How can township health system be strengthened in Myanmar?

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28 July 2015

Myanmar Context

• GNI per capita 1,270 USD (2014)
• A township health system (THS): the backbone of health systems
  – Catchment population 150,000-200,000.
  – Led and supervised by Township Medical Officer (TMO),
• Urban health systems:
  – 16-25-bed township hospital: 2–6 doctors (general or specialists), 6-16 nurses,
    1 urban health unit/maternal health center for PH services,
  – Provides medical care at the second referral level for rural health systems.
• Rural Health Systems: the critical role of Basic health staffs (BHS)
  – One to two 16-bed station hospitals [2 doctors, 2 nurses, 1 Lady Health Visitor, 1 Midwife and 1 Public Health Supervisor 1] providing clinical and public health services;
  – 4–5 rural health centers (RHCs) [1 Health Assistant, 1 Lady Health Visitor, 1 midwife and 1 Public Health Supervisors 2].
  – Under jurisdiction of each station hospital or RHC,
  – 4-5 Sub-RHC [one midwife ± Public Health Supervisors 2]
  – + 600 CHW/AMW in each township
Imbalance growths

<table>
<thead>
<tr>
<th></th>
<th>1988</th>
<th>2011</th>
<th>% changes</th>
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</thead>
<tbody>
<tr>
<td>RHC</td>
<td>1,340</td>
<td>1,635</td>
<td>+ 22%</td>
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<tr>
<td>Hospitals</td>
<td>631</td>
<td>1010</td>
<td>+60%</td>
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</tbody>
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• Source: Asia Pacific Observatory, 2014

• Hospital efficiency
  – Pabon Lasso graph: bed turn over plot against occupancy rate:
  – Poor performing 544 hospitals (58.9%) of which 90% were station and township hospitals.

The problem

• Inadequate staffing,
• Insufficient supply of medicines and equipment,
• Geographical and financial barriers among the poor, especially hard to reach areas in 100 townships where midwives in sub-centre do not have her facility to provide service,
• Weak management and supervisory practices
• Midwives overburdened by vertical projects, not able to provide main MCH tasks
• Skill and competencies on Infectious control and NCD management
• TMO rapid turn over, transfer/rotation is detrimental to strengthening THS.
Opportunities for reform

- Decentralization mandated by 2008 Constitution,
- Decentralized township health plan: assess / address health needs of township population with participatory engagement by local community representatives, adequate budget, effective M&E

Suggestion for policy discussion

1. Declare a decade for THS strengthening [2016-2025]
   - Strengthening THS is the key platform to achieve UHC, achieve national goal of health equity.
   - Ten year master plan, secure budget, priority given to strengthen station hospitals, RHC, Sub-RHC the only promising source of rural health services for hard-to-reach populations] phasing manner.
   - Rural retention HWF: rural/ethnic background recruitment + hometown placement through mandatory rural services at THS, adequate financial and non-financial incentives
   - Adequate supply of essential medicines and basic medical equipment
   - Effective out-reach service package
   - Improve technical efficiency of the station hospitals
   - Strengthen the role of volunteers [CHW, AMW] with support by BHS, supervision, refresher course
   - Strengthen skills and competency of BHS, appropriate task shifting, increase motivation and productivity
Suggestion for policy discussion

2. Extension financial protection to population groups

- Increase fiscal space: tax =3% GDP (2004), revenue exclude grant 6% of GDP (2004)
- Increase fiscal space for health: proportion of government budget on health, current 2%
- SHI: rapid scaling up, effective premium collection, ensure proper design especially provider payment
- Sustain universal access to free MCH services
- Innovate universal access to free essential medicines (OP and IP) by all citizen in hard to reach areas /townships, then gradually expand to other population groups when fiscal space for health allows.
- Clear milestone for progressive realization of UHC and resource planning.