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EQUITABLE GROWTH, FINANCE & INSTITUTIONS
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Improving Health Services in Myanmar through Public Financial Management Reform

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Improving Health Services in Myanmar through Public Financial Management Reform

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To support socioeconomic development objectives and improve service delivery, the former government of Myanmar issued a public financial management (PFM) reform strategy (2019–2022). Plans were underway to modernize PFM legal and regulatory frameworks, systems, and practices to improve the efficiency of public expenditures and services that are critical for citizens. First COVID-19 and then recent political events in Myanmar not only disrupted service delivery, but also emphasized the criticality of public health service delivery.

This brief offers a selective overview of a more in-depth assessment of the health sector conducted jointly by the former government and the World Bank in 2020 to support this effort (World Bank 2021). While it does not take into account the impact of political events that occurred in February 2021, it summarizes the assessment's central findings and recommendations for enhancing health financing, service delivery, and efficiency at all levels of health care, when the conditions are right. The assessment is based on a large survey of health practitioners, including at the frontlines.

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Introduction

Public financial management systems focus on the stages of the budget cycle from budget formulation and execution to accounting and reporting as well as external security and audit. A well-designed system can ensure public resources flow to agreed-upon strategic priorities and are reallocated from lesser to higher priorities when necessary. In short, the government can achieve maximum value for money in the delivery of services through a system that boosts financial and operational efficiency.

After decades of conflict, underinvestment, and fragmentation, access to essential health services varies across the country. Myanmar has a mix of public and private systems, both in financing and providing health services. The Ministry of Health and Sports (MoHS) is the largest health care provider and is responsible for delivering preventive, curative, and rehabilitative services and promoting healthy living. Before the crisis, it made significant attempts to address coverage and care bottlenecks, especially for maternal, neonatal, and child health, and to increase the number of health professionals.

In addition to financial management challenges, the health sector remains underfunded (see figure 1). Costs and risk land on the shoulders of citizens. Out-of-pocket spending accounts for more than 75 percent of total health expenditure in Myanmar. As a share of household spending, it is greatest for the poorest, with adverse implications for financial protection. While COVID-19's effects are fluid and difficult to forecast, they are expected to be deep and wide. Particularly hard hit are the labor-intensive sectors of tourism, service, manufacturing, and agriculture, which notably affect vulnerable groups and the poor.

Novel approaches, including demand-side financing to increase the purchasing power of the destitute and underserved, are planned, and new laws could enable them in the coming years. Beyond the bottlenecks, Myanmar needs to increase its funding and make changes to the way it is used.

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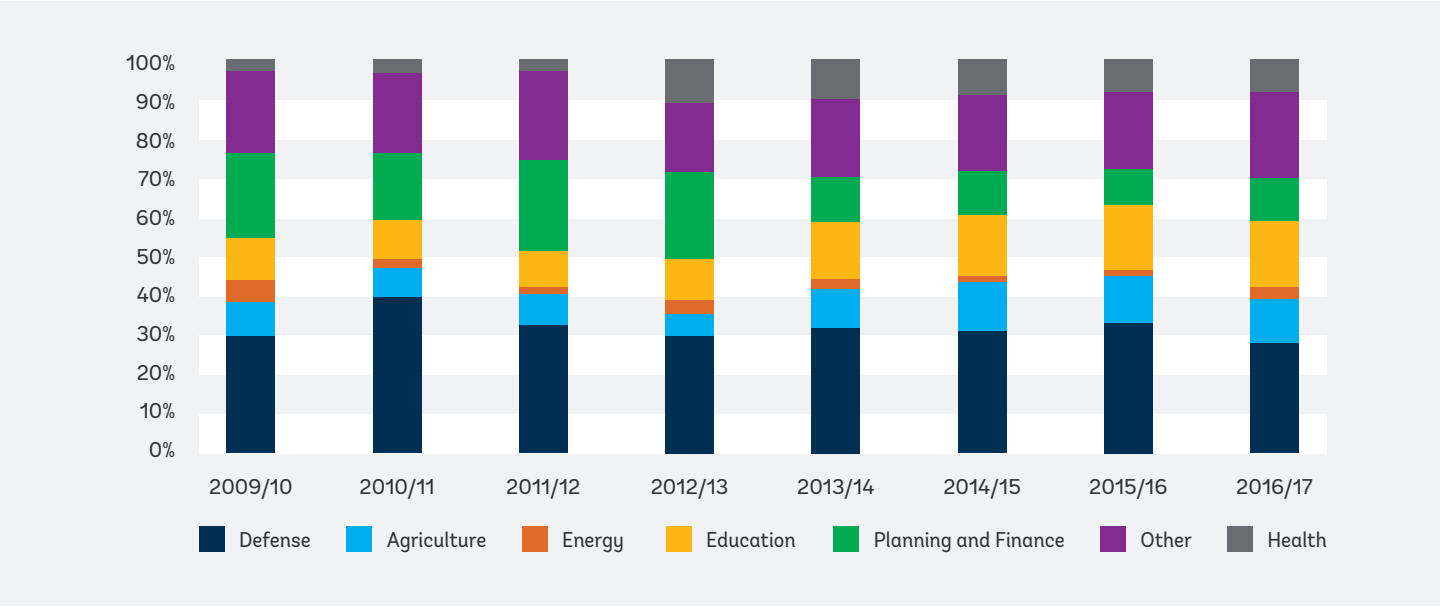
FIGURE 1 - Union Government Spending by Function and Fiscal Year



Source: Teo and Cain 2018.

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PFM's Importance for Health Service Delivery in Myanmar

The answer is simple though its implementation is complex and requires careful planning and steadfast support and implementation. Good PFM can identify and eliminate bottlenecks that cause inefficiencies in health care systems and restrict the delivery of health services. The ultimate outcome is a healthier population. A country's future largely depends on the health of its people. For example, childhood and maternal undernutrition is a persistent public health and development concern in Myanmar. Nearly one in three children under the age of 5 suffers from stunting, which increases a child's susceptibility to disease and reduces cognitive abilities, educational achievement, and productivity.

While health outcomes in Myanmar improved steadily over the last few decades, they are now threatened by the pandemic's adverse effects. Life expectancy at birth rose steadily from just 42 years in 1960 to 67 years in 2020. However, wide variations in health outcomes and access to services are found across the country based on geography, gender, and income. COVID-19 exposed a variety of gaps in vital public health services, including the insufficiency of funding, human resources, and prioritization. The government and its development partners swiftly reallocated resources to the health sector. While these efforts helped lessen short-term impacts, they highlighted the importance of long-term health care financing, especially for health security and pandemic preparedness.

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Insights from the Frontline

To achieve success, the government urgently needs to better understand the bottlenecks affecting frontline service delivery. In Myanmar, frontline providers are the township hospitals and health departments that implement their own budgets, together with the rural and subrural health centers managed by township health departments. All departments and facilities are part of a centralized structure. Important fiscal responsibilities in the health sector are retained at the Union level and subject to the Union budget processes.

A range of financial management bottlenecks constrain the ability of frontline health service providers to implement plans and respond to local health needs and priorities. Budget proposals are prepared on the basis of historic allocations rather than needs and priorities, undermining the efficient distribution of scarce resources. Limited operating budget hinders the capacity of hospitals, health centers, and communities to effectively deal with public health emergencies, including the transport of specimens or basic equipment, medicines, and supplies. Budget norms for travel allowances thwart service delivery particularly in remote areas.

Survey results also confirm MoHS subnational units manually prepare paper-based budget proposals that do not significantly influence allocations decided by Union-level departments to meet the tight calendar of the Ministry of Planning, Finance, and Industry (MoPFI). Anecdotal evidence indicates frontline health workers are paying travel expenses out of pocket and seeking community donations to send specimens for testing and fund outreach activities to support remote or difficult to access communities.

At the frontline, significant challenges also exist to match the supply of health professionals with higher demand. These include the unequal distribution of health professionals and greater demand due to population growth and increasing life expectancy. Working in the public health sector also carries significant disadvantages, including long hours, heavy workloads, difficult environments, and low rates of pay and living conditions.

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Resolving Main PFM-Related Bottlenecks to Improved Service Delivery

Major goals and recommended actions are grouped into four main areas along the budget cycle. Summaries for each follow and, for ease of reference, include an indicator for related bottlenecks (e.g., BN 1), which can be found in the full assessment report. Figure 2 arranges bottlenecks into four levels based on how MoHS could address them.

Ensuring Priority Public Health Services Receive the Necessary Resources

Another name for this goal is allocative efficiency, which occurs when resources are used in areas where they provide the greatest value to society and industry as a whole. Actions to resolve bottlenecks follow:

- Key service delivery ministries, such as health and education, must implement medium-term public policies and strategies, which require greater certainty or predictability in medium-term funding of priority programs and construction projects. It can only come from the early participation of the cabinet in setting national policy priorities over the medium term, including health priorities, and making a political commitment to finance agreed-to national strategic priorities. (BN 2)

- Until a PFM law and reforms can provide more timely, integrated, and reliable budget ceilings, MoHS could pursue a needs-based approach to annual budget allocations by providing its own internal ceilings early to subnational units, allowing them to generate more realistic and aligned proposals. It could also switch to an electronic budget preparation process for the rapid consolidation of subnational budget proposals and for conformity with MoPFI guidelines and templates for budget submission. (BN 1 and 3)

- Assets management ensures the provision of needed equipment and supplies. Only some MoHS departments and programs maintain asset registers, and no national guidelines or software programs support assets management and maintenance. MoHS can explore affordable options for creating a simple Union-level digital register for physical and high-value assets that is accessible at the subnational level. It could incorporate financial and geospatial information, physical verification, working conditions, climate risk exposure, and maintenance requirements and costs. (BN13)

Ensuring Funds Flow Where and When They Are Most Needed

A common term is operational efficiency, or the ability to deliver products and services cost-effectively while ensuring high quality. Ways to resolve related bottlenecks follow:

- Budget flexibility and proactive budget management, along with real-time information on allocations and execution, are essential. The government could enhance the contingency fund and treat it as an emergency or disaster fund rather than routinely pre-allocate it to states, regions, and ministries. Underspending is also a problem for MoHS, partly from multiyear planning limitations and the lack of an integrated financial management information system. Steps to assure its resources are being allocated and spent based on priority and need include (i) tracking domestic and external resources by program and location in its budget preparation and reporting tools; and (ii) working closely with MoPFI to ensure consistency with the revision of the unified chart of accounts. (BN 4 and 5)

- Health infrastructure development depends on astute public investment management and procurement.

A single-year approach to planning, budgeting, and execution of construction projects and the lack of project readiness create allocative and operational inefficiencies, under execution, and delays in critical health infrastructure projects. MoHS can still budget for and implement construction projects that are sequenced around a prioritized medium-term infrastructure plan. It would function within the MoPFI budget cycle and ceiling by ensuring a pipeline of already-prioritized, agreed-to projects with the necessary preliminary work done on stages such as design, specification, land, procurement, and approvals. (BN 12)

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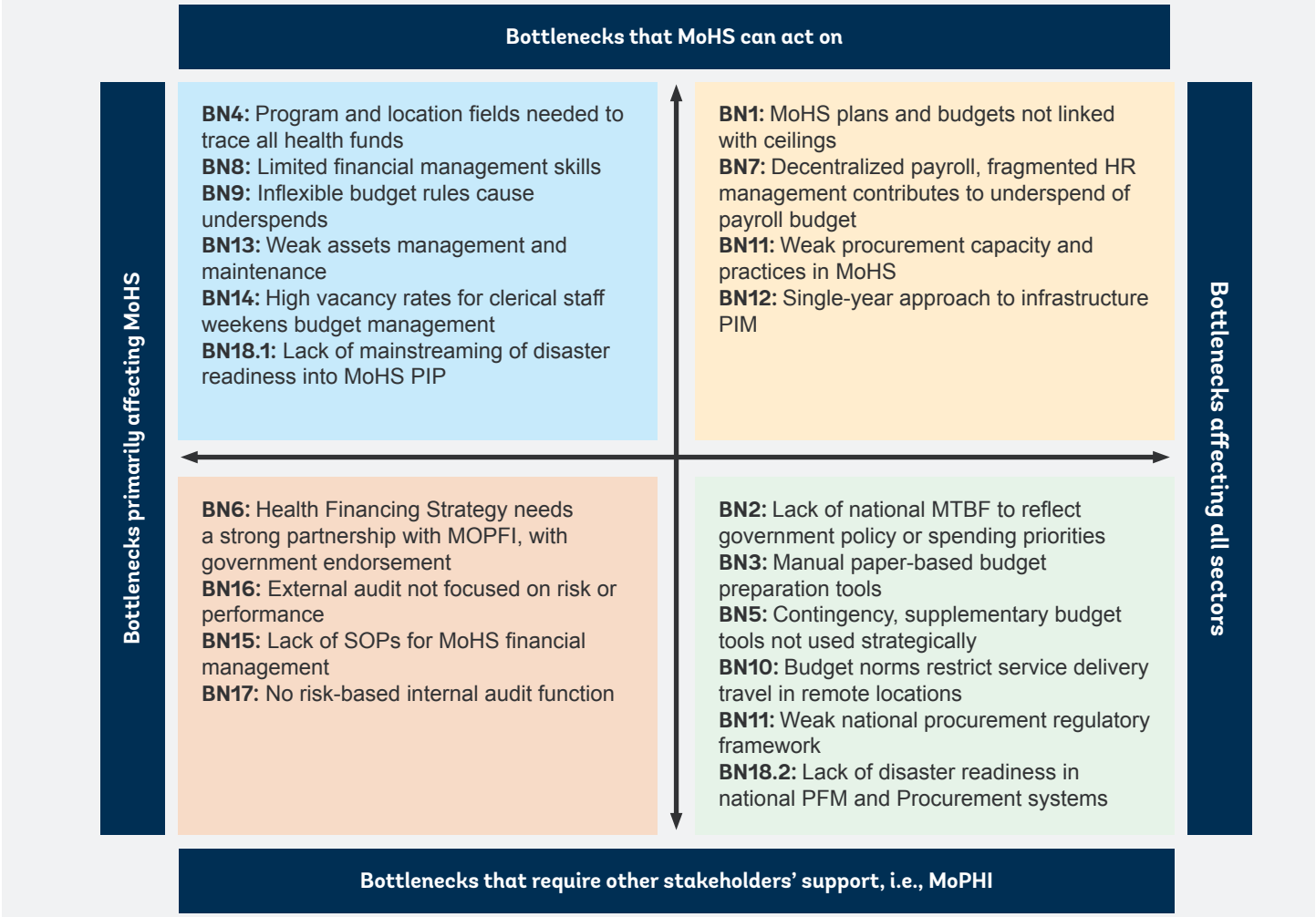
FIGURE 2 - Four Levels of Bottlenecks and How They Relate to Myanmar's Ministry of Health and Sports



Source: World Bank 2021.

Note: The boxes are positionally related to each type of bottleneck. BN = bottleneck; HR = human resources; MoHS = Ministry of Health and Sports; MoPFI = Ministry of Planning, Finance, and Industry; MTBF = medium-term budget framework; PFM = public financial management; PIM = public investment management; PIP = public investment plan; SOPS = simple standard operating procedures.

Ensuring the Required Level of Human Resources to Manage Financial Resources

Lack of financial management qualifications and skills is common across most government sectors, including health. Also, a recent study of human resources for health identified staff shortages in almost all states and regions, including major cities, as well as wide disparities in urban and rural areas.

- Officials responsible for financially managing departments and hospitals at the subnational level may lack relevant qualifications or skills. In the medium term, MoPFI could institutionalize PFM capacity building for all sectors and ministries through the PFM Academy, with modules that meet the needs of clerical finance staff at the subnational MoHS level. MoPFI could work in partnership with MoHS to adapt materials and modality to suit subnational requirements. (BN 8)

- The high vacancy rate of PFM personnel (60 percent) undermines getting resources when and where they are needed and achieving seamless health service delivery. Short- and medium-term solutions revolve around recruitment, skills development, and performance recognition. MoHS could also provide guidelines for use at state and regional levels to manage the shortage of crucial finance staff, including temporarily hiring skilled contractors. A staffing and pay scale review for important PFM support functions could inform a more strategic approach to staffing levels, workforce composition, and allocation in remote and conflict areas. (BN 14 and 19)

Managing Risks

Fiduciary and climate risks and resilience must be considered when developing and implementing a new Health Financing Strategy (HFS) and PFM systems.

- Myanmar is one of the world's most disaster-prone countries. COVID-19 highlighted fiduciary risks associated with emergency spending. Efforts are underway to identify new sources of financing and more flexible funding channels for frontline providers to allow more efficient responses to local needs. Greater budget autonomy or flexibility would improve the level of readiness and resilience of subnational providers. Also, MoHS could seek government endorsement of the proposed HFS in close partnership with MoPFI, government agencies, and development partners. (BN 6 and 16)

- Enhanced and modernized external audit practices are being rolled out, and a strategy has been adopted for auditing expenditures related to COVID-19 responses. The Office of the Auditor General of Myanmar (OAGM) is undergoing a process of modernization to introduce a risk-based methodology and adopt computer-assisted auditing techniques. MoHS could prepare for audits by ensuring compliance with MoPFI instructions and coordinating with OAGM to understand documentation and other requirements. Adopting the Government Accounting System would allow for applying computer-assisted auditing techniques. Survey results confirm that very few MoHS subnational entities or facilities have been the subject of an internal audit. MoHS could consider leveraging the existing cadre of internal reviewers to pilot an internal audit manual being developed with support from the International Monetary Fund. (BN 16 and 17)

It is important to note that consultation with MoPFI and its full commitment are critical in making changes to health budget allocation processes, treasury arrangements for purchasers and providers, and financial reporting and accountability responsibilities of health service providers.

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