



# Strategic Purchasing Pilot

## Learning Brief 2: Where and for whom?

The CPI-KEHOC pilot is the first example of strategic purchasing for health services with an Ethnic Health Organization (EHO). As such, it has meant a step into new territory in terms of the mechanics of the purchasing process. The pilot is intended to increase the understanding of all parties about how purchasing from an EHO could work: not only CPI and the KEHOC, but the Myanmar Ministry of Health and Sports (MoHS), other EHOs and other NGOs and iNGOs operating in Myanmar.

In the first brief we focused on definitions for purchasing, the purchaser-provider split and “strategic” purchasing, before going into why purchasing from EHOs is particularly important and concluding with how this pilot effectively demonstrates “strategic” purchasing.

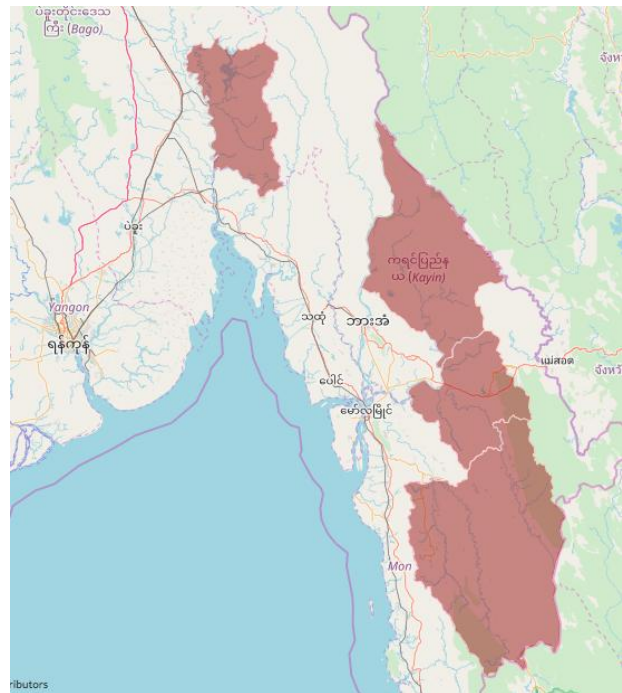
This second learning brief aims to explain our process of defining our target population, and selecting whom the pilot will purchase services for.

### 1. Selecting Clinics

In the setting of a finite project budget (funded by 3MDG), the project had to start work from on-the-ground realities and possibilities, rather than theoretical best plans. It was not feasible to first specify a package of health services and define a population then spend whatever was necessary. The first step was therefore to identify clinics with catchment populations that could plausibly be covered, then to identify their capabilities and the best package.

In order to select clinics that would maximize the impact and learning potential of the pilot, we set the following criteria for clinic inclusion:

- Clinics should have a track record delivering health service in hard-to-reach areas.<sup>1</sup>
- Transparent M&E and research should be permitted. This excluded restricted areas.
- Staff would have to travel regularly between headquarters and facilities so the clinics should not be overly far apart (in terms of travel time)



<sup>1</sup> It was also noted that with research we could demonstrate that people who live near a government clinic can be “hard to reach” for those clinics if they are unwilling to go.



- Although there are funds for clinic improvements and training, the facilities chosen should be in decent condition. They should not, however, be unrepresentative (brand new facilities, etc. that are in unusually good condition).
- Clinics should be in different districts/townships to improve the reach of learning and support among local levels of political players (both national government and Karen EAOs).

At the time, this led to the confident inclusion of three clinics (Htu Lu, Loh Baw and Ka Toh Hta) and a list of four others for consideration (in Khaw Htee Khee, Meh Pra, Thatone and Tha Ya Koh). In the end Ka Toh Hta clinic had to be removed because it is being incorporated into the nearby Doh Naw hospital, which meant it was going to be too dissimilar to other clinics to provide useful lessons for elsewhere. It was therefore replaced by Meh Pra clinic, and Tha Ya Koh was selected as the final clinic.

The final four clinics were within three townships in Karen State and one within Bago, as shown on the map.<sup>2</sup> According to the HARP/MIMU study of vulnerability, the three townships in Kayin State are described as “Type 1: Extreme outliers in terms of development needs and/or exposure to conflict.” Shwegyin in Bago is classed as “Type 4: Very Low access to basic services and infrastructure.”

Loh Baw is operated by Border Guard Force 3rd Cantonment Department of Health (BGF) while Meh Pra, Tha Ya Koh and Htu Lu are operated by the Karen Department of Health and Welfare (KDHW) (both part of the Karen EHO Consortium (KEHOC)).

The clinic selection process took longer than anticipated. Working with EHOs is a far more political process than working with private GPs. Decisions matter and require approval from not only leaders within an EHO, but EAOs with different influence in different places. This was an early lesson learned.

## 2. Who will the clinics serve?

Once the clinics were selected, the purchaser (Steering Committee) had to decide for whom, of those living near to (and/or using) the clinics, the Steering Committee would pay. Key questions were:

- Should we only cover the poorest? This could make sense in a context of scarce resources, particularly if it is what the national purchasing body would purchase in future.
- How many villages should we include (and pay for)? Arguments could be made for a broad range of inclusion criteria: at one extreme, we could limit enrollment to people living in the village where the clinic is located; at the other extreme, we could include everyone for whom the pilot clinic is the nearest clinic.
- What will happen to those seeking care who are not “paid” for or registered in the scheme? Within migrant communities, this is a particularly pressing issue.

We explored different options to each of these questions. The outline of what we decided and why appears below:

<sup>2</sup> HARP-F and MIMU (2018). “Vulnerability in Myanmar: A Secondary Data Review of Needs, Coverage and Gaps.”



## a) Should we only cover the poorest?

The National Health Plan 2017-2021 (NHP) identified as its key aims the provision of a basic package of services to the entire population and a reduction in health-induced financial hardship. This has generally been viewed as a call for progressive universalism: prioritizing the poorest of the population, to ensure that resources are utilized where they are most required. The proportion of the population (and the proportion of services) covered could then be increased as economic development generates greater resources.

The history of civil conflict, coupled with under-investment in social and economic development, has left a legacy of deep poverty among the majority of households in EHO areas. By targeting remote rural EHO areas the pilot is inherently progressive, and disproportionately targets the poor. For many countries, initiatives to reduce health inequities target populations defined at the level of geographic or administrative region, such as the poorest townships or poorest states.

Although we selected inherently low-income communities, we additionally considered targeting our resources at the poorest households within these Karen communities. This targeting of the poorest-of-the-poor would align with the National Health Plan, and could provide KEHOC and the Karen EAOs with a more detailed understanding of those with the greatest need among their populations, and how these people might be identified and provided with services.

In order to only cover the poorest we needed to develop a way to identify the poor, and a way to differentiate between the services (or fees) for those who were categorized as poor and those categorized as able to pay. This posed a series of ethical challenges about how to identify those in need without creating stigma. Furthermore, because historically KEHOC have not charged for their services, this would represent the wholesale creation of a user fee (or prepayment) scheme.

In order to make this choice CPI and KEHOC made some preliminary assessments of the potential for payment among communities, the cost of the identification process and the appetite of EHOs and the Karen EAOs for the creation of a form of cost sharing. Furthermore, CPI conducted a literature review of approaches to identification of the poor in order to propose a methodology (or methodologies) that might ethically enable learning.

In the end, however, it was decided that the poor would not be identified in this stage of the pilot, for several reasons:

- Anecdotally it was felt that in the communities selected, very few would be considered as wealthier than “vulnerable” in national classifications (though this will be researched during the pilot). This would therefore limit the number of residents we could collect funds from.
- The proportion of the population able to pay 5,000MMK per person per year was considered to be no greater than 25%. This would have the potential to raise about \$10,000 within the total pilot. However, it was felt that to ensure it was done ethically, and develop a full payment structure and publicise it, at least that much money would also have to be spent. It was therefore not going to be a money raising scheme in the short run.
- There was interest within both KEHOC and the Karen EAOs for the development of a cost sharing scheme. However, it was believed that this would require significant public outreach to sensitize citizens and prepare them. Including this within the first stage of testing of the



purchasing pilot therefore seemed likely to overwhelm the measurable impacts of strategic purchasing with people's impressions of the new cost sharing system devised.

- Both CPI and KEHOC were hesitant to break the solidarity created by collective action providing free health care to all. This is particularly important in a population with a history of enduring decades of civil conflict.

For all of these reasons, it was decided that the first stage of the pilot, clinics' services would remain free at point of care regardless of socioeconomic status. In order to prepare for possible alternative approaches, additional research would be conducted on household wealth and other aspects of socioeconomic status, willingness to pay and the financial implications of introducing cost sharing.

## b) How to identify the catchment area? How many villages?

In order to purchase services for a population, we need to know the population the clinic covers. For example, a clinic in our pilot cannot claim to be serving the whole population of Myanmar even if it would provide free services to anyone who came. The fact is most people will seek care elsewhere.

The ideal target catchment area would be *“all those who would come to the clinic if they had a health need.”* This group is significantly easier to identify in remote villages than in the suburbs of Yangon where there are numerous options: from hospitals to GPs to pharmacies to traditional medicine practitioners. In hard to reach areas, the number of options is severely limited. Yet difficulties remain:

- People who live far away from the clinic: even if they would go to the clinic in case of emergency, those living further away may choose to forego care if it means walking for several hours to receive it. These people are clearly covered *less well* by the clinic.
- Even without other trained medical professionals, there remain options in the form of informal medicine sellers, which may be used for certain types of conditions or certain sectors of society.
- Where there is significant and continuous migration, as in Htu Lu (and, again anecdotally, to a lesser extent the other clinics) people may seek care in one place for some of the year in one place and some of the year elsewhere. They should not be purchased services in both places (and therefore cost twice as much).

These are all complex problems that purchasing arrangements struggle with around the world. Given the lack of information about the communities at the start of this pilot, we have taken the most straightforward and transparent approach: we are registering everyone within the geographic area that was previously served by the clinics' outreach services.

We believe this is the best estimate approach at this stage because:

- We do not know whether the current number of migrant workers would be an over or an underestimate of the average throughout the year. Given this, we have no reason to expect counting everyone to be either an underestimate or an overestimate.
- With improved knowledge developed during our pilot an alternative approach may become possible, but at this stage registering everyone in hard to reach areas feels like the only likely approach that could be scaled to national level.



- We will track who uses the services to see how many people access services that aren't within the catchment area or who are new migrants (or returning migrants) to understand better how our catchment circle is appropriate.

This methodology will be reflected upon when data is collected about the usage of our services and the populations we are serving.

**c) What to do about those not registered (or “paid for”) in the scheme, such as new migrants?**

This is particularly linked to the second question above: if a migrant arrives in our catchment area after our registration process (or returns from work elsewhere), can they receive care? Or what if people come from further afield to seek care in our clinics?

At this stage we made the decision not to place limits on who can receive care free of charge at the clinic. That is, even if the person is not registered at the clinic, and therefore the services have not been “purchased” for them, there will be no charge.

We made this decision because it improves the research potential for the project. It will allow us to investigate the size and shape of the communities that are served (and *could be served*) by EHO clinics. Secondly, this is for health reasons: if people have travelled for a long distance to come to the EHO clinic, we do not want to deny them. The lesson from such people making journeys should be for us to increase the payments to that clinic to reflect its widespread appeal, rather than subdue demand (and instill confusion) by denying care. And lastly, denying care (or charging for it) would again require both the creation of a financing structure and increase the need for security to ensure people are identified to be within the registered group or not. Both of these would have added cost and complexity to the project for a concern that so far is only hypothetical.

In order to understand those populations being treated by the clinic but not registered initially (migrants or those seeking care from afar), we will register new patients in the clinics. We will give them a registration card and unique identifying code so that their needs, like those registered initially, can be better understood using the monitoring and evaluation system in place.

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