Qualitative Study of Out-of-Pocket Expenditures (OOPE) on Health: Further Expanding the Knowledge and Evidence Base of Health Financing in Myanmar

FINAL REPORT
30th June 2017

This study was implemented by Save the Children with funding from the World Bank and 3MDG Fund.
Executive Summary

Background

Out-of-pocket health expenditure (OOPE) is any direct spending by households, including gratuities and in-kind payments to public or private health practitioners or pharmaceutical suppliers, for therapeutic appliances and other goods and services, whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. High out-of-pocket payments are strongly associated with catastrophic and impoverishing spending. Financial protection involves protection against the economic impact of ill health, which implies preventing people from becoming poor or incurring expenditures as a result of a health problem that threatens subsistence expenses and forces them to choose between their physical and mental health and their economic well-being.\(^1\) Financial protection primarily, but not exclusively, involves out-of-pocket payments at the time of service delivery. Other expenses incurred in using health care may also cause financial hardship, such as transport costs or the opportunity cost associated with seeking care, inability to pursue income-generating activities,\(^2\) or lost income due to illness.\(^3\) Many studies of OOPE do not take into account wider social costs beyond fee for service, so less is understood about the impact and interactions of these costs.

Out-of-Pocket Expenditure in Myanmar

The literature and data on out-of-pocket health care expenditure in Myanmar is limited in quantity, but points to a long history of OOPE as the main source of health sector financing. In 2012, government public health spending was 1.6 USD per yearly capita, while OOPE accounted for almost 80 percent of total health spending.\(^4\) The Myanmar National Health Plan (2017-2021) indicated that Myanmar allocates 3.65% of its total budget on health, which is extremely low by both global and regional standards. This historical underinvestment in the health sector has resulted in a difficult situation for both providers and users within the health care system of Myanmar.

Myanmar’s Commitment to Universal Health Coverage

The Government of Myanmar is committed to the goal of achieving Universal Health Coverage (UHC) by 2030 and in recent years has introduced a number of policies aimed at improving service delivery, increasing service utilization and strengthening financial protection. These initiatives have been accompanied by a significant rise in public spending on health. Major investments have also been made in improving quantitative data on health and living conditions through the national Census, Demographic and Health Survey (DHS), Service Availability and Readiness Assessment (SARA) and Myanmar Poverty and Living Conditions Survey. Additionally, the Ministry of Health and Sports is conducting end line evaluations of the GAVI Health System Strengthening Project investments with the support of WHO. The findings from these studies would be further enriched by qualitative research that would delve into the whys and the hows of out of pocket spending on health. The qualitative data would be a useful resource to better

interpret the quantitative data, inform future surveys and National Health Accounts, and build a better understanding of the broader reasons for and impact of OOPE—thus contributing to the evidence base for policy makers to improve financial risk protection.

OBJECTIVES

The overall objective of this qualitative study is to improve the current understanding of OOPE on health care, in order to inform evidence-based health financing reforms and policy-making in Myanmar.

This overall objective is to be achieved through two specific objectives:

(i) generate a deeper understanding (the why and how) of the impact of OOPE, decision making related to OOPE, related coping mechanisms including forgone care, at the household level;
(ii) generate an understanding of how health providers and informal service providers perceive out-of-pocket spending and manage resources to deliver services at the primary health care level.

The purpose of the two specific objectives is to strengthen the foundation for an evidence-based understanding of OOPE on health care from both household and provider perspectives. These objectives were approached in tandem as they are understood to be inter-related according to demand and supply dynamics within the health system.

STUDY LOCATIONS

As qualitative research this study did not seek to be representative, but purposeful in the selection of study areas to include a range of experiences and perspectives from households, health providers and informal service providers. Based on a review of existing data and literature from the same or similar geographical contexts, the study was designed to include peri-urban, rural and hardship areas across three States/Regions, so that three geographical areas with differences in the experience of OOPE could be explored. These locations were selected purposefully to include areas that have received GAVI HSS Maternal Health Voucher Scheme support, GAVI HSS Hospital Equity Fund support or neither of these. Based on these parameters the study areas selected were as follows: Yangon: Hlaingtharyar & Shwe Pyi Thar Townships; Bago: Yedarshay and Oaktwin Townships; Chin: Hakha & Tedim Townships.

METHODOLOGY

Qualitative methods were determined to be most appropriate for this study based on its aim to generate an in-depth understanding of how and why OOPE impacts the lives of people in Myanmar. The study took a primarily deductive approach to addressing defined research questions through Content Analysis.5 Multiple analytical tools were used with the Analytical Framework at the center of its coding process. The preliminary analysis started during the data collection process, as the research team collected, reviewed and discussed the data to begin building a description of the context and core theoretical concepts. The core theoretical concepts and the relationships between them were visually summarized in Concept

5 Content analysis looks to code for themes in the raw text and can follow three distinct approaches: conventional, directed, or summative. With a conventional approach, coding categories are derived directly from the text. With a directed approach, analysis starts with a theory as guidance for initial codes. With a summative approach, counting and comparisons of keywords or content is conducted followed by interpretation of the underlying context.
Maps, which were integrative diagrams used to support further team-based reflection and discussion of key findings in Senior Consultation Group review meetings. Finally, note based transcriptions of interviews and focus groups was further explored through a more fine-grained Content Analysis using Nvivo software, in order to verify and substantiate the articulation of key findings.6

PURPOSEFUL SAMPLING

From the Township level, key informants were selected along the line of service provision from township to village/ward level, so that the dynamics of service provision and care-seeking within the particular context of the key informants could be considered. Public, private and informal service providers were purposefully selected, in order to understand public health care service provision within the wider context of health care service provision. Two villages or wards were selected in order to represent variations in access to health services, one remote access (i.e. village or ward with “hard to reach” populations) and one with more immediate access (i.e. village or ward where the SRHC/MW is based). At the village level, initial consultations were held with the village administrator, then community representatives were convened to conduct a social mapping and wealth ranking exercise. This exercise aimed to identify households considered the most poor/vulnerable and those known to have experienced a recent major health event as well as health providers most active within the village.7

FINDINGS: HOUSEHOLD PERSPECTIVES

Encounters and Perceptions of OOPE: All patients encounter some form of OOPE regardless of the type of health care they seek. In addition to costs for diagnosis and treatment, costs for meals and transport are encountered often at great expense, except when care is obtained from local providers within the same village or ward. Costs encountered from private providers are usually more clear and predictable than costs encountered from public providers. All health care is perceived to come at some cost, regardless of the type of provider. Access to health care requires “money in hand” with perceived minimum thresholds to seek care. Paying for health care is seen as an obligation, which is worthwhile, yet largely unpredictable.

Access to Funds: Households obtain “money in hand” to make OOPE payments from a range of funding sources. The most common sources are household finances and borrowing, followed by selling of assets, loaning and pawning. Poorer households depend more on borrowing, wage advances or pawning than richer households with more household finances and access to loans. Loaning and pawning are common in Bago and Yangon, but almost entirely absent in Chin. Contributions of remittances from abroad to household finances, borrowing or charity are common in Chin, but infrequent in Bago or Yangon. Provider credit acts as a temporary substitution for “money in hand” to access services at local level and delay OOPE payments.

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6 NVivo is a qualitative data analysis software package designed for qualitative researchers working with very rich text-based and/or multimedia information, where deep levels of analysis on small or large volumes of data are required.

7 Major health events were explained to include recent emergency cases where hospitalization may have been sought or unresolved/chronic conditions that interfere with normal daily activities. Households known to have experienced a recent major health event were not necessarily from poor/vulnerable households, but rather could be from all wealth quintiles (Q1-Q5).
Influence of OOPE on Care-Seeking: The influence of OOPE on care-seeking across all geographical contexts and household quintiles appears to result in consistent trends. In almost all cases care is sought locally first, then other options for care are considered based on the perceived severity or urgency of the health event(s) involved.

Impact of OOPE on Health and Socio-Economic Status: OOPE for health affects the whole household and often extended family networks. Care seeking involves a complex decision-making process that balances the dimensions of payment and care-seeking across a spectrum. While negative impacts are most clearly illustrated at the extremes of maximum payment and forgone care, the experience of most households is somewhere along this spectrum. Negotiating a balance between these extremes usually involves accessing less expensive, locally available health care options mixed with periods of forgone care, which result in undiagnosed and unresolved health issues for many households.

FINDINGS: PROVIDER PERSPECTIVES

Resource Management Strategies and Coping Mechanisms: Public providers function with longstanding resource constraints, so their coping mechanisms are actually a part of their usual management strategies, which include use of donations/fees and sending patients elsewhere for care (i.e. “referrals”). A plethora of tactics are used to deal with insufficient and near expired medicines and commodities. Inadequate and unpredictable fund flow reinforces reliance on donations/fees. Centralized management of human resources limits the ability to prioritize the most critical human resource needs across a Township and incentivize staff to meet these needs. Lack of replacement and maintenance of equipment and instruments results in inability to provide basic investigations and procedures.

Understandings and Perceptions of Health Financing Options: Providers have limited understanding of health financing options, but generally describe government, donors and users as the primary health financing sources. However, user sources of funds (i.e. OOPE) are seen through a lens of necessary “cost sharing” to cover health care costs. Supply side gaps are viewed to compromise the ability to retain “free of charge” services and maintain trust with patients. Initiatives to reduce OOPE for patients should be accompanied by efforts to ensure sufficient resources for providers.

Impact of OOPE on Patients and the Wider Population: Public, private and informal providers perceive that OOPE has a negative impact on health outcomes for patients and the wider populations, especially those who are poor. To help enable poor patients to receive needed care, providers may reduce charges, give credit, provide financial support or refer and advise patients on where they can receive affordable treatment.

DISCUSSION

The findings of this study describe the multifaceted roles and impacts of OOPE within both the demand and supply sides of the health care system in Myanmar. A rich understanding of OOPE has been generated through insights from both household members with varying levels of engagement with the health system as well as public, private and informal providers. These findings highlight that historical underinvestment in the health sector has resulted in a difficult situation for both health care users and providers. Those seeking care and those providing care have a strong mutual dependence on the role of OOPE for health, which can be seen in how “money in hand” is needed to seek almost any health care option as well as in how dependent all health providers are on donations/fees to deliver and maintain services. This mutual
dependence on OOPE introduces a number of incentives and consequences that are not optimal for health system functionality or health outcomes. However, the ways that OOPE for health is currently used and why it is used in these ways point toward priorities for improving how the health care system works for both users and providers in the future.

CONCLUSIONS AND RECOMMENDATIONS

Findings from this study give support and added rationale to many of the initiatives already outlined within the National Health Plan 2017-2021, particularly those related to emphasis on primary health care delivered at the township level and below, a switch from top-down planning to a more inclusive bottom-up approach and close collaboration across the many actors within the health system, including providers outside the MOHS and communities. Additionally, the National Health Plan (NHP) calls for temporary measures to reduce catastrophic expenditure by poor and vulnerable households with recognition that developing robust risk pooling mechanisms to ensure long-term financial protection will take time. The findings of this study suggest considerations for such temporary measures, which would support expansion of access to an essential package of health services and greater financial protection. Progress on these initiatives over the next few years would critically contribute to addressing the needs of providers to maintain service availability and readiness as well as users to access quality health care with greater financial protection, thus advancing the country’s aim to achieve Universal Health Coverage by 2030.
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<td>3 MDG</td>
<td>Three Millennium Development Goal (Fund)</td>
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<td>AMW</td>
<td>Auxiliary Midwife</td>
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<td>AN</td>
<td>Antenatal (patient)</td>
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<td>Antenatal Care</td>
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<td>Assistant Surgeon</td>
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<td>BHS</td>
<td>Basic Health Staff</td>
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<td>CBO/CSO</td>
<td>Community Based Organization/ Civil Society Organization</td>
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<td>Community Health Worker</td>
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<td>CMSD</td>
<td>Central Medical Store Depot</td>
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<td>D/C</td>
<td>Discharged (patient)</td>
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<td>Expanded Programme on Immunization</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>Free of Charge</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>GRET</td>
<td>Groupe de Recherches et d’E changes Technologique</td>
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<td>H2R</td>
<td>Hard to Reach</td>
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<td>HA</td>
<td>Health Assistant</td>
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<td>Health Education</td>
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<td>Hospital Equity Fund</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HSS</td>
<td>Health System Strengthening</td>
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<td>INGO</td>
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<td>International Organization for Migration</td>
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<td>Japan International Corporation Agency</td>
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<td>MC(H)VS</td>
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<td>Myanmar Medical Association</td>
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<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
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<td>MOHS</td>
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<td>Myanmar Red Cross Society</td>
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<td>MS</td>
<td>Medical Superintendent</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<td>MSF</td>
<td>Medecins Sans Frontieres</td>
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<td>MW</td>
<td>Midwife</td>
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<td>NGO</td>
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<td>Obstetrician and Gynecologist</td>
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<td>OOPE</td>
<td>Out-of-Pocket Expenditure</td>
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<td>OOS</td>
<td>Out of School</td>
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<td>OPD</td>
<td>Out Patient Department</td>
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<td>PHS I/II</td>
<td>Public Health Supervisor Grade I / II</td>
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<td>Postnatal (patient)</td>
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<td>Postnatal Care</td>
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<td>PSI</td>
<td>Population Services International</td>
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<td>Q</td>
<td>Quintile</td>
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<td>QSEM</td>
<td>Qualitative Social and Economic Monitoring</td>
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<td>R/MNCH</td>
<td>Reproductive, Maternal, Newborn and Child Health</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>RHC</td>
<td>Rural Health Center</td>
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<td>SARA</td>
<td>Service Availability and Readiness Assessment</td>
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<td>Station Hospital</td>
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<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<td>TH</td>
<td>Township Hospital</td>
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<td>Trained Nurse</td>
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<td>UHC</td>
<td>Urban Health Center</td>
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<td>United Nations</td>
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<td>USG</td>
<td>Ultrasound</td>
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<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
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<td>World Health Organization</td>
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Introduction

The Government of Myanmar is committed to the goal of achieving Universal Health Coverage (UHC) by 2030 and in recent years has introduced a number of policies aimed at improving service delivery, increasing service utilization and strengthening financial protection. These initiatives have been accompanied by a significant rise in public spending on health. Major investments have also been made in improving quantitative data on health and living conditions through the national Census, Demographic and Health Survey (DHS), Service Availability and Readiness Assessment (SARA) and Myanmar Poverty and Living Conditions Survey. Additionally, the Ministry of Health and Sports is conducting end line evaluations of the GAVI Health System Strengthening Project investments with the support of WHO. The findings from these studies would be further enriched by qualitative research that would delve into the why and the how of out of pocket spending on health. The qualitative data would be a useful resource to better interpret the quantitative data, inform future surveys and National Health Accounts, and build a better understanding of the broader reasons for and impact of OOPE—thus contributing to the evidence base for policy makers to improve financial risk protection.

Over the past three years the World Bank (WB), in collaboration with government officials from Ministry of Health and Sports (MOHS) as well as the Ministry of Planning and Finance, has helped to undertake analysis, provide technical assistance and build capacity that focuses on improving the health financing system in Myanmar, and on aligning and strengthening the public financial management system to support health financing functions. As part of this program of support, the WB engaged with the Ministry to support implementation of a qualitative study to explore the current explanatory knowledge gaps in understanding OOPE for health in Myanmar.

This study was financed by the 3MDG Fund and the WB and implemented by Save the Children in Myanmar with guidance from the senior officials of MOHS and Myanmar experts (academics and retired government officials) to ensure the maximum value of this study to relevant government decision makers. A Senior Consultation Group was formed, which engaged the same Senior Advisors providing guidance to the GAVI HSS Assessments, in order to facilitate synergy and complementarity of learning from these studies. The Senior Consultation Group was convened at key moments during the research process, particularly during the preliminary analysis of results and presentation of findings after completion of work in each State/Region. This was done in order to ensure real time review, engagement and discussion of data as it became available.

Background
Out-of-pocket health expenditure (OOPE) is any direct spending by households, including gratuities and in-kind payments to public or private health practitioners or pharmaceutical suppliers, for therapeutic appliances and other goods and services, whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. High out-of-pocket payments are strongly associated with catastrophic and impoverishing spending. Health expenditure is widely defined as being catastrophic if a household’s financial contributions to the health system exceed a certain percentage of income (often 20 or 40 percent) remaining after subsistence needs have been met, which may push a household into poverty as a result. Studies find that countries where out-of-pocket payments constitute a higher share of total health expenditures are more likely to have a higher proportion of households facing catastrophic expenditure after controlling for other possible determinants. A
Qualitative Study of OOPE on Health | INTRODUCTION

Household is considered impoverished by medical expenses when health care expenditure causes the household to drop below the poverty line or fall deeper into poverty.6,9

Financial protection involves the protection against the economic impact of ill health, which implies preventing people from becoming poor or incurring expenditures as a result of a health problem that threatens subsistence expenses and forces them to choose between their physical and mental health and their economic well-being.10 Financial protection is primarily, but not exclusively, associated with out-of-pocket payments at the time of service delivery. However, other expenses incurred in using health care may also cause financial hardship, such as transport costs or the opportunity cost associated with seeking care, inability to pursue income-generating activities,11 or lost income due to illness.12 Many studies of OOPE do not take into account wider social costs beyond fee for service, so less is understood about the impact and interactions of these costs.13

There are three main sources of health sector financing: public, external and private. In Myanmar, public funding includes government revenues channelled through the budgets of the Ministry of Health and Sports, other ministries and departments, City Development Committees involved in health services and the government social security scheme. External funding mostly consists of Official Development Assistance provided by the government and health NGOs. Out-of-pocket expenditure and private social security schemes make up private health expenditure.14 Out-of-pocket expenditure is often used when prepaid and pooled health financing is insufficient to cover the costs associated with needed health care (i.e., the health financing system does not provide sufficient financial protection).

**Out-of-Pocket Expenditure in Myanmar**

The literature and data on out-of-pocket health care expenditure in Myanmar has long been limited in quantity, but has been increasing in recent years. Existing evidence points to a long history of OOPE as the main source of health sector financing. In 2006-2007, a household-level study conducted in Yangon Division, Mandalay Division and Mon State found that per capita health expenditure for sampled households amounted to approximately 50,000 Kyat, and was almost entirely OOPE.15 World Bank Development indicator country statistics show that per capita health expenditure has increased from 6.92 USD in 2007 to 19.79 USD in 2012, with government expenditure representing 0.23% of GDP in 2007 and

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15 San San Aye, Soe Tun, Kyaw Swar Min, Htwe Htwe Myint, Htay Htay Win, Kyawt Kay Khine (Unpublished).
Qualitative Study of OOPE on Health | INTRODUCTION

0.43% in 2012. Despite an increasing trend in government expenditures, per capita government health expenditure during the same period was a mere 427.8 Kyat.

These low levels of public health sector financing perpetuated until recently; in 2012, government public health spending was 1.6 USD per yearly capita, while OOPE accounted for almost 80 percent of total health spending. Human resource and government expenditure increases during this period were disproportionately focused on hospitals rather than primary health care centres, with hospitals taking about 70% of the total budget with public health programs receiving about 2%. The latest available data as cited in the Myanmar National Health Plan (2017-2021) indicates that Myanmar currently allocates 3.65% of its total budget on health, which is extremely low by both global and regional standards.

Overview of Recent Literature on OOPE in Myanmar
Most studies reviewed use the threshold of 10% or more of total expenditure or income to define catastrophic health expenditure. Another study uses two thresholds – these are 10% of total expenditure and 40% of non-food expenditure.

These same studies show high levels of health expenditure, which is almost entirely out of pocket. The Myanmar Poverty and Living Conditions Survey (MPLCS) showed that 16% of sampled households faced catastrophic expenditure. Studies in Upper Myanmar in 2005 showed an incidence of 8% and in lower Myanmar 10% in 2010. A study in Magwe showed that 25.2% of households sampled in urban areas and 22.7% in the rural areas faced catastrophic expenditure. Contrary to this, in one cross sectional study of one State and five Regions, catastrophic health care expenditure was significantly higher among households in rural areas than urban areas (p=0.001). The Magwe study notes that risk increases in larger households with the Odds Ratio of a family of four or less facing catastrophic health expenditure being 0.34 (95% CI 0.17–0.68) when compared to a family of more than four people.

The cross sectional study of one State and five Regions estimated catastrophic health expenditure at 37.1% using the threshold of 10% of total annual expenditure and 32.9% using the threshold of 40% of annual non-food expenditure. The MPLCS finds that this is not the case with households living below the poverty line as many people in this bracket do not pursue care as they are unable to pay for it. The Magwe study corroborates this and even finds that the risk of catastrophic expenditure rises with household consumption expenditure. This is contrary to the cross-sectional study – where catastrophic expenditure

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17 San San Aye, et al. (Unpublished).
19 Su Su Zin, et al. 2015.
20 Ibid.
24 Khaing Ik, et al. 2015.
25 Win Myint Oo, et al. 2015.
was associated with both annual household income (p = 0.012) and expenditure (p = 0.009). This was highest in the lowest income households (42.3%) and lowest in the highest income households (21.2%), (p = 0.008). This was similar in the expenditure quintile groups (p = 0.013).

Two of the reviewed studies indicate higher odds ratios associated with in-patient care. One shows an odds ratio of catastrophic expenditure of 7.79 (95% CI 3.73–16.26) for hospitalization and 1.08 (95% CI 0.36–3.23) for outpatient care when compared to no care.26 While the other finds that in a household where someone is hospitalized, they are much more likely to face catastrophic expenditure (p = 0.001).27

All study results suggest that in order to deal with health shocks, households employ negative coping mechanisms, such as borrowing (at 32% in the MPLCS, where poorer households are more likely to borrow from informal sources at high interest rates), sell productive assets (14.5% in the MPLCS, more common amongst the non-poor), or cut consumption expenditure, likely to food consumption (20.7% in the MPLCS; 19% in urban areas and 5% in rural areas in the Magwe study). These all affect welfare in both the short and long term and can contribute to ‘cycles of deprivation,’ which is also detrimental to the economy, with an estimated 4% of working days lost to ill health.28

The MPLCS estimated that households spend an average of 175,000 Kyat per year on health care, with richer households spending much more. The Magway study reports higher average rates of 310 USD in 2014 (with 419 USD in urban areas and 79 USD in the rural areas (p<0.001)). In total the MPLCS equates this average spending to 2.2 trillion Kyat on health care expenditures (0.1 trillion on transport, 0.9 trillion on outpatient care, 0.7 trillion is spent on inpatient care and 0.5 trillion on medicine).

26 Khaing Ik, et al. 2015.
27 Win Myint Oo, et al. 2015.
Factors Influencing Variation in OOPE across Myanmar
Based on the available literature and data, there are a number of factors noted to influence OOPE in Myanmar, which were considered in the design of this qualitative study. Broadly these include the following:

1. **Geography**, including differences in terrain, urban/rural and related impacts on the distribution and accessibility of health facilities;
2. **Socio-economic factors**, including ethnic and language diversity, gender, poverty levels and livelihood zones;
3. **Environment and disease transmission**, including the nature and severity of endemic disease, access to curative medical services, preventative public health services and other basic services, such as water and sanitation systems;
4. **Governance and security**, including consideration of areas under government or non-governmental administration as well as areas affected by conflict;
5. **Sub-national risk-pooling arrangements or other health financing support**, including insurance, loan schemes, maternity voucher schemes, equity funds or other government, non-government or donor support that minimizes or mitigates OOPE for health care and resulting indebtedness.

Objectives
The overall objective of this qualitative study is to improve the current understanding of OOPE on health care, in order to inform evidence-based health financing reforms and policy-making in Myanmar.

This overall objective is to be achieved through two specific objectives:

(i) generate a deeper understanding (the *why* and *how*) of the impact of OOPE, decision making related to OOPE, related coping mechanisms including forgone care, at the **household level**;
(ii) generate an understanding of *how* health providers and informal service providers perceive out-of-pocket spending and manage resources to deliver services at the **primary health care level**.

The purpose of the two **specific objectives** is to strengthen the foundation for an evidence-based understanding of OOPE on health care from both household and provider perspectives. These objectives were approached in tandem as they are understood to be inter-related according to demand and supply dynamics within the health system. Recognizing that individuals seek health care and other related services from a broad range of formal health providers and informal service providers, this study sought to include the perspectives of a range of public, private and informal service providers. However, focus was placed on understanding how public providers maintain service availability and cope with resource constraints within the broader context of the Myanmar health system, including any roles they may have in private or informal service provision (i.e. forms of “dual practice”). The study used a qualitative methodology in order to provide an in-depth depiction of OOPE.

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29 Note: Health providers include all biomedical health care practitioners, including those providing direct patient care, paramedical services and administrative functions as well as registered traditional medicine practitioners; informal service providers include those who provide other informal services, such as faith-based healers, traditional birth attendants and drug sellers.
Analytical Framework
An analytical framework was developed based on a review of existing literature to provide guidance to both data collection and analysis throughout the research. It is intended to describe how the issues explored within the two specific objectives relate to one another. In the diagram below this is represented by blue boxes (specific objective 1); yellow boxes (specific objective 2); a green box (combination/interaction between specific objectives 1 and 2). The analytical framework was intended to be simple enough for researchers to internalise and use as a guide for probing and analysis.

Research Questions
Based on the research objectives and analytical framework, specific research questions were defined as follows:

**Question 1.** How do people encounter and perceive OOPE?
**Question 2.** How do people access finances to make OOPE payments?
**Question 3.** How does OOPE influence care seeking decisions?
**Question 4.** How does OPPE impact health status and socio-economic welfare?

**Question 5.** How do providers manage finances and supplies to maintain service availability?
**Question 6.** How do providers cope with resource constraints?
**Question 7.** How do providers understand and perceive health financing options?
**Question 8.** How do providers view the impact of OOPE on their patients and the wider population?

These specific research questions focused on “how” with the understanding that the “why” would be addressed through the combination of information gathered across the two specific objectives, including the bringing together of both household and provider respondent perspectives.

30 Note: Measurement of out-of-pocket health expenditure using quantitative methods does not cover indirect costs such transportation, meals and opportunity costs. Consequently, we do not expect global, regional and in-country figures on OOPE to reflect such indirect costs. It is anticipated that the actual burden of health related expenditure (direct and indirect) on households is much higher than what those figures show. This qualitative study is intended to shed light on the impact of these indirect costs as well.
Methodology

Qualitative Analysis

Qualitative research focuses on studying phenomena in their natural settings and striving to make sense of or interpreting phenomena with respect to the meanings people bring to them. Qualitative data analysis is a range of processes and procedures that allow researchers to move from the raw qualitative data to a form of explanation, understanding or interpretation. Like all research methodologies, qualitative methods have both strengths and limitations. Qualitative methods were determined to be most appropriate for this study based on its aim to generate an in-depth understanding of how and why OOPE impacts the lives of people in Myanmar. The study took a primarily deductive approach to addressing defined research questions through Content Analysis. Multiple analytical tools were used with the Analytical Framework at the center of its coding process.

The preliminary analysis started during the data collection process, as the research team collected, reviewed and discussed the data to begin building a description of the context and core theoretical concepts, which were explored through further data collection and the primary analysis process. The analytical tools used to build these descriptions included several compilation forms (used to compile and sort data, including case studies and quotations) and preliminary analysis forms (used to start roughly coding and analyzing data). The core theoretical concepts and the relationships between them were visually summarized in Concept Maps, which were integrative diagrams used to support further team-based reflection and discussion of key findings in Senior Consultation Group review meetings. Finally, note-based transcriptions of interviews and focus groups were further explored through a more fine-grained Content Analysis using Nvivo software, in order to verify and substantiate the articulation of key findings.

The study proceeded through the analytical process as follows:

1. Preliminary Analysis: Analysis was conducted during the fieldwork through the use of compilation forms, preliminary analysis forms and team-based debriefing sessions.

2. First Order Primary Analysis: Building on the preliminary analysis, Concept Maps were developed as integrative diagrams to help summarize and make sense of the data with respect to the emerging explanations of phenomenon. These were developed through an iterative process where different members of the research team interacted and shared ideas to increase insight. At the same time, Nvivo software-based coding of the translated note-based transcriptions commenced through the initial development of a codebook according to the domains of the analytical framework (i.e. deductive coding).

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31 The main limitation of qualitative studies is that data is usually collected from a relatively small number of cases or individuals, so findings cannot be generalized to a larger population.

32 Content analysis looks to code for themes in the raw text and can follow three distinct approaches: conventional, directed, or summative. With a conventional approach, coding categories are derived directly from the text. With a directed approach, analysis starts with a theory as guidance for initial codes. With a summative approach, counting and comparisons of keywords or content is conducted followed by interpretation of the underlying context.

33 Concept Maps that proved particularly useful for summarizing findings are included in this final report.

34 NVivo is a qualitative data analysis software package designed for qualitative researchers working with very rich text-based and/or multimedia information, where deep levels of analysis on small or large volumes of data are required.
Code definitions were revised and sub-codes defined based on emerging concepts in the data (i.e. inductive coding).

3. **Second Order Primary Analysis:** After the coding of all interviews, the content was further analyzed to explore recurrent themes, respondent clusters, event sequencing and emerging concepts to address the research questions. New observations from the team-based reviews and refinement of Concept Maps led to new linkages, revision in the coding and further in-depth analysis of the dataset. This stage involved exploration of similarities and differences within subsets of the data (i.e. townships/states/regions; urban/rural/hardship; wealth quintiles). As a result, the core theoretical concepts and domains were identified and fleshed out in detail.

4. **Findings and Interpretation:** Based on the culmination of all steps of analysis, refined Concept Maps, descriptions of core theoretical concepts and illustrative case studies were presented and discussed in Senior Consultation Group Review Meetings with the aim of furthering the interpretation and articulation of findings to address the research questions and overall study objectives.

**Schematic of Qualitative Analysis**

![Schematic Diagram]

**Study Locations**

**Purposeful Sampling of Study Locations**

As qualitative research this study did not seek to be representative, but purposeful in the selection of study areas to include a range of experiences and perspectives from households, health providers and informal service providers. Identified informants were expected to enable enriched exploration of experiences and perceptions relevant to OOPE. The geographical scope of the study is important given the multiple dimensions of variation across the country where there is a clear theoretical rationale for assuming meaningful differences in the experience of OOPE.
Based on a review of existing data and literature from the same or similar geographical contexts, the study was designed to include peri-urban, rural and hardship areas across three States/Regions, so that three geographical areas with differences in the experience of OOPE could be explored. These locations were selected purposefully to include areas that have received GAVI HSS Maternal Health Voucher Scheme support, GAVI HSS Hospital Equity Fund support or neither of these. Based on these parameters the study areas selected were as follows: **Yangon**: Hlaingtharyar & Shwe Pyi Thar Townships; **Bago**: Yedarshay and Oaktwin Townships; **Chin**: Hakha & Tedim Townships (see Annex 1: Contextual Background of Study Townships).

**Overview of State/Region and Township Study Locations**

<table>
<thead>
<tr>
<th>State/Region</th>
<th>Township</th>
<th>Type</th>
<th>Maternal Health Voucher</th>
<th>Hospital Equity Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yangon</td>
<td>Hlaingtharyar</td>
<td>Peri-urban</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Shwepyithar</td>
<td>Peri-urban</td>
<td>No</td>
<td>Yes (3rd Year)</td>
</tr>
<tr>
<td>Bago</td>
<td>Yedarshay</td>
<td>Rural</td>
<td>Yes</td>
<td>Yes (1st Year)</td>
</tr>
<tr>
<td></td>
<td>Oaktwin</td>
<td>Rural</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Chin</td>
<td>Hakha</td>
<td>Hardship</td>
<td>No</td>
<td>Yes (1st Year)</td>
</tr>
<tr>
<td></td>
<td>Teddim</td>
<td>Hardship</td>
<td>No</td>
<td>Yes (3rd Year)</td>
</tr>
</tbody>
</table>

**Purposeful Sampling of Respondents**

From the Township level, study locations and respondents were selected *along the line of service provision* from township to village/ward level (i.e. Township Health Department/Township Hospital, Station Hospital, Rural Health Center/Urban Health Center, Sub-Rural Health Center and Village/Ward), so that the dynamics of service provision and care-seeking within the particular context of the respondents could be considered in interpretation of the qualitative data. At each level, health providers were selected to include public providers with key roles in administration, medical care and public health service provision (e.g. TMO, THN, SMO, HA, MW) as well as private (e.g. GPs, Specialists, Pharmacists) and informal service providers (e.g. drug sellers, spiritual healers, traditional birth attendants and unregistered traditional medicine practitioners) most active within the township based on stakeholder consultations at the township level and mapping at the village/ward levels. Users were identified at each health facility level based on review of service provision registers, then households identified at the village/ward level through a community social mapping and wealth ranking exercise.

This purposeful sampling process started with township level consultations with the Township Health Department as well as non-governmental organisations and professional associations active within the township. Information was triangulated in order to identify the public, private and informal providers active at the township level as well as the most hard to reach populations within the township. The concept of “hard to reach” is used extensively in the Myanmar health system, but there is no official or consistent definition of “hard to reach,” so this was guided by the triangulation of inputs from the stakeholders consulted in each township. Once the locations with “hard to reach” populations were identified, consultation with the THD determined which Sub Rural Health Center (SRHC) catchment areas these populations were located and then the SRHC catchment area with the longest serving MW was

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35 Within peri-urban/urban townships, “hard to reach” was defined by socio-economic characteristics (e.g. migrants) and in rural townships “hard to reach” was defined by geographic characteristics (e.g. distance and ease of travel to/from township head).
selected. This purposeful selection was chosen given the key role in primary health care service provision of MWs within the public health system and value of selecting a key informant knowledgeable of the selected study location. Two villages or wards were selected from within the SRHC/MW catchment in order to represent variations in access to health services, one village or ward representing remote access (i.e. village or ward with “hard to reach” populations) and the other village or ward more immediate access (i.e. village or ward where the SRHC/MW is based).

At the village level, initial consultations were held with the village administrator, then community representatives were convened to conduct a social mapping and wealth ranking exercise. This exercise aimed to identify households considered the most poor/vulnerable and those known to have experienced a recent major health event as well as health providers most active within the village. Based on the ranking of the community representatives, respondents were selected from these households and health providers to include a diversity of perspectives. For household respondents, inclusion of female-headed households, ethnic minorities and migrants were prioritized. A balance of men and women were sought for interview, including both the husband and wife within a household when possible. For health provider respondents, inclusion of the most active health providers (i.e. those who are perceived by community representatives to be most highly sought for their services) were prioritized to include a mix of public, private and informal service providers (in some cases very few providers were in the village, so not all types of providers were present).

### Schematic of Purposeful Sampling of Respondents

<table>
<thead>
<tr>
<th>Discussion with TMO, NGOs &amp; Professional Associations Active in Township</th>
<th>Triangulation of Information to Identify H2R Populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect Township Profile &amp; HMIS Data</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discussion with HA and LHV from RHC/UHC</th>
<th>Confirmation of H2R Areas &amp; Selection of SRHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect RHC Profile &amp; HMIS Data</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discussion with MW from SRHC</th>
<th>Selection of H2R Village/Ward &amp; Users of Health Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collection of SRHC Profile &amp; HMIS Data</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Village/Ward 1 (with SRHC) &amp; Village/Ward 2 (with “Hard to Reach” Population)</th>
<th>Identification of Households (most poor/vulnerable &amp; recent major health events) &amp; Mapping of Service Providers (Public/Private/Informal) through Social Mapping &amp; Wealth Ranking</th>
</tr>
</thead>
</table>

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36 Major health events were explained to include recent emergency cases where hospitalization may have been sought or unresolved/chronic conditions that interfere with normal daily activities. Households known to have experienced a recent major health event were not necessarily from poor/vulnerable households, but rather could be from all wealth quintiles (Q1-Q5).
A total of 114 Key Informant Interviews (KIIs) with public (57 KIIs), private (21 KIIs) and informal (36 KIIs) providers were conducted. A total of 174 KIIs with household respondents were conducted in Yangon (53 KIIs), Bago (55 KIIs) and Chin (66 KIIs). A total of 12 Focus Group Discussion (FGDs) were conducted (one for every village in the study).

Positioning of Respondents within Wealth Quintiles
In order to position respondents within national and State/Region wealth quintiles, a few structured questions from the 2014 Myanmar Census regarding household assets were asked of all households respondents (i.e. users at health facilities and household members at community level). The responses given were then analyzed using the Equity Tool, which has been recently contextualized for use in Myanmar. This enabled interpretation of interview data with an understanding of the respondent’s relative national and State/Region socio-economic profile. This allowed for second order content analysis to be conducted according to quintile cluster groupings, in order to explore theoretical concepts across the wealth index in Myanmar. Given the purposeful sampling of households considered poor/vulnerable at the community level, it should be noted that the majority of the household respondents were from the three lower wealth quintiles (Q1-3) with only a minority of household respondents from the upper quintiles (Q4-5) captured primarily through the targeting of users at public health care facilities and households known to have experienced a major health event at community level (Annex 2: Wealth Quintile Profile of Respondents by State/Region and Township).

Informed Consent and Confidentiality
Informed consent was obtained from all participants prior to interviews and focus group discussions. Interviewers were responsible for explaining the research and asking the consent of the respondent(s) at the beginning of interviews and focus group discussion. Individual written consent was obtained from individuals interviewed and from individuals participating in focus groups. A section on the consent form was used to document that they have discussed the aims and use of the research with participants fully, shared the time requirements and requested and obtained consent for participation. Data collected was kept confidentially and anonymity protected with names of respondents kept separate from the data forms. Interview notes and related data forms were labelled with unique identifiers consisting of a combination of codes related to points of information important to the research team (i.e. identity of interviewer, identity of note taker, township location, type of interview and date).

Data Collection
A Roving Field Research Team of six Field Research Officers collected the data from the six Townships. The team collected data together in each Township, moving from the Township level to each level of service provision and spending four days in each village. Consistent pairs of researchers worked together, alternating between the roles of interviewer and note taker.

Each Field Research Officer was equipped with copies of the field guide, informed consent forms, semi-structured interview and focus group guides and structured household socio-economic questionnaires (i.e. 2014 Census Module). Each Field Research Officer was responsible for maintaining three notebooks as follows: 1) one for original interview and focus group notes, 2) one for rewritten interview and focus group notes; 3) one for general field journal observations and reflections. The team was also equipped with a series of forms used for collecting and compiling the required data as well as preliminary analysis.

More information on the Equity Tool found at: http://www.equitytool.org/myanmar.
forms used to guide team based content analysis of data in each township *(Annex 3. Overview of Compilation and Preliminary Analysis Forms).*

In Chin, the research team was divided into two (i.e. three Field Research Officers traveling to each Township) for simultaneous data collection due to timeline considerations and practicalities of integrating translators into the research team. The translators were provided orientation to the study and research protocol, then worked with the field research officers to translate and back translate the informed consent forms, semi-structured interview guides and household socio-economic questionnaire into the respective Chin languages (i.e. Lai in Hakha Township; Zomi in Tedim Township). Emphasis was placed on ensuring common understanding of key terms important to the topics of the research and note taking protocols. Pretesting of tools in Chin language also served for validating tools in Chin language, practice of skills and team building between officers and research before collection of data.

**Quality Assurance**

Approaches for ensuring data quality and validity of findings in this research drew on the practical experience and learning of the Qualitative Social and Economic Monitoring (QSEM) analytical program in applying feasible qualitative approaches to monitor changes in livelihoods and social relations across rural Myanmar. The QSEM series has focused intensively on developing detailed methodology plans and refining steps a research team can feasibly take to ensure data quality and validity of findings. This research was informed by the practical approaches the QSEM team has developed to ensure quality in gathering, managing, and analysing data at different stages of the research process: (1) training; (2) pre-testing; (3) data collection; (4) field based compilation and preliminary analysis; and (5) post-field work analysis and review of findings *(Annex 4: Quality Assurance Across Stages of the Research Process)*.

**Study Limitations and Further Research**

As qualitative research this study did not seek to be representative, but purposeful in the selection of study areas and respondents, so the findings of this study cannot be considered generalizable to the entire population of the study areas or the country as a whole. However, the study purposefully included contrasting geographical areas, selected according to multiple dimensions of variation across the country where there is a clear theoretical rationale for assuming meaningful differences in the experience of OOPE.

Additional prioritizations with purposeful sampling had to be made in order to keep the study within a manageable scope for the allocated resources and timeframe. The study narrowed focus on the experiences and perceptions of OOPE within the context of primary health care, so the provision and seeking of care from Township level and below. Therefore, interviews were not conducted with providers or patients in higher level clinics and hospitals at state, region or national level. Additionally, the study purposefully selected populations considered hard to reach by health providers, households considered poor and vulnerable by community members as well as households recently affected by a major health event as identified by community members. These particular populations were targeted in order to explore the experiences and perceptions of individuals that are likely to have been most seriously affected by OOPE, but this means that the experiences and perceptions of individuals in higher wealth quintiles and with greater geographical access to health facilities are less represented in the study sample.

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*QSEM is a partnership between the Livelihoods and Food Security Trust Fund (LIFT), the World Bank and Enlightened Myanmar Research (EMR) and consists of a core longitudinal panel study (the QSEM series) and a number of targeted thematic studies on topics emerging from the QSEM series from 2012 to 2018.*
Finally, purposeful selection of public, private and informal providers were guided by a number of factors, including length of service for public providers, popularity for private and informal providers as well as availability during the time of facility and village visits. These factors were considered in order to focus on respondents most knowledgeable and active in service provision as well as realistically balance practicalities of study timeframe and intrusion into the schedules of the selected health providers. While a cross section of different kinds of providers were included from Township to Village level the selection cannot be considered representative of all kinds of providers. Additionally, in order to maintain confidentiality, the study report is not able to present some contextual details (e.g. the locations where providers practice), which may limit the reader’s ability to put provider quotations into context.
FINDINGS

Part I: Household Perspectives

1. Encounters and Perceptions of OOPE (Question 1)

This study explored both the encounters and perceptions of individuals who have sought various health care options. Within the context of this study, “encounters” are descriptions of costs that individuals have actually experienced (not generalized or theoretical impressions), while “perceptions” are how individuals understand and interpret the meaning and value of these costs. For an overview of key words in Myanmar language used to describe both encounters and perceptions of costs, see Annex 5. Key Words in Myanmar for Donations, Fees and Offerings.

1.1 Encounters of OOPE

Key Findings: All patients encounter some form of OOPE regardless of the type of health care they seek. In addition to costs for diagnosis and treatment, costs for meals and transport are encountered often at great expense, except when care is obtained from local providers within the same village or ward. Costs encountered from private providers are usually more clear and predictable than costs encountered from public providers.

People encounter OOPE across all levels of the health system with all types of health providers. This includes in-patient and out-patient services from providers considered to be public, private or informal. These costs are encountered as fees for service across the public, private and informal health sectors. It is difficult to differentiate when costs are incurred within the context of public or private service provision, since a continuum of dual practice exists across all types of health workers from community to facility levels with fees often being charged in both spheres of practice (see Findings 5/6.5.2 Dual Practice to Generate Supplemental Income and Resources). Patients may incur these various costs in combination or succession, since care is often sought from one or multiple providers simultaneously or successively, especially in the case of multiple or chronic health issues. In addition to costs for treatment, costs for meals and transport are encountered often at great expense (in amount and in proportion to other costs), except when care is obtained from local providers within the same village or ward.

1.1.1 Costs Encountered with In-Patient Services

A wide variety of costs are described by individuals who have sought in-patient care from both public and private facilities. Descriptions of how costs are encountered and paid indicate that there are many different systems for collecting fees for services. The terminology, amounts and modes of collection by whom and when all vary. These systems appear to be facility or provider specific or entirely ad hoc. Fees may be charged individually or combined in different ways in both public and private facilities.

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39 Part 1 could be understood as “User Perspectives,” but this label would imply only consideration of those who have used health care services. Purposeful selection at community level was intended to include both those who seek or forgo care. Almost all household respondents (all except one) reported seeking care from local providers at minimum and about half had experienced hospitalization at some point in time.
1.1.1.1 In-Patient Services in Public Facilities

In public hospitals, costs are encountered by patients and their attendants (usually family members or relatives) throughout the course of treatment. This starts with an initial registration/admission fee of around 500-1,000 kyats, which is often understood to be for the patient’s registration book or chart. In the initial stages of care, there are various kinds of investigation, lab and imaging fees, which might include blood tests, urine tests, x-rays and ultrasounds ranging in costs of around 500 – 8,000 kyats each. If the facility has the equipment, commodities and technician to conduct these tests the charges are often lower (e.g. only 500 kyats paid to the technician), but the costs for these tests are greater if the facility does not have the capacity to conduct the tests as the specimen must be sent to a higher level public hospital or the patient needs to be referred to another facility, such as a private clinic or hospital in the area (and pay for the transport involved).

Once some form of medical intervention is deemed necessary, patients encounter more substantial costs for medicines and commodities as well as possible surgery and delivery fees. Patients and their attendants will receive a list of medicines and commodities that they need to purchase, usually outside the facility, before treatment can commence. In some cases, it will be explained to patients that certain medicines are available in the facility, while others are unavailable and need to be purchased outside. These costs vary greatly and are usually not encountered all at once, but incurred gradually throughout the hospital stay (e.g. daily amounts around 10,000 – 20,000 kyats, which can eventually add up to 100,000 kyats or more). Certain surgery and delivery fees will also be communicated to the patients and their attendants, which can range in costs of around 16,000 – 100,000 kyats. In many cases, there are set amounts for normal or assisted deliveries, which are well known by patients. The cost of surgery and delivery is often discussed as simply the amount charged (i.e. the “usual cost”), without specification as a particular fee, or it might be referred to as an offering or donation (see Findings 1.2 Perceptions of OOPE). Providers in the facility might give a service at a “reduced cost,” if the patient is perceived as particularly poor and unable to pay.

During a hospital stay, there is very little certainty around the amount of money that will be necessary to continue or complete treatment. There are costs for meals for both the patient and attendants, which are considered substantial by respondents, but expected. Depending on the course of treatment, there can be additional medicine and commodity costs or even additional surgery costs, which cannot be anticipated. Respondents describe receiving little or no information about what can be expected in this regard, even when referral to a higher level of care is recommended by providers, so they describe dependence on hearsay among family, friends and others in the hospital. Respondents also describe encountering a number of miscellaneous costs to be paid or given to staff within the facility, including ward nurses, cleaners, guards and those assisting with trolleys and wheelchairs, etc. These costs are often small and may be given as cash or in-kind (e.g. food items or snacks), but can add up quickly when it is necessary to pay multiple individuals each day (e.g. 500-10,000 kyats per day). There may also be charges for accommodation costs for patients around 1,500 – 4,000 kyats per day, although charges are not usually encountered for accommodation in the common patient room.

Finally, once a patient is ready to be discharged, there may be a small discharge fee (e.g. 500 kyats) usually associated with discharge records and an opportunity to provide a donation. This might be presented in a number of ways, either by explanation by nurses in the ward, distribution of envelopes or the presence of a donation box at the discharge counter (see Findings 1.2 Perceptions of OOPE). Descriptive quotations about the kinds of costs encountered by in-patients in public hospitals can be found in Annex 6.1 In-patient costs in public facilities.
Spotlight: Two women describe in-patient costs encountered for their deliveries in public facilities

A woman in Hlaingtharyar describes her experience of surgical delivery in a public hospital, ‘I spent 200,000 kyats in total at hospital. I had to buy everything from gloves to medicines. Nothing was free. The surgery was free, of course, but before entering the theatre for surgery, I had to buy medicine, masks and gowns for 40,000 kyats. Later on, I was frequently asked by nurses to buy other little things too. Each time, I had to spend from 3,000-10,000 kyats. For food, it cost us around 25,000-30,000 kyats. Medicines were bought from drug stores outside. Nurses wouldn’t touch a patient until the medicines were ready. The blood test cost 2,000 kyats. I took 200,000 kyats with me and spent almost all of it.’

Similarly, another woman in Shwepyithar describes her experience, ‘They asked for money for different reasons. My stepmother had to buy medicines at least three times a day. It was 5,500 kyats each time and it cost 16,500 kyats for three times a day. Altogether it costs about 80,000 kyats including for syringes. I had to buy three threads for stitching it up, at 8,000 kyats each, as well as plaster for the wound. I had to buy medicine to do the dressing. Nothing was for free.’

1.1.1.2 In-Patient Services in Private Facilities

In private hospitals and specialist clinics, costs are determined by the owner and are usually standardized within the facility and clearly communicated to patients. These costs include consultation fees (e.g. specialist or non-specialist), procedure fees (e.g. delivery or surgery), service fees (e.g. administration and cleaning), and costs for medicines and commodities (usually with itemized billing). There are usually specific investigation, lab and imaging fees and accommodation costs, but other miscellaneous costs throughout a hospital stay are rare and donations are not requested. However, as described by respondents, costs of transportation to the facility and meals are still a concern for patients seeking care at private facilities.
Concept Map 1.1: Encountering OPPE for In-Patient Services

Note: Overlapped circles indicate that the two or more costs are sometimes combined or are otherwise indistinguishable (e.g. distinction between “requested donation” and “usual cost”).
1.1.2 Costs Encountered For Out-Patient Services
Costs encountered and described by individuals for out-patient care are diverse, because more types of providers are involved in the provision of out-patient services from facility to community levels, including those that can be considered public, private and informal. Costs for meals and transport are still encountered for out-patient services received at facilities, but these costs are often avoided by seeking care locally from any providers that happen to be available at the village or ward level. The continuum of dual practice is especially apparent in the provision of out-patient services as a provider’s public or private roles are often merged and there are few ways to distinguish between them, since services in both cases are often provided outside facilities—at the community level or in the homes of providers or patients (see Findings 5/6.5.2 Dual Practice to Generate Supplemental Income and Resources). It is common for people to seek care from multiple providers simultaneously or to combine this care with self-medications.

1.1.2.1 Out-Patient Services with Public Providers
For out-patient services provided at the Township and Station Hospital level, there are many similarities with the ways that costs are encountered for in-patient services. Respondents often describe an Out Patient Department (OPD) registration fee, then investigation, lab and imaging fees charged at various rates or referrals to other facilities for these tests (explained by provider respondents to vary according to the availability of equipment, reagents and technicians; see Findings 5/6. Resource Management Strategies and Coping Mechanisms for more information from the provider perspective). The costs for medicines and commodities are described by respondents as the most substantial costs encountered. These may be purchased within the facility or more often prescribed for outside purchase. Often service fees still exist (e.g. for injections and other minor procedures), but these are described as minimal in cost. There is less description of different kinds of donations requested for out-patient services at the Township or Station Hospital level, but donation boxes seem to be the most common mode of collection (see Findings 1.2 Perceptions of OOPE).

For out-patient services provided at the Rural Health Center (RHC), SRHC and community levels, costs are usually combined and associated with provision of oral medicines and injections. At the RHC or SRHC facility level, fees and donations may be collected for OPD services as well as during outreach services and home visits at the community level. Many respondents describe these fees at RHCs or SRHCs as inclusive of consultation and medicines (e.g. “cost of treatment at SRHC is 2,000-2,500 kyats including medicines”). It is clear from respondent descriptions that service charges are linked to the provision of medicines and injections. Similarly, small fees will sometimes be charged by AMWs and CHWs, linked once again with the provision of medicines or injections. For example, “I fell ill and I saw the CHW. He gave me an injection and three doses of medicines. It cost me 2,000 kyats” (male TB patient in Oaktwin). However, public provider respondents noted that they do not usually charge fees for ANC or EPI services, although donations may be given. For example, one Midwife in Yedarshay described her work as follows, ‘I don’t charge AN patients. For OPD patients, we only ask for donations and some patients donate 500 kyats, but some don’t. I give injections at patients’ homes if they can’t come here and I charge a patient with normal illnesses 2,000 kyats for treatment with 5 doses of oral medicines’ (see Findings 5/6 Resource Management Strategies and Coping Mechanisms for more information from the provider perspective).

Based on respondent descriptions, there is little to no distinction between services provided through public or private dual practice roles outside of private hospitals or clinics (which rarely exist within the same proximity as RHCs or SRHCs in rural areas or at the village level) from the user’s perspective.
Providers may refer to differences in the services they provide and the costs they charge in these two spheres of work, but this distinction is usually still blurred across a continuum of dual practice for out-patient services (see Findings 5/6.5.2 Dual Practice to Generate Supplemental Income and Resources).

1.1.2.2 Out-Patient Services With Private Providers
There are virtually no differences in how costs are charged for in-patient or out-patient services in private hospitals and clinics based on respondent descriptions. As described in relation to in-patient services, consultation fees, procedure fees, service fees, investigation/lab/imaging fees and costs of medicines and commodities are consistently charged individually, clearly communicated to patients and usually documented through receipts. However, General Practitioners and other types of private providers who work out of small clinics or conduct home visits simplify their charges by combining them. With these private providers, consultation fees, service fees and costs for commodities and medicines are almost always described as combined.

1.1.2.3 Out-Patient Services With Informal Providers
Informal providers play a significant role in the provision of various out-patient services for patients, including selling of drugs to assisting in deliveries and setting of broken bones. Identifying and classifying these kinds of providers can be complex, since most do not have formal training and many different terms are used for them—by themselves, by community members and by formal health providers (see Annex 7. Overview of Informal Provider Types). These types of providers are usually sought locally (i.e. within the village or ward where a patient lives) for the purposes of treatment by the provider or self-medication. Some of these providers charge particular fees, but often function solely off the basis of donations or offerings (see Annex 5. Key Words in Myanmar for Donations, Fees and Offerings). Drug sellers always charge fees for their medicines (e.g. around 200 kyats for a dose of prepared medication), while traditional birth attendants, unregistered traditional healers and other spiritual healers usually function solely on donations or offerings. These donations may be in the form of money or in-kind items (e.g. joss stick, soap, longyi, candle, etc.).
Concept Map 1.2: Encountering OPPE for Out-Patient Services

Note: Overlapped circles indicate that the two or more costs are sometimes combined or otherwise indistinguishable (e.g. distinction between “requested donation” and “usual cost”).
1.2 Perceptions of OOPE

**Key Findings:**
All health care is perceived to come at some cost, regardless of the type of provider. Access to health care requires “money in hand” with perceived minimum thresholds to seek care. Paying for health care is seen as an obligation, which is worthwhile, yet largely unpredictable.

Across interviews of individuals at public facilities and at the community level, there was no expectation that health care services could be received completely for free. Even public services that are known to be “free of charge” are noted to involve costs, “It’s supposed to be free, but I had to pay half the costs” (male UHC patient in Shwepyithar). Thus, different kinds of services are perceived to be affordable or unaffordable by respondents. This is highlighted by a man in Hlaingthayar reflecting on his inability to afford treatment at a hospital, “I can’t afford the costs there at the hospital...staying at hospital for treatment would cost 400,000-600,000 Kyats. Even though it’s free of charge, it would cost that much. I can’t afford it. Even with the AMW, I have to get treatment on credit.” Therefore, perceptions of OOPE are grounded in a pre-existing understanding that health care comes at a cost.

### 1.2.1 Access to Health care Requires Money in Hand

It is universally acknowledged throughout interviews with respondents across geographical contexts and wealth quintiles that “money in hand” is needed to access health care regardless of the type of provider. Whether or not a person has “money in hand” and how much is clearly the most important factor in considering whether or not to seek health care. The emphasis on “money in hand,” rather than simply ability to pay is important, since there are few options for accessing care without paying upfront. It is commonly stated that if a person doesn’t have money, he or she must simply “endure” or “accept fate,” which means that an individual without access to the necessary funds will either not seek or stop seeking care once “money in hand” runs out.

Even once an individual has gained access to services a facility, it is necessary to pay for the costs at each step of treatment. This is a pattern that contributes to the unpredictability of paying for health care, because once a household seeks care it is difficult to anticipate the duration of treatment or number of care-seeking steps that will be involved (e.g. a patient might be sent elsewhere to get tests, purchase drugs or obtain higher level treatment). This experience often involves households needing to access additional sources of funds (see Findings 2. Access to Funds). At times this will involve a family member or attendant needing to travel back home to get more money. For example, ‘At the hospital, the nurses gave me prescription notes for me to buy medicines. They wouldn’t touch the patients until the medicines were there. I didn’t have enough money to pay, so somebody had to go home to get some more money. I had to wait. The baby was on its way out, but they wouldn’t do the surgery until they got the medicine’ (woman from Hlaingthayar, who delivered her baby in a public hospital). In summary, “money in hand” is understood to be needed to seek care, gain initial access and continue along the pathway of treatment. Descriptive quotations about access to health care requiring “money in hand” can be found in Annex 6.1 Access to Health Care Requires “Money in Hand”.

### 1.2.2 Paying for Health care is Obligatory

The costs that are requested by providers are seen as obligatory and at the discretion of the provider, so costs are rarely questioned. As one woman with a child recently treated in a public hospital in Shwepyithar stated, “It cannot be total beneficence there should be something left for him [the provider].” This is supported by a sense that there could be negative consequences or it would simply be shameful to not
pay what is expected. This theme in particular depends on how household respondents explain the costs that they pay and why. For example, “We had to pay whatever amount the providers asked. Otherwise, they would not give treatment if we seek health care there again” (man in Hlaingthayar who uses MW services) and “We were told to donate, it would look bad not to donate the surgery fee” (woman in Hlaingthayar with a son who recently received surgery in a public hospital). However, if an individual does not have enough money to pay the costs he or she might make this known. For example, ‘They gave us a long list of drugs to buy and we bought as many as we could afford. I told them if I cannot buy. When specialist doctors came to examine later, they instructed to give free of charge.’ (poor woman in Hlaingthayar with high blood pressure and an eye problem). In these cases the provider may “take pity” and “give” the service for free or at a reduced cost, “It cost 10,000 kyats in total. I gave it all together at last. She [MW] felt pity for me and just charged so” (elderly woman in Yedarshay recently treated for an eye injury). These descriptions by household respondents highlight that patients see costs as being determined by the discretion of the health provider. According to the accounts of household respondents, these costs are rarely questioned, either in terms of amount or purpose.

The perception of payments being somehow both voluntary and an obligation is reflected in the way individuals describe the costs that they have paid as patients or attendants of patients (e.g. “I had to offer...” or “I had to give donation...”). It is sometimes noted, “I was told I could give as much as I wanted” or “according to my goodwill,” which indicates the voluntary nature of some donations have been emphasized to patients in some cases. However, it is evident from interviews that patients and their attendants are not always clear when the amount they are paying is supposed to be a fee or a donation. In some cases the use of donation boxes and envelopes makes this no less confusing. As a mother in Hakha explains, “I had to pay 12,000 kyats once my son entered the operation theater. The nurse asked me to put it in the donation box.” and the attendant of a woman in Yedarshay reflects, “‘They asked her to donate 65,000 kyats for surgical delivery. After delivery, she was asked to donate it to the donation box, it was probably for the delivery cost.’

**Spotlight: Use of envelopes for donations in a public hospital**
The husband of a woman who received an operation in a public hospital in Chin recounts, “We were given two envelopes. Nothing was written on the envelopes. A nurse handed us these envelopes and she said that she would divide the envelope herself. She told us to put 20,000 Kyats in one and 15,000 Kyats in another one. She wore a red nurse’s uniform. These envelopes were kept by the ward keeper nurse on the day after operation. She said that they were to be given to doctor as present. In my mind, I estimated that we could use operation room free. I have nothing to say [I am speechless] when we are asked to pay the cost of using the operation room as a present.”

### 1.2.3 Paying for Health care is Worthwhile
Paying for health care costs is seen as **worthwhile** in terms of gaining access to better care, getting back to work or saving a life. These themes appeared across interviews with respondents across geographical contexts and wealth quintiles. For example, as one man in Hlaingthayar explains, “If health care service is expensive, its quality is good. Poor people go to cheap health care facilities. Rich people go to Pun Hlaing Hospital.” Paying for health care is also expressed as worthwhile through the idea that it is possible to make an income when one is healthy. For example, “This is my opinion that we can find money whenever we are healthy” (10 Household Leader in Hakha). Finally, any cost of health care is perceived as worthwhile (at least in hindsight) if a life has been saved, ‘It was worth the cost. My father is still alive, after all’
(daughter of a man who was hospitalized for a chest infection in Yedarshay). There was no sense of regret in paying for health care costs noted in responded interviews, even when these costs were described as having a negative socio-economic impact on the respondent’s household. In short, access to health care is perceived to be worth the cost.

1.2.4 Paying for Health care Is Largely Unpredictable

People function with little information and confidence around the costs for health care services, especially when it comes to seeking services at hospitals. There is a great deal of awareness around the costs that can be expected from the various types of local providers, including the availability of credit. It is apparently also possible for respondents to estimate the costs for transport and meals with some confidence. However, when it comes to seeking care outside their locality, people depend mostly on previous experience and word of mouth to estimate the total cost of treatment. Across contexts, many respondents stated that the amount needed to seek care at a Township or Station Hospital would be at least 200,000 kyats, then care beyond this level at State/Region, Yangon or Nay Pyi Taw level is expected to cost at least a million kyats.40

This lack of predictability of costs is encountered not only before making an initial decision to seek care, but even during treatment in a facility and when being referred. It is unclear why patients do not receive more information from providers, but based on interviews with both users and providers, it seems likely that it is equally difficult for providers to estimate what a patient’s costs will be, especially when a patient is being referred without a diagnosis yet determined. One man in a public hospital in Shwepyithar, who ultimately decided to forgo care, recounts his experience of this, ‘I had some patients telling me that they had to spend about 2-3 million kyats. So it wasn’t ok for me to have the operation. The doctors wouldn’t tell me how much it would cost.’ The lack of information from providers or other official sources of information as well as the possibly inaccurate estimates of costs by word of mouth all contribute to the lack of predictability in health care costs for patients.

The blurring of lines between “donations” and “fees” as well as the generally accepted notion that “free of charge” does not really mean “free,” do not help with clarifying or making health care costs more predictable for patients. This can be confusing for those who have had limited exposure to the health system at the facility level, which several respondents stated was the case for themselves. One example of how double meanings can lead to unpredictable health care costs are highlighted in one woman’s story of having an operation in Oaktwin, “They asked for the operation cost. They called me in the room and said medicine was for free but the operation cost was 25,000 kyats. When I asked if the operation wasn’t for free, they said that only medicine was for free but had to pay the operation cost. My husband said I got cheated because I was dumb. When he went and asked, the answer was the same. My husband said if he had known, he wouldn’t have had the operation. The sign says it is free. That’s why he had the operation.” The lack of predictability in health care costs can negatively influence care seeking beyond the local level, but it can also result in unexpected health care costs, which can be a burden for patients and their families. This does not appear to encourage similar care seeking in the future by those who experience these unexpected costs or those who hear about these difficulties from their relatives, neighbors and friends.

40 These estimates were usually based on assumptions by the respondent that in-patient care at these facilities would be necessary.
2. Access to Funds (Question 2)

**Key Findings:** Households obtain “money in hand” to make OOPE payments from a range of funding sources. The most common sources are household finances and borrowing, followed by selling of assets, loaning and pawning. Poorer households depend more on borrowing, wage advances or pawning than richer households with more household finances and access to loans. Loaning and pawning are common in Bago and Yangon, but almost entirely absent in Chin. Contributions of remittances from abroad to household finances, borrowing or charity are common in Chin, but infrequent in Bago or Yangon. Provider credit acts as a temporary substitution for “money in hand” to access services at local level and delay OOPE payments.

### 2.1 Range of Funding Sources

Interviews with individuals at public health care facilities and in communities identified a range of ways that people access funds to make OOPE payments. The range of sources available to an individual were found to vary across household wealth quintiles and geographical contexts, while prioritization of the sources of funds accessed depends on the severity of the health event(s) involved within a household.

These different sources of funds identified through interviews can be categorized and described as follows:

- **Household Finances:** any funds that household members possess, including daily wages earned and any savings, regardless of the usual or intended purpose of funds (e.g. money used for daily subsistence; money saved to build a house).

- **Wage Advances:** any funds that household members expect to earn and can be accessed from an employer in advance, including daily wages or earnings for crops/livestock that will be harvested and sold later (amounts advanced are usually less than the expected earnings would have been).

- **Borrowing:** any funds that are lent without interest, usually obtained from friends, neighbors and relatives in small amounts.

- **Selling Assets:** any possessions of value that are sold, most often gold or jewelry and crops or livestock, but may include other personal or livelihood assets (e.g. computer, house, land or sewing machine).

- **Loaning and Pawning:** any funds that are lent with interest, either without collateral (usually at a higher interest rate) or with collateral (usually at a lower interest rate); loans without collateral are obtained from money lenders, friends/relatives, government or non-profit supported microfinance groups or local community/religious groups; loans with collateral (i.e. pawning) are obtained from formal money lenders or pawn shop owners.

- **Charity:** any support given to help those perceived to be in need without expectation of return, usually obtained from relatives, friends, community members, CBOs/NGOs/Donors and

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41 “Wage advances” are described by those interviewed in close conjunction with “household finances” as an almost immediate way to get “money in hand”.

42 Within this study these amounts were usually less than 50,000 Kyats in Bago and Yangon, but to around 100,000 Kyats in Chin.

43 These were originally categorized together, because of the interchangeable terminology respondents sometimes use to refer to these concepts and how frequently both loaning and pawning were used by respondents in early study sites (i.e. Yangon), but were distinguishable in later data collection and analysis.
sometimes health providers in the form of services and medicines for free or reduced cost and money for transportation.\textsuperscript{44}

- **Provider Credit:** any services or medicines given to a patient with an expectation of later payment, most commonly described in relation to local health providers, who know and live in close proximity to their patients.

Across all individuals interviewed, the most common sources of funds for OOPE were clearly **household finances** and **borrowing**. **Selling of assets, loaning and pawning** are common secondary sources, which are accessed based on the situation of the household. Within these broad categories there are some variations in availability and use across household wealth quintiles and geographical contexts, which will be covered in the sections below. The Myanmar language commonly used to describe various kinds of borrowing, loaning and pawning do not always make it immediately clear what the form of exchange is (e.g. whether or not it is with or without interest or collateral), so often this needs to be probed in interview and understood in context (see Annex 8. Key Words in Myanmar for Borrowing, Loaning and Pawning).

### 2.1.1 Availability by Wealth Quintile

The number of sources of funds a household uses to pay for OOPE does not appear to be strongly associated with the wealth quintile of the household, with the exception that households in the richest quintile (Q5) appear to use a fewer number of sources than the other quintiles (see Figure 2.1). The more distinct variation across household quintiles was the type of source used with differences observed around **borrowing, loaning, pawning, selling of assets** and **charity**.

**Figure 2.1: Sources of Funds Used by Households Respondents per Wealth Quintile**

Source: OOPE Study 2017. Note: households in the richest quintile (Q5) appear to use a fewer number of sources of funds than households across the other quintiles (Q1-4), but this is based on a small number of respondents in the richest quintile (Q5).

In terms of patterns around the types of sources across wealth quintiles, **borrowing** was emphasized by individuals from all household wealth quintiles, but the **selling or pawning of assets** were much more

\textsuperscript{44} Originally categorized as “charity and donations” to make it clear this includes institutional donor support, but simplified to “charity,” so as not to be confused with use of the word “donations” for payment to health providers.
common in the descriptions from individuals in the lower household wealth quintiles.\(^5\) This is striking since the lower household wealth quintiles are assumed to have fewer assets that would be available to sell or pawn, but this view can be balanced by a recognition that even small household items can be sold or pawned, including quite commonly both longyis and household utensils. It is also more difficult for very poor households to get loans without collateral, because of concern for the ability to pay back (both by the lender and the borrower). As one woman in a poor (Q1) household in Yadgarshay explains, “I can't borrow money [get a loan]. If I borrowed, lenders wouldn't believe me. When you go and [try to] borrow, they won't lend. Only those who own farms and buffalos can borrow money. As for me, I just have to take out advance wages [from advance payment for beans and paddy yields].” In contrast, the selling of assets was almost entirely absent from the description of accessing sources of funds by individuals from the richest household quintiles, which may indicate that wealthy households have access to and preference for other sources of funds.

Receipt of charity was described infrequently by respondents, but this was clearly more common among the poorest household wealth quintiles. In some cases support from 3MDG or GAVI was referred to either by name\(^6\) or through description of support (only in the study townships where this support is available), but other kinds of charity were more common (even within townships with 3MDG and GAVI support). These more common forms of charity were described as being from existing local CBOs, monks, community or religious groups or more informally from community members and relatives. Support in these cases seemed to be directed towards households perceived by community members to have the most severe needs, especially those with long term health needs (e.g. cancer, paralysis or prolonged undiagnosed illnesses) and no other remaining sources of funds.

**Spotlight: Elderly woman in a poor household (Q1) in Shwe Pyi Thar borrows and pawns to survive**

“I just borrow a little only. I dare not borrow 30,000 or 40,000 kyats. I borrow 500 or 1000 kyats only. I have neither income nor salary. So I dare not borrow much. I borrow from my relatives. If you borrow from strangers, you have to pay interest. I borrow mainly for meals. I've never borrowed more than 5,000 kyats. You have to borrow money, because you are in need. I don't know if there any places in the neighborhood where one can pawn stuff and borrow money. I pawned two longyis and some clothes at government pawnshop and if I cannot redeem them this month, I will lose them. It lasts only for three months and ten days. I don't know whether it is 5% or 10% interest. I pawned 3 longyis and I got 1,500 kyats for each. You have to pawn when you don't have money.”

### 2.1.2 Availability by Geographical Context

The availability of sources of funds was described to have some variation across geographical contexts included in the study. Sources of funds were similar in Yangon and Bago for the most part, while several differences were noted in Chin. These differences mostly centered on limitation of household finances, frequency of borrowing, absence of loaning/pawning, kind of assets sold and prevalence of provider credit.

**Household finances** are prioritized as a first source of funds for OOPE in all contexts, but finances are limited for most households and those in Chin seem to have even less available. In Chin, **remittances**

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\(^5\) However, there were few examples of loaning and no examples of pawning in Chin.

\(^6\) Name of the donor mechanism (i.e. 3MDG or GAVI) or the implementing partner (e.g. Save the Children).
received from relatives and community members abroad are common, particularly at request when there is a health need. In Bago and Yangon, remittances received from overseas were almost entirely absent, but wage advances from employers were relatively common. The general lack of household finances in Chin appears to be associated with more frequent borrowing without interest from relatives and community members locally (money received from relatives and community members abroad is usually given rather than borrowed). Notably, in Chin descriptions of loaning with interest were infrequent, but most often obtained from community, religious and microfinance groups, along with a complete absence of pawning. This is in contrast to frequent descriptions of obtaining loans with interest from money lenders and with collateral in pawn shops in both Yangon and Bago.

**Selling of assets** is a common source of funds for OOPE in all contexts with significant differences in the types of items sold. In Bago and Yangon, gold and jewelry are the most common items to be sold or pawned, while some instances of selling a house or land were also described in Yangon. However, selling of these types of assets are completely absent in Chin, where the most commonly sold assets are crops and livestock. While house ownership was common among the individuals interviewed in Chin, there were no descriptions by those interviewed of selling their house or property to access funds. The types of assets that people possess and how these assets are used to obtain funds varies across the three contexts included in the study.

**Provider credit** appears to differ across the three contexts with provider credit among public, private or informal providers being most common in Chin. This may in part be a function of the lesser extent of household finances and greater prevalence of local health providers in Chin. In all contexts provider credit is given almost exclusively by local providers, who both know and live in close proximity to their patients; there is an even greater dependence on local health providers in Chin. Availability of credit offered by local providers seems to be another pull factor toward care seeking at the local level (see Findings 3. Influence of OOPE on Care-Seeking).
Concept Map 2.1: Accessing Sources of Funds (Yangon)

Concept Map 2.2: Accessing Sources of Funds (Bago)
Concept Map 2.3: Accessing Sources of Funds (Chin)

Note: Size of circles for Concept Maps 2.1-2.3 indicate the relative frequency the particular source of funds was described as accessed by respondents.
2.2 Prioritization by Perceived Severity of Health Event(s)

People choose which available sources of funds to turn to depending on the severity of health event(s) involved within their household. While there is a strong preference in all cases to use household finances or borrowing as a source of funds for any health care need, this is not always possible if household members do not have sufficient household finances, cannot borrow or amounts accessed through these sources are insufficient to address the health care need. In these cases, additional sources of funds may be accessed depending on the perceived severity of the health event(s) involved. The level of severity is based on perceptions of urgency and threat to life as well as the type of care that is deemed needed, often without the benefit of clinical diagnosis or skilled provider recommendations. These two broad categories can be described as follows:

1) **Non-urgent/out-patient care sufficient:** these health event(s) are not perceived as immediately life-threatening and out-patient care (either through public, private or informal providers) is considered sufficient for ongoing treatment or full recovery.47

2) **Life-threatening/hospitalization required:** these health event(s) are perceived as immediately life-threatening and hospitalization (either through public or private providers) is considered necessary for life-saving treatment or full recovery.

In the case of health events perceived as non-urgent/out-patient care sufficient, accessing household finances and borrowing are prioritized as sources of funds. The amounts borrowed will be relatively small (often less than 50,000 kyats in Bago and Yangon; around 100,000 kyats in Chin), in order to be easily paid back within a matter of days or weeks. This means that household members will limit their care options to those that are closest and most affordable, including self-medication options and local public/private/informal providers, so that the amount of funds needed to seek care does not exceed the amounts that can be obtained from these preferred sources of funds. If available, provider credit may also be accessed within similar amounts that might otherwise be borrowed and thus paid back within a short timeframe. As amounts borrowed or accessed through provider credit are usually small (e.g. 5,000 – 10,000 Kyats), these will mostly be paid back through regular or increased work by members of the household, without resorting to selling of assets to pay back these debts. Though keeping costs within the amounts accessed through these sources of funds may lead to sub-optimal care seeking choices and thus health outcomes, it also appears to limit impact on the livelihood and socio-economic status of the household, since debt is not taken on and assets are not lost. The provider credit acts as a temporary substitute for “money in hand” at the time of care-seeking.

In the case of health events perceived as life-threatening/hospitalization required, accessing household finances, borrowing and selling or pawning of assets are all prioritized as sources of funds. It is rare for any household to have enough “money in hand” to travel outside of the locality for care and possible hospitalization, so money is almost always borrowed immediately, then assets sold or pawned shortly after. The selling and pawning of assets takes place in these cases both to access sufficient funds for care (usually once the patient has arrived at the point of care) and eventually to pay back the amounts borrowed (usually in these cases in amounts larger than what can be easily paid back in a short period through regular work). In cases where referrals or longer term care is needed (e.g. conditions that are

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47 Chronic conditions are usually considered non-urgent/out-patient care sufficient, unless these suddenly escalate to a perceived life-threatening level where hospitalization is required.
undiagnosed, unresolved or known chronic conditions), options for **borrowing and the selling or pawning assets will be fully exhausted**. At this point, some households may access additional loans without collateral at a much higher interest rate if they can (usually wealthier households, who have a guarantor or are thought to be able to pay) while others will only be able to resort to charity (usually only those viewed by community members as people with truly no options, such as the elderly). However, there are **limited options for accessing further sources of funds**, so it is common to revert back to the closest and most affordable care options (i.e. self-medication and care from local providers) or to forego care entirely.
3. Influence of OOPE on Care-Seeking (Question 3)

**Key Findings:** The influence of OOPE on care-seeking across all geographical contexts and household quintiles appears to result in consistent trends. In almost all cases care is sought locally first, then other options for care are considered based on the perceived severity or urgency of the health event(s) involved.

The expected OOPE to be encountered for different kinds of care-seeking seem to be consistent across different subcategories of household respondents (e.g. hard to reach vs. non-hard to reach; poor vs. wealthy), while the range of the sources of funds households can access vary greatly across these groups. The kinds of OOPE to be encountered with different care options are taken into consideration alongside the sources of funds a household can expect to access in order to make care-seeking decisions. While the available sources of funds vary across households, these combined considerations appear to result in some consistent trends. In most cases, **care is sought locally first** and other options for care are considered based on the **perceived severity or urgency of the health event(s)** involved. As a village administrator in Hakha explained, “There are a lot of people who don’t do anything because they have no money. It’s usually true for my family too. When we can’t endure it anymore and are in a critical condition, we borrow money to go to the clinic.”

3.1 Care is Sought Locally First

In almost all cases, **care is sought locally first**, regardless of how scarce or plentiful the provider options are within a given context. This holds true as much for the rural or hardship areas where provider options at the village level are generally limited as it does for the urban/peri-urban areas where provider options are relatively diverse. Care-seeking locally includes the option of self-medication through purchases of medicines from a local drug seller or other types of consultation, service and treatment from informal, private or public health care providers available within an individual’s village or ward. Self-medication and seeking care from a local provider may happen in alternating or simultaneous patterns, "When we don’t have money to see the MW, we buy and take medicines. When medicines can’t help us, we see the MW" (man with a respiratory problem in Yaydarshay). The only major exception to this trend of seeking care locally first is in the case of emergencies (i.e. situations where a person’s life is perceived to be immediately at risk), although notably in Chin even emergency care is sometimes sought locally. There are **three major OOPE related factors** that appear to drive this trend of seeking care locally first: 1) cost of transport; 2) need for “money in hand;” and 3) access to provider credit. 49

3.2 OOPE Related Factors Driving Care-Seeking Locally

The **cost of transport** to possible locations for care are well known and are usually the first consideration for any possible care-seeking. If funds to pay for cost of transport cannot be accessed and other possible assistance, such as charity ambulance support are not available, then seeking care outside the locality is usually not considered. The total amounts needed for transport vary greatly between rural and urban areas as well as between states and regions, but in all of these contexts the cost of transport is a strongly

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48 The term “health event(s)” is used here rather than illness, in order to include events such as pregnancy and delivery.

49 While noting that there might also be some non-financial considerations at play (e.g. fear of unfamiliar places and providers; limited health knowledge).
stated concern and obstacle. This greatly hinders consideration of care-seeking beyond providers available within the village or ward.

The need for “money in hand” to seek care is cited consistently and if sufficient funds cannot be accessed, then seeking care outside the locality is usually not considered. A sufficient amount of “money in hand” depends on the type of care to be sought, previous experience seeking that type of care and hearsay among family and community members. This amount often ranges between 200,000 – 500,000 kyats for care at Station or Township Hospitals, while care at secondary or tertiary levels is often judged to be in the range of 1-3 million kyats. For example, as one woman in Shwepyithar describes, “Without much money to spend, I’m afraid of going to clinics and hospitals for treatment. I need 80,000-100,000 kyats to go there for treatment.”

The possibility to access provider credit from local providers offers a way to avoid the barriers of both cost of transport and need for “money in hand.” Credit is offered by providers in amounts that are small and almost exclusively to those who are known and live nearby, both to minimize risk of loss and maximize feasibility of payback. As described by one man in Yedarshay, “If we take treatment in the village, we can pay the cost later, but if we take treatment at the clinic, we have to pay the cost at once.”

3.3 Influence of Perceived Severity and Urgency of Health Event(s)

The OOPE related factors driving care to be sought locally first are influenced by the perceived severity and urgency of the health event(s) involved. The severity and urgency of health event(s) can be categorized as emergency, minor, chronic or expected as outlined in the concept map and described below:

When a health need is perceived as an “emergency” (e.g. accidents, snake bites or any situation where a person suddenly loses consciousness), care is sought from a provider outside the locality (e.g. public or private facility), regardless of anticipated costs or ability to pay. When a health need is perceived as a “minor sickness” (e.g. coughs and colds or any illness that do not prevent normal activities), self-medication or care from a local provider is sought. This trend also applies to “chronic conditions” where self-medication or care from a local provider is sought first, then only from a provider outside the locality if it is unresolved, interferes with normal activities and the individual/household anticipates ability to pay. If the condition is still not resolved and “money runs out,” (i.e. all money in hand as well as options for other sources of funds are exhausted), then the individual returns to self-medication or local providers and continues to “endure” for the long term or even until death. Finally, when a health need is “expected” as in the case of a pregnancy, individuals/households plan for deliveries with local providers (e.g. AMWs, TBAs or in a few cases MWs), only seeking other providers outside the locality once a complication has been identified, regardless of anticipated costs or ability to pay (as in other emergency situations).

3.4 Notable Exceptions to OOPE Related Drivers and Trends

The OOPE related drivers and trends were described as largely consistent across the geographical contexts included in this study with a couple notable exceptions. In the urban/peri-urban context of Yangon, there is a larger range of providers available locally, including a high number of GPs throughout the township. This means that in Yangon more highly skilled providers are available locally and thus receive care from these types of providers without the burden or hindrance of transport costs. In the rural/hardship context of Chin, there is more forgone care overall, especially for chronic conditions and even in some cases emergencies. This is explained by one Midwife in Tedim as follows, “In an emergency, patients can’t go on a motorbike. But if they hire a car, it costs at least 100,000-150,000 kyats. So they think a lot before going
to hospital.’ However, the presence of 3MDG emergency referral support was frequently noted to at least increase willingness of patients to be referred for care outside the locality.

While proximity and perceived costs were the most influential factors noted by patterns in household respondent interviews, there were also some patterns related to **perceptions of quality**, which seem to influence care-seeking decisions. Some of these perceptions of quality related to the availability of service times (i.e. when consultations could take place), cleanliness of facility, attentiveness of providers to patients and information given by providers to patients. Several patients also mentioned being afraid of being shouted at, or ignored, when visiting public hospitals. Patterns in household respondent interviews indicated that care-seeking and perceptions of quality are influenced by **word-of-mouth** (e.g. a household seeks care from a certain provider based on “what people said in the village”). Finally, perceptions of quality also strongly related to “**quality medicines,**” particularly based on the brand of the drug or country of manufacture.
Concept Map 3: Influence of OOPE on Care-Seeking

Note: Only significant exception to the above is that respondents in Chin did not consistently describe seeking skilled providers outside the locality for emergency cases.
4. Impact of OOPE on Health and Socio-Economic Status (Question 4)

**Key Findings:** OOPE for health affects the whole household and often extended family networks. Care seeking involves a complex decision-making process that balances the dimensions of payment and care-seeking across a spectrum. While negative impacts are most clearly illustrated at the extremes of maximum payment and forgone care, the experience of most households is somewhere along this spectrum. Negotiating a balance between these extremes usually involves accessing less expensive, locally available health care options mixed with periods of forgone care, which result in undiagnosed and unresolved health issues for many households.

This study explored the impact of OOPE on poor and vulnerable households below or just above the poverty line (includes households across wealth quintiles, Q1-3), as well as households that have experienced a recent major health incident or have recently accessed care from a public facility (includes households across all wealth quintiles, Q1-5). Nearly all respondents described accessing some kind of care through payment. Two-thirds of respondents travelled outside of their locality to access health care services and almost half described forgoing care that was considered necessary to address a health need (i.e. save a life, cure an illness or sufficiently treat a condition that interferes with normal daily activities) due to cost. In interviews, respondents described individual and household member illness histories, which involved a wide range of recalled OOPE amounts over time. Figure 4.1 shows that the range of recalled OOPE amounts are spread across all wealth quintiles and the majority of respondents recalled amounts that fell within two payment brackets: (1) Very low: less than K100,000; (2) Low: K249,999 - 100,000. The impact of OOPE on health and socio-economic status was explored through a wide range of household experiences within this respondent sample.

![Figure 4.1 Total Costs Recalled by Respondents per Wealth Quintile](image)

Source: Household respondent KIIs. Note: Total amount for Household OOPE recalled by respondents was separated by the following five brackets: (1) Very Low: less than K100,000; (2) Low: K249,999 -100,000; (3) Medium: K499,999 -250,000; (4) High: K999,999 -500,000; (5) Very High: more than K1 million.50

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50 Amounts recalled by respondents are linked to one or more health events, across one or more household members and across different periods of time. This graph is intended to give an overview of the range of costs discussed in relation to the household experiences recounted in interviews.
4.1 Households are Collectively Affected by OOPE for Health

Household finances are the first source of funds accessed to pay for OOPE (see Findings 2. Access to Funds), so payments and impacts of OOPE are a household affair. Households invest resources in the form of time and money when looking after a sick person. The communal household resources are invested from the beginning, for example when all household finances are drawn on to seek care and household members usually accompany the sick person to seek care. The pooling of resources continues throughout the illness episode, for example when other household members or extended family members sell assets or take on loans in order to provide “money in hand” to access health care, then take on additional work in order to pay off the debts incurred. Therefore, the family network, both nuclear and extended, plays an important role in the dynamics and impacts of OOPE.

Individuals or households that are well connected to extended family networks (especially relatives of working age or those working abroad) are in a better position to cover the costs of health care and avert the negative effects of these costs, than households that are more isolated from their own extended families, such as migrants living in peri-urban areas of Yangon. Household networks are crucial for accessing additional sources of funds, either as borrowing or charity. This kind of support is most often observed as coming from relatives, but other community networks at times provide support to households perceived as extremely poor, vulnerable and without other options. This type of support enables households to access health care in situations where care might otherwise have been forgone and is sometimes the only buffer against the most desperate consequences of indebtedness (e.g. local community groups providing food to poor, vulnerable households affected by illness with limited ability to earn income).

**Spotlight: Household (Q3) in Hakha Accesses Sources of Funds through Extended Networks**

“We have relatives in Malaysia and they gave help. They sent 1 million kyats. The community in the village gave 5,000-10,000 kyats for tea. Actually, we borrowed the money from someone abroad and my brother in Malaysia repaid it.”

4.2 Dimensions of Payment and Care-Seeking Across a Spectrum

The majority of respondents described OOPE as impacting the health and socio-economic status of their household either by limiting their health care options and/or by the consequences of significant payments to access health care. As some amount of payment is needed to access almost any type of health care, both the benefits and consequences of making payments and accessing health care are related. Making payments to access health care presents positive potential to address a health need, while also introducing a range of potential negative socio-economic consequences associated with making the payments. Not making payments to access health care presents limited potential to address a health need, while also introducing the consequences associated with poor health. The impact of OOPE on health and socio-economic status can be described at the extreme dimensions of payment for and access to health care, but analysis of household respondent descriptions reveals these dimensions are usually experienced in combination and across a spectrum over time.

If the dimensions of payment and care-seeking are seen as a spectrum, then one extreme would be the maximum payment and care-seeking a household makes to address health need(s) as where the other extreme would be a total absence of payment and care-seeking (see Figure 4.2). This means that when there is an illness episode within the household, options range from no payment and care-seeking to a maximum level of payment and care-seeking (for that particular household). These extreme dimensions
could be thought of as “forgone care” and “catastrophic payment” respectively, although as qualitative research exploring the experiences and perceptions of household respondents this study did not seek to determine “catastrophic payment” in interviews. Some respondents described reaching levels of payment perceived as a maximum, which based on their descriptions, exhausted resources and seriously indebted their household. Other respondents described an absence of payment and care-seeking. However, most households fall somewhere between these two extremes the majority of the time, since most households oscillate between periods of paying for and seeking care or not paying for and forgoing care.

Figure 4.2 Care-Seeking and Payment Spectrum

<table>
<thead>
<tr>
<th>Maximum level of care-seeking and payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care-seeking: 53%</td>
</tr>
<tr>
<td>Combination of care-seeking, forgone care: 29%</td>
</tr>
<tr>
<td>Loss to follow-up/referral: 7%</td>
</tr>
<tr>
<td>Forgone care: 11%</td>
</tr>
<tr>
<td>No care-seeking or payment</td>
</tr>
</tbody>
</table>

Source: Household respondent KII. Note: percentages indicate the proportion of household respondents that described care-seeking or a type of forgone care in recounts of their household illness histories.

4.3 Minimum level of care-seeking and payment: “Forgone Care”
Forge care was frequently described by respondents, but took place under different household circumstances and points along illness histories. Analysis of these descriptions revealed three major types of forgone care. The first type of forgone care could be considered the classic type, where care is forgone from the beginning of the illness. The second type is forgone care that is combined with care-seeking, meaning that care is not sought consistently, but only when resources are available. The third type of forgone care could be described as loss to follow-up or referral, where care has been sought for an illness.

51 “Catastrophic payment” is a quantitative measure used in health economics to determine when a household has exceeded a certain threshold of spending on health care, which is determined by comparing household expenditure for health care against total household income.
52 In some of these cases the information provided in the interview would strongly suggest that the household exceeded a “catastrophic payment” threshold, although it is not possible to formally determine this without a structured quantitative questionnaire.
53 Only one respondent described absolutely no spending on health care, while others at least incurred a small cost for self-medication; most individuals practice self-medication even if no other care is sought and this comes at a small cost for buying traditional or western medicine.
but is stopped before treatment is complete (e.g. follow-up visits discontinued or referral to a higher level facility not followed).

**Type 1 Forgone Care:** Households do not seek care deemed necessary to address an individual’s health need from the beginning of the illness or health event. This could be considered forgone care in its most classic sense, although it should be qualified that within the respondent sample these cases include those that self-medicate (either with drugs from drug sellers, traditional medicine or home remedies) or took treatment from a masseur/se. This type of forgone care is seen among households that are poor (all cases in the respondent sample coming from households Q1-3) and/or indebted (due to OOPE costs or other reasons) and/or otherwise vulnerable, such as elderly individuals without household members or extended relatives available to provide support for care-seeking. As care is not sought from the beginning, most illnesses are described only in terms of general symptoms (e.g. abdominal pain, dizziness, difficulty breathing, blurry vision, paralysis). In these cases, households have determined that their resources are not sufficient to seek care, even though need for care is recognized. Self-medication focuses on pain or symptom management.

**Type 2 Combination of Care-Seeking and Forgone Care:** Households forgo care deemed necessary to address an individual’s health need after at least one instance of care-seeking and treatment. Among these are households facing medical episodes that are not resolved easily and chronic illness. The defining feature of this type of forgone care is the interruption (or stop and start) of treatment until sources of funds for payment are available, which results in irregular care-seeking or treatment, rather than discontinued care-seeking or treatment. This type of forgone care is associated with descriptions of “enduring” symptoms of illness as long as possible or until sufficient funds to seek care can be found.

**Type 3 Loss to Follow-up/Referral:** Households that seek care, but are not able to continue follow-up or do not follow the specific type of referral advised by a health care provider. Among these are households facing medical episodes that are either not successfully diagnosed or resolved at a primary care hospital level and chronic illnesses. The key feature of this type of forgone care is that care-seeking is expressly discontinued due to lack of resources. In the case of discontinued follow-up, the household may take up treatment again, which then places the forgone care experience back into the type 2 category. However, this is rarely seen when a household makes a decision for forgo higher level referral due to lack of resources. Loss to follow-up/referral is different from temporary stopping of treatment while trying to access sufficient sources of funds, because in these cases the individual/household members have given up on the possibility of accessing sufficient sources of funds.

When the different types of forgone care are explored across wealth quintiles, only a small portion of respondents in lower quintiles (Q1, Q2 and Q3) mentioned no care-seeking from beginning (Type 1), while the combination of care-seeking and forgone care (Type 2) is the most common across all wealth quintiles (see Figure 4.3). All three types of forgone care are frequently combined with self-medication and sometimes treatments from informal providers (e.g. spiritual healer or masseur/se), which are described as the only available options by household respondents in these circumstances, but rarely result in resolving the health problem.
Two primary reasons were described by respondents to explain why forgone care takes place. First, forgone care is the result of lack of household finances and other sources of funds (i.e. no “money in hand” or options to access funds from the beginning). Second, forgone care is the only option available after all household finances and sources of funds are depleted (i.e. all “money in hand” and options to access money are depleted for the time being). However, household finances and access to other sources of funds change over time, so in many instances health care is sought again after a period of forgone care. Independent of its duration, forgone care is closely linked with access to sources of funds. Correspondingly, respondents from households in higher wealth quintiles (Q4 and Q5) described less instances of forgone care than respondents from households in lower wealth quintiles (Q1, Q2 and Q3) overall.

4.4 Maximum level of care-seeking and payment: “Catastrophic Payment”
In this study, respondents from 25 households described reaching a maximum level of care-seeking and payment in response to health needs within their household. None of these households were from the richest wealth quintile (Q5). The level of care-seeking and payment considered to be a maximum varied according to available household finances and other sources of funds available to the household. All of the households that reached a maximum payment used household finances and at least one other source of funds. A higher maximum payment amount was noted as possible when there are several household members able to work and earn income. In some cases poor households are able pay a higher maximum payment than would be expected according to the household’s wealth quintile, because of the support of relatives outside the household. The amounts recalled by respondents in households where maximum payment was described varied greatly and ranged over different lengths of time and numbers of illness histories (see Figure 4.4).
Figure 4.4 Total Costs Recalled by Maximum Payment Respondents per Wealth Quintile

Source: Household respondent KIlIs. Note: Total amount for Household OOPE recalled by interviewees was separated by the following five brackets: (1) Very High: more than K1million; (2) High: K999,999 - 500,000; (3) Medium: K499,999 - 250,000; (4) Low: K249,999 - 100,000; and (5) Very Low: less than K99,999.\(^5^4\)

The amount a household considers to be a maximum payment appears to be influenced by the range of health care providers available locally and the perceived likelihood of resolving the health condition. If households are able to continue treatment with relatively small amounts of “money in hand” (i.e., care does not need to be sought at far distances where the costs of transport would be great), then they can slowly keep spending until possibly reaching a payment maximum. However, if the next step of care-seeking would require a very large sum of “money in hand” (e.g., household respondents that indicate it would cost 2-3 million kyat to seek care in Yangon), which the household cannot access, then the household may stop seeking care and making payments. In these cases, self-medication or care from a range of local (often informal) providers focused on relief of symptoms is often still sought. As the costs associated with these kinds of providers are often small (or based solely on donations, including material donations) the household does not usually approach the maximum payment. However, this is still possible for the poorest households without extended relatives, family networks or others to provide support on a charity basis. Finally, if an individual and/or household members perceive that resolving the health need is unlikely (e.g., multiple failed attempts at treatment, poor prognosis indicated by provider or elderly patients with overall poor health), then the household may stop seeking care and making payments as well.

Despite the diversity of individual illness histories and household scenarios described, patterns observed across interviews indicated that maximum levels of payment and care-seeking are reached most often through illness event(s) involving hospitalization, but also repeated care-seeking for unresolved illnesses and chronic health conditions. While some households described reaching a maximum payment point due to one health need, a substantial proportion of these households within the respondent sample described multiple health needs (related to one or multiple household members). In these cases it can be difficult to piece apart which health need pushed the household to the maximum payment level, especially when health needs occur simultaneously or in close succession, but usually the illness perceived as most life-threatening is treated in these circumstances while care for other health needs is forgone.

\(^5^4\) Amounts recalled by respondents are linked to one or more health events, across one or more household members and across different periods of time. This graph is intended to give an overview of the range of costs discussed in relation to the household experiences recounted in interviews.
Households that have reached a level of maximum payment have often sought care from several providers, either following referrals given to them by providers or simply seeking the care of new providers after treatments have failed with others. Within the respondent sample that described reaching a maximum payment point, almost half had sought care from more than four providers. This included a substantial proportion that had sought care from a private clinic or hospital, which was notable given that treatment at private clinics and hospitals was infrequent within the overall household respondent sample. It should be noted that private clinics and hospitals were most prevalent within the two study Townships in Yangon and over half of the maximum payment respondents in the sample came from the two Yangon Townships, which may point toward a trend that households with greater range of providers within their local context tend to seek care (even at great cost), while those with more remote access tend to forgo.

Unfortunately, the high levels of care-seeking and associated payments for households do not always (or even often) seem to result in resolving an illness or adequately managing chronic conditions. Within the respondent sample over half of households that described reaching a maximum payment level were still dealing with an unresolved health need, most of which have serious consequences for the individual’s quality of life and ability to work. Perhaps unsurprisingly, most of the maximum payment respondent households also described some form of forgone care as the only option once maximum payment is reached and a health need is unresolved. Many of these households described a combination of care-seeking/forgone care or loss to follow-up/referral. Some households also described the first type of forgone care, in instances where reaching the maximum payment level for one health need results in no ability to seek care for another health need within the household.

4.5 Impact of OOPE at the Extremes of the Payment and Care-Seeking Spectrum

As discussed above, both ends of the payment and care-seeking spectrum have negative consequences that impact the health and socio-economic status of a household.

The negatives consequences linked to maximum payments were described in summary as follows:

1. Debt due to borrowing, pawning or loaning;
2. Loss of assets, personal or productive (e.g. house, land or tools for livelihood);
3. Increased stress and reduction in quality of life due to more work to pay off debt;
4. Reduced quantity or quality of food consumption;
5. Children put to work and/or taken out of school.

The negative consequences linked to forgone care were described in summary as follows:

1. Illness remains undiagnosed and unresolved;
2. Reduced ability to work (for the sick individual and possibly a household caregiver), which reduces household income;
3. Reduced quality of life due to an unresolved illness or inadequately managed chronic health condition;
4. Death.

Quotations that describe these negative consequences and the impact of OOPE on health and socio-economic status within the experiences of household respondents can be found in Annex 6.7: Impact of OOPE on Health and Socio-Economic Status.
4.6 Impact of OOPE across the Payments and Care-Seeking Spectrum

In order to cope with health needs, the majority of households described seeking care and making payments to access that care. A third of respondents described balancing the negative consequences of making payments and forgoing care by shifting between periods of making payments to access care and avoiding payments by forgoing care. More than half of these household respondents describe inability to resolve an illness. They also describe experiencing a loss of income and reduction in food consumption (quantity or quality). However, extreme coping measures, such as selling a house/land or taking children out of school are not mentioned as frequently. It appears that these households make decisions in such a way to balance the negative consequences of both making payments to access care and forgoing care.

Balancing the negative consequences of making payments to access care and forgoing care goes beyond decisions related only to health care. Descriptions from respondent households illustrated that these dynamics influence many other aspects of daily life as well. Many households have to find ways to reduce spending due to the loss of income during prolonged illness or paying back debt for OOPE payments. Households that are affected reduce their expenditures, mostly through reduced quality and quantity of food consumption for short periods of time. Borrowing and pawning are ways to initially afford OOPE, but in turn the indebted households have to reduce household expenditures and work more to pay off the debts. This often involves the whole household and sometimes the extended family network. When households lose their homes or productive assets, then household members might move in with extended family or one household member might migrate for work. If household income is no longer sufficient to cover basic household needs, then a household might become dependent on donations from relatives and family members or credit from shops to buy food. Decisions to pay for access to health care or forgone care are made within the context of these interdependencies within a household and extended family network, where decisions related to health and health care can have an influence on virtually all other aspects of life.

4.7 Descriptions of Households Not Affected by OOPE

When exploring the quarter of respondent households that did not describe being negatively affected by OOPE, it was found that:

1. These households did not experience negative health outcomes. This applies even to those that had forgone care or sought limited health care options; in these cases it appears that the health conditions were not severe, easily treatable or resolved without intervention.
2. These households did not suffered negative socio-economic outcomes for one of two reasons. First, the OOPE amounts were small enough to be covered by household finances or borrowing with payback possible within a short period of time (e.g. a few days of extra work). Second, OOPE was paid for by support from others, such as extended relatives, or by receiving services for free/reduced cost, usually with some form of donor support.

However, these cases were the exception and not the norm as the majority of household described negative health and socio-economic impacts along the care-seeking and payment spectrum.
Case Studies: Household Perspectives

The following case studies were gathered from household respondent interviews. These case studies place the key findings presented in Part 1: Household Perspectives within the context of the lives of particular individuals. Each case study is preceded by a “Key Findings” box in order to highlight some of the key findings illuminated by the particular case study.

Case Study 1: A young man with an unresolved medical condition in Oaktwin

Key Findings: This case study shares the decision making processes of a couple after being unable to resolve a medical issue affecting their son. After seeking care from three providers, the young man and his parents were unable to get a diagnosis for his medical condition, despite hospitalization and follow-up. Hearsay and perceptions of costs to seek care in Yangon has caused the family to forgo next level referral. The key findings illustrated in this case study relate to Findings 1. Encounters and Perceptions of OOPE and 3. Influence of OOPE on Care-Seeking.

The husband and wife of a family of eight members were interviewed. Four members of the family are able to work and all do shift cultivation or casual labor. Last year the third son in the family injured his knee while cutting grass. The family sought treatment for him, but eventually determined that they could not afford the cost of specialist care. He is now taking traditional remedies at home, but his condition is unresolved and he is not able to work.

After first injuring his knee, he received treatment from a medical assistant at a nearby army base. The medical assistant gave him stitches as well as injections, oral medication and traditional ointment for one week. He knew the family, so only charged K1,000 for each injection and sometimes they did not have to pay at all. After this treatment, he seemed to be fine, so he did not get any treatment for about twenty days. During this time he continued to clean the wound with water that was boiled with herbal leaves and apply betadine solution. However, the wound began to feel painful, so the medical assistant asked him to go to the District Hospital.

The family took him to the District Hospital where the total cost of treatment was within K200,000-300,000. The doctor from the hospital wrote him a prescription to buy medicines at the drug store outside the hospital. The main costs during his 10 day hospital stay were for meals and transportation costs. It took K10,000 per roundtrip visit from the village to the hospital, but these costs added up with multiple trips to the hospital by the patient and attendants. They also paid donations in the amount of K500-1,000. After 10 days in the hospital, he was discharged and the doctor asked him to follow-up in one week. He went there again and had a blood test, urine test and X-ray. The doctor asked him to follow-up again after two weeks again. He returned for this second follow-up visit and at that time the doctor asked him to go to Yangon.

The young man learned from his uncle that the cost would be about K500,000 if goes to Yangon. However, the family could not afford this amount, so he did not go. About this decision his mother said, “The cost would be 500,000 kyats if we go to Yangon, but there is nothing in our hand, so we couldn’t go….we couldn’t afford, so we apply this and that herbal roots [as instructed by others].” Currently, his hand and leg joints are swollen and he cannot properly move them, so he is not able to work. Sometimes his symptoms are less severe, but other times very painful. At those times, he applies a mixture of herbal roots. The family believes that selling their house would be the only option for him to travel to Yangon for treatment.
Case Study 2: Household with a Major Health Incident in Shwe Pyi Thar

**Key Findings:** This case study describes the multiple ways one household accessed funds to seek care and make payments for treatment of a mother with a uterine mass after the delivery of her youngest child. The key findings illustrated in this case study relate to *Findings 1. Encounters and Perceptions of OOPE, 2. Access to Funds, 3. Influence of OOPE on Care-Seeking and 4. Impact of OOPE.*

A woman with a uterine mass had an operation to remove it in a public hospital. She was indebted from borrowing and pawning to pay for the health care costs. Her husband lost his job, she lost of livelihood and her son died while migrating for work to help pay for her medical costs.

She noticed the uterine mass when she was pregnant with her youngest child. She didn’t go to the clinic for treatment, but first took traditional medicines. However, the mass started to feel painful and she saw a doctor at a nearby clinic. He said she needed to have an operation on the mass, but it would cause death to the baby, so she decided to have the operation after delivery. She didn’t have an operation until she felt strains in her abdomen and severe pains seven months later. At that point she decided to go to Insein Hospital. The doctor there said that she needed to have an operation right away. She couldn’t afford the costs, so she had to borrow 350,000 kyats from a money lender in the community to pay for the initial costs. Her husband borrowed the money from a money lender with the help of her uncle.

The total cost of her treatment at the hospital was 840,000 kyats. During her stay in the hospital, her husband couldn’t go to work for over a month, so he lost his job as a porter in a factory. She had to pawn her sewing machine for 35,000 kyats to buy meals. The machine was pawned at a 15% interest rate. In order to pay for the costs of follow-up treatment, her husband considered taking a job in Yay (Mon State) through a broker. However, her son decided to go to work there instead. He was offered an advance payment of 300,000 kyats for work onshore and 500,000 kyats for work offshore. He chose the work at sea. The broker gave an advance payment of 200,000 kyats right away and transferred the remaining 300,000 kyats through a bank in Yay four or five days later.

The cost of her treatment at the hospital was 840,000 kyats. She used to make 5,000 kyats per day on average by sewing, but she has not been able to get it back since pawning it. Now she does not have the machine and so has no livelihood. Her husband made 3,000 kyats a day by working as a porter at a factory before having to quit because of his absence from work during his wife’s stay in hospital. He has since been able to find another job as a porter at a new factory. However, her son died from a ruptured cerebral vessel a few months later while working in Yay. For now, the family has to buy things on credit at shops in the community.
Case Study 3: A couple’s story of the birth of their firstborn daughter in Yedarshay

**Key Findings:** This case study shows how additional funding sources are accessed as a household is unable to resolve a medical problem. Each visit to a provider or facility required the household to access additional funding sources as they lacked sufficient money in hand. This means that each referral increased the indebtedness of the new mother, as well as other relatives that helped to cover the costs. The key findings illustrated in this case study relate to Findings 1. Encounters and Perceptions of OOPE, 2. Access to Funds, and 4. Impact of OOPE.

A woman living in a remote village of Yedarshay Township shares the story of the birth of her first baby. She and her husband make a living from farming their land and her husband does additional work as a daily laborer producing charcoal. She had to give birth to her baby at the hospital after the Auxiliary Midwife (AMW) in her village could not deliver her. After the delivery, she had to take her sick baby to a hospital in Nay Pyi Taw and the unexpected costs indebted her immediate family and relatives.

I took antenatal care from the AMW in the village and from the Midwife (MW) on her field visits after I got pregnant. I saw the MW twice during my pregnancy, she examined my womb and gave me vitamin tablets. When I went into labor, I tried delivering with the AMW and a Traditional Birth Attendant (TBA) as the MW lives far away. However, when they had problems with the delivery, I was sent to the hospital.

I borrowed K150,000 from a friend with a 10% interest rate. I was carried by men to the village where the Sub-Rural Health Center is located (about half an hour by vehicle). From there, we hired a car from the charity group run by a monk. The monk said care was better at the Station Hospital that is farther away (more than one hour by vehicle), so we were driven there and had to pay K25,000 for the fuel.

At the Station Hospital, I had to pay K25,000 for the delivery and I had to buy medicines. I also had to buy injections every day as my baby was sick. After three days, they could not treat my baby anymore, so they referred me to a hospital in Nay Pyi Taw. It cost me K110,000 in total at the Station Hospital, including costs for meals and medicines. I had just 40,000 kyats left before going to Nay Pyi Taw, so I pawned my earrings for 70,000 kyats. The hospital arranged a car for us to go to the hospital in Nay Pyi Taw and it cost me 15,000 kyats for fuel. At the hospital in Nay Pyi Taw, we had to get blood tests four times. The first three tests cost K9,500, but we did not have to pay for the fourth test. We were short of money at Nay Pyi Taw, so had to borrow K150,000 from my mother-in-law and K150,000 from my uncle. My mother-in-law had to pawn her gold to get the money and my uncle lent to me at a 7% interest rate. We had to stay in hospital for 16 days. On discharge, I donated K5,000. I had taken over K400,000 to Naypyitaw Hospital and had K70,000 in hand when discharged. Once back home in the village, I offered a donation of K15,000 cash and K5,000 worth of snacks to the AMW.

I have now repaid the first money I borrowed before going to the Station Hospital (i.e. 150,000 kyat at 10% interest), but I haven’t paid back the interest yet. To make repayments, we had to save the proceeds of the sesame from our land and my husband’s daily wages for two months. There are still the other loans to repay and we will need to work to make the repayment. It cost a lot of money to stay in hospital, so my family has faced some hardships. While I was in hospital, my husband could not work the farm and half of the paddy was destroyed by pests. As a result, we have had fewer yields. We used to have 100 bushels of paddy from one harvesting season, but now we only have 50 bushels. It is not going to be enough for the whole year and we are going to have to buy some rice in the rainy season. It is difficult to make money, so we have tried to spend less on food. We used to buy edible oil in buckets, but now we have to buy a half or one viss (0.65 kg) each time. I still haven’t redeemed my earrings. And the interests on my debt keeps increasing. I also have not yet redeemed the ring I pawned for our family expenses. “We had to spend a lot on the health care, but it’s ok as long as our child is fine. Of course, we do have hardship due to those costs though.”
Case Study 4: Family seeks affordable health care from informal providers in Hakha Township

**Key Findings:** This case study describes the decisions of a household, which lead to seeking care from an informal service provider and forgone care. The key findings illustrated in this case study relate primarily to *Findings 3. Influence of OOPE on Care-Seeking* and *4. Impact of OOPE* as it describes how OOPE influences care-seeking and impacts the health and socio-economic welfare of a household.

A husband and wife live in a household with their five children and their uncle. Last year their youngest daughter was born in Hakka hospital. She was a month overdue, but otherwise the delivery was normal. The wife received regular antenatal care at Rural Health Center (RHC) in her village and followed the advice of the Midwife there. However, the Midwife was on a 3-month leave when she was due, so when she began to have pains the wife borrowed money from relatives and went to the hospital. She stayed in hospital for a week. Afterwards, the family was able to pay back some of the borrowed money (K58,000 out of the total cost of K200,000) from funds given by Save the Children (i.e. 3MDG Fund emergency referral reimbursement) and her husband worked to pay back the rest.

A month or two later, still feeling unwell, she went to see a well-known masseuse in a nearby village. She borrowed K20,000 to pay for travel. She stayed a night there, giving the masseuse a bag of sugar and a jar of Ovaltine for her help (at a cost of K6,000 or K7,000). The masseuse told her that ‘her uterus had got cold’ (an infection) and she had to take ten ampules of Benzyl (penicillin) and 30 ampules of Genta (gentamycin) at home. The CHW (who also happens to be her sister in law) asked someone to buy these in Hakka (at a cost of K50,000) and also gave her the injection. She did not charge for the injection since she is family.

Feeling slightly better, but not totally cured, she took honey and turmeric frequently. When she could bear the dizziness, headache and numbness in her toes, she went to see the Midwife from the RHC. The Midwife gave her vitamins to take once daily for two weeks, which were free of charge. She noticed that her appetite increased and numbness improved, but her symptoms were not completely relieved. At the end of that month, she went to see another informal health provider in a village 4-5 hours’ drive away, recommended by other villagers. Her relatives encouraged her to go to Hakha, but she went to see the informal provider instead as it was more affordable. The motorcycle rental alone to go to Hakka would cost K60,000-K70,000 and the family estimated that the total cost would be at least K250,000 as medicine and meals cost a lot in Hakka.

At the same time, their 12-year-old daughter was also unwell with frequent abdominal pain, so the mother and daughter went to see the informal health provider together. She had saved K10,000 through work breaking stones used in road construction for two weeks. She did not know how much it would cost, so she took K10,000 with her. K5,000 was used for fuel and the other K5,000 to pay the informal health provider. He prescribed Fortified Penicillin and 500mg paracetamol for her and Aneso-D (Esomeprazole & Domperidome) for her daughter, advising that if there is no improvement to go to the hospital. When she was back in the village, she asked someone going to Hakha to buy the medicines. It cost K18,500 for both her and her daughter. She borrowed K10,000 to buy the medicine and K8,000 for fuel. Her daughter started taking hers, one tablet daily for a week. This did not seem to make a difference, “perhaps because she missed some doses or ate lots of fruit.” The mother feels that it would be best to go to the hospital if she had enough money. However, there are no jobs with regular income in the village, so it is difficult financially.
Case Study 5: A 60-year-old man loses consciousness in Hakha Township

**Key Findings:** This case study shows how households are able to have more flexibility for covering costs with informal providers, because credit is given, transport costs are less and it is possible for household members to continue working while the patient is treated at home. The key findings illustrated in this case study relate particularly to Findings 3. Influence of OOPE on Care-Seeking.

A 60-year-old man has had a history of abdomen pain since he was a teenager. He drank soda powder with water to relieve pain when he was younger, but stopped when he was told that it would thin his intestine. Instead, he bought antacid, from a pharmacy in Hakka whenever he had money (it costs K10,000 - K20,000 for a one to two-month period), but he never sought care for this problem at a clinic or hospital. In 2014, he took antacid for several months, but it did not help so he tried soda powder in water again and traditional remedies. These also did not work and the pain got worse. He started vomiting blood and his stools became black and tarry. Concerned villagers urged the man and his wife to go to the famous informal health provider in the village.

One day the man lost consciousness, so the family asked for the midwife at the SRHC. She came to their home, gave him an intravenous drip and advised them to go to Hakha hospital. As they did not have the money to go, they called the informal health provider, who also visited and referred him to Hakha hospital. Since they did not have any available cash to pay for transportation to Hakha and they were unable to borrow any money (too much of a risk, as they are too poor and had previous bad experience with repaying a loan from the agriculture bank), his wife requested the informal health provider to treat him as best he could at home. He continued to visit twice a week. Eventually he improved and the informal health provider told them that he vomited blood, because he ate too much bamboo shoot curry. The husband believes he got better by God’s mercy. They thanked the informal health provider with K5,000 and a chicken.

The wife took care of her husband throughout the illness, so she could not work and there was no income for a month. The medicine cost K165,000 - a huge amount for the family in 2014. The informal health provider asked the pharmacy to give them drugs on credit in his name and a relative collected them. He also paid off the credit, to be reimbursed by the family at a future date. The family was also given K50,000 by relatives in Hakha. The wife did not try to borrow money in the village, because she felt that there would be no one who would lend to them. They received two bags of rice from the local church group. They used a bag of rice for a month when her husband was seriously ill (the usual consumption of rice for the family). When he recovered, she used the second bag the next month as she resumed work. She bought soap, cooking oil and salt on credit from four grocery shops in the village, with a total loan of K20,000-K30,000. She was let off paying interest.

The wife had to work for five months to pay the debt just for medicine. This was hard labour in paddy fields, clearing farmland, unearthing potatoes, manually crushing stones to pave roads (earning K4,000 a day or K8,000 for a fixed volume). She earned K5,000 a day for cutting and carrying wood and K1000-2000 a day for digging yams. She saved this, paying back K5,000 - K8,000 each time. Although the husband’s health has improved, he is unable to return to paid work, but helps out at home. They have three children (22 years, 20 years and 10 years) - all in education. The family borrows money to pay for school fees and pays for food on credit, then repays debts when some money is made. It is difficult to keep up with this vicious cycle. The wife worries that, as the only wage earner, if she became ill, what her family would possibly do.
PART II: Provider Perspectives


**Key Findings:** Public providers function with longstanding resource constraints, so their coping mechanisms are actually a part of their usual management strategies, which include use of donations/fees and sending patients elsewhere for care (i.e. “referrals”). A plethora of tactics are used to deal with insufficient and near expired medicines and commodities. Inadequate and unpredictable fund flow reinforces reliance on donations/fees. Centralized management of human resources limits the ability to prioritize the most critical human resource needs across a Township and incentivize staff to meet these needs. Lack of replacement and maintenance of equipment and instruments results in inability to provide basic investigations and procedures.

Health care providers at public facilities strive to maintain service availability with insufficient resources in a context of uncertainty. The allocation and timing of government/WB resources is largely described as unknown or unpredictable (e.g. “I don’t know about the budget;” “Only the TMO knows about it;” “It’s according to higher-ups”). The use of government/WB resources are described predominately as reactive, “The budget isn’t available until the middle of the year. Then when it comes in bulk, we have to draw up plans to spend it.” (TMO provider respondent). This results in a range of management strategies and coping mechanisms being used by public providers at each level of the primary health care system. This study sought to identify both management strategies and coping mechanisms of public providers, but it became clear through the research that this distinction is not practically meaningful. Public providers function with longstanding resource constraints, so their coping mechanism are actually a part of their usual management strategies—as norms rather than exceptions to their ways of working to maintain service availability.

**Resource Categories and Cross-Cutting Features**

Interviews with providers at public facilities about their resources, needs and strategies for maintaining service availability identified four broad resource categories of importance to providers, which are listed in order of emphasis as follows: 1) Commodities/Medicines; 2) Human Resources; 3) Operational Costs; 4) Equipment/Instruments. Descriptions of these resource categories revealed some variation in the sources of support and needs existing within the context of each Township, but management strategies and coping mechanisms for each resource category were largely the same.

Cutting across all resource categories were two underlying common features—use of “donations/fees” and “referrals.” Within a resource constrained environment, public providers depend on a variety of donations and fees to enable service provision as well as the option to send patients elsewhere when resources are insufficient or exhausted. These common features profoundly shape the experience of users within the health system as well (see Findings Sections 1 and 3).

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55Providers often refer to “government budget” or “World Bank funds” interchangeably with apparent differences in understandings about the sources of these funds and associated requirements for management, use and accounting.
Concept Map 5/6: Resource Management Strategies and Coping Mechanisms

Note: Blue circles represent resource categories described by respondents (size of circles indicates relative frequency of reference in interviews); yellow circles represent cross-cutting features described by respondents; orange circles represent management strategies and coping mechanisms described by respondents.
5/6.1 Cross-Cutting Feature: Donations and Fees

Donations and fees collected at the point of service delivery are actively managed at all public provider levels to meet needs across all resources categories. The lines between “donation” and “fee” are blurred or non-existent as the terminology used by both providers and users is often nonspecific or interchangeable. For example, there might be a particular cost for a cesarean section, which is known by both providers and users. This amount may be referred to as a fee “a phoe or a kha” or as an offering “gadotngway” (see Annex 5. Key Words in Myanmar for Donations, Fees and Offerings). The methods for collecting and managing donations/fees vary, but are often systematic and known across staff within a particular facility. At Township and Station Hospital levels donations/fees may be pooled together for use across the facility or at RHC and SRHC levels donations/fees may be used to cover the costs of travel and medicines for conducting outreach services. Quotations from public providers that describe how donations/fees are managed and used can be found in Annex 6.3. Management and use of donations and fees.

5/6.2 Cross-Cutting Feature: Sending Patients Elsewhere (i.e. “Referrals”)

Public health care providers depend on the option to send patients elsewhere when resources are insufficient or exhausted. This is usually referred to as making a “referral,” although it does not necessarily indicate a clinical determination that a higher level of care is required or a systematic arrangement for managing patient cases. “Referrals” are often based on a lack of adequate human resources, medicines or diagnostic equipment to either diagnose or provide the necessary care. As one Lady Health Visitor in Shwepyithar simply stated, ‘If we can’t handle their case, we refer them to Shwepyithar [Hospital]. Then they are referred again if necessary.’ This leads to patients seeking care at multiple locations without knowing if the next facility will likely be able to meet their medical needs or not.

“Referrals” can also be based on a perception of the availability of resources. Public providers may send patients to higher level public facilities (i.e. hospitals at District or State/Region level or in some cases Nay Pyi Taw and Yangon) or private clinics and hospitals. This may be based on the provider’s understanding of the services or resources available at that facility. If resources have been spent on a patient without the money to pay and a provider is not able to provide more, then the provider may refer the patient to a higher level public facility that is perceived to have more resources or services free of charge. As one Assistant Surgeon noted, ‘We don’t have so much funding. We can’t spend so much on just one particular patient.’ If private clinics or hospitals nearby are known to have certain diagnostic capabilities, then a provider may direct a patient to go to the private facility for particular diagnostic tests and return with the results for further consultation. Additional quotations from public providers describing how and why patients are sent elsewhere when resources are insufficient can be found in Annex 6.4 Sending Patients Elsewhere when Resources are Insufficient.

5/6.3 Resource Category: Medicines and Commodities

Interviews with public providers about their resources, needs and strategies for maintaining service availability centered on the importance and insufficiency of medicines and (to a lesser extent) other commodities. Several providers noted recording and reporting monthly consumption and balance, but it was widely noted that government supply was still based on a quota system, where supply rarely aligns with demand.
Once medicines and commodities reach Township level, these resources are usually prioritized for use in the Township Hospital and for outreach services at community level. Within the context of Township and Station hospitals, restricting usage and allocating on a request basis is a common practice with the TMO, MS or SMO giving approval for taking items from the drug store every couple of days. Medicines and commodities can sometimes be borrowed or shared between wards when there are needs, but maintaining separation between the departments of public health and medical care supplies can hinder this flexibility. Within the Township the needs of the Township Hospital are usually prioritized, so scarce supplies may be unavailable to lower level facilities. There are often no vehicles or funds available for transport of supplies, so providers working at RHC or SRHC levels pick up supplies when attending meetings at the THD or RHC levels. Once supplies are in the hands of providers at RHC and SRHC levels, then their use at “community clinics” (i.e. outreach services usually combined with EPI village visits) is usually prioritized.

5/6.3.1 Managing Insufficiency

Insufficient medicines and commodities, both in terms of an adequate range and quantity, is a major concern for public providers at all levels within the Township. Public providers deal with this insufficiency in two primary ways, either by prescribing for purchase by patients (or their attendants/families) at drug shops or by purchasing for resale to patients. The resale of medicines and commodities is noted to either be at cost or a small profit. At the Township and Station levels, it is more common for providers to prescribe medicines or commodities to patients for purchase outside. Within Township and Station Hospitals, medicines or commodities received through the government supply are usually prioritized for use with in-patients, while prescriptions for purchase outside are more often given to out-patients. At RHC and levels below, it is common for providers to purchase medicines and commodities for resale to patients. This difference in practice seems to be a function of the availability of drug shops. At Township and Station levels, there are usually private drug shops with “prescribed medicines” within the same locality, while limited medicines are available through drug sellers at the RHC, SRHC or village levels. As one MW described, “I buy as much medicine as I have in short supply and charge the patients at the rate it was bought. I also explain it to them. I don't ask them to go and buy the medicine themselves as they would have to go a long way.”

Providers are aware that purchasing medicines is a burden for patients and use of available stocks is considered important, so some adjust medicines prescribed to patients based on stock availability. While providers often emphasize that they provide medicines with similar efficacy in these cases, it is unclear if the adjusted prescriptions are always pharmaceutically equivalent.

5/6.3.1 Managing Expiration

Receiving near expired or expired medicines is a major concern for public providers at all levels within the Township. A “first in, first out” practice is widely acknowledged as standard protocol, but this is not described as adequate for dealing with the substantial ebbs and flows in supply.

Many providers note that supplies received from the CMSD and State/Regional Health Department are often already near expiration (within six months). Pressure to “reallocate” and use near expired drugs falls from the Regional Health Department to Township Health Department, then Township health Department to RHCs and SRHCs. As described by one TMO, “When the Region asks us to use up the drugs

56 Both medicines and commodities are described as “prescribed” for outside purchase, because patients are often directed to buy the items needed for procedures in addition to the required medicines.
that are near their expiry dates, the Township has to reallocate them. We have to use them all up. The medicines we receive without asking are a burden to us. We can’t say no to the Region. I raise that issue with them when I meet them or at meetings. The thing is it’s not good for anybody to have medicines that are near their expiry. It’s also a waste of the country’s budget.’

Challenges with receiving medicines near expiration also extend to those procured through tenders at State/Regional or District levels with companies sometimes fulfilling tenders with medicines without optimal remaining shelf life. In some cases, there are practices in place to check the expiration dates when receiving the medicines, so that those close to expiration can be sent back to the company, but in other cases those near expiration are still accepted and sent to Townships. If medicines cannot be used before expiration, then these medicines are registered as consumed and disposed (e.g. flushed down the toilet, dissolved in water or burned). Most providers emphasized that they do not give expired medicines to patients for their safety, but they still need to register these as consumed, so that the quota of medicines to be received in the future is not reduced. As one AS described, “Those medicines from Region are mostly near their expiry dates. We don’t use them but we record them in the list of medicines used. We have to put up a list of more than is used. And we don’t want our patients to suffer the side effects.”

5/6.4 Resource Category: Operational Budget

Public providers at Township levels and below receive budget from the government, but these funds are not adequate or predictable enough to fund all operational needs to maintain service availability at facility, outreach or community levels. Providers describe the availability of funds for operational costs as a relatively new phenomena (often associated with the flow of additional funds from the WB since 2016), which they have limited experience with to date. The availability of these funds is viewed positively even though the quantity, predictability and flexibility are deemed inadequate. Most providers admit a limited understanding for how the allocation and accounting of these funds works, often stating only the TMO or Clerk know this in detail. Provider descriptions seem to indicate inconsistent practices or understandings for how this funding can be used, but continued reliance on donations/fees to meet basic operational needs is clear.

5/6.4.1 Managing Inadequacy

It is difficult for public providers to judge the adequacy of funds from the government to date, since these have typically not been approved and received within a timeframe feasible to plan and use the funds. As one TMO described, ‘As the budget was approved just before its closing, we had to return the money without using any. The WB said it would provide support, but this time around, it was only received in January and it was to be returned if not used by the 20th of February.’ However, many providers indicate that the allowable travel allowance is inadequate (e.g. for EPI outreach, provision of supervision or attendance at meetings), particularly for work in hard-to-reach areas. As another TMO described, ‘The rate by the government is out of date now. But UN, UNICEF and NGOs give more than the actual cost.’

5/6.4.2 Managing Restrictions

While a few public providers seem to have an understanding for the wide range of ways that these government funds can be used. Most public providers have a fairly restrictive understanding for how the funds can be used (e.g. no budget line to use funds for the repair of equipment) and a high burden perception for how the funds need to be accounted. Whether these restrictions are accurate or not, these understandings and perceptions reinforce reliance on other sources of funds to cover their needs, particularly donations/fees taken from patients at point of service.
Based on provider descriptions, relatively small routine costs and those that are unplanned are more difficult to cover with government/WB budget. For example, if electricity is not available consistently and alternative arrangements need to be made (e.g. buying of fuel for a generator and use of charcoal for sterilization), then there are “difficulties” that need to be managed flexibly, “We don’t have electricity. The power from the hydro generator is available on and off and it can’t generate the required voltage. We can’t use the autoclave. So we use charcoal to sterilize the instruments. They have difficulties in the Ward. So patients are asked by the nurses to donate a little money if they want to.” (MS quote). Moreover, small expenditures are either seen as not applicable or too much of a nuisance to put forward through official procedures for reimbursement. For example, one AS stated, ‘I don’t know much about that [government budget]. So far, we still have to ask patients for money. We still need to use donated money to buy things like brooms and detergent powder. Things like blue fluorescent lamps worth about 30,000 kyats are bought with that money. These expenses are too small to put forward to the MS. If it’s about the X-ray machine, I submit to the MS. Also a broken window and roof damage are reported to the MS for expenses.’ Additional quotations from public providers describing the limitations and burdens of using government/WB budget can be found in Annex 6.5. Limitations of Using Government/WB Operational Budget.

5/6.5 Resource Category: Human Resources

Public providers at Township levels and below highlight insufficient human resources and government salary as challenges to maintaining service availability. Centralized management of human resources limits the ability to prioritize the most critical human resource needs across a township and incentivize staff to meet these needs. Submitting and awaiting response to requests to fill vacant positions is common, but it is difficult to attract and maintain staff in positions where service provision challenges are greater and options for supplementary income generation are limited.

5/6.5.1 Requests and Rotations to Fill Gaps

The most common response to dealing with insufficient human resources is to make a request to the “higher level” to either fill a vacant post or sanction a new post. In some cases, analysis of population coverage and workload are calculated by providers and discussed in Township, District or State/Regional Health Department meetings. However, very little action can be taken beyond making a request and awaiting a response. In some cases sanctioned posts have never been filled or remain open for extended periods (i.e. months or years). In other cases, positions have been filled, but are open for several weeks or months while staff participate in training opportunities.

Providers note few options for dealing with this other than taking on additional work (e.g. longer hours or covering multiple roles) and temporarily reallocating staff. However, rotation of staff does not result in consistency of service provision. One example of this is the rotation of an AS from the District to Township Hospital or Township to Station Hospital for a week or two per month (described in multiple locations included in the study). Certain services can be provided while the doctor is visiting, but otherwise these services cannot be provided—and the inconsistency influences care seeking, thus resulting in a partially functional Station Hospital with few patients.

5/6.5.2 Dual Practice to Generate Supplemental Income and Resources

Multiple factors contribute to the difficulty in filling public provider posts in poor and underserved areas. Based on provider interviews, ability to generate supplemental income and resources for service provision
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are two important factors closely linked with the concept of dual practice. The term “dual practice” is often used to describe doctors providing services in both public facilities/posts and private facilities/functions, but other cadres take on these public/private dual functions as well. Dual practice serves multiple purposes, including generating additional income for providers, resources for service provision and service options for the population (at least for those who can pay). Some public providers note that they are too busy to do private practice, while others indicate it is the only way they have been able to survive on their government budget or function in their public provider role.

It is difficult to differentiate between public and private service functions of providers given the fluid nature of dual practice across all types of public providers at all levels. Some doctors establish private clinics where they provide services generally in the early morning and evening, but many also provide private services through consultations throughout the day (on call) or by making home visits. Other types of public providers also establish their own clinics, provide services from their own homes, make home visits to patients or provide services during village visits. This continuum of dual practice extends to the collection and use of donations and fees for services. It is clear that some providers engage in dual practice activities primarily to complement their public salary, but others also do so in order to supplement their operational budget to provide public services. Based on interviews with public providers, it seems that doctors at Township and Station Hospital level mostly view their dual practice as a necessary income generating activity, while providers at RHC, SRHC and Village levels view their dual practice as a source of budget for the cost of medicines and travel needed to fulfill their public service functions. It becomes increasingly difficult to differentiate between public and private functions at the lower levels of service delivery, particularly at SRHC and Village levels. This is illustrated by the description of one MW, “For field trips, I use donations made by patients, my own money and the money I have made from working as a GP outside. I charge patients 1,500 kyats for GP services.”

### Spotlight: Reasons and Purposes of “Dual Practice” Among Doctors

- “They don’t want to be posted here because they cannot do dual practice. We have a physician here. With a small population size, the surgeon and orthopedic specialist have no surgical cases to work on outside, so they are not happy here.” (Assistant Surgeon)
- “I joined government service because I wanted to do post-graduate studies. I do private GP work because my salary from the government service is not enough for my family. The motivational factor behind my GP work is my need for money. If the government could support us well, I wouldn’t work out there. I work here and then I work there at the clinic. That’s not good.” (Specialist Assistant Surgeon, Dual Practice)
- “I treat OPD patients at the hospital on Mondays, Wednesdays and Fridays. There are 30-50 patients a day. They have to wait. Those who can’t wait come for my private GP services. People who are well-to-do come over, like people from the villages. They mostly come for treatment because they can’t wait.” (Township Hospital Physician, Dual Practice).

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57 The only difference between doctors/dentists and other cadres is that the former is officially allowed to do private practice after hours while the latter is not.

58 This emphasis within interviews might be influenced by a hesitation to highlight the aspect of income supplementation, since these providers are not officially allowed to practice in this way like doctors/dentists.
Equipment and instruments were the least emphasized resource category described by public providers in terms of either their needs or management strategies. This is a noted area of support from donors, both through projects funded by international donors (e.g. midwife kits, incubators and computers) and charity provided by local donors (e.g. labor beds, wheelchairs, drip stands). In order to maintain service availability, providers use equipment for alternative or broader purposes (e.g. using an operation theater bed for deliveries or a child suction for both children and adults) or look for local donors to meet particular equipment needs. When it comes to small instruments needed for surgery, these are requested for purchase by patients and their families or paid for through delivery or surgery donations/fees. For example, one Health Assistant described as follows, ‘We give patients lists of things to buy. For caesarean surgery, we ask patients to buy the instruments needed. In the operation theater, we have the medicines but we ask patients to buy what we need. Most often, the patients’ attendants have to do the shopping in Taungoo.’

While the availability of certain equipment and instruments was raised as a challenge, it was more often functionality that was noted as a concern, especially for diagnostic equipment. Availability of resources for maintenance of equipment was highlighted as a difficulty, ‘MOH allocates budget under different names including for electricity, but not for maintenance of equipment’ (Medical Supervisor). Without functioning diagnostic equipment, patients need to be sent elsewhere for tests and investigations, thus contributing to the cross-cutting feature of “referrals” and increased costs to patients. For example, ‘We had the ECG machine fixed but it’s still broken. We send patients to take ECG tests at Kaytu Clinic in Taungoo. We charge 500 kyats, which is for the consultant who reads the result.’ (Assistant Surgeon)
7. Understandings and Perceptions of Health Financing Options (Question 7)

**Key Findings:** Providers have limited understanding of health financing options, but generally describe government, donors and users as the primary health financing sources. However, user sources of funds (i.e. OOPE) are seen through a lens of necessary “cost sharing” to cover health care costs. Supply side gaps are viewed to compromise the ability to retain “free of charge” services and maintain trust with patients. Initiatives to reduce OOPE for patients should be accompanied by efforts to ensure sufficient resources for providers.

### 7.1 Limited Understanding of Health Financing Options

Providers have limited understanding of health financing options, but patterns in the description of possible financing sources focused on government, donors and users. This limited understanding of health financing options was frequently stated by provider’s themselves, (e.g. “I don’t know about health financing”). These statements were often followed by more general reflections on how to improve the health system in terms of ensuring adequate income and resources for providers as well as geographic and financial access to services for patients. However, few providers suggested ways for how adequate finances for these improvements could best be assured from their perspective. Overall, the sense that government resources are limited and need to be complemented either by donor support or cost sharing with users was commonly described. The mechanisms for how these sources of finances should optimally be drawn on were generally not detailed, but public providers emphasized the need for reliability of fund flow, flexibility in allocating funds and simplicity in accounting procedures.

### 7.2 Benefits and Challenges of Existing Financing Mechanisms

Providers described differences in the benefits and challenges of existing financing mechanism for themselves and their patients. The benefits and challenges associated with government sources of finances were described more in relation to providers, while the benefits and challenges of donor sources of finances were described more in relation to patients. The benefits and challenges of user sources of finances (i.e. OOPE) were not addressed directly, but were expressed through descriptions of the necessity of “cost-sharing.”

Increased provision of medicines and operational budget from government (with support of WB) was noted as beneficial, but challenging in terms of the reliability of supply/fund flow, flexibility in budgeting and simplicity in accounting procedures. A common theme described by providers was the lack of alignment between government allocation of resources and the needs of providers or their patients. This is viewed mostly as a challenge for the providers themselves, but gaps in government supply of medicines were noted as a challenge for both providers and patients, since providers have to explain why medicines are not available for free and patients have to pay for them.

Providers appreciate the benefits of donor assistance to patients in terms of providing direct benefits, free of charge services or reimbursement of health care costs, but in some cases express concern over the implications for patients when donor assistance is discontinued. For example, one MW stated, “If [INGO] does not give support, they will die of diseases. I want [INGO] to continue support without stopping… I have to cover seven villages with salary from this government. There is nothing for my family. If [INGO] support is until 2017, I do not know what would happen beyond this.” Additional quotations from public providers describing the benefits of donor sources of support to patients can be found in Annex 6.6. **Benefits of Donor Sources of Support to Patients.** Challenges with donor assistance for providers was
expressed primarily in terms of additional burdens to manage these funds separate from government resources and ensure compliance with donor requirements. Related to this point, one Health Assistant stated, “I would appreciate to receive all funding sources in one place. Fund provided from WB is not the same as MOH. They’re in different account. It would be great if it was provided from the same place [source]. It would be less busy when collecting data and writing reports.”

7.3. User Fees Understood through a Lens of “Cost Sharing”

The benefits and challenges of user sources of finances (i.e. OOPE) were not addressed directly, but the need for “cost sharing” between government and users was a common theme. Descriptions of “cost sharing” often referred back to policies and practices under the former “cost sharing” scheme from the 1970s. Based on the descriptions from providers, “cost sharing” is more broadly perceived as any situation where users pay part of the cost of services at the point of service delivery. This theme of “cost sharing” was commonly associated with three premises. First, even if services are “free of charge” they are not “free of cost,” so services need to be paid for in some way. Second, the government will never have enough resources to pay for all health services indefinitely. Third, those who can afford the cost of services should pay for them, rather than expecting everything to be free. As one dual practice physician expressed, “No country can give all FOC for everything. It is impossible to give the medicine in stock for free... so, the cost should be shared” and another Assistant Surgeon suggested, “If there is a fixed price for normal delivery like K6, 000 / K10, 000 or K10, 000 / K15, 000, then K5, 000 out of them should give to the MOHS.”

7.4. Demand and Supply Side Tensions with “Free of Charge” Services

As described in Findings 5/6. Management Strategies and Coping Mechanisms, lack of reliable fund flow and gaps in supply of medicines result in continued public provider dependence on donations/fees, which makes the realization of “free of charge” policies difficult. A common theme across provider descriptions on this issue were that improvements for patients in terms of reducing OOPE should be accompanied by improvements to address provider resource gaps. Providers highlighted gaps in resources to maintain service availability as well as insufficient salaries as issues to be addressed, “If we want to reduce OOPE, the government should support systematically. Moreover, the staff should get enough salary. We cannot survive with the government salary only. The amount we charge to the patients is a little” (Station Medical Officer). Providers highlighted that any initiatives to reduce OOPE payments for patients need to be “explained well to the population.” Necessary communication about the “free-of-charge” services from this perspective includes a clause that services/drugs/commodities cannot be provided for free when there are shortages in supplies.

Public providers expressed doubt about long term maintenance of providing services “free of charge.” This linked back to the theme that it is impossible for the government to provide services for free indefinitely. These concerns are grounded in provider experiences with the free medicines initiatives where essential medicines are provided by the government and dispensed for free to patients in public facilities. Many public providers recount experiences where they have had to explain to patients that the medicines they need are not available and need to be purchased. This is particularly difficult when patients are aware that medicines are supposed to be provided for free or patients have received medicines for free in the past. Providers view supply side shortages not only as compromising their ability to retain free-of-charge services, but also to maintain trust with patients.
Spotlight: Demand and Supply Side Tensions of “Free of Charge”

Several public providers described the challenges they face in providing medicines or services “free of charge” and explaining supply side limitations to patients:

- “A lot of diabetes medicine are provided but the needed medicine like antibiotic and multivitamins aren’t provided… It is difficult to work when there is no supply for patients. I feel disappointed to explain patients to understand all of this. Patients want to use RHC medicines” (Health Assistant)
- “What I wonder is with the people and the medicines, how much care can be provided free of charge….Patients might report that they are asked to buy medicines, because we want to sell them. It is good that the drug stores are no longer in the hospital” (Health Assistant)
- “I tell patients that they can have free health care at hospitals. But in reality, they have to spend a lot if they have to stay in hospital. After their discharge, they come and complain to me” (AMW)
8. Impact of OOPE on Patients and the Wider Population (Question 8)

**Key Findings:** Public, private and informal providers perceive that OOPE has a negative impact on health outcomes for patients and the wider populations, especially those who are poor. To help enable poor patients to receive needed care, providers may reduce charges, give credit, provide financial support or refer and advise patients on where they can receive affordable treatment.

8.1 OOPE affects Health Outcomes, especially for the Poor

Most public, private and informal providers perceive that OOPE has an impact on their patients and the wider population, especially those who are poor. Put simply by one Midwife, “Those who are poor have a hard time when sick.” This negative impact is viewed mostly in terms of health outcomes rather than socio-economic welfare. While many providers described how OOPE affects health outcomes, few described health care costs as a cause of impoverishment. Financial barriers related to the cost of transport, meals and treatment were all highlighted as challenges for poor patients. This was described to have negative impacts on care-seeking, especially when transport is required. Providers highlighted the reluctance of poor patients to seek care that might involve hospitalization for fear of the costs involved and also the challenges of dealing with chronic illness, because of the need for follow-up visits and long-term costs of medication. While socio-economic welfare implications were not specifically highlighted by providers, several mentioned the burden families face when caring for someone with an unresolved or chronic health condition.

8.2 OOPE Influences Care-Seeking

Providers described OOPE as a cause of delay in care seeking, loss to treatment follow-up, and forgone care. The need for “money in hand” to seek care was well noted from the perspective of providers. As one Midwife explained based on her experience, “Some lost their lives because they didn’t have the money. Others got worse. For diabetes and hypertension, patients need to go to town frequently to get treatment and take medicines, but they don’t. They show up here only when the condition is severe. When I asked them to go to hospital, it was too late and they died on the way.” The difficulties faced by poor patients to get sufficient “money in hand” to seek care was also acknowledged, “Most of them are daily wage workers and so they cannot afford to pay even K2, 000 for one injection. Some people cannot afford to seek health care immediately and so they borrow some money and come to the clinic after some days. It takes some days for them to borrow some money because their neighbors are also daily wage laborers and it is difficult to borrow. I cannot provide free of charge and so I take K1, 000 instead of K2, 000.” (Midwife not in government service, who opened clinic attached with drug store). Overall, provider reflections on the influence of OOPE on care-seeking mirrored the descriptions provided by household respondents at the facility and community level of how OOPE influences care-seeking decisions, including concerns around costs for transport and meals during hospitalization (see Findings 3. Influence of OOPE on Care-Seeking).

Some public and private providers described OOPE having an additional negative influence on care-seeking in terms of inappropriate and potentially harmful seeking of care from some informal providers (often referred to as “quacks”). As one private GP in Yaydarshay noted, “Because of expenses, people in the remote areas take treatment by taking prescribed medicine from drug shops and quacks, and finally if they could take loans and go to hospital, it is already late.” Additionally, this same private GP noted, “Because of quacks, patients would encounter double suffering like Mi Aye,” meaning those who have
difficulty paying for health care also suffer the consequences of seeking care from unqualified providers. Several informal drug sellers also acknowledged that their services provide an option to poor people who cannot afford to seek care elsewhere. As one drug seller explained, “People who come here to buy medicine are poor people. They cannot afford to pay for motorcycle transport and so they come here to buy medicine prescribed by my drug shop.” Altogether, less than optimal care is seen to contribute to negative health outcomes, either by delaying care that is needed or by the harmful practices of unqualified providers.

8.3 Mitigating the Negative Impact of OOPE

In order to help enable patients to receive needed care, providers describe reducing charges, providing financial support, giving credit or referring and advising patients on where they can receive affordable treatment. These five mitigation strategies are employed to varying degrees across public, private and informal providers with decisions generally made on a case-by-case basis depending on the resources of the provider or facility and the need of the patient. These descriptions from providers echo the experiences household respondents describe of encountering OOPE with reductions at the discretion of providers (see Findings 1. Encounters and Perceptions of OOPE) as well as the practices providers describe of managing resources and coping with resource constraints (see Findings 5/6. Management Strategies and Coping Mechanisms).

Most public, private and informal providers describe giving treatment for free or at reduced charges as well as providing financial support to those they consider in real need. Judgment of need or poverty are usually assessed through informal means (e.g. what the person says, how they are dressed, where they live in the community). These decisions are largely ad hoc, as described by one LHV who conducts dual practice, ‘Normally, I charge 1,500 kyats but when I look at them, their faces change if they don’t have the money. In that case, I wouldn’t charge them anymore. I give my services free of charge.’ Several public providers explained that they just take as much as the patient can pay, even if it is not in accordance with usual costs (e.g. a provider usually charges 6,500 kyats, but accepts 5,000 kyats from a poor patient). Informal providers are perhaps the most flexible, since they receive most of their compensation through donations. While private and informal providers will often describe these reductions in charges as donations to patients, which they cover from their profits, public providers will often describe covering the cost of these reductions through donations from other patients. As one Assistant Surgeon describes, ‘We buy medicines for patients who can’t afford it, with the donated money. We sometimes ask discharged patients to donate their remaining medicines and give them to patients who can’t afford it.’ Additionally, all types of providers mention providing additional financial support in some cases, especially contributions to help poor patients cover transport costs if they are being sent elsewhere for care.

Some providers describe giving credit to patients or referring and advising patients on where they can receive treatment at an affordable cost. Many private and informal providers as well as some public providers give credit to patients, especially to those they know and live in close proximity to (see Section 3. Influence of OOPE on Care-Seeking). While some providers describe providing services on a credit basis to meet the needs of patients, they also describe problems with repayment in some cases. However, descriptions from providers in these cases are often expressed in terms of understanding the limitations of poor patients and flexibility on repayment in these cases. For example, one AMW explained ‘[One patient had a baby] and wasn’t able to pay me yet. When I was there at her home, I saw her eating rice with just fish paste. I felt so sad. In that case, I wouldn’t keep asking for it.’ This is also seen with informal

59 “Mi Aye” is a well-known character from primary school books in Myanmar, who is known for getting into double trouble.
drug sellers, ‘There are many customers who came over with prescription from hospital and bought medicines on credit. Only about half of them buy in cash. Some repay later and others repay long afterwards. Some just never repay. We sell medicines and it’s about health. So we can’t refuse to sell things on credit.’ Finally, some providers will specifically refer and advise patients on where they can receive services free or at a reduced cost. This theme appeared more with private providers, who also described discussing costs with patients in advance of providing services. This kind of referral and advice involved in some cases identifying resources locally, such as charity groups that organization emergency transport (for free or at a subsidized cost) as well as public or non-profit facilities known for providing certain services for free, whether for investigations or treatment. Particularly in Bago, providers mentioned referring patients to Nay Pyi Taw, because the 1000 bedded hospital in Nay Pyi Taw is known for providing free services. As one informal provider noted, “I asked them to go to Nay Pyi Taw. Over there, everything was given free of charge. Even food was provided all the time. Here at this township hospital, medicines are in short supply and it’s not good to ask patients to buy medicines outside.”

Providers express a desire to assist patients to access needed care and avoid the negative impact of OOPE on their health outcomes, but most agree there are limits to what any provider or facility can do. This theme was present across public, private and informal providers. All providers note that there are limits to the amount of services they can provide free of charge and other forms of support depend on the availability of donor or charity resources. Therefore, these types of assistance are not planned or systematic, but based on the individual decisions of the provider and the availability of resources at a given time.
Case Studies: Provider Perspectives
The following case studies were gathered from provider respondent interviews. These case studies place the key findings presented in Part 2: Provider Perspectives within the context of the lives of particular individuals. Each case study is preceded by a “Key Findings” box in order to highlight some of the key findings illuminated by the particular case study.

### Case Study 6: A General Practitioner’s “Unforgettable Patient” in Oaktwin

**Key Findings:** This case study shows the distress one provider felt for a poor patient who forwent care due to income constraints. The key findings illustrated in this case study relate to Findings 8: Impact of OOPE on Patients and Wider Population. In this case the provider was unable to convince the patient and family to seek care, since this poor household did not have money to pay for treatment.

A General Practitioner (GP) in Oaktwin shares from experience of running a private clinic for four years in the area of a town with a very poor and vulnerable population. Most people in this area depend on daily earnings as casual laborers in the local market. They can’t take work carrying bamboo from the mountains uphill into town as they do not own buffalo or bullock carts. Based on the GP’s observations, they usually take medicine prescribed by drug sellers at a cost of K500 for a pack of three doses. If they do not get better, then they usually take injections from quacks who provide home visits at a cost of K1,500 per injection. They only come to see him after taking injections for 5 to 6 days at home if the illness is not resolved. The GP sometimes provides home visits if he has time and he charges a total cost of K10,000, including a five-day course of medicine with consultation and home visit fees. He charges K3,500 for consultation with a three-day medicine course for patients with fever in the clinic. For those who cannot afford to pay, he reduces the charges.

In 2015, someone requested a home visit to see a patient. He was afraid to make the visit, since he knew the case must have become very severe if they were calling him to make a home visit. He followed with caution to the home of the patient. The patient was a mother in her twenties who had delivered a baby boy just two weeks ago. When the GP arrived, the patient was inhaling smoke from turmeric burning on a small stove. The GP told the patient to stop inhaling that turmeric, but she told him it made her feel better and she kept inhaling it. Her blood pressure was high and her face was red, but her heart rate was normal. Based on his physical examination of the patient, the GP was concerned and advised the family to go to the hospital and not to stay at home any longer. The relatives asked the GP whether she would survive if she went to the hospital. They pressured him to guarantee her survival. The GP replied that he could not give a definite yes or no answer, but it was necessary to treat the patient, then wait and see in the hospital.

The mother died at home that evening. The GP thinks that she passed away after having polycythemia. She had fever and breathlessness, but he was not able to make a proper diagnosis during the home visit—he could only know for sure if an autopsy had been performed. He noted with sadness that she was an “unforgettable patient” in his practice.
Case Study 7: An AMW in a Hard to Reach Village of Yedarshay Township
Receives Limited Resources and Support for Service Delivery

Key Findings: This case study describes the roles of one AMW in providing health care and referral services in her hard to reach village in Yedarshay Township. The key findings illustrated in this case study relate to Findings 5/6. Management Strategies and Coping Mechanisms. This AMW receives limited resources and support from the Midwife and THD, so she supplements her resources through fees to patients and direct purchases of medicines and commodities.

A new AMW from a hard to reach village of Yedarshay Township was recruited and trained, because the old AMW is no longer cooperating with Midwife. She attended AMW training and malaria training in 2012. Until now, she has received several malaria refresher trainings and AMW refresher training once. She received daily allowance and transport cost when she attended the malaria trainings. She received an AMW kit from the THD when she finished her initial AMW training. She sometimes receives clean delivery kits and a few medicines (e.g. paracetamol and amoxicillin) from the Midwife, who gives her medicines only when she has overstock. Although she received malaria test kits and medicines at the beginning, she has only test kits now, because malaria medicines are out of stock at the THD. Therefore, she has to buy the medicines and commodities she needs to gives services in her village (e.g. vitamins, antibiotics and gloves). Each time she stocks up on medicines she buys 30,000-40,000K worth. She had to buy a new blood pressure cup after her original one broke and she does not have weighting scale at the moment. As clean delivery kits are not enough, she keeps the extra threads from the clean delivery kits and uses them when she runs out of kits.

She charges 500k for three doses of oral medicines, 1,500-2,000 K per injection, 3,000K per drip infusion of vitamins and 3000-4000K for draining of abscesses and wound dressings. She delivers babies together with TBA and charge 15,000 -20,000K per delivery. She refers high risk pregnancies and patients with high fever or chronic disease to the nearby Station Hospital. Patients have to pay 25,000K for transport by car or 10,000K by motorbike taxi to the Station Hospital. She notes that it costs 100,000K for normal delivery and 300,000K for surgical delivery at the Station Hospital. This cost includes medicine, doctor’s round, delivery service fee, transport and meals. Regarding her services, she has challenges with the costs of buying medicines and commodities, because she does not charge some poor patients in the village. It is also challenging and difficult to buy medicines in rainy season, because there is no proper road to town. She would like to receive a sufficient supply of medicines for the needs in her village.
A Health Assistant has been working at the Rural Health Center (RHC) for almost a year. He works at the RHC during office hours and is at his private clinic the rest of the time.

He receives medical supplies from the THD for his work in the RHC, but he does not need some of them, and other essential items not included, “If medicines are allocated by the officials' ideas, it is difficult.” Medicines for diabetes and hypertension were provided a lot, but without patients, those medicines just piled up.” As the essential items he needs are not included (e.g. amoxicillin and paracetamol), he has to buy these with either contributions from patients or with his own money. He does this with the income from his private clinic. He generally charges 1000 - 1500 kyats per patient at his private clinic, although he charges more for some services. For example, draining an abscess costs 2000 – 3000 kyats.

He provides most services for free at the RHC, except for blood sugar tests, which cost 400 kyats – to pay for the test refills. If he doesn’t have medicines, then patients have to buy them outside. Most who come to the RHC are poor, and it is difficult to provide services to them without the right medicines. He is able to give free malaria tests, because he gets receives test kits from an NGO. He was also given a solar refrigerator by JICA to keep vaccines. He still has no oxygen apparatus. If equipment is broken, he has to replace it with his own money. He received operational costs from the WB and some costs from GAVI recently, but it was just for a few months. He prefers to receive all support from a single source, because different donors have different systems. For example, funds from the WB need to be managed through different procedures than the MoHS budget.

As there are many villages under one of the Sub-Rural Health Centres, the Midwife is not able to provide services to all of them, with the exception of EPI visits. An additional health centre has been requested, but there has been no response to date. He cannot often go to hard-to-reach villages, because the roads are bad. He wants all health staff to be given a motorcycle. He notes that it is helpful to have two ambulances in the RHC village, which are owned by a village funeral group. Patients have to pay for fuel when referred to the station or township hospitals. It costs 15,000 to 35,000 kyats depending on the distance. He thinks that people don’t go to health facilities, because of the transport costs and fear of public hospitals. “When the salary of health workers is low, they struggle to get-by and how can they give a proper care to patients? I think if it [their salary] improved, they would be able to give more care and they would be more in touch with patients. Then patients would trust them more.” People mainly depend on TBAs and AMWs for childbirth and traditional healers for other illnesses. GAVI funds encouraged people to come to the health centre. He thinks that this is because people are persuaded more by money than health talks.
Case Study 9: Views on health financing options from the perspective of a longtime serving Township Medical Officer

Key Findings: This case study describes some of the challenges faced by public health care providers in Myanmar. The key findings illustrated in this case study related primarily to Findings 7. Understanding and Perceptions of Health Financing Options. Donations are collected and used as needed to manage gaps and variations in government fund flow. This TMO thinks it is not possible for the government to provide free health services without cost sharing with patients who can afford it.

A Township Medical Officer with 20 years of government experience and has been in her current post for about six and a half years. With the MOHS restructure, she manages both public health and medical services in the Township. She explains that most of the medical supplies and financing comes from the MOHS, but it is not enough and the amount of funding varies annually. Donations are recorded in a register (receipts are not given) and used as needed. It is difficult for her to say how the operational budget is allocated, because it is complicated. The WB budget was received late, so they then had to rush to spend it. The audit was conducted in such detail it felt like they had committed a crime. They also received funding from GAVI, but the Health Equity Fund was not practical in her view, because of its scoring criteria and need to administrator’s recommendation letters, which community members were not always aware of in advance. Photos had to be taken in the hospital, which was additional work for health staff. In the end, all in-patients (poor and rich) were given the Health Equity Fund in order to spend the budget.

All medical supplies are kept in the main Public Health store; this includes supplies from the CMSD, the RHD and donors. The hospital has to make orders. The compounder position has been vacant for a year and two PHS II, who have little knowledge in pharmacy, are filling the gap. The RHD calls a drug tender every six months. Whenever they ask the township to use medicine that is nearly expired, the THD has to relocate it in whatever ways it can be used. In state level meetings they have raised concerns that this is misuse of national budget with wastage and no added benefits for patients or providers. Supplies are distributed in turn to the hospital and the public health sector. There is a shortage of medicine for NCDs, like diabetic and antihypertensive drugs, Random Blood Sugar (RBS) strips and RBS machines. There has been an increased demand for these this year as the period for which these can be prescribed free of charge has increased from 3 days to two weeks to one month nationwide.

There is a real problem with staffing. There are vacancies everywhere, from the hospital to the sub centers, from Assistant Surgeons to cleaners. There are only two Assistant Surgeons in the hospital and there are none in Public Health. So, there are no holidays and days off for them. There has been no HA1 for about a year and no THN for about 3 months, no counsellor for Highly Active Anti-Retro Viral Treatment (HAART), but HAART is provided to patients referred by an INGO. Because of lack of staff, they received many areas for improvement after the recent specialist tour in the health facilities. These difficulties made her want to resign. However, to get her pension, she needs to work five more years and has few other work options in other fields. She preferred her former post in Shan, though there is no little outside income apart from the government salary there.

Most patients are given free services, but it is not always possible. She believes that patients who can afford should pay, because it is not possible for the government to cover all the costs as this is a poor country. If the government cannot provide medicine for chronic conditions, then staff will bear the brunt of this (particularly if some medicine is only free for a short period of time). She thinks it needs to be clearly communicated to the public on which drugs are free and which are not. There are also needs for renovations, medical supplies, staff and budget.
DISCUSSION

The findings of this study describe the multifaceted roles and impacts of OOPE within both the demand and supply sides of the health care system in Myanmar. A rich understanding of OOPE has been generated through insights from both household members with varying levels of engagement with the health system as well as public, private and informal providers. These findings highlight that historical underinvestment in the health sector has resulted in a difficult situation for both health care users and providers. Those seeking care and those providing care have a strong mutual dependence on the role of OOPE for health, which can be seen in how “money in hand” is needed to seek almost any health care option as well as in how dependent all health providers are on donations/fees to deliver and maintain services. This mutual dependence on OOPE introduces a number of incentives and consequences that are not optimal for health system functionality or health outcomes. However, the ways that OOPE for health is currently used and why it is used in these ways point toward priorities for improving how the health care system works for both users and providers in the future.

Strong Mutual Dependence on OOPE for Health

As described by household respondents, “money in hand” is needed to access almost any type of health care, both prior to care-seeking and throughout treatment in unpredictable amounts. In addition to costs for medicines and services, the costs for meals and transport are encountered often at great expense, except when care is obtained from local providers within the same village or ward. Public, private and informal providers all depend on a diversity of systems for collecting donations/fees in order to maintain service availability and readiness.

As described by public provider respondents, a plethora of tactics are employed to deal with the insufficiency and expiration of medicines and commodities needed to provide health services, which often results in costs to patients (e.g. prescriptions for medicines to be purchased outside or purchase of medicines for resale to patients), while inadequate and unpredictable fund flow reinforces reliance on donations/fees to supplement or fill resource gaps (e.g. charges for deliveries, surgeries, diagnostic tests). In the context of public provider service provision, blurred lines exist between the language and perceptions of “donations” and “fees” for both providers and users, but regardless of the variety of terms used, all describe a form of OOPE. Both public provider and household respondents recognize that health care services come at a cost and appear to perceive their current mutual dependence on OOPE in order to provide and receive health care services.

Influence of OOPE on Health care System Functionality and Outcomes

Public providers describe many ways that donations/fees enable service delivery and readiness, both in terms of filling resource gaps to provide services (e.g. use of donations/fees for reagents needed for diagnostic tests or fuel for generator power during surgery) and cross-financing of services for poor patients (e.g. using donations to help pay for medicines/services that poor patients cannot afford). Out-of-Pocket Expenditure is also essential for patients of public providers to obtain medicines from private drug sellers or diagnostics test from private providers when these resources are not available from public facilities and providers. While donations/fees fill gaps and enable services in a number of ways, this form of financing makes providers dependent on the wealth of the population they serve, which influences not only the distribution of private providers (e.g. few GPs are present in poor, remote communities in Bago or Chin, while many are present in Yangon), but also the distribution of public providers (e.g. government posts in “hardship” areas are described as less desirable by respondents in part due to limited options for
supplementing provider income and resources). The continuum of dual practice observed across all types of public providers as a response to insufficient means of income and resources for service delivery as well as a response to health care needs (e.g. Midwives or AMWs as frontline primary health care cadres providing services beyond their scope of training/qualifications on a private/informal basis) contributes to provision of services with inadequate regulation and unknown quality.

Both providers and household respondents describe a number of ways that OOPE currently influences health outcomes comes negatively. Many households are faced with limited health care options, because of the costs associated with seeking care, particularly outside their localities. Household respondents perceive health care costs to be largely unpredictable for care-seeking that goes beyond what is available locally (i.e. costs associated with services from local providers are often well known), which is compounded by the largely known substantial cost for transport and meals. If a household seeks care, this can result in substantial OOPE, which can make the household highly vulnerable to falling into or deeper into poverty. If a household delays or forgoes care, this can result in undiagnosed or unresolved illnesses as well as inadequately managed chronic health conditions. Ill health comes at a cost to the socio-economic welfare of households and the national economy as well.\(^\text{60}\)

Priorities for Improving the Health System for Providers and Users

The ways that OOPE for health is currently used within the health system by providers and users as well as why it is used in these ways point toward priorities for improving how the health system works for both providers and users in the future.

Over the course of many years, donations/fees have been one of the most predictable and flexible sources of resources for providers to use for the delivery of services. Many public providers describe how donations/fees are collected, managed and used for service delivery, but few could explain how government or WB resources were allocated, budgeted or used. This is important to recognize, because public providers emphasize the need for predictable and flexible resources in order to maintain service delivery and link resources with local needs. As a funding source, donations/fees are also advantageous as the management of these funds do not require complex budgeting or reporting procedures. This is also important to note, since public providers emphasis the need for low burden management and user-friendly accounting procedures for health financing resources. Review of minimum standards for financial management at Township level and below that support flexibility while maintaining accountability for use of resources would respond to this priority.

Given that OOPE has been a norm for accessing health care, users recognize that health care comes at a cost and largely view this cost as worthwhile. The challenges of insufficient access to funds and the limiting health care options this presents were noted by many household respondents. However, when household respondents have sufficient access to funds, they describe using their resources to access health care they believe is most likely to resolve their illness with emphasis placed on perceived quality of medicines, familiarity with the provider and desire for patient information (i.e. about costs, diagnosis and care options). These ways in which OOPE is used by household respondents indicates a desire for health care options and quality of care that is defined not only by the quality of the clinical intervention itself, but the way it is provided (i.e. close to home, by providers that know their patients and provide adequate information to them).

\(^{60}\) MPLCS, CSO 2015 (forthcoming) states, “On average, individuals who reported being morbid stopped their normal activities for seven days. Myanmar lost 4 percent of potential work days due to ill-health”
CONCLUSIONS & RECOMMENDATIONS

Findings from this study give support and added rationale to many of the initiatives already outlined within the National Health Plan 2017-2021, particularly those related to emphasis on primary health care delivered at the township level and below, a switch from top-down planning to a more inclusive bottom-up approach and close collaboration across the many actors within the health system, including providers outside the MOHS and communities. Additionally, the National Health Plan (NHP) calls for temporary measures to reduce catastrophic expenditure by poor and vulnerable households with recognition that developing robust risk pooling mechanisms to ensure long-term financial protection will take time. The findings of this study suggest considerations for such temporary measures, which would support expansion of access to an essential package of health services and greater financial protection. Progress on these initiatives over the next few years would critically contribute to addressing the needs of providers to maintain service availability and readiness as well as users to access quality health care with greater financial protection, thus advancing the country’s aim to achieve Universal Health Coverage by 2030.

Focus on Primary Health Care Delivered at Township Level and Below

The NHP states that specialized or tertiary care has long been prioritized, mainly in urban areas at the expense of basic essential care for the majority of the population, then outlines a strategic emphasis on primary health care delivered at township level and below. This strategic emphasis is underpinned by the aim of ensuring access to essential health services for the entire population. The findings of this study, both from the perspectives of provider and household respondents, support this emphasis on primary health care in several ways.

Public providers at the Township level and below have indicated a range of supply side gaps that need to be addressed in order to enable service availability and readiness at these levels of the health system, including adequate availability of medicines and commodities. As public providers noted throughout interviews for this study, any initiative to reduce the OOPE payments of users must be accompanied by efforts to address the needs of providers at these service delivery levels. This need was frequently illustrated by challenges providers face with providing essential medicines for free when supplies are inadequate. Significant resources have been invested in making medicines available for free in public facilities, but findings from this study suggest that challenges and need for improvements remain. A comprehensive review to identify supply chain bottlenecks and solutions to address these would support making these improvements. Additionally, some of the challenges associated with this initiative could be reduced at least in part by updating and simplifying the list of essential medicines to align with the basic essential package of health services provided at Township level and below as well as improving supply chain systems to allow for an efficient consumption-based pull system of supply.

Household respondents highlighted the need for quality health services that are accessible within their locality. Illness histories recounted by household respondents in this study indicated that for the majority of health needs, households first seek care locally from the range of providers available within the local context. Even if households seek care outside their locality, if household resources are exhausted, then any care-seeking is reverted back to providers available within the local context. Thus, focus on primary health care delivered at Township level and below must consider how the health care system will extend to the community level, so that care-seeking at this level can at minimum be an entry point to quality health care by skilled providers. This emphasis on improving service availability at Township levels and
below would also help address the challenges household respondents face with repeated care-seeking and higher level referrals for diagnosis and treatment that could be provided at a primary care level. These improvements would result in a reduction in patient travel time and costs (including opportunity costs) as well as improvements in patient experience of care, which can in turn influence choice of provider and care-seeking in the future. These improvements would also contribute to more efficient delivery of services across the health care system, thus resulting in more effective use of public budgets.

Inclusive Bottom-up Approach to Health Service Planning

The NHP outlines an inclusive bottom-up approach to health service planning, based on the roll out of an Inclusive Township Health Plan, which includes the inputs of all health service delivery actors, civil society organizations and communities. This bottom-up approach to health service planning aims to better align resource allocations with the supply-side needs of providers and demand-side needs of populations across a great diversity of contexts within the country. The findings of this study, particularly from the perspectives of providers, support this emphasis on an inclusive bottom-up approach to health service planning in several ways.

Public providers highlighted that current resource allocation and fund flow mechanisms do not adequately respond to their service delivery needs. Many public providers emphasized that resource allocation must be based on needs at the service delivery level by those most familiar with these needs. This was often illustrated by the lack of availability of essential medicines, where medicines that are needed are not available, while others are available in excess, which leads to users needing to buy medicines and providers needing to dispose of expired medicines. Public providers also expressed a desire for greater flexibility and predictability of resources, so that they have more ability and options for addressing resource gaps at the level of service delivery. Simplification of service delivery planning guidelines at Township level and below, which are based on data and evidence, along with alignment of planning and budget processes would help enable public health providers to plan and request resources based on their known needs. Streamlining financial management procedures with greater flexibility to move resources across budget lines would also support public health providers to allocate resources toward real time areas of need. Improved communication on any differences between funding sources and required financial management procedures (e.g. confusion around “government funds” and “WB funds”) would give public providers more confidence to spend resources according to their needs as well. Beyond communication and training, providing ongoing support (or at minimum intentional question and answer opportunities) would also support adaption to new systems.

Collaboration across Actors within the Health System

The NHP puts forward a strategy that is inclusive and emphasizes fostering collaboration within the MoHS as well as between MoHS and key partners. This includes leveraging the contributions of service providers outside the MoHS as well as increasing community engagement to enhance responsiveness of the health system. The findings of this study highlight that certain elements of collaboration between actors within the health system are already apparent and support a movement toward enhanced collaboration, accountability and responsiveness.

Both provider and household respondents described an element of collaboration happening between public and private providers in the form of sending patients elsewhere (i.e. “referrals”). This is observed particularly when resources to provide certain services (e.g. diagnostics based on lab testing or imaging) are absent in public facilities or when private providers give guidance to patients on where they can
receive certain services at a more affordable cost. Both provider and household respondents also described an element of collaboration happening between providers and civil society in the form of mechanisms to provide blood for transfusion and support transport for referrals. These forms of collaborations were described as supporting service availability and access to services, which points to the potential for greater and more coordinated synergy between these actors within the health system.

An increased understanding of service availability across all service delivery points (as outlined in the NHP) as well as capacities of local civil society to assist in non-clinical functions that support access to services and social accountability would help enhance and systematize these types of collaborations across actors. Leveraging civil society organizations to communicate information to the public about health services as well as support channels of feedback to providers would contribute to addressing inadequate communication on the availability of public services and benefits. Improved communication and transparency about services, benefits and costs at all service delivery points would also help to improve the appropriateness of provider referrals and encourage patients to follow through with referrals based on enhanced understanding of the benefits and costs.

Considerations for Temporary Measures to Reduce Out-of-Pocket Spending on Health

The NHP calls for temporary measures to reduce catastrophic expenditure by poor and vulnerable households with recognition that developing robust risk pooling mechanisms to ensure long-term financial protection will take time. The findings of this study suggest considerations for such temporary measures must take into consideration the needs of both providers and users, in order to expand coverage of an essential package of health services and move towards greater financial protection.

Public providers outlined a number of constraints that they face in providing “free of charge” services to patients, which they note are not “free of cost.” Temporary measures to reduce OOPE on health would have a greater likelihood of effectiveness if targeted toward at least some of these constraints. Reviewing the essential drug list and addressing supply chain issues at Township level and below would help to address the OOPE encountered when public providers do not have adequate medicines for service delivery. Allocation of sufficient funds for transport of medicines from Township to RHC and SRHC levels would also help to ensure public providers have the medicines needed to provide care without costs being passed onto patients. Increased availability of operational costs, particularly to support the routine costs of facilities and maintenance of equipment, would also help alleviate need for coping mechanisms that depend on donations/fees to cover these costs. Making fund flow more predictable and building greater flexibility into systems of resource allocation would also enable public providers to optimize the use of resources that are available to maintain service availability, rather than funds going unspent while providers and users compensate for resource gaps. Finally, reviewing remuneration and benefit packages of public providers with priority on those involved in service delivery at Township level and below could reduce the pressure that public providers face in findings ways to ensure sufficient income for themselves and their families.

Addressing the needs of public providers to maintain service availability can begin the process of reducing dependence on donations/fees to fill resource gaps. Meanwhile, temporary measures can then also move towards addressing the blurring of lines between “donations” and “fees” as well as the “continuum of dual practice” across all types of health providers. Addressing the blurring of lines between “donations” and “fees” is important for any temporary measures targeted toward reducing OOPE particularly for the poor and vulnerable as these households are likely to be the most negatively affected by confusion around
fees/donation. Even small amounts of payment given as “donations” can be a difficult burden for these households and lack of predictability in costs can contribute to decisions to forgo care. Temporary measures should at minimum include clear communication of any applicable costs in public facilities and spaces as well proposals to remove overt mechanisms for collecting donations in public facilities (e.g. donation boxes at discharge counters of facilities). Addressing the “continuum of dual practice” will likely be even more complex and will require acknowledging the existence of this phenomena as well as careful review of the drivers involved. Some of the drivers for fluid forms of dual practice may be addressed by some of the responses to public provider resource needs outlined above, but these options are certainly not exhaustive. Once a clear direction is set, oversight in the forms of regulation and supervision will be needed to ultimately influence changes in behavior and practice at the level of service delivery.

Finally, the substantial costs of transportation and meals described by both provider and household respondents cannot be ignored given their emphasis by the vast majority of respondents. Temporary measures to improve financial protection should consider options for alleviating this burden of cost, which either increases the cost of seeking care or deters households from seeking care at all. Adoption of a national system for emergency referrals and benefits (e.g. mechanisms that currently exist with donor support for obstetric, newborn and under five emergency cases) could be one temporary measure. While mechanisms for covering the costs of transport at least to the first point of care, especially in non-emergency situations may not be feasible in the long term, options for bringing preventative and curative services closer to communities and improving the quality of services at primary health care levels would contribute to reducing the need for transport and meals to seek care at distance, with multiple instances of care-seeking and referral. This would also help to address the challenges and cost burdens of repeated care-seeking for chronic conditions noted by both household and provider respondents. As stated in the NHP, collaboration across all actors involved in the delivery of services, including service providers outside the MoHS and communities, is essential to ensuring an Essential Package of Health Services is delivered to the whole population.
Annex 1: Contextual Background of Townships

**Hlaing Thar Yar** is a peri-urban township in Yangon Region with around 500,000 people residing in 20 wards, 9 village tracts, and 18 villages. Migrants residing in slum areas are considered the primary “hard-to-reach” population from socio-economic perspective. There is a high density and diversity of public, private and informal providers in the township, including public, private and non-profit hospitals, private General Practitioners, specialist clinics, drug sellers, traditional birth attendants and other informal providers. Public health infrastructures in Hlaing Thar Yar consists of one recently-upgraded 200-beded Hospital, one 16-beded Station Hospital, one Rural Health Centre (RHC), 6 Sub-Rural Health Centres (SRHC), one Primary Urban Health Centre and 2 Secondary Urban Health Centres, while there are also 120 private and non-profit clinics.

The most significant public provider human resource gap noted at the time of the research was lack of an OG Specialist at the public hospital, making cesarean sections impossible. Private GPs are largely the first point of contact for primary health care services, because of their flexible operating hours noted as convenient for factory workers and casual laborers. Insein and West Yangon General Hospitals are frequently used referral facilities outside the township, but transport costs to these locations were noted as a challenge for those seeking services. Several non-government organizations (e.g. Myanmar Health Assistants Association, Terre des homes, Marie Stopes International, Care and Medical Action Myanmar) currently provide support to provision of health services in the areas of HIV, Malaria, TB and RMNCH.

**Shwe Pyi Thar** is a peri-urban township in Yangon Region with around 270,000 people residing in 23 wards, 4 village Tracts and 5 villages. Migrants/floating population are considered to be socio-economically hard to reach population. There is a high density and diversity of health providers in this township, including many private general practitioners, specialist clinics and drug sellers as well as public and private hospitals, traditional birth attendants and other informal providers. Public health infrastructures in Shwe Pyi Thar consists of one township hospital with 25 beds, two RHCs, 10 SRHCs, one primary Urban Health Center (UHC), while there are also 110 private and non-profit health facilities.

The most significant public provider human resource gap noted at Township level at the time of the research was availability of only one on-duty Assistant Surgeon and no Medical Officer at Urban Health Center. Private General Practitioners are largely sought as a first point of contact for most health services, while public health providers are sought for immunization and obstetric services. In the case of hospitalization, it was widely noted in interviews that people prefer to go to Insein Hospital, because the Shwe Pyi Thar Hospital is a “referral hospital” (meaning that limited services are offered and people who go there are often simply sent onwards to larger hospitals). Several non-government organizations (e.g. FHI 360, Pyi Gyi Khin, Marie Stopes International, and IOM, UNFPA and MSF) currently provide support to provision of health services in the program areas of HIV, TB and RMNCH. Notably, Shwe Pyi Tar received GAVI HEF support until the end of 2016.

**Oaktwin** is a rural township in Bago Region with a population of around 170,000 residing in 11 wards, 40 village tracts and 225 villages. For geographical access reasons villages scattered around the mountainous area of Bago Yoma are considered the “hard-to-reach” population, but these areas also include migrants.
working in the logging industry. There is a relatively low density and diversity of formal health providers in this rural township as there are few GPs and no specialist or non-profit clinics. Public health infrastructures consist of one 25-bedded Township Hospital, two 16-bedded Station Hospital, one MCH Center, four RHCs, and 23 SRHCS.

The most significant public provider staffing gap noted at Township level at the time of the research was the absence of two assistant surgeons and a TB/HIV team focal. At the village level, care is usually first sought locally from formal or informal providers, which include a range of Midwives, AMWs, CHWs, Ex-military health workers, Malaria Volunteers, Spiritual Healers, Traditional Birth Attendants and “Quacks” (i.e. those without formal qualifications who provide injections and other services). Higher level referrals are primarily made to Taungoo District Hospital and other specialist clinics or hospitals in Taungoo. There are two local charities active in the township, one that provides ambulance services and another blood donation services. A few donors and non-government organizations (e.g. Global Fund, JICA, Save the Children, PSI, Pyi Gyi Khin) currently provide support to provision of health services in the areas of HIV, Malaria, TB and RMNCH.

**Yedarshay** is a rural township in Bago Region with a population of around 200,000 residing in 21 wards, 63 village tracts and 284 villages. There are a total of 27 villages considered geographically hard to reach by the Township Health Department due to travel distance and poor roads. There is a relatively high density and diversity of formal health care providers including one private Specialist Clinic in this rural township. Public health infrastructures consist of one 25-bedded Township Hospital, three 16-bedded Station Hospitals, one MCH Center, seven RHCs, and 43 SRHCS, while 23 private General Practitioners providing services throughout the township.

The most significant public provider staffing gap noted at Township level at the time of the research was the absence of assigned assistant surgeons, which is filled by temporary assistant surgeon from Taungoo Township. At the village level, care is usually first sought locally from formal or informal providers, which include a range of AMWs, Malaria Volunteers, Midwives, Spiritual Healers, Traditional Birth Attendants and Quacks. Higher level referrals are primarily made to Taungoo District Hospital or 1000-bedded Naypyidaw Hospital. There are multiple local charities at town to village level, which provide emergency transport, blood donation, oxygen tanks and funeral services. A few donors and non-government organizations (e.g. JICA and Karen Baptist Church) currently provide support to provision of health services in the program areas of Malaria and RMNCH. Notably, Yedarshay received GAVI HEF and MC(H)VS support until the end of 2016.

**Hakha** is a hard to reach township in Chin State with a population of around 50,000 residing in 7 wards, 30 village tracts and 66 villages. A total of 25 villages are identified as hard to reach based on geographical accessibility to the nearest health facility according to available modes of travel in different seasons. There are 7 private clinics that also provide basic investigations and diagnostic imaging services in Hakha. Many of the specialist doctors from the State Hospital practice in private clinics through stationary clinics or on an on-call basis. Public health infrastructures consist of one 200-bedded State Hospital, one 16-bedded Station Hospital, one MCH Center, 4 RHCs, and 18 SRHCS.

The most significant public provider staffing gap noted at Township level at the time of the research was the absence of station medical officer and having only one Health Assistant. At the village level, care is usually first sought locally from formal or informal providers, which include a range of Midwives, AMWs, CHWs, Traditional Birth Attendants, Quacks and Spiritual Healers. Higher level referrals are primarily made
to Mandalay General Hospital or Yangon General Hospital. Local charities are mainly faith based from different church groups providing a small amount of financial assistance, fundraising through contacts abroad, coordinating blood donation and providing food assistance to those in need. The Hakha Baptist Church assigned a pastor to the State Hospital to help those in need by fundraising (both locally & abroad) to give assistance to patients from their hospital fund. Many donors and non-governmental organization (e.g. Save the Children, PSI, MSI, UNICEF, MRCS, MIID, GRET, Mya-Sein-Yaung) currently provide support to provision of health services in the areas of RMNCH, Malaria, Nutrition and Emergency Response. Notably, Hakha received GAVI HEF support until the end of 2016 and continues to receive 3MDG Fund for emergency referral and MNCH services.

Tedim is a hard to reach township in Chin State with a population of around 93,000 residing in 4 Wards, 55 village tracts and 130 villages. Those villages located near India border and Kalay side, which are very far away from Tedim downtown are considered as hard-to-reach. At the township level, there is one private hospital and two private clinics across the town. Public health infrastructures consist of one 100-bedded township hospital, three 16-bedded station hospitals, one MCH center, 18 RHCs and 71 SRHCs.

The most significant public provider staffing gap noted at the time of the research was the absence of obstetric and gynecologist, anesthetist, pediatrician and radiologist at the township hospital and there were no assigned Station Medical Officers. At the village level, care is first sought locally from formal or informal providers, which include a range of Midwives, Ex-military health staff, Traditional Birth Attendants, Drug Sellers and “Quacks”. People from villages near the Indian border take care from both public and private providers in a nearby district of India, because it is closer and transport costs are estimated to be cheaper. When seeking health care outside the village, people prefer to go to private clinics or hospitals for out-patient care (based on opening hours and availability of specialists) and the Township Hospital for in-patient care (based on availability of some free medicines and reimbursement of some costs). Higher level referrals from the township are made to Kalay Hospital. There is one local charity organization in the town, which has ambulance for transport of emergency patients within township and also provides blood donation and oxygen. Many donors and non-governmental organizations (e.g. Save the Children, GAVI, World Vision, Marie Stopes International, PSI, UN Habitat and Myanmar Council of Churches) currently provide support to provision of health services in the areas of Malaria, TB, WASH and RMNCH. Notably, Tedim received GAVI HEF support until the end of 2016 and continues to receive 3MDG Fund for emergency referral and MNCH services.
Annex 2. Wealth Quintile Profiles of Respondents by State/Region and Township

**Yangon Region**

**Wealth Quintile Profile of Hlaing Thar Yar Township Respondents**

![Bar chart showing socio-economic profile of Hlaing Thar Yar Township respondents](image)

**Wealth Quintile Profile of Shwe Pyi Thar Township Respondents**

![Bar chart showing socio-economic profile of Shwe Pyi Thar Township respondents](image)
**Bago Region**

**Wealth Quintile Profile of Oaktwin Township Respondents**

![Socio-Economic Profile](Reference: National Population)

![Socio-Economic Profile](Reference: Bago Rural Population)

**Wealth Quintile Profile of Yedarshay Township Respondents**

![Socio-Economic Profile](Reference: National Population)

![Socio-Economic Profile](Reference: Bago Rural Population)
Chin State

Wealth Profile of Hakha Township Respondents

Wealth Profile of Tedim Township Respondents
Annex 3. Overview of Compilation and Preliminary Analysis Forms

- **Form 1: Township Background Information**: completed within the first two days in the Township, but reviewed and updated if more information comes available during the team’s stay in the Township.
- **Form 2: Narrative Descriptions of Health Facilities Visited**: completed whenever a public health facility is visited (e.g. Township Hospital, Station Hospital, Rural Health Center, Sub-Rural Health Center).
- **Form 3: Village/Ward Profile**: completed within the first two days in each purposefully selected village or ward.
- **Form 4: Participant List for KIIs and FGDs**: completed throughout each day as KIIs and FGDs are being conducted (not including names, but details such as gender and community or health provider role).
- **Form 5: Summary of Key Quotes**: completed throughout each day to summarize insightful quotes pulled from KIIs/FGDs (thus captured in the re-written notes) or from informal conversations (thus only captured in Field Officers’ Field Journals).
- **Form 6: Summary of Case Studies**: completed after KIIs, FGDs and informal conversations are completed for each research site (e.g., location of Township head, selected Station Hospital, selected Rural Health Center and each of the selected villages/wards) in order to summarize personal stories shared by respondents during KIIs/FGDs and informal conversations.
- **Form 7: Preliminary Analysis**: completed immediately following completion of data collection within the township, based on review of rewritten notes and review of all compilation forms.
Annex 4: Quality Assurance Across Stages of the Research Process

1. Training
A detailed field guide was developed in order to serve as a handbook to the research team in the field. The research team participated in a one month training process which familiarised the researchers with the content, aims and methods of research, including the basic tenets of qualitative research methods. This training also included peer-learning and scenario based exercises in order to practice some of the critical skills needed during the fieldwork. These skills included techniques in interviewing and conducting focus groups, note-taking, consolidating and triangulating information, and organizing and documenting data.

2. Pre-testing
Immediately following the training, a pre-test of the tools and process was carried out in an area of Yangon not included in the study. A debriefing was held with the full team, in order to learn from the experience and improve the field guide, field protocols and research tools for data collection, documentation, compilation and preliminary analysis before commencing data collection for the study.

3. Data Collection
The field guide provided the research team with guidance on how to make arrangements for the research at the township level along with detailed identification protocols for selecting key informants. A common challenge in qualitative research is potential selection bias that is not purposeful, but dependent on key influencers such as village or other administrative leaders. Several tactics were used to address this, including the use of procedures and targets for different categories of respondents per village or health facility. Training also emphasized the need to triangulate information and seek informants from categories of respondents who are not easily accessible and use of appropriate snow-balling techniques.

Semi-structured interview and focus group guides were used and training emphasized the need to internalise these semi-structured guides, so that they are not read word-for-word during the interviews, but used as a job-aide or reference instead. Interviews were conducted in pairs, with one person assigned as interviewer and the other as note-taker. Focus groups were conducted by three people, with one person assigned as interviewer and two others as note-takers. The field guide provided detailed guidance on procedures for taking verbatim notes of both interviews and focus groups. Emphasis was placed on not censoring the information recorded according to what seems important at the time nor summarizing in ways that are based on immediate analysis of the content. The QSEM experience has demonstrated this to be an effective approach, when researchers are provided with guidance and training to practice and review note-taking procedures. At the end of a day’s data collection, the verbatim notes captured were rewritten, by hand, into a second notebook according to the defined note taking protocol. This was done by the note-taker(s) for each interview or focus group with review and input from the respective interviewer all in Myanmar language. Therefore, the notes reflected a near transcription of the qualitative data collected through interviews and focus groups. Both the original and rewritten notes were scanned and stored on a shared drive to be reviewed by the co-investigator on an ongoing basis. Supervisory field visits were made by at least one of the study’s investigators (either co-investigator or co-principal investigator) to all townships in order to support the field research team.

Audio recording of interviews and focus groups was not conducted for several reasons: 1) sensitivities surrounding use of these devices and the likelihood of respondents feeling uncomfortable to speak freely while being audio recorded; 2) recognition that the exact transcript is not necessary for the final product
as the research will not include finely-grained textual analysis; 3) previous experience from QSEM has shown that the presence of a recording device can actually decrease the quality of both the interview and note-taking (interviewers can rely on it as back-up and then pay less active attention to how the interview is going and how they need to probe, resulting less rigorous interviews and notes); 4) time and resources needed to produce transcripts would outweigh the added benefit, particularly given translation needs.

4. Field Based Compilation and Preliminary Analysis
At the end of each fieldwork day, field research officers conducted peer debriefing sessions where they discussed and compared what they have observed during the day’s research. They also began to review their rewritten notes in order to compile and sort the data collected through the use of compilation and preliminary analysis formats. These structured templates were based on the key research questions developed from the study objectives and analytical framework and enabled the team to start sorting data for interpretation and ease of future reference. If certain interviews or focus groups will be conducted at night, time was set aside for this discussion and debriefing the following day, and that overall, adequate time was set aside for this while in the village or township to avoid losing rich information that is captured (i.e. data should be recorded and reviewed within 12 hours maximum). During these debriefing sessions, researchers identified gaps in understanding and strategies for further data collection and triangulation the next day.

5. Post-Fieldwork Analysis & Review of Findings
The QSEM experience has found that the process of doing peer debriefings has emerged as one of the strongest means in practice of ensuring quality assurance. They have found this to be a critical step in ensuring data quality, particularly given the varied educational and analytical backgrounds of researchers, and that the discursive ‘back and forth’ nature of building interpretation, with attendant probing of results, unpacking of assumptions, clarifications on data, and investigation into deviant findings, which helps the teams to strengthen their analysis.

Team-based debriefing happened after collection of data in each township, then again at the end of data collection within each state/region. The debriefing session after data collection in each township involved completion of the preliminary analysis forms and cross-checking data collected by all field research officers to ensure completeness and identify case studies, key quotes and other data that best illustrate key findings. Further review and discussion with the Co- and Principal Investigators, both after data collection in each township and again at the end of data collection in each state/region provided another level of checks in translation of data between steps of analysis.

Throughout the team-debriefing sessions, reference was made to the ‘raw’ data (i.e. the rewritten notes) and compilation forms to clarify questions and provide additional insight. This process was intended to reduce potential error by ensuring all interpretation and preliminary findings are repeatedly checked against the ‘raw’ information collected in the field. The debriefing sessions also served to discern whether particular findings are idiosyncratic or true more generally, and to ensure that the team is able to verify that the findings presented are not merely one person’s impressions, but driven and supported by the data. Debriefing sessions also provided the opportunity to recognize data that does not seem to support the general findings, so that it is not ignored, but explored more intentionally. Finally, these debriefing sessions allowed for research strategies to be refined progressively building on the learnings from each township and state/region.
Senior Consultation Group Meetings were convened after data collection and preliminary analysis of data from each state/region, in order to review and discuss key findings to date. Core features of these meetings involved discussion of the Concept Maps, feedback on emerging concepts to be further explored through team-based and Nvivo supported content analysis as well as interpretation of findings to address the aims and objectives of the study.
### Annex 5. Key Words in Myanmar for Donations, Fees, and Offerings

<table>
<thead>
<tr>
<th>English</th>
<th>Myanmar/Myanglish</th>
<th>Observations from Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donation</td>
<td>လွတယ္ (hlu-dae): Verb meaning “to donate” (either money or material).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>အလွေငြ (ah-hlu-ngwe): Noun meaning “donated money”</td>
<td>These terms denote a voluntary act of donation, but are also used to request donations that are understood to be either voluntary donations or required payments. Often used at hospital discharge.</td>
</tr>
<tr>
<td>Fee</td>
<td>အဖ ိုး (ah-pho): Meaning “price” and is often used by providers or users when talking about paying for cost of medicines and commodities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>အခ (ah-kha): Meaning “fee” and is often used by providers or users when talking about paying for cost of services</td>
<td>ah-pho &amp; ah-kha can also be used together to generally describe a cost (e.g. when payment for a medicine and service is combined)</td>
</tr>
<tr>
<td>Offering money</td>
<td>ကန္တာင် (ga-dot- ngwe)</td>
<td>These term denote giving money or materials as an expression of gratitude, but are used when referring to both free will giving and requested fees. These are often used to refer to payments to formal providers before or after a delivery or surgery (usually in the form of money); or to informal providers for services in communities (sometimes in the form of money, but more often materials).</td>
</tr>
<tr>
<td>Offering material</td>
<td>ပစည္ညိးဖင္ာကန္ (pyit-sie-phint-ga-dot)</td>
<td></td>
</tr>
</tbody>
</table>
### Annex 6.1: In-patient costs in public facilities.

**Medicines and Commodities Costs**
- ‘For the delivery of the baby, it cost us around 200,000 kyats in total. We had to buy medicine every two or three days. The drugs cost about 10,000-20,000 kyats each time.’ (Husband of woman who gave birth in Hlaing Thar Yar)
- ‘I had to buy them [medicines] from outside and it cost 12,000 kyats to buy the medicines each time. It included injections, infusions and oral medicines.’ (Female patient in Hakha Hospital)

**Investigation, Lab and Imaging Fees**
- “It cost 2,000 kyats each time to travel to Taungoo and 8,000 kyats for taking the USG test...It cost 6,500 kyats to take a blood test at Oaktwin Hospital. We had to pay the staff who did the test.” (Husband of woman in recently gave birth by caesarean in Oaktwin)
- “It cost 7,000 kyats for the blood test and 1,000 kyats for the X-ray. I don’t remember how much the urine test cost.” (Female patient in Hakha Hospital)

**Miscellaneous Costs**
- ‘The bed sheet for my bed cost 3,500 kyats. And the cups, dishes and layette cost me 13,000 kyats’ (Delivery patient in Shwepyithar Hospital)
- ‘We had to pay cleaning fees to the cleaner. If I don’t, they will shout at me in front of others. For the cleaning, we had to pay 4,000-5,000 kyats.’ (Woman with hypertension in Yaydarshay)

### Annex 6.2: Access to Health Care Requires “Money in Hand”

- “We need money to go hospitals and clinics for treatment. We can’t go there if we don’t have money. Nobody will welcome me at the hospital.” (Widow in Tiddim, who was seriously ill last year and received treatment paid for by her sister).
- “To go to hospitals and clinics, you have to bring money with you. You can’t just go like that. You have to buy medicines there. Now, I’ve come to know about hospitals and clinics. I had to buy medicines by myself. I have experienced that” (Widow in Yadarsay, who lives with her daughter).
- “Without any money in hand, you can’t stay in hospital” (AMW in Hakha).
- “I want to take treatment to get complete recovery, but I can’t afford money to do so...if you go to the hospital, you surely have to pay” (Elderly man in Shwepyithar, both husband and wife suffer from chronic illness).

### Annex 6.3 Management and Use of Donations/Fees

- “We give the donated money to the TMO at the end of the month. The TMO uses it to buy what is needed. An AS has to keep a record of the donated money. It’s also used for general expenses.” (SMO quotation)
- “All the donations are used for the Ward...the sister nurses in the Ward use the little fund they received to manage their needs.” (MS quotation).
- “We use the money paid by delivery patients to buy medicines, cleaning stuff and other things needed. And we spend it on soap, liquid soap for cleaning floors and others. Then what’s left is divided between the nurses.” (Assistant Surgeon quotation)
Annex 6.4: Sending Patients Elsewhere when Resources are Insufficient

- ‘Though we have a surgeon, we don’t have an anesthetist. So we have to make referrals to Kalay. For orthopedic cases too, major operations, which need a GA, cannot be done here. We have to make referrals to Kalay.’ (Assistant Surgeon)
- ‘Sufficient medicine and medical supplies should be provided to the hospitals and clinics. Otherwise, just referring would make patients die. If we had everything here, we wouldn’t need to refer. We could give treatment here.’ (Township Medical Officer)
- ‘Most of the lab tests are not available here. We provide tests for Hb % and G&M only. We can’t give other blood tests here. Patients don’t want to take blood tests when asked, because it costs a lot. We advise them to take tests out there [private facility] if necessary. Some patients have to go out there to get electrolytes tests or creatinine tests. We just tell them the estimated costs.’ (Assistant Surgeon)

Annex 6.5: Limitations of Using Government/WB Operational Budget

- ‘We have to follow the budget set by the auditors. We can’t spend next month’s quota this month. We spend donations on our needs.’
- ‘Starting this year, the Region asked us to put up a fund request for minor expenses. I most often used my own money rather than putting it up. It’s much of a hassle. I most often use the donated money.’
- ‘Fund provided from WB isn’t the same as MOH. They’re in different account. It would be great if it was provided from the same place (source). It would be less busy when collecting data and writing report.’

Annex 6.6: Benefits of Donor Sources of Support to Patients

- **3MDG:** ‘Eligible mothers and children can submit the actual costs. They need to put forward the D/C certificate, the referral note and the costs. With the signature of the MS, they can get reimbursed. 3MDG won’t pay the allowance if the request doesn’t meet their requirements. They also reimburse the taxi charges if any and the costs of the medicines. No support is given for things provided free of charge. 3,000 kyats a day is given for caregivers’ (Township Health Nurse)
- **3MDG:** “One good thing is 3MDG reimburse cost for medicines with some limits. Sometimes, physicians pay for them. Some patients borrow money for the costs and Save the Children pays back later” (Medical Supervisor).
- **GAVI:** ‘We make a list of poor patients and give away 3,000 kyats a day. Patients might have to buy things during their stay but the costs are covered later. So it’s not a burden anymore. Some patients coming all the way from 30-40 miles away get a reimbursement of over 100,000 kyats. Medical social worker registers patients and gives support’ (Medical Supervisor).
- **GAVI:** “GAVI is effective. When giving Health Education, patients come if they get treatment free of charge. People know that GAVI support money for delivery patients. So, they come. If you talk only and don’t give support, people won’t come” (Health Assistant)

Annex 6.7: Impact of OOPE on Health and Socio-Economic Status

- A woman from a poor household in Tedim, “If I could work today, I would get paid 3,000 kyats and I would buy oil for 2,000 kyats and soaps and other things with the rest of the money. But I am sick and cannot work. So I can’t buy oil and I just make porridge to eat... My children want to eat sugar and milk but I can’t buy for them... I don’t cry but it is painful in my heart. I bought foods on credit.”
- Husband of a chronically ill woman in Hlaingthayar, “She has been so sick that I can’t go to work. I do the cooking and the laundry at home. My son makes 200,000 kyats. So it is not too bad although
I can’t get jobs. My son left school and has had jobs since my wife became ill eight years ago. Although I want to get jobs, I can’t as I have to look after my wife.”

- A woman who recently gave birth in Shwepyithar, “I had to borrow money. I am surrounded by debts. I am despaired and worried. I have difficulties to repay the debts... One of the family members had a health problem, the family got more and more deprived over time for one year. The interest added up and I kept paying the interest. If you cannot pay the interest this month, you have to pay more in the following month.”

- A household in a Yedarshay, “We had hardship. Instead of eating for 1,000 kyats like before, we eat only for 500 kyats now. After selling the crops, nothing is left for us to eat.”

- A father of five children in a poor household in Oaktwin, “It was hard to find the money to pay for the treatment. We have neither income nor land...We had to repay the money. It affected the family's meals. We could buy and eat vegetables before. Now we have to find and eat what we can get.”

- A household in Hakha, “We spent quite a lot. We spent total about 165,000kyats for medicines only. That amount is quite huge for us at that time. We had to repay bit by bit after getting sick. There are expenses for meals. We don’t have money to buy little things such as oil, soap, salt and other necessary things. We are living in deficiency because we have to repay the money we borrowed non-stop. We owed money to every shop.”

- Elderly couple in Hakha, “We don’t have money, so she has to take treatment in the village. She has to send for a quack from another village and take injections. If they can't handle and refer to the hospital, she can't go there. We only have him if we are to live or die.”

- Village administrator in Hakha, “As we didn’t have money for medicines or transport, we didn’t go to clinics for treatment. We just didn’t do anything because we did not have money.”
Annex 7. Key Words in Myanmar for Borrowing, Loaning & Pawning

<table>
<thead>
<tr>
<th>Myanmar/Myanglish</th>
<th>Words in English(^{61})</th>
<th>Description of Myanmar Words</th>
<th>Observations on how these words were used by respondents in this study</th>
</tr>
</thead>
<tbody>
<tr>
<td>ဗိုးတ (CheeTar)</td>
<td>++</td>
<td>General term for borrowing something (i.e. money or material) from somebody with or without interest.</td>
<td>Most common word used for taking money from somebody with or without interest. Occasionally used to refer to pawning.</td>
</tr>
<tr>
<td>စိုးတ (Swal Tar)</td>
<td>++</td>
<td>Informal word only used in verbal conversation, which literally means to “pull” (i.e. take) something (used idiomatically) and implies taking money from somebody.</td>
<td>Most often used to mean borrowing, but occasionally used to mean loaning.</td>
</tr>
<tr>
<td>လိက်တ (Hlae Tar)</td>
<td>+++</td>
<td>Informal word only used in verbal conversation, which means taking and giving (i.e. “give and take”) from friends/relatives usually for a short period of time. This implies two steps—first borrowing from one person, then borrowing from another person to pay back the first.</td>
<td>Used to mean borrowing, usually from a second person to pay back the first person (which could have been a loan or borrowing).</td>
</tr>
<tr>
<td>ပေါင္တ (PaungTar)</td>
<td>+++</td>
<td>Most common word used when talking about taking money by giving something as collateral (i.e. pawning). This is the word used to specifically mean “pawing,” while “CheeTar” is occasionally also used informally to refer to money obtained through pawning (see above).</td>
<td>Most common word used when talking about taking money by giving something as collateral (i.e. pawning). This is the word used to specifically mean “pawing,” while “CheeTar” is occasionally also used informally to refer to money obtained through pawning (see above).</td>
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</table>

Symbol Key:

+++ Strongly associated with this word/concept  
++ Moderately associated with this word/concept  
+ Rarely associated with this word/concept

\(^{61}\) Note: In this study, researchers use “borrowing” to mean any lending without interest, “loaning” to mean any lending with interest, and “pawing” to mean any lending with collateral, although the definition of the word “borrowing” in English does not make the distinction of no interest.
Annex 9. Overview of Informal Provider Types

<table>
<thead>
<tr>
<th>Common Name</th>
<th>Definition</th>
<th>Identification by Community Members</th>
<th>Identification by Formal Providers</th>
<th>Self-Identification</th>
<th>Remark</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quack</strong></td>
<td>Quacks are the informal providers without formal training, who have been providing services like oral medication, injection, infusion and/or delivery almost always using Western medicine.</td>
<td>1. Provider who gives injection (Say-Htoe-Saya) 2. Quack (Yanku) 3. Local provider/healer</td>
<td>Quack (Yanku) (Up Pone)</td>
<td>health care provider (Say-Ku-Pay-Tae-Saya)</td>
<td>In Chin (Tedim) and Bago only, users used the word- quack (Yanku). Commonly called with their name in the community by putting sayar in front of the name.</td>
</tr>
<tr>
<td><strong>Traditional Healer</strong></td>
<td>Giving massage and/or treat bone fracture using traditional medicine, mostly sesame oil and soil potsherd and/or treats something like bewitching</td>
<td>1. Masseur/Masseuse (Ahnake-Thae/ Akyaw-Pin- Saya/Sayama) (oh-kyaw-ah-sit-pyn-pay-thu) 2. Chin provider/healer</td>
<td>Masseur/masseuse (Ahnake-Thae/ Akyaw-Pin-Saya/Sayama)</td>
<td>Sayar/Sayarma (sayar)</td>
<td>They are like traditional Orthopaedic.</td>
</tr>
<tr>
<td><strong>Traditional Healer</strong></td>
<td>Treat patients with traditional medicines(with or without reciting mantra) without having formal training</td>
<td>1. Traditional Healer (Vaindaw Saya) 2. Mantra healer (Ah-kyan-Sayar) 3. Local provider/healer</td>
<td>Traditional Healer (Vaindaw Saya)</td>
<td>Sayar (sayar)</td>
<td></td>
</tr>
</tbody>
</table>
### Spiritual Healer

Treat patients by reciting mantra. Some examine whether the patient has been bewitched or not by holding the patient's hand.

1. Mantra Healer
   - Akyan-Saya
   - Ohnphwas-Saya
2. Provider who recites Buddhist sermon
   - Pahtan-Saya
3. Spiritual healer
   - Wie-nyin-nae-ku-tu
4. Mental Healer
   - Sein-paing-sai-yar-sayar
5. Shwe-yan-kyaw-sayar

### Traditional Birth Attendant

Deliver baby without getting formal training.

1. Provider who delivers baby
   - Let-Thae
   - Wanswae-sayama
2. Local provider who deliver baby
   - Ayet-let-thae

### Drug Seller

The one who sells or prescribe medicines without having formal training.

1. Drug shop
   - Say Saing
2. Drug seller
   - Say-yaung-thu

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<table>
<thead>
<tr>
<th>Cannot mention what other providers and own-self call</th>
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</thead>
<tbody>
<tr>
<td>Shwe-yan-kyaw-sayar</td>
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<tr>
<td>Uses the holy arts of subject of Shwe Yin Kyaw that can cure the people who are attacked by bad evils and ghosts. They followed in Shwe Yin Kyaw (art of self-defence, occult science-reciting mantra and other traditional ways like piercing with big needle)</td>
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<table>
<thead>
<tr>
<th>Traditional Birth Attendant</th>
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<tbody>
<tr>
<td>Deliver baby without getting formal training</td>
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<tr>
<th>Drug seller</th>
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<td>Gender neutral</td>
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<tr>
<th>1. Provider who deliver baby</th>
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<tr>
<td>(coo-sa-le) Let-Thae</td>
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<tr>
<td>Wan-swae-sayama</td>
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<tr>
<th>2. Local provider who deliver baby</th>
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<tbody>
<tr>
<td>Ayet-let-thae</td>
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<th>Drug seller</th>
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<tr>
<td>Drug seller</td>
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<tr>
<td>Say-yaung-thu</td>
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<td>Say-yaung-thu</td>
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</tbody>
</table>
Annex 10. Summary of Key Terms

This summary of key terms is intended to be a reference for how certain terms were used within the context of this study.

**Accommodation cost**: special room fees in a public hospital and room/bed fees in a private hospital.

**Borrowing**: any funds that are lent without interest, usually obtained from friends, neighbors and relatives in small amounts.\(^{62}\)

**Catastrophic spending/payment/expenditure**: expenses in relation to health care that can push households into or deeper into poverty.

**Charity**: any support given to help those perceived to be in need without expectation of return, usually obtained from friends/relatives, community members, CBOs/NGOs/Donors and sometimes health providers in the form of services and medicines for free or reduced cost and money for transportation.

**Chronic condition**: illnesses that require follow-up treatment over a period of weeks, months or years. In this study, these included, but were not limited to, paralysis, hypertension, diabetes mellitus, chronic episodes of fits, arthritis, lung cancer, liver cancer, gastric cancer, HIV, kidney disease, poor eyesight, asthma and gout.

**Collateral**: something pledged as security for repayment of a loan, to be forfeited in the event of a default. In this study, collaterals included, but not limited to, land, farm, house, jewelry, any other personal belongings, clothes, and even kitchen utensils.

**Community clinics**: outreach services conducted by public providers, usually combined with EPI village visits to provide primary health care in communities.

**Cost of medicine and commodities**: costs to purchase medicine and commodities.

**Cost of surgery**: costs associated with a surgical operation, described as a fee in private facilities and as a charge or donation in public facilities.

**Cost of delivery**: costs of vaginal or assisted delivery, described as set amounts by providers and users for different types of delivery at a patient’s home or in a public or private facility.

**Consultation fees**: costs for patient management by health care providers.

**Care-seeking locally**: care sought from informal, private or public health care providers available within an individual’s village or ward; includes self-medication through purchases of medicines from a local drug seller.

**Discharged fee**: fees paid for discharged record; in public hospitals donations at discharge are also common.

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\(^{62}\) Within this study these amounts were usually less than 50,000 kyats in Bago and Yangon, but around 100,000 kyats in Chin.

\(^{63}\) Originally categorized as “charity and donations” to make it clear this includes institutional donor support, but simplified to “charity,” so as not to confuse with use of the word “donations” for payment to health providers.
Dual practice: this term is usually used to describe doctors providing services in both public facilities/posts and private facilities/functions, but other cadres take on these public/private dual functions as well.\(^{64}\)

Dual practice continuum: used to describe the fluid nature of public providers engaging in both public and private service provision, including in a separate private facility or during consultations “on call,” outreach visits or home visits, which makes it difficult to differentiate when a provider is functioning in a “public” or “private” capacity.

Encounters: costs that individuals have actually experienced (not generalized or theoretical impressions) while seeking health care with public, private or informal health providers.

Endure: described by respondents as not seeking care even though someone suffers from an illness.

Elderly: people above the age of 60 years.

Emergency condition: any condition considered life-threatening (e.g. in this study, snake bites or any situation where a patient loses consciousness are perceived to require urgent medical intervention).

Free of charge: a designation given to services that are provided to patients without cost at the point of service delivery.

Forgone care: individuals who do not seek health care or who stop seeking health care for an unresolved medical condition.

Hard to reach: concept used extensively in the Myanmar health system, but with no official or consistent definition; in this study, a triangulation of inputs were gathered from stakeholders consulted in each township. In Yangon region, migrants were considered hard to reach for socio-economic reasons whereas in Bago and Chin region, populations were considered hard to reach based on geographic accessibility.

Household finances: any funds that household members possess, including daily wages earned and any savings, regardless of the intended purpose of funds (e.g. money used for daily subsistence; money saved to build a house).

Investigation, lab & imaging fees: this includes payments for diagnostic services (e.g. blood tests, urine tests, X-rays and ultrasound).

Loaning: any funds that are lent with interest without collateral (usually at a higher interest rate) obtained from money lenders, friends/relatives, government or non-profit supported microfinance groups or local community/religious groups.

Major health event: any serious health event, such as accidents, hospitalizations or chronic illness that have interfered with a person’s normal daily activities.

Minor illness: cough, cold or any illness that does not interfere with a person’s normal activities.

Meal cost: costs spent on food for patients and their attendants during the time of seeking health care.

Money in hand: having cash in one’s possession at a certain moment in time.

\(^{64}\) Only doctors/dentists are officially allowed to conduct after public service hours, while other types of public providers are not.
**Miscellaneous costs**: either cash or in-kind (e.g. food items or snacks) given to the staff within a public health facility (either at request or not at request), including ward nurses, cleaners, guards and those assisting with trolleys and wheelchairs, etc. Also includes expenses incurred by patients for buying miscellaneous items like bed sheet, dishes, cups, layette, etc.

**Offering**: one of several terms used across the blurred lines of donations/fees. See Annex 5. *Key Words in Myanmar for Donations, Fees and Offerings*

**Operational budget**: funds provided by any source, but usually government, which are intended for use in the daily functions of a public health provider or facility.

**Out of Pocket Expenditure on Health**: any direct spending by households, including gratuities and in-kind payments to public or private health practitioners or pharmaceutical suppliers, for therapeutic appliances and other goods and services, whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. Other costs incurred in using health care, such as transport and meal costs, are also considered in this study.

**Prescription**: a health care provider’s written authorization for a patient to purchase a prescription drug from a drug store.

**Pawning**: any funds that are lent with interest with collateral (usually at a relatively lower interest rate than the loans without collateral) as obtained from formal money lenders or pawn shop owners.

**Provider credit**: any services or medicines given to a patient with an expectation of later payment, most commonly observed among local health providers, who know and live in close proximity to their patients.

**Perceptions**: how individuals understand and interpret the value and meaning of the cost spent to seek care from public, private or informal health providers.

**Registration / admission fees**: payments for a registration book or chart at the time of hospitalization.

**Referral**: any type of health provider advising/requesting a patient to seek care elsewhere (this may be based on clinical determination that higher level care is needed or based on a lack of resources to provide care).

**Remittance**: money transferred by a worker in foreign country to a family or community member in his or her home town.

**Selling of assets**: any possessions of value that are sold, most often including gold or jewelry and crops or livestock, but may include other personal and livelihood assets (e.g. computer, house, land or sewing machine).

**Service fees**: any fees for non-clinical services in private facilities (e.g. administration or cleaning costs); donations/fees for consultations or minor procedures with public providers.

**Transportation cost**: costs to take any type of transport (e.g. motorcycle, car or truck) to seek care from any type of provider or facility (either for initial care seeking, follow-up or referral).

**Wage advances**: any funds that household members expect to earn and can be accessed from an employer in advance, including daily wages or earnings for crops/livestock that will be harvested and sold later (amounts advanced are usually less than the expected earnings would have been).