

## PROJECT INFORMATION DOCUMENT (PID) CONCEPT STAGE

Report No.: PIDC5201

<b>Project Name</b>	Myanmar Towards Universal Health Coverage (P149960)
<b>Region</b>	EAST ASIA AND PACIFIC
<b>Country</b>	Myanmar
<b>Sector(s)</b>	Health (85%), Other social services (15%)
<b>Theme(s)</b>	Health system performance (85%), Other social protection and risk management (15%)
<b>Lending Instrument</b>	Investment Project Financing
<b>Project ID</b>	P149960
<b>Borrower(s)</b>	Ministry of Finance
<b>Implementing Agency</b>	Ministry of Health
<b>Environmental Category</b>	B-Partial Assessment
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<b>Concept Review Decision</b>	Track II - The review did authorize the preparation to continue

### I. Introduction and Context

#### Country Context

Myanmar embarked on a path of reforms towards a “triple transition” after the elections in 2010 under the leadership of President U Thein Sein: from an authoritarian military system to democratic governance; from a centrally-directed economy to a market-oriented one; and from 60 years of conflict to peace in the border areas. This transition has required –and is still requiring– bold and immense effort from all sectors of Myanmar—public, private, and the civil society.

At present, Myanmar, with a population estimated at up to 60 million people, remains one of the poorest countries in East Asia, with an estimated GDP per capita of between \$500-\$800, and about 30 percent of the population living in poverty. UNDP (2013) classifies Myanmar as a “low human development” country and ranks it 149th among 186 countries in its Human Development Index (HDI).

Health status of the people of Myanmar is low and does not compare favorably with other countries in the region. Among ASEAN countries, Myanmar has the lowest life expectancy at birth. About 2,000 pregnant women and 50,000 children still die every year from preventable causes. In 2009, 1 in 7 infants was born with a low birth weight, 35 percent of children under the age of five were stunted, 23 percent underweight, and 8 percent wasted. About seventy three percent of pregnant women had at least one antenatal visit and only 43 percent at least four visits to a health care provider in 2010. Emergency obstetric care is often not available or affordable.

Myanmar had one of the lowest Government expenditures on health globally. In 2011-2012 the health sector accounted for only 1.3 percent of total government expenditure (about US\$ 2 per person per year). As a result of these low levels of spending, out-of-pocket (OOP) payment was exceptionally high. It accounted for almost 80 percent of total health spending, which was one of the highest in the world. Out-of-pocket spending on health as share of total household spending is greatest for the poorest. In Myanmar, households spend on average 2.4 percent of its overall spending for health care; however, for poorest households, they spend on average 6 percent, higher than any other ASEAN country.

The country has made substantial improvements in health conditions since 1990, but significant inequities persist and the country is unlikely to reach its MDG 4 (maternal health) and 5 (child health) targets. Maternal mortality fell from 520 per 100,000 live births in 1990 to 200 in 2010. Whereas under-five mortality dropped by almost half amongst the richest between 2000 and 2010, for the poorest, mortality was only reduced by a quarter. For reproductive health, 55 percent of women in the top quintile group have access to contraceptives, whereas 38 percent of the bottom quintile does.

Financial barriers lead to forgoing care when needed. According to Multi-Cluster Surveys, nearly 1 in 3 of the poorest did not seek medical care the last time they were sick. In 2010 the most frequent sources of curative care for the poor were home visits (31 percent) of unknown quality followed by private clinics (26 percent) and rural health centers (13 percent). The wealthiest, on the other hand, receive care from the private sector in nearly 80 percent of the cases.

Improving the health of citizens, and ensuring that health care spending does not push more people into poverty, represents an integral part of Myanmar's road to sustainable growth and poverty reduction. The Lancet Commission in December 2013 revisited the case for investment in health and developed a new framework to help achieve large health gains by 2035. The report shows that there is an enormous payoff from investing in health. Reductions in mortality account for about 11% of recent economic growth in low income and middle income countries using national income accounts. When the value of additional life-years is considered on top of national income accounts, Lancet Commission found that between 2000 and 2011, about 24% of the growth in full income in LICs and MICs resulted from value of additional life years gained.

### **Sectoral and Institutional Context**

Myanmar's transition and the reforms of its health sector are closely intertwined. Conflict, military rule and closed economy have shaped the health system that Myanmar has today. Moving forward, a health system that is inclusive, coherent and equitable will support sustainable peace; a health system that enables bottom-up accountability, greater transparency and efficient use of resources will reinforce democratic governance; and a health system that has a strong stewardship of the government over an integrated private and public sector involvement will strengthen an open

economy. Effective health service delivery builds legitimacy of the transition process, and ensures that Myanmar people experience the democracy dividend.

Myanmar has a strong political leadership and commitment to accelerate progress towards health goals. Universal Health Coverage (UHC), defined as everyone having access to affordable quality health services they need and no one is forced into poverty, or be kept in poverty, has gained significant traction in Myanmar. President U Thein Sein made a speech in 2012 calling for comprehensive health care and universal health insurance, especially for the rural poor. In February 2014, he called upon his Ministers to step up “people-centered” reforms in the health sector to advance towards the goals of UHC. The President called for actions to:

- Improve the supply side readiness and availability to scale up access and quality of services, in particular human resources, medicines, equipment, infrastructure, and information system.
- Enhance governance of the health sector, through improved planning and management of budget and finances, greater monitoring and supervision of service delivery, increased transparency in administration, such as deployment and promotion of health staff
- Provide greater oversight of quality in both private and public sectors
- Better communication with community and patients/customers
- Introducing performance-based incentives for health providers
- Involving communities in service delivery and monitoring and evaluating the services
- Greater and clearer role of State/Region governments, as decentralization agenda advances

The reforms called for both visible and tangible improvements in health service delivery in the short term and a path for systems strengthening over the medium and long term.

The Ministry of Health (MoH) has defined the country’s path towards its UHC goals. Myanmar’s UHC goals are to expand equitable access to quality health services, focusing first on the maternal, newborn, and child health, and to reduce financial burden on poor households due to ill health. MoH has prepared a Strategic Direction paper that outlines key areas in need of policy interventions, investments, institutional strengthening, and analysis over the short, medium, and long term.

The Government of Myanmar quadrupled its allocations to the health sector over the past few years and the estimates suggest that government spending on health is now closer to US\$9 per capita, and total health spending per capita is about US\$25. Development partners have also scaled up its financial support since 2010; a total of about US\$800 million have been committed to date, with the majority of the funds channeled outside the government.

With the increase in public spending on health, share of out-of-pocket spending on health has declined. In 2012-2103 OOP spending accounted for 60 percent of all health spending, down from 79 percent in 2011-2012. However, in terms of absolute numbers, private out-of-pocket spending on health has been increasing: between 2009-10 and 2012-13, it increased from around US\$ 588million to around US\$ 642 million.

Government has recently introduced three key policies that have great potential to help reduce out-of-pocket spending in health. The first is the provision of free essential drugs at primary health care facilities, including rural health centers and station hospitals. The second is the provision of free health care services for children under 5, pregnant mothers, and patients needing emergency surgery (only first day of hospital admission). The provision of services of these populations includes free drugs. The third is the provision of free essential drugs to children under 5 years of age in township

hospitals. Ensuring effective implementation of these policies, especially in hard-to-reach and border areas, would be critical.

Myanmar faces many impediments to expanding access to quality health services and increasing financial protection. In addition to difficult geographical terrain and conflict, systemic challenges seriously stretch the capacity of the public sector in Myanmar to deliver basic health services to all its population. The challenges are many, involving human resources, medicines and technologies, and information systems. Inappropriate skills mix of health workers, inequitable geographical distribution and a lack of linkage between performance and salaries/ payment severely constrains human resources for health. The workforce recruitment quotas fail to respond to the staffing requirements of the health system; inadequate financial arrangement of education/training institutes and of professional associations to enable quality production of health personnel; deficiencies in the quality of education and training of health workers leading to weak professional, practical and clinical skills; and deployment and retention problems, leading to shortage of qualified health workers in remote/hard to reach areas. Poor state of health facilities at the primary care level, shortage of essential drugs and supplies pose barriers to provision of basic services. The supply chain system is not yet well developed, and there are problems with storage and distribution of supplies, especially to facilities at township level and below.

Myanmar's health system is very fragmented and the Ministry of Health is struggling to re-assert its stewardship functions. With chronic underinvestment in health and international sanctions barring external development aid to flow through the Government, there is a strong prominence of international and local NGOs carrying out front-line delivery supported by development partners, as well as the private-for-profit health care sector at both primary and tertiary levels. The fast growing private sector, however, is largely unregulated.

Unreliable, inaccurate and incomplete data pose a huge challenge to any robust assessment and evaluation of the health sector and evidence-based policy making in Myanmar. Over the past ten years, data on health has come from either administrative sources or from four large household surveys. These surveys have been critiqued for its sampling errors as well as limited quality control. Furthermore, the only health financing data that is well recorded at source is public spending, which explains a small percentage of total spending on health. Spending on health from external sources, including bilateral aid and assistance from development partners, is not completely and accurately recorded. Private out-of-pocket spending on health, which is the single largest financier of health in Myanmar, is the most poorly documented.

### **Relationship to CAS**

After more than two decades of absence, the WBG began re-engagement for the development of Myanmar. On November 1, 2012 the WBG endorsed an Interim Strategy Note (ISN) which outlines support around three Pillars: the first aimed at supporting government's efforts to transform institutions to allow them to deliver for citizens; the second aimed at building confidence in the ongoing reform process; and the third focused on preparing the way for the resumption of a full country program. With ISN expiring in June 2014, WBG has initiated the preparation of the Country Partnership Framework (CPF), which is expected to be delivered in August 2014.

The proposed operation is well aligned with the ISN and pathways to end poverty and boost shared prosperity in Myanmar. As emphasized in the ISN, the operation would support quick and tangible impact for communities through the improvements in the delivery of essential health services,

which in turn would build trust and confidence in the reform process. It would also build the institutional capacity of Ministry of Health to successfully fulfil the stewardship function, an oversight of the entire health sector that delivers services equitably to its populations. Furthermore, the proposed operation would directly contribute to CPF's critical pathways to ending poverty and boosting shared prosperity in Myanmar—job creation and higher incomes through inclusive growth, expanded coverage of pro-poor and critical basic services, and expanded social protection. It would contribute directly to expanding access to quality health services and making households more resilient to health shocks by preventing impoverishing and catastrophic health related expenditures.

## **II. Proposed Development Objective(s)**

### **Proposed Development Objective(s) (From PCN)**

The objective of the proposed operation is to increase access to essential health services, with a focus on progress towards MDGs related to maternal, newborn and child health (MNCH).

The proposed project is the first phase in the program of support that aims to advance Myanmar towards UHC goals of equitable access to quality essential health services and enhanced financial protection.

### **Key Results (From PCN)**

Increase in number of deliveries by skilled birth attendants, postnatal visits, and appropriate treatment for acute respiratory infections among children under five.

In addition to using data from the Ministry of Health, we would use new household surveys, such as Myanmar Poverty and Living Conditions Survey planned for end of 2014 and the Demographic and Health Survey, to help establish the baseline.

## **III. Preliminary Description**

### **Concept Description**

#### **A. Project Concept**

To advance towards the UHC goals of equitable access to quality essential health services and enhanced financial protection, Myanmar would need a program of support that delivers: (i) service delivery readiness, quality, and performance; (ii) sustainable and equitable health financing; and (iii) strong governance and stewardship of the health sector. The proposed operation is the first phase of this program of support, which would focus on service delivery readiness, quality and performance at the Primary Health Care (PHC) level and also provide capacity-building and program support and lay the ground-work for Phase II.

To facilitate smooth and timely implementation, the proposed operation, to be financed by IDA credit and Health Results Innovation Trust Fund Grant, would be complemented by a coherent and well aligned program of technical assistance (TA) – finances for which would be mobilized from other development partners with shared interests.

Component 1: Strengthening Primary Health Care Delivery and Utilization. A priority for achieving UHC is making the delivery of a basic package of services of good quality available to the entire population. In order to achieve this, the Government would need to make sure that medical supplies including pharmaceuticals and other consumables, are regularly supplied to primary care facilities to

prevent any stock-outs, that staff in the facilities are well trained, be present in sufficient numbers and treat patients in a friendly and respectable manner. The facilities would need to be well maintained. These efforts would need to take into account existing service delivery models in the country, such as social franchised networks of General Practitioners, NGOs, and faith-based organizations in the ethnic and border areas.

While long-term sustainable financing mechanisms are being developed, in parallel, urgent measures are needed to empower local level health care managers to ensure the smooth operation of health services. In order to achieve the MDGs 4 and 5, in the immediate-term, the supply of MNCH services at the PHC level need to be of acceptable quality, with adequate coverage and utilization. Enhanced service utilization will also need effective communication efforts to inform and empower communities – both to improve health-care seeking behaviors and to be able to demand services from the providers and provide feedback.

To assist Myanmar in realizing the above short-term strategy, World Bank financing would support:

- Channeling funds through MOH to Township levels and below for operational costs, medical consumables and minor maintenance. Grants would be provided to TMOs, for onward disbursement to RHC and SC levels based on Standard Operating Procedures, for eligible expenditures
- Strengthening FM capacity at Township and Central levels, which could encourage other development partners to channel funds through Government systems
- Health Care Waste Management and social safeguard compliance activities
- Community empowerment: Building on existing mechanisms, such as Village Health Committees, communities will be informed and empowered to demand services, provide feedback and community oversight.
- Results-Based Financing: Phase I will be used for sensitization of policy-makers, planners and implementers to the concepts of RBF, and for designing and developing the pilot interventions.

Component 2: Program support, capacity building and Phase-II ground-work. The component would provide management support to the program, and finance the development of strategies, guidelines and operational manuals (e.g., Health Financing Strategy, Definition of Essential Package of Health Services, Quality Assurance and Accreditation Systems, Health Care Waste Management Guidelines, Social Assessment, Standard Operating Procedures for fund-flow). It would strengthen fiduciary systems so as improve efficiency in the sector and create more transparency, accountability and a smooth flow to frontline services. The Bank funds would support consultation workshops, training programs, South-South exchanges, and independent verification of Disbursement Linked Indicators achievements through third party monitoring and make funds available for training.

Progress in this focus area would be further bolstered by leveraging USAID technical support program on supply chain management, and service availability and readiness assessments funded by GAVI Health systems strengthening project and 3MDG Fund.

#### Proposed Instrument

The proposed operation would use Investment Project Financing with Disbursement Linked Indicators. DLI progress will be reviewed annually and will be subject to independent verification.

The arrangements for the review, its financing as well as its timing will be decided with Government during project appraisal, so that IDA disbursements can be made at a proper time in the Government's budget cycle.

World Bank plans to mobilize additional financial support in the form of international and national technical assistance to be focused on monitoring and evaluation of the programs and capacity building to enhance program implementation towards achievement of DLI targets.

The project is conceived as the first phase of a larger program of support to the sector, which would include health financing and broader sector reforms. Such program will be prepared in the coming year and may run contemporaneously with this first phase.

#### IV. Safeguard Policies that might apply

Safeguard Policies Triggered by the Project	Yes	No	TBD
Environmental Assessment OP/BP 4.01	x		
Natural Habitats OP/BP 4.04		x	
Forests OP/BP 4.36		x	
Pest Management OP 4.09		x	
Physical Cultural Resources OP/BP 4.11		x	
Indigenous Peoples OP/BP 4.10	x		
Involuntary Resettlement OP/BP 4.12		x	
Safety of Dams OP/BP 4.37		x	
Projects on International Waterways OP/BP 7.50		x	
Projects in Disputed Areas OP/BP 7.60		x	

#### V. Financing (in USD Million)

Total Project Cost:	115.00	Total Bank Financing:	100.00
Financing Gap:	0.00		
<b>Financing Source</b>			<b>Amount</b>
BORROWER/RECIPIENT			0.00
International Development Association (IDA)			100.00
Health Results-based Financing			15.00
Total			115.00

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