การรับรู้ของชุมชนเรื่องระบบการร่วมแบ่งภาระรับผิดชอบด้านต้นทุนในโรงพยาบาลทั่วไป ในประเทศพม่า

นายพิว เมือง เถ่า

ศูนย์วิทยทรัพยากร
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วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาวิทยาศาสตร์มหาบัณฑิต

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PERCEPTIONS ON COMMUNITY COST SHARING SCHEME IN SELECTED TOWNSHIP HOSPITALS IN MYANMAR

Mr. Phyo Maung Thaw

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A Thesis Submitted in Partial Fulfillment of the Requirements
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พิว เมือง เถ่า : การรับรู้ของชุมชนเรื่องระบบการร่วมแบ่งภาระรับผิดชอบด้านต้นทุนในโรงพยาบาลทั่วไปในประเทศพม่า (PERCEPTIONS ON COMMUNITY COST SHARING SCHEME IN SELECTED TOWNSHIP HOSPITALS IN MYANMAR) อ.ที่ปรึกษาวิทยานิพนธ์หลัก : รศ.ดร. ศิริเพ็ญ ศุภกาญจนกันติ, อ. ที่ปรึกษาวิทยานิพนธ์ร่วม : ศ.น.พ.ภิรมย์ กมลรัตนกุล, 57 หน้า.

การศึกษานี้ต้องการสำรวจแนวทางปฏิบัติในระบบการร่วมแบ่งภาระรับผิดชอบด้านต้นทุนบริการสุขภาพในประเทศพม่า ซึ่งเริ่มใช้มานานกว่า 18 ปีแล้วโดยเริ่มตั้งแต่ พ.ศ.2536 การศึกษานี้มุ่งความสนใจไปที่การรับรู้ของผู้ให้บริการสุขภาพ ผู้รับบริการสุขภาพและผู้ที่มีฐานะยากจนในชุมชน

วิธีการศึกษาใช้วิธีการเชิงคุณภาพคือ การสัมภาษณ์เชิงลึกและการสนทนากลุ่มในโรงพยาบาลทั่วไปสองแห่งและในหมู่บ้านสองแห่ง ผลการศึกษาแสดงให้เห็นปัญหาหลายอย่างที่ผู้ให้บริการและผู้รับบริการสุขภาพเผชิญอยู่ ค่าธรรมเนียมผู้ใช้บริการในระบบการร่วมแบ่งภาระรับผิดชอบด้านต้นทุนเป็นอุปสรรคในการเข้ารับบริการ ในขณะเดียวกันการจ่ายค่ารักษาพยาบาลที่มีระดับสูงทำให้ป่วยมีฐานะยากจนลง โดยสาเหตุหลักมาจากค่าใช้จ่ายด้านยารักษาโรควิธีหลักในการรับมือกับปัญหาคือ การขายทรัพย์สินและกู้ยืมเงินในอัตราดอกเบี้ยที่สูง ผลการศึกษาพบว่า ชุมชนไม่มีความร่วมมือและไม่ตระหนักถึงปัญหานี้ ประชาชนไม่รู้เรื่องสิทธิ์ยกเว้นการจ่ายรักษาพยาบาล นอกจากนี้ยังไม่มีความชัดเจนเกี่ยวกับนโยบายในการให้สิทธิ์ยกเว้นการจ่ายค่ารักษาพยาบาลแก่ผู้ป่วยและผู้ป่วยส่วนใหญ่ได้รับการยกเว้นค่ารักษาพยาบาลบางส่วนเท่านั้น รายได้จากระบบการร่วมแบ่งภาระรับผิดชอบด้านต้นทุนสามารถยกระดับคุณภาพการรักษาพยาบาลและยกเว้นค่ารักษาพยาบาลให้แก่ผู้ป่วยได้เพียงเล็กน้อย

ผลการศึกษาแสดงให้เห็นว่าการนำระบบการร่วมแบ่งภาระรับผิดชอบด้านต้นทุนมาใช้ในพม่ายังไม่บรรลุวัตถุประสงค์ของการคืนทุนและในขณะเดียวกันผู้ที่มีฐานะยากจนยังได้รับผลกระทบจากค่าธรรมเนียมผู้ใช้บริการ ผลการศึกษาเสนอแนะให้เห็นถึงความจำเป็นในการค้นหาระบบการเงินการคลังสุขภาพทางที่มีความเป็นธรรมและปกป้องสวัสดิการทางสังคมมากขึ้น

ศูนย์วิทยทรัพยากร
จุฬาลงกรณ์มหาวิทยาลัย

สาขาวิชา เศรษฐศาสตร์สาธารณสุขและการจัดการบริการสุขภาพ ลายมือชื่อนิสิต..........

ปีการศึกษา 2553.......... ลายมือชื่อ อ. ที่ปรึกษาวิทยานิพนธ์หลัก..........

ลายมือชื่อ อ. ที่ปรึกษาวิทยานิพนธ์ร่วม..........

##5385729629: MAJOR HEALTH ECONOMICS AND HEALTH CARE MANAGEMENT
KEYWORDS : USER FEES / EXEMPTION / COST RECOVERY

PHYO MAUNG THAW: PERCEPTIONS ON COMMUNITY COST SHARING SCHEME IN SELECTED TOWNSHIP HOSPITALS IN MYANMAR. ADVISOR : ASSO PROF. SIRIPEN SUPAKANKUNTI, Ph.D. CO-ADVISOR : PROF. PIROM KAMOL-RATANAKUL, M.D., 57pp.

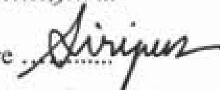
The Community Cost Sharing scheme has been implemented in Myanmar for more than 18 years, since its first implementation in 1993 and this study attempted to explore on the current practices and focused on the perceptions of not only the health providers and health consumers but the poor of the community.

Qualitative methods such as in depth interview and focus group discussions were carried out at two township hospitals and in two village communities.

The study revealed a number of problems faced by both health providers and consumers. The user fees charged in CCS acted as a barrier to those seeking health and also at the same time pushing those receiving health into impoverishment due to high out-of-pocket expenditure. Mainly pharmaceuticals are the reason for high out of pocket payment. Selling assets and borrowing at high interest rates were revealed as coping mechanisms. Community participation and awareness were lacking and people did not know of their right to receive exemption. There was no clear exemption policy being practiced and majority of the patients only received partial exemption. The revenue generated from CCS could only make a meager contribution towards upgrading the quality of services and for the cost of giving exemption.

The study show that implementation of CCS in Myanmar, is not achieving its objective of cost recovery and at the same time poor are being affected by user fees and suggests for the need to explore a health financing system which would be more equitable and give more social protection.

Field of Study: Health Economics and Health Care Management Student's Signature

Academic Year: 2010 Advisor's Signature 

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LIST OF ABBREVIATIONS

CCS	Community Cost Sharing
CBHI	Community Based Health Insurance
CHMF	Community Health Management Financing
CMSD	Central Medical Store Depot
CSO	Central Statistical Organisation
DOH	Department of Health
ED	Essential Drugs
FGD	Focus Group Discussion
IDI	In depth interview
TMO	Township Medical Officer
MEDP	Myanmar Essential Drugs Project
MOH	Ministry of Health
MD	Ministry and Departments account
OA	Others account
UNDP	United Nations Development Programme
UCGF	Union Consolidated Government Fund
UNICEF	United Nations International Children's and Education Fund
WHO	World Health Organisation

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CHAPTER I

INTRODUCTION

1.1 Background

Health and economics are critically related and health system performance incorporates goals that are related to health care financing and economics. Like any other country Myanmar's health care financing policies has evolved according to numerous and ever-changing conditions, such as populations changes, disease burdens shift, new infectious diseases and changes in economic and political landscape.

Health care had been provided free of charge in public hospitals in Myanmar following independence from British rule in 1948 through the socialist era. Following expansion of health facilities with subsequent need for more medicine annual budget allocation for medicine grew. With the advent of market economy following change in the political system within the country, together with growing prices of medicine necessitating more budget allocation for procurement of medicine, combined with the expansion of more health facilities resulted in expenses outpacing revenue. Provision of free medical care with government budget alone became no longer practical. Imposing charges for medicine to those who can afford was considered as an option for overcoming this. It was also expected at that time that this will also ensure availability of essential medicine adequately as and when needed by raising seed fund from sale of medicine to those who can afford in time of seeking medical care. In this way Community Cost Sharing scheme was introduced into the country in 1993 (Aye et al., 2007).

Current situation of Myanmar health care system can be described as a plural mix of private and public sectors, in both financing and provision of health care, with the Ministry of Health acting as the main provider of comprehensive health care("Health in Myanmar"2009). Based on the National Health Accounts (from 1998 to 2008) the total health expenditures on health have been increasing from twenty nine thousand million Kyats in 1998 to six hundred and seven six thousand million Kyats (1US dollar =

850kyats) in 2008 within a period of 10 years. We must note that this total health expenditure include not only expenditure of Ministry of Health but other ministries such as Ministry of Defense, Mines, Railways, Industry I, Industry II, Energy, Home affairs and Transport. The total health expenditure as a percentage of GDP also increased from (1.9) per cent in 1998 to (2.1) per cent in 2008. General government expenditure on health as a percentage of general government expenditure rose from 0.7 per cent in 1998 to the highest of 1.5 in 2002, followed by the slow decline to 0.9 per cent in 2008. Although government health expenditure has been increasing it is not in pace with the GDP and percentage of government expenditure has been failing to meet increasing population and health care demand. The private sector remains the major source of health care financing, accounting for 90 percent of total health expenditure (National Health Accounts, 1998-2008). This means families have to pay out of pocket and recent household studies show that 30 percent result in catastrophic health spending (Obermann, Sein, and Griffith, 2009). There is no form of health insurance in Myanmar.

1.2 Problem Statement

Health care financing in Myanmar is mainly based on the Community Cost Sharing Scheme which was first implemented in 1993. It is simply a user fee system, with the primary objective of cost recovery, where the rich have to pay and the poor are given exemption. Monks, prisoners, patients during outbreaks and medical emergencies are also given exemption. However there seems to be no clear policy guidelines on giving exemption. Who gives the exemption? Who is entitled to receive exemption are questions which still need answering. User fees charged does not include consultation fees for doctors and nurses but patients have to pay out-of-pocket for the drugs, X-ray, laboratory diagnosis and use of medical equipment. Pay wards are also one source of cost recovery for the hospital. Whether there is practice of standardized user fee in all hospitals remains unknown. No consultation fee for doctors and nurses also mean that the health providers receive no incentive from this scheme, and studies in other countries highlight the

presence of informal payments in such situations where providers are not appropriately compensated (Bitrán and Giedion, 2002).

The revenue generated from the user fees are divided into 3 portions (1) 50 percent for government revenue (2) 25 percent for drug and medical equipment replenishment and (3) 25 percent for maintenance according to guidelines provided by the Ministry of Health. The sufficiency of the costs recovered from user fees to be able to cross subsidize the poor and replenishing drugs and medical equipment remains a grey area which needs further exploration.

The concept of Community Cost Sharing also requires the involvement of the whole community in the decision making process, raising funds and use of resources. Little is known about the level of involvement of the Myanmar community in Community Cost Sharing Scheme.

The concept of community cost sharing scheme sounds good in theory but have many difficulties in implementation. To clearly understand to which extent this Community Cost Sharing Scheme has been effective in protecting the poor from catastrophic health spending and underlying difficulties in implementation needs further exploration.

1.3 Justification

A few studies(Kyi, 1993; Sanda, 2002; Tangcharoensathien, 1999) which look at the health facility utilization patterns in relation to implementation of CCS Scheme have been done during the past years, however these studies fail to examine the perceptions of the community especially the poor. This study aims to fill the knowledge gap by using qualitative methods as to help identify the poor within the community and elicit their perceptions on community cost sharing scheme.

Moreover, as Myanmar is a developing low income country striving towards achieving its health goals, re-evaluation of its mainstay health financing scheme is more than essential. This study aims to contribute towards future policy making decisions by covering a comprehensive view of the current practices to identify barriers and

difficulties in implementation of community cost sharing scheme from the perceptions of both health providers and consumers.

1.4 Objectives

General objectives

To assess the perception of health consumers and health providers on the existing practice of community cost sharing scheme in providing equitable access to health care.

Specific objectives

1. To describe the actual practice and difficulties faced in implementing community cost sharing scheme at the township hospitals.
2. To elicit the perceptions of the poor concerning community cost sharing scheme.
3. To explore the sustainability of Community Cost Sharing Scheme in terms of revenue generated from user fees and trust funds at township hospital.

CHAPTER II

LITERATURE REVIEW

2.1 Health Care Financing In Myanmar

Myanmar is a developing country and like most developing countries has been trying to fulfill health care needs of a growing population with available resources for health care services. Adequate and sustainable financial support is a vital requirement for providing health services with the objective of raising the health status of the people. There are several methods of financing health care, each of which has its own strengths and weaknesses. The method that a nation chooses to employ depends greatly on its history, culture, and current institutions and on the trade-offs in objectives that the nation is willing to make.

Myanmar experienced different types of health care financing throughout history in accordance with the changing political scenario. After gaining independence in 1948, Myanmar enjoyed free health care services where the expenditures were provided through general government tax revenue. In 1956 Myanmar established the Social Security scheme, which is the sole social health insurance scheme in the country under the Ministry of Labor. However, coverage of the scheme remains low at 0.89 per cent of the total population in 2006 (Department of Health Planning, 2006). Myanmar started to practice Socialist System in 1962 and during the period of 1962 to 1974, all the sectors including health sector were owned by government. There was very limited private sector for health care in that period. Government taxation and international aid from WHO, UNICEF remained the major source of financing for health care during that period. After 1988, with the emergence of market-oriented economic system in Myanmar which paved the way for the growth of the private health care sector and with the growing population and development of border areas, health care cost could not be considered as only the sole responsibility of the government but also the coordinated effort and responsibility of the community and also the willing contribution of the non-governmental organization.

The establishment of the National Health Committee in 1989 lead to the formulation of fifteen National Health Policy guidelines, in which one stated " To explore and develop alternative health care financing system", which lead to a number of health care financing reform activities.

2.2 Concept and Emergence of Community Cost Sharing in Myanmar

According to Jakab and Krishna (2001), there are four general models of community financing schemes:

(i) The first model is **community cost-sharing scheme**, where the resource mobilization instrument is out-of-pocket payments. Although the community participates in setting user fee levels and developing and managing exemption criteria in this design, it ***lacks prepayment and risk sharing***. The Bamako Initiative is a good example of this model, which does not meet the key characteristics of a community based health insurance (CBHI). It is to be noted that user fees are generally inequitable as they can post as barriers to access to health care by poor.

(ii) The second model is **community-based pre-payment scheme or mutual health organisation**. Schemes under this model involve voluntary membership, prepayment, and risk sharing. Catastrophic benefits are also covered. There is a very strong involvement of the community in designing and managing the scheme. An example of this design is Grameen Health Plan of Bangladesh.

(iii)The third model is **provider-based community health insurance**. Schemes under this model are centred on single provider units. These may be a town or a city or a regional hospital. Although the elements of voluntary membership, prepayment, risk sharing and coverage of catastrophic benefits are there, they are initiated by the providers themselves or through donor support. Bwamanda Hospital insurance scheme in the Democratic Republic of Congo is an example of this model.

(iv) The fourth model is **government or social insurance-supported community-driven scheme**. In this model, the schemes are attached to formal social insurance arrangements or programmes run by the government. The Thai Health Card scheme is an example. This model should not be included as a CBHI since it possesses minimal grass-root community involvement.

Community Cost Sharing (CCS) approach in Myanmar started in 1989 in terms of cost recovery when the WHO introduced the Essential Drugs (ED) Programme. The government provided funds and technical assistance to assist the ED project in nine pilot townships for four years. Since then the developments of the project began and has been followed by various CCS projects, namely the Community Health Management and Financing (CHMF) project funded by the Nippon Foundation; the Myanmar Essential Drug Project (MEDP) funded by WHO; the Human Development Initiative-Extension (HDI-E) project funded by UNDP; the Central Medicine Store Deport (CMSD) funded by the government (Supakankunti, 1999).

Implementation of Myanmar Essential Drugs Project (MEDP) in 1989 started with all essential drugs being provided free of charge at four pilot townships till 1993, after which MEDP introduced cost sharing system for essential drugs. Following the concepts and principles of essential drug the basic health division of Department of Health introduced the drug financing for essential drugs using Community Cost Sharing (CCS) system in additional townships with the assistance of Nippon Foundation in 1994. Up to 1999, CCS for essential drugs was operating in 54 townships by MEDP and 72 townships by basic health division. Starting from 1994 Department of Health introduced a user charges system for selected items of drugs. Total of forty three items of drugs included in the essential drug list were charged at factory price of Myanmar Pharmaceutical Factory. This was the cost recovery scheme for selected items of drugs supplied at public hospitals. Exemption can be made for those who cannot afford, by the decision of respective medical superintendent or township medical officer. All revenue except a small margin added for overhead charges of drug stores, are credited to government

accounts. The revenue collected from selling drugs supplied by Central Medicine Store Deport (CMSD) in 1999 was kyat 19.9 million (Kyaing, 2000).

According to recommendation made by the 11th National Health Committee meeting, with the aim to achieve adequate and sustainable financial support Myanmar extended the Community Cost Sharing Scheme in 1993 with the introduction of user fees for all health services at public hospitals, in which the poor are given exemption (Health in Myanmar, 2009). The Community Cost Sharing Scheme in Myanmar context requires the cost for the drugs, medical equipment laboratory tests, radio-imaging, private room, physician and nurses fees to be paid by those who can afford. Only after 2001 that physician and nurses fees are not necessary for pay according to the decision made during the 31st National Health Committee meeting.

The revenue from the CCS was divided into four portions (25 per cent each): (i) government revenue, (ii) maintenance, (iii) drug and medical equipment replenishment, (iv) staff's welfare. Starting from 2007 this revenue is divided into only three portions (i) 50 percent going to government revenue, (ii) 25 percent is for drug and medical equipment replenishment, (iii) 25 percent is for maintenance. The percentage going to government revenue is used for human resources and capital assets for high technology medical equipment (Aye et al., 2007). The Community Cost Sharing Scheme is being implemented in all hospitals levels expect Station hospitals. Both of the decisions in 2001 and 2007 meant that health providers do not gain any benefits from the CCS scheme expect their fixed government salary.

A unique feature of the Community Cost Sharing Scheme in Myanmar context is the building up of trust funds in hospitals by the donation of well wishers. Trust funds are kept normally as saving accounts at banks and the annual interests earned from that account can be utilized according to the rules set by trust fund management committee or hospital management committee. Normally certain amount from earned interests is put into main trust fund account in order to increase the fund. One of the main objectives of trust funds is to finance the cost for waiving poor patients who cannot pay for the costs of

care at public hospitals. The policy for Trust Fund is ONE BED ONE LAKH (100,000 Kyat) where trust funds are to be proportionate to the bed size of the hospital. Only the interest from that fund has been used for the patient who couldn't afford the cost for hospitalization.

Community cost sharing scheme has been developed in many developing countries and comprehensive evaluation studies from Africa, Nepal, Indonesia, Thailand and Costa Rica shows that user charges have been implemented by the governments, where the cost recovered are used to replace government revenue rather than to supplement it, making the users view that they have to pay for the health services rather than contributing. These programmes are mostly not well managed and decrease in level of utilization is seen (Suryawati , 1997).

2.3 Consequences of User Fees for Health Care in Developing Countries

Government budgets for the health sectors have failed to keep up with population growth and health demand, and many poor countries have resorted to the widespread implementation of formal or informal user fees for health care in government health systems (World Bank, 2002). User fees are refered to the out-of-pocket charges at the time of use of health care (Arhin-Tenkorang, 2001). However user fees as a source of revenue can only be implemented in the context of having preconditions such as (i) Purchasing power of the consumers (ii) Quality of the services as perceived by the consumers (iii) Prices of other goods and services (Yisa, Fatiregun, and Awolade, 2004). User fees are generally an output based payment because the health facility gains income if the services that it is charging for are delivered. Poor performance in terms of provision is directly reflected by reduced revenue. However, when a government pays fixed wages and supplies drugs for free, the health facility gains resources irrespective of its production and is therefore operating under an input based payment regimen. The difference in payment regime for the providers makes a difference to the quality of serives and under input based payment regime, it should not be expected to improve

quality, since providers receive a constant income, irrespective of their performance (Meessen , Damme , Tashobya and Tibouti , 2006).

As demand for health is considered to be inelastic, it is practical to say that demand will drop little if charges are made. Therefore user fees are imposed on health services to generate revenue. However such systems which require direct payments at the time people health need care – including user fees and payments for medicines – prevent millions from accessing health services and result in financial hardship, even impoverishment ("World Health Report"2010).

The pros and cons of imposing user fees in developing countries remain debatable. According to Steven Fabricant (2006) user fees are used for deterring unnecessary demand for health and to encourage primary health care facility usage. However this may not hold true for developing countries in which insufficient demand for health services is common and where primary health care institutions are least developed. On the other hand it was argued that even though user fees are intended to raise funds for running facilities by charging modest amounts in comparison to private sector, most of the funds raised do not act as supplementary to the government budget but end up as substitute. It was noted that even low user fees can suppress demand for health and in reality low revenue generated by modest user fees can be replaced by a small increase in public funding to ensure free health care. International analysts have also suggested that using revenues from user fees to improve the quality of services will generate efficiency and equity gains through their impact on utilization (Griffin 1992; Shawand 1995; World Bank 1987, 1993). However, while some countries have employed user charges to foster efficiency-related objectives, such as discouraging unnecessary use and preventing by-passing of lower level facilities, only one of the countries surveyed by Nolan and Turbat (1995) explicitly identified improving equity as an objective.

The objective of imposing users fees has been seen to differ from one country to another but the majority was used to subsidize certain users (e.g. poor) and also to promote efficient use of certain services by price differentiation (Russel & Gilson 1995).

However support for the abolition of user fees gained strong momentum in 2005. The Commission for Africa Report argued strongly that primary health care and education should be provided free to users. The experience of Uganda (where fees were abolished in primary care facilities in 2001) shows that with sufficient political commitment the elimination of fees can have a very positive effect (Pearson, 2005).

2.4 Exemption mechanism for the poor

According to Jacob andPrice (2007) in countries where user fees for health care services have been introduced in the public sector, exempting the poor from payment is the main mechanism advocated for protecting the poor and ensuring equity of access to services. Identification of the poor in the exemption mechanism and who gives the exemption remains major obstacles. A main reason behind the practical difficulty of telling poor from non-poor resides in the incentives facing the non-poor to misreport their identity.

Ricardo and Ursula (2002) identify four methods as for classification and choice of individuals needing protection as:

(i) The **Individual identification method** in which a person is judged on his income, assests, health and nutritional status by a social worker or health staff is mainly based on ability to pay. However in an informal economic setting assessing income may prove difficult.

(ii) The **Identification based on group characteristics** is applied to a whole community in a certain geographic area known to be poor and no effort is made to filter out the non-poor minority on efficiency grounds.

(iii) In **Self-identification** method, no effort is made by the agency granting the protection to identify its recipients because individuals self-select. That is, the health services are provided in such a way that it is mostly those individuals eligible for protection who will come forth and demand the services, whereas non-target persons will mostly demand services elsewhere, due to reasons such as long waiting line, safety and stigmatization.

(iv) The idea of **self-selection by service type** is to offer subsidized services that, for epidemiological, cultural or other reasons, are demanded disproportionately by the poor, or target group, given the special health circumstances and income constraints they face. This is the main idea imbedded in the supply of a basic package of health services in developing countries. The treatment of dehydration from diarrhea, nutritional supplements, and the caring for sexually transmitted disease and tuberculosis are all examples of services that, if made universally available, would especially benefit the poor.

A study in Kenya showed that nurses, clinical and medical workers, and other professional staff are usually in charge of granting waivers, an activity that interferes and competes with their regular health care duties. The process of assessing and exempting patients is thereby often delayed or postponed. No explicit policy is in place to compensate facilities for revenue foregone due to waivers and exemptions, and thus more waivers and exemptions mean less revenue for the facilities (Owino and Were, 1999).

It has been stated in one of the few evaluation studies of the implications of CCS in Myanmar as follows "in practice, there is no systematic arrangement for exempting the poor […] a recommendation letter from local authority is used for exemption, but in-depth interview found no one producing it […] in practice there was not a single out-patient exempted from drug charge" (Tangcharoensathien, 1999).

2.5 Research methodological issues

The nature of current study is a formative research. A formative research is an exploratory tool to provide feedback to project managers to help them adjust programme objectives. Formative research studies use a mix of research methods that can rapidly provide relevant information to programme managers. These methods include: reviews of existing information; focus group discussions and individual in-depth interviews (Rehle, Saidel , *et al*, 2001)

The most frequently cited methodological criticism of formative evaluation is its lack of external validity or generalizability. Because the results derive from small-scale rapid

assessment procedures, one cannot generalize from them to a larger population. Despite this limitation, formative evaluation research can usually identify unacceptable or ineffective intervention approaches and designs. I believe this will be a helpful tool to answer my objectives.

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CHAPTER III

RESEARCH METHODOLOGY

3.1 Conceptual Framework

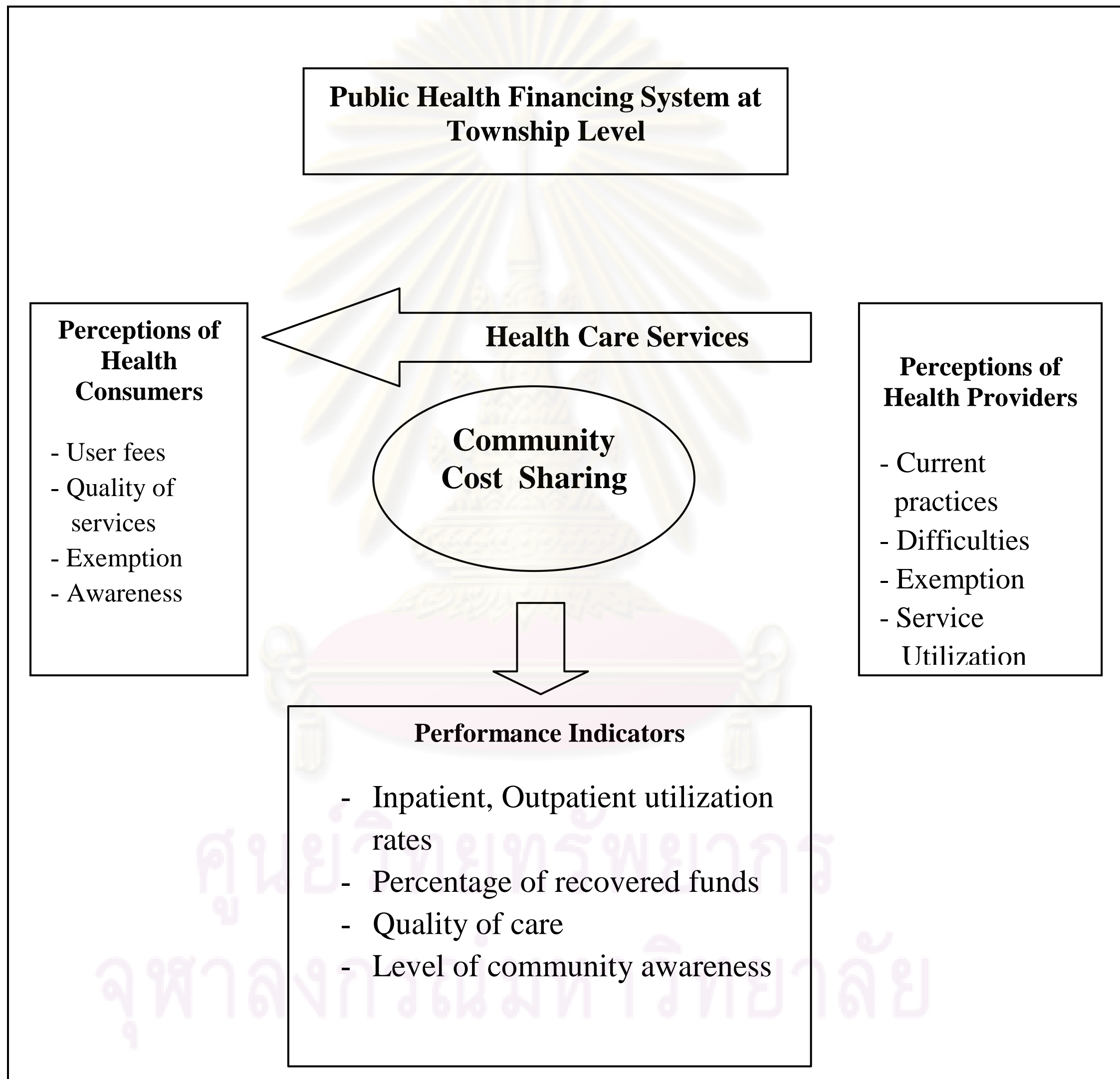

Figure 3.1 Conceptual Framework

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3.1 Study design

Cross-sectional descriptive study using qualitative participatory methods was conducted at the two township hospitals and at one village in each township.

3.2 Study area

Two townships Hmawbi and Hlegu from within the Yangon division were purposefully chosen based on the information gained from prior key informant interview with personal from Department of Planning, Ministry of Health. The townships were chosen since it represented a rural-urban population with low and middle income class families which has to greatly rely on government delivered health care services and these were the populations which were more likely to be impacted by the Community Cost Sharing Scheme.

Hmawbi has a total population of 180,945, with 23,432 residing in urban area and 157,513 residing in rural area. Hlegu township has a total population of 185658, consisting of 27,983 in urban and 157,675 in rural area (Department of Health Planning, 2008)

Both townships have a 50 bedded hospital catering its health needs.

3.3 Study period

The study took place from 20th February 2011 to 18th March 2011.

3.4 Study Population

The study population was from two different settings: Hospital based setting and Community based setting which best allowed a comprehensive insight into the current situation of Community Cost Sharing Scheme.

Hospital based setting included not only inpatients and outpatients but also the administrators, doctors, nurses, clerks, compounder(dispenser) and laboratory technicians engaged in Community Cost Sharing scheme at the hospital.
Community based setting was done to capture the voices and perceptions poor members of the community who may face challenges with Community Cost Sharing Scheme.

3.5 Sampling Methods

3.5.1 Sampling of Health providers

In this study a total of 18 health workers were sampled from both township hospitals. Within each township health providers from the township hospital were sampled according to their job title. Health providers were divided into the following categories: Township Medical Officer, Medical Officer, Nurse, Clerks, Compounder (Dispenser) and Technicians.

Table 3.1 Number of appointed personal and respondents from township hospitals

Job Title	**Personal in Hmawbi**	**Respondents from Hmawbi**	**Personal in Hlegu**	**Respondents From Hlegu**	**Total Respondents**
TMO	1	1	1	1	2
Township Health Nurse	1	1	1	1	2
Clerk	1	1	1	1	2
Compounder (Dispenser)	1	1	1	1	2
Medical Officer	3	2	3	2	4
Nurse	4	2	4	2	4
Technician	1	1	1	1	2
Total		9		9	18

In cases where there was more than one appointed person, the persons who have worked the longest at the hospital were chosen to be interviewed. Focus Group Discussion (FGD) was not carried out among health providers, because respondents would prefer to keep their opinions on community cost sharing scheme confidential. In depth interview (IDI) was performed with the health workers according to the in depth interview guideline in Annex 3.

3.5.2 Sampling for Health Consumers

Hospital setting

A total of 12 outpatients and 12 inpatients from both township hospitals were sampled in this study.

According to the health profile of the two townships (Department of Health Planning, 2008) average number of inpatients per day and average number of outpatients per day was 45 and 14 for Hmawbi and 33 and 24 for Hlegu township, with an average duration of stay of 8.8 days and 4.6 days respectively. Based on this data, we decided to include in this study 6 outpatients and 6 inpatients of both sex who are above 18 years of age from each township hospital.

Criteria for outpatient**:** Age - above 18 years, Sex - both male and female

Criteria for inpatient: Age - above 18 years, Sex- both male and female

Inpatients included in the study were those that had been admitted for at least 7 days.

Exclusion criteria: Patients who were critically ill, mentally unstable and those wishing not to take part were excluded.

On the day of data collection patients attending to the hospital outpatient department matching the outpatient inclusion criteria were selected. Inpatients matching the inclusion criteria that were discharged on the day of data collection were selected for in depth interview. In both cases a balance in gender was considered but strict gender specification would have made the study unfeasible. Female respondents who had recently given birth were also included.

After explaining to the patients about the purpose of the study, informed consent was taken and an In Depth Interview (IDI) was done outside the hospital compound at a non-threatening place, using the guidelines shown in Annex 4.

Community Setting

During the study Myaung Dakar Village from Hmawbi township and Kyun kalay village from Hlegu township were chosen to carry out the community based study since they were within the criteria range of 3-5 miles walking distance from the study township hospital and this was considered as the distance which the poor were willing to walk to receive health care. In this study a total of two focus groups were organized in each village consisting of participants who satisfied our criteria of poor members of the community who have had some health problems(or pregnancy experiences) themselves or among immediate family members.

In this study poor members of the community who have never received or have attempted but have failed to receive health care from the Township Hospitals were identified. A two-steps approach was taken in which the first step was to identify the poor of the village, through informal discussion with local elders and leaders. Within Myanmar community the term “Let-loke-let-sar”(literally meaning those working with hands and eating with hands) or “kya-barn”(odd job) is referred to poor families. The local village elders and leaders had knowledge of poor and non-poor since they were very familiar with the community and they were asked to identify people from their village with this community description and to organize a meeting at a non-threatening area such as a school building or local monastery at a fixed time. Then from that group the investigator identified the marginalized group who have not come to use or have failed attempt to use health care service. The local village authorities were asked to organize a meeting of at least 12 individuals (6 male and 6 female) of mixed gender who are between ages 18 and 55. One Focus group discussion (FGD) was done in each village with these individuals using the guidelines shown in Annex 5.

Table 3.2 Population and distance of study village from townships

	Myaung Dakar Village (Hmawbi Township)	Kyun Kalay Village (Hlegu Township)
Population	639	535
Households	140	110
Distance from township hospital in miles	3	5
Informal interview with village elders	4 males and 2 females	5 males and 3 females
Poor interviewees in FGD	5 males and 3 females	6 males and 6 females

3.6 Data Collection Techniques

Data collection was conducted from 20th February 2011 to 18th March 2011. The data collection team was formed with one primary investigator and four co-investigators. Before starting of the study, one week of intensive training of all investigators was conducted which included discussion with resource person from Department of Health Planning to familiarize with the concepts of Community Cost Sharing and pretesting of IDI and FGD guidelines to provide the investigators with insight into how their target group members will react to certain lines of questioning. Some questions were rephrased and new questions added according to the issues which came up during of the pre-testing of the guidelines.

3.6.1 Conducting Focus Group Discussion with the Poor

- A visit was made to the selected village in the morning. An informal meeting took place with local elders and local leaders. (Information for this Meeting was sent in advance to the village authority with the kind assistance of the TMO of the township concerned).
- During this informal meeting, the authorities were explained about the study and informed them that what would be elicited from this study will be beneficial for the rural people in general and poor families in particular as regards how to provide financial protection for them by the Government.
- They were be asked to identify six women and six men, from different families, and whose ages are 18-55 years who have had some health problems(or pregnancy experiences) themselves or among immediate family members., from "Let-loke-let-sar" (or, "kya-barn") families staying in different sections of the village. As already described, the term is understood well by them as reference to poor people.
- Starting time for FGD was set at 1:00 pm, which was the time when "Let-loke-let-sar" family members of the village have returned from their work in the field and have had their lunch. In both villages venue was set at a monastery which was a non-threatening place. The village elders and the leaders were told not to force for the participation of the poor people. However during the study at Myaung Dakar village in Hmawbi township we were only able to conduct the FGD with 5 males and 3 females since the interviewees did not turn up.
- No inducement was made to the poor participants. But, as tokens of expressing gratitude for their participation, they were given small gifts at the end of the FGD session.
- **Facilitator:** The most important point was that the facilitators avoided being placed in the role of experts and that they were appropriately dressed as a common villager.

- **Note taker**: Two persons acted as note takers (recorder) in each FGD session. They sat within listening range on the opposite side of a semi-circle facing the participants. The recorder kept a record of the content of the discussion as well as taking note of emotional reactions (if any) and important aspects of the group interaction.

In accordance with the key characteristic of FGD, participants were not expected to reveal personal experiences. The emphasis was on the participants' opinions about what "people like them" were doing or might do, rather than on the participants' personal behaviour.

In addition, **quantitative data** was also incorporated whenever considered relevant and available. The themes discussed in the conceptual framework were taken into consideration for acquiring information whenever considered relevant in all the interviews. Some of the key quantitative data that was collected included:

- Inpatient and outpatient data from hospital records
- Health expenditures: percentage of households facing catastrophic health expenditures
- Effect of catastrophic health expenditures on household assets
- Examples of lending schemes for health; effect on households over the following years, e.g. paying interest and re-payment as percentage of household income

These quantitative data were explored during Informal Interviews with local leaders and elders, and during FGD with poor members of the village. However, being neither individual structured interviews in a household survey, nor individual in-depth interviews with persons having experienced catastrophic spending, we collected stories told by selected informants.

3.7 Data compilation and analysis

All interviews were recorded and transcribed in Burmese. All transcriptions were also translated into English. FGDs with were transcribed and organized on the basis of emerging themes and sub-themes. Investigator read over the transcripts to identify themes before organizing data. Matrix analysis was done manually on findings according to the key themes of the findings of informal interviews, in depth interviews and focus group discussions. Some triangulation was undertaken from findings of different data collection methods.

3.8 Ethical consideration

Informed consent was obtained from the respondents after explaining to them the objectives of the study and assuring them that their names, positions will be kept confidential during the writing up of the findings.

CHAPTER IV

RESULTS

4. 1. Township health profiles of study townships

Table 4.1 Population and health indicators on study townships

	Hlegu Township	**Hmawbi Township**
• Population (Total)	185658	180945
(Urban)	27983	23432
(Rural)	157675	157513
• Population density	103.89 per sq-km	359.52 per sq-km
• Ward	5	4
• Villages	179	205
• Township hospital(50 bedded)	1	1
• Private clinics	8	12
• IMR/1000 live	11.7	18.4
births	18.5	24.0
• U5MR/1000 live	0.5	1.2
births	270	507
• MMR/1000 live		
births	31	32
• Total number of deliveries		
• Total annual number of deaths		

Source: Township health profiles of Hlegu and Hmawbi Township Health Departments, 2008

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The results of the qualitative findings from in depth interviews and focus group discussions with health providers and health consumers are shown as a collective summary according to emerging themes and sub-themes rather than revealing individual specifics such as names and workplace to protect the confidentiality of the respondents.

4. 2. Health Providers Perspective

Theme 1: Current Practices of Community Cost Sharing

When the health providers were interviewed only those directly involved in CCS at the hospital could explain well the current practices being done in hospitals and the rest of health personal have just heard of it but are not clear on the procedures.

The township medical officer and the compounder or pharmacist were identified as the key informants who could give a comprehensive view of the current practices of community cost sharing, since they were the main persons responsible in the hospitals. We learned that CCS has four main revenue sources which are from (a) selling drugs provided by Central Medical Supply Depot (CMSD) (b) Fees charged for Radio Imaging (c) Fees charged for Laboratory Tests and (d) Fees from pay rooms.

According to the interviews the funds are managed by the Township Health Committee (Annex 6) and monthly reports are sent to the Ministry of Health. Each month the initial cost of the drugs, radio imaging and laboratory tests are removed from the revenue generated and it is deposited into an account called Ministry and Department Accounts (MD account) which all go to Union Consolidated Government Fund(UCGF).

The remaining revenue is divided in 3 portions (1) 50 percent for government revenue (2) 25 percent for drug and medical equipment replenishment and (3) 25 percent for maintenance according to guidelines provided by the Ministry of Health. The 50 percent which is allocated for government revenue goes to an account called the Others Account (OA) in which the money deposited in this account can be borrowed again by the respective township hospital by the approval of the Township Health Committee. Funds in this OA account can be used as initial start up money for the revolving drug funds. This finding leads to the understanding that all revenue generated by the hospital from

CCS scheme remains under the authority of the Township Health Committee in the OA account.

Table 4.2 CCS revenue of Hlegu township hospital in 2010

Revenue (Income in Kyats)		Revenue (Expenditure in Kyats)	
Selling drugs and medical equipment	3,915,367	MD Accounts (Ministry and Department Accounts)	1,093,679.25
Radio imaging	224,550		
Laboratory Test	83,900	OA Accounts (Other Accounts)	3,281,037.75
Room Charges	150,900		
Total	4,374,717	Total	4,374,717

Exchange rate: One US dollar = 850kyats

Table 4.3 CCS revenue of Hmawbi township hospital in 2010

Revenue (Income in Kyats)		Revenue (Expenditure in Kyats)	
Selling drugs and medical equipment	4,868,540	MD Accounts (Ministry and Department Accounts)	1348497.5
Radio imaging	283,900		
Laboratory Test	32,600	OA Accounts (Other Accounts)	4,045,492.5
Room Charges	208,950		
Total	5,393,990	Total	5,393,990

Exchange rate: One US dollar = 850kyats

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Table 4.4 Revenue Generated from CCS in each township(2006-2010)

Year	Hmawbi Township	Hlegu Township
2006	3,836,799	4,483,719
2007	5,872,651	7,441,944
2008	5,233,800	2,974,034
2009	4,587,480	5,600,115
2010	5,393,990	4,373,717

The revenue generated from CCS in Hmawbi and Hlegu townships were not constant over the past five years and it showed a slight decreasing trend in Hlegu township.

The highest revenue generated was from the selling of drugs and medical supplies in both townships, followed by the revenue generated from pay room fees. Health providers expressed their views on revenue generated as:

"*…we charge 700kyats/day for pay rooms and they create good income for the hospital so our hospital has extended the number of pay rooms…*"

Drugs and medical supplies sold as part of CCS scheme are only drugs and medical supplies provided from the Central Medical Store Depot (Annex 8). According to the regulation of the Ministry of Health, the Township Health Committee is allowed to add on a profit of 10-15% when selling the items, except for the drugs for malaria, TB, Leprosy, HIV, oral rehydration salt and anti-snake venom which are to be given free of charge at the hospitals. The drugs and medical supplies are supplied 2 times each year according to the indent prepared by the hospital. One health staff expressed her view on drugs provided by CMSD as

"*… .we make an indent of our requirements but we only get what they give and CMSD drugs are never enough and we always have a shortage of supply…*"

However the health providers made it clear that CCS scheme is not profit oriented but aimed for cost recovery and sustainability of the services. The mark up price is mainly for covering the costs of the scheme and not enough for major procurements. All health staff agreed that revenue generated from CCS can only cover for minor costs and cannot contribute much for major procurements. A hospital staff with 22 years work experience expressed his view on CCS as:

"*… in my view what the government tried to do was compete with the private sector. The government knew people were willing to go to private clinics, so they expected that people will still utilize public health services if charged at a lower rate….*"

Health staff acknowledged that the intention of introducing user fees at health facilities were to collect funds to help run these facilities by introducing modest fees which were lower than private clinics, in order to help the poor reduce the high out of pocket payment and increase their demand and consumption of health services.

The overall response of the health staff held a positive tone in regards to the benefits of the current CCS scheme in regards to being able to give reasonable health care but majority of health staff acknowledged that although it has been implemented for a long time, there is still room for improvement.

All health staff confirmed that there is also no benefit for them from this CCS scheme.

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Theme 2: Alternative Health Financing Schemes

The interview with the health staff were able to reveal that CCS is not the lone health financing system practiced at the township hospital but it is augmented by two alternative health financing schemes at the township hospital. One is known as Trust Fund in which the policy for Trust Fund is ONE BED ONE LAKH (100,000 Kyat) where trust funds are to be proportionate to the bed size of the hospital. Only the interest from that fund has

been used for the patient who couldn't afford the cost for hospitalization. The trusts funds are raised mainly by the donations of the community. The degree of mutual concern that community members have for each other (social capital) within a typical Myanmar community is reflected by the donations of well-wishers which helped raise the funds. A typical example of the donation money being used for improvement of the hospital conditions was seen in one township hospital:

"… *Sayadaw (high ranking monk) have helped us in raising our funds and we have been able to provide clean and free drinking water system in our hospital with the donation money…*"

Hmawbi township hospital has set up 5.6 million kyat and Hlegu has set up 5.2 million kyats as trust funds. All the trust funds are kept in the OA account.

Since shortage of drug supply was a common problem seen among township hospitals, another alternative health financing mechanism which was set up was the revolving drug funds, from which the money from OA account is borrowed as start up money to buy drugs which are not included in the CMSD drug list. The revenue collected from the sale of drugs are used for replinishing the drug supply. The drugs from the revolving drug fund are also sold at a lower price than private pharmacies. This finding was also confirmed from the interviews of the patients.

Theme 3: Training and assignment of jobs

Majority of the staff in the interview had not received any formal training concerning CCS but they said they learned from their senior colleagues when they first arrived at the hospital. A few staff has attended workshops but many years ago. From the interviews emerged the key role players in the community cost sharing at the township hospital to be the township medical officer and the compounder or the pharmacist.

"… I am appointed as a compounder at this hospital but have to carry out record keeping, accounting, and reports concerning with CCS in my hospital…"

".… I believe that if we have a person specifically appointed, such as an account, to carry out CCS functions it will improve. Now I feel that I cannot do my routine work as a nurse.…"

This revealed the lack of personal trained and appointed specifically for community cost sharing.
The health staffs expressed their reluctance to carry out CCS functions as they feel they are not trained to handle such matter and fear of making mistakes and are felt burdened by the extra workload. A common line of answering when asked about the difficulties faced during implementing of CCS.

"*…Of course there are difficulties (laughing) …. Sometimes we have to make things work…in our own ways…*"

The main problem faced by the health workers is the management of different accounts of the different health financing schemes.

Theme 4: Exemption of the Poor
When asked about the exemption of the poor at the hospital one staff pointed to the sign and said:

"*…. In front of the hospital we have put up a sign which reads as Free Health Care is given to the poor at this hospital and we practice community cost sharing for those that can pay…..*"

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Inpatients are the majority whom need to be given exemption. The number of exemptions given varied from 10- 15 patients each month and the maximum cost of the exemption can be around 200,000kyats depending on the case. Health staff explained that the cost of exemption varied since there are cases of partial exemption in which patients would pay only for what they can and the hospital funded the rest of the medical expenses. However there are patients who were very poor and could not pay at all and in that case the hospital had to cover all its costs. In such cases, the TMO has the authority to give exemption and pay the costs of drugs, medical equipment, laboratory testing and radio imaging by using the revenue of the revolving drug fund and interest of the trust funds.

However services such as childhood immunization, ante-natal care, treatment of malaria, tuberculosis, human immunodeficiency virus and leprosy are health care services to which all individuals are given exemption.

The interviews pointed out that the TMO was the main authority who could give exemption. The patient was judged as either being poor or not mainly on his clothing and personal appearance at the time of admission. Usually the village mid-wife would accompany the patient and the word of the village mid wife was taken as granted for the social status of the patient. The hospital also gave exemption to patients coming with a letter from respective village or township authorities in support of their social status.

Hospital staff say that they practiced the policy of treat first, ask money later which raised difficulty for them, since some patients do not pay once they have become well. There have been cases of patients who are not poor but refused to pay claiming to be poor. Nothing can be done in such situation. The health staff expressed their frustration and in dealing with patients who cannot afford health services.

"*.. one thing I hate about this job is asking people for money after treatment is given. It is very difficult to ask for the cost of the treatment once the person is well and I am quite reluctant to do it…*"

"*.. there was a case of a woman seen taking off her jewelry before entering the hospital and demanded free treatment, claiming to be poor…*"

"*… a pregnant women whose husband worked at the factory (meaning to have good income) came for delivery at our hospital but had to be transferred due to complications. We gave her the necessary care and even arranged for transportation. When she was well, she later came back to our hospital to get the birth certificate of her child. We explained to her of the costs of her medical treatment and to pay as much as she can. But she never paid…*"

Concerning the availability of funds to give exemptions the majority of health workers claimed that by giving unnecessary exemptions they are faced with the difficulty of insufficient revenue. Health providers reported that they tried to encourage the patients to give as much as they can to contribute towards cost sharing. This reflects the reluctance of the health providers to forgo significant revenue by giving exemptions.

Theme 5. Perceptions on Utilization of Health Services

Health providers believed that the patterns of using health services have increased over years. While the interpretations of the reasons are not consistent, doctors reported increased patient usage of the health services. Some doctors believe the reason is that the health status of the patients has worsened. Others, see the reason as improved health services and people becoming familiar with the concept CCS scheme. One health worker expressed his view on the utilization of services as:

"*… people have come to use our health services more because it is much cheaper than private clinics. They do not have to pay for doctor and nurses fees and drug prices are lower than outside…*"

Some doctors reported an increased workload due to the increased number of patient visits.

Table 4.5 Showing hospital utilization rates at Hlegu and Hmawbu Township hospitals

Year	Hlegu Township				Hmawbi Towship			
	IP No.	Admission rate	Occupancy rate(%)	OP No.	IP No.	Admission rate	Occupancy rate(%)	OP No.
2006	2665	0.014	62	5692	2256	0.012	92	4368
2007	2626	0.014	88	5024	2147	0.011	85	5372
2008	1302	0.007	42	6226	2002	0.011	98	5096
2009	1810	0.009	61	6021	1783	0.009	100	6372
2010	1427	0.008	66	4736	1820	0.010	91	6280

However if we do look at the admission rates we will find that it is low. In Hlegu, there were 1427 admissions in 2010 from a population of 185658; an admission rate of 0.008 per capita per year. In Hmawbi there were 1820 admissions in 2010 from a population of 180945; an admission rate of 0.010 per capita per year.

The study revealed that there was a total of 8 private clinics in Hlegu and 12 in Hmawbi township. One private clinic in Hlegu had an average of 80-120 patient visits a day compared to 13 visits per day at Hlegu township hospital in 2010.

The health staff admitted that even though CCS has been implemented for a long time there have never been any efforts from their part to educate the public on their health rights nor have there been any program to educate the people on the concept of community cost sharing. They acknowledged that many of the locals may not even have heard of it and most are only likely to know of it when they have come to the hospital, since they explain to the patients why they have to pay.

They felt that public awareness would encourage utilization of the services.

4.3 Health Consumer's Perspective

Social groups and livelihood within the community

The informal discussion done with village elders helped us to identify the different levels of social class within the village community. From the different social groups we were able to identify the poorest for our focus group discussion. The classification of the village elders and leaders were consistent in both villages from the different townships.

According to the perceptions of the elders, the village community could be divided into 4 social groups: the upper, the middle, the lower and the lowest. Those in the upper social group own 20 acres and above and had assets such as brick house, tractor, buffalos; those in the middle social group own 10 acres or less but do not own tractors or buffalos; those in the lower social group do not own land but worked at factories earning 2000-2500 kyats per day ; and those in the lowest social group are landless manual laborers engaging in various categories of odd jobs. This lowest social group was referred to as *Let-loke-let-sar" (literally meaning those working with hands and eating with hands)* or *"kya-barn"(odd job)* and they were also referred to as *"nway-ta-lote moe-ta-lote" meaning seasonal workers*. Within each village lives of the lowest social group, filled with hardship was described as:

"…the very poor from our village cannot manage to eat 3 meals a day…"

Theme 1: Knowledge and experiences with community cost sharing

Majority of the people from the community have not heard of CCS scheme even though it has been implemented for over two decades. Even patients who were discharged from the hospital after being admitted for 7 days were baffled when asked of community cost sharing scheme. Even those of who have heard of the scheme do not know the eligibility criteria for exmeption. There seem to be confusion and mixed opinions regarding CCS scheme. All responses were the same when asked about payment at the hospital and they

all said they have to pay when we go to the hospital. Stories of exemption being given were rare among the respondents and a woman shared her neighbor's story:
"*… my neighbor had a delivery at the hospital and it cost her 100,000 kyat but she could only pay 40,000kyat, so the hospital accepted just the amount she could pay….*"

The respondents expressed their reluctance to go to the hospitals because of its costs. Focus group discussion revealed the voices of the poor social group regarding their perception on community cost sharing:

"*…. If you don't have money, there is no point in going to the hospital and better to die…*"

"*…. All I do is cry, since I didn't have any money in my hand to go the hospital….*"

These findings clearly showed that majority of the people do not know their health right to receive exemption. On the other hand, some patients are not consulting the health services at all or waiting until the last minute because of the fear of costs of medical services.

Theme 2: Perceptions on quality of care and services

Respondents expressed positive feelings towards the health care providers but majority are not happy with paying for the services and complained of the expenses. Others measured the quality of care by their recovery from illness and most were content to be well again. Overall patients' expectations were for their township hospitals to be well equipped so that they will not have to be transferred to bigger hospital as it would cost them more in terms of transportation costs and social costs of having to leave the children behind. They were willing to pay for services at local hospitals rather than being transferred since the opportunity cost was too high. One women respondent shared of her husband's ordeal at the hospital after a car accident:

"*… hospital staff rushed to our help as soon as we arrived at the hospital….my husband had a car accident and, he was given immediate treatment and we were not asked any money at all, which is quite different from private clinics in which we have to show money first….the doctors and nurses treated us like family members … but we still needed to buy the drugs and other things… I had to spend 100,000 kyat within 3 days during admission for drugs and equipment …*"

The patients described the kindness of doctors and nurses and expressed their appreciation for their hard work under limited resources. This opinion was similar to the feelings of the health workers who wanted to do more for the patients but were facing shortages of drugs and equipment. The findings from the health users confirmed that in public hospitals money was not the top priority but life saving was the top priority. It showed that the public hospitals are the last resort for treatment of the poor and people still have to rely on the public hospitals services which are much cheaper when compared to private clinics. Some reported the waiting time to receive treatment to be long but this was not due to negligence of the health staff but due to the overcrowding of patients.
There were no reports of informal payments to induce health services from the staff but the patients did admit that they did give fruits and village products to show their appreciation to the health staff and it is a common tradition of Myanmar people.

Theme 3: User fees and coping mechanisms

Health consumers hold negative opinions upon user fees imposed at hospitals and complained of out-of-pocket payments especially for pharmaceuticals. Patients reported to buying pharmaceutical from shops in the hospitals or from the market if it was not available in the hospitals shops. Price of the pharmaceuticals at hospitals were reported to be cheaper than private shops at the markets. In most cases, out-of-pocket payments were quite large compared to the patient's monthly income. However they did not have to pay for doctor and nurses fees.

" …. *I had a pile of prescription papers on the bedside but I could not buy the drugs and had to wait one day to get money from my relative, so that I could buy the drugs*…."

However it was also found that family networks were not always guaranteed to deliver and were limited because poor people tended to have family members with similarly low-income levels. Other than user fees patients also had to cope with the opportunity costs which arise when needing treatment and one woman narrated her experiences as follows:

"…..*a boy with TB in our village could not get TB medications even though they were free since he could not afford the transportation fee of 500kyat by trishaw to go to the hospital and also because he could not pay for the chest X-ray fees…he is still not receiving any treatment*.."

Medical expenditures for serious health problems and accidents represent expenses beyond the affordable range for health users, not only for the poor but also with respect to non poor resulting in catastrophic health expenditures. For example during in depth interviews with the patients, no one answered that his or her medical costs were affordable. Most patients interviewed on affordability of payment at hospitals used commonly used the words " *shar- kyan-pi- lar –ya-tel*" meaning we cannot afford but have to find our own means to get money to come to the hospital. Such means included selling of assets such as gold, cows, land or borrowing from loan sharks at high interest rates. Food expenses were also found to be part of the hospital expenditures.

Unexpected health care expenses resulting from serious illness or accidents impact on the well being of the affected person and their immediate family, as other family members attempt to assist with the costs of medical treatment. The impact was greatest when illness strikes the bread winner.

Narrations of when a family member faces an operation, tends to make the entire family fall into poverty quite rapidly as a result of the treatment expenditures is very common.

The following case of an impoverished woman with 3 young children coping with her husband's illness is a common story in which the family suffers from the cost of health care:

" *Two years ago when my husband fell ill due to stroke I had to take him to the township hospital. Our village is far and had to hire a car and it cost 10,000kyats. When I got to the hospital I had to buy many drugs and 50,000kyat was gone in one day. They later transferred my husband to YGH and the costs mounted. Some drugs were given free but everything is expensive in Yangon, including the food so I had to sell and pawn everything I had but it was still not enough so I had to borrow money with an interest rate of 10%. It was a difficult time since we stopped having income and I had to leave my young children with the neighbors. My husband has recovered but he cannot work anymore. It cost me about 600,000Kyats within 2 weeks*. "

While people used many number of coping strategies such as selling assets, borrowing at high interest rates; for getting through health crises, it was reported that it is still not easy to acquire sufficient financial resources to meet each crisis.

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CHAPTER V

DISCUSSIONS, CONCLUSION AND RECOMMENDATIONS

This qualitative study explored both consumer and provider's perspectives on issues regarding CCS scheme at two township hospitals, and it was found that there were many problems ranging from administrative and management matters of health providers to confusion and catastrophic payment of patients.

5.1 User fees

Although the intention of introducing user fees at health facilities were to collect funds to help run these facilities by introducing modest fees which were lower than the private clinics, which in turn help the poor reduce the high out of pocket payment and increase their demand and consumption of health services but in reality it was found to be depressing demand, especially for the poor. In our study user fees was not only acting as a barrier for those seeking health care but putting those receiving health care into impoverishment.

The findings have shown most of the user charges are retained and used where they are collected acting as an additional revenue to the health budget, rather than make up for budgetary reductions from a central funding source. If the additional revenues generated from user charges are used to improve the quality of services (better drug supplies, cleaner facilities, motivated staff, etc.), the poor potentially could benefit more than the wealthy if they make relatively greater use of the improved services. However, our findings also indicate that the revenue is not sufficient to improve the quality of services, since it is only marginal compared to the total cost and mainly because CCS is not profit oriented. As the charges imposed are limited only to medicine, medical equipment and some diagnostic procedures the revenue thus generated will provide only a meager contribution to overall health expenditure. Since the health providers do no gain any benefit from the user charges, there seem to be lack of motivation for the staff to improve performance, which in turns leads to poor quality.

Despite their potential adverse effect on equity, user fees are relatively easy to implement and therefore they tend to be preferred over other, harder to adopt policies. Optional policies, but ones that generally are viewed as less viable than user fees, include an increase in government health budgets, additional taxation earmarked for health, the reallocation of government health funds from richer to poorer regions, risk sharing arrangements, the reallocation of public funds from urban hospitals to rural primary level facilities, and the targeting of public health subsidies towards the poor. Prepayment with wide risk-pooling is more equitable and efficient than user fees, but requires a large commitment from government.

5.2 Utilization of services

It has been shown in the literature(Pantularp, Supakankunti, and Srithamrongsawat, 1998) that inpatient and outpatient utilization rates are an indicator of the performance of community cost sharing scheme. The health providers felt there has been an increased in utilization of their services and felt an increased workload but careful examination of the admission data showed low admission rates. For example, In Hlegu, there were 1427 admissions in 2010 from a population of 185658; an admission rate of 0.008 per capita per year. In Hmawbi there were 1820 admissions in 2010 from a population of 180945; an admission rate of 0.010 per capita per year. The majority of the population relied on private sector and only those that cannot afford depended on the public hospitals. Low utilization rates at the township hospitals can be for many reasons such as shortage of drugs and loss of confidence in the system. This choice was reflected by the health users from the community who pointed out that those who could afford preferred private clinics and only poor people used the public hospitals. In this case since only the poor utilize public hospitals the objective of cost recovery cannot be achieved. However we could not establish which percentage of those using the public health care system were poor or not but all of our respondents answered that health care was not affordable to them. This study did reveal that those utilizing health care services were paying from

selling their assets or from borrowing with high interest rates resulting in catastrophic health expenditures.

5.3 Exemption of the poor

In current practice there was no systematic arrangement or clear policy in giving exemption to the poor and was mainly based of the judgment of the TMO at the point of service. Health consumers were also not clear on their right to get exemption and in reality no respondent in our study got full exemption. Partial exemption, in which the health consumers paid as much as they could and the rest was subsidized by the hospital, was a more common practice. Since the exemption mechanism was not perfect in targeting the beneficeries, leakage of funds was seen when exemption was given to those not poor. A previous study in Myanmar revealed that civil servants who had low salary but high social status and were better off compared to the peasant were the main beneficieries(Tangcharoensathien, 1999). Absence of staff incentives to grant and promote exemptions and waivers, including the lack of mechanisms for compensating health facilities for revenue foregone leads to poor performance of exemption mechanism. In the whole picture health users lack of understanding to receive exemption maybe be due to insufficient public information as it was found in the interviews. The low level of reported exemptions by health consumers within the background context of high reporting of poverty, reveals the existence of serious problems of under-coverage, and thus points to major deficiencies with this protection mechanism.

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5.4 Community awareness

The nature of a community based financing scheme requires the participation of the community members in setting the user fees and exemption criteria. Our study found the majority of respondents showed lack of understanding or participation in community cost sharing. This was reflected by the structure of the Township Health Committee (Annex 6) in which all members were government officials but no one representing the community

households. Our findings clearly point out that no attempt is made on the part of the health workers to raise awareness of community cost sharing. The reason behind this was not established in our study. One study from Kenya has suggested that sometimes health workers deliberately do not want to promote awareness since it will result in forgone revenue(Owino, 1998). A study in Sudan found that effective publicity of exemption entitlements lead to an increase service use and inporved treatment seeking behavior(Abdu , Mohammed , Bashier , & Eriksson , 2004). Insufficient awareness of the patients in regards to their health rights to receive exemption lead to the poor being left out from receiving proper health care.

5.5 Administrative and Management difficulties

Many problems occurred during the implementation of CCS, including lack of clear policy and guidelines to give exemption and the mixture of the triad of health financing schemes being implemented causing burden to health personal due to duplication of work. Lack of trained personal to carry out CCS was evident. WHO has identified "setting right financial incentives for providers" as one of the purposes of financing health. However community cost sharing could not provide financial incentives for the providers since all health providers reported to not receiving any benefit from the scheme. Experiences from the townships under study revealed that they did not have significant problems in carrying out the directives issued by the department of health in relation to monthly reports and monitoring of the system.

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5.6 Conclusion and Recommendations

Access to affordable and effective health care is a major problem in low and middle income countries and out of pocket expenditure for health care is a major cause of impoverishment. There is a need to develop the health system looking for equitable utilization of health care services including curative services. Placing health equity as the central goal of health system requires substantial and coordinated reorientation through re-framing of policy and institutional transformation. This in turn requires active management of the policy development and implementation process and needs to be based on the wider political and policy commitment to social equity through which such action is enabled.

The study did provide evidence that poor are denied access to health care because of implementing the CCS due to user charges, with consequent high out of pocket payment. Therefore it is still essential that existing protection mechanism be further assessed so as to make it work better and more effectively. At the same time, taking into account that there have been growing evidence that user fees in the health sector create exclusion of poor and also considering high out of pocket health expenditure experienced in the country, a more appropriate health financing method for the country should be explored("World Health Report"2010). One way to facilitate access and overcome catastrophic expenditure is through a prepayment mechanism, whereby risks are shared and financial inputs pooled by way of contributions. While trying to overcome challenges and constraints encountered in developing or expanding prepayment schemes it is important that protection mechanisms are in place so that poor are not denied access to health care.

In reality the CCS scheme is not achieving its primary objective of cost recovery, since the well-off from the community prefer to use the private clinics, so the public hospitals end up with only the poor to gain its revenue which contradicts with its policy to give exemption to those who are poor. A negative consequence resulting from this low cost recovery leads to poor quality of the health care services. Poor quality acts as a deterring force to those who can afford to utilize private health care clinics. This vicious cycle

leads to the failure of the existing CCS scheme. Policy makers should consider ways to promote healthy competition between public hospitals and private clinics in order to capture those consumers who can afford to pay, in order to achieve cost recovery in a sense of cost sharing. An issue needing considering by policy makers is the nature of CCS not allowing for provider incentive which leads to lack of motivation of the providers to improve quality and to give exemptions to the poor. Furthermore user fees were seen to be acting as a barrier for the poor to access health care and it was evident that there is still need to improve the current exemption mechanism with a better design to target beneficiaries and to raise community awareness in regards to their health rights. Since this study was limited to only two townships further studies should be done on a wider scale and more efforts should be put in to explore the possibilities in a Myanmar context of an alternate health financing mechanisms which are equitable and give greater protection for the poor. Preparatory measures should be explored and undertaken so that out of pocket payment practice prevailing in the country can be replaced by a prepayment mode of health financing such as community based health insurance.

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APPENDICES

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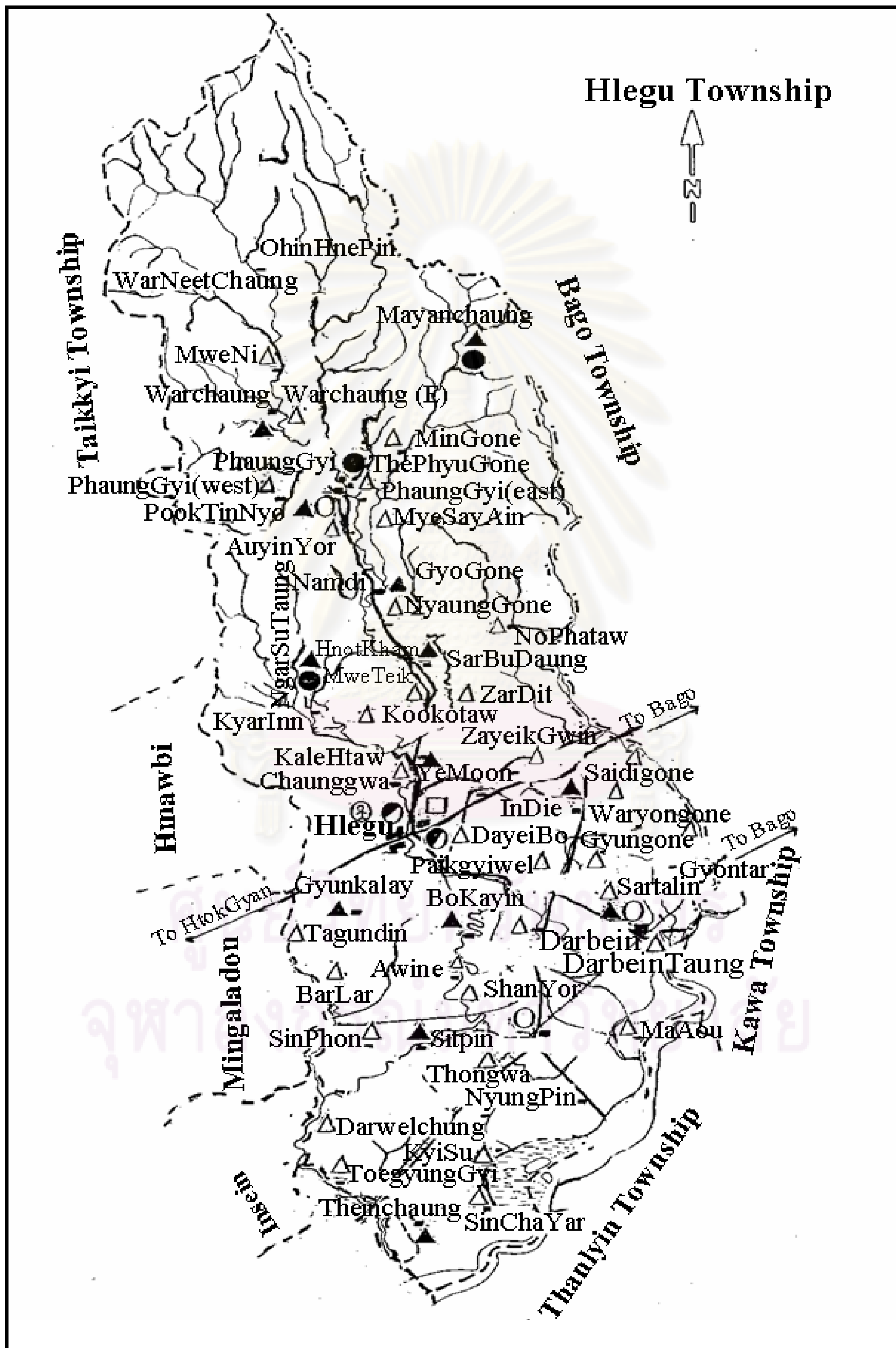
APPENDIX A

APPENDIX B



APPENDIX C

In depth Interview Guideline for Health Providers

The outline of the IDI guide has five main themes which starts with an opening question to encourage the respondents to discuss freely followed by questions probing for details. All health providers will be asked according to the themes, however level of probing into detail may differ for separate job titles.

Health workers will be divided into the following categories: Township Medical Officer, Township Head Nurse, Medical Officer, Compounder (Dispenser), Nurse, Clerks, and Laboratory Technicians.

1. **Current practice of Community Cost Sharing:** Could you please tell us about the practice of CCS in your hospital?
    - *What role do you play in CCS in your hospital?*
    - *What are the current practices?*
    - *What difficulties do you face in implementing CCS?*
    - *Who are the people involved in CCS in your hospital?*
    - *Have you received any form of training for CCS? Where and when was the training given? By Whom? What training is needed for strengthening capacity?*
    - *Do you think it is necessary to share information regarding CCS with community members? If yes, why?*
    - *Do you believe CCS has changed utilization of services?*
    - *Or improved quality of care?*
    - *Who do you think benefit from CCS?*

2. **User fees:** If a patient comes to the hospital what costs does he have to pay?
   - *Do you have a standardized fee? Where is the guideline from?*
   - *Who sets the price for the user fees*
   - *Do patients have to pay for drugs at the hospital or purchase from private shop?*
   - *How much are drugs charged?*
   - *Is the revenue used for revolving drug fund?*
   - *How much are the pay rooms charged?*
   - *Who manages the user fees?*
   - *Are charges made per visit or does the initial fee cover all the costs?*
   - *Are charges made for ante natal care of pregnant mothers? Birth-spacing?*
   - *Are charges made for communicable diseases, e.g Tb, Malaria, HIV, Leprosy ?*
   - *Do you receive from patients any form of payment in cash and kind? Gifts? Food?*

3. **Exemption of the poor:** Please explain to me what do you do when a patient comes to you and he cannot pay?
   - *What is the criteria for exemption?*
   - *Who has the authority to make this decision?*
   - *What procedure is needed for exemption?*
   - *How do you distinguish poor and non-poor?*
   - *How many exemptions are given each mth/year?*
   - *Which number have the greater number of exemptions inpatients or outpatients?*

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4. **Management of Funds/Cost Recovery:** Please explain what problems do you face in the present system of management of funds?
    - *Where and how is the revenue kept?*
    - *Can the revenue collected from drugs and services recover its initial costs?*
    - *Who should be responsible for fee collection at the hospital?*
    - *Is there an accountant at each level?*
    - *What level of authority is needed for use of the funds? (Level of decentralization)*
    - *What should the funds be used for?*
    - *Do you use the funds for the welfare of the staff?*
    - *Is there a committee involved? Who are the members?*

5. **Monitoring and evaluation of CCS:** Do you have to report data concerning CCS to MOH?
    - *What do you include in your report?*
    - *What difficulties do you face?*
    - *Do you think there is an effective system for monitoring and evaluating the CCS? If not, which elements are missing?*

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APPENDIX D

In depth Interview Guideline for Inpatients and Outpatients

Experiences with CCS

- *Do you have to pay when you go to public hospital?*
- *What do you have to pay for?*
- *How do you feel about paying for your health care?*
- *In your society or based on your experience please tell us if you can afford to pay or what do others like you do when they cannot afford to pay?*
- *Please share with us what you have heard from your community members or based on your own experience what happens when you go to the hospital and you cannot pay?*
- *Have you any experience about or heard about paying for the doctors/ nurses in cash or kind such as food, gifts in return for health services?*
- *Why do you not go to private clinics?*

Knowledge and Understanding of Community Cost Sharing

- *Have you ever heard of Community Cost Sharing?*
- *How do you understand CCS?*
- *Do you feel you are involved with CCS?*
- *How would you like CCS to change?*

Perceptions on Quality of Care and Attitude of Providers

- *How were you treated at the health facility when you sought care for yourself?*
- *Can you describe the steps you had to take when you went to the health facility?*
- *Are you satisfied with the kind of care you received?*

APPENDIX E

Focus Group Discussion Guideline with the Poor

The following provides a draft outline of the themes and the sub-themes to be explored during the study.

Provide an introductory statement of study objectives. Explain that their participation is voluntary. Emphasize that privacy and confidentiality will be maintained. Obtain consent form from respondents.

Background Information of the participants

1. Age – 18 to 55 years
2. Sex – Both sex
3. Those who have experienced ill health or have immediate members of the family who have been sick.

The objective of the focus group discussions is to develop an understanding on the effectiveness community cost sharing scheme from the perspective of users in the community. The discussions will help gather information on their knowledge and understanding and experiences with the community cost sharing scheme and will also seek to elucidate information on the barriers in the utilization of the scheme.

Knowledge and Understanding of Community Cost Sharing

- *Have you ever heard of Community Cost Sharing?*
- *How do you understand CCS?*
- *Do you feel you are involved with CCS?*

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Experiences with CCS

- *Have you or any members of your family been sick?*
- *Where do you go for treatment?*
- *How did you reach the hospital? How long did the travel take? How long did you have to wait before you received a consultation?*
- *Do you have to pay when you go to public hospital?*
- *What do you have to pay for?*
- *How do you feel about paying for your health care?*
- *In your society or based on your experience please tell us if you can afford to pay or what do others like you do when they cannot afford to pay?*
- *Please share with us what you have heard from your community members or based on your own experience what happens when you go to the hospital and you cannot pay?*
- *Have you any experience about or heard about paying for the doctors/ nurses in cash or kind such as food, gifts?*
- *Why do you not go to public hospital?*

Note

Remember to say thank you to all the participants and to give a token of appreciation for their participation.

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APPENDIX F

Township Health Committee Members

The township health committee is composed of the following members:

1. Township Administration Committee Chairman - Chairman
2. Township Medical Officer - Secretary
3. Official from Ministry of Education - Member
4. Official from Police Force - Member
5. Official from Ministry of Construction - Member
6. Official from Township Municipal Department - Member
7. Official from Ministry of Sports - Member
8. Official from Ministry of Telecommunications - Member

APPENDIX G

Central Medical Store Depot Drug List

I. Injections

1. Adrenaline	10amp
2. Burmeton	10amp
3. Burplex Forte	10amp
4. Dextrose water	100 bottles
5. Dextrose saline	100 bottles
6. Ringer Lactate	100bottles
7. Normal Saline	100bottles
8. Quinine	100amp
9. Aquapro	1000amp
10. Artemeter	60amp
11. Hydrocortisone	20amp
12. ATS (1500 IU)	30amp
13. Anti-snake venom	30amp

II. Tablets

1. Burplex	30 bottles (1bot × 100tab)
2. Folic Acid	30 bottles (1bot × 100tab)
3. Thiamine	30 bottles (1bot × 100tab)
4. Furamine BC	30 bottles (1bot × 100tab)
5. Cevit	30 bottles (1bot × 100tab)
6. Chloroquine	30 bottles (1bot × 100tab)
7. Gelmag	20 bottles (1bot × 50tab)

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Item	Quantity
8. Paracetamol	30bottles (1bot × 100tab)
9. Amoxycillin	10bottles (1bot × 100tab)
10. Ciprofloxaxin	10 bottles (1bot × 100tab)
11. Benzyl Penicillin	10 bottles (1 bot × 50tab)

III.Others

Item	Quantity
1. Aseptol 500ml	5 bottles
2. Burscabie 500ml	5 bottles
3. Mezincal 500ml	3 bottles
4. Methylated Spirit	20 bottles
5. Traditional balm 120ml	7 bottles
6. Blood set	100sets
7. Catgut	5 dozen
8. 5cc Syringe	300
9. 20cc Syringe	200
10. TEO Tube	20 tubes
11. ORS	100 packets
12.Zinc oxide	2 bottles
13.Bandage 2inch	200 rolls
14. Bandage 3 inch	150 rolls
15.Bandage 4 inch	100 rolls
16. Cotton wool	10 roll
17. Gauze	2 packet

ศูนย์วิทยทรัพยากร
จุฬาลงกรณ์มหาวิทยาลัย

BIOGRAPHY

Name: Phyo Maung Thaw

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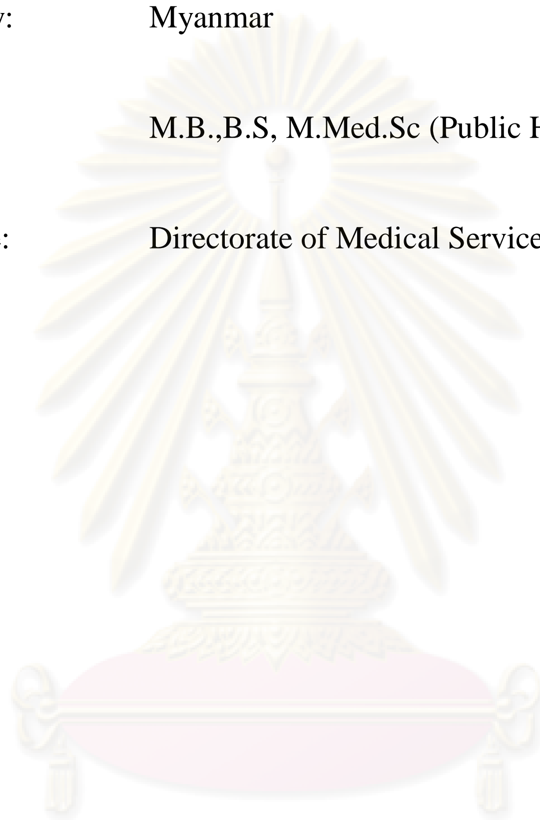

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