A framework for private sector engagement opportunities in Myanmar

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Introduction

The private healthcare sector in Myanmar includes hospitals, clinics, drug importers and wholesalers, pharmacists, informal drug sellers, and a large and growing number of medical practitioners working primarily, or exclusively, in private practice. These for-profit entities are complemented by a number of local and international non-governmental organizations. Many areas of private provision are underregulated, leading to both the potential for harm and missed opportunities for improving health. As the economy grows, the number of private facilities and practitioners is expected to increase. Setting in place structures to plan an appropriate, safe, and positive role for the private sector within the larger health system is both urgently needed and, at this period of rapid growth, particularly open to effective action.

The arguments for engagement with the private sector in Myanmar are twofold:

- First, the private sector is already the dominant delivery system for healthcare in both urban and rural areas. This primacy necessitates engagement for public safety and to assure provision of care across the full health system is aligned with national goals.
- Second, engaging the private sector increases healthcare efficiency by providing competition, attracting new investment, and spurring overall responsiveness to the public's healthcare needs.

In all neighboring countries, effective private sector stewardship means assuring consistent standards of practice and the delivery of high quality care. This involves an ongoing process of coordination both within government and with a range of professional organizations, private investors, voluntary organizations, self-regulatory authorities, and healthcare purchasers. Regulating dynamic health markets requires many forms of engagement, and assuring safe healthcare across a health system requires attention to all forms of service provision, both public and private.

Given the current landscape of private healthcare sector in Myanmar, eight key areas require special attention to guide private sector engagement:

1. **Government regulation and stewardship**
2. **Hospitals**
3. **Ancillary services (such as blood banks and diagnostic services)**
4. **Private outpatient (clinic) services, maternity homes, and practitioners**
5. **Pharmaceutical supply**
6. **Licensing and professional accreditation agencies**
7. **Professional representative groups**
8. **Non-governmental organizations (NGOs)**

At each of these levels within the health system, there are opportunities for positive engagement that align with government policy, with existing activities of the Ministry of Health, and with recent strategic planning decisions addressing both Universal Coverage and Human Resources for Health. In the pages below we summarize our recommendations for possible engagement according to the eight key areas and indicate where these recommendations are aligned with existing strategic plans.

We have organized the suggestions at each level as Priority, Medium, and Long-term according to their urgency and 'actionability.'

Context

Primary care

Myanmar, like four of its neighboring countries (Cambodia, Indonesia, Laos, and Vietnam), has a shortage of doctors, nurses, and midwives measured by the 2.28 per 1000 population WHO minimum. A large and growing number of the providers that do exist work primarily, or exclusively, in private practice. The work of these clinicians is supported by multiple cadres of community health workers in the public sector, a small but important number of local and international non-governmental organizations, and a very large number of pharmacies, some licensed, some not. There is also an extensive range of informal medical practitioners ('quacks'), and drug vendors whose practices are unregulated.

Hospital/specialty care

There are currently 150 private hospitals, all registered since the 2007 law on private medical practice, although some have existed as private clinics before that time. The number of new hospitals is growing rapidly, with foreign investment a key driver in urban centers. Fully private, foreign-staffed hospitals are currently under consideration for licensure. Private cosmetic treatment, dental, and optometry centers exist in cities. As in other countries in the region, skilled personnel tend to be concentrated in the urban areas.

Financing

Approximately 80% of health expenditure in Myanmar is in the form of private direct, Out-Of-Pocket (OOP) payments for medical services, often in the form of purchasing medicines for self-treatment. Private insurance is growing, but still very limited, and while government financing is growing rapidly—with a commitment to increase from 2% of government expenditure to 5% of gross domestic product in the next three years—concurrent growth in private expenditure means that financing is expected to remain largely OOP for some time.

Options for private sector engagement

1. Government regulatory and stewardship

The formal responsibility of the Government is to provide oversight and enforce the 2007 law on private medical practice. As the private sector grows, more capacity for oversight within the health and justice ministries will be needed to accomplish this. This should involve three steps:

PRIORITY

1. The creation of a process within the Ministries and Education and Health for **accreditation of private professional training institutions** for doctors, nurses, pharmacists, laboratory technicians, and other medical personnel. This will help to rapidly increase the number of health professionals to the levels recommend by WHO.
   a. In Southeast Asia, the Philippines have the most experience with private medical training, and their successes and challenges should be studied.
   b. After the creation of accreditation standards and enforcement systems, private investment in educational training institutions should be permitted, and their graduates subject to, and considered for, service requirements and positions in the same manner as graduates of current training institutions.

MEDIUM

2. A second step should be the expansion, and increased prominence of a **dedicated unit within the ministry** to build expertise specifically on public-private interaction (e.g. contract negotiations) and to provide a locus for consultation among departments across the ministry. There is evidence from a growing number of countries that a prominent and effective "PPP Unit" can be a useful way to consolidate knowledge and skills.

LONG-TERM

3. A third step toward stronger regulation and stewardship should be legalization and subsequent encouragement of **market consolidation**. Increasing the number of chains of hospitals, pharmacies, and other facilities, will increase standardization of prices and quality, and facilitate regulatory oversight.

These recommendations align with the *Myanmar Strategic Directions for Universal Health Coverage*, Strategic Area #4, to enhance Public-Private Partnerships (pg 14–15)

These recommendations align with the *Myanmar Strategic Directions for Universal Health Coverage*, Strategic Area #2, on Human Resources for Health, which recommends a "national accreditation body for all health training courses and institutions" As one of the targets for 2017 (pg 11).

2. Hospitals

Myanmar has a small number of private hospitals relative to other countries in the region; however the number is growing quickly. Evidence from OECD countries suggests this is a good thing—competition, examples of alternative management practices, and patient choice are all known positive outcomes of private hospital participation. However there are some important regulatory, systemic, and stewardship efforts that should be strengthened in order to assure that these benefits are delivered.

PRIORITY

1. A **standard-setting body** is needed within the MOH, to develop or adapt hospital regulations for all issues from infection prevention to equipment voltage and language, to disease reporting, to obligations regarding emergency care, and to transparency of fee schedules.
2. Develop common standard for medical equipment interfaces. Technical assistance from external or local experts should be engaged to assist in the development of a common standard for medical equipment interfaces (e.g. power, language, units, and other standards) used in both public and private facilities.

MEDIUM

3. **Foreign direct investment (FDI)** in hospitals should be permitted, but not subsidized.
   a. It is unlikely that the government could receive good value-for-money from any formal or informal subsidy based on regional experiences with difficulties forecasting and valuing future demand.

LONG-TERM

4. Greater clarity is needed regarding **regulatory oversight and enforcement authority** and responsibilities at the District and Township levels, including norms for implementation of periodic assessment of adherence to regulatory guidelines for health care delivery.
   a. Standardized reporting requirements are needed to assure increased consistent sharing of data by private facilities

LONG-TERM

b. New staff for these roles could be funded through facility licensing fees or expanded central government budget allocation.

5. Non-binding **guidelines for purchasing** of services between public and private facilities, and for referrals between public and private facilities, should be crafted to provide guidance to District and Township governments to manage situations when demand for services exceeds government capacity.
6. **Public-private-partnerships (PPPs)** for hospitals should be considered with great caution.
   a. The difficulty of forecasting noted above, limited legal negotiation experience within government, and inherent conflicts of interest in assigning long-term use of public assets to private entities are ongoing concerns.
   b. Expert technical and legal advice should be solicited to evaluate all proposals for FDI facilities or PPPs with a value larger than $30 million USD. Introductions to advisors should be solicited from the World Bank, WHO, UN, and other objective agencies, and payment for third-party advice should be sought from the same agencies.

These recommendations align with the *Myanmar Health Workforce Strategic Plan 2012–2017*: "MoH will…monitor and regulate the development of health services provided by the private health sector and ensure that they are will aligned with national health priorities" (page 12).

These recommendations align with the *Myanmar Strategic Directions for Universal Health Coverage*, Strategic Area #4, to enhance Public Private Partnerships and "review and revise the Private Medical Practices Law 2007."

3. Ancillary services

The 2007 Private Healthcare Law specifically mentions diagnostic laboratories, and radiology/imaging services. Many of the private laboratories and blood storage institutions in Myanmar currently operate within hospitals and are regulated as a part of the larger institution, but within limited service-specific oversight. More specific standards are needed, both for in-facility services and for laboratories and blood banks that currently, or may eventually, operate independently. Laboratory accreditation programs exist in Thailand, India, and a number of other middle-income countries that could provide experiences useful for planning in Myanmar.

PRIORITY

1. A **standard-setting body** is needed within the MOH to develop or adapt licensure and regulation requirements for blood banks and diagnostic laboratories operating within hospitals or independently as stand-alone institutions.
   a. Regulatory standards from neighboring countries such as Thailand or Malaysia are established and could be easily adapted.
   b. Guidelines for obtaining samples, blood, and other body fluids testing, human tissue storage, laboratory operations, sample disposal, and reporting requirements including confidentiality and staff qualifications are all needed.

MEDIUM

2. The creation of **professional associations** for blood banks and laboratories should be encouraged and these associations empowered to develop standards for self-regulation and certification.

These recommendations align with the M*yanmar Strategic Directions for Universal Health Coverage*, Strategic Area #3, on essential medicines, equipment, technologies, and infrastructure systems. This Strategic Area makes specific reference to laboratories and blood banks.

4. Private outpatient services, maternity homes, and practitioners

The responsibility, authority, and expectation for regulatory oversight and enforcement of private clinic standards sits at the MOH, with devolved authority on implementation of regulations given to States/Regions, District, Township, and Villages. At whichever level authority is vested, resources to assure quality and prevent patient-harming practices should be allocated, and regulatory standards and penalties, documented and clearly described and shared. Just as legal and regulatory uncertainty slows investment in other fields, it also slows the expansion and adoption of new practices in healthcare.

PRIORITY

1. Due to the current the lack of medical personnel, **foreign nationals should be eligible to practice medicine** contingent upon appropriate home-country qualifications and compliance with Myanmar standards. [note: this change is already in process]
2. The Myanmar Medical Council (MMC), Myanmar Medical Association (MMA), and the international non-governmental organizations engaging private practitioners for communication and clinical support (particularly Population Services International and Marie Stopes International) should be

encouraged to continue **developing and carrying out clinical trainings** for private providers in the near and mid-term.

MEDIUM

3. The MMC should be encouraged to take on a stronger institutional role, including the creation and regular updating of standards, mandatory **continuing medical education (CME)** requirements as well as the introduction of CME opportunities, and a scheduled professional re-certification program.
   a. These MMC activities should be clearly distinct from the quasi-NGO function of the MMA.
4. District and Township Medical Officers and their staff should be trained on their **regulatory role and responsibilities**. This will be particularly relevant to local FDA staff in the future.

These recommendations align with the *Myanmar Strategic Directions for Universal Health Coverage*, Strategic Area #2, which calls for collaboration with "health professional councils…and other stakeholders including private sector to effectively integrate pre- and in-service training programs."

These recommendations align with the *Myanmar Strategic Directions for Universal Health Coverage*, Strategic Area #4, to enhance Public Private Partnerships, particular with reference to medical practice regulations.

5. Pharmaceutical supply

The regulation of pharmacists and pharmacies appears to be clear and effectively addresses the current role of pharmacies in primary care delivery. However, to meet the needs of changing health delivery in Myanmar, four areas for reform should be considered.

PRIORITY

1. A pharmacist-assistant license, or equivalent, should be created that permits 'quasi-pharmacy' retail registration where providers are licensed to sell a restricted set of essential medicines.
   a. This kind of 'quasi-pharmacy' outlet exists in Vietnam and other countries in the region, serving rural areas where profits are not sufficient to attract pharmacists.

MEDIUM

2. Regulations on corporate ownership of pharmacy outlets should be examined, and the creation of pharmacy chains both permitted and encouraged.
   a. Research from India, South Africa, and Latin America suggest that chain pharmacies raise quality across all competing outlets, including those not in the chain.
3. Increase the number of pharmacies to 'crowd-out' non-pharmacist sellers of western medicines in rural, urban, and per-urban regions.
   a. Licensure of private training institutions should be considered as a means to accelerate this.
   b. Standards for pharmacy training, and institutional accreditation requirements, should be developed based on norms used in Malaysia, Singapore, Hong Kong, or elsewhere.
4. Physician ownership and/or operation of pharmacies should be curtailed because of the inherent conflict of interest that results.

MEDIUM

These recommendations align with the *Myanmar Strategic Directions for Universal Health Coverage*, Strategic Area #3, on essential medicines.

There are related opportunities to engage with other aspects of the overall pharmaceutical supply system that would be complementary to the reforms suggested above.

PRIORITY

1. Until alternative sources of care exist, work with drug vendors through NGO intermediaries as a means of increasing quality, standardization, and ongoing communication for public health activities.

MEDIUM

2. Restrict unlicensed drug vendor numbers, and what medicines can be sold without a pharmacist's license.
   a. This should be undertaken only after alternative sources of care—from expanded government rural health stations or pharmacists, or 'quasi-pharmacists'—have been assured.
3. Increase the supply of essential drugs of high quality and safe, reliable potency through investment in pharmaceutical capacity in collaboration with foreign manufacturers.
   a. For example, through a public-private partnership, even if it requires investment concessions.

These recommendations align with the *Myanmar Strategic Directions for Universal Health Coverage*, Strategic Area #4, to enhance Public-Private Partnerships.

6. Licensing and professional accreditation agencies

Singapore, Malaysia, and Thailand all have national, nearly universally adopted, hospital accreditation systems that are supported by, but independent of, government. As their standards are applied equally to private and public facilities, these accreditation programs have established the nationally recognized quality standard, and quality assurance mechanism, for all hospitals. Similar input into standard-setting by professional bodies is common in many countries.

PRIORITY

1. Lengthen the duration of facility licenses. Clinics/ hospitals should be re-licensed every three years creating an opportunity for less pressured inspections for safety and infection control.
   a. Require facility quality compliance assessment for relicensing.
   b. At the time of licensing, gather information on performance criteria that are markers for improved quality (e.g. post-operative wound infection rates, blood transfusion reactions, hospital deaths, neonatal deaths, and mislabeled imaging tests).
2. Hospital Accreditation programs should be researched. Australia,UK, Thai, and Malaysian hospital accreditation programs provide excellent source templates for adaptation.
   a. Note that accreditation in all countries is mandated as a pre-condition for reimbursement of services under social health insurance. Because comprehensive social health insurance reimbursement programs are not currently planned in Myanmar, hospital accreditation should be studied for future, not current, implementation.

MEDIUM

3. Engage professional-representative bodies as partners in the re-accreditation process. Use accreditation as a pre-requisite for hospital relicensing. Employ existing expertise to manage the various technical assessment responsibilities. These may be permanent employees of an accreditation body, employees of other public or private hospitals temporarily engaged for this purpose, or experts from neighboring countries, replicating the experiences of the ASEAN network of examiners.
4. Train professionals to complete compliance assessments. Train appropriately qualified employees to build a sustainable national pool of professional experts to do the compliance assessments.

These recommendations align with the *Myanmar Strategic Directions for Universal Health Coverage*, Strategic Area #2, which recommends a "national accreditation body for all health training courses and institutions…health professional councils…and other stakeholders including private sector to effectively integrate pre- and in-service training programs."

7. Professional associations

Professional associations in nearly all countries play a role in defining the content of medical education and, relatedly, in setting the standards for medical certification. In middle-income countries, continuing medical education (CME) requirements are obligatory for annual or bi-annual re-certification, and the standards for acceptable CME courses. Often professional organizations undertake the provision of CME courses, and it is common for these professional organizations to include both public and private medical practitioners.

PRIORITY

1. The government should encourage existing and future associations to take a more active role in standard setting, enumeration, and quality assurance within their profession.
2. Professional associations should be encouraged to expand access to Continuing Medical Education (CME) opportunities, and to introduce CME requirements for re-certification of members.

MEDIUM

3. Associations should be granted authority to register all members of their profession, with unregistered members receiving increased governmental scrutiny or restriction on practice.
4. Professional associations should be used as a conduit for communication.
   a. News of new protocols, drug approvals, legislation, outbreaks, etc., should be communicated from government to National and State/Division associations, and from them to members.
   b. Associations should similarly be asked to act as a channel for communication from members to government—representing professions in the review and consideration of new legislation, assuring internal compliance, and reporting according to government regulations.

LONG-TERM

5. Formal representation of professional associations should be including for Ministerial policy committees.
   a. Engagement on both policy oversight, and policy development committees.

LONG-TERM

b. Options for inclusion of multiple associations, or for a representative of an 'association of associations' should be considered depending on the focus.
c. This will improve the effectiveness of governance and collaboration on technical matters.

These recommendations align with the *Myanmar Strategic Directions for Universal Health Coverage*, Strategic Area #2, which recommends engagement with professional associations.

These recommendations align with the *Myanmar Health Workforce Strategic Plan 2012–2017* which states that the Ministry of Health will "manage and facilitate information sharing with the private sector in a confidential and secure manner." (page 11)

"The Department of Medical Science was designated as the focal point for all aspects of production of the health workforce including oversight and regulation of all education and training institutions and continuous support for the professional development of managerial and technical health staff, including:

- Cooperate with the Professional Councils in the development of a mechanism for accreditation of training institutions and national licensing exam to verify professional competence of graduates
- Monitor and promote complementary contribution of the public and private sectors to health profession education." (page 14–15)

8. Non-governmental organizations

Both Myanmar and international NGOs play important niche roles in reaching at-risk and marginalized populations in Myanmar. While direct provision of health services by NGOs remains a minor component of the overall health system, it is important in some health areas (specifically TB, reproductive health, and HIV/AIDS) and is widely agreed to be pro-public health. As such, care provision should be encouraged by Myanmar and international NGOs, as should the continued engagement of international agencies and donors.

PRIORITY

1. NGOs should be directed and/or supported to address health topics and populations that are challenging—due to economic, societal, or political reasons—for the government to serve directly.
   a. For example, patients with HIV/AIDS, sex-workers, users of family planning and reproductive health services, TB care, and all those without the financial resources to assure private treatment.
2. Data sharing by NGOs should be improved, and reporting standards on treatment numbers enforced at both the MOH and District level.
   a. Guidance on standardized reporting protocols will clarify the responsibilities of NGOS.

These recommendations align with the *Myanmar Health Workforce Strategic Plan 2012–2017* which states that the Ministry of Health will "manage and facilitate information sharing with the private sector in a confidential and secure manner." (page 11)

The Global Health Group

The Global Health Gorup (GHG) at the University of California, San Francisco (UCSF) is an “action tank” dedicated to translating major new paradigms and approaches into large-scale action to positively impact the lives of millions of people. Led by Sir Richard Feachem, the founding and former executive director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GHG works across the spectrum—from analysis, through policy formulation and consensus building, to comprehensive implementation of programs in collaborating low- and middle-income countries.

One of GHG’s programmatic focuses is documentation and analysis of the private sector components of health systems. The GHG studies a variety of innovative delivery platforms that leverage the strengths of the private sector to achieve public health goals.

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