic disparities. For example, the MMR in Chin State is 357, compared to 213 in Yangon, and the U5MR ranges from 108 in Magwe Region to 48 in Mon State. Children from poorer households are more than twice as likely to be undernourished than those from better-off households.

One of the factors explaining this situation is the failure of the health system to ensure the availability and accessibility of essential health services and interventions of quality*. Among poorer households, for example, only slightly more than half of the pregnant women give birth with the assistance of a skilled health worker. In Chin State, less than 10 per cent of all deliveries take place in a health facility. One fourth of all women of reproductive age do not currently meet their family planning needs. While on average one household out of four has no access to improved toilets, in Rakhine State this is the case for more than two thirds of the households. It is important to recognise that many factors beyond the health system, and in particular the social determinants of health, also contribute to the present situation.

There are many health systems challenges to overcome. These relate to the availability and distribution of inputs (e.g. human resources, physical infrastructure, supply chain, financial resources) and to

¹ The reader may not be familiar with some of the terms used in this document. A glossary of terms was prepared to facilitate the reading. It can be found in an accompanying document. For each term, the glossary provides a definition in English, as well as a translation and/or definition in Myanmar language. Terms included in the glossary are indicated with an asterisk (*) the first time they appear in the text.

weaknesses in key functions (e.g. supervision, referral, health management information system*, public financial management*). They also result from a lack of oversight, leadership and accountability.

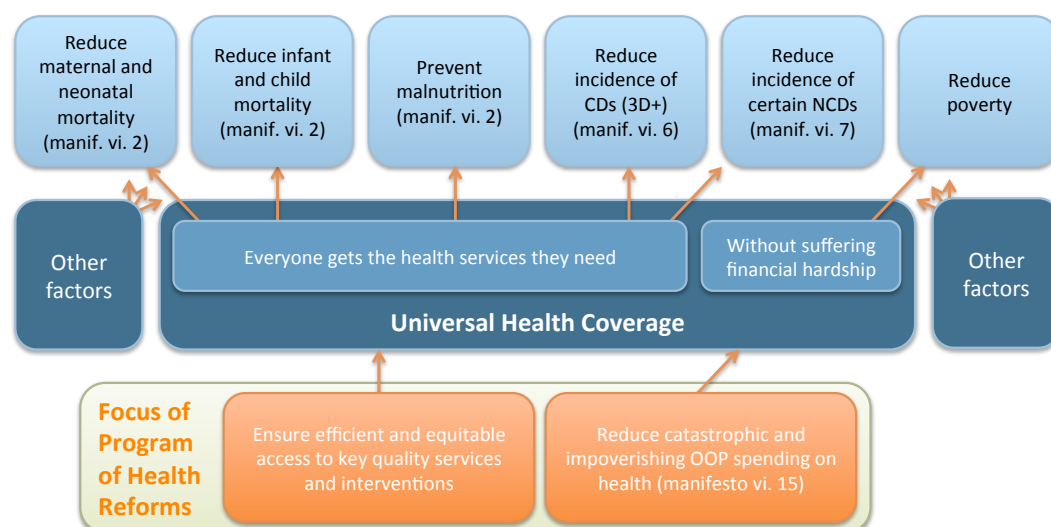
Out-of-pocket payments for health at the point of care result in financial hardship and prevent many poor* and near-poor* households from accessing the care they need. Despite recent increases in government spending on health, close to 70 per cent of total health financing still comes in the form of out-of-pocket payments. This percentage figures among the highest in the world.

The proposed Programme of Health Reforms aims to address these challenges

At the core of the programme is NLD's vision, as articulated in the NLD 2015 elections manifesto, to move towards Universal Health Coverage (UHC), which means that all people in the country should be able to use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, without experiencing financial hardship due to the use of these services. In addition to being the NLD's vision, UHC is also part of the Sustainable Development Goals*, to which Myanmar has subscribed. The Programme of Health Reforms proposes a roadmap towards UHC.

Advancing the country towards UHC is expected to translate in improvements in outcomes that are explicitly highlighted in the NLD Manifesto (see Figure 1). These include health outcomes such as maternal, neonatal, infant and child health, nutrition and the most common communicable and non-communicable diseases. Advancing towards UHC can also be expected to reduce poverty by protecting households against catastrophic and impoverishing* out-of-pocket spending on health.

Figure 1 – NLD's vision of Universal Health Coverage



In order to make progress towards UHC, both the health delivery system and the health financing functions need to be strengthened. Creating a strong health delivery system requires the empowerment of citizens to take greater responsibility in their own health and in creating a healthy society. It also requires the strengthening of the supply side to ensure that citizens can access key quality services and interventions, and to guarantee the provision of important public health functions, such as vector control and disease surveillance. In order to strengthen the health financing system, three key questions need to be addressed: (i) how will the country raise more resources for health; (ii) how will it reduce catastrophic* and impoverishing out-of-pocket payments through the development of

adequate prepayment and risk pooling* mechanisms; and (iii) how will it use the pooled resources, i.e., how will it allocate them, both geographically and to the different levels of the health system, and how will it improve efficiency* and maintain quality standards by developing provider payment mechanisms* that generate the right incentives*.

Health is a conduit for peace and harmony. Improving access to health without financial hardship will be directly felt by the population. Moreover, payoffs from investing in health are considerable.² Global evidence shows that making the right investments in health stimulates economic growth. Between 2000 and 2011, health improvements accounted for about 11 per cent of economic growth in low- and middle-income countries. Improving access to and quality of essential health services is critical to building all citizens' capabilities and enabling them to compete for jobs and opportunities generated through inclusive and sustainable development.

Health is not the sole responsibility of the Ministry of Health (MoH). Many of the health inequities observed in the country are directly related to the social determinants of health (the conditions in which people are born, grow, live, work and age), which are shaped by the distribution of money, power and resources. This is captured by the 'other factors' boxes in Figure 1. Actions in sectors other than health are therefore equally important to improve health and to address systematic disparities. This requires close collaboration and coordination across Ministries and agencies.

Purpose and organization of the Program of Health Reforms

This Programme of Health Reforms provides a broad roadmap towards UHC in Myanmar for the period from 2016 to 2030. While this roadmap is not meant to be an implementation plan, it will be used to guide the development of future policies and plans.

Key to the success of the proposed reforms will be buy-in from all relevant stakeholders and strong political will and commitment by the country's leaders. The present document should therefore be seen as *version 1.0*. Even though its development already involved broad and repeated consultations, it was not yet possible, for various reasons, to consult with all the relevant stakeholders. This version of the document will therefore be further discussed after its release. Feedback will be sought from parliamentarians, government officials, ethnic health organisations* (EHOs), civil society, the community, etc. The feedback will be taken into consideration during the preparation of *version 2.0*.

Many of the proposed reforms build on important on-going initiatives. Moreover, a commitment to accelerate progress towards UHC was already expressed by the former government. That commitment was publicly announced at several national, regional and global meetings, where the country's broad strategic directions towards UHC were presented.

As these reforms are translated into implementation plans, existing programmes and interventions will need to be considered. Mapping these programmes and interventions and assessing how they can contribute to the implementation of the reforms will be an important exercise.

² Jamison DT, Summers LH, Alleyne G, Arrow KJ, Berkley S, Binagwaho A *et al.* 2013. Global Health 2035: A world converging within a generation. *The Lancet* **382**(9908): 1898–1955.

Obviously, it will not be possible to introduce all the reforms proposed in this programme at once.

Also, while some reforms can be implemented relatively quickly, other will take many years to materialise. At the same time, some reforms are more critical and urgent than others and should therefore be prioritised. Annex 3 presents some milestones for the Programme of Health Reforms that could be achieved within 2 years and within 4 years. It also proposes a series of immediate actions that can be completed within 100 days. Some of these actions will help secure buy-in and support for the Programme of Health Reforms, while others are essential to initiate the reform process.

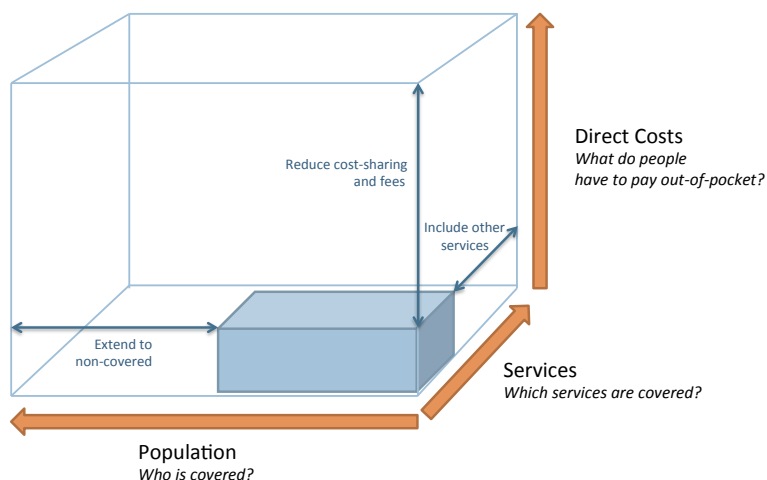
The document is organized as follows. First, it presents the big picture together with a framework around which the subsequent six sections of the document are organised. Then follows a broad outline of a monitoring framework to track progress in the implementation of the reforms. The final section discusses the importance of internal and external communication in keeping the different stakeholders informed and engaged. Annex 1 describes the process that was adopted for the development of the Programme of Health Reforms.

MYANMAR'S PATH TO UHC – THE BIG PICTURE

Background

- Before summarising where we are now, where we want to go and where we want to start, it may be useful to provide some background information on UHC.
- Many paths can lead to UHC. Learning from global experience, certain pitfalls can be avoided as Myanmar chooses which path to take.
- Moving towards UHC involves an expansion of the so-called 'UHC cube' (see Figure 2) along each of the three dimensions: population, services and direct costs.

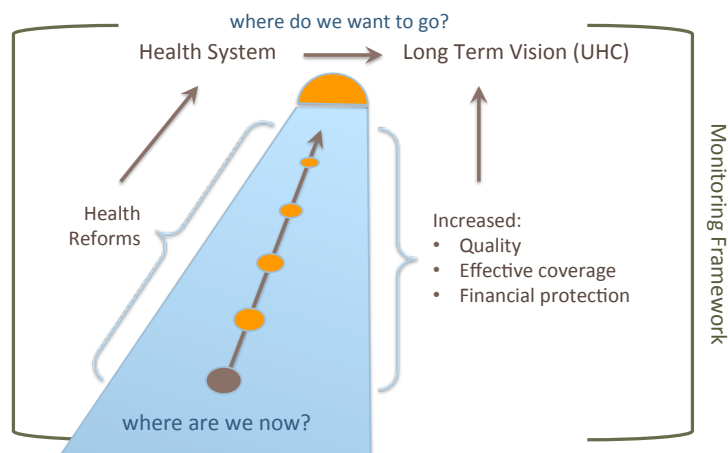
Figure 2 – The UHC cube



- Resources and capacity are limited. Covering everything, fully, for everyone is not feasible, neither today nor tomorrow. It is therefore important to make fair choices at each step along the path to UHC, with respect to:
 - Whom to include first, whom next, etc.
 - Which services to cover first, which next, etc.
 - How to shift from out-of-pocket payment toward prepayment and risk pooling arrangements
- Key questions to consider at each step are:
 - What can the country afford? This is constrained by available fiscal space* for health;
 - What can the country deliver? This is constrained by service availability and readiness.
- Main risks that need to be mitigated are:
 - Jeopardising financial sustainability (spending more than the country can afford);
 - Implicit rationing of care ('broken promise');
 - Increasing inequity (public resources benefit the better-off disproportionately).

- Considering today's realities, opportunities and constraints, a key question is: what changes in Myanmar's health system are needed to support the realisation of the country's vision of UHC? This is illustrated in Figure 3. The figure also shows that, as reforms bring about the desired changes in the health system, gradual improvements in quality of care, effective coverage* of essential services and interventions, and financial protection* should already be observed. Both the implementation of the reforms and the resulting changes in those outcomes will need to be closely monitored.

Figure 3 – Towards a health system that will help realise the vision of UHC in Myanmar



- This section focuses on the big picture; details are provided in the next sections of the document.

Where are we now?

- The UHC movement in Myanmar has been picking up momentum over the past few years. This translated in the Government's increased commitment to health, as reflected in the eight-fold increase in health budget.
- Despite these recent increases in health budget, government spending on health as a proportion of total government expenditure remains low by international and regional standards. The system continues to rely heavily on out-of-pocket payments by patients at the time of care, which drives large numbers of households (further) into poverty and prevents many to access the care they need. This in turn creates considerable inequities.
- Funding from other sources, 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.
- Delivery of health services and interventions by the public sector does not reach the entire population. Where public health facilities exist, their level of readiness varies widely. While other actors – private for-profit, private not-for-profit and Ethnic Health Organisations (EHOs) – are also involved in service delivery, government oversight and engagement is limited. Among all types of service providers, quality of care shows great variations.
- Potential efficiency gains are considerable throughout the health system.

Where do we want to go?

- Eventually, all people should be able to use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, without experiencing financial hardship due to the use of these services.
- The main changes in Myanmar's health system that are needed to support the realisation of this vision include the following:
 - An explicit essential package of health services* (EPHS) should be guaranteed for everyone. Definition of this package should be based on evidence and on explicit criteria. This package should grow in accordance to what the country can afford and what the health system can deliver.
 - The delivery of this EPHS to poor and vulnerable* (including the near-poor) should be fully subsidised. For the other groups, contribution (either through general taxation or through a mandatory earmarked contribution* mechanism) should be linked to ability to pay. The basic EPHS should be free for all at the point of care.
 - Different types of providers (including public, private-for-profit, private not-for-profit and EHOs) should be engaged for the delivery of the services and interventions included in the EPHS. Irrespective of the type of provider, common standards of care should be enforced.
 - A single entity should be responsible for purchasing* the services from the different types of providers; the mix of provider payment mechanisms should be defined so as to best align the incentives of service providers with the goals of the health system.
 - Government spending on health should increase. The various sources of funding, including funding from general revenues* or earmarked taxes*, funding from development partners, funding from contributions and funding from philanthropy* and corporate social responsibility* (CSR) should, to the extent possible, be pooled.
- Core public health functions that may not be included in the EPHS, such as vector control and disease surveillance, will also need to be further strengthened to support progress towards UHC.
- These changes are guided by the general principles of equity*, quality, efficiency, accountability*, inclusiveness and sustainability*.
- In order to facilitate these changes, a strong enabling environment is needed. This includes a reliable evidence platform, a comprehensive and coherent regulatory framework, clear supportive policies, strong leadership and a supportive organisational structure.
- The framework presented in Figure 4 provides a simplified picture of the different pieces described above.
- The reforms that are needed to realise these changes in the Myanmar health system are ambitious and will take time to implement. They will need to be carefully paced and prioritised, and their implementation as well as their impact will need to be closely monitored.

Figure 4 – Framework around which the Programme of Health Reforms is structured



Where do we start?

- The reforms needed to realise the changes in the health system described above can be organised around each of the following questions, which are linked to Figure 4:
 - *What are the different population groups to consider?*
 - The different population groups to consider in the context of UHC are the poor and vulnerable (including the near-poor), the informal non-poor, and those in the formal sector*.
 - An important consideration is that the poor and vulnerable should not be left behind. Their access to the services and interventions included in the EPHS will therefore be fully subsidised from the start.
 - Given the challenges to identify the informal non-poor and to enforce pre-payment from this group, their access to the EPHS will initially also be subsidised.
 - The current mechanism to raise payroll contributions from the formal sector will be further expanded.
 - *What package(s) of services and interventions should they be entitled to under UHC?*
 - The on-going exercise to define an explicit EPHS using a set of criteria will be continued and the size of the package will consider what the country can afford and what the health system can deliver. The EPHS will have a strong focus on primary health care* and on the needs of the poor and vulnerable.
 - The EPHS that Myanmar can promise will initially be very basic and may do little to provide financial protection to the poor and vulnerable. In the beginning, it will therefore be supplemented by a 'catastrophic package' provided free of charge to the poor, and possibly the near-poor, in selected health facilities.

- *How to ensure services in the package are of quality and can be accessed by everyone?*
 - Service availability and readiness* will first be assessed, considering the different types of providers (private-for-profit, private non-for-profit and EHOs); gaps in inputs (e.g. infrastructure, human resources, equipment, medicines...), functions (e.g. HMIS, referral) and skills will be identified; resources will be mobilised to fill these gaps; services will then be upgraded so that the EPHS can be delivered. The poorest townships will be prioritised.
 - Private sector* and EHO providers will need to be engaged to guarantee access to the EPHS for the entire population. This will require strengthened regulation and oversight (including, for example, accreditation* and licensing*), and the adoption and enforcement of common quality standards.
 - For delivery of services by the public sector, considerable efforts will be needed to ensure availability of both human resources with the right skill-mix and quality medicines and other supplies.
- *How should these health care providers be paid and by whom?*
 - Public financial management (PFM) will be strengthened and revised to facilitate the execution of the purchasing function.
 - A parastatal entity will be established to become the single purchaser for the EPHS on behalf of the entire population.
 - A gradual move away from the current line-item budget will be initiated to move towards provider payment mechanisms that are better at incentivising improved performance and quality.
- *Where should the money come from?*
 - To the extent possible, a single pool will be established to which the different funding sources will be channelled. Part of the funding from development partners (DPs) will be used to finance systems strengthening efforts in support of the Programme of Health Reforms; this funding may therefore not need to flow to the single pool.
 - Government spending on health will be gradually increased and innovative methods to generate domestic revenues, such as *sin taxes**, will be explored. At the same time, available resources will be used more efficiently to increase value for money*.
- As indicated in Figure 3, implementation of the proposed reforms will need to be closely monitored. A broad description of the proposed monitoring framework is presented in a separate section towards the end of the document.

GUIDING PRINCIPLES

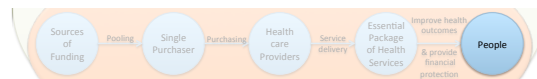
- Six principles have guided the development of this Programme of Health Reforms, namely equity, quality, efficiency, accountability, inclusiveness and sustainability. These principles need to be considered when thinking about each of the questions around which this document is organised. A few illustrative examples are provided below.
 - The path towards UHC chosen by Myanmar is one that is explicitly pro-poor. This is illustrated by the following examples:
 - Access to the EPHS will be fully subsidised for the poor and vulnerable (including the near-poor) from the start;
 - The EPHS will have a strong focus on primary health care services and interventions that the poor and vulnerable need most; it will be supplemented by a ‘catastrophic package’ to improve financial protection for the poor and possibly the near-poor;
 - Priority will be given to the expansion of service delivery in the poorest townships;
 - Through strategic purchasing, health providers can be incentivised to reach out to the poor and the hard-to-reach;
 - Increased government spending on health will allow reducing out-of-pocket payments by poor and vulnerable households.

In addition to socio-economic equity in health, gender equity and other types of equity will also need to be closely monitored. Moreover, various dimensions of equity will need to be considered (e.g. equity in health outcomes, equity in utilisation, equity in access or equity in financial contribution). Efforts will need to be made to explicitly address equity under its various forms in the formulation and implementation of policies.

- The definition of quality considers both ‘technical quality’ – i.e., providing the right kind of care in the right way and at the right time – and the patient’s expectations. Examples of the way quality has been taken into consideration include:
 - Improving quality of primary health care will benefit all population groups;
 - The specification of the services and interventions included in the EPHS will also include clear quality norms;
 - Accreditation and licensing will be strengthened to improve quality standards across all types of health providers;
 - Patients’ role in monitoring quality of care will be enhanced, for example through the use of Community Score Cards;
 - Provider payment mechanisms will be chosen to also incentivise greater quality of care.
- Efficiency gains result in greater value for money. They can be achieved in all areas of the health system. For example:
 - In the way different population groups are approached, by considering the administrative cost associated with each option;
 - In the selection of services to include in the EPHS, by focusing on primary health care and considering cost-effectiveness as one of the selection criteria;

- In the organisation of service delivery, by strengthening the supply chain or tackling irrational prescribing to reduce wastage, or through task-shifting;
- In the way providers are paid, by incentivising greater performance;
- In the way resources are pooled, by reducing inefficiencies associated with the co-existence of parallel systems.
- Many of the proposed reforms will result in greater accountability of the different stakeholders. For example:
 - Community score cards will provide an opportunity for the population to give feedback on service availability and quality;
 - The definition of the EPHS will be based on transparent criteria and will involve broad consultations;
 - post-identification of the poor for access to the 'catastrophic package' will be based on a common set of explicit criteria;
 - Professional associations and councils will be made more accountable to the population; information on provider performance will be more widely shared with the public, e.g., through balanced score cards*;
 - Paying for outputs or rewarding good performance increases the accountability of service providers.
- Inclusiveness is an important part of the proposed reforms, as reflected in the following examples:
 - Different stakeholders, including parliamentarians, government officials, ethnic health organisations (EHOs), civil society, and the community will be consulted prior to the preparation of *version 2.0* of the Programme of Health Reforms;
 - The needs of the people, and in particular the poor and vulnerable, will be taken into account when defining and revising the EPHS;
 - Various mechanisms will be established to allow communities to express their voice (e.g. through community score cards, making budgets and spending more transparent, inclusive township planning, etc.)
 - Efforts will be made to establish a process of constructive dialogue and confidence building with EHOs.
- Sustainability, both institutional and financial, will be essential to the success of proposed reforms. Examples of how sustainability has been taken into consideration include the following:
 - The size of the EPHS will largely depend on what the country can afford;
 - A gradual increase in the use of government financial management systems by DPs will contribute to greater institutional sustainability;
 - Efforts to improve and demonstrate value for money will help increase and sustain government financing for health;
 - The development of a strong regulatory framework to support the reforms will ensure the process to move towards UHC is sustained.

WHAT ARE THE DIFFERENT POPULATION GROUPS?

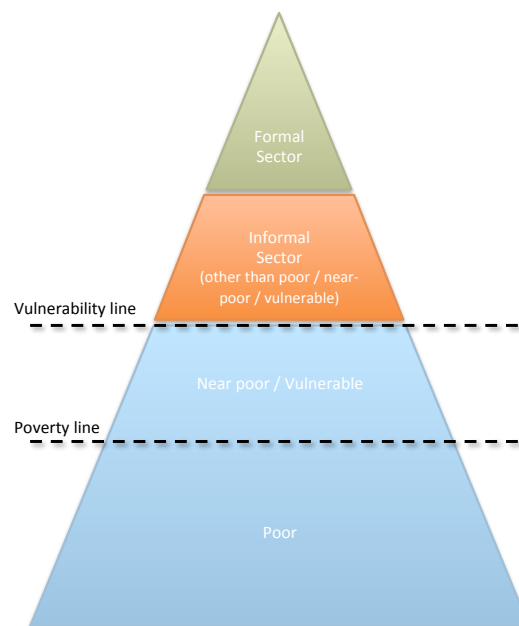


Where are we now?

Important considerations with respect to the different population groups (see Figure 5):

- At present, the poor and vulnerable (including the near-poor) represent a large share of the Myanmar population.
- There is currently no targeting mechanism in place to identify the poor and vulnerable, neither in the health sector, nor in any other sector.
- The majority of the working population is in the informal sector*.
- The social health insurance* system that is currently run by the Social Security Board (SSB) covers only a small fraction (less than 2 per cent) of the formal sector. At present, only the contributing member is covered, not his or her dependents.
- SSB's key functions –including enrolment, entitlements, payments, information system– are in need of further strengthening.
- Coverage by private voluntary health insurance is still very low.
- The table in Annex 2 summarises current schemes covering the different population groups.
- While the current situation, as described above, will likely change, the changes will take time. We can expect, for example, to see:
 - A gradual decrease in the share of poor and vulnerable within the total population, as a result of, for example, poverty reduction efforts and economic growth;
 - The development of a national targeting mechanism that allows the identification of poor and vulnerable;
 - A gradual increase in formality of employment.

Figure 5 - Typology of the population groups to consider in the context of UHC



Source: Adapted from Cotlear, Nagpal, Smith, Tandon, and Cortez, 2015

Where do we want to go?

- Ultimately, we want the entire population of Myanmar to have access to the health care they need without suffering undue financial hardship (Note that this is the actual definition of UHC). This implies the following:
 - Services of quality are available and can be accessed by everyone

- No one falls into poverty (or is pushed further into poverty) due to spending on health care.
- Choose a path of “*progressive universalism*”, which is defined as ensuring that the poor and vulnerable gain at least as much as the better-off at every step of the way towards UHC. In other words, particular attention is paid from the start to ensuring that the poor and vulnerable can access the services they need and are protected from financial hardship.
- Whether through mandatory contributions or taxes, payment for health will be linked to households’ ability to pay; for the poor and vulnerable, access to the EPHS will be fully subsidised and free at the point of care. In addition, access to some public health services and interventions (especially preventive and promotive) should be free for all at the point of delivery.

Where do we start?

Poor and vulnerable

- The category ‘vulnerable’ in the context of UHC will need to be clearly defined. In addition to the near-poor, this category should include those population groups that society feels need to be partially or fully subsidised in order to remove financial barriers and to provide financial protection. It is important to note that some population groups may have special needs when it comes to health care (e.g. adolescents, pregnant teenagers, drug users, transgender...); while these special needs will have to be addressed and barriers to utilisation for these groups will need to be removed, the complexity involved in doing so deserves more in-depth analysis and special attention.
- The poor and vulnerable (including the near-poor) will be fully subsidised from general revenues for the services and interventions they are entitled to (see next section – “What should everyone be entitled to”).
- In order to ensure that the services and interventions they are entitled to are available and accessible, efforts to improve the availability and readiness of these services and interventions will prioritise townships with the largest shares of poor and vulnerable populations, as identified using data from, for example, the 2014 Census or the Myanmar Poverty Living Conditions Survey (MPLCS).
- Entitlements will emphasise primary health care services as well as services and interventions that the poor and vulnerable need most.

Non-poor informal

- Initially, collecting contributions from the informal non-poor, whether on a voluntary or a mandatory basis, will be extremely difficult, because of (i) problems with the identification of this group and (ii) limited ability to enforce contribution. Moreover, efforts to collect contributions from this group may lead to adverse selection*, meaning that only those who are sick and in need of health care will contribute. For these reasons, the informal non-poor will also be fully subsidised.
- Obviously this will be taken into consideration when determining what package of services and interventions the country can afford.
- Meanwhile, systems will be strengthened and capacity will be built to collect mandatory contributions and/or, in case of a general revenue-funded system, taxes.

Formal sector

- Coverage of the formal sector, which is currently the responsibility of SSB, will be further expanded, also to public sector workers and to dependents of those who contribute.

WHAT SHOULD EVERYONE BE ENTITLED TO?



Where are we now?

- Myanmar to date does not have an explicit Essential Package of Health Services (EPHS) for UHC. Yet, efforts involving both MoH and the Ministry of Labour, Immigration and Population (MoLIP) are on-going to define a common package for the entire population.
- Current thinking within MoH is that the EPHS should be guaranteed for all in Myanmar without financial hardship, and that it should be introduced in three phases:
 - A *basic* package by 2020;
 - An *intermediate* package by 2025; and
 - A *comprehensive* package by 2030.
- Selection of services and interventions for the three phases would depend on prioritisation according to criteria such as disease burden, cost-effectiveness, availability of resources and capacity.
- The packages would prioritise preventive and public health interventions as well as basic investigative and curative services in the areas of Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH), nutrition, communicable and non-communicable diseases (CD and NCD, respectively), including injuries and mental health.
- Services not included in the packages will continue to be provided though not guaranteed for all.
- Services may be delivered by public, private (both for profit and non-profit) and EHO providers.
- Work is now on-going to:
 - Further specify the services and interventions by tiers of care, as well as the inputs required to deliver them;
 - Identify service gaps and resource gaps;
 - Cost the package;
 - Analyse the fiscal space available to fill the gaps; and
 - Broaden consultations and consensus building.
- Apart from these on-going efforts to move towards a common package for UHC, several 'entitlements' currently co-exist, as summarised in the table presented in Annex 2.
- Some of these currently co-existing entitlements share, to some extent, a number of weaknesses, including:
 - Uncertain financial sustainability;
 - Questionable quality; and
 - Implicit rationing, which means that some of the services and interventions in the entitlement may not be available or accessible.

- Hospital Trust Funds* (HTF) have been created in all hospitals (16-bedded and above). These trust funds are at the discretion of the superintendent and an overseeing committee. They are meant to cover the cost of medicines for poor patients, but are often underutilised (and accumulating).
- In some township hospitals, Health Equity Funds* (EHF) have been established. These funds cover the cost of transportation and the cost of emergency care for poor mothers and children, as well as some costs associated with hospital stay. Note that the cost of transportation, accommodation and meals is considered to be high, especially for poor and near-poor households.

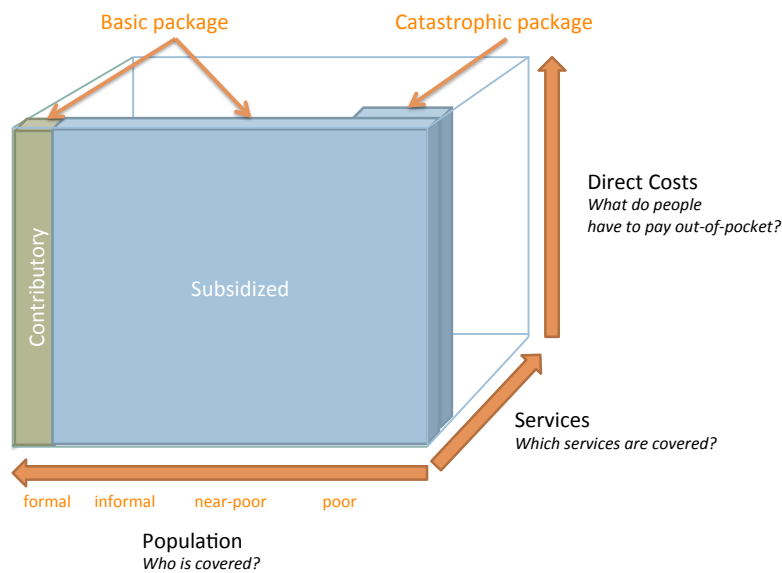
Where do we want to go?

- Eventually, all people should be able to use the promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective, without experiencing financial hardship due to the use of these services.
- However, what is included in the package should be made explicit and level-of-care specific, starting with community-based care; it should reflect what the country can afford and deliver.
- The package should not be set in stone; it should be subject to periodic review and revision in response to:
 - Changes in the country's demographic and epidemiological profile;
 - Changes in the country's economic situation, which will alter what the country can afford;
 - Changes in the population's expectations; and
 - The development of new cost-effective treatments and interventions.
- The review and revision process should be institutionalised and transparent; it should be based on explicit criteria and available evidence. A mechanism needs to be in place to assess technologies and interventions (similar to NICE in UK or HITAP in Thailand).

Where do we start?

- Two packages of services and interventions will be developed simultaneously (see Figure 6):
 - A basic package; and
 - A catastrophic package.
- A transparent process to periodically review and revise the composition of these packages needs to be agreed upon by all stakeholders concerned and institutionalised. This should be based on explicit criteria, including, for example, burden of disease and cost-effectiveness.
- Initial steps can already be taken to establish a body charged with the assessment of technologies and interventions inspired by best practice in other countries.
- Services and interventions not included in either package will continue to be delivered; yet, they cannot be guaranteed for everyone and they cannot be subsidised.
- In addition to the basic and the catastrophic packages, the coverage of transportation, food and accommodation costs for poor (and perhaps near-poor) patients, possibly using HTFs, will be explored.

Figure 6 – Initial packages for UHC



Defining a basic package

- On-going fiscal space analysis needs to be completed in order to assess what the country can afford today and how this is likely to change in coming years.
- Simultaneously, the cost of delivering the package (both the investments needed to ensure service availability and readiness, and the cost for the provision of the services) needs to be estimated.
- Fiscal space information, cost information and information from the on-going prioritisation exercise described above (under the heading “Where are we now?”) need to be combined to define the EPHS that can realistically be afforded and delivered.
- The definition of the EPHS and the definition of the Essential Drugs List should go hand in hand.
- Start with a basic EPHS that can be made available to everyone within 2 years.
- Efforts to ensure service availability and readiness (further discussed in the next section) should prioritise the poorest townships.

Defining a catastrophic package

- While offering a basic EPHS will improve health outcomes, it may do little to protect the poor and vulnerable from impoverishing spending on health (which is more likely linked to high-cost services and interventions). Therefore, additional measures are called for.
- As an intermediate solution, an additional package (which we refer to as the ‘catastrophic package’) will be defined and made available in certain hospitals, but to the poor and possibly the near-poor only.
- The definition of the catastrophic package will largely be guided by evidence generated from research around impoverishing spending (yet to be conducted); it will also need to take into

consideration available fiscal space (this exercise will therefore need to be done in conjunction with the definition of the basic EPHS).

- Depending on the generated evidence, the package may consist of a limited number of low-incidence high-cost services and interventions, delivered by a smaller number of higher-level health facilities, that are associated with high impoverishing spending. Alternatively, it could be defined in terms of a cap on the health spending by poor and possibly near-poor (for a defined list of services or interventions and/or with certain exclusions). The operational and financial feasibility of both approaches will need to be assessed.
- Certain services or interventions (e.g., related to the treatment of childhood cancer) may be included in this package to gain society's approval and political capital for the reform.
- Initially, the establishment (or strengthening) of Health Equity Funds (HEFs) for the poor (and possibly the near-poor) will be explored in selected facilities to cover the cost of the catastrophic package. Administration of these HEFs, however, will be harmonised and the funding will come from a single source (see section "Where should the money come from?" below).
- The poor (and possibly the non-poor) who are to benefit from the services included in the catastrophic package will be identified through a standardised post-identification mechanism (which will be developed in close collaboration with any broader effort to establish a targeting mechanism in the country).

HOW TO ENSURE SERVICES IN THE PACKAGE ARE OF QUALITY AND CAN BE ACCESSED BY EVERYONE?



Where are we now?

Regulation and oversight

- The private sector is largely unregulated and its role within the broader health system is not clearly defined. The limited private sector regulation that is available lacks clarity, which results in variable enforcement practices.
- The regulatory framework for the pharmaceutical sector is in urgent need of further strengthening.
- Oversight of both public and private providers is generally weak. In the public sector, for example, supportive supervision is irregularly conducted due to insufficient funding for operational expenses.
- Professional councils are under-resourced and their overall capacity tends to be rather weak. They do not have the independence that is expected of councils.
- There are currently no formal accreditation bodies and no accreditation mechanisms, neither for health facilities, nor for educational institutions. The Myanmar Nurses and Midwives Council (MNMC) is now in the process of developing an accreditation mechanism for nurses and midwives training institutions.
- Proper licensing of health professionals is not really being practiced. What is currently referred to as licensing is closer to a simple registration that is periodically renewed.
- MNMC is in the process of developing re-licensing mechanism that is linked to continuing professional education* (CPE). Health assistants and public health supervisors, in collaboration with University of Community Health, are also working around recognition and continuing education.
- Policies and regulations around skill mix and task-shifting are inadequate, leading to both inefficiencies and inequities.

Service delivery

Public sector provision

- There is currently a strong emphasis on tertiary care. Station Hospitals and below have received less attention over the past few decades. This has led to shortcomings in terms of service coverage:
 - The numbers of facilities and outlets delivering PHC is inadequate;
 - There is limited public service delivery in conflict-affected (or post-conflict) areas as well as in geographically hard-to-reach areas.
- In terms of human resources, there is insufficiency in all cadres, including those that are essential for the delivery of PHC. Available human resources tend to be highly concentrated in urban and easy-to-reach rural areas as a result of recruitment and allocation plans and practices as well as incentives (both financial and non-financial) or lack thereof.

- Community-based health workers are inadequately resourced by the public sector.
- There are efforts to overcome human resource gaps through the so-called ‘temporary employment’ programme, which allows health professionals that are not civil servants to be appointed in hard-to-reach areas, based on needs expressed by Regional/State Health Directors. An example is the midwives model where screening and recruitment is done by the Myanmar Nurses and Midwives Association (MNMA); funding is provided by DPs; MoH coordinates and manages the programme.

Private sector provision

- The private sector is already prominent in both urban and rural areas, and continues to grow.
- In many parts of the country, private sector providers (including general practitioners (GPs) and non-governmental organization* (NGO) clinics, for example) already provide primary health care services that are likely to be part of the EPHS.
- There is limited information sharing with the public sector.

Private for-profit

- The households’ ability to pay dictates largely their health seeking behaviour. A large share of the population relies on the direct purchase of medicines from private outlet such as pharmacies, drug vendors and shops.
- Myanmar has a large network of private clinics organised under a social franchise arrangement.

Private not-for-profit

- Civil Society Organizations* (CSOs) and NGOs tend to be extremely dependent on donor support. This puts the sustainability of their projects at risk. It also often results in vertical programmes that are largely donor driven, that are implemented through parallel systems, and that may not be well aligned with country priorities. This creates both gaps and duplication in service delivery.
- Health services supported by local philanthropy tend to under-emphasise preventive care.
- While there is significant on-going operational research carried out by international NGOs and their partners, findings are insufficiently shared among INGOs and with MoH.

Provision by Ethnic Health Organisations

- In conflict and post-conflict areas, EHOs have long been providing essential services to populations that public sector providers do not reach.
- Generally speaking, coordination, communication and information sharing, not only among EHOs but also between EHOs and local health authorities are relatively weak. As a result, there is also limited standardisation across the different EHOs.
- There is limited recognition of EHO staff qualification and EHO service provision by the public sector.
- EHOs in general have limited access to technical and financial resources. They are extremely dependent on donor support, which puts the sustainability of their service delivery model at risk and which often results in vertical programmes that are largely donor driven and that are implemented through parallel systems. This in turn creates both gaps and duplication in service delivery. For

example, several EHOs are currently unable to deliver some of the essential primary health care services, such as immunisation and maternal care, in certain areas.

Referral system

- The referral system is extremely weak, not only within the public sector, but also between the different types of providers (public, private for-profit, private not-for-profit, and EHOs).
- Legal and political barriers are partially responsible for the reluctance of EHOs to refer patients to public facilities.
- As a result of the weak referral system, the continuum of care cannot be guaranteed.

Quality of care

- Quality of care across all types of providers is often questionable. It is rarely adequately measured.
- Prescription practices vary widely and standard treatment guidelines, when available, are not always adhered to.
- There is a lack of clear job descriptions and a mismatch between skills and expected roles and responsibilities.
- The quality of pre-service education varies widely.
- In-service training tends to be project-oriented and not for professional development.
- There is limited quality assurance of diagnostic services.

The pharmaceutical sector

- Considerable money is spent on medicines in Myanmar, especially imported ones, with procurement taking place ad hoc at national and sub-national levels. Due to limited quality control, however, the quality of medicines is a big concern irrespective of the delivery channel. Use of generic medicines is limited and counterfeit, and sub-standards drugs are widely available.
- The population relies heavily on drug vendors and unqualified service providers for the purchase of medicines.
- For the public sector, the Central Medical Store Depot (CMSD) is responsible for procurement of all medical supplies and medical equipment. To the extent possible, priority is given to direct purchase of drugs from state-owned enterprises. Items that are not available are procured through the private sector.
- Procurement and supply chain systems are currently fragmented: DoPH, DoMS, vertical programmes within MoH and via Global Fund principal recipients, and some DPs all have their own procurement system and supply chain. Moreover, staff availability and capacity for the management of the different supply chains are generally weak.
- Efforts are on-going to strengthen the supply chain management system in the public sector.

Where do we want to go?

- Ultimately, services included in the EPHS should be of quality and accessible by all.
- The public sector alone will not be able to achieve this; engagement of private providers, both for-profit and not-for-profit, and EHOs will therefore be critical. A greater involvement of the community will also be important.
- Proper regulation (and enforcement) and oversight will be needed to ensure that comparable standards of care are guaranteed across these different types of providers. Standardisation will also be critical in areas such as pre-service and in-service training, staff qualifications, quality assurance, supply chain, infrastructure, etc.
- In order to ensure a continuum of care, effective coordination and information sharing will need to be coupled to a strong referral system. Ensuring the availability of the desired skill mix and allowing for task shifting where proven to be cost-effective will also be essential.
- In the public sector, adequate incentives – both financial and non-financial – will need to be in place to motivate enhanced performance and to promote rural retention*.
- All health facilities (across all sectors) should be subjected to accreditation and periodic re-accreditation by an independent accreditation body.
- Likewise, all pre-service training institutions, both public and private, should be accredited and periodically re-accredited; professional councils could take on this responsibility. To this end, they will need to be more independent.
- All health professionals (again across all sectors) will need to go through proper licensing and periodic re-licensing linked to continuing professional development programmes.

Where do we start?

Strengthening of regulation and oversight

- Ensure the legal unit within MoH (responsible for the development and enforcement of regulation) is functional.
- Ensure the human resources management division within MoH is tasked with the actual tasks of human resource planning and management (including coordination with training and deployment).
- A regulatory framework for the private sector, both for-profit and not-for-profit, and for EHOs needs to be developed and enforced. This should also cover private training institutions.
- The establishment of chains of hospitals, pharmacies and other facilities could be encouraged and legalised. This will increase standardisation of prices and quality, and facilitate regulatory oversight.
- Regulate dual practice and introduce incentives to limit the negative consequences (e.g. establish top-up for doctors in rural areas who refrain from dual practice).
- Actions needed to make professional councils more independent should be identified.
- Health facility accreditation and periodic re-accreditation systems should be developed and applied equally to private and public facilities. These need to be supported by, but independent, from

government. Professional councils should be involved as partners in the (re-)accreditation process. Note that the required minimum standards to be accredited could be increased gradually. Moreover, it is possible to define different levels of accreditation and to provide financial incentives to a health facility for reaching a higher level of accreditation.

- Guided by international best practice, processes and mechanisms for the accreditation of pre-service training institutions (both public and private) should be developed, possibly in collaboration with professional councils.
- The respective roles and responsibilities of professional councils and professional associations in the accreditation of training institutions and the licensing of health professionals need to be clarified.
- A standard-setting body should be established within MoH that would closely collaborate with professional councils and associations:
 - To develop or adapt hospital regulations including infection prevention, standardised reporting requirements, emergency care obligations, transparency of fee schedules, etc.;
 - To develop or adapt licensure and regulation requirements for blood banks and diagnostic laboratories – operating within hospitals or as stand-alone institutions;
 - To develop common standards for medical equipment interfaces (e.g. power, language, units, and other standards) for both public and private facilities.
- Harmonised reporting standards and protocols for non-public providers (private for-profit, private not-for-profit and EHOs) need to be developed. The data from those providers should be incorporated into the national HMIS. Incentives will need to be introduced to ensure compliance (e.g., through the provider payment mechanism, as a condition for re-licensing, etc.)

Expanding access to services in the EPHS

- A timeline for the improvement of service availability and readiness and for the expansion of geographical coverage will need to be defined, prioritising townships with the largest shares of poor and vulnerable populations.
- Within each township, the following will need to be done:
 - Conduct a mapping exercise of existing service availability and readiness, focusing on candidate services for inclusion into the EPHS that figure at the top of the list, and including services provided by public, private for-profit, private not-for-profit and EHO providers;
 - Based on this mapping exercise, identify gaps, considering all inputs (e.g. infrastructure, human resources, equipment, financing, etc.), functions (e.g. HMIS, referral, etc.) and skills required;
 - In collaboration with public sector actors, private sector actors and EHOs, identify approaches to fill those gaps, possibly considering intermediate solutions where relevant (e.g. outreach or mobile clinics);
 - Develop a costed plan and mobilise resources needed to fill the gaps, so as to get to a point where the EPHS can be effectively delivered to the entire population of the township.

Expanding the reach of services provided by the public sector

- Strategies to increase rural retention of health workers need to be developed and implemented, including:
 - The introduction of financial incentives for working in remote areas (e.g. increased capitation* amount);
 - The recruitment of locals to be trained at the regional/state medical school to become doctors and serve in their own communities. Consider ways to compensate for the fact that educational levels in remote areas may be lower (e.g. special pre-training programme organised in collaboration with the Ministry of Education);
 - The development of nonfinancial incentives such as living quarters, better working conditions, training and conference support, career ladder advancement and public recognition.
- In collaboration with professional associations, the on-going 'temporary employment' programme could be expanded, also to other skills needed for the delivery of the EPHS (incl. doctors, health assistants, administrative support staff, etc.). Subsequent absorption of these temporary hires into the civil service could then be facilitated. This mechanisms could potentially also be adopted for EHO-run health facilities.
- Consider allowing health workers in the public sector who have left the public sector to work in the private sector to re-enter public service.
- Job descriptions for different levels will need to be updated.
- The skill sets of auxiliary midwives (AMWs) and community health workers (CHWs) need to be updated, enhancing their role in health promotion, prevention and health education within the community.

Engaging the private sector

- Encourage professional associations to take on a more active role in standard setting, enumeration, and quality assurance within their profession.
- Encourage professional associations to expand access to continuing professional education opportunities, and introduce CPE requirements for re-licensing of members of the profession by the professional councils. Encourage self-regulation by the profession.
- Encourage professional associations and councils, as well as networks of private providers, to continue developing and carrying out clinical trainings for private providers in the near and medium term.
- On-going efforts by social franchises to improve quality of care for essential services and interventions in the private sector should be built upon. Social franchise networks also provide good platforms for exploring engagement with the private sector.
- CBOs and NGOs, both national and international, should continue delivering services included in the EPHS in areas where public services are not available.

Engaging Ethnic Health Organisations

- Ensure health is a prioritised matter along the on-going peace dialogue by the government. Critical will be to establish a process of constructive dialogue and confidence building.
- A communication and coordination mechanism with EHOs needs to be established.
- Encourage different levels of health administration to collaborate and coordinate with EHOs.
- Activities that can be introduced quickly and show rapid results should be identified, such as joint immunisation activities, information sharing, establishing a forum for coordination at township level.
- A process for the recognition and licensing of existing health professionals from EHOs should be established.
- Ways to strengthen pre-service training based on a standardised curriculum for health professionals in EHO areas need to be identified.
- Consider ways for EHOs to express their voice, e.g. participation in MHSCC or TSG.

Strengthening the referral system

- As availability and quality of services at the township level or below improve, patients may feel less need to bypass.
- Referral guidelines between private or EHO facilities and public facilities, but also between different levels of facilities within a same sector, should be developed.
- Provider payment mechanisms should be used to introduce the incentives needed for providers to adhere to these guidelines.
- Referral patterns should be monitored on a routine basis.

Quality of care

- Training curricula of health professionals will need to be reviewed and revised.
- Training tools and guidelines need to be developed to ensure common standards in the delivery of services included in the EPHS among all providers.
- Consider rewarding financially the achievement of a higher level of accreditation (for example, a facility that reaches a higher level of accreditation could receive a higher capitation amount).
- Adoption of quality improvement processes at the level of the health facility should be encouraged and facilitated.
- A process for the periodic review and improvement of standard treatment guidelines should be institutionalised.
- Providers' prescription behaviour needs to be monitored and the use of provider payment mechanisms to incentivise more rational prescribing should be considered.
- Patients' role in monitoring quality of care needs to be enhanced, for example through the use of Community Score Cards. The monitoring should also cover the quality of the interaction with the

provider. Patients and clients of all backgrounds, identity and affiliations (e.g. adolescents, pregnant teenagers, drug users, transgender...) should be treated with respect and without stigma, and recognising possible special needs.

The pharmaceutical sector

- Current efforts to harmonise different supply chain systems (DoMS, DoPH, vertical programmes, DPs...) and to strengthen management capacity should be continued. Incentives for better performance and for the use of generic, WHO-prequalified medicines should be considered.
- A comprehensive assessment of the pharmaceutical sector is needed. This includes a review of policies and regulations, and a thorough study of the pharmaceutical market, public and private spending on medicines, pricing, distribution and logistics, and rational use of drugs. The findings from this assessment should guide efforts to strengthen the pharmaceutical sector in a phased approach.
- An assessment of whether domestic production of essential medicines is feasible and makes economic sense should be conducted.
- Necessary measures need to be undertaken to minimise the negative impacts and to best utilise the Trade Related Aspects of Intellectual Property Rights (TRIPS) Agreement.
- Both the role and the capacity of FDA need to be strengthened to ensure, for example, adequate quality control of medicines (including traditional medicines) and combating sales of counterfeit drugs.
- Prescribing of medicines should be separated from their delivery to avoid perverse incentives.
- Until alternative delivery channels for medicines become accessible to all, NGOs should continue working with drug vendors. After that, the number of unlicensed drug vendors and the list of medicines they can sell without a pharmacist's license should be restricted.
- Standardise specifications when tendering equipment

HOW SHOULD PROVIDERS BE PAID AND BY WHOM?



Where are we now?

- The Myanmar health system relies heavily on patient out-of-pocket payments; a considerable share of what patients pay out of their pockets goes to unnecessary care, in particular unnecessary and/or poor quality medicines and unnecessary diagnostic tests.
- Most of the funding that goes to public sector health facilities takes the form of line item budgets. Operational budgets are limited.
- Health workers in public health facilities receive salaries, which are unrelated to performance. If posted in a hard-to-reach township, the salary is doubled. Salaries are low, which is one of the reasons for the prevalence of informal payments* and dual practice (where patients are charged for each service). Fringe benefits (e.g. accommodation, fuel), however, can be substantial, especially for higher-grade levels.
- Public facilities have no financial or administrative autonomy. Moreover, public financial management rules are very strict and constraining for providers and managers.
- Per diems and travel allowances to attend trainings and workshops are not standardised across funding agencies.
- Social Security Board (SSB) reimburses the cost of services provided to enrolled employees on a fee-for-service* basis, unless the services are delivered by SSB's own health facilities (which are financed based on inputs).
- National and international NGOs, CSOs and EHOs involved in service delivery receive most of their funding from development partners; this funding is channelled through parallel systems. These organisations may also charge the patients for their services on a fee-for-service basis.
- Private sector health providers charge patients on a fee-for-service basis.
- No public financing currently flows to private (for profit or non-profit) or EHO providers.

Where do we want to go?

- Using funds from various sources (see next section "Where should the money come from?"), a single entity, independent from the providers, purchases services included in the EPHS from any accredited provider, i.e., public, private or EHO. Management of services that are outside the EPHS and delivered by public providers will remain the responsibility of MoH.
- This single entity defines and continuously adjusts the mix of provider payment mechanisms for the different levels of care, so as to create the right incentives for both providers and patients, i.e., incentives that help improve the performance of the health system and are aligned with the health system goals.

Where do we start?

Establishing a single purchaser

- The different functions of the single purchaser, as well as its roles and responsibilities first need to be defined. This entity will be in charge of purchasing services included in the EPHS from any accredited provider, i.e., public, private or EHO, on behalf of the entire population. Note that the full cost of those services may not be channelled through this entity immediately; for example, MoH is likely to continue paying for salaries and investment costs in the public sector for a while. The required strengthening of the supply side discussed above – more particularly, the strengthening of the public sector provision – will therefore remain the responsibility of MoH.
- All the changes that need to be made to existing legislation and to Public Financial Management rules to support the functions of a single purchaser need to be identified.
- A supporting legal framework will need to be developed.
- It will then be possible to establish the single purchaser by law, either by transforming the current SSB into a parastatal entity with a board representing the different key stakeholders (Note that, apart from civil society representation, membership of the current SSB Board is already quite representative) or by replacing it by a new parastatal entity with a broader scope. The name of this new entity will need to reflect the fact that it is responsible to purchase services and interventions on behalf of the entire population (and no longer solely for formal sector workers). Health facilities that are currently run by SSB will need to be managed by MoH.
- Existing capacity and systems within the newly established entity will need to be assessed, adapted and strengthened; this includes, for example, the systems and capacity to negotiate and sign contracts with health providers, to determine the mix of provider payment mechanisms, to review provider payment amounts, to track and verify performance, etc. This is a huge task that should not be underestimated.

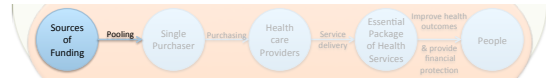
Developing alternative payment mechanisms

- A resource allocation formula, for both geographical allocation –based on need– and allocation across levels of care, will need to be developed. The formula will initially be relatively simple. It will be refined and improved as better data becomes available and as the necessary capacity is built.
- Changes required in Public Financial Management rules and/or in the legal status of public facilities, to make the adoption of provider payment mechanisms other than line item budgets possible, will need to be identified. Waivers may then need to be obtained from Ministry of Planning and Finance (MoPF) and/or revision of some of the rules may need to be negotiated; for example, the existing line item system could be adapted (e.g. by creating a single line item to capture all the inputs for PHC) or relaxed (e.g. by providing more flexibility to transfer funds across line items).
- Consultations with the different types of providers – public, private, EHOs – will be critical during the design, implementation, monitoring and evaluation of any new payment mechanism.
- The mix of provider payment mechanisms that best aligns the incentives of providers with the goals of the health system will then need to be designed to purchase the services and interventions included in the EPHS. This will likely involve, at least to some extent, a move away from paying for inputs towards paying for outputs and/or performance (through, for example, capitation payments,

performance-based incentives*, case-based payments, etc.). Defining and rewarding good performance throughout the health system (i.e., not only for health facilities at all levels, but also for management teams, for example) will be one way to increase accountability. This should be coupled to third-party verification.

- Public facilities will need to be given increased administrative and financial autonomy as this move takes place so that they have the ability to take the actions that are required to improve their performance. At the same time, necessary checks and balances will have to be put in place and accountability mechanisms will need to be strengthened.
- In order to design and further refine alternative provider payment mechanisms, financial information will need to be routinely collected and analysed in conjunction with performance data included in the HMIS; the two types of data will need to be linked and if possible combined into a single system. Both the purchaser and MoH will need to have access to this expanded HMIS. This will have to be specified in the legal framework referred to above.

WHERE SHOULD THE MONEY COME FROM?



Where are we now?

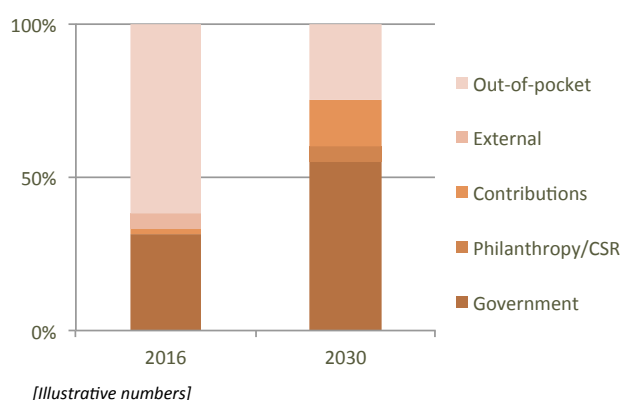
- Out-of-pocket spending on health by households accounts for the largest share of total health expenditure, causing indebtedness and impoverishment and acting as a barrier to care seeking. Out-of-pocket spending is one of the factors responsible for observed inequities in health. Most of the out-of-pocket spending goes to curative care.
- Government spending on health has increased in recent years, but it still remains low by international standards. A considerable share of government spending goes to medicines and infrastructure.
- Alternative revenue collection approaches such as earmarked taxes are being discussed and work has started to assess the potential impact of one of these approaches, namely a 'sin tax' on tobacco products.
- External assistance* for health is mostly 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.
- While representing a modest share of total health expenditure, external assistance is an important source of funding in specific areas, in particular areas relating to public health.
- Recent cuts in external assistance demonstrate the high level of unpredictability associated with this source of funding.
- As macroeconomic conditions of the country improve, financial support from some multi-donor mechanisms such as the Global Fund for Aids, Tuberculosis and Malaria (GFATM) or the Global Alliance for Vaccines and Immunisation (GAVI) is likely to gradually decrease.
- Local philanthropic giving for health, while providing life-saving services in some instances (especially in response to natural disasters or crises), is largely uncoordinated and haphazard, with limited planning and information sharing.
- CSR for health has so far been insignificant in scale, and of varying degrees of success and usefulness. CSR typically focuses on very specific geographical areas, populations, and types of services.

Where do we want to go?

- The desired shift in funding sources is illustrated in Figure 7.
- Risk pooling is essential to reduce OOP payments, and in particular impoverishing spending on health. Households should ideally contribute for health – whether through mandatory contributions or through taxes – based on their ability to pay and they should be able to use health care based on their needs.

- Government spending on health will reach a level that is both desirable for the delivery of a more comprehensive EPHS and fiscally sustainable. At the same time, available resources will be used more efficiently to increase value for money.
- External assistance for health will be better integrated and channelled so as to support progress towards UHC, while considering the mandates of the agencies providing the assistance.
- Funds from local philanthropy and CSR will be better coordinated, channelled and managed in order to avoid duplication and ensure these funds support efforts to move towards UHC. This will be done while respecting, to the extent possible, the original intended use of the funds and providing the desired acknowledgement (e.g. through better mapping, use of ICT and greater transparency*).
- Resources from all sources will, to the extent possible, be consolidated into a single pool. This will require political buy-in from the highest level and reassurance that players will not lose everything. Note, however, that part of the funding from development partners will be used to finance systems strengthening efforts in support of the Programme of Health Reforms; this funding may therefore not need to flow to the single pool.
- Funding from the single pool will be used to subsidise care for the poor and vulnerable and, as long as deemed necessary, for the informal non-poor.

Figure 7 – Desired shift in funding sources for health



Where do we start?

- Opportunities to mobilise additional resources for health should be actively sought, considering the following five options:
 - Conducive macroeconomic conditions such as economic growth and increases in overall government revenue that, in turn, might lead to increases in government spending for health;
 - A re-prioritisation of health within the government budget;
 - An increase in health sector-specific resources, such as taxes that are earmarked for health. Simulations and projections of both the public health impact and the financial impact of various types of sin taxes (i.e., on alcohol, tobacco products, sugar drinks), as well as estimations of the potential financial impact of other kinds of earmarked taxes, should be prepared in close collaboration with MoPF. Advantages and potential drawbacks of earmarking should be carefully considered, again with MoPF. For the most promising option(s), a bill should be drafted;
 - An increase in grants and foreign aid specific to the health sector; and
 - An increase in the efficiency of existing government spending on health. While mobilising additional resources of health is important, equally critical is to address leading sources of inefficiency, such as:

- The underuse of generics and the higher than necessary prices for drugs and medical supplies;
- The inappropriate or ineffective use of medicines;
- The use of sub-standard and counterfeit medicines;
- Medical errors and sub-optimal quality of care;
- The oversupply and overuse of equipment, investigations, procedures;
- By-passing and unnecessary hospital admissions;
- Inappropriate or costly staff mix;
- Unmotivated workers leading to low productivity;
- Waste, corruption and fraud.

Many of the proposed reforms described in the other sections of this document are aiming to do just that.

- The information in the Public Expenditure Review* (PER) needs to be updated and key findings from the PER should be communicated to policy makers.
- Investment in primary health care needs to be re-prioritised.
- The Programme of Health Reforms will need to be costed as soon as possible. Indicative budget estimates for at least the first 2 years of the reforms will need to be prepared to already sensitise budget committees, MoPF and DPs. These should include clear financial projections with several scenarios showing how much is needed to improve service readiness and to deliver the EPHS (including the 'catastrophic package').
- Guided by these financial projections, increase the budget allocation to health (a first review of the approved budget for fiscal year 2016/2017 will be in June 2016; the next one will be in October 2016).
- Get DPs to buy into and financially support the Programme of Health Reforms. Develop strategies to address the main concerns that make some DPs currently reluctant to use government systems (for example, strategies to strengthen PFM, procurement and accountability). Gradually increase the share of funding from DPs that is channelled through the government system and that fuels the single pool, accommodating for each DP's specific mandate.
- Further expand coverage of the formal sector, also to public sector workers and to dependents of those who contribute.
- A system to collect and manage philanthropic giving and CSR needs to be designed and developed, and these actors need to be sensitised in order to channel an increasing share of funding from these sources to the single pool (to the extent possible, accommodating for their preferences)
- Gradually, National Health Plans should consider all sources of funding for health (i.e., not only public funding).

CREATING AN ENABLING ENVIRONMENT

Developing and using an evidence platform

Strengthening and expanding the HMIS

- Currently, there are numerous reports with considerable duplication and overlap (e.g. 26 different paper based reports). These are time consuming for health workers to complete. There are also significant delays in the release of compiled reports by the central level, which limits their utility.
- A functional HMIS division within the Minister's office is urgently needed. This division should lead a comprehensive assessment of all existing information systems (such assessment has already been planned). This should also include logistics management information system* (LMIS), human resources information system* (HRIS), financial information, facility mapping, etc. It should also look at information systems used by private (for-profit and not-for-profit) and EHO providers.
- A comprehensive health information policy then needs to be developed, that provides a roadmap towards a more integrated and expanded HMIS.
- Purchase of services from private and EHO providers should be conditional on data sharing.
- Ensure that the extended HMIS can generate HSS/UHC indicators, including indicators relating to equitable coverage and quality of care, both nationally and sub-nationally, in a timely manner and at least once a year.
- Institutionalise updating of HRIS; the system should include information that health workers need to regularly update, such as leave requests.
- Consider making access to the EPHS conditional on having a health check-up, as a way to get individual patient data into the system; before doing that, however, the system needs to be prepared to absorb all that information. Explore alternative ways for personal identification of service users (biometrics).
- Household surveys and facility surveys should be repeated at regular intervals; indicators across the different surveys and survey types should be harmonised.
- Strengthen vital registration, including cause of death data
- Establish population-based NCD database such as cancer registry nationwide

Generating evidence to support policy making

- A Centre for Health Policy and Systems Research should be established, possibly as a semi-autonomous entity, to generate/gather and compile evidence, formulate independent policy recommendations and tailor messaging to different audiences. Different options for such Centre have already been drafted in a concept note. Note that prior to the establishment of this Centre as a separate entity (which is likely to take time), some of its functions could be carried out by the 'Health Reforms Office' discussed below.
- The research programme of this Centre should be closely linked to the Programme of Health Reforms.

Sharing and using available evidence

- For each level of the system, tools such as dashboards* and scorecards should be developed to capture and present essential pieces of information relevant to different stakeholders.
- Information should be put online, with clear access rules (some parts may be password protected for example, while other may be accessible to the general public).

Policies

- Policies should be developed following a clear policy cycle, and policy makers should be kept accountable throughout the cycle (from formulation to implementation).
- A mapping exercise should be conducted of policies, decrees and directives, and necessary revisions should be identified.
- Several comprehensive national policies will need to be drafted, such as:
 - National drug policy;
 - Policy on non-communicable diseases;
 - Population policy;
 - HIS policy;
 - HRH policy (including task-shifting).
- Policies should be informed by evidence. The Centre for Health Policy and Systems Research mentioned above should contribute to this, e.g., through conducting or commissioning literature reviews, additional research, reviews of international best practice, and/or gathering community voice...).

Regulations – Developing a supportive legal framework

- A strong legal framework will need to be developed to support the implementation of the Programme of Health Reforms. This will need to be based on a comprehensive review of existing policies and legislations.
- The process will need to be:
 - Consultative: e.g. consumers, Attorney-General's Office, law departments from universities, international professionals, health authorities
 - Participatory: e.g. various stakeholders both local (internal and external) and international
 - Parallel (concurrent): e.g. multiple task forces with relevant domain of knowledge
 - Effective: e.g. enforcement of framework
 - Prioritised: e.g. foundations, fundamental, urgency, impact, resource availability
 - Efficient: e.g. maximise the use of finite resources by targeted implementation, concurrent tasks
 - Transparent: e.g. sharing, communicative

- Specific areas that may need to be reviewed and revised include:
 - The constitution (articles pertaining to rights and responsibilities of citizens on healthcare)
 - Encompassing (umbrella) legislation on health sector reform, such as a 'UHC Law':
 - The law should clearly outline the objectives and elements of reform: particularly securing financing with effective means such as sin-taxing (no matter who becomes the government), ensuring access to service for everyone (every individual in the country legally covered by the system), particularly subsidising the poor and vulnerable, and managing potential self-interests of individuals and groups.
 - While maintaining the flexibility to adapt to the changing environment, challenges encountered on the path, and lessons learned during implementation, it is of utmost importance that the law shall survive the changes in the political setting.
 - Health services legislation:
 - The "Law Relating to Private Health Care Services (2007)" may need to be amended in order to align it with proposed service delivery models (if necessary). This legislation should also cover the not-for-profit private sector. Alternatively, a different law could be promulgated to cover the private not-for-profit sector.
 - Healthcare finance legislations:
 - New healthcare finance legislation will need to be enacted based on proposed financing model, risk-pooling, and provider payment mechanisms.
 - It will be important to regulate private health insurance* so that it does not detract from the UHC agenda.
 - Health manpower legislations:
 - Existing legislations for healthcare professionals such as 'Myanmar Medical Council Law (2015)', 'Dental and Oral Medicine Council Law (1989)(Revised in 2011)', 'Law relating to the Nurses and Midwives (1990) (Revised in 2002)', and 'Traditional Medicine Council Law (2000)' will need to be amended and strengthened;
 - If considerable amendments are needed, enactment of a new law may be considered.
 - Laws to regulate other health-related professionals such as physiotherapist, imaging technicians, etc. will need to be promulgated.
 - Medicines and health products (including devices) legislations:
 - The 'National Drug Law (1992)' will need to be amended. This may include expansion of its scope to cover devices. Internationally accepted good practices such as 'good manufacturing practices (GMP)' will need to be adopted.
 - It will be important to ensure that this law or another other law covers regulation of production, registration, distribution, sales and dispensing of drugs and other health commodities.
 - Public health and communicable disease legislations:
 - Both the 'Public Health Law (1972)' and 'Prevention and Control of communicable Diseases Law (1995)(Revised in 2011)' will need to be amended to be in line with the reforms.

- Medical research:
 - If not already covered by existing legislation, a new law will need to be enacted.
- The development of a strong legal framework also covers the amendment and/or drafting of new subsidiary legislations such as rules, regulations, directives, guidelines, orders, etc.
- Either the existing division in charge of legislation under MoH or a new independent task force will be responsible for regulatory matters. At least 3 separate divisions will be needed for:
 - *Licensing, inspection and audit*: Made up of professionals trained to carry out inspection, audit and some administrative support staff to handle licensing matters;
 - *Surveillance and enforcement*: Made up of staff trained to carry out surveillance, enforcement activities such as raids, seizure, interviews, prosecution, etc.;
 - *Policy and legislations*: Made up of staff (which includes some professionals like medical doctors, nurses, pharmacists, etc.) trained to carry out policy analysis, formulation, legislation processes, etc.
- In addition, a designated group within the division or task force should be established to deal with quality assurance and patient safety.
- If possible, seconded legal officers from the Attorney General's Office and legal professionals from other bodies should assist the division or task force.
- In addition to the supportive legal framework needed to support the broad reforms, more specific changes in existing regulations or new regulations may also be needed to support the delivery of specific services or interventions, such as those aimed at population groups with special needs.

Leadership and organisation

Managing the reform process

- A special unit, which could be referred to as a 'Health Reforms Office,' should be established either within MoH or (preferably) outside (e.g. under the president or vice-president) to help plan, orchestrate and monitor the reforms. The main responsibility of this unit would be to ensure that the reforms remain on track. This would involve considerable coordination, conveying, facilitation and organisation. The unit could also oversee PR efforts around the reforms. It should have sufficient authority and resources to address bottlenecks.
- The unit should include a mix of skills and expertise, including legal, private sector, CSO, EHO, public health, clinical, health financing, public relations*, etc. Also critical will be strong facilitation and interpersonal skills.
- The unit should keep the long-term vision and goals in mind and anticipate necessary institutional and systems changes as well as required evidence to support upcoming policy decisions. Note that prior to the establishment of the Centre for Health Policy and Systems Research (described above) as a separate entity (which is likely to take time), some of the functions of that Centre could be carried out by the unit.
- The unit will need to clearly articulate and communicate the roles and responsibilities of each entity or institution involved in the reforms process.

- The structure and functions of MoH need to be reviewed and clear job descriptions need to be prepared for each position to ensure that profiles match roles and responsibilities. In addition, workflow and decision making processes should also be carefully reviewed. Empowering managers and technical staff at all levels – Central, State/Region, and township – while at the same time increasing their accountability may reduce implementation bottlenecks.
- A functional Planning Division is needed within the Minister's office.
- Current efforts to move towards a more inclusive and participatory planning, budgeting and monitoring cycle (that is linked to the broader development planning process) should be continued at all levels, starting with the township level.
- The results of the split between DoMS and DoPH should be assessed at all levels of the health system and the best organisational structure to support the reform process should be identified.
- HMIS and HRH divisions should become operational; their roles and responsibilities should be redefined within the Minister's office.

Coordination and collaboration

- Hardware, software and connectivity should be made available at all levels of the system to promote use of emails as official communication channel.
- Electronic calendars for meetings, trainings and workshops should be shared.
- Roles and relationships of MoH versus state/regional governments and townships need to be more clearly defined.
- Coordination and collaboration should be strengthened at all levels, starting with the township health planning process.
- An effective mechanism to strengthen coordination and collaboration with other ministries needs to be established. In order to ensure high-level participation from the different ministries, this effort could be lead by the President's Office.
- Cross-learning between ministries should also be promoted.
- The Myanmar Health Sector Coordination Committee (MHSCC) should be strengthened. The committee should focus on the bigger picture (as opposed to programme updates), including progress in the implementation of the programme of health reforms.
- The current setup with the Technical Strategy Groups should be revised to become more effective.
- Several measures would need to be adopted to further strengthen coordination of DPs, including:
 - Good development partner practices and behaviour should be systematised in a simple development partner 'compact.'
 - A roadmap for fiduciary and administrative capacity building and for a gradual increase in the use of government financial management systems by DPs and global partnerships (e.g. GAVI and GFATM) needs to be developed, building on current efforts to strengthen Public Financial Management.
 - Harmonised planning, budgeting and reporting formats should be developed and adopted at all levels.

- DPs' policies on salary supplements should be harmonised.
- Rules and guidelines regarding missions by DPs should be developed and efforts should be made to move towards joint missions.
- Work with DPs to prepare for the gradual transition away from donor financing in order to ensure both institutional and financial sustainability.

MONITORING FRAMEWORK

Monitoring implementation of the Programme of Health Reforms

- As mentioned earlier, one of the responsibilities of the 'Health Reforms Office' will be to monitor implementation of the reforms and to ensure that the reforms remain on track.
- Information provided by analytical tools such as National Health Accounts (NHAs) or Public Expenditure Reviews (PERs) will be used to track changes in funding sources and resource allocation.
- An area that deserves special attention is service availability and readiness (e.g., number and distribution of human resources with required skills, availability of essential medicines...).
- A continuous feedback loop will need to be institutionalised to monitor implementation of the reforms on the ground and to identify areas where corrective measures need to be taken. This implementation research will also track changes in patient/client perception, in provider behaviour, in staff attitude and perception, etc.

Monitoring achievements of the Programme of Health Reforms

- Progress towards UHC should be closely monitored. To this end, tracer indicators aligned with WHO/World Bank recommendations need to be defined and monitored on a regular basis. These indicators will also be needed to comply with global requirements under the Sustainable Development Goals.
- Additional research, coordinated by the Centre for Health Policy and Systems Research may need to be commissioned to assess the impact of the reforms.
- Equity should become an integral part of the monitoring and evaluation of any policy or initiative and it should be part of the monitoring of progress towards UHC. To make that happen, several measures will need to be adopted, including the following:
 - Build capacity in equity analysis within MoH (e.g. within a health economics unit);
 - Incorporate equity in the dashboards to be developed for each level of the health system;
 - Make equity part of the analysis plan of large household surveys;
 - Establish clear guidelines for equity measurement and monitoring that start with the requirement to clearly define equity;
 - Include stratifying variables in routine data collection and surveys (gender, socio-economic position, ethnicity, religion, geographical area, etc.);
 - Promote and facilitate the use of low-cost approaches to measuring the extent to which services and interventions reach the poor.
- Changes in quality of care at the different levels of the system and among different types of health providers will also need to be closely monitored.

INTERNAL AND EXTERNAL COMMUNICATION

Where are we now?

- MoH has no clear internal and external communication strategy or unit.
- Communication tends to be reactive rather than pro-active; it also tends to be rather unidirectional (from MoH to public, and not vice versa).
- No one is clearly assigned to be the spokesperson of MoH.
- Staff is insufficiently trained in communication skills.
- There is limited or no use of social media.
- Decisions made at the central level are not always clearly communicated to the implementers (e.g. health providers and health managers) in the field, leading to a lot of confusion and inaction

Where do we want to go?

- Health institutions need to move from reactive to pro-active communication with their audiences. Proactive communication must be bidirectional (not only providing information but also listening) in order to meet the needs and satisfy the interests of the audiences.
- Clear internal communication channels ensure that decisions taken at the top, together with clear implementation guidelines, are fully understood across all levels and by all stakeholders in the health system.
- Communication professionals need to work closely with policy makers and the media to ensure consistency in the messaging (i.e., to minimise the risk of conflicting messages being spread).
- CSOs should be used as a 'bridge' for communication with the general population.
- MoPF and MPs understand that health is a conduit for peace and harmony, and improved access to health without financial hardship is directly felt by citizens.
- The general population is aware of its entitlements under UHC.

Where do we start?

- The programme of health reforms needs to be communicated clearly to all audiences in order to manage expectations (e.g. this is a major reform that will take time to implement and that aims to address many challenges within the current health system) and generate buy-in. This will be the responsibility of the 'Health Reforms Office.'
- MoH will need to establish or strengthen a unit to handle internal and external communication. Decision makers need to be made aware of the fact that recruitment and training of communication experts is an investment that has tangible benefits in the medium to long term.
- Key entities involved in the implementation of health reforms need to identify their internal and external audiences (e.g. MoH, MoPF, MoLIP, parliamentarians, media, EHOs, CSOs, DPs, general public...) and identify the most adequate channels to reach them.

- Within each of those entities, one or more persons should be made responsible for communication with both internal and external audiences, with clear job descriptions (communication experts may need to be hired)
- A communication strategy needs to be developed that specifies the different communication channels and methods to be used to reach the different audiences and how best to 'package' information to make it relevant and tailored to those audiences.
- The public needs to be educated about rational use of medicines.
- Internal staff needs to be trained in how to deal with the media and how to communicate with the different audiences.

ANNEXES

Annex 1. The Process of developing the Programme of Health Reforms

- The National Health Governance Core Group was established in December 2015 to kick-start the process of developing the Programme of Health Reforms.

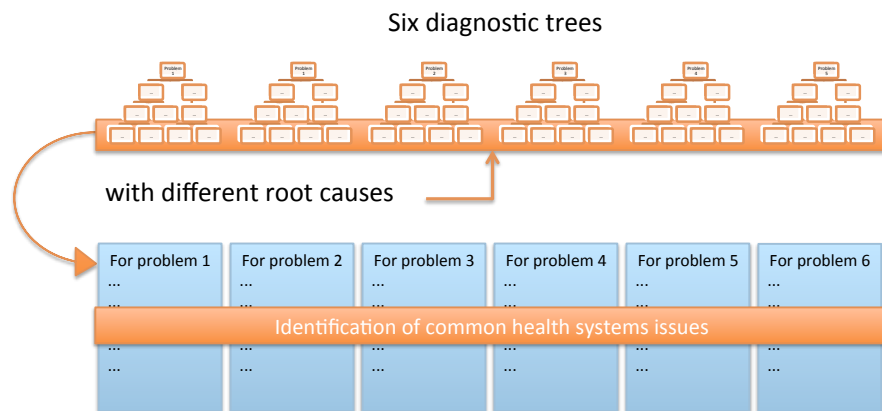
Starting point

- The starting point for this exercise was the NLD 2015 elections manifesto, from which vision and goals were extracted, as displayed in Figure 1 at the beginning of this document. NLD's vision is the realisation of UHC, shown in the centre of the figure. Moving towards UHC will contribute to improvements in the health outcomes stated in the manifesto (shown at the top of the figure). This requires efficient and equitable access to key quality services and interventions. In addition, efforts to reduce catastrophic and impoverishing out-of-pocket (OOP) spending on health, which is one of the objectives stated in the manifesto, will contribute to reducing poverty. Both are shown at the bottom of the figure. The Programme of Health Reforms focused on that level.
- The process described below was designed so as to ensure that the resulting Programme of Health Reforms would indeed facilitate the realisation of NLD's vision, i.e., the realisation of UHC.

Diagnosis

- At a first workshop organised in early January 2016, participants identified the main problems in the current health system. The problem diagnosis focused on the following question: in current health system, what stands in the way of ensuring:
 - Efficient and equitable access to key quality services and interventions;
 - Reduced catastrophic and impoverishing OOP spending on health?
- This question was further broken down to look at each of the six desired outcomes displayed at the top of Figure 1 in the introduction.
- Participants were divided into three groups; each group worked on two diagnostic trees to get to the root causes of the problems.
- Root causes were then compared across the six diagnostic trees to identify common health systems issues that the health reforms should address (Figure 8).

Figure 8 – Identification of common health systems issues



- Root causes and common health systems issues were then reorganised by theme (e.g. human resources, quality of care, governance* & oversight...).
- Three working groups were established. Terms of reference for these working groups were drafted and approved in plenary. Each theme was then assigned to one of the working groups, and a working group lead was appointed for each group considering the group's overall thematic focus.
- Working groups collected additional information on root causes, on national and international evidence and on initiatives that may already be on-going in the country to address those root causes.

Policy responses

- A second workshop was organised two weeks later to review all the information gathered by the different working groups and to start identifying possible policy responses. This was first done within each working group before being shared and discussed in plenary to ensure coherence.
- The outputs from the three working groups were subsequently compiled.

Sounding board

- The international Prince Mahidol Award Conference (PMAC) organised in Bangkok during the last week of January 2016 provided an opportunity for a small group made of technical working group leads and members to meet and discuss with experts on various topics such as rural retention of health workers, accreditation of health facilities, regulation of the pharmaceutical sector and others.

Bringing it all together

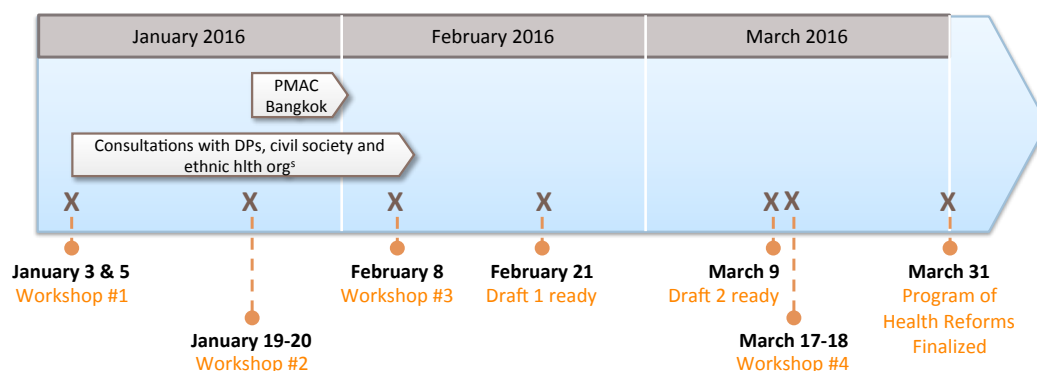
- During a third workshop, organised on February 8, 2016, both the compiled output from Workshop #2 and a summary of the discussions from PMAC were first shared with the broader group. The main proposed reforms that were slowly emerging from previous exercises and discussions were further discussed and a first attempt to prioritise them was made.
- Following this third workshop, a small group including the three working group leads prepared a first draft of this document. The draft was reviewed by and discussed with members of the NHGCG. Taking into consideration the feedback received, a second draft was produced.

- The second draft of the Programme of Reforms was shared with all the working group members and the Development Partners (DPs). It was then discussed at a fourth workshop, conducted in mid-March 2016.
- The current document, *version 1.0* of the Programme of Health Reforms was finalised following Workshop #4.

Timeline

- Figure 9 displays the different steps of the process described above on a timeline.

Figure 9 – Overview of the process for the preparation of NLD’s Programme of Health Reforms



Annex 2. Overview of current situation

	Public sector - MoH	Private sector not-for-profit	Private sector for-profit	Social Security Board, MoLIP (direct provision or contracted out)	Private Health Insurance (contracted out)	Ethnic Health Organisations
Source of funding	General Revenues/ Budget Out-of-pocket for incidental costs*	External Aid	Out-of-pocket	Employer-employee contribution Out-of-pocket	Voluntary insurance premiums*	Out-of-Pocket
Population	All	Poor/informal	All	Formal	Anyone willing to pay the premium	Ethnic population
Entitlements	Unclear; process for defining EPHS on-going	Depends on donor and implementing partner; mainly MNCH, HIV/AIDS, TB, and malaria	Available services in private clinics, labs, drug sellers (vendors), unlicensed providers, and hospitals	No explicit criteria	Unclear	Unclear

Annex 3. Milestones

Within 100 days

A series of immediate actions that can be completed within 100 days are also being proposed. Some of these actions will help secure buy-in and support for the Programme of Health Reforms, while others are essential to initiate the reform process.

Key actions that can be publicly announced

- ‘Listening’ campaign conducted throughout the country to listen to the voice of all stakeholders, including community and health workers
- Public announcements of achievements feasible within 100 days that are based on already planned or on-going activities; examples include:
 - The number of vacant posts that will be filled at the rural health centres
 - The number of midwives whose skills will have been upgraded
 - The number of rural health facilities equipped with solar energy to keep vaccines safe
- Public announcement of patient’s rights, to be captured in a ‘Patient Rights Charter’
- ‘Clean health facilities’ commitment (joint effort that will involve communities)

Key actions to improve the working conditions of MoH staff

- ‘Temporary Employment’ programme expanded to fill human resource gaps at township level
- Unnecessary ‘red tapes’ – such as those relating to travel of staff during weekends – removed

Actions needed in order to initiate the reform process:

- Decree issued to support the Programme of Health Reforms
- Health Reforms Office established and functional
- Catchy slogan selected for the Programme of Health Reforms
- Feasible and affordable Basic EPHS defined
- Findings around impoverishing spending available and catastrophic package defined
- Mechanism and conditions (in which cases, for whom...) for the coverage of cost of transportation, food and accommodation defined, considering financial and operational feasibility
- Updated information on where government money for health comes from, where it is going, and who benefits from it should be available for sharing with key stakeholders, including parliamentarians, policy makers and the general public

Within two years

Milestones relating to the implementation of reforms

- x% of townships are able to deliver the EPHS to at least x% of the population
- Transparent mechanism for periodic revision of the EPHS institutionalized
- Basic Health Staff available in sufficient number in at least x% of all townships
- Job descriptions developed for all types of health workers at every level
- Mechanism to assess knowledge and skills of basic health workers of EHOs jointly developed and adopted
- HMIS and planning divisions within the Minister's Office functional
- Incorporation of information from private and EHO providers into the HMIS established
- Procurement and supply chain management systems harmonized
- Use of generic medicines increased by x%
- Single purchaser established by law
- Mechanism to identify the poor and near-poor developed, preferably across Ministries
- Comprehensive review of existing policies and regulations conducted to identify gaps and necessary revisions
- User-friendly community feedback mechanism established
- Government resources for health as a share of GDP increased to x%

Milestones relating to achievements in terms of progress towards UHC

- Effective coverage of essential interventions has increased by x% (measured for selected tracer indicators)
- Quality of care improved as measured using a standardized quality assessment tool
- Systematic disparities in health service utilization across population groups have narrowed (measured for selected tracer indicators)
- Catastrophic and impoverishing OOP spending on health have been reduced by x%

Within four years

Milestones relating to the implementation of reforms

- x% of townships are able to deliver the EPHS to at least x% of the population
- Different types of providers (public, private and EHOs) contribute towards UHC in a more coordinated way
- Basic Health Staff available in sufficient number in public facilities in at least x% of all townships

- Rural retention of human resources increased
- At least x% of training institutions accredited
- Formal accreditation and re-accreditation procedure in place for public, private and EHO health facilities
- Licensing and re-licensing mechanism established for different cadres
- More strategic mix of provider payment mechanisms used to pay for services in the EPHS

Milestones relating to achievements in terms of progress towards UHC

- All people in the country know their entitlement under UHC (including preventive, promotive, curative, rehabilitative care)
- Effective coverage of essential interventions has increased by x% (measured for selected tracer indicators)
- Quality of care improved as measured using a standardized quality assessment tool
- Systematic disparities in health service utilization across population groups have narrowed (measured for selected tracer indicators)
- Catastrophic and impoverishing OOP spending on health have been reduced by x%