2020

Universal Health Coverage

Policy Brief

A Strategic Challenge for Myanmar:
Reducing Out-of-pocket Spending on Health

Key messages

Based on the National Health Account analysis, and a number of studies conducted (see references):

- OOPS has kept being very high over the past two decades in Myanmar [1,5];
- High OOPS affects health seeking behaviors, particularly among economically vulnerable families, pushes the poor and near poor to impoverishment, and is an inequitable and inefficient way to finance health services.

THIS POLICY BRIEF RECOMMENDS

- More public resources for health, which should be generated from higher allocations to health AND better spending of existing resources;
- Considering moving towards strategic purchasing through these options:
    - Funding the EPHS nation-wide via enhanced public finance management mechanism, including the use of resource allocation formula that considers effective coverage and need;
    - Funding the EPHS through a demand-side scheme built around a purchasing agency, where resources complement allocated budgets and link funding to effective coverage and need.

1.WHAT IS OUT OF POCKET SPENDING (OOPS)?

Out-of-pocket spending on health (OOPS) refers to any direct health related payments made by households at the point of service. OOPS includes payments to healthcare providers, including laboratories and pharmacies. [7] Evidence suggests that to ensure adequate financial protection for families, and to progress towards Universal Health Coverage[1], policy makers should aim to reduce **OOPS to less than 20 percent as a share of total current health expenditure.**

To better understand the current level of OOPS in Myanmar, this policy brief analyses the National Health Account 2016-2018 [4] including i) estimates of OOPS and ii) the types of services that families pay for.

The policy brief concludes with a set of recommendations and suggested policy instruments to reduce OOPS in Myanmar.

2.WHAT IS THE IMPACT OF HIGH OOPS ON HEALTH AND WELFARE?

Global evidence suggests that high OOPs negatively impacts households and the health system in a number of ways.

First, high OOPS contribute to financial hardships and drives families, particularly the poor and near poor, further into poverty. Health needs are often unpredictable and, in many instances, costly. [6] When faced with high health expenditures, families with limited financial means often resort to risky coping mechanisms such as borrowing money and/or selling assets.[3,7] For some families, this may lead to impoverishment -- increasing their vulnerabilities to further shocks.

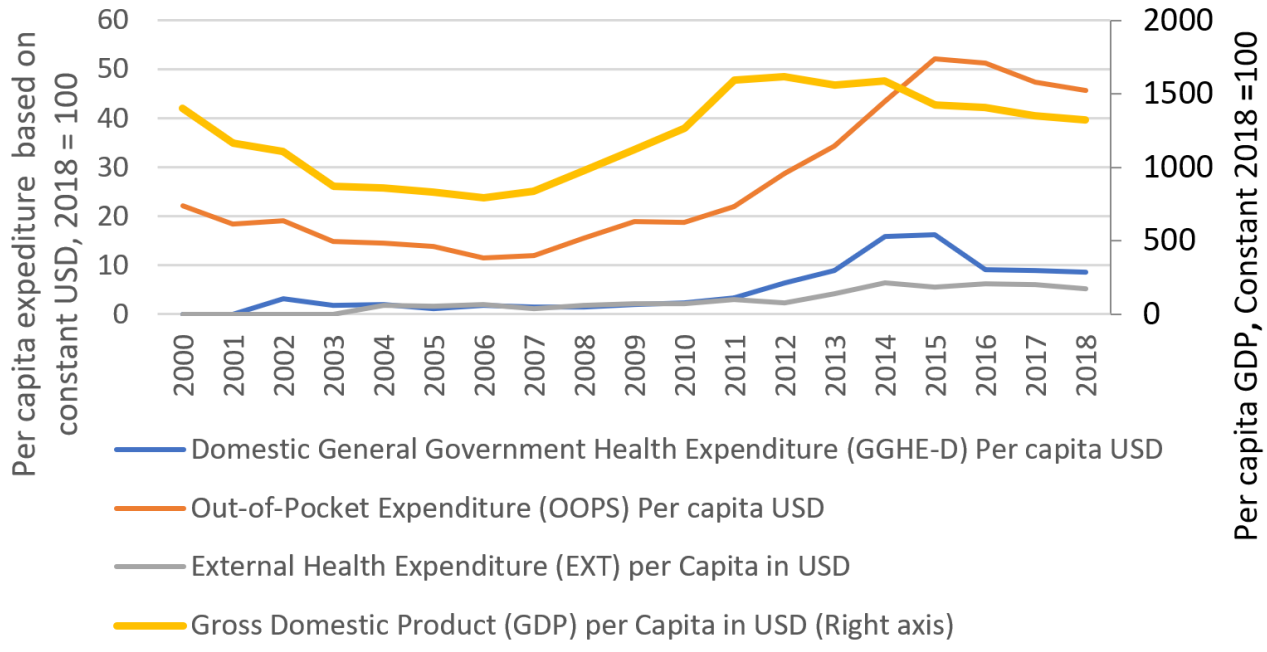
Furthermore,high OOPS is a barrier to accessing health services. Care seeking involves a complex set of decision-making process. Families often weigh the benefits of treatment against financial (and non-financial) costs. And certainly, other social determinants such social norms and accessibility of care, also play important roles in the decision-making process. Focusing on out of pocket expenditure, studies show that when faced with high OOPS, many decide to postpone, forego care, or seek alternative ways of treatment including self-medication. [6]

Finally, high OOPS is an inefficient and inequitable way to finance health services. Payments at the point of care do not allow the health system to cross-subsidize among groups with different risk profiles. Furthermore, the poor, regardless of the medical bill, tends to pay a greater proportion of their household expenditure on health. [7] A lack of financial protection places the greatest burden on the poor and near poor.

3. WHAT IS THE LEVEL OF OOPS IN MYANMAR AND FOR WHAT TYPE OF SERVICES?

OOPS in Myanmar: OOPS is the main source of financing for health expenditure. According to the 2016-2018 National Health Account (NHA) analysis, OOPS accounts for an estimated 76% of total health expenditure in 2017. Figure 1 provides an overview of trends from 2000 to 2018 for four key indicators: domestic general government health expenditure, out-of-pocket health expenditure, external health expenditure, and GDP per capita (in constant US dollar). The external health expenditure changed very little during this period. However, the domestic general health expenditure and OOPS steadily increased from 2000 to 2015, and then both declined from 2015 onwards. The trends are more or less synchronized with that of GDP per capita in the same period.

Figure 1: Trends in Health expenditure, by source of payment and GDP per capital

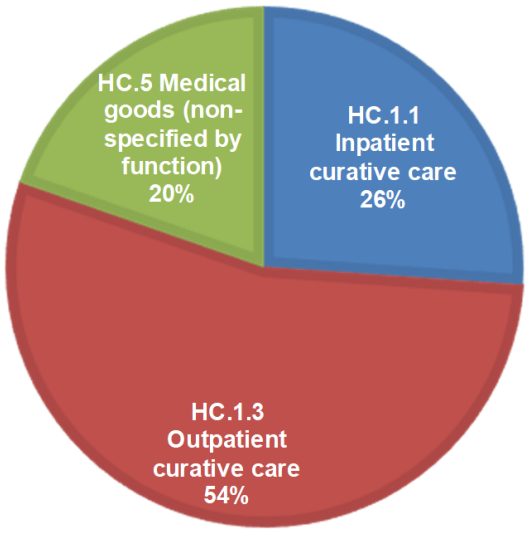


Source: WHO GHED based on MoHS, NHA 2016-2018

Impact of high OOPS on economically vulnerable families: According to a study conducted by Ergo et al., an estimated 1.7 million people fell below the national poverty line due to health spending in 2015. Among Myanmar households that reported going to a health facility in 2015, 28 percent took loans and 13 percent sold assets to cover the health expenditures.[3] The findings underscored the need to have a financial protection system in place to protect the poor.

Level of care and types of services:
According to the National Health Accounts Analysis 2016-2018, and based on MLCS 2017, OOPS goes towards payment for three types of services: outpatient care, inpatient care, and medicine and goods (Figure 2). Of the three, outpatient care provided at clinics and/or outpatient centers at hospitals, accounts for the largest share of OOPS (54 percent). Inpatient care and payments for medicines and other medical goods accounts for a much lower proportion (26 percent and 20 percent, respectively).

Figure2: Percentage of household spending by types of services (2017)

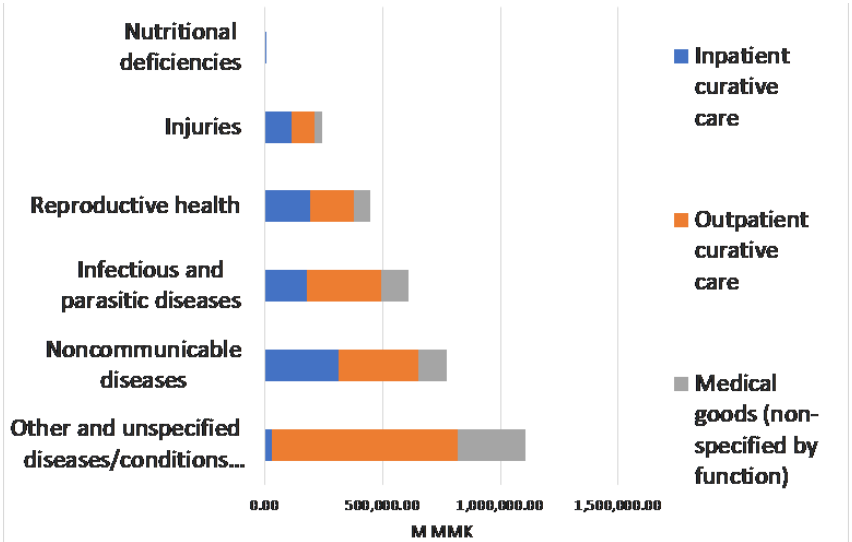


Source: MoHS National Health Accounts 2016-2018 estimates based on MLCS 2017. WB-CSO MOPFI.[2]

Focusing on the types of illnesses addressed, NHA data shows that for inpatient care, the largest share of OOPS goes towards treatment of non-communicable diseases, while for out-patient care the largest share of OOPS goes towards treatments classified as 'other'.

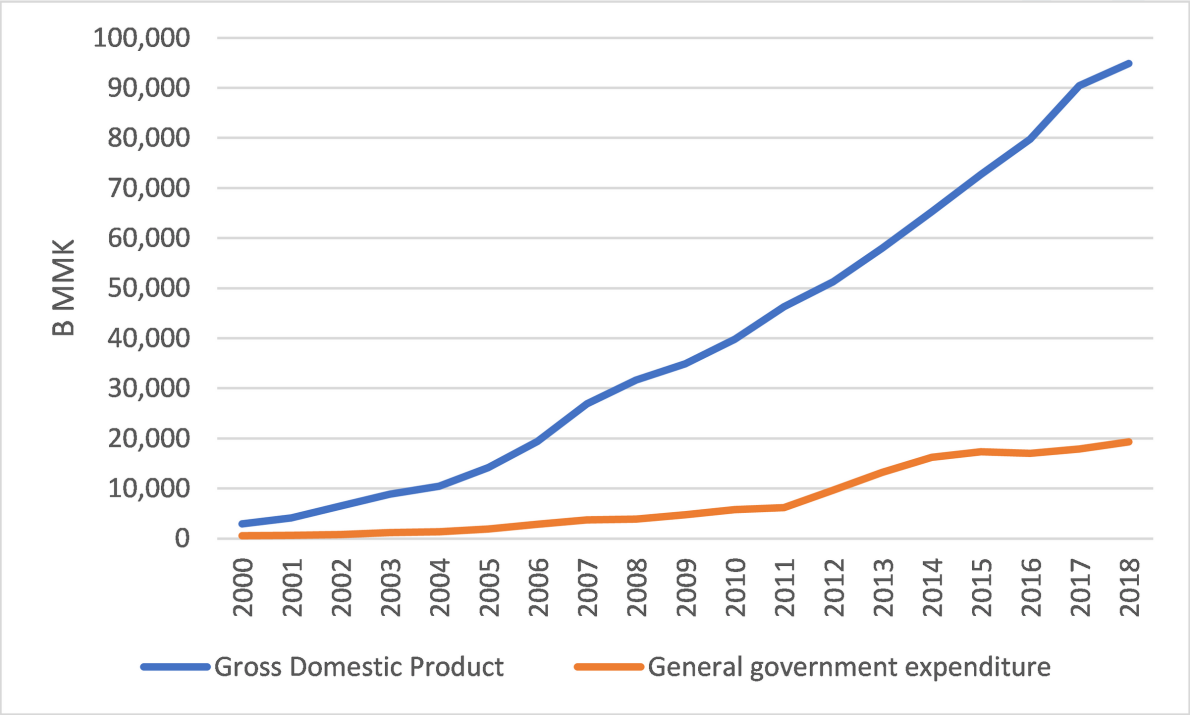
The analysis highlights a need for MoHS to explore mechanisms to reduce families' financial burden to treat NCDs. With regards to outpatient care and households' spending on medicines and medical goods, the information system needs to be further improved to allow for a more granular disease classification. (Figure 3). The more detailed and accurate the data are, for both inpatient and outpatient care, the better they could be relied on informing more targeted policy responses .

Figure 3: Household direct payment by types of diseases, Myanmar 2017 (Million MMK)



Source: MoHS National Health Accounts 2016-2018 estimates.

4. WHAT ARE THE POLICY RECOMMENDATIONS AND POTENTIAL INTERVENTIONS TO REDUCE OUT OF POCKET EXPENDITURE?



Policy Recommendation 1: Increase government revenue and expenditure. Data shows that while there is a gradual increase in general government expenditure, it is far less than increase in GDP (Figure 5).

The low tax revenue limits the government's capacity to invest in human capital, including increase in health spending. By improving general tax collection, the fiscal space for health will likely increase.

Policy Recommendation 2: Advocate for larger allocation of spending on health within existing government budget. Focusing on health and the Sustainable Development Goals (SDGs), table 2 provides estimates of the amount that Myanmar government should aim to increase in order for the country to provide adequate financial protection to the people as well as to meet SDGs.

A quick back-of-the-envelope calculation would suggest that in order to reduce OOPS to 20 percent of current expenditure of health [8], GGHE should increase by 4.9 fold, from 602,725 Million MMK to 2,942,683 Million MMK. (see Table 1)

To achieve these ambitious goals, stepwise approach to increase government spending would be needed.

Table 1. Estimated increase in governmental domestic expenditure on health to reduce OOPS to 20 percent of CHE

Policy Objectives: OOPS 20% CHE	
Current OOPS (2017, Million MMK)	3,180,158
OOPS 20% of CHE in Million MMK	840,200
Difference in Million MMK	2,339,958
To reach the objective of reducing OOPS to 20% if CHE:	Increase D-GGHE by 4.9-fold

Policy Recommendation 3: Improve efficiency in public health expenditure. Part and parcel to increasing fiscal space in health is a need to improve efficiency and absorption capacity. Within the limited resources allocated, MoHS needs to make strategic choices on what to prioritize; how to efficiently and effectively achieve the goals; and how to improve program planning and implementation in order to increase utilization of allocated funds. Towards this goal, the Ministry of Health and Sports is investing in improving public financial management. Efforts should be accelerated, particularly as the GDP is likely to contract in 2020 as a result of global recession.

To address the policy recommendations, the NHA team recommends the following policy interventions:

Policy Intervention 1: Fund through budgetary mechanisms a prioritized Essential Package of Health Services (EPHS) to improve access to essential health services and reduce OOPS. The Basic EPHS developed in 2017 as part of the National Health Plan aims to ensure that a set of essential services are available and accessible to all populations. A key part of the on-going policy dialogue is to ensure that when families access this set of services, they do not face undue financial barriers. Implementing the EPHS will require different ways of resources to flow to facilities. Allocations of resources shall be based on effective coverage of package implementation, rather than by inputs available.

Policy Intervention 2: Implement strategic purchasing mechanism. One of the main principles guiding health financing reforms to accelerate progress towards universal health coverage is strategic purchasing. [9] The objectives of strategic purchasing are to enhance equity in the distribution of resources and increase efficiency. Furthermore, strategic purchasing also enhances transparency, accountability of providers and purchasers to the population. Establishing a strategic purchasing system may involve setting a new mechanism/ institution that channels funds through explicit agreements with service providers that complements regular budgetary funding.

References

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[8] World Health Organization , "World Health Report 2010: The path to universal coverage," WHO, Geneva , 2010.

[9] World Health Organization, "Strategic purchasing for universal health coverage: key policy issues and questions," WHO, Geneva, 2017.