Extending the network of health care facilities of the Social Security Board

Technical report on the feasibility of a Purchaser Provider Split

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Contents

List of Acronyms

AMS	Assistant Medical Superintendent
CMSD	Central Medical Store Department
ENT	Ear Nose and Throat
FBO	Faith-Based Organizations
HO	Head Office
ILO	International Labor Organization
IS	Information System
MOH	Ministry of Health
MOLESS	Ministry of Labor, Employment and Social Security
MS	Medical Superintendent
NPT	Nay Pyi Taw
O & G	Obstetrics and Gynecology
OPD	Out-Patient Department
PHF	Public Health Facilities
PPS	Purchaser Provider Split
RHC	Rural Health Center
SH	Station Hospitals
SHI	Social Health Insurance
SRHC	Sub Rural Health Center
SSB	Social Security Board
TH	Township Hospital
TMO	Township Medical Officer
TO	Township Office
UHC	Universal Health Coverage
WB	World Bank
WH	Workers' Hospital
YWH	Yangon Workers' Hospital

Introduction

The International Labour Organization (ILO) in Myanmar supports the Social Security Board, Ministry of Labour, Employment and Social security, to revise and implement the new Social Security Law, 2012. The SSB currently runs a Social Health Insurance scheme and provides directly health services to the workers via a network of 93 SSB clinics and 3 Workers' hospitals. Since the number of workers joining the scheme is increasing, the SSB wishes to expand the number of health facilities to provide quality healthcare services to the enrolled workers, which also corresponds to the provisions of the new law. To do so, it will be necessary to put in place a Purchaser Provider Split (PPS) – i.e. a separation of the purchaser and the provider that will allow the SSB to provide medical care to its beneficiaries in both its own medical facilities and other external facilities, public or private. The present report is intended to assess the current situation under the social security medical care scheme and to lay out concrete steps to extend the SSB network of health care providers.

The ILO social protection team in Myanmar as well as a health insurance expert, Mr Josselin Guillebert, conducted an assessment of the situation and drafted the present report.

1. Context

1.1. SSB medical care scheme

Workers registered at the SSB, contributing regularly 4 per cent of workers salary (Worker: 2 per cent and Employer: 2 per cent) and 5 per cent for workers enrolling above 60, can benefit from:

- Medical treatment and delivery (out-patient, in-patient, medicine, laboratory, transportation in case of referral outside urban areas) for a maximum of 26 weeks and for the first year of the new born;
- Those services are provided for free in all SSB facilities except for retired workers;
- In case of referral to other public facilities, workers get reimbursed on the basis of fixed rates.

Some particularities can be noted:

- It covers only the worker and not the family (with the exception of the dependent new born until one year of age);
- Retired workers have a co-payment of 50 per cent of the treatment cost;
- Services are free only in SSB clinics (93) and workers' hospitals (3);
- There is a mobile clinic (bus) managed by a private company providing medical care at the work site;
- There is a referral system to provide access to secondary and tertiary care; and
- There is no waiting period.

The Social Security Scheme is the sole scheme providing social health insurance in Myanmar and covers about 700,000 beneficiaries (706,750 registered workers in December 2013) in 110 townships in 13 States and Regions (except for Chin State).

SSB manages the scheme with 77 branch/township offices across the country and supplies medicine to the health facilities with its own medical store.

Since 2012, the new Social Security Law is in force replacing the Social Security Act, 1954. In addition to raising contribution and benefit levels, as well as planning voluntary enrollment for the informal sector, the new law opens the possibility to increase the number of health facilities and therefore to a provider-purchaser split.

The current vision to improve services

To develop its services the SSB started engaging in the below steps:

- Increase the network of clinics by modernizing them, a process started by the upgrade of the former TB hospital into a General Hospital, and potentially building new ones;
- Collaborate with other organizations such as the Public Health Foundation;
- Hire more medical staff on their own, additionally to the staff allocated by the Ministry of Health (allowed by the 2012 Law); and
- Strengthen the mobile clinic and monitor its cost.

The possibility of contracting with other health facilities is being considered in order to increase the number of health facilities accessible to the workers, as mentioned by the Social Security Law, 2012. Contrary to the previous Law, the current one allows drugs to be purchased outside the SSB

medical store. It therefore has the potential to contribute to improve services by giving access to more drugs and of better quality.

In social health insurance, one can distinguish between two forms of health-care provision:

- The direct method where the social security institution owns and manages health providers.
- The indirect method where the social security institution contracts external providers (only public providers or both public and private providers).
- Most social security institutions use both direct and indirect methods.

In Myanmar, the SSB practices the direct method. Although there are advantages like controlling the operations of providers and therefore their cost as well, there is a trend internationally to discourage this approach mainly because of conflicts of interest between the function of financing, i.e. purchasing services, and the function of service provision.

1.2. Health financing perspectives in Myanmar

Myanmar engaged in the path towards Universal Health Coverage (UHC), with high-level policy commitment to extend access to health to all. Within this framework, the country will need to develop a health financing strategy which will lay out the path chosen to make essential health care accessible to all without suffering financial hardship. This also corresponds to the first pillar of a national social protection floor. This process is meant to start in 2015. Meanwhile, a number of scattered health programmes with limited coverage co-exist.

In public facilities, the population can get some services and medicine for free. The government increased its budget for health with a focus on maternal and child health, and therefore public facilities receive more drugs and equipment related to those focus areas. However, the access to a number of services, medical kits and drugs are based on user fees.

Therefore the health system combines:

- Some free services in public facilities,
- Some Out-Of-Pocket (OOP) payments in public facilities for user fees,
- OOP in private facilities, which are entirely financed by user fees,
- Social health insurance for the workers registered to the SSB.

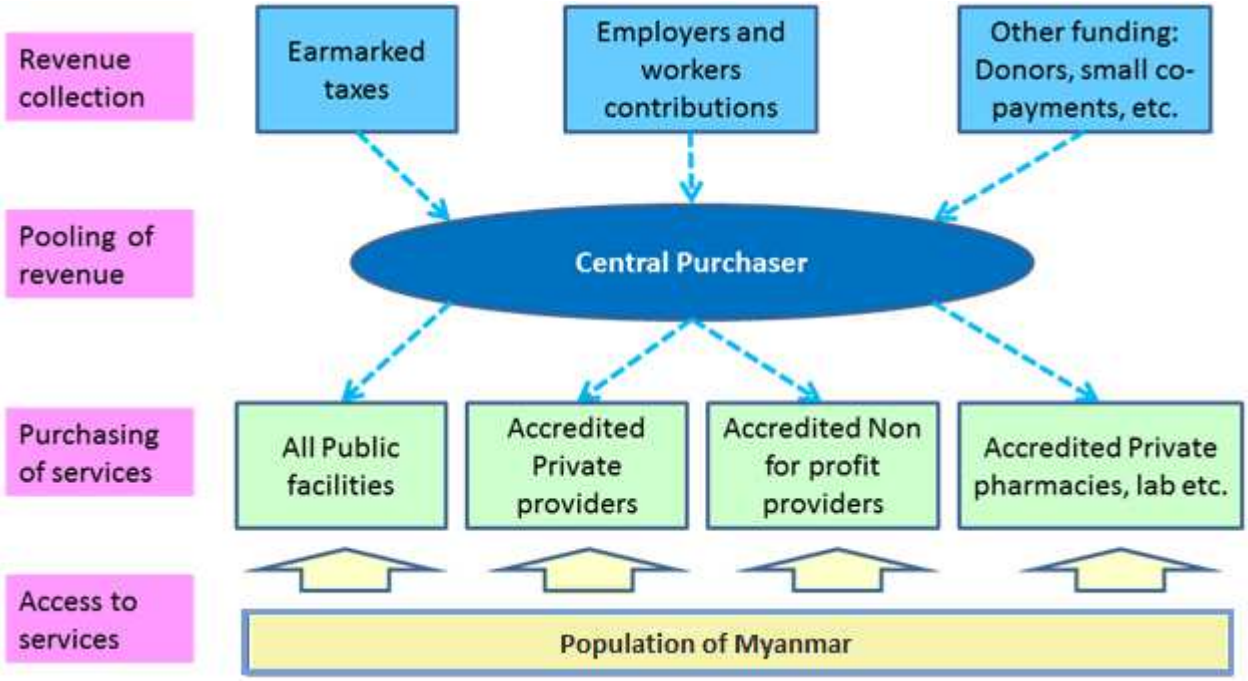
However, the overall financing of the health system which should rely on the three common pillars of health financing, namely revenue collection, pooling resources, and purchasing services, is still to be defined. The country could opt for several options of health financing, with one pool or several pools (formal / informal economy). If a single pool option is chosen, which could allow for greater equity, it could be put in place through either a national health service or a subsidized social health insurance scheme. In both scenarios, there is growing international evidence that separating the purchaser from the provider of health services is a good practice for the following reasons:

- It avoids a conflict of interest between the two functions and promotes greater transparency in terms of financial management.
- It provides a grievance mechanism to the beneficiaries and a monitoring mechanism for quality of care and effective service delivery.
- It ensures greater cost containment.

1.3. Situation analysis of the SSB

If the government decides to set up a mechanism based on a national social health Insurance scheme (NHIS) in the future, the SSB medical care scheme could be well positioned to serve as a basis for the development of this potential NHIS.

Figure 1. Possible model of NHIS in Myanmar



The SSB should keep this picture in mind to design its short, medium and long term strategy, and should actively participate in the formulation of the national health financing strategy, in close collaboration with the Ministry of Health, first provider of health services in the country.

In this context, it is crucial that the SSB be capable to demonstrate its capacity to be an efficient purchaser of health services.

The SSB could have the following missions:

> ***Extend medical care coverage to the workers and their families:*** *To avoid catastrophic expenditures, but also to demonstrate its capacity to manage more beneficiaries and more complex risk due to the extended nature of the beneficiaries (ie. Including dependents).*
>
> ***Extend its network of health care providers to public facilities managed by the Ministry of Health, thus contributing to financing the wider health system:*** *Not only SSB health facilities; today the system is not equitable because it is fragmented; and the role of Social Health Insurance is also to help the government finance the health system in order to ensure equitable access to quality health services for the population of Myanmar.*
>
> ***Become a purchaser of health services, thus experimenting one of the potential solutions for the future national system:*** *Covering more beneficiaries (including the family) and contracting (PPS) with public and potentially private health providers.*

By having this comprehensive approach, it would build partnerships where the landscape is currently scattered. With this vision the SSB should be seen as the laboratory for the country to develop a subsidized NHIS for all (both informal and formal economy, and inclusive of the poor).

2. Assessment of the SSB medical care scheme

This general assessment results from several visits to SSB, public and private facilities as well as meetings with the below institutions:

SSB stakeholders of the medical care scheme	Clinics: Tamwe SSB Clinic; Ahlon SSB Clinic; Hlaing Tayar SSB Clinic; Pyinmana SSB Clinic; Hospitals: Former TB hospital and Yangon Workers' Hospital SSB Head Officer: DDG + Directors of departments SSB Township offices: Ahlon, Hlaing Taya and Pyinmana Data center
Public facilities	48 Urban Health center (North Dagon); Mawbi Township Hospital; War Nat Chaung Station Hospital; Myaung Da Gar Rural Health Center; Myaung Da Gar Sub-Rural Health Center; Thanlyin District Hospital; West Yangon General Hospital Ministry of Health - Planning
Private facilities	Thiri Sandar Private Hospital

This chapter provides a picture of:

- How the health facilities are operating and what could be done to prepare them to enter into a system with effective provider-purchaser split (PPS), including the development of a contractual relationship with the SSB;
- How existing reimbursement procedures could be a potential step towards contracting public health facilities;
- How the new SSB information system needs to be adapted to a PPS and particularly for the SSB to act as a central purchaser (i.e. payment centre).

2.1. Health facilities' management

2.1.1. Facilities

	SSB facilities	Public facilities	Private facilities	Comments
Advantages	Services are delivered to the registered workers at clinic level and at the workers hospitals (WH). Health facilities are open only for registered workers.	A wide network. The increase in budget of the public health sector improves the availability of medicine in PHF and may increase the access to health services.	The private sector comprises: - General practitioners close to the place of residence of workers - Clinics - Hospitals	All together public and private health facilities can contribute to extend the network of SSB clinics and WH in a complementary manner, in order to ensure greater geographical equity in the access to care. Workers are already attending all types of health facilities (SSB, public, private) so contracting public facilities would not significantly increase attendance. PPS would create positive competition between the health facilities and push them to improve quality. To be competitive, investments should be made into existing SSB health facilities instead of creating new facilities. Low attendance in some SSB clinics might be due to low attractiveness. Risk pooling would make access to private facilities affordable for low income workers, who cannot currently access.
Challenges	Services at clinic level are limited. The attendance varies according to the clinics and depends on the number of enrolled workers in the area but also on the quality of services delivered by the clinic. There are few workers hospitals to ensure equitable geographical access to all registered workers. Facilities tend to be overcrowded, and workers may face long waiting times. Distance to reach the clinic and WH are often far and they are not open after working hours.	Attendance varies from one PHF to another. Some tend to be overcrowded such as General Hospitals in Yangon. The package of free services is in the process of being defined. As a consequence at the moment free services may vary from a facility to the other. Additionally, awareness on which services are free is limited among beneficiaries. This is a barrier to contracting with a central purchaser (difficulty to assess the cost of services that will need to be paid OOP).	They are more expensive than the public health facilities and serve those who can pay. Some private practitioners are also working in the public sector. This creates a risk of limited presence of medical specialists in private hospital. Empanelling them would require a better oversight of the sector.	

2.1.2. Patient experience in health facilities

	SSB facilities	Public facilities	Private facilities	Comments
Advantages	There is a proper mechanism to verify the entitlements of patients, which will be even more simplified with the smart cards. The history of the patient is recorded in their medical records.	Information is available in the medical records of the patient. Some basic accounting tools are available to monitor the payments (cash books, receipts and registrars).	Information is available in medical records of the patients (computerized during the last months). Some facilities are open to disclose costs. Financial management system available, producing receipts to patients.	In all three types of facilities, it is possible to track services delivered to patients, so it is possible to assess the cost of services on the basis of a costing survey. However due to free services in PHF, some services might not have been recorded. In facilities under MoH, when patients are required to buy drugs outside the facility the prescription is not recorded in the medical file. This is needed to assess the cost of external prescriptions and estimate the complete cost of treatment.
Challenges	Need to crosscheck with the drugs price list of the medical store.	Need to crosscheck with the drugs price list of MOH. Free care might not be recorded. Difficulties to identify external prescriptions for drugs not available at public health facilities.	Some private health facilities might not be open to full cost disclosure (i.e. adopt transparent practices).	

2.1.3. Financial management system

	SSB facilities	Public facilities	Private facilities	Comments
Advantages	The SSB clinics and WH focus only on service delivery and not on financial issues. Facilities have a biannual budget allocation based on their own estimate of passed consumption of medical supplies.	A number of health facilities have a bank account. Health facilities such as general hospitals can manage some funds related to the payment of several services.	In major hospitals and clinics, financial management procedures are in place.	To put in place a PPS, there is a need for a professional administrative team in each health facility. Although the SSB new information system will simplify the work, in case of contracting facilities, staff would need to be reallocated. At township level, administrative staff of PHF need to be trained on financial management. Accreditation procedures would be needed to control private sector facilities if they are to be integrated in a social insurance scheme.
Challenges	No financial management at the health facility level (purchaser and provider functions not separated). Administration in clinics and WH is light since most of the management is done by the medical unit head office in Nay Pyi Taw, while a PPS implies a professional management of service providers within each facility.	Financial management processes and capabilities are not developed since little budget has to be managed autonomously.	Management of funds might not be transparent in all private facilities.	

2.1.4. Elements on quality of care

	SSB facilities	Public facilities	Private facilities	Comments
Advantages	Doctors are available in clinics and hospitals, although not in sufficient number / outside workers' working hours. Drugs are available in the main medical store. Clinics and WH are forecasting and ordering drugs and equipment on time. Interviewed registered workers expressed the desire to receive services primarily in SSB facilities, if they are improved.	Medical doctors are present at Township hospitals and Station hospitals. Several specialties are covered in General Hospitals. Drugs are available in all PHF for most common diseases.	Being for profit, they have to satisfy the patients who are clients. They work on communication and take time with patients. No waiting time.	SSB facilities and PHF do not have autonomy to improve the quality of services they deliver since their budget is not linked to effective services provision and patient satisfaction. There is a need to incentivize service improvement. The system does not encourage facilities to improve services, since there is no direct link between what they produce/deliver (output) and what they are paid for (input). A PPS would encourage staff to improve their practices and SSB facilities would become a more attractive place to work.
Challenges	Interviewed workers questioned the quality of drugs; and often resort to private pharmacies out of their own pockets. In some cases the medical staff did not seem motivated by the work; they face routine; lack of prospects of evolution; and lack tools to improve the services and waiting time of patients.	Shortage of staff. Question about the quality of drugs available in PHF. Staff may not be motivated to improve the services, as there seems to be no direct link between their work and resources of the facility.	Price should not be the only factor that determines quality. Accessible only to those who can afford a higher user fee.	

2.1.5. Lessons from the assessment of health facilities and next steps

Lessons

⇒ Currently, SSB medical staff has often little motivation to work at SSB facilities because they do not have the means to improve services.
⇒ In addition, although workers are willing to receive services at SSB facilities, they expect higher quality in relation to their contributions.

Potential impact of a purchaser-provider split

⇒ There is great potential for the SSB to extend its network of providers via contracts with public facilities and maybe some private facilities.
⇒ It is a necessity to improve the quality of SSB facilities; an appropriate provider payment mechanism would develop the quality orientation of facilities and motivate the staff. Via a provider payment mechanism, the medical staff would get more autonomy; this would contribute to addressing local challenges to improve quality and give more responsibility to the personnel.
⇒ Contracting with public facilities would contribute to increase accessibility. This implies that required administrative / financial staff is trained and present in the facilities.
⇒ Contracting with private facilities should be technically feasible as they have financial management capacities. Still, in order to negotiate properly provider payment mechanism and rates, a specific survey should be carried out. In addition, a fair negotiation of tariffs and modalities of payment would be facilitated if the SSB had a bigger pool of insured persons (i.e. cover more workers and their families).
⇒ Competition between providers could create incentives to improve services.

Next steps

a) Improving SSB facilities and preparing them for a PPS:

- Conducting an external satisfaction survey of registered workers would be useful to set a baseline for improvement and adapt facilities to the needs of patients.
- Along with contracting, the SSB needs to upgrade and modernize its own medical facilities in order to improve their attractiveness and avoid unfair competition, particularly with the private sector.
- The SSB needs to reallocate staff in medical facilities for administration and train them on the financial management of health facilities.
- A detailed analysis of the current reimbursement processes of the SSB would provide more information on equity of access to care upon referral.

b) Assessing the cost of medical services in SSB, MoH and private facilities

- Conducting a costing study based on the information available at facility level (SSB, MoH and private facilities) would allow to assess the price of services in both public and private facilities and therefore fix tariffs.
- For the three types of providers (SSB, MoH and private), the costing analysis or the estimation of prices of health services delivered is the key entry point of any negotiation:
  - To set tariffs which will enable the SSB to improve its own medical services;

- To demonstrate that SSB, rather than adding an administrative burden on MoH facilities, can contribute to finance the wider health system in Myanmar; and
- To have negotiation tools in case contracting private facilities is envisaged, in order to avoid private providers making too high a margin on SSB patients.

2.1.6. Why do workers seek outpatient care in private facilities? Some evidence from the field to help the SSB in designing its Purchaser Provider Split strategy

A recent study conducted by Daw Mi Win Thidar[1] indicates that most workers registered at the SSB tend to seek outpatient care, especially primary care, in private health facilities as their first choice of health care provider.

When are people going to private facilities? For minor diseases and for emergencies (also go to public hospitals for emergencies). Families of workers living around the industrial zone also go to private clinics.

Who are the private providers? They are generally medical doctors also working in the public sector; young doctors waiting for employment in PHF; retirees; or some are purely private.

Private facilities are profit oriented. To make money they need clients; to have clients they need to have a good reputation; to have a good reputation they need to take care of patients; to take care of patients they need to have good infrastructure. In public health facilities run by the Ministry of Health (PHF) there is a shortage of staff, who therefore cannot spend much time with each patient. Alternatively, in private hospitals it is easy to meet a specialist; they keep appointments and there is no waiting time. In public facilities, the specialists may be delayed and there tends to be a long waiting period.

Since private facilities cater for those who can pay, they collect more resources which can then be invested in the quality of service provided.

By implementing a PPS, the SSB can incentivise all contracted facilities (its own, MoH and private) to improve quality.

Contracting private clinics could reduce attendance at SSB clinics if services are not improved. Therefore, the mission recommends to mitigate this risk through:

- Investments are made to upgrade the clinics.
- Private clinics are contracted when SSB clinics are overcrowded and far from the SSB clinics in order to limit competition.

=> Thanks to risk pooling and solidarity among workers, if the SSB negotiates contracts with a wide range of public and private providers, it will allow poor workers to access quality health services. It would also put pressure on private providers to contain their costs.

[1] Thida, Mi Win. 2013. "Determinants of Choice of Health Facilities Among Workers in the Private Sector in Yangon, Myanmar." Chulalongkorn University (Thailand).

2.2. Claims reimbursement mechanism

The mechanism is operational and workers are refunded for health services they have paid for in MoH hospitals upon referral. However it remains a burden for them to advance payment particularly for services at the hospital level where bills can be expensive. In addition, even though some services are free in the public sector, it remains unclear which ones and for whom. It is likely that SSB workers are charged for services that are meant to be free, since the personnel knows that the patients will be reimbursed.

In practice, it is not a problem that SSB pays for services which are supposed to be free, as long as it is clearly stated that SSB subsidizes MoH facilities and is recognized as such. A contract could be signed directly between MOH and SSB to avoid that workers registered at SSB have to advance payment, implementing a third party paying mechanism.

In fact, some SSB patients might sometimes not claim for reimbursement as they may be discouraged by the lengthy procedure (three months in the past, recently reduced to one month) and opportunity costs (time and transportation cost to go to the SSB township office).

Recommendations:

1) Instead of having many medical doctors verifying claims at the SSB head office, having medical advisers or medical auditors at Township offices could be an efficient alternative. They would be in charge of moving between clinics to verify the claims, and would also control the quality of private and public facilities.

2) As far as the contract between the MOH and the SSB is concerned, a transfer of funds between two public institutions would not be allowed by current regulations. Nevertheless, revising such regulations in the framework of the extension of social health protection would make sense and be in line with international good practice.

2.3. Management information system

The new computerized information system of the SSB presents a powerful capacity for the development of the medical care scheme and potentially for the management of a universal scheme. In fact, management of information is the basis of the effective provision of health care in general and social health insurance in particular. Without precise statistics on the covered population and services provided, the scheme cannot expand.

Recommendations for each component:

Component	Details	To be improved
Enrolment	The system produces enough information regarding the characteristics of each person enrolled.	All the necessary information in the registration form need to be properly entered into the system and updated upon changes. It should be linked with the services provided to each beneficiary, and

		automatically generate dashboards in order to monitor the extension of coverage, the evolution of health consumption and quickly identify fraud.
Service provision	In the insured patient record system, information will be available when the IT system is fully implemented.	However the system does not yet generate dashboards allowing the monitoring of risk per scheme, per service, per provider, per category of worker, etc. This is crucial to track contracts with each provider and contain cost.
Finance	The accounting system is quite comprehensive and produces statements of income and expenditure as well as a balance sheet.	For the PPS, the SSB has to develop its function as Payment Center, and each health facility contracted should be followed independently as a specific account.

Risk monitoring

The SSB should be able to compare the consumption of beneficiaries with estimates made to calculate the cost of benefits. This consumption monitoring should enable the SSB to identify the origin of any cost escalation, determine the cause, and take the necessary control measures.
But risk monitoring also allows the SSB to adjust costs based on evidence or anticipate a change in their costs structure of the scheme. It is possible that the forecasts made when negotiating contracts with health facilities overestimate consumption of certain benefits. In this case and if the SSB knows the actual price of each service, it may better adjust the cost of its scheme and possibly expand the range of its services covered, without increasing contributions. ***The more the risk monitoring is detailed, the better the SSB can control and adjust its package of benefits, have greater negotiation power with providers and ultimately improve beneficiaries' access to quality care.***

The mission has designed tools to assess the cost of services in potentially contracted health facilities and SSB facilities. These are available in annex. These tools can also be used for risk monitoring. The computerized system should be set to automatically generate these kind of dashboards and related indicators, such as average costs and frequency of consumption of services. Further support to implement those tools could be provided by the ILO.

3. Purchaser-Provider Split: a Methodology to improve the SSB medical care scheme

3.1. The PPS in theory

During the brainstorming workshop on provider-purchaser split held on 20 August 2014, the different aspects to take into consideration for the implementation of a PPS were presented.

- Selecting providers
- Providing accreditation and contracting providers
- Negotiating with providers
- Controlling cost and ensuring quality
- Referral system and Pre-Authorization
- Standard Treatment Guidelines and Essential Drugs List
- Provider Payment mechanisms

The necessary tools and procedures to implement a PPS are detailed in the chart below. The sample of a contract and a claim form are proposed in annex.

Tools	Details
Contract / Agreement	-General Agreement with the MOH and specific contracts with each PHF -Contracts with each private provider -List of agreed services -Price list for services and exclusions -Price list for drugs
Accreditation form	-To be filled for each contracted health facility
Claim forms	-To be filled for each patient / case
Invoice	-Summary of claims for reimbursement from the provider to the insurer with copy of each claim form
Manual of procedures	-For each provider
Medical audit procedures	-For SSB medical auditors controlling quality of services and claims
Several monitoring tools	-To manage the risk

3.2. Particularities for each type of provider

3.2.1. Contracting SSB facilities (internal purchaser-provider split)

This is where the SSB has more influence to implement the PPS, but also where it will imply more internal adjustments. Initiating the PPS within the SSB medical care scheme will require restructuring

the organizational chart and medical unit. It is necessary to start the process early enough since it will contribute to the improvement of SSB facilities.

In order to have a role within the national health financing strategy, the SSB needs to demonstrate that it can be an efficient purchaser of quality health services for a large number of people covered.

The best option for the SSB would be:

- To extend the beneficiaries eligible for SSB health insurance coverage starting with family of workers and potentially extending to the whole formal economy (including civil servants and their families for example);
- To start the split within the SSB and achieve it completely via three steps (Virtual contracting, Virtual split and Real split);
- To contract with public and potentially private facilities; and
- To develop a reliable long-term plan to develop professional social health insurance management capacities.

3.2.2. Contracting with public health facilities (PHF)

It has already been mentioned that contracting PHF requires two issues to be resolved first:

1) MOH should be convinced that the SSB can contribute to financing the health system in Myanmar.
2) Transfer of funds between two public institutions should be allowed in the case of a social protection institution and via a special agreement between the MOH and the SSB.

The mission recommends:

- To organize an assessment of tariffs which would be paid by the SSB for each service delivered to a worker; even if supposed to be free, the health facility will claim reimbursement from the SSB;
- Based on the tariffs assessment survey, share results with technicians of the MOH to start discussing the basis of an agreement;
- Co-organize with the MOH a high level meeting to discuss the possibility of having an agreement between the MOH and the SSB, to allow SSB workers to get services in public facilities without any payment (the reimbursement being done directly by the SSB to PHF through third party payments);
- Encourage, as a first step, the reimbursement of referred patients to General Hospital;
- Identify where workers would be interested to receive services in the public system. Starting at least with the Township hospital, as an intermediary between clinics and Workers hospital / General hospitals;
- Involve the SSB township offices in the collaboration, since the claims will channel through township offices;
- Since the SSB would pay for the delivered services, the PHF should ensure the continuity of service and SSB workers should not be given external prescriptions; and

- For all providers, the SSB should put in place a reliable complaint mechanism in order to bring any issues encountered during contract monitoring meetings; the providers will then understand that the SSB cares about the quality of services delivered to its workers.

3.2.3. Contracting with private facilities

Contracting private facilities for primary care in areas with little or overcrowded SSB clinics may be considered in the short run because:

1. Workers already go to private providers for primary care.[2]
2. There is an interest on the side of the private providers and the internal administrative capacity.

Risks related to this approach need to be carefully considered and mitigated, in particular:

- Unfair competition with SSB and MOH facilities (mitigation includes investing in public facilities and contracting carefully with private facilities only where they complement the public network).
- Cost escalation, which should be mitigated by: a) a costing study before contracting in order to ensure proper negotiation, b) training of all parties on transparent financial management, c) close monitoring of health consumption patterns and spotting of fraud.

Particular steps would include:

- Identify providers likely to welcome SSB workers without competing with SSB facilities.
- Use monitoring tools to estimate the cost of services and how much it would cost the SSB to contract such a provider.
- Design a contract and enter in negotiation with the identified provider.
- Negotiate discounts based on the assessment of costs and the fact that SSB represents a potential number of patients for the provider with an estimated frequency of treatment, and therefore a potential turnover for the provider.
- Keep in mind that the contract has to serve the interests of both parties, but the SSB has to provide the best services for its workers while containing costs.
- Search for the best mode of payment (Fee-For-Service, DRG, Capitation, etc.).
- In the contract, plan regular meetings (1 per quarter) to monitor closely the collaboration (at least in the beginning).
- Develop management tools (information system) to produce monthly statistics on frequencies and average costs to control expenditure.

Once everything is well in place, it will be paramount to inform workers on the possibility to attend the new providers.

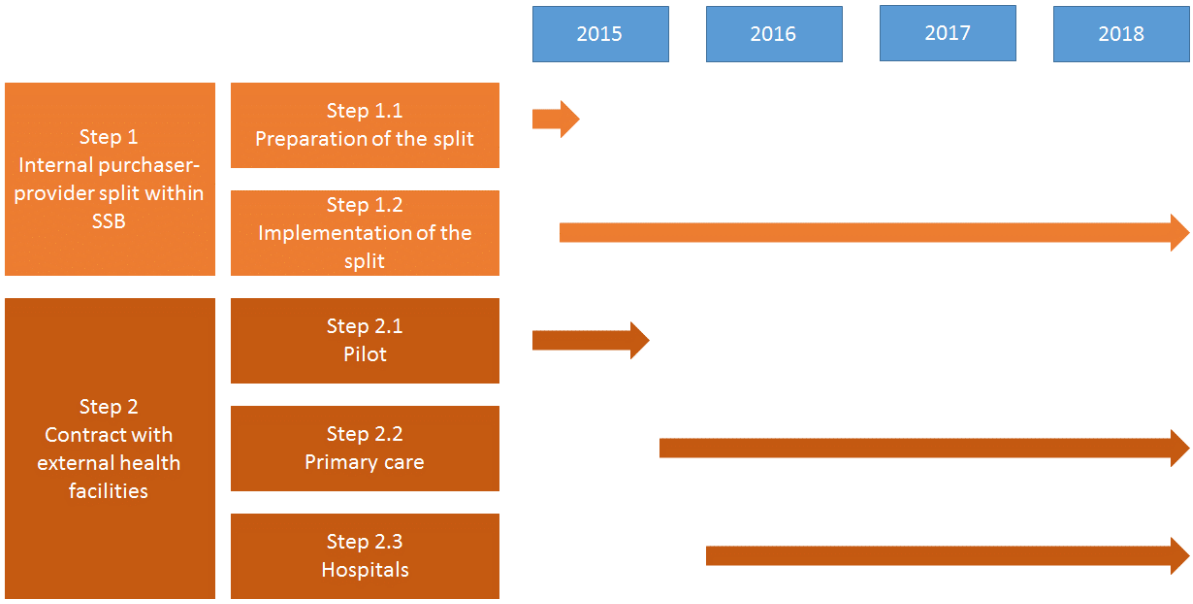
[2] Thida, Mi Win. 2013. "Determinants of Choice of Health Facilities Among Workers in the Private Sector in Yangon, Myanmar." Chulalongkorn University (Thailand).

4. Concrete steps for the SSB to put in place the PPS

The concrete steps for the SSB to put in place the PPS are presented below.

Although the strategy relies on a progressive methodology, the SSB may decide to start with the private sector first, followed by the SSB clinics at a later period.

Figure 2: Road Map



Concrete next steps could be categorized as follows:

- Step 1: internal purchaser-provider split within the SSB: 1.1) Preparation of the split, 1.2) Implementation of the split.
- Step 2: contract with external health care providers: 2.1) pilot with a limited number of clinics for outpatient care in pertinent areas, 2.2) contract with primary care facilities, and 2.3) contract with hospitals.

4.1. Internal purchaser-provider split within the SSB

Step 1.1: preparing the split

Concrete actions	Explanations / justifications	Rough cost implications	Timeframe
1) Assessment of "costs" of services: -Costs of drugs and medical supplies: A survey to track back the information in health facilities (see Annex). 2) Fixing draft tariffs covering the costs of drugs and medical supplies. 3) Producing tools to put in place the mechanism: Claims forms, invoices, budget template for health facilities, accounting tools at health facility level, accounting tools at head office and township offices (vouchers / payment of providers). 4) Eventually including in the tariffs a small cost for the maintenance of health facilities (see cost analysis methodology in Annex). 5) Explaining the process to SSB staff including trainings on the utilization of tools: Training of medical staff, branch offices and head office. 6) Designing medical audit procedures and training medical advisers to control the quality (at branch office). 7) Designing monitoring tools (information system) to prepare reports on services provided and costs based on tariffs. 8) Drafting a "contract" explaining the procedure (basis for the future real contracting approach).	Better monitoring of services delivered and consumed. This "virtual" claims reimbursement mechanism will allow for a smooth flow of information from the health facilities to the head office; the head office will manage to produce statistics, particularly average costs per service, per health facility, per worker, as well as accurate utilization rates. The SSB will therefore be in a position to estimate its expenditure in the medium and long term and adjust its package of benefits and improve the quality of services without jeopardizing the financial sustainability of the scheme.	Estimating the cost implications for each concrete action: 1) Cost of the survey (time of staff, forms to fill information, etc.) 2) No specific cost, except the time of SSB staff to work on fixing tariffs and information of health facilities (list of tariffs). 3) Cost of tools to collect and manage information: This accounts for administration costs and should not be underestimated. 4) No specific cost (short survey). 5) Training will be crucial for a smooth implementation of the process: Each staff linked with the mechanism at each level (clinic, hospital, branch and head office) should be involved (could be done by starting with one region and progressively extending). 6) Cost of the software developer with a social health insurance specialist.	Short term: as soon as the decision is made to put in place a PPS mechanism within the SSB, the process can start. (2015)

Step 1.2: Implementing the provider-purchaser split internally

Concrete actions	Explanations / justification	Rough cost implication	Timeframe
1) Based on former contracts, design real contracts setting the rules of the payment mechanism (type of services delivered, level of expected quality, tariffs, modalities of payment, medical and financial audits, monitoring of the contract, etc.). 2) Opening a bank account for each SSB health facility dedicated to the payment of invoices. 3) Organizing financial procedures at health facility level for the management of funds (budgeting, bookkeeping, cash and bank books, claiming and invoicing, financial statements for each health facility and consolidation at head office level). 4) Identifying and training health facility managers in financial management. 5) Planning financial and medical audits. 6) Organizing the payment mechanism at the branch office level for small amounts and at Head office for other bills, and adjusting the accounting system to pay the health facilities. 7) Designing procedures for purchasing drugs and medical supplies to be used by clinics and WH.	At this stage, the most complicated step has been launched, that is to say changing the culture from output to input based financing. Although virtual: • The clinics are adjusting to the claims mechanism. • The head and branch offices are adjusted to manage a wider provider payment mechanism. The contracting approach can shift from virtual contracts to real contracts between SSB management and health facilities (clinics & hospitals). The clinics and hospitals remain owned by the SSB, but they will get more autonomy in their management. Based on the tariffs fixed in step 1.1., the clinics/hospitals will make claims and be reimbursed by SSB. With the payments, the health facilities will have to purchase drugs and manage the maintenance of their facilities. With this logic, there will be a SSB Purchaser and a SSB Provider. At this point, the SSB can decide whether it wants to keep the ownership of its facilities or wishes they be transferred to MOH as central public provider of health care.	1) Cost of signing contracts with each health facility: negotiation process (meetings) and paper for contracts. 2) Initial amount to open an account. 3) Cost of producing a manual of procedures and related tools to manage the provider payment mechanism. 4) Costs of training of at least two managers per health facility as well as branch offices for supervision and initial technical support. 5) Cost of designing procedures for both financial and medical audits, training of auditors, and one medical adviser per branch office. 6) Cost related to managing the bills, both validation and payments (computerized and paper based). 7) Cost of transferring procedures from medical stores to each health facility, and the necessary training.	After 6 months of implementation, step 1.1 will depend on the ownership by all staff in the mechanism. This real payment mechanism can be put in place step by step, not all clinics at once. Testing first with one region and extending progressively. (2015-2016)

4.2. Contracting with external facilities

Step 2.1: Pilot - Contracting with private clinics where SSB clinics are overcrowded or far from workers' home.

Concrete actions	Explanations / justification	Rough cost implication	Timeframe
1) Use the same tools as for the split with SSB health facilities: contracts with list of services to be delivered and tariffs, claims forms and invoices, as well as payment mechanism via the Township offices or SSB head office. 2) Before using the tools, undertake a market analysis in the SSB zone of intervention: -What other private facilities could workers attend or already attend? -Map the SSB health facilities and analyze their capacity to deliver the expected services to the workers in their zone: utilization rate, quality, satisfaction of workers (satisfaction survey), number of industries in the zone, number of workers, etc. 3) Enter in a negotiation process: analysis of tariffs, estimation of the potential frequency of SSB workers in private clinics and impact for the SSB viability. Choose a provider payment mechanism. 4) Contract with private clinics. 5) Implement the same process as for the "real split" between SSB/health fund and SSB facilities.	In the assessment of SSB health facilities, two main issues regarding the services were identified: 1) Limited services at SSB clinic level. 2) Distance from workers' home and the waiting time in some specific industrial areas. If the first steps are implemented, i.e. contracting out the SSB clinics, or if they are given more management autonomy, the quality of services should improve because the clinics will be incentivized to deliver adapted services to the workers. In addition, by managing their own budget they will have margins to adapt their supply according to the demand of the workers. As far as the second challenge is concerned (distance and waiting time to meet a doctor), improving the quality alone will not be sufficient. Instead the SSB has three options to extend its network of health facilities: 1) increasing the number of SSB clinics, 2) contracting with private clinics, or 3) both. In addition, Mi Win Thidar's survey observed that workers already attend private clinics, where they prefer the services (less waiting time, better drugs), and which are closer to their home and open after work.	Different activities are important and represent a cost: 1) Mapping of SSB facilities and other public and private clinics. 2) Market analysis and satisfaction survey among the SSB workers (expectations?). 3) Survey to assess utilization and cost of services in private clinics. 4) Negotiation costs: meetings, etc. 5) Cost related to the partnership: administrative costs at branch offices level, monitoring of the contracts, etc. 7) Medical audits by SSB medical auditors/advisers. 6) Implementing the SSB computerized system in contracted clinics. 7) Training of private clinics to implement the collaboration (utilization of tools).	This step can be implemented in the short term, as soon as the decision to contract with private clinics is made. (2015)

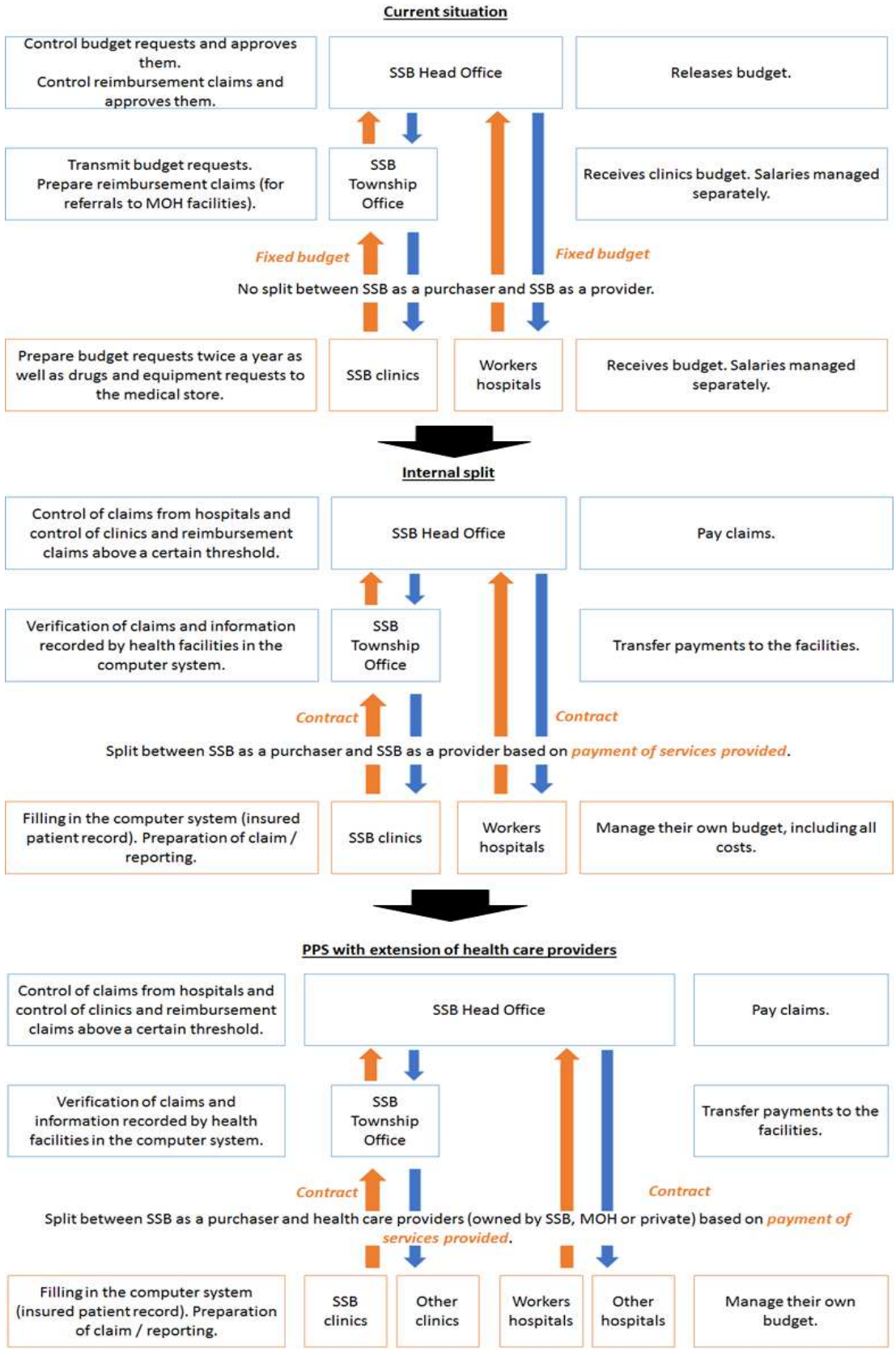
Step 2.2: Generalization - contracting primary care and outpatient services in public and private clinics.

Generalization of the process described in step 2.1 on the basis of the lessons learnt.

Step 2.3: Contracting hospitals

Concrete actions	Explanations / justification	Rough cost implication	Timeframe
It will follow the same approach as for the clinics, but at a more complex level: 1) Market analysis of Workers Hospital: satisfaction survey and health seeking behavior analysis: Where do workers attend services and why (preferences)? What are the options in the private sector? Mapping of hospitals, both public and private. 2) Entering a negotiation process with the MOH and, if envisaged, private hospitals: analysis of frequencies and tariffs (see tools in annex); assessment of the impact on SSB financial situation. Choose a provider payment mechanism. Designing a General agreement between the two ministries (MOH and SSB). 3) Contracting, which implies solving the legal issue of financial transfers between two public or semi-public institution (SSB and MOH). Designing specific contracts to be signed between SSB and each public facility contracted (including type of services, list of drugs and tariffs). Here, on the basis of the information collected in phase 2, the SSB needs to decide whether it can afford contracting private hospitals and, if so, ensure that does not create unfair competition with public facilities. 4) Implementing the same processes as described earlier for clinics.	Workers face challenges in accessing services at workers hospitals: 1) There are only three hospitals and one (former TB hospital) is not yet operational; therefore there is some inequality of access. 2) Services are limited in WH and patients have to be referred to general hospitals in some cases, where they need to advance the funds. 3) Waiting time to meet a doctor is also a challenge for the workers. For these reasons, the need to extend the SSB network of hospitals is justified. Since workers are already reimbursed by the SSB if they are referred to public hospitals, it would be seem obvious to give priority to a contracting approach between the SSB and public facilities. This should be the preferred option as it would ensure: greater equity in the access to care, long term cost control, coverage of heard to reach areas. Contracting with private hospitals can also be considered as a complement, but the relative cost increase needs to be considered carefully.	1) Cost of the market analysis (but can be conducted on SSB own resources – staff at township level). 2) Cost of negotiation. 3) Cost of tools to manage the system: However it is in the interest of contracted hospitals to collaborate, they should contribute by producing their own invoices. 4) Implementing the computerized system using Smart cards and training of medical staff. 5) Cost of monitoring the contracts (quarterly meetings). 6) Financial and medical audits for quality control.	The process of contracting with hospitals can start as soon as the decision is made to extend the network of hospitals. The market and health facility analysis could be done in the short term. Contracting could be planned in 2015 to start in 2016-2017.

Figure 3. Towards the extension of health care providers



5. Recommendations to go further in the analysis

A long term vision for health financing needs to be developed in Myanmar. The main concerned ministries are the Ministry of Health, the Ministry of Labour, Employment and Social Security / Social Security Board and the Ministry of Finance. In order to effectively reach universal social health protection coverage, a model needs to be chosen: a National Health Service model where care is accessible without OOP in all public facilities or a national social health insurance subsidized where care is accessible without OOP in all contracted facilities (with one pool, or with separated pool for formal and informal economy, which is less desirable in terms of equity of access). In any of the options, a provider-purchaser split is essential in order to link properly the effective delivery of care to beneficiaries with the resources provided to medical facilities.

The new Social Security Law, 2012, offers an opportunity to the SSB to implement such a split and demonstrate that it can act as a central provider.

The sooner a common vision for health financing is developed among relevant line ministries, the better the collaboration among those ministries will be. That collaboration is crucial to reach effective social health protection for all.

The ILO can further support the SSB as well as the MOH and MOF in developing such a vision through the facilitation of a multi-stakeholder dialogue to develop concrete proposals for a health financing strategy.

Additionally, the ILO can support the SSB and the MOH in the key steps for the implementation of a purchaser provider split. Steps to implement such a split include:

- Definition of a health package and costing study;
- Definition of a provider payment mechanism and subsequent negotiations with providers.
- Implementation of the contracting method internally on the basis of an output-based financing method.