

How can financial risk protection be expanded in Myanmar?



Policy
Note #4

Myanmar Health Systems in Transition
Policy Notes Series



Asia Pacific Observatory
on Health Systems and Policies

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How can financial risk protection be expanded in Myanmar?



1. What is the challenge?

Protecting people from financial hardship when they fall ill is one of the two key elements of universal health coverage (UHC). In practice, this means that the majority of health care costs have to be met from government revenues so that services are provided free or with a small affordable co-payment. The alternative is to rely on pre-payment through some form of insurance, where risks are pooled across all contributors. These two approaches are not mutually exclusive; tax funding and insurance can be complementary.

The challenge in Myanmar is that at present neither approach is functioning. Government spending is too low to meet people's health needs and the proportion of the population covered by insurance is negligible. As a result, families face a stark choice in the event of serious illness: either defer treatment and face the consequences, or incur what can amount to catastrophic expenses and a downward spiral of disinvestment and poverty.

2. What do we know?

- **Total health expenditure (THE) in Myanmar is well below internationally agreed minimum standards:** Myanmar's THE per capita, which includes spending from all sources (public and private), was US\$20 in 2013. Despite recent increases, it

remains the lowest among countries in the South-East Asia Region. The World Health Organization's (WHO) Commission on Macroeconomics and Health estimated that a minimum per capita health spend of about US\$40 in 2007 prices would be needed in low-income countries to provide a basic package of essential health services. More recently, the Taskforce on Innovative Health Financing recommended US\$54 per capita.

- **Health receives low priority in government budgets:** As a proportion of gross domestic product (GDP), THE in Myanmar was less than 2.4% between 2001 and 2011 (again, the lowest among all countries in the South-East Asia and Western Pacific Regions). The proportion of the overall government budget spent on health was equally low, at 1% between 2003 and 2011. This means that in the period to 2011, the Government spent less than 0.3% of GDP on health. More recently, these figures have improved: the proportion of government health spending to GDP has risen to 0.76%, and the proportion of overall government spending to 3.14%. Nevertheless, this level of health investment is still insufficient to meet current demands for health care, let alone future demands, given rising public expectations and the demographic and epidemiologic transitions now facing the country.



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- **Out-of-pocket payment remains the dominant source of financing for health:** User charges for government health services were introduced in the 1990s as part of a series of political and economic reforms. As a consequence, health service provision was no longer free, and out-of-pocket payment became, and still remains, the dominant mode of paying for health. Consumers also pay the full price for goods and services from private-sector pharmacies, clinics and hospitals, as well as consultations with traditional healers. The net result is that out-of-pocket expenditure accounted for more than 80% of THE between 2001 and 2009.
 - **Out-of-pocket payments put people at risk of catastrophic expenditure:** Household out-of-pocket expenditure as a share of THE has dropped marginally since 2009, but remains over 75%. This is well beyond WHO's recommendation that out-of-pocket payments should not exceed 30% of THE in order to avert catastrophic expenditures.¹ Hard data are scarce and not representative, but various studies have indicated that up to 18% of households suffer catastrophic expenditure in meeting health care costs. More concrete evidence needs to be generated on the incidence of catastrophic spending and impoverishment.
 - **Exemption mechanisms to protect the poor do not work as intended:** When user charges were introduced, indigents were to be exempt from paying. However, an evaluation of the equity implications of community cost sharing in Myanmar found that, when drugs were actually available, there were no arrangements in place for exempting the poor, and no outpatients whatsoever were exempted from drug charges. At hospital level, the net income from a revolving drug fund was inadequate to subsidize free medicines for the poor.
 - **Social security is in its infancy and focuses only on the formal sector:** Social security for the formally employed, which has been in place for many years, is managed by the Ministry of Labour, Employment and Social Security, but covers just over 1% of the population and excludes families. Contributions are levied at 1–6% of salary by employees, and matched at the same rate by employers. Benefits include medical treatment, maternity leave, cash benefits for the sick, old age pensions after retirement, family assistance, invalidity, funeral grants, and unemployment benefits.
 - **Social security and private health insurance have had little impact on patterns of health spending:** The

¹ Catastrophic expenditure is defined by WHO as occurring when health spending exceeds 40% of household income after subsistence needs have been met.



government is considering further measures for the formal sector including the establishment of a Myanmar Provident Fund. The Ministry of Finance has launched a pilot private health insurance scheme, but enrollment numbers remain low. The Provident Fund as currently designed will not enhance risk pooling. It is also important to note that should private health insurance advance beyond the pilot stage, such a decision is hard to reverse and will have a negative impact on the poor. Currently, however, the national health accounts show that out-of-pocket payments still account for almost 100% of spending for private health care, suggesting that the limited public and private prepayment mechanisms that exist have so far had little impact on patterns of health-care spending.

- **None of the proposed mechanisms will provide financial protection for the poor:** The vast majority of people in Myanmar work in the informal sector, mostly engaged in subsistence agriculture. More than one-quarter of the population lives in poverty. None of these people are covered by the statutory social security system as it is currently designed. Thus, financial risk protection measures that work for the poor and informal sector are still yet to be introduced.

3. What needs to be done?

Considering the current low levels of health expenditure, the limited coverage of social insurance and the sheer size of the informal economy, the challenge of providing financial protection for the whole population is daunting.

The *recommendations* in this Policy Note are based on six areas in which the Government should consider action. While no single recommendation provides a complete solution, significant progress is possible with all six.

Raising overall tax revenues

The economy is expanding. GDP in Myanmar grew annually by 5% in constant prices for the years 2009, 2010 and 2011. Earlier this year, the Addis Ababa Action Agenda on Financing for Development stressed the importance of increasing domestic resources as a source of social sector financing. Currently, however, Myanmar has the lowest tax-to-GDP ratio (8% in 2014–2015) of all countries of the Association of South-East Asian Nations (ASEAN). Consequently, there is a need for reform that will widen the tax base, assess new sources of tax revenue from goods and services, and increase the efficiency of existing collection systems. The prospects for improvement are positive, and the Ministry of Finance aims to increase tax-to-GDP ratio to 10% this year.



More public money for health

Increasing revenue on its own would not necessarily imply additional fiscal space for health, unless the Government prioritizes the health of the population. In other words, increasing overall tax revenues is necessary but not sufficient. In recent years, health has benefited from a more or less constant share of a growing government budget. However, evidence shows that current levels of spending are far from sufficient. The most pressing decision for government will therefore be to increase the allocation to health from its current low level. The business case for increasing health's proportion of the budget has a number of elements.

- **Internationally agreed norms:** It is generally accepted that to provide a minimum package of services, THE needs to be at least US\$50 per capita, depending on the cost of an essential package of health services for UHC. This would require that THE in Myanmar be more than double its current rate. However, if 80% of THE is made up of out-of-pocket payments, then merely doubling the current government contribution would have little effect. A much greater increase in public expenditure is needed.
- **Assessing the potential fiscal space for health:** Arriving at an estimate of what might constitute a realistic level of public

sector spending on health is urgent. On the basis of existing evidence, a target of 12.5% of total government expenditure to be allocated to health by 2025 is proposed here. To reach this level progressively, the current proportion of 3.15% in 2012–2013 should increase to 5% by 2017.

- **Using the growing body of evidence that shows the economic return on health investment:** This will include the Lancet Commission's work presented at the Myanmar Health Forum, which argues for increased health investment, and calculates a return of between US\$9 and US\$20 for each dollar invested.

More money for health from other sources

As in most countries, the reallocation of a larger share of the budget to health may not be easily achieved, as different ministries and departments compete for funding. New health-specific resources such as earmarked taxation can create additional fiscal space for health.

- **Sin taxes:** As part of an expanding tax base the government plans to raise taxes on tobacco and alcohol. Adding an additional surcharge to excise taxes, which is allocated to health, not only provides an additional stream of income, but



also has public health benefits through its deterrent effect. Legislation that allows such surcharges is already in place in the Lao People's Democratic Republic, the Philippines, Thailand and Viet Nam. Income has been used to promote healthy lifestyles, to finance health related campaigns and to subsidize health services for the poor.

Financial risk protection for the poor and those in the informal sector is urgent

The twin problems of inadequate health care and catastrophic expenditure are urgent. Ideally, what is needed is a comprehensive health financing strategy that will maximize risk pooling. Myanmar has the opportunity to avoid the creation of parallel systems which are likely to result in inequitable benefits and increase overall administrative costs. However, international experiences suggest that expecting full contributions from the poor and self-employed is unrealistic, and that full or partial subsidies will be required.

- **Experience from countries in the Region:** In moving towards UHC, most countries that have introduced contributory financing schemes in the informal sector have initially provided partial subsidies from government revenues. This has been the case in the Philippines, Thailand (with

the Health Card Project) and Viet Nam. In Viet Nam, when more fiscal space became available, public subsidies for the informal sector gradually increased. Thailand, by contrast, fully subsidized the whole of the non-salaried sector from general taxation. In China, the Philippines, Thailand and Viet Nam the poor were fully subsidized by the government through an annual budget allocation, and in Lao and Cambodia through a health equity fund. These experiences provide useful pointers for policy in Myanmar.

- **Building institutional capacity:** Whatever approach is agreed in Myanmar a process of capacity building will be required to ensure the institutions concerned can be effective in carrying out their key tasks, namely: enforcing premium collection from the formal sector; purchasing services by contracting competent public and private providers; and ensuring health care providers are acting in the interests of social security members.

Learning from national experience

Several measures are currently being implemented to increase financial risk protection. They need to be closely monitored in order to learn lessons that can inform future policy.



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- Since 2012 the government has significantly increased spending on free essential medicine. An expansion of this programme would benefit from a rapid assessment of progress to date, to ensure that existing measures are effective, equitable and sustainable, and that supply bottlenecks have been overcome.
 - Community-based financing schemes have been introduced, and the Ministry of Health is piloting a maternal voucher scheme in two townships. Their effectiveness is a matter of debate. Evaluation is needed to assess their potential as an interim financial protection strategy, while a more comprehensive health insurance scheme is established.

Getting more health for the money

Existing resources can be used more effectively and more efficiently.

- **Manage external aid effectively:** External aid plays an important role in health financing in Myanmar. It is therefore important that this aid is additional to, and does not displace, domestic funding. In light of the growing numbers of international and national organizations active in the health sector, the government needs to ensure that

their contributions are aligned with national priorities, and responsive to the health needs of the people. It also needs to plan ahead for programmatic and financial sustainability when external funding ends.

- **Securing the best value for money:** Allocating funds for prevention and health promotion – for example, combating the use of tobacco and alcohol and preventing deaths from road traffic injuries – makes efficient use of scarce funds. Other measures to increase efficiency include: using lower-cost but effective generic medicines rather than proprietary brands; investing more in primary health care (particularly station hospitals); and improving provider incentives for providers to support national priorities for health care; and promoting the rational use of services through effective referral systems.
- **Reviewing and revising public financial management systems:** With increases in the levels of spending rigid financial rules and regulations, restrictions on international procurement, and cumbersome manual information systems have become serious impediments to effective delivery and getting value for money.



