CONTRACTING HEALTH CARE SERVICES FOR COVERAGE EXPANSION OF THE SOCIAL SECURITY SCHEME IN MYANMAR: POTENTIAL AND PROBLEMS

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A Thesis Submitted in Partial Fulfillment of the Requirements
for the Degree of Master of Science Program in Health Economics and Health Care Management
Faculty of Economics
Chulalongkorn University
Academic Year 2013

การทำข้อตกลงในการให้บริการสุขภาพเพื่อการขยายความครอบคลุมของระบบประกันสังคมในประเทศเมียนมาร์: ความเป็นไปได้และปัญหา

นางสาวเย เมียว ฮิน เพียว

วิทยานิพนธ์นี้เป็นส่วนหนึ่งของการศึกษาตามหลักสูตรปริญญาวิทยาศาสตรมหาบัณฑิต
สาขาวิชาเศรษฐศาสตร์สาธารณสุขและการจัดการบริการสุขภาพ
คณะเศรษฐศาสตร์ จุฬาลงกรณ์มหาวิทยาลัย
ปีการศึกษา 2556

Thesis Title	CONTRACTING HEALTH CARE SERVICES FOR COVERAGE EXPANSION OF THE SOCIAL SECURITY SCHEME IN MYANMAR: POTENTIAL AND PROBLEMS
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ACKNOWLEDGEMENTS

First and foremost I would like to express a heartfelt thanks to my advisor Chanta Herber holz Ph.D. for being kind and patient to me for complete thesis. Her experiences and wisdom in the field of contracting allowed me to understand and progress with my work. I also would like to special thinks to the thesis committee, my chairperson Assoc.prof. Siripen Supakankunti, my examiner Touchanun Komonpaisarn Ph.D. and external examiner Associate Professor Narathip Chutivongse for sharing their valuable time and advising precious suggestion to my work.

In addition, I would like to express gratitude to Mi Win Thida who helps to get this opportunity for this thesis. Other special thanks to my interviewees from Social Security Board and other participants, giving their times for answering my question patiently. Their enthusiastic answers make more meaningful my thesis.

Moreover, I would like to thank to my beloved family, all of my classmates and CU scholarship program. Without their supporting, I would not complete for this Master degree successfully.

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ABBREVIATIONS

ADB:	Asian Development Bank
ALOS:	Average Length of hospital stay
AMDP:	Alternative Methods Demonstration Project
CBHCOs:	Community-Based Health Care Organizations
CIFHC:	Central Inland Freight Handling Committee
CTDC:	Central Trade Disputes Committee
DBP:	Development Bank of the Philippines
DHTC:	District Health Technical Committee
DOL:	Department of Labor
ECG:	Electrocardiogram
ECP:	Electronic Claim Processing System
FGLLID:	Factories and General Labor Laws Inspection Department
HMIS:	Health Management Information system
HRSA:	Health Resources and Services Administration
ICNL:	International Center for Not-for-Profit Law
ICT:	International Code Term
ILO:	International Labor Organization
INGO:	International non-government organization
IPD:	In Patient Department
IRR:	Implementing Rules and Regulations
LGU:	Local government unit
LNGO:	local non-profit organization
MOA:	Memoranda of agreements
MMU:	Medical Mobile Unit
MOH:	Ministry of Health
MOL:	Ministry of Labor
MOA:	Memorandum of agreement

NHIP:	National Health Insurance Program
NHSPA:	the National Health Service Performance Assessment
NSP:	Non-state Provider
OHD:	Operational Health District
OPA:	Office of Pharmacy Affairs
OPD:	Out Patient Department
PCA:	Principal Components Analysis
PHIC:	Philippine Health Insurance Corporation (PhilHealth)
PHC:	Primary Health Care
PROs:	PhilHealth Regional Office
PAP:	Resource Allocation and Purchasing
SERVQUAL:	service quality model was developed by a group of American author
SSS:	Social Security Scheme
SSB:	Social Security Board
UMFCCI:	Union of Myanmar Federation of Chambers of Commerce and Industry
WHO:	World Health Organization

CHAPTER 1

PROBLEMS AND SIGNIFICANCE

1.1 STATEMENT OF PROBLEM

Myanmar is behind in many sectors due to close economic and political conditions especially health and education. According to (Ministry of Health, 2013), the population of Myanmar is estimated at 60.38 million and growth rate of 1.01 percent in 2011. Most of the population about 70 percent resides in rural area, the rest is urban dweller. The population density for the whole country is 89 per square kilometers.

Currently, health care is organized and provided by public and private providers although Ministry of Health remains the major provider for comprehensive health care. As well as that, some ministries are also responsible for providing health care for their employees and their families; such as Ministries of Defense, Mines, Industry, Energy, Railways, Home and Transport. Also, Ministry of Labor as three general hospitals, two in Yangon and one in Mandalay and 93 clinics to render services to those entitled under the Social Security Scheme. At present, the number of total labor force is 27,000,000 among those, total insured workers is 566,665. Therefore, Social Security Scheme covers just 2.1 percent of total labor in Myanmar.

This low coverage must be viewed against the fact that Myanmar has some of the worst health indicators in the region. According to World Bank Statistics, 2012, the mortality rate of under-five years is 62.4/1,000 live births and estimated maternal mortality rate is at 200/100,000 live births. Also, Myanmar has one of the highest out of pocket health expenditure about 81% of total health expenditure in the world (World Bank, 2012). This situation shows that Myanmar health care system is still weak. Therefore, Myanmar health care system needs reform for citizens. One of those reform proposals focuses on the Social Security scheme. The Social Security Board is considering the expansion of coverage for workers in terms of quantity and quality of health care services. In this situation, the Social Security Board considers two ways:

1. To run the delivery of health care services by themselves setting for primary, secondary of health care.

2. To contract health care services to outsiders, both private and public.

According to (Liu, 2008), contracting-out primary health care services in developing countries can improve equity, efficiency, access and quality of health care services. Also, contracting with health care services has been increasingly employed by developing countries such as Cambodia, Afghanistan (as examples of low income countries) and Thailand (as an example of a middle income country) (Liu, 2008). In this regard, Social Security Board pays attention to contracting health care service to outsiders. Social Security Board considers contracting health care services to improve health benefits and expanding plan coverage for workers. The most important thing is that it is necessary to increase for transforming health care services which basic need for insurance workers because of current health service is insufficient for insured worker. Therefore, it is important to find out the way of contracting which able to apply and suit with local situation by discussing with stakeholders.

1.2 RESEARCH QUESTION

Could contracting of health services improve coverage and provision of health benefits for the Social Security scheme in Myanmar?

1.3 RESEARCH OBJECTIVES

1.3.1 General Objective

To explore the potential of contracting health services as a means of expanding coverage and better provision of services by the Social Security scheme in Myanmar.

1.3.2 SPECIFIC OBJECTIVES

- To review contracting models employed in others countries and to analyze how these contracting models can incentivize and impact contractors, providers and consumers.

- To determine a strategies for Myanmar's Social Security scheme to implement contracting to purchase health service to public and private sector.

- To identify the perceptions of stakeholders about the possible impact of contracting for health services from Social Security scheme.

1.4 SCOPE OF THE STUDY

This study seeks to assess the potential of the SSB in Myanmar contracting primary and secondary health services. Primary data were collected from key stakeholders. These key stakeholders include Social Security office staff and health care providers under Ministry of Labor, where the primary health clinics and hospitals are located. It also covers employers and employees in selected participating companies which fall under Social Security. In addition to that the other organizations from private and public sectors will be included in this study as future providers. It supposes total 26 interviewees in this study as the type of in-depth interview and group discussion.

The data were collected in Yangon in March 2014. It is a qualitative study that focuses on the medical benefits of the Social Security Scheme, i.e. primary and secondary care for insured workers for the purpose of efficient and effective health service provision by establishing contracting with outside for the planned coverage expansion.

CHAPTER 2

BACKGROUND INFORMATION

2.1 Myanmar's economy

Table 1: Myanmar's economy

Table 4. **Myanmar: Economic Indicators, 2008–2012**

Economic Indicator	2008	2009	2010	2011	2012
Per capita GNI, Atlas method ($)	...	...	...	...	...
GDP growth (% change per year)	3.6	5.1	5.3	5.5	6.3
CPI (% change per year)	22.5	2.3	8.2	2.8	3.5
Unemployment rate (%)	4.0	4.0	4.0	4.0	...
Fiscal balance (% of GDP)	(2.5)	(5.2)	(5.4)	(3.9)	(5.4)
Export growth (% change per year)	12.3	(1.4)	25.8	13.3	11.2
Import growth (% change per year)	25.6	1.9	15.8	24.4	22.0
Current account balance (% of GDP)	(3.1)	(2.6)	(1.2)	(2.5)	(4.0)
External debt (% of GNI)	...	...	...	...	...

( ) = negative, ... = data not available, CPI = consumer price index, GDP = gross domestic product, GNI = gross national income.

Source: ADB. 2013. *Asian Development Outlook 2013*. Manila; economy sources.

Source: (Asian Development Bank, 2013)

According to Asian development Bank, 2013; gross domestic product is gradually increased 3.6 to 6.3 from 2008 to 2012. The consumer price index decrease 19% from 2008 to 2012. However, the unemployment rate is steady throughout the period about 4%. Also, import and export growth rate are decrease compared with the started year 2008 and end of year 2012.

2.2 Key health indicators

Since 1991, the Ministry of Health have been formulated and implemented four yearly Health Plans starting year from 1978. A long-term (30) years health development plan had been drawn up to meet the future health challenges due to changing in demographic, epidemiological and economic trends both nationally and globally. Myanmar Health Vision 2030 (2000-2001 to 2030-2031) was formulated during last decade and composed of (9) main areas namely called health policy and law; health promotion; health service provision; development of human resources for health; promotion of traditional medicine; development of health research; role

of co-operative, joint ventures, Private sectors and NGOs; partnership for health system development; international collaboration (Ministry of Health, 2013).

The table showing that the situation of life expectancy at birth, infant mortality rate, under five mortality rate and maternal mortality ratio for past, present and future health indicator in Myanmar. It is clear that the Ministry of Health plan gradually reduce for all health indicators as follows.

Table 2: Myanmar Health Indicators

Indicator	Existing (2001-2002)	2011	2021	2031
Life expectancy at birth	60 - 64	-	-	75 - 80
Infant Mortality Rate/1000 LB	59.7	40	30	22
Under five Mortality Rate/1000 LB	77.77	52	39	29
Maternal Mortality Ratio/1000 LB	2.55	1.7	1.3	0.9

Source: (Ministry of Health, 2013)

Nowadays, Myanmar is facing double burden of diseases as Communicable Diseases & Non-Communicable Diseases. In National Health Plan (2011-2016), priorities actions has been developed with the aim to prevent, control and reduce disease, disability and premature deaths from chronic non-communicable diseases and conditions. The chronic non-communicable diseases/conditions with shared modifiable risk factors tobacco use, unhealthy diet, physical inactivity, harmful use of alcohol. Base on this people suffer cardiovascular disease, diabetes Mellitus, cancer, chronic respiratory disorders. The non-communicable diseases/conditions of public health importance are accidents and injuries, disabling conditions (blindness, deafness and community based rehabilitation), Mental Health, substance abuse and snake bite (Ministry of Health, 2013)

AIDS, TB and Malaria are primarily affecting the working age as in many other countries. Thus, these three diseases are considered as a national concern and

treated as a priority. The ministry of Health also has determined to tackle these diseases with the main objectives of reducing the morbidity and mortality related to them (Ministry of Health, 2013).

2.2.1 Health Expenditure and Financing

The government of the union of Myanmar increased budget for health sector from 1 to 4 percent of GDP in recent years (Ministry of Health, 2013). The government, private households, Social Security Scheme, community contribution and external aid are the sources of finance for health care service. The total government health expenditure has been increased from USD (8,542,222$) (2000-2001) to USD (112,027,777 $) (2011-2012). (1$= 900 kyats)

2.3 Health Care Resources

In Myanmar, the country profile of health sector can divide by two sectors as public and private sectors. In 2009, the total number of hospitals beds in government hospitals are 39,060, an average, it represent 67 hospital beds per 100,000 populations in government medical services in Myanmar (Ministry of Health, 2013).

However, the distribution of government medical doctors varies due to the geographical location and population from 6 to 59 per 100,000 populations. Following that the distribution of nurses across states divisions related to medical officers about 10 to 160 nurses per 100,000 populations. Also, the midwives who are front line workers for primary health care especially in rural areas are distributed minimum 25 midwives to maximum 89 midwives 100,000 per population (Ministry of Health, 2010).

2.3.1 Public Health Care Delivery

So, the budget comes from central minister but responsibility and management is region minister according to proposal for budget of requirement. Actually, the administration of public health system form together state-district-township government hierarchy and medical officers overseeing all health related activities in designated areas.(Risso-Gill I, 2013).

Currently, the Ministry of Health (MOH) has seven departments of Health namely: Health Planning, Medical Sciences, three department of Medical Research (Lower Myanmar, Upper Myanmar and Central Myanmar) and Traditional Medicine. Ministry of Health is responsible for preventing diseases, providing effective treatment and rehabilitation to rise for health status of population. Due to changes in the political and administrative system, some roles of providers changed, although the Ministry of Health stays a major role for comprehensive health care. Under the Ministry of Health, the Department of Health plays the role of providing comprehensive health care throughout the country includes the remote of border areas (Ministry of Health, 2013).Also, the Ministry of Health introduced township-based micro- health insurance mainly target for poor people in September 2011 as a form of pilot test for future plan (Risso-Gill, 2013).

According to Ministry of Public Health, there are 1,010 hospitals in public sector, 944 hospitals from Ministry of Health and others ministries own 66 hospitals. The total number of hospital beds is about 55,305, the number of primary and secondary care center is 87, the number of maternal and child health center is 348, number of rural health center 1635, number of school health team is 80, number of traditional medicine is 16 and traditional medicine clinic is 237 respectively in Myanmar. Additionally, about 12,800 doctors work in public and around 17,032 doctors serve in Co-operative and private service Myanmar (Ministry of Health, 2013) .

2.3.2 PRIVATE HEALTH SECTOR

The private sector can be divided into the for-profit and the non-profit sector. This for-profit sector is mainly responsible for ambulatory care that developed in some cities as Nay Pyi Daw, Mandalay, Yangon and some large cities. They are regulated in conformity with the provision of the laws related to private health care services. The funding and provision of care are fragmented in private sector. Actually, there are necessary register to authority to open clinic or hospital. Also, the private must tax for the services regularly. Also, Myanmar Medical Association with its branches and townships support for general practitioners to update and exchange their knowledge and experience by hold the seminars, talks and currently energizing issues regarding diagnostic and treatment. In 2010, the numbers of private hospitals are 103 which are 87 general hospitals and 16 specialist hospital, 192 specialist clinics and 2891 general clinics in Myanmar (Ministry of Health, 2013).

According to (World Bank, 2012), private health is 92.7% take place for Myanmar health sector which lead to out of pocket health care expenditure (Placeholder1) (Saha, September 2011). At present, some private hospitals pay for incentive related to performance for workers for the purpose of motivation in their work place.

The Private non-profit sector is quite different. It is run by community based organizations and religious based society for non-profit sector. Also, they provide the ambulatory care through providing intuitional care and social health protection settled in large cities and some townships. Since Cyclone Nargis attacked the country, the number of NGO increases obviously as a reason of humanitarian sense (Saha, September 2011).

Nowadays, the number of NGO and INGO are gradually increase in not only health sector but also others sectors as education, agricultural, microfinance and disaster response. There are 65 international non-profit organizations (INGO) in Myanmar. As well as that from the international center for not-for–profit website, Ministry of Home Affairs reported local non-profit organization (LNGO) registered over 300 since 2012 although there are approximately 10,000 NGOs active in Myanmar. Generally, the government legal framework for NGOs is restrictive. According to (WHO, 2008–2011) there are 31 international NGOs and 10 NGOs are participate for health development as maternal and child health, primary health care, environmental sanitation, communicable disease control and rehabilitation of the disable and border health (Nishino, 2011).

2.4 MINISTRY OF LABOR, EMPLOYMENT AND SOCIAL SECURITY

The Ministry of Labor is organized as follows: Department of Labor (DOL), Social Security Board (SSB), Central Inland Freight Handling Committee (CIFHC), Factories and General Labor Laws Inspection Department (FGLLID) and Central Trade Disputes Committee (CTDC). Therefore, Social Security Scheme is one department of the Ministry of Labor (Hlaing, 2011).

2.4.1 Myanmar Social Security Scheme

Myanmar Social Security scheme was enacted in 1954 with the technical support from International Labor Organization (ILO). Following that it implemented in 1956 according to the 1954 Social Security Act. The Ministry of Labor, Employment and

Social Security Scheme runs three general hospitals render health services which are two in Yangon and one in Mandalay as well as 93 clinics for those who entitled under Social Security scheme.

Table 3: Population of Labor Forces

Description	Number	% on Total Population
Total Population	57,370,000	
Total Labor Force	27,000,000	47
Male Labor Force	17,000,000	30
Female Labor Force	10,000,000	17
Insured Workers	566,665	0.99

At present, there are three hospitals and 93 clinics are being run for free medical care under Social Security scheme for the purpose of delivery for health care services. It is started 15 townships then increased 82 in 1990 and now 110 townships among are which mainly located in cities under Social Security scheme. As a country level coverage area 80 Social Security local offices in 110 townships in 14 states and region except Chin State. The Social Security Board also has been planned for extension to the rest of townships across the country in near future. The government has been planned for covering Social Security scheme across the whole country for better health care services for citizens. At present, the number of total labor force is 27,000,000 among those, total insure workers is 566,665 (Hlaing, 2011).

In Social Security Scheme, there are two main types of benefit namely free medical care and cash benefit. There are three main kinds of free medical care as in form of medical certificate: Sickness benefit, Maternity benefit and Employment injury benefit (Temporary and Permanent) (Hlaing, 2011).

Table 4: Cash Benefits

Benefit	Qualified Period	Cash
Sickness benefit	4 months	50% of wages
Maternity benefit	6 months	66.67% of wages
Funeral grant	1 month	40,000 kyats
Temporary Disability benefit	1 month	66.67% of wages
Permanent Disability benefit	1 month	loss of earning capacity
Survivor's Pension	1 month	66.67% of wages

Source: Cash Benefit (Hlaing, 2011)

2.4.2 Cash Benefits and Medical benefits

Due to the recurrent sickness, chronic disease and suffering more than one disease or sickness of special importance, it can extend the medical treatment up to 52 weeks or to a period specifically stipulated by the Social Security Board even though a period up to 26 weeks starting from the treatment. The insured worker could be taken after qualified period all cash benefit as mention in table. There are three kinds of free medical care as in form of medical certificate: Sickness benefit, Maternity benefit and Employment injury benefit (Temporary and Permanent).

In this phase, insured workers accept medical services through the Social Security Board's clinics, hospitals. Apart from this, the insured worker can take medical service from large employer and clinics which reimbursement system. Insured workers are covered only services provided by the Social Security clinics as well as referral from the clinic in the case of emergency in some situation. Medical benefit services include the medical care from the clinic, emergency home care, specialist and laboratory services at diagnostic center, necessary hospitalization, maternity care and medicine. Normally, the duration of coverage is 26 weeks for one illness but the coverage may be extended sometime because of unpredictable medical reasons or in the interest of public health. In addition, the benefit is paid up to 12 weeks (6 weeks before and 6 weeks after) the expected data of childbirth. Pediatric care is

included for an insured woman's child up to the age of 6 months as dependent's medical benefit (Social Security Board, 1954).

There are free medical care services for ensured workers as following. There are Out Patient Medical care (SSB Clinics), Antenatal, Confinement and Postnatal care (Clinics & Hospitals), Investigation and diagnostic tests (Hospital), Specialist consultation (Specialist OPD), Hospitalization Medical certification (Fit for Job and Training Course), Supply of prosthesis and orthopedic appliances (for Injured workers), Supply of pharmaceuticals and appliances (Purchasing), Preventive measures and mass vaccination (ATT), Health education (Hospital, Clinics and Workplaces), Clinical assessment by medical boards (Invalid Pension, Permanent Disability Benefit) and Medical education (Medical Student, Training Nurses and Nurse aids) (Hlaing, 2011).

2.4.3 Financial management

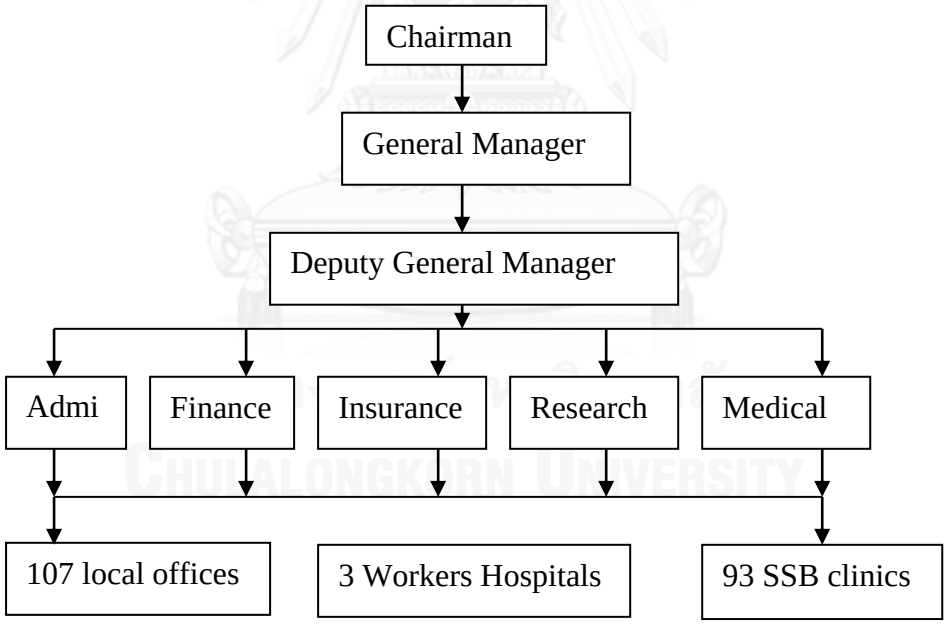
For the financial side, this organization received tripartite contribution 2.5 % of the worker's salary from employer, 1.5% from the employee and the government supports the capital investments as necessary in this moment. The contribution is collected according to 15 wage classes. The coverage groups include state enterprise employees, temporary and permanent employees of public or private firms with five or more employees in certain establishments such as railways, ports, mines and oilfields. The State subsidizes more than 222,222 $ USD (1$=900 kyats) annually for the purpose of capital expenditure to be utilized in-building hospitals, clinics, offices and purchasing medical equipment, vehicles, furniture and office equipment. (Hlaing, 2011).

The Social Security Board maintains three separate accounts in the Social Security Fund as follows: General Insurance (sickness, maternity, death) Account, Employment Injury Account and Administrative Expenditure Account. (Hlaing, 2011).

Currently, the Social Security Scheme runs the services by themselves. As using historical line item budget, the Social Security Board make proposal for annually budget which is review based on last year's cost and expenses to government. They contract some medical staffs as doctors and nurses from Ministry of Health (MOH) and buy the drug bidding annually for Social Security workers. As Medical procurement costs and Medical reimbursements, the Social Security Scheme fills up the medicine, is look back previous year which demand according to occurrence

diseases and conditions, medical instruments and medical equipment are procured yearly through State allocated budget. Thus, sometime the way of medicine buying medicine system is not fixing. Currently, Social Security Board is still using reimbursement system for patient. Even though the claiming system is a bit faster than before there are still burden for patient who invest much invest amount for medical treatment. However, the Social Security is allowed to set the own budget in October 2013. Thus, the Social Security Board stands own budget a few months. In this regard, the Social Security Board spends all costs of organization from their own fund except office staff salary. The insured worker who cannot have access to the Social Security clinics, they have received medical treatments at the other clinics and hospitals as reimbursement system then claim from Social Security Board. According to current experience of Social Security Scheme in Myanmar, there are every month reimbursement cases is 250 cases and average reimbursement per each in 61 $ USD. (1$=900 kyats)

Figure 1: Organization Chart



Source: Social Security Board Organization Chart taken from (Hlaing, 2011).

In Social Security Board, the Board of Directors is responsible for the administration of the Social Security Scheme. It set up the Chairman, the General Manager, the Deputy General Manager and five mangers from different departments of the Board. The

Chairman is also the head of the Social Security Board. There are totally 250 officers and 2396 office staffs serving in the Headquarter, the operation of the scheme comes under five Divisions what is called the Insurance Division, the Finance Division, the General Administrative Division, the Planning and Research Division, and the Medical Division. Also 107 local offices, 95 Social Security clinics and three hospitals have been set up in the whole country (Hlaing, 2011).

2.5. The Social Security Law, 2012

In Myanmar, the new Social Security law is enacted in 2012 and now this new law implements in 1st April 2014. According to new law, there are five objectives as follows:

- 'Causing to support the development of the State's economy through the increase of production to enjoy more security in social life and health care of workers who are major productive force of the Union by the collective guaranty of the employer, worker and the Union for enabling to fulfill health and social needs of the workers;
- Causing to enjoy more security in social life and health care by the public by their voluntary insurance;
- Causing to raise public reliance upon the Social Security system by providing benefits which are commensurate with the realities;
- Causing to have the right to draw back some of the contributions paid by the employers and the workers as savings, in accord with the stipulations;
- Causing to obtain the right to continued medical treatment, family assistance benefit, invalidity benefit, superannuation benefit, survivors' benefit, unemployment benefit, the right to residency and ownership of housing after retirement in addition to health care and pecuniary benefit for sickness, maternity, decease and employment injury of the workers.' (Social Security Board, 2012)

To implement in this objectives, the Social Security Board increase another departments as audit and information technology (IT) in organization. Following that there are plans to fill up the work force to strong the internal organization because all programs will supposed to run computer program system in new law. This is planning to increase server year by year among cities. Currently, there are 405170

insured cards already produced. Also, for management side, last time, the branches officers are responsible for checking the responsible townships. From now onward, the audit team will check 77 branches office of under SSB. Therefore, the Social Security Board becomes seven departments in current organization.

2.5.1 Social Security System

According to Social Security Law 2012, Chapter 5, The Social Security Board shall manage the following Social Security systems for enjoyment of Social Security benefits by the insured in accord with the stipulations:

- Health and Social Care Insurance System
- Family Assistance Insurance System
- Invalidity Benefit, Superannuation Benefit and Survivors' Benefit Insurance System
- Unemployment Benefit Insurance System
- Other Social Security System

Thus, the new law is increased Social Security benefits compared with old law, there are added in Family Assistance Insurance System, Invalidity Benefit, Superannuation Benefit and Survivor's Benefit Insurance System, Unemployment Benefit Insurance System and Other Social Security System (housing plan) (Social Security Board, 2012).

However, Social Security Board unable to start Invalidity Benefit, Superannuation Benefit and Survivors' Benefit Insurance System, Unemployment Benefit Insurance System and Other Social Security System the initial stage. It will be implemented step by step when the country's economic development. Also, the rate of contribution system increase both employer and employee. From employer side, there will be collect 2% for health and social care insurance system and 1% from work injury benefit insurance system, total 3% from employer. Also, employee will contribute 2% for health and social care insurance system. Thus, the contribution is all together 5% from employer and employee sides. It became high 0.5% of contribution from each employer and employee. Moreover, the way of contribution rate will deduct upon real salary of workers whereas the old law deduct classify 15 classes of salary.

In new law, there are four types of medical benefits with related to social care for workers as follows:

2.5.2 Health and Social Care Insurance System

- medical treatment and cash benefit for sickness;
- medical treatment and cash benefits for maternity and confinement;
- medical treatment for the insured after retirement;
- funeral benefit for decease due to any cause;

2.5.3 Medical Treatment and Cash Benefit for Sickness

According to Social Security Law (2012), for cash benefits, the insured can enjoy cash benefit relating to sickness when only the insured person had paid contribution for a minimum of four months during the establishment for a minimum of six months before sickness. The insured has the right to enjoy 60 percent of average wage of the previous four months as cash benefit relating to sickness up to 26 weeks in accord with the stipulation (Social Security Board, 2012). Actually, all benefits rates are increase compared with the old law.

The insured person can get those opportunities for health care and medical treatment at the hospitals and clinics owned by the Social Security Board or at State owned or private hospitals and clinics concluded agreement with that Board, or at hospitals and clinics arranged by the employer. In addition to that this insured person has the right to take health care and medical treatment if he or she is unable to come to the hospitals and clinics, from coming to the establishment which are owned by the Social Security Board or hospitals and clinics concluded agreement with that Board where the insured works by the arrangement of the Social Security Board (Social Security Board, 2012).

2.5.4 Medical Treatment and Cash Benefits for Maternity and Confinement

According to the Social Security Law 2012, the insured pregnant women can get free medical treatment from the permitted hospital and clinic in cases of pregnancy and confinement as well as medical treatment for her child up to one year after confinement. The maternal women has to chance maternity leave for six weeks before confinement and a minimum of eight weeks after confinement, so minimum of 14 weeks in total. Moreover, if it is the twin delivery, the mother has to get

another four weeks after enjoying maternity leave for child care. In cases, the pregnant women suffer of miscarriage being not a punishable; she can get six weeks for rest.

The pregnant insured can get maternity leave up to a maximum of six weeks together full wages. For prenatal examination at the permitted hospital or clinic, they can get on the basis of at the rate one day per time and up to a maximum of seven times. There has the right for adopted mother to enjoy leave less than eight weeks for child care for one adopted child only, until that child began the age of one year. If a child under one year of age is adopted in accord with existing law by registration also has the right the cash benefit during such enjoyment period.

The insured women can take 70 per cent of average wage of a year as benefit relating to maternity for the period of maternity leave, 50 per cent of average wage of a month as maternity expenses for single delivery, 75 per cent of average wage of a month for twin delivery, and 100 per cent of average wage of a month for triplet delivery and above respectively. Moreover, the insured women can get 70 per cent of average wage for the period of maternity leave when suffer miscarriage.
In new law, the male insured also is entitled to enjoy the following paternity benefit for confinement of his wife according to the medical certificate as 15-days leave for infant care on confinement of his insured wife together 70 per cent of average wage of previous one year. In addition to that the benefits contained the right to enjoy half of maternity expenses contained on confinement when his wife is uninsured.
As mentioned above benefits related to maternity, both male and female should be insured worked a minimum of one year at the relevant establishment before enjoying leave and paid contribution for a minimum of six months within one year (Social Security Board, 2012).

2.5.5 Medical Treatment for the Insured after Retirement

By following insured civil service and insured persons are can get medical treatment as being a person who had paid contribution for 180 months and above as well as a holder of identity card for retirement issued by the Township Social Security Office after retirement.

When the insured retires for leaving up from work, the following benefits are entitled from the fund for invalidity benefit, superannuation benefit and survivors' benefit in accord with the stipulations:

"If retired person contribution has been paid for 180 months before superannuation, he can enjoy 15 times of an average wage of a month for the period contributed of that insured as in installment or in lump sum according to his desire. Again, if contribution has been paid for more than 180 months, the retired person right to enjoy additional benefit contained in accord with the stipulations.

If the contribution already paid for 12 months and above but less than 180 months, the retired worker right to enjoy 40 per cent of the contribution paid by the employer and by that insured together with interest in accord with the stipulations. Also, if contribution paid for less than 12 months, the right to withdraw the money contributed by that insured in lump sum.

In new law, the employer also is to achieve 25 per cent of his personal contribution for 12 months and above paid to the fund contained together with interest in accord with the stipulations when the insured obtains superannuation benefit (Social Security Board, 2012)."

2.5.6 Funeral Benefit for Expenses

According to Social Security Law, 2012, if the insured is deceased of occupational injury or any other cause, dependent of that person or a person who claimed for the expenses which he incurred for the funeral a maximum of five times of the average wage of a month within the last four months of that deceased person in accord with the stipulations.

It is clear that 2012 new law of Social Security is allowed for health and social benefit not only insured worker but also their related family members and employer. In addition, there are many benefit items also increase the amount for cash benefit for those benefit package compare with old law. Also, it can enjoy those opportunity only who has been paid certain time of contribution.

CHAPTER 3

LITERATURE REVIEW

3.1 INTRODUCTION

There are many literatures review for contracting for health care services. There are different types of contracting. Many of them are showing that benefit of contracting-out for health care services the way of improving quality care services, equity access, and performance of health workers. Also, the amount of utilization for health care services increase among people when contracting for health care services. This literature review first explains what contracting is and the major types of contracting that exist, then highlights the importance of provider payment mechanisms for the contractual relationship and finally reviews other countries' experiences with contracting while distinguishing contracting primary care services from contracting hospital services. Potential problems and possible solutions are also discussed.

3.2 Definition of Contracting and Types of Contracting

There are many authors defined the types of contracting as follows. (Loevinsohn, 2008), defined "the contracting is a mechanism for a financing entity to produce a defined set of health services form a non-state provider (NSP)". The definition of services includes what services, where to, which groups of beneficiaries for how long. Also, (Loevinsohn, 2008) explained performance-based contracting is "a clear set of objectives of indicator, systematic efforts to collect data on the progress of the selected indicators and consequences either rewards or sanctions for the contractor, that are based on performance".
(Loevinsohn, 2008), concluded that seven steps are needed for contracting as follows:

1. Contract dialogue with stake holders
2. Define the services
3. Design the monitoring and evaluation
4. Decide how to select the contractor
5. Arrange the contract management and develop a contracting plan
6. Draft to contract and bidding documents
7. Carry out the bidding process and manage the contract

Two main types of contracting are discussed in the literature, namely contracting-in and contracting-out.

(Soeters, 2003) showed that "contracting out means contractor give total responsibility to the provider who will become contracting-out provider for staffs salary, running cost, and medication and consumable related to cost."

(Liu, The impact of contracting-out on health system performance: a conceptual framework, 2007), suggested that "according to Principle-Agent Theory contracting-out can improve access to health services by aligning the incentives of health providers with policy-desired outcomes as expressed in contracts the way of contracts are specified and performance is monitored are posited as critical determinants of their potential effects. Principle-Agent Theory saying that agent may have different incentive from the principle."

(Taylor, 2003), defined "the contracting out or outsourcing is purchasing one or more services from an outside source that provides the service to either a government entity or patients, using primarily an external work force and resources." For health care services that might include contracting with a nongovernmental organization to manage a number of district facilities or a service package to identified users in their own facilities.

(Taylor, 2003) also explained that contracting in is a "means purchase management services from an outside source that is assigned responsibility for managing an internal service or work force as include hiring a private firm to manage a hospital's housekeeping staff or external technical assistance to direct an internal task force."
(Soeters, 2003), explained that "contracting-in provides private sector management within public sector set-up the services the relationship between two sector operators who will be the government sector and private sector operator."

Therefore, it is clear that contracting can one or more services not only health care but also other services as laundry. Also, the contracting could be specific service as maternity package or cataract surgery. In addition, the contracting starts from the whole organization for service. The contractor can contract the whole service from provider or just a part of service. For example, contract the whole hospital service include clinic or just contract clinic service.

3.3 PAYMENT METHODS

(England, October 2008), described the technical partner paper regarding about provider purchasing and contracting mechanism for reform health system in developing countries. England mainly points out that the issues of purchasing mechanism for four things. Firstly, contract specification in term of purchasing can set target utilization levels and prices to maximize health improvement within available budgets, avoid creating for providers and consumer to over-provider or over-consume, and providers and purchasers can be overcome in practice by using the capacity constraints.

Also, (England, October 2008) highlighted payment mechanism in contracting that primary care is a better alternatives method by using a capitation payment for the population covered and incentive payments for results, especially for prevention. Purchaser payment methods are typically fee-for-service reimbursement or simple block grants, neither creating incentives for appropriate utilization and treatment. Fee-for-service payment which in turn to over-provision, reimbursement also generates excessive transaction costs in claims assessment, processing, and payment, and can lead purchasers and providers to seek sophisticated information technology with its high risks of failure. Block grants can be happened under-provision and case avoidance or case shifting to save costs.

Following that (England, October 2008) explained services purchasing usually from providers offering primary or hospital services. The author suggested that health maintenance organization model covering both primary and secondary care might offer better incentives to achieve the right level. The last but not the least, England explained the purchasing is a process rather than contract. Both purchaser and provider have an interest in a successful outcome for the renewal of purchasing arrangements. Additionally, it is essential that they need to communicate regularly and constructively even if there lefts a healthy underlying tension. Only few countries look like to be employing for joint reviews a formal constructive process of performance evaluation.

(Taylor, 2003) , describe that the way of optional contract payment strategies related to anticipated results and contract applications. Block grant or fixed price payment is a single fixed amount which includes direct and indirect costs and profit for all

specified services for a specified period. Provider assumes risks of changing or unknown costs may reduce or terminate services if costs increase. Thus, contract is easy to administer also information needs are minimal. This type of payment is contract for technical assistance, delivery of package of basic health services and useful where purchaser has limited experience or limited ability to project or monitor actual costs.

(Taylor, 2003), continued explanation another payment what is called fee-for payment that based on an agreed-on price per procedure or test. As the anticipated results, provider assumes risk of increased unit costs, volume that encourages increased volume of covered services. It leads the greatest profit margins. As a consequence, provider may neglect less well reimbursed services. For contract application, it can contract with private doctors to provide specified health promotion or preventive services and hospital services.

Next, (Taylor, 2003), highlighted Capitation payment which based on an agreed-on amount per person covered or enrolled for a specified package of covered services. Provider assumes risk of increased costs and volumes. However, it may encourage provider to reduce quantity or quality of service. Thus, this type of payment could contract for primary care services and hospital services.

The last payment strategy the author mentioned that pre-payment which provided in advance for specified services to be rendered. It can assume risk of increased volumes for provider, as a consequence, discourages over utilization of covered services. It can be contracted for several services.

All types of payment mechanism have pros and cons. However, it could be contract as the authors mention above, capitation is suitable primary and hospital services, fee-for service is suit with contract to private doctors for specific health service as promotion or prevention and hospital services. As per-payment, it can contract for several services.

3.3.1 Types of PHC and Outpatient Payment Methods, Characteristics and Incentives

The provider payment systems can be a useful tool to promote health systems development and achieve health policy objectives by applying mechanism for transfer funds from the purchaser of health care services to the providers. This study from (Langenburnner, 2009), for the purpose of strategic purchasing for health services in which a continuous search for the best ways to maximize health system performance by deciding for purchasing intervention, from whom they should be purchased, and payment system.

There are three main types of PHC payment methods. There are line-item budget, per capita and fee-for-service which is with or without a fee schedule. They have their characteristics, and the incentives they are likely to create are outlined, within each type of payment method, there are variations that may create a different set of incentives, and the payment methods may be used in combination to enhance or mitigate the incentives that are created by each method individually.

Line Item Budget

A line-item budget is paid method for provider based on the allocation of a fixed amount to a health care provider to cover specific line items, or input costs during a certain period of time. This system is run by government which offer strong administrative controls and valued. In theoretical level, line item budget is technical and allocation efficiency of health interventions by operating the government budget lines over time. It could be increase delivery of cost-effective health interventions and decrease delivery of less cost-effective intervention. It seems that governments can find and know the right combination to achieve these outputs. However, they often cannot for lack of good monitoring information.

Fee-For-Service

The provider is reimbursed for each individual service provided in fee-for-service system. It may be either input-based or output-based. If input-based, services are not bundled, and fee schedules are not set in advance which providers are endorsed for bill payers for all costs providing each service what is called “retrospective cost-

based" payment which is commonly applied in the United States and other countries. A fee-for-service provider payment system can also be output-based if fees are set in advance in Canada, Japan, and Germany, and services are bundled to some degree. In this case, the provider is paid the fixed fee for the pre-defined service regardless of the costs incurred to deliver the service.

Per Capita

The provider is paid a pre-determined fixed rate in advance to provide a defined set of services for each individual enrolled with the provider for a fixed period of time for per capita payment. This payment is output-based, and the unit of output is the coverage of all pre-defined services for an individual for a fixed period of time as one month or one year. The payment to a provider is not linked to the inputs the provider uses or the volume of services provided. As a consequence, some risk is moved from the purchaser to the provider. If the provider sustains costs that are greater than the per capita budget, the provider is liable for these costs where as if the provider achieves efficiency gains and incurs costs that are lower than the per capita budget, the provider can retain and reinvest this surplus.

3.3.2 Hospital Payment Systems

There are five main types of hospital service payment methods. There are line-item budgets, global budget, per diem (bed-day), case-based, fee-for-service. Among those payments systems, line-item budget and fee-for-service are discussed above which can be applied to inpatient services as well.

Global Budget

As the hospital level, global budget is a fixed in advance to cover the aggregate expenditures of that hospital over a given period to provide a set of services that have been broadly agreed upon. It may be based on either inputs or outputs or both. In the 1990s, Canada and Denmark were determined largely on the basis of historical, whereas France and Germany have incorporated measures of output, such as bed-days or cases, into global budgets for hospitals. Then, Ireland introduced a case-mix adjustment to global budgets for acute hospital services. It spread out all EU countries with global budgets have followed with some case-mix adjustment.

Per Diem

This system is dominant incentive is to increase the number of hospital days, increasing bed occupancy, possibly increasing bed capacity. Generally, it is shifting from outpatient and community-based rehabilitation services to the hospital setting. As well as that there is an incentive to reduce the intensity of service provided during each bed-day. High occupancy rates are achieved due to increasing hospital admissions and average length of hospital stay (ALOS). The incentive encourages the ALOS likely to be stronger than the incentive because of increase admissions which is also an incentive to reduce inputs per day, and hospital days early in a hospital stay tend to be more expensive than later in the stay. For calculation average per diem rate is portable to calculate and implement which based on the total historical annual hospital costs divided by the total number of bed-days. This payment is reflecting characteristics of patients, clinical specialty and variations in case-mix across hospitals.

Case-Based

Case-based hospital payment systems make two ways for hospital service as create the incentives to increase the number of cases and to minimize the inputs used on each case. The reason is that providers have a chance more control over resource use per case than the total number of treated cases following that the latter incentive become stronger. By using case-based hospital payment systems in the hospital sector, it has been used as a mechanism to control costs and reduce capacity.

3.4 POTENTIAL PROBLEMS AND POSSIBLE SOLUTIONS

Although the Principal-Agent Theory stipulates that contracting has many advantages, in reality, contracting for health care services may not always the best solution for the organizations. There are giving problems depend on the situation. (Vining, 1999), found out potential problems from contracting out and possible solutions for it. (Vining, 1999), mentioned that various costs in contracting out as following.

Bargaining cost which will occur contract breaking mechanism either sides or one side disputes the costs which changes pre-agreed resolution mechanism. However, it is

positive sign for both parties within the organization as over wages, bonus and internal transfer prices. Bargaining costs was happened as costs arising from negotiating contract details, the costs of negotiating changes to the contract in the post-contract stage when unforeseen circumstances arise, the costs of monitoring whether performance is being adhered to by other parties, and the costs of disputes which arise if neither party wishes to utilize pre-agreed resolution mechanisms, especially 'contract breaking' mechanisms. While only the first cost is experienced at the time of contracting (the others are experienced in the post-contractual period), virtually all of these costs can be anticipated and dealt with at the time of contracting.

Next, the opportunism cost means that even one party behave over interest within organization for the purpose of taking a better opportunity which negative effect to organization. Opportunism is more likely with contracting-out than within organizations, since who gets the profit is more relevant in dealings between organizations.

The last cost what is called production cost in term of the opportunity cost of the resources as land, labor and capital. Production costs are seems the lower for competitive contracting-out due to the minimum efficient scale and technically feasible. There are two reasons for the lower with competitive of contracting-out. Firstly, the production costs should be conceived broadly; the most significant economies of scale might be in intangible factors such as administrative systems, knowledge and learning and access to capital markets. It is often difficult to design government organizations that can use several political jurisdictions to take advantage of economies of scale. On the other hand, not-for-profits may be able to compete on this dimension. Secondly, public provision may fail to achieve the minimum production costs that are technically feasible as two ways: firstly, it eliminates comparative performance benchmarks for customers and, secondly, the service is likely to be paid for through aggregate taxes, thereby obscuring the price and efficiency of a government supplier.
Also, (Vining, 1999) mentioned that bargaining and opportunity costs are governance cost which have three major factors namely task complexity, contestability and asset specificity.

Task complexity include product or service complexity the degree of difficulty in specifying and monitoring the terms and conditions of a transaction. Although specifying and measuring the quality of food served by the contractee is quite easy whereas the quality of complex medical services is relatively difficult. The degree of task complexity also can occurs due to the uncertainty surrounding the contract (this effects both contracting parties equally) which raises the probability that 'bounded rationality' will come into play, the potential for information asymmetry (the probability that one party to the contract will have information that the other party does not have) and the probability that there will be externalities that will affect other organizational or health sector activities.

Contestability means a few firms are suddenly come out to provide given service, but many firms or non-profit organizations would quickly become available if the price paid by the governmental organization over the average cost incurred by contractee. The importance thing is that the level of contestability sometime appears rather than the number of firms really provides service in some cases. However, sometime governmental entities can often reduce production costs by contracting-out activities without demand from private market. As a result, there may be some degree of local, regional, or even national, natural monopoly may involve extensive scale economies. Thus, there is no direct competition. However, if provides are able to adjustment production to the good without sinking large direct costs, there is contestability.

Asset specificity creates a necessary contribution to the production of a good and has much lower value in alternative uses as physical asset specificity, location specificity, human asset specificity, dedicated assets and temporal specificity.

To be more detailed, the author explained the low task complexity and low asset specificity. This combination provides the clearest case for contracting-out as non-medical health care-related activities at the organizational level, e.g. laundry, housekeeping and food services. It offers the potential for lower production costs for the service, as well as minimal bargaining and opportunism costs.

Again, the author explained low task complexity and high asset specificity problems almost certainly involve high temporal or location specificity. There are likely to be

few efficiency costs arising from high physical asset specificity if the contractor makes the relevant specific investments as hospital services.

There are two possible ways for solution raising the bid price and utilizing a higher cost production technology that requires less physical asset specificity. However, Vining AR et al suggested that both strategies increase aggregate costs in turn to the inefficient and should be avoided. These problems can be avoided if the contractor owns the specific asset and rents.

Another explanation is high task complexity and low asset specificity. This can occur perhaps best characterizes the supply of a wide range of clinical services provided by physicians and other health care professionals. For solved out the problem, Vining AR et al suggest that an alternative arrangement would involve the formal contracting-out of the management of these professionals.

The last problem is high task complexity and high asset specificity which can come out between the situation and case is that rely on other third-party contract enforcement procedures. This flows from the fact that it is more difficult for the third party to identify whether contract breach has occurred. The authors suggest that only comprehensive monitoring of the behavior of the clinic would identify the changes as shrinking.

3.5 INTERATIONAL EXPERIENCES OF HEALTH INSURANCE FOR CONTRACTING

There are many international experiences of health insurance. However, this study focus on the primary and hospital contracting of literature reviews as follows.

3.5.1. CONTRACTING FOR PRIMARY HEALTH CARE SERVICES

The literature review by (Liu, 2008) showed that the effectiveness of contracting-out primary health service more popularly in developing countries. It describes that many reasons for a better health care service by contracting-out among low income countries. From this study, the author group explained detail each improvement in contracting-out health services that there are positive effects on access of health services and improved the equity in access although there are little evidence on the impact on contracting-out health services for the quality and efficiency among different countries.

This author group gathered documents, both journal publications and technical reports regarding contracting services, then screened according to two inclusion criteria: Content criterion which ensure that clear categories of contracting-out interventions are discussed or compared, following that selected studies that evaluate contracting-out of private health care providers for multiple primary health care services in developing countries.

Another criterion is quality criterion for the purpose of capture a broad range of studies that assess the effectiveness of contracting-out based on a wide range of research designs. These included experimental controlled designs; non-randomized controlled designs; pre-designed before and- after designs without controls; retrospective before-and after study designs (i.e. based on provider records); and cross-sectional study designs with controls.

Additionally, the author supposed that this study clarifies different types of services for contracting as specific services for defines health condition like diarrhea, package and specified primary health care including maternal and family planning and unspecified primary health care.

Upon this study, the authors (Liu, 2008) reviewed 13 contracting-out projects in different countries. Among those projects, 12 projects implemented for clear objective for access to the contracting out health services. From this 10 project presented that positive outcome for access of health care services.

However, the author group found out that only two experiences could prove that in terms of explicit objective for equity improving physical or economic access to basic health care for poor people among thirteen projects by experience from Bangladesh and Cambodia case studies.

Finally, the author mentioned again 11 out of the 13 experiences were assessed using one or more indicators of quality of care namely uni-dimensional process indicators, studies with health outcome indicators, and studies with multi-dimensional measures. It could be either measure of structural attributes, process of care and health outcomes. Studies for quality measurement with uni-dimensional structural or process indicators included like patient satisfaction, patient waiting time

and the percentage of disease treatment interventions that were in accordance with standardized medical practice guidelines that map different aspects of quality.

Another quality measurement studies with health outcome indicators among four of the 13 projects. Liu found out that from four projects, three projects are contracting out the services for improvements in nutritional status.

The last quality measurement was multi-dimensional measures which used indicators covering two or more dimensions of structure, process and health outcomes for the purpose of evaluate quality of care. From this study this is the least number of projects performed for two of the 13 interventions.

Quality of care at both health centers and referral hospitals were measured through direct observation techniques as a set of indicators to construct a health care quality score. The author found that the quality score for contracted providers was slightly better than the score for public providers. Even though contracting out gradually growing interest and experience in developing countries, there is still relatively little evidence on the impact of these initiatives on efficiency.

Another study from (Macque J, 2008), found that it is contracting external primary care providers in four places of Central America the namely Costa Rica, Guatemala, Nicaragua and San Salvador. The study is for the purpose of better responsiveness, efficiency of health care and public governance. In Latin America, several health system need to reforms low equity and efficiency for citizens. Thus, public providing agencies contracting external provider for primary care provision. The author described this paper showed the two stage process that the initial analytical framework bases on literature and interlinking characteristics the contractual relationship with health system performance criteria. Another step is the use of this framework in four case of cross-cutting issue.

From this study, (Macque J, 2008) mentioned that responsiveness takes a vital role that refers to the capacity of health services to react to the patient's demand. Following that public entitlement refer to the correspond to a balance between the needs for medical care and the level of specific national that issues of equity, human right in health are inter correlated with the concept. (Macque J, 2008), suggested that for reshaping health system need not only technical but also political choice. It

should be flexible and reactive approach for evolution when reform the health system.

This case study by (Soeters, 2003) showed that the contracting of health care services in Cambodia. This paper describes the Ministry of Health contracting 8 districts by covering one million populations for health care services. In this study, 5 districts for health care management were subcontracted to private sector operators, and their results were compared with three control districts. Both internal and external reviews showed that after 3 years of implementation, the contract areas was a better quality health utilization compared with control districts of others Ministry of health.

As a methodology, the author described the calculating the individual performance bonus of health staff 30% of agreed incentive method base on the percentage achievement of financial target. A comparison of the during one year from 1999 to 2000 output statistics showed that the utilization of health services increased considerably before and after the introduction of cost-sharing and incentive payments.

(Soeters, 2003), found that even though the officer user fees significantly increase, the utilization of services increased too. However, it is reasonable price for patients instead of paying for informal way of the government health workers. Another important thing is that the result of monitoring performance-based-incentive makes decrease for family health expenditure. Also, (Soeters, 2003) suggested that the contractor need to use two management systems the difference between the NGO contractors manager and government manager that as by individual contracts with health workers and by sub- contracting directly health center. Finally, the study found out the contracting-out is better performing than contracting-in districts. Cambodia contracts with international NGO for contracting system rather than local NGO (Soeters, 2003).

Another case study from Afghanistan showed that contracting for health and curative use for contracting from 2004 to 2005. From this paper written by (Arur, 2010), regarding the primary health services of utilization is increase under contracting-out with private as well as contracting-in with Ministry of health Afghanistan. In addition, the author described detailed that there were different payments methods among

contracting out as lump sum contract and base line budget also difference performance incentive payments.

For contracting in, (Arur, 2010)found out that the government was able to manage contracts effectively although there was no experience in early stage, and that contracting has helped to improve utilization of basic health services. It gives the information in term of scale of contract, performance- based payment as part of bonus, contract management responsibility and monitoring process.

This study gets data from a national facility survey (the National Health Services Performance Assessment, or NHSPA), donor and Ministry of Public Health (MoPH) records, and the routine information reporting system from The Health Management Information System (HMIS) constitutes. For data analysis, the author used Principal Components Analysis (PCA) methods in each province to create a wealth index based on the asset ownership, housing characteristics and primary source of income for each household surveyed in 2004.

Next, this is another study from (Liu, 2007), regarding the impact of contracting-out on health system performance for a conceptual framework. It mainly focus the conceptual framework which present the full and standardized description of contracting-out intervention, characterized of provider and purchaser, assessment of the impact of contracting-out on all dimensions of health system performance, and cross project analysis. In addition, it describes the type of services and potential for contracting depend on the diseases.

This study is mainly focus on maintaining delivery outputs from government by contracting in with NGO during 3 years from 2004 to 2007 in Cambodia. Jacobs B, et al., 2009, supposed that how NGO managed return to government-managed for health care output level. As a contracting in health services, the contractor just follow the way of the government structure regardless of managing budgets, supply system, staffs and others infrastructure. In this study, the operational health districts are health service delivery entities covered the populations of 100,000– 200,000. The operational health districts (OHD) responsible for an administrative center, a referral hospital delivering a complementary package of activities which include the surgery and obstetrics, and health centers that deliver a minimum package of services for a population of 8,000–12,000 people in Cambodia.

(Jacobs B, 12 August 2009), described that reforming health services in contracting districts as a systematic approach in Cambodia as follows. In the first phase, the contractor already experience in early stage for health care service in the first contract years as financing, health provision and resource generation. Thus, in the next contract in with government, it easily to identify important issues then discuss with local authority to formulate the locally appropriate intervention by holding workshop local administrative authorities. Also, for reforming process, the reforming team takes sample from initial reviews from others studies for selection input, process and output for define the capacity and 10 principles of management outlined for quality standards of health care delivery.

Again, (Jacobs B, 12 August 2009) mentioned that the contractual hierarchy organized for reforming team as Ministry of Health, Swiss Red Cross, District Health Technical Committee (DHTC), health facilities and individual staff members. From base on this, all team members performed activities according to categories as deciding on the amount of subsidies, developing indicators and targets, performance bonus distribution, management of contracts for performance, facility performance, and individual staff performance, allocating contractor budget and MOH funds, monitoring and respecting internal rule and regulations.

According to (Jacobs B, 12 August 2009), they used four sources of data documenting from the contractor to the senior management, and consequent impact on performance by facilities as cross-sectional surveys, monthly HMIS reports, quarterly performance results based on data collected by the contractor for performance management and salary supplement payment, and financial reports from the facilities. For a pilot test for pretested structured questionnaire, four interviewers were trained. Then, 15 women per village were interviewed identified by questioning villagers about which women had delivered during the 18 months. Data analyzed using by the statistical software package Epi-Info version 6.04.

(Jacobs B, 12 August 2009), suggested that the performance of contracted health facilities is linked for consideration for financial incentive to administrator. The results for case study, the government sustained well the process of health care delivery especially, the service delivery increase when the bonus system was modified.

3.5.2 CONTRACTING FOR HOSPITAL SERVICES

(Mostafa, 2005), use SERVQUAL model for determines the both private and public hospitals. For SERVQUAL, it might categorize for different variation. Thus, the author develops three components as factor 1 contains items similar in nature of responsiveness and empathy factors labeled “human performance quality”. Factor 2 contains items relating to reliability in the original model SERVQUEL. This factor was called “human reliability”. Factor 3 contains items relating to the tangibility of the service what is called “facility quality”. As a result, Total variance explained (67.4 percent) by these three components exceeds the 60 percent threshold commonly used in social sciences to establish satisfaction with the solution. Among these three components, the factor one got the highest total variation about 49.6 percent, meaning that both patients seem hospitals services offer a better responsiveness and empathy to serving patients.

Next, (Mills, 1998) presented the issue of low and middle income countries contracting hospital services. The author described five countries namely: Bombay, Papua New Guinea, South Africa, Thailand and Zimbabwe. From this study, Anne Millis showed that contracting clinical and non-clinical for hospital services in five different countries. In this study, the author used a common evaluation framework which applied in each country to selected, existing contractual diagnostic services and the whole hospital. The process of agreeing contracts contain the facts that the extent of competition which mean the method of pricing, quality indicators and monitoring of contract performance in which contract duration and sanction for poor contractor performance. This all information is represents the design of contract. Following that compared with the quality of contract out and directly provided service among different countries. Then analysis could be done gathering with information on the capacity which include the level of development of the private sector.

As a result, (Mills, 1998) found out that in non-clinical services, contracting showed a better value than direct provision as Bangkok and Bombay contract services for diet. However, it leads to poor quality services due to the contractor pay a low wage and poor management. For clinical services in Bangkok and Africa, it is a positive result for quality service because of a better maintains and reduces time. However, the cost of contract hospital is higher than direct provision for two reasons. The price is

substantial difference between the contract and the cost of the contractor providing the services.

Again, (Mills A, february 1997), proposed the improving the efficiency of district hospitals in South-Africa. This paper shows the economic arguments for contracting district hospital care in two different settings in South Africa using private-for-profit providers, and in Zimbabwe using NGO (mission) providers. In South African study, the performance of three 'contractor' hospitals compared with three government-run hospitals, then analyzing data on costs and quality. Also, the Zimbabwean study compared the performance of two government district hospitals with two district 'designated' mission hospitals.

The methodology for each hospital in both studies, a detailed cost analysis was done to calculate unit costs of in-patient, out-patient care and productivity levels. In South African study, a very large the number of quality indicators were produced, covering structural, process and outcome aspects of quality where as those detailed and time-intensive investigation was impossible in the other study, which collected a limited list of quality indicators covering aspects of structural and process quality.

From this study, (Mills A, february 1997) found out that in Southern African, contractor hospitals provided care at significantly lower unit costs even though insignificant differences in quality between the two sets of hospitals. However, the cost of the government contracting was close to that of direct provision, indicating that the efficiency gains were captured almost entirely by the contractor. The importance of developing government capacity is to design and negotiate contracts that ensure the government is able to derive significant efficiency gains from contractual arrangements. The Zimbabwean study, the two mission hospitals served the similar services for two government hospitals but the cost was at substantially low. The nature of the contract was implicit between missions and government because of long standing.

3.5.3 CONTRACTING FOR PHARMACY

The study from US, Federal Register report for the guidelines is that government the operation and compliance of contract pharmacies for 340B covered entities Section 602 of Public Law 102–585. The ''Veterans Health Care Act of 1992'' was enacted Section 340B of the Public Health Service Act (PHS). Then, Section 340B implements

a drug pricing program as manufacturers must agree to charge a price that will not exceed the amount determined under a statutory formula for sell covered outpatient drugs to particular covered entities listed in the statute. (Federal Register, 2010). The purpose of this Final Notice is to give information interested parties of final guidelines regarding the utilization of multiple contract pharmacies and suggested contract pharmacy provisions which stand last time as limited to the Alternative Methods Demonstration Project program. The covered entity is responsible for compliance of their contract pharmacy arrangement(s) and must maintain ownership of the 340B drugs at all times.

From the final notice report, there are showed the process of Contract Pharmacy Services Mechanism as follows.

(1) Basic Compliance Issues in Utilization of Pharmacy Services Contracts

In this sub-title, a covered entity in which utilizes contract pharmacy services to dispense section 340B, the outpatient drugs must have a written contract in place between itself and a specified pharmacy. This mechanism is support to the program participation for ‘‘in-house’’ pharmacy services those covered entities that do not have access to available or appropriate but provide to supplement these services; under covered entities that wish to utilize multiple contract pharmacies to increase patient access to 340B drugs. The covered entity has the responsibility as ensure against illegal diversion and duplicate discounts in which maintain readily auditable records; and meet all other 340B Drug Pricing Program requirements.

(2) Potential Alternatives to Single Location/Single Pharmacy Model

In addition to contracting with a single pharmacy for each clinical site, covered entities may pursue more complex arrangements that include multiple pharmacies if there are:

(a) “There is a written agreement and procedures that meet the requirements outlined above and between the covered entity and each pharmacy;

(b) The written agreement will includes fully addresses, all of the essential elements outlined in and below which a full listing of all pharmacy locations that may be utilized under that agreement;

(c) The operation under the contract continues to meet all 340B Drug Pricing Program requirements and does not create diversion of covered drugs or duplicate discounts;
(d) the arrangements are one of the two following models either individually or in

combination: (i) The use of multiple contract pharmacy service sites, and/or (ii) the utilization of a contract pharmacy to supplement in-house pharmacy services.

(e) The arrangement involves a single identifiable 340B covered entity and does not include a network, or other similar arrangement, unless specifically authorized in writing by HRSA through an AMDP or by other official written authorization."

(3) Essential Covered Entity Compliance Elements

The following are essential elements to address in contract pharmacy arrangements: (a) "under cover the entity will purchase the drug, maintain title to the drug and assume responsibility for establishing its price, pursuant to the terms of an HHS grant and any applicable Federal, State and local laws.

(b) The agreement will specify the responsibility of the parties for pharmacy services as dispensing, recordkeeping, drug utilization review, formulary maintenance, patient profile, patient counseling, and medication therapy management services and other clinical pharmacy services.

(c) The covered entity will inform the patient's freedom to choose a pharmacy provider as their choice.

(d) The contract pharmacy may provide other services to the covered entity or its patients at the option of the covered entity as home care, delivery and reimbursement services.

(e) The contract pharmacy and the covered entity will adhere to all Federal, State, and local laws and requirements.

(f) The contract pharmacy will provide the covered entity with reports consistent with customary business practices (e.g., quarterly billing statements, status reports of collections and receiving and dispensing records).

(g) The contract pharmacy will establish and maintain a tracking system suitable to prevent diversion of section 340B drugs to individuals who are not patients of the covered entity by keeping customary business records.

(h) The covered entity and the contract pharmacy will develop a system to verify patient eligibility, as defined by HRSA guidelines.

(i) Neither party will use drugs purchased under section 340B to dispense Medicaid prescriptions, unless the covered entity, the contract pharmacy and the State Medicaid agency have established an arrangement to prevent duplicate discounts.

(j) The covered entity and contract pharmacy will identify the necessary information for the covered entity to meet its ongoing responsibility of ensuring that the elements listed herein are being complied with and establish mechanisms to ensure availability of that information for periodic independent audits performed by the covered entity.

(k) Both parties understand that they are subject to audits by outside parties (by the Department and participating manufacturers) of records that directly pertain to the entity's compliance with the drug resale or transfer prohibition and the prohibition against duplicate discounts.

(l) Upon written request to the covered entity, a copy of the contract pharmacy service agreement will be provided to the Office of Pharmacy Affairs." (Federal Register, 2010)

(4) Ongoing Responsibility of Covered Entity to Ensure Compliance

Covered entities are responsible for the system of distribution chosen fully meets statutory obligations of ensuring against diversion to non-patients or creating a situation that results in a State Medicaid Program seeking a rebate on a discounted drug. Also, it remains responsible at all times for the disposition of covered outpatient drugs it purchases through a contract pharmacy. Even though the exact method of ensuring compliance is left up to the covered entity, the annual audits performed by an independent, outside auditor with experience auditing pharmacies are expected. To ensure the reaching the responsibility, the covered entity must have sufficient information.

(5) Certification

The annual process would include certification by a duly authorized official as follows:

(a) "All information listed on the database for that covered entity is complete, accurate, and correct

(b) The covered entity met the 340B eligibility requirements throughout the prior year and continues to do so;

(c) That any contract pharmacy arrangement was actually performed in accordance with specified requirements including, but not limited to, that the covered entity obtained sufficient information from the contractor to ensure compliance with applicable policy and legal requirements; and

(d) The methodology utilized to ensure compliance." (Federal Register, 2010)

(6) Anti-Kickback Statute

Contract pharmacies and covered entities should be alert of the potential for civil or criminal penalties if the contract pharmacy violates Federal or State law. It should be taken into account the provisions of the Medicare and Medicaid anti-kickback statute by negotiating and executing a contract pharmacy service agreement pursuant to these guidelines.

(Goel, 1996), proposed that the retail pharmacies in developing countries. For the purpose of ease of access which means availability of medicines; quality of service without waiting time and convenient hours for open time and low price products, availability of credit, or the option to buy drugs in small amounts. In this paper, the author describe a conceptual framework in which to analyze factors that may affect retail pharmacy prescribing, and suggestion strategies for behavior change.

From this study, (Goel, 1996) realized after literature review that for retail pharmacies, the author group find out four major factors that could affect prescribing behavior of pharmacy staff. These factors are pharmacy staffing and organizational patterns, client expectations, physician practice and local regulatory factors.

For pharmacy staffing and organizational patterns, the authors find out that the actual role of the professional staff within a pharmacy, which is often limited to administrative/managerial functions as a consequence it is affecting a pharmacy's ability to control the quality of care received by its clients. Also, one important thing is sources of information on pharmaceuticals. In this phase, it could be lack of unbiased information on drugs leads to contribute for inappropriate prescribing among pharmacists and their assistants. In developing countries, the primary source of information available to prescribers appears to be drug company salesmen. Next, economic incentives, however, among pharmacy staff, profit is likely to be an important motivating factor in product recommendations. If this is the case, economic incentives could be one of the prime determinants of product selection and sales.

In addition, for staff training and education also mentioned earlier, there are only a few trained pharmacists in many developing countries, resulting in staffing of pharmacies with minimally trained or untrained persons. Also, it should consider workload in a pharmacy may vary in order to geography and time of day as pharmacies located in urban central business districts may have greater workloads than in rural areas. Moreover, a retail pharmacy could be considered a social organization with established authority and communication structures as well as for pharmacy's location with respect to community SES and the type of town urban or rural because it could create less opportunity for training.

Next, (Goel, 1996) mention that the client's characteristic also important because of demanding the certain type of treatment by affecting their knowledge upon their illness. For physician practice, retail pharmacies exist and function in a medical dominated by physicians, practicing both in hospitals and in private clinics. If these physicians are supposed to be professionally competent, pharmacy staff may model their behavior on physician prescribing patterns.

From this study, the author describes the characteristics of retailed pharmacy behavior as professional, health advisory behavior of retail pharmacists and their assistants; thus focusing on those services provided by a retail pharmacy in which pharmacists and their assistants, similar to physicians.

3.5.4 Contracting by PhilHealth

In this section, the study by (Bultman J, 2008) on contracting providers by the Philippine Health Insurance Corporation (PhilHealth), which provides a very comprehensive overview of the issues surrounding contracting in an Asian developing country, is reviewed. This study reviews international experiences with contracting, provides a situation analysis and develops steps towards contracting.

The review of international experiences by (Bultman J, 2008) revealed that there are various methods. In Netherlands, they used to co-payment for contract for specific health service in hospital as cataract surgery as well as pharmaceutical services. Even these specific contracts will different price, the whole price for contract insurance could not over the government price. Also, by doing specific contract leads to easily

reimbursement for health services. In Korea, they practice the co-payment ceiling which the member must pay certain amount for their health insurance. Then, the payment will stop when money arrive the limit level. In such way that it could protect over enrolling the member as well as the avoiding the catastrophic payment for household. In US, the citizens used for co-payment for insurance but due to technological changes, the medical treatment are more costly also people are live long. It will be challenges for future insurance system in US.

The analysis of the current situation revealed that PhilHealth suffered many problems as following. From PhilHealth Health Management Information System (HMIS), there was a lack of a leader to integrate the whole system for streamline processes to see HMIS that a lack of a health data dictionary and the lack of communications between departments on the HMIS-related developments within their own organizations. All of these deficiencies, the Corporation definitely focus on the substantial attention to the re-design of its whole information systems.

Hence, the Philippine Health Insurance Corporation maintained from a contracting mechanism with selected preferred providers. However, it should re-design due to health management information system to make it streamlined and efficient. For implement this planning successfully, the previous recommendations have emphasized as follows. Track 1 which means streamlining, data dictionary; eliminate attachments and Track 2 the full implementation of the New Claims (N-Claims2) that processing system the average processing time of 94% of the PhilHealth Regional Office (PROs) is within 60 days period and Supercenters. These tracks appear very slow, as a consequence, there are not proceeding at a rate required to meet the needs of contracting.

(Bultman J, 2008), proposed that the current PhilHealth framework for contracting as following. The first thing is Legal, in the Philippines contracts are generally governed by the general law on contracts. It means that found in the Civil Code, which provides for contracting parties may establish as stipulations, clauses, terms and conditions. Following that they may deem convenient, provided they are not contrary to law, morals, good customs, public order or public policy. The PhilHealth (PHIC) is authorized, under its Charter and the Implementing Rules and Regulations (IRR) enter into contracts with: health care institutions, health care professionals as doctor of medicine, nurse, midwife, dentist or other health care professional should

have licensed to practice in the Philippines accredited by PHIC, health Maintenance Organization (HMOs) and community-based health care organizations.

Additionally, the author described the consent of the parties in PhilHealth that a party must have capacity to be able to do service for contract. Juridical persons have the capacity to give consent, through their respective Boards as well as natural persons give their consent personally or through agents duly authorized for the purpose. Health care providers, juridical or natural, must be accredited as a health care provider before it can be capacitated as a party to be give consent.

Next, (Bultman J, 2008) showed the current PhilHealth contracting the object in either health services or the benefit package granted to the beneficiaries shall include: for inpatient hospital care include that room and board, services of health care professionals, diagnostic, laboratory, and other medical examination services, use of surgical or medical equipment and facilities, prescription drugs and biological subject to the limitations stated and inpatient education packages.

For Outpatient care enter the services of health care professionals, diagnostic, laboratory, and other medical examinations services, personal preventive services; and prescription drugs and biological subject to the limitations , emergency and transfer services; and Such other health care services that the Corporation shall determine to be appropriate and cost effective. Then, there are four steps for cause of the contract in PhilHealth in Financial Protection in 2010 Resolution target as following. There are shifting to New Payment Mechanism, Contracting or Preferred Provider Service Agreements, Investing in Health Care Providers, particularly Public ones and expanding Patient Benefits.

For second fact for PhilHealth, (Bultman J, 2008), point out the practice of law, court rulings and relevant context. For daily practice, it is a conflict between two parties arises when they have the option to go to court. However, this may prove to be a time consuming and costly procedure with an uncertain outcome, making a simple and less time or cost consuming alternative attractive. In the Philippine Legal System, there are various modes of settling disputes, as provided by law. Apart from the judicial process the resolving disputes through the court system is governed mainly by the Rules of Court as the Supreme Court of the Philippines. These alternative dispute resolution mechanisms are under the Civil Code, the Arbitration Law, the

Alternative Dispute Resolution Law, Katarungang Pambarangay Law and pertinent Supreme Court Circulars on Court- Annexed and Court Referred Mediation. Those dispute mechanisms can be made applicable to PhilHealth, the health care providers and members when it comes to their disputes are provided for these laws.

The third fact, the PhilHealth used enforcement effectiveness as a tool. The Philippine Health Insurance Corporation in its charter has quasi-judicial powers for enforce the National Health Insurance Act. Thus, it can enforce the law through the appropriate procedures as outlined in its charter and the Implementing Rules and Regulations (IRR). The enforcement of the contract is made effective by the stipulations of the parties, and more so their will.

The last but not the least, the author mentioned that the current contracting practices PhilHealth is not totally a novice in the area of contracting. It is a limited scope since 1997 it has been involved in the process. PhilHealth concludes a contract via warranties of accreditation for most of its providers. Based on the capability of the institutions and its professionals, Providers that comply with the accreditation requirements of PhilHealth are given the privilege to provide a wide range of health care services to PhilHealth members. PhilHealth has also concluded memoranda of agreements (MOAs) with Local Government Unit (LGUs) for them to manage accredited rural health units (RHUs) to provide outpatient care packages for the purpose of the further expand its number of providers available to their members. In 2005, PhilHealth began its organized group enrolment initiative, which aimed to include organized groups like CBHCOs (community-based health care organizations) and cooperatives.

This all mentioned above things are current situation of PhilHealth describing. Then, the author continued eight facts the future developing contracting for PhilHealth. In this phase, the options from Philippine Health Insurance Corporation (PHIC) can chose the conditions to be fulfilled and the challenges to making the contracting system effective. Thus, the concrete steps towards the introduction of a contracting system will be explored for PhilHealth contracting. Therefore, the PhilHealth set for what to achieve with contracting as general and specific objectives. For general objectives PhilHealth want to explicitly formulate its objectives for entering into contracting and then what it wants to get out of it such as to achieve a supportive framework in which providers are enabled to deliver excellent services to their

patients in partnership with PhilHealh. Thus, the PhilHealth may focus on the contracting for getting: availability of providers in a circumscribed area, providing a defined benefits package to defined population and delivering defined quantity and quality of outputs (e.g. cataract operations, immunizations, screening procedures etc.)

For specific objectives are contracting for providers to ensure as follows:

- “Comply with the terms of their contract and deliver the service in line with the service specification (in compliance with the PHIC benefits package);
- Deliver improved, high quality, effective services that reflect good practice. (The quality specifications should be a key component of the contract);
- Increase geographic and financial access to PHIC members
- Achieve successful outcomes for service users;
- Protect patients from balance billing and overcharging
- Encourage service user (patient) feedback that can be used to inform strategic
- commissioning decisions of PHIC;
- Focus on the strategic priorities set out in PhilHealth strategic planning;
- Allow risk to be monitored, managed and action to be taken to mitigate risks.
- Meet local and nationally agreed performance targets in health and health care;
- Deliver value for money;
- Provide information that informs wider commissioning and procurement activity
- Provide performance information to all relevant stakeholders.
- Other?”

The second thing for developing contracting is so called what to contract meaning that PHIC will be restricted to contract only those health services that are described in the Health Insurance Act and its regulations. Therefore, it divided three categories. The first category is that listed benefits in general which means the actual benefits must be included and referred to in a contract will always cover the current range of inpatient packages according to the capacity of the provider. For outpatient packages, currently included in the benefits package can also it could be included in a contract. When the benefits package changes, the content of a contract can change. In this regard, the contract cannot go beyond or outside the services as included in

the benefits package of PhilHealth. However, sometimes it depends of the formulation of the benefits package which subsequently can be included in the contract what exactly can be offered by the provider.

The second category is specific interventions/services for the purpose of offering by selected providers such as it does already covered by the benefits package for cataract surgery.

The third category is that the contract its can also determine the volume of the services of the specific interventions to be provided. It aims for quality reasons and compensate with this option for the short comings in the health planning system in the Philippines, whether it can use this instrument to eventually concentrate high-tech or high-risk medical interventions for cost/effectiveness.

The third developing contracting for PhilHealth is called whom to contract which involved ten facts as follows: (1) needs of population to be served in which epidemiological profile and geography. (2) Price of service offered by the provider, (3) Volume of service, (4) Quality as accreditation, licensure and certification (5) Organizational: part of vertically integrated network as for getting better services and for the effective use of a referral system as not only maternal and child care but also for care in general and horizontal integrated network such as midwives or family physicians may offer advantages over individually organized practitioners as the regards of the continuity of care, or for offering better opportunities for internal medical audit, peer review and for post-graduate education.(6) Practical which involve: certainty the provider can deliver, willingness of provider to contract on the conditions offered and other. (7) Financial/admin which include: no balance billing, zero fraud and timely submitting of claims. (8) Ideological reasons: only, or preferably, public or private providers and mixed. (9) Attracting private investment as Development Bank of the Philippine (DBP) and other. (10) Any combination of the above.

The fourth developing for contracting is that how to contract will be selected which include handpicking the providers as base on the current experience and the mention above criteria. For positive side, this method can move steady and choose one provider after the contract. For negative side, it seems secrecy image for PhilHealth due to absence of transparency in the procedure and absence of any

resources by the providers. This method may skip to corruption and favoritism. The alternative method for how to contract is organize a tender which main aim for specific categories of providers as nationally, provisionally and provisionally.

The fifth developing contracting for PhilHealth is how to pay meaning that what payment mechanism wants to use to pay the contracted provider. In this phase, PhilHealth still use current system, and add a certain amount per unit like day, intervention and capita.

The sixth contracting for future in PhilHealth is what incentive to offer. PhilHealth could be offered one or more for incentive as follows: timely payment, support for admin optimization which improve speed of billing process and prevent RTH and deduction/refusal of claims, advance warning, dialogue and explanation of changing PHIC policies, higher fees, reflecting performance and differences in investment costs, status of preferred provider on top of accreditation, marketing by PHIC to members of services of preferred providers and feedback on comparative performance.

The seventh fact is that conditions for selecting providers assumes from public providers in which for not all may get a contract and all their services may be contracted. For private providers also the same as public providers in addition to that for private provider will base on the explicit criteria as may be include bankruptcy.

The eighth fact for the developing contracting for PhilHealth is content of the contract. PhilHealth has authorized to add or delete from the model what it considers to fit its objectives and administrative practice for a flexible instrument of contract. This model for contracting can adapt for hospitals and doctors whether specific benefits and of services or for contracting different categories of providers.

The above eight factors is the author, explain for future developing contracting for PhilHealth. Also, the author put the major role for claiming process in future business process in contracting. In the early phase, the PhilHealth face the problem in claiming process. In addition, PhilHealth successfully implement step by step for transforming current to future, the PhilHealth consider for a gradual roll out by following steps when implement current to future. These steps are in the first step is decide about the contracting policy, check if the conditions for successful and efficient contracting are met. The second step is defines of the specific aim of the

pilot as testing the contract and the tools to implement. The third step is testing the organization and business processing at PHIC as well as providers and testing the communication between PHIC and providers.

The fourth step is choose option for a pilot for Nationwide as for a small category of providers and selected services, then restricted to a region, Province or Municipality and broader category or categories/services. The fifth step is only Contracting, or contracting plus OPB and/or case based payment. The sixth step is start dialogue with providers. The seventh step is develops contract offer as determine contract payment and strategy also write specifications. The eighth step is organizing tender or hand-pick provider. The ninth step is negotiates contract: terms and conditions. The tenth step is providing training to PHIC staff and providers. The eleventh step is implementing the plan. The twelfth step is management and evaluation then this strategy can adjust and roll out again.

3.6 SYNTHESIS OF THE LITERATUREVIEW

It is generally understood that under contracting-out the provider get fully responsible and authority from contractor for running operations cost and providing health care services in experience. Under contracting-in, on the other hand, it is contractor only use partial service from provider as management level for contracting service. Apart from that the contractors run the service by themselves. Also, the performance-based contracting which include key performance indicators is vital role for contracting process which include the measurement tool for renew contract. The contract formality is important for contracting service which determine between relationship contractor and provider as formal relationship or informal relationship. Base on this, the contractor considers for reward and sanction for contract as well as renew contract period with provider.

For the payment system, there are many payment systems for contracting health services as capitation, fee-for-service, pre- payment etc. However, every payment has advantage and disadvantage. Capitation payment given the fix amount for the population and it is suit with incentive especially for prevention. Provider assumes under capitation the risk of increased costs and volumes. Fee-for-service payment in turn leads to over-provision, reimbursement also generates excessive transaction costs in claims assessment, processing, and payment, and can lead purchasers and providers to seek sophisticated situation with its high risks of failure. Fee-for-service

payment can contract with private doctors to provide specified health promotion or preventive services and hospital services. For pre-payment, it provided in advance for specified services to be rendered. For provider, it can be assumed risk of increased volumes, as a consequence, discourages over utilization of covered services. It can be contracted for several services. In addition to that case-base payment method mainly suited for hospital service as well as sophisticated because of the related to diagnostic treatment.

From the potential problem and possible of contracting, there are various costs and effect. Bargaining cost occur when contract breaking mechanism either sides or one side as the cost was change pre-agreed. However, it is good for both sides in terms of increasing salary, bonus etc. This cost occurs when both parties want to persuade for motivation in work place. Bargaining costs appear when costs arising from negotiating contract details, the costs of negotiating changes to the contract in the post-contract stage when unforeseen circumstances arise, the costs of monitoring whether performance is being adhered to by other parties, and the costs of disputes which arise if neither party wishes to utilize pre-agreed resolution mechanisms. While only the first cost is experienced at the time of contracting closely all of these costs can be anticipated and dealt with at the time of contracting.

The opportunism cost happen one party behaves over interest within organization. It is negative sign for organization because of this person taking opportunity which lead to bad image for organization by showing in bad-faith. Opportunism is more likely with contracting-out than within organizations because of gets the profit is more relevant in dealings between organizations.

The last but not the least, the production cost are seems lower compartment for contracting-out service due to the minimum efficient scale and technically feasible. There are two reasons for the lower with competitive of contracting-out. Firstly, the production costs should be conceived broadly; the most significant economies of scale might be in intangible factors such as administrative systems, knowledge and learning and access to capital markets. It is often difficult to design government organizations that can use several political jurisdictions to take advantage of economies of scale whereas not-for-profits may be able to compete on this dimension. Secondly, public provision may fail to achieve the minimum production costs that are technically feasible as two ways: firstly, it eliminates comparative

performance benchmarks for customers and, secondly, the service is likely to be paid for through aggregate taxes, thereby obscuring the price and efficiency of a government supplier.

In addition, task complexity include product or service complexity the degree of difficulty in specifying and monitoring the terms and conditions of a transaction. The degree of task complexity largely defines as the uncertainty surrounding the contract, the potential for information asymmetry and the probability that there will be externalities that will affect other organizational or health sector activities. Contestability means a few firms are suddenly come out to provide given service, even though they can afford to provide previous time. It can occur when many firms or non-profit organizations would quickly become available if the price paid by the governmental organization over the average cost incurred by contractee. The importance thing is that the level of contestability sometime appears rather than the number of firms really provides service in some cases.

However, sometime governmental entities can often reduce production costs by contracting-out activities without demand from private market. When the providers are able to switch for direct cost for production, the contestability occurs in market. Asset specificity creates a necessary contribution to the production of a good and has much lower value in alternative uses as physical asset specificity, location specificity, human asset specificity, dedicated assets and temporal specificity. This has leads to reduce the investment cost for economist.

A wide range of clinical services provided by physicians and other health care professionals, the high task complexity and low asset specificity, this can occur perhaps best characterizes the supply. For solved out the problem, Vining AR et al suggest that an alternative arrangement would involve the formal contracting-out of the management of these professionals. The high task complexity and high asset specificity which can come out between the situation and case is that rely on other third-party contract enforcement procedures. This flows from the fact that it is more difficult for the third party to identify whether contract breach has occurred. The authors suggest that only comprehensive monitoring of the behavior of the clinic would identify the changes as shrinking.

Again, the author explained low task complexity and high asset specificity problems almost certainly involve high temporal or location specificity. There are likely to be few efficiency costs arising from high physical asset specificity if the contractor makes the relevant specific investments as hospital services. There are two possible ways for solution raising the bid price and utilizing a higher cost production technology that requires less physical asset specificity. However, (Vining, 1999), suggested that both strategies increase aggregate costs in turn to the inefficient and should be avoided. These problems can be avoided if the contractor owns the specific asset and rents.

For contracting services, all cost are important as transaction period, To be more detailed, it is make consider for contracting services by reviewing past, present and future. However, it doesn't mean contracting service is always offer increase utilization, assess and quality. The service also has drawback thing. If people can manage well for contracting services, it could be achieved as increase utilization, improve quality and access. On the other hand, according to principal agent theory, there are three ways of problem could happen in which agent change behavior their principal. There are the agent prefer the different from their initial principal, different incentive and information asymmetry. Those problems force to diverse the contracting advantage to disadvantage. It is clear that mentions above some cost as bargaining cost, opportunism cost and task complexity etc.

The last but not the least, it is experience from Philippine. The PhilHealth take reference from other countries experience health insurance from Northlands, Korea and US. Then, try to emphasis the re-design the current weak system as organize well for management information system and claiming system. Following that set a legal as stipulation, clause, terms and conditions as well as focus on the contracting the object as outpatient, inpatient. Also, the PhilHealth enforce the law through the appropriate procedure. Next, for future plan, PhilHealth continue eight facts developing plan.

The study from (Bultman J, 2008) the PhilHealth experience, it is not only showing the Philippine health insurance but also describe contracting service from others countries. For example, in Netherlands, there are used to specific contracting service both insurance company and insured people. As the insure agency contract for specific service from hospital for cataract surgery as well as pharmacy contracting to

other place. However, the citizens also practice for those services. As a result, it could make easy to reimbursement from those specific contracting. Even though the price will varies among different specific contracting, the maximum amount will not over government ceiling price. Also, in Korea, they use ceiling price for co-payment amount for individual. By doing this, it already prevent over enrolling for individual as well as catastrophic payment for family member. It can see that different countries practice different contract and different way of contribution system.

In addition, the way of pharmacy contracting in US, there are systematic develop for pharmacy contracting. First, they realize compliance from utilization service. Second, they find the alternative way for available service than before in single location as single pharmacy model. Third, try to cover the entity for compliance elements. Fourth, this cover entity will include responsibility for contracting pharmacy services. Fifth, the contracting service should set the certification. Last but not the least, contract pharmacies and covered entities should be alert of the potential for civil or criminal penalties if the contract pharmacy violates Federal or State law.

3.6.1 Primary contracting versus Hospital contracting

From the study of contracting for primary health care services, it seems suited for developing countries in term of increase access, equity, quality and efficiency. However, different countries from Cambodia and Afghanistan, there are proved that contracting-out of health care service are obviously benefit. Afghanistan succeeds at contracting-in for government whereas Cambodia survived contracting-out. It means that different countries have different health setting. Also, most of the case studies show that how importance of management in contracting-out system. In Afghanistan, They are also closely monitored both technically and financially using a system of monthly reimbursements based on a line item budget. In addition to that Cambodia return keep the health service the contracting from NGO, then continuing successfully for output for health services as the way of taking information from NGO manager, deal with local authorities and maintaining quarterly report for management.

From the experience from hospital contracting, most of the studies focus on quality care of service especially responsiveness. Normally, The process of agreeing contracts contain the extent of competition which mean the method of pricing, quality

indicators and monitoring of contract performance in which contract duration and sanction for poor or good contractor performance for next contract. For the clinical services, the cost of contract hospital is higher than direct provision for two reasons. The price is substantial difference between the contract and the cost of the contractor providing the services.

In addition, there are evidence studies from primary contracting easily to measure access, utilization although still less to measure for quality and efficiency study by (Liu, 2008). However, most of the studies for hospital mainly focus quality care service as patient satisfaction. According to (Mills, 1998), the quality of care and cost are high in hospital in Bangkok and Africa.

3.6.2 Private versus Public

Regarding contracting private versus public, here from study the author (Liu, 2008) explained that quality of care at both health centers and referral hospitals were measured through direct observation techniques as a set of indicators to construct a health care quality score. The author found that the quality score for contracted private providers was slightly better than the score for public providers. Even though contracting out gradually growing interest and experience in developing countries, there is still relatively little evidence on the impact of these initiatives on efficiency.

Again, (Mills A, february 1997), proposed the improving the efficiency of district hospitals in South-Africa. This paper shows the economic arguments for contracting district hospital care in two different settings in South Africa using private-for-profit providers, and in Zimbabwe using NGO (mission) providers. In South African study, the performance of three ‘contractor’ hospitals compared with three government-run hospitals, then analyzing data on costs and quality. Also, the Zimbabwean study compared the performance of two government district hospitals with two district ‘designated’ mission hospitals.

3.6.3 Non-clinic versus clinic

Also, according to (Mills, 1998), compare non-clinical services and clinical service different among countries. For non-clinical service, contracting showed a better value than direct provision as Bangkok and Bombay contract services for diet although it leads to poor quality services due to the contractor pay a low wage and poor

management. For clinical services in Bangkok and Africa, it is a positive result for quality service because of a better maintains and reduces time. However, the cost of contract hospital is higher than direct provision for two reasons: the price is substantial difference between the contract and the cost of the contractor providing the services. Therefore, the non-clinical service is a better value with poor quality whereas clinical service is high cost with high quality in among different countries.

To conclude from literature review, there are contracting service is quite effective for developing countries I terms of effective, access and quality. The important thing is that the success contracting services are which they have closely monitoring and management system as Cambodia and Afghanistan in primary contracting. Also, the hospital contracting from South African prove that closely observation make the less cost even though quality level is the same. Again, for pharmacy contracting from US also take a vital important for management for customer compliance which keep for service quality. Thus, every level of contracting services from specific to general, the management system and monitoring and evaluation are necessary to achieve the goal.

CHAPTER 4

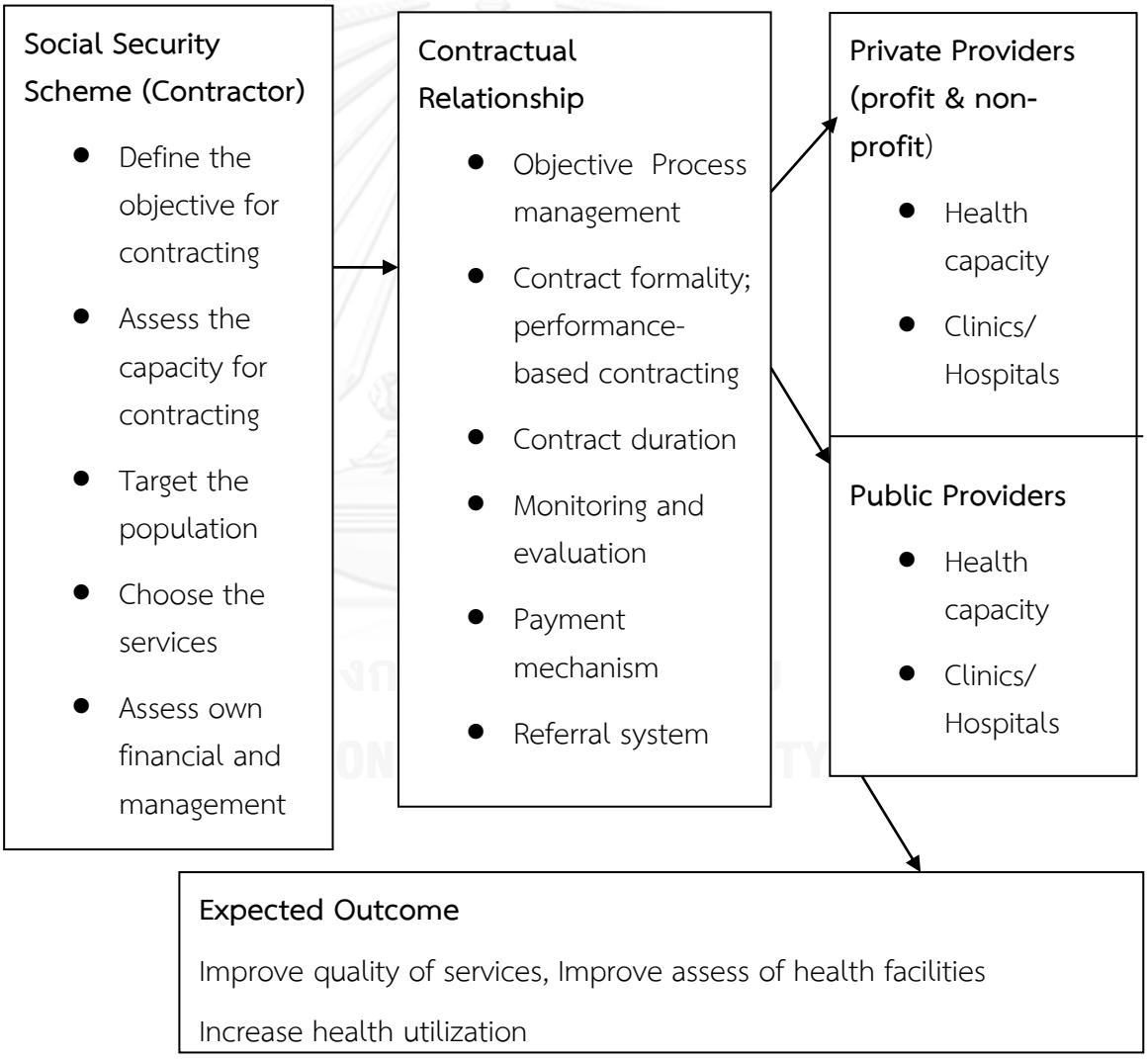
METHODOLOGY

In this chapter, the research methodology is developed. First, the conceptual framework is explained then the data collection and finally the qualitative analysis will come.

4.1 CONCEPTUAL FRAMEWORK

Figure 2: Conceptual Framework

The conceptual framework is shown in the figure below.



Source: This conceptual framework was reference from Liu et al., (2007) a conceptual framework for evaluating contracting-out of health services.

According to conceptual frame work, the first box represents the contractor/Social Security Scheme. This group must identify to the objectives for contracting health services such as coverage expansion or improvements in the quality of health care services and outcomes etc. Also, they need to assess capacity for contracting based on provider inputs and facilities. For example, services for diagnostic, room for board, emergency and transfer services. Another considering for contractor is the target population for utilization of health services which confirm for certain number for delivery of health care services in contracting. Following that it could be considered contracting for either primary or hospital services as well as the referral system and sub-contract clinic service from hospital. Apart from this, this contractor side should have maintain the financial capacity and management capacity for contracting.

For the providers as private hospitals and clinics services, this group should focus types of service what they could be contracted as either hospital or clinic service. Also, providers must assess if there is enough capacity to provide health services as the number of staff and other technical support for the coverage of population for insured workers.

Then, both parties contractor and providers will discuss the conceptual relationship for contracting as how they will develop the objective as inpatient hospital care which include the number of room for patients, perception drugs, medical examination, services of health care professional for patients and medical and surgical equipment and facilities for patients. For outpatient care involve the services for health care services for quality control, laboratory test service for clinic, essential drug list, and emergency and transfer service for hospital.

For management the process, both contractor and provider continue the observing whether the process move forward or backward. In this stage, normally, making report as quarterly or annually by checking for the services and financial management and sometime technical support for services.

Another contractual relationship between contractor and provider is to decide the contract formality for health services. It means that the contract relationship either reward and sanction upon the responsibility for performance-based contracting or just mutual relationship for contracting.

For contract duration, the contract and provider must make the decision the contracting year which not too long or too short for contracting for the purpose of to review the contracting service whether effective or not. Normally, minimum one year and maximum five year for contracting but some literature review recommended that the most suitable time is three for each contracting **(Liu, 2007)**.

The payment mechanism, it could be discussed contractor and provider which payment mechanism suited for contracting as line item budget payment, capitation, co-payment, pre-payment and case-base payment.

The last contractual relationship for contractor and provider is monitoring and evaluation for contracting. Also, it is vital important for key success for contracting services because it insufficient just maintaining health service for effective outcome. Thus, it could be able to evaluate system for contracting health services due to comparing the last time, service and capacity.

All purpose for contracting is in turn to improve access, equity and quality for insured workers. Therefore, the lowest box will be interviewed for contributors because they are currently use the services as well as they will use for future expansion of social security scheme. In this reason, those people expected the improve quality of services, assess and utilization.

4.2. DATA COLLECTION

This is a qualitative study that uses primary data collected through in-depth interviews and focus group discussions regarding contracting of private and public health care services in the planned coverage expansion of social security scheme in

future. Also, it will ask permission to use transcription and interviewee's position and work place for respect and security reason for interviewees.

The data were collected at Yangon which has the biggest population estimated 4.35 million in 2010. Total number of public hospitals are 74 and private hospitals 37 respectively from 2010 to 2011. The distributions of medical doctors are 46 per 100,000 populations and nurses are 55 per 100,000 populations respectively **(Ministry of Health, 2010)**.

4.2.1 Stakeholder group definition

Four key stakeholders were identified as follows the contractor Social Security Board, the future provider private and public, contributories who are employees and employers and current provider as medical person.

The first stakeholder is the contractor, i.e. the Social Security Scheme. Their target is to increase coverage and ensure that health care services of adequate quality are provided for insured workers in an effective and efficient way, given limited budgets. Thus, they need to set strong objective, proper management and contractual relationship for positive outcomes. The interview with those contractors, we may know what plan for contracting, current situation and service in Social Security Board.

For provider side, they supposed to get for contracting services by distribution of quality care of health services. They may responsible not only services but also management from contractor side because both contractor and provider must consider the contractual relationship and both parties assess the capacity of providers. Also, it will be varies facilities among private provider as depend on how they can effort to delivery service because they will belong different health facilities. As hospital owners, they can offer general service as well as specific service as clinic or cataract surgery. Following that the polyclinic can responsible some minor surgery and medical checkup. Finally, the clinic can offer outpatient service for insured workers.

In addition, the interview will conduct from Ministry of Health (MOH) because of MOH responsible general service for as a whole country level. If Social Security has a chance to contract with MOH, it will be improved for insured worker to accept the service easily. Last but not the least, the Non-Government organization which is example from literature review of Cambodia experience, the health service output improve MOH contract with NGO in contracting year. Currently, there are some NGO and INGO are participate in health sector of MOH for communicable disease control program as TB, AIDS, Malaria and maternal and child care. Although no one starts contract with public and private in regionally for curative care services.

The third group is the contributors. Contributors represent perception from employees and employers. It mainly concern for changes contribution which is really effective for health care. Additionally, the contributors are focus on the quality of health services from their payment as well as that the contracting health care will improve the access of health facilities and health utilization for them. It supposed to choose who current hold the Social Security card and giving contribution regularly. The reason for choose those persons that more given information current service and Social Security function.

The last target group is current health care provider as medical doctors who work hospital and clinic. As current provider, they may know closely the requirement of services as well as patients' needs. Following that the patient want quality care of health services, effective treatment and enough health access.

Last but not the least, the current user who put together with current provider can express their feeling upon current health service. Base on this, they can say their feeling what they want in contracting health services.

4.2.2 Sampling Design

Table 5: Sampling Design

Interviewees	Number
Contractor	7
Future providers (private and public)	8
Contributors (employer and employees)	4
Current providers	8

A purposive sampling approach was chosen to select 27 persons for in this primary data for interview.

7 persons are chosen from contractor side. These are managers and senior managers of the Ministry of Labor, Employment and Social Security offices. The reason for choosing seven persons from contractor side due to the Organization set up of Social Security Board. There are five departments for admin side, so it supposes to choose one persons from each department. Actually, for this study, the contractor want to know regarding about contracting thus it contact with one person from researcher who work in research institute then it will allow to take interview. Therefore, it start introduce and interview to senior management person to interview. From this person permission, it could choose others persons from different departments.

For the provider sides, the private sectors as hospital the interview will be conducted Human Resource managers, Medical Superintendents (MS) and shareholders of hospitals as well as clinics owners about 5 persons. For public sector, it supposed 2 persons from the Ministry of Health as admin side and 1 person from Non-Government Organization (NGO). Actually, some providers get appointment via email. Apart from that it get information from the as some providers will select from pre-agreement with Social Security Board for contracting service. This information received from the person who contact for research also, for MOH as well. However,

for INGO contact by email because it work as volunteer for a while in this organization.

For contributors' side, 2 persons for each employees and employers were selected. From this side total 4 persons from employer and employee were chosen because they can express what kind of services they expect and how much pay for contribution for future Social Security Scheme. It will be finding from some organizations which work development for workers. For finding employer, it supposed to contact the UMFCCI because this is one of the organizations for industry in Myanmar. Following that it could find possible way for to get interviewees for employers.

For the last group, interview for current provider, 3 persons were selected from medical doctors and 2 nurses who work in Social Security clinics and hospital as well as about 3 patients who use health services in Social Security Scheme respectively. The perception from this group also important because they could present well for current situation of health services as current provider and current user in Social Security Scheme as well as they could be described urgent needs for health services reform area. Additionally, they could highlighted that contracting services should difference facts in current serving health status.

For those current providers and current users, it will ask permission from the Social Security Board which one of the senior manager. It could make permission when interview in Nay Pyi Daw. Following that it will ask permission from Medical Superintendent to allow interview to current providers and current providers.

These selected persons were mainly approached by phone and to a lesser extent by email.

4.2.3 Group Discussion

In this study, it will be conducted focus group discussion as well. Even though can't say exactly in this stage, it will be about 7 or 8 persons in group discussion. It mainly

purposes for to get more information than individual interview by sharing all participants experience from different background.

The group discussion will be conducted in Yangon. It supposed to mainly contractors and providers to share their regarding the in-depth interview questionnaires. If possible, it will add in some current provider and some contributors in this group discussion. For group discussion, it seems brain storming rather than group discussion because of it supposed to get some result if contractor and provider discuss upon contractual relationship.

4.2.4 Guideline Question

For in-depth interview for purchaser/contractor side, it mainly focuses on the source of funding; how the Social Security Board define the objective for contracting services, which type of service want to contract as either primary care or hospital as well as the whole services or specific services as cataract surgery, duration of contract approximate time for each contract and how to manage the monitor and evaluation the contracts process and how to arrange the financial management for contracting as contribution, patrol tax and co-payment etc. Follow conceptual framework: contractor box and box on contractual relationship.

For provider/contractee side, the interview will focus on the health capacity from provider, following that the question will develop the conceptual relationship between the Social Security Scheme. For example, how the provider will develop the contract objective, how will consider the payment methods as fee- for –service, capitation or prepayment, also how the provider construct the relationship with the Social Security Scheme as formal way or informal way and performance-based contracting, how to monitor and evaluate for financial, performance services and how long for contract services. Follow conceptual framework: provider boxes and box on contractual relationship.

Also, the interview will be conducted both employee and employers regarding services and payment methods. The question will start the perception of current health services in Social Security Scheme, then how they expect future contracting

health services. The questions will focus on what they expect quality of services from contracting as well as how they think whether contracting will increase health utilization and access of health facilities. Base on this, the question will ask they are willing to pay roll increase when Social Security Scheme expansion the coverage.

As current provider side from health sector, some medical workers and patients will include for their perceptions for health services and facilities. It mainly focuses on current situation of Social Security Scheme health services. Following that the question turn to the current providers for contracting health services will be able to effective insured workers the way of improve the quality services, access of health facilities and utilization the Social Security Scheme.

For focus group discussion, the questions will the same as in-depth interview because it supposed to find out some way for contracting among contractor, provider, current provider and contributors.

All detailed guideline questions are described in appendices A.

4.3 ANALYSIS OF QUALITATIVE

In this study, the data analysis will do manually analysis rather than using software. By using recorder, it can transcribe all interviews later. For analysis section, it supposes to make identifying and labeling (coding) for items interview to another interview. From base on this, the analysis will be done for the final outcome (Hancock, 1998).

By following the guideline questions, it can develop coding from different answers from respondents as interview 1, paragraph 2, and sentence 3 (I1P2S3). As a qualitative data analysis, content analysis is a procedure for in this study. It will be included categorization of verbal or behavioral data, for purposes of classification, summarization and tabulation. The content can be analyzed on two levels. The first level, it is called a descriptive account of the data or the manifest level or type of analysis this is what was actually said with nothing read into it and nothing assumed about it. The higher level of analysis is interpretative called the latent level of

analysis in which concerned with what was meant by the response, what was inferred or implied (Hancock, 1998).

It supposes to go through in-depth interview to following guide line question to all stake holders. Before this, it need to prepare a list of item in which information contain. It may be different answer among different stake holders. Base on this, the items also become several categories. For next step, it will be separate two categories as the original represent major category which link in some way in one category and the smaller category will be minor category. Following that this two different categories will compare and contract. Then, it needs to revise original items list whether any data exclude which relevant for analysis. The process of content analysis will keep on revising data and reviewing categories until make sure complete and truthful which reflect the data results.

For example, coding '1' to '3' represent the stages of perception for contracting. As a chronological order, 1 represent disagree for contracting, 2 represent contracts with condition for health service, 3 represent agree health services for contracting-out. So, the labels will appear as agree, agree with condition and totally disagree. It will become increase by after interview to 27 persons because the result will enter this different category according to the different responding from people. In such way that the various result will come out from different the coding. Then, for analysis the data, compare and contrast the coding results according to their categories (Hancock, 1998).

However, it could be challenge for describe to transcriptions as appendix in final thesis because of some participants will not allow to show their position as well as transcriptions. For analysis the qualitative, it must translate Myanmar language to English by recorder. Then, analysis will be done by coding following interview, paragraph and sentence.

4.4 POSSIBLE BENEFITS

This study will support for future expansion of social security scheme by knowing that perception of both purchasers and providers. From based on this, policy maker

could be decided proper discipline for contracting-out of health care services. Also, this study will be helped for health care financing which country preparing for reforming period.

CHAPTER 5
RESULTS AND DISCUSSION

5.1 INTRODUCTION

From this chapter, it categorized by all interviewees changes by table and reasons for changing. Because when I meet some situation is quite difference actual situation in Myanmar. Thus, some interviewee's number is change. Also, some participants are not allows to show their positions as well as transcripts in appendices C. Thus it will not appear in appendices most of participants transcription and group discussion.

5.1.1 SITUATION ANALYSIS

Currently, Social Security Board run two hospitals in which 250 bedded and 100 bedded capacity respectively in Yangon. Also, in Yangon, there are 22 clinics run the health care services for insured workers. It is obvious that Social Security Board necessary increase when expansion Social Security Scheme for security workers due to insufficient current health facilities. At present, private and public health sector are quite broadening in Yangon because it is one of the biggest city in Myanmar. There are 74 public hospitals and 37 private hospitals.

However, according to World Health Organization (WHO), the standard of physician-patient ratio is 1:600. Therefore, the number of physician- patient ratio in Yangon is still a low compared with World Health Organization (WHO) standard. **The following is a survey of healthcare facilities in Yangon in 2010–2011.**

Table 6: Health Care Facilities in Yangon

2010–2011	Public hospitals	Private hospitals	Physician-patient ratio
Eastern District	16	10	1:3638
Western District	10	21	1:1400
Southern District	23	1	1:18,176
Northern District	25	5	1:13,647

Nowadays, the population of workers is increasing gradually due to political and economic changes especially in Yangon. As a consequence, Social Security Board unable to coverage for workers health because of insufficient health facilities. The worst thing is that the insured workers are accepted poor health services unless they still spend out of pocket for their health care services.

In this regard, Social Security Board consider to contract for health care services with outsiders. Additionally, for expansion of coverage Social Security Scheme, there are enough to contract for health facilities in Yangon. Also, it is a less cost and time for delivery health service instead of running health services by themselves. Currently, Social Security Scheme has been planning for their services including health benefit for insured workers.

Thus, it could be considered for contracting health services either private or public health care services and clinic or hospital or sub-contract under hospital. It is opportunity for Social Security Board to choose relevant health facilities because according to health facilities in Yangon, it is plenty of both private and public health services.

However, there is little doubt that even though it possible contract for health services in this area, some extent might be difficult for contracting as contract with public sector because it is a bit challenge for public sector side due to standing long time for free of service for citizens. Thus, when contract with Social Security Board, the public sector necessary change rule and regulation. This process may take time to accomplish as well as complicated for public sector side.

Additionally, there is another challenge for referral system because the way of referral system in Myanmar is not systematic way as following the physician order and sometime patient's family decision to transfer patient either clinic to hospital or hospital to another hospital. For transforming to contracting health services, it could be considered for registration system for patient to admit contract hospital. This is one of major concern for contracting to public sector side because normally public hospitals registration system is very simple just accepting patient as long as patient have transfer letter.

Following that it could be incomplete picture for initial stage because Social Security Board will face a number of challenges to develop the contracting system in Myanmar. For example, the providers are unfamiliar of contracting mechanism from as the way of providing quality care is insufficient for the expectation of insured workers in expansion of coverage.

At the moment, Social Security Board discuss about payment system because if Social Security Scheme supposed to expansion coverage the scheme, it necessary increase the contribution from workers for the purpose of enough financial management for contracting health care services for workers.

5.2 Actual Interviewees

There are a couple of changes due to situation. First of all, the total number of interviewees changed. As opposed to interviewing 27 persons in line with the proposal, only 26 persons were seen for the in-depth interview.

To be more detailed, the number of contractor is 4 people instead of 7 people because of the changing situation. At first, it is planning for interview from Ministry of Labor (MOL) and Social Security Board (SSB). However, it is cancel to interview to Ministry of Labor (MOL) because contracting is just idea only from Social Security Board (SSB). Thus, it is mainly responsible and available data from Social Security Board (SSB). There are five organizations in Ministry of Labor, Employment and Social Security. Each organization has different function as well.

In addition, even though this study is useful for contractors, some departments are unavailable to interview because as new departments IT, the director is go for training and some departments are busy for prepare to implement new law. Also, some departments are not willing to answer the interview. Apart from that future provider both about 8 persons but it can increase the number of private sector 8 person instead of 5 persons. However, some private providers, it meet same problem for answering interview especially the high class hospital even though it try to know all level of private provider attitude for contracting. Also, it got only one person from

MOH instead of 2 people but it can give useful information for current health system in Myanmar. Also, it got a chance to interview to one NGO which make more meaningful for all stakeholders perceptions from all health services sectors. It can get exact number for contributors and current providers as plan before.

Table 7: Actual Interviewees

Interviewees	Numbers
Contractors	4
Future providers (private and public)	
Private Hospitals (private providers)	5
Polyclinics (private facilities)	2
Clinic (private facility)	1
Department of Health Planning (MOH)	1
Communicable **Disease Control Program (INGO)**	1
Contributors	
Employers	2
Employees	2
Current Providers	
Doctors	3
Nurses	2
Current user (patients)	3

5.3 Contractors' Perceptions

The interviews for people were selected 4 persons from Social Security Board. The study could start because of it get information from friend as the Social Security Board interest to contracting service. Thus, the contractor side allows to interview. As a government sector side, it gets agreement and permission first to interview the senior authority person then for interview to other departments as choice from senior manager. There are department from medical, insurance, audit and as a person from senior of management for those departments. During the transforming period, some departments are busy for preparing as well as going for training as IT.

After interview to the senior authority person, it allows to others departments to interview. Thus, it starts from introducing to each department then make appointment time. However, some department are unavailable for interview due to training and busy even get agreement time to interview some people are refuse to answer. The in-depth interview conducted in Nay Pyi Daw which mostly government office are situated. The in-depth interview takes time about two days in Nay Pyi Daw.

Table 8: Contractors' Perceptions

Contractors	Location
C1	Nay Pyi Daw
C2	Nay Pyi Daw
C3	Nay Pyi Daw
C4	Nay Pyi Daw

From the in-depth interview with contractor, they are plans for specific contracting rather than general contracting. However, for initial stage, there are many requirements that should change; not only internal organization but also dealings with external. Also, new law implement 1st April 2014, thus Social Security increase work force to strengthen their internal organization such as audit and information technology (IT). The audit department will be responsible for checking 77 branches of Social Security office for the whole country. Also, the information technology (IT) will serve for computer system because the new law will introduce computer card system for workers. It is easy to use for both workers and health care providers because the computer card will keep all history of workers - not only checking for contribution but also storing the health history of worker.

5.4 Providers' perceptions

For hospitals side, some hospital has appointment from e mail and some from telephone. Following that it go through step by step as introduce for personal, purpose of study, topic and some contracting terms. Then, some are agree to interview at that time some are make another appointment. From P1 to P5 represent private hospitals, to be exact; it could be general health service for contracting. 1

hospital from Bahan township in Western District, 3 hospitals from Eastern District which situated in North Okkalapa and Thingangyun and 1 hospital from Takata in Southern District. To be more detailed, those hospitals are own different facilities level from 200, 100 bedded capacity to 25 bedded capacity including operational room and investigation in different region in Yangon except P4 and P5 because even though they are same region, the place is quite far, one hospital located near the industry zone.

For polyclinic, there are 1 polyclinic from Sanchaung in Western District and another 1 polyclinic from Mingala Taungnyunt in Southern District. As clinic, there is 1 clinic from Shwepyithar which is located in factory area in Northern District. For those polyclinics and clinic are get agreement from Social Security Board. One of the polyclinic is current working with Social Security Board as Mobile Medical Unit (MMU) which mobile care contains medicine and four investigations. The way of the delivery of service is go around the factory by checking medical conditions from Social Security doctors then the MMU given the service according to medical doctors. Therefore, it 1 person from clinic manager about and 2 administrators from polyclinics will involve the interview due to responsible for running the whole clinic services. Currently, private health sector is mainly responsible health care for citizen in Yangon.

However, it got only one person from Department of Health Planning (MOH) although plan for 2 persons from MOH. Again, it chance to interview to this person because of pre agreement from friend who introduces the topic which Social Security Board and Ministry of Health. Also, it get a chance to interview to Deputy Director from operational department of INGO which do for communicable disease program in Myanmar. This is directly get permission from country director by via email without supporting from anyone.

Table 9: Providers' Perception

Providers	Position	Location (Township)	Service
P1	Executive Director	Thingangyun	Hospital
P2	General Manager	Thaketa	Hospital
P3	Medical Superintendent	Bahan	Hospital
P4	Administrator	North Okkalapha	Hospital
P5	Medical Officer	North Okkalapha	Hospital
P6	Manager	Shwepyithar	Clinic
P7	Managing Director	Sanchaung	Polyclinic
P8	Director	Mingalar Taungnyunt	Polyclinic
P9	Deputy Director	Nay Pyi Daw City	Health Planning
P10	Deputy Director	Bahan	INGO

For the future provider sides, initially it was envisaged to interview 8 people. However, there was a chance to interview 10 people. They are 5 people from private hospitals, 2 people from polyclinic and one person from clinic respectively. Therefore, it will be selected 8 persons from private sector side. The private sectors as hospital the interview will be conducted to Medical Superintendents (MS), Managing Director, Executive Director and Managers from hospital (5 persons) because those persons are mainly responsible for the whole hospital services. According to some literature review from Cambodia experience, study by (Jacobs B, 12 August 2009), Cambodia can keep output of health level after contracting with NGO. Thus, in this study, it considers to interview to INGO. Also, the public sector is important in Myanmar because responsible for as the whole country level for people. Currently, the Social Security Board contracts some medical doctors from MOH. Thus, it is a chance to interview to Deputy Director from operation side from INGO. However, it got only one person from Deputy Director of Health Planning from MOH instead of 2 persons but it can answer useful information for current health system in Myanmar.

By in-depth interview from providers, there are possible contract to private sector rather than public sector. Also, some provider are interest the whole service for contract for clinic and hospital whereas some are interest specific contract as maternity package or medical checkup. However, there could be negotiated with private for terms of contracting as contract duration, way of contract relationship between contractor and provider, payment mechanism and type of contract service as specific contracting. From in-depth interview to MOH, it could be impossible to contract with Social Security Board because of current payment system in both sides. Both MOH and Social Security Board use reimbursement system as a consequence, MOH can't reimbursement for Social Security patients. Thus, the contracting will be delay with MOH at the moment. Also, when interview to INGO, it is less interest for contracting especially the interviewee suspect how Social Security manage for payment to high cost of medical treatment.

5.5 Contributors' perceptions

For contributors side, the interview held about 2 persons from employees who work in shoe factory about six years and sunflower manufacturing about 2 year service respectively Hlaing Thaya township in Northern District. For those person, there are get permission from one of the organizer who support the workers development. The interview conducted when the employees attend the computer training class the one of the weekend day. It just picks up the person who wants to interview the question. Also, there are conducted in-depth interview to employers from difference two Factory Managers in Garment Manufacturing which run 1500 workers and around 600 workers in Hmawbi township in Northwest of the city of Yangon. For interview to those persons, it contact first to Union of Myanmar Federation of Chambers of Commerce and Industry (UMFCCI). Base on this, it is choosing the garment factories, then it targets the location due to time consuming.

Table 10: Contributors' perceptions

Contributors	Position	Factory	Location (Township)	Number of Worker
Employer 1(Er1)	Manager	Garment	Hmawbi	1500
Employer 2(Er2)	Manager	Garment	Hmawbi	600
Employee 1(Ee1)	Worker's Leader	Shoe	Hlaingthaya	1200
Employee 2(Ee2)	Worker	Sunflower Manufacturing	Hlaingthaya	500

Regarding the current health services in the Social Security Scheme, both employees feel insufficient service due to two reasons: first, it is difficult to go out during the office hours from their factory and second, Social Security clinics are open office hours even office hours sometime open late the clinic as poor service from Social Security health care provider. Also, the employee worry contracting service will discriminate among the others patients as giving poor quality medicine as well as worry for high contribution rate from their salary. In addition, Er1 think that contracting health service nothing change for worker because of current health system from both public and private are still weak in service delivery.

5.6 Current Providers' Perceptions

The Social Security Board own 3 general hospitals and 93 clinics as the whole country. However, for in depth interview, it would pick up from Worker's hospital because it stand long time for insured worker as well as it could useful for to catch up the level of the health facilities and multiple opinion from many people. The next group interview were current providers, 3 medical doctors who work in Medical and Surgical Wards and 2 nurses who work in Surgical ward at Worker's hospital in Yangon. Therefore, it totals 5 persons in this group. To get a chance to interview to those persons, it gets permission from the Social Security Board authority person and Medical Superintendent. After get permission from them, it could start the available wards. Some have long working in Worker's hospital as shone in table.

Table 11: Current Providers' Perceptions

Current Providers	Working Year
Current Provider 1 (CP1)	8 months
Current Provider 2 (CP2)	7 months
Current Provider 3 (CP3)	2 years
Current Provider4 (CP4)	10 years
Current Provider (CP5)	7 years

From the current provider perspective, they first explained the current health care service in Social Security Scheme. Base on this, the current health facilities are considered insufficient for workers. Also, there are fewer users for Social Security service because in surgical ward, the numbers of patient admitted are only half of the bedded capacity. In addition to that one of the current provider mention the quality of care will not fulfill the contracting service because of current situation of working habit in Myanmar. Again, it will be another issue for worker's socioeconomic factors drawback for their health status.

5.7 Current Users' Perceptions

It will be 3 persons who admit in surgical ward for different diseases. Their perceptions also important because of those people are currently admitted in Worker's hospital at that moment. To interview for current user, it need to permission from as current provider moreover from ward doctor to interview. Following that it just pick up the interviewees who willing to answer the question. All current users are difference background as from different education level and work place. Base on this, their subjective also varies for answering question.

Table 12: Current Users' Perceptions

Current User (Patients)	Type of job
CU1	Office Staff
CU2	Factory Worker
CU3	Mechanist

As current user perceptions for current health service from Social Security, they are satisfied with current services. However, it comes out again for relationship between employer and employee for mutual relationship. Also, the current provider thinks for contracting service should balance all stakeholders as contribution rate.

5.8 Group Discussion

Group discussion was conducted in Yangon. Pt2, Pt3 and Pt4 represent contractor and current provider. The rest Pt1, Pt5, Pt6 and Pt7 are providers. To be more detailed, Pt2 and Pt3 are already answered the in-depth interview but they can discuss again with others participants. Pt4 is new participant who is working the Social Security clinic. Also, Pt6 and Pt7 are new participants from provider side who working in Medical Center. The rest Pt1 is who run clinic and Pt5 is who run the MMU service for Social Security Board are passed through in-depth interview. For group discussion, it already gives all interviewees since in-depth interview. Therefore, it exactly knows who want to attend and who are not attend. Base on this, some are interest to attend the group discussion for further information as well as some new participants join the group discussion because of the contractors want to give more information to their future providers.

Table 13: Group Discussion

Participants	Working Place
Pt1	Medical University, Clinic Owner
Pt2	Social Security Board
Pt3	Social Security Clinic
Pt4	Social Security Board
Pt5	Mobile Medical Unit
Pt6	Medical Center
Pt7	Medical Center

From the group discussion, it mainly concern for current situation health service in Myanmar and review international experience from other countries. All questions are the same from in depth interview. Actually, it more look like brain storming for current problem which both contractor and provider face to set up the contracting. Most of participants are pass the in-depth interview but still unclear thing for some contracting services. On top of this, all participants discuss their opinions. Thus it will support in next chapter which analysis the problem and finding way for potential for contracting which relevant current situation.

As a result of group discussion, the participants can find out the way of possible contracting which match is current situation. Also, the contractor can get how they should manage and accept for insurance worker. For example, to set the medical checkup for annually or six months by using accept form or denial form as well as fully responsible primary care service as opening new account for individual prevention service as international standard, to give awareness to training for trainer to facilitate the develop the plan, to re-design for internal organization as motivate qualify workers and important role of research and planning to find out the needs to set the objective, to coordinate with other department as umbrella organization in Ministry of Labor as effective and efficient way of delivery Social Security services. Also, as quality assurance, Social Security considers giving for more salary than the government as incentive for contracting to provider. All of information is useful for both contractor and provider because they never discuss for those general things as

before. Even though they have their own idea in order to their different background and knowledge, they have less chance to share idea for as group discussion.

5.9 SUMMARY FROM RESULT

There are some additional information that came out which doesn't seem directly related to the study by conducting the in depth interview. However, in this chapter, it mainly focus on contracting health services which is possible way for improving in current situation for Social Security. Hence, information that is not relevant was dropped for discussion.

5.9.1 Reason for contracting from Contractor side

This is summary from all contractors' opinion for contracting.

According to C3 contracting clinical services could offer effective medical care for workers, regardless of the fact that increased utilization could mean more time spent away from work. Also, C4 added that health is most important for people life. C1 sees two reasons for contracting, namely (i) enough coverage for workers and (ii) split provider and purchaser role, which Thai and Japan currently use the way of health insurance system. Besides, C2 added the importance of offering good services for international factory for future as well as reduce burden for worker long claiming process, far distance to clinic for medical service and good communication with health care provider.

Thus, first of all, even though there are many things needed to reform the Social Security Board, the Social Security nevertheless wants to start pharmacy contracting rather than general contracting. It could be either distribution of pharmacy to Social Security clinics or contracting pharmacy shop near the Social Security clinic. Its main purpose would be to allow workers to purchase medicines at the lowest possible cost to reduce out of pocket expenditures. Also, the Social Security Board wants to reduce the burden associated with the annual tender for purchasing medicine because of many weak points as uncertain amount for medicine, transportation fees, packing fees, wasting for expiry and difficult for store multiple drugs.

5.9.2 Opinion for contracting health services from other stakeholders

Regarding opinion for contracting, most of the interviewees' opinions are discussed here. The reason use for other stakeholders is this question is the same for all stakeholders as general question except contractor. Based on this, it could be categorized three level as (1) represent not agree for contracting, (2) represent agree with condition and (3) is totally agree for contracting. In this phase, total responds 13 people, among those persons only one person did not agree for contracting service saying that contracting is nothing changes for insured worker's health. Then, majority 9 person are agree with condition for contracting giving the reason for contracting is good but how the SSB manage or enough budget and 3 persons are totally agree for contracting service saying that contracting is good for worker health. In addition to that some interviewee said that government support is insufficient for insured workers thus contracting private for health services is necessary because private sector has competitive compared with public. It will upgrade for health status for insured workers. Some interviewees are not response for this question as saying that no idea or how to see future.

Table 14: Opinion for contracting health services from other stakeholders

No of Interviewees	Answers	Level of statement
1.Er1	Nothing change in contracting	Level 1
2. P10	Good, but should be sustainable	Level 2
3. P1	Good, but needs systematic plan	Level 2
4. P3	Good, but still plenty to do	Level 2
5. P2	Good, but difficult	Level 2
6. P4	Good for both sides, also workers	Level 2
7. Ee1	Happy but worry about high contribution	Level 2
8. CU1	Should have fair contribution for workers	Level 2
9. CP4	Should balance between contractor and provider	Level 2
10. CP1	Could improve in some circumstance for worker	Level 2
11. CP3	Better for patients & workers	Level 3
12. CU3	Contracting will better health status	Level 3
13. Er2	For better life, welcome	Level 3

When analyzed this question from all stakeholders, some people are know immediately and response, some are answer others things as saying it depend on how contractor set the fees and some are really no answer for this question. Thus, by analyzing the answer, even Social Security Board contract with outside provider, it may need more information for all stakeholders. By analyzing this question, it can find out the attitude of all stakeholders not only responds but also non-respond for

this question. It make aware if Social Security introduce the contracting service to stakeholders, it must clear and effective message for all.

The level one represent is contracting can't improve insured worker health.

The level two represent is contracting health service is good but if has enough budget or other drawback reasons.

The level three represent is contracting health service is need for worker for better life.

5.10 Discussion

In this section, it will discuss each internal and external problem for Social Security Board. Based on this the perception of all stake holders for contracting service will show which relevant with situation as well as from group discussion opinion for solution will be added for each issues. Beforehand, this some changes are described from Social Security Board.

5.10.1 Current situation of Social Security Scheme

There are a couple of comments from contractors for the organization.

C1 realized that "Social Security Scheme has not been successful in past because of several weak points. Under the old law, the key problems were weak contributions is not enough for coverage; poor services, less trust from both employers and employees."

C2 also comment for opinion of future expansion that "the old law coverage is quite low about 1% of population as well as low contribution according to 15 classes contribution rate which is 3,000 kyats for minimum and 30,000 kyats for maximum because everyone salary is above 30,000 kyats."

C3 comment that "We aim to increase effective benefits for worker flexible with current situation. Regarding to contracting health benefit, we expect that workers can accept more effective medical care because our clinics open only office hours, if we contract with outside provider the insured workers can get medical treatment after

office hours so they can escape difficult to go out office hours from their work place."

Nowadays, Social Security Scheme starts new law 2012 in 1st April 2014. In new law, there are 6 insurance system whereas 2 insurance system in old law. In addition, the new law accepts 15 types of job compared with old law accept 9 types of job. It means that increase the number of insured worker in new law because last time above 5 employees can enroll the Social Security Scheme. Also, the contribution rate increase.

5.10.2 Current management system in Social Security Scheme

To run the new law effectively, the Social Security Board increased the number of worker in each division as well as set up the new division in organization setting as audit and information technology (IT). The audit sector will responsible for check services from 77 branches of Social Security Scheme the whole Myanmar. Also, the information technology (IT) will support the smooth communication and share information because the computer card system will start use in new law.

At present, Social Security own 93 clinics and 3 general hospitals as the whole country. Among those health facilities, 22 clinics are located in Yangon. Also, Social Security contract health workers from Ministry of Health (MOH) to run the health services. The rest clinic are situated depend on the insured worker population.

C2 explained the how Social Security manage the distribution health service in current. It seems depend on location as well as number of insured worker population.

Regarding settle the clinic, C2 explained that "the cost of operating the clinic is quite high as land, labor, building and office equipment prices are high. Thus, it needs to consider the monthly income from contribution rate for investment. As a consequence, a few worker places will still far from medical service."

For financial management, the Social Security use government budget account as collecting all contribution then give to all contribution to government then propose again for all cost will going to use. The cost of Social Security spends about a half for monthly usage within the limit amount from government budget. However, this system change since October 2013, now Social Security stand own account for running service. Therefore, now all cost including benefits for workers and office spend as transportation use from the current account from Social Security Board expect Social Security worker's salary.

5.11 Analyzing the answers

From the in depth interviews from all stakeholders, we can deduce two main categories. The first parts will be the analysis the problem for contracting and the other part will be the potential for contracting. In addition, some idea from group discussion from brain storming will support to solve out the problem for possible solution.

However, even though the Social Security fills up the quantity of man power for internal organization, there are still have many problems. Thus, it could be separate two parts of problem as internal reforming organization and external dealing with problems for contracting services.

5.11.1 Analyzing the problem

There are two main parts of problems: internal and external. For internal problem, the Social Security still weak for reforming to increase quantity and quality of services. To prepare for this part, Social Security needs to change their staff mindset as well as support the in service training which is apply for technical terms and quality services. According to conceptual framework, the contractor should enough and strong financial and management for capacity. Currently, Social Security Board increase for departments and workers. However, even though increase the work force, there are still need to change the mind set for staff both office side and health services sectors side. Therefore, it could support for quantity as well as quality for improvement.

For external problem, the Social Security needs to negotiate to external parts as providers regarding to contractual relationship in conceptual framework and others professional for setting contracting terms. To be more detailed, both contractor and provider negotiate for contracting process as setting objective. However, in this phase, Social Security needs to find out the requirements for insured workers. Thus, the research and planning become important part. Then, setting the objective for contracting and manage the process. Currently, the Social Security haven't find out yet for contracting. It just set the general objective as reduce out of pocket, effective health care for workers. It will be continued for develop the process for contract in future. Also, the contractor and provider are discuss for contract formality, it get same result both of them are enjoy formal way as reward and sanction for contracting, it will be include for next contract term for provider. In addition, the contractor side considers the third party evaluation team but the contractor side request to MOH for it. However, the contractor will set up the team if the MOH will not organize for monitoring and evaluation team. For payment mechanism, it is also the same attitude between contractor and provider as reimbursement system for contracting services. At present, both sides want to continue reimbursement then it will test the payment system step by step. For referral system, although it is not clear answer for in this stage, it supposed to make clear instruction for insured workers and providers in contracting. It result come out from group discussion.

5.11.2 Potential for contracting

After analyzing the problem, it could be guess for some service for contracting. Even though there will be many requirements for contracting services, it could start local way rather than international standard for initial stage. It seems that Social Security could start specific contract for pharmacy. Following that they plan step by step for other services as clinic, polyclinic and hospital.

5.11.3 Reforming internal organization

There are a couple of things to reset the Social Security Board. First of all, the Social Security needs to upgrade their workers ability by giving them technical support. Another thing is the need to change the mindset to deliver effective services. C2 mentioned when interview as follows:

“For monitoring and evaluation, main office is too busy. Our business also involves clinics. These normally have 2 nurses and 1 doctor or 2 nurses and 2 doctors. It needs to increase workers who understand about medicine and include at least one pharmacist. Other way, we need to upgrade the current worker quality and change management process from our side”.

C2 continued that “Sometimes, even we give correct treatment to person it takes time for half day due to long queue or long distance to the clinic. Sometimes, our service has a bad image compared with private service. When we scold the person for forgetting record or not following our order, it will prevent the person from coming again.”

In addition, Ee1 comment the current service of Social Security as follows.

“We just hold SSB card but for using service it is not effective, because of their office hours. Even if the clinic opens at 9 am, in reality the clinic opens at 10 am. Sometimes nurse and doctor come late so we need to wait. We want to escape having our salary deducted, thus we go SSB clinic during lunch time but then they take break time. So after 4pm we go SSB clinic, but then the clinic is close.”

CP2 explain that “in the ward situation, 40 bedded capacities are just over a half of patients admitting in hospital. Thus, it means that less user in current service among insured workers.”

This fact points out that the Social Security service is less use among insured worker. It is more clear when the group discussion discuss for how to set the objective for contracting. It necessary needs to do research for customer needs. Thus, the planning and research division need to fill up the part.

In addition to that the Pt4 admit that there are a few people interest to attend seminar and foreign lecture. Thus, it is always the same people who attend foreign capacity building programs.

Therefore, there are two main parts for reforming internal organization as changing the mind set the workers for quality issue which motivate to awareness training for forward organization services because some internal body are useful for future plan of Social Security. At the same time, the Social Security could support for the purpose of worker capability of working as using software for computer system.

Currently, the Social Security Board faces the problem for current health services review from the analysis above.

- Limited time of clinic hours it has leads to less trust from both employees and employers as well as less utilization for service.
- Insufficient health worker in work place makes to poor quality of service and poor relationship because of tight schedule.
- Poor health facilities increase catastrophic health care expenditure for insured worker.

Thus, there are less utilization, poor quality of services and high of out of pocket money from insured workers from current health services.

5.11.4 Negotiating with external organizations

Just planning the initial stage, there are many requirements for Social Security Board as well as many challenges because there is no institution for contracting in Myanmar. Next, the Social Security needs to discuss with private sectors for delivery health care services. In this regard, the discussion will start the requirement for contracting terms. Thus, the provider P9 comments as follows.

"Social Security Board (SSB) turns to private sector, but in this case, do they have a ceiling price, i.e. the level of treatment cost which set the offer amount for cases as hepatitis C, renal dialysis etc. Can the SSB afford it? They haven't prepared yet for inclusion & exclusion criteria. There is no defined benefit package. Thus, SSB wants to discuss. Preliminary discussions with MOH, but they haven't started yet. Also, they have no package identification, economic evaluation for observe the service whether effective or not, unit cost for each intervention and provider payment mechanism."

C1 also comment that “it will take time for standardized medical procedure. The medical provider sends to third party the medical record. This team has in Japan & Thai. We need third party which includes doctors to check correct treatment or not. If those parts become settle, we can start contracting.”

Therefore, the contractor side also knows what they need to settle for contracting services. However, it will take time to develop for such things.

5.11.5 Contracting with public sector

Again, the Social Security supposed to contract with both public and private sectors. However, the current situation of health system and payment mechanism seems to delay contract with public contracting. Due to practice the same payment system as line item payment which fix amount for annual cost. Next, there is no service charge which is not paid for medical workers from patient in public sector whereas private sector includes exactly service charges. Here are both P9 and C2 comment as following.

“The payment is reimbursement. The worker needs to pay first then claim from Social Security Board (SSB). The way is impossible because Myanmar health care system is arrange the historical line item budget which is input from start year from end of the year because all cost are fixed already. Thus, the Ministry of Health (MOH) can’t accept until now for those contracting.”

“Also, in government hospital, there are no include service charges but private hospital, it will be exactly included service charges. But government hospital will not include service charges. We are not given for service charges now as well as in future. If we give service charges for private sector, we need to pay for public sector for government hospital. Then, patient choose only private sector, it will destroy for government hospital side. Actually, we haven’t decided yet for those things.”

Thus, it is clear that the current situations of both sides are not ready to contract with Social Security and public sector due to payment mechanism and services charges.

5.11.6 Contracting with private sector

So, the Social Security Board tries to deal with private sector for contracting. It seems possible for some specific contracting. Currently, the Social Security Board contracts with Mobile Medical Unit (MMU) service for delivery health service as a pilot test starts in March. This MMU service is contract MMU (Medical Mobile Unit) which include X-ray, Ultra sound, ECG & Lab as well as medicine mobile car. The purpose of this contract is to deliver for portable service for insured workers. Thus, these mobile cars go around with factories together Social Security's medical workers.

5.11.7 Differences in Capacity and Strategy among Private Providers

After interviewed to private providers, there are differences in terms of capacity and management systems. All private providers are diverse according to their main services and responsibility. All of them offer different services depending on their capacity. However, some private providers seem willing to contract specific services and even they have general health care services.

P1 who is responsible Executive Director, run the health care service about 15 years for 100 bedded capacity and 300 workers saying that "If they contract with clinics, we will not accept it even though we can offer the service because in my opinion, we are able to contract all services. Also I think it is easy for worker which can get service in one place without pickup from different places. We also have economy class as well as high class but I can't fix for room."

However, another P4 who is administrator also shareholder in hospital service about 25 years mainly responsible for investigation, operation & diagnostic 25 bedded capacity and 40 workers. P4 just interest for specific contract, it will better for us because we have limited ability.

It is clear that for the private providers interest for contracting depend on their capacity. Also, the private providers manage the difference way of financial and management system. Some are use informal way their internal organization, some give incentive and some arrange for workers vacation for annually.

5.11.8 Opinion for objective of contracting

Regarding for setting objective, it is only from contractor side answer some objective for generally. Most of the provider who interest for contracting with Social Security answer negotiate and try to follow the contractor side. Here, some contractor set objective for contracting.

C3 answer that "Our clinics are open only during office hours. If we contract with outside providers, the insured workers can get medical treatment after office hours so they can escape difficult to go out during working hours from their work place. Thus, I think the contracting private clinic & hospital for effective medical care."

C1 also told that "we need to get trust from employees and employers, if those people trust to SSB, the number of workers will increase, so the financial also will become strong, as a consequence, we can be responsible for more of the workers who really need health care. This is the objective for contracting."

C2 said that "some patients invest first for health services, some patient pay high interests for debt, some patient are selling their assets they can't buy again when they receive claim money from Social Security. Thus, we want to prevent for those long processing. This is the reason for contracting. For private, they could spend and invest in pharmacy service compared with patient".

However, the provider answer the objective will depend on contractor side. It could be negotiate when the contractor show the objective by try to fix the facts. It is clear that private provider prefer to deal with contractor. Thus, it is only confirm for objective for contracting services. Base on this, it can say general objective for contracting. Therefore, it general objective for contracting are to increase utilization, to build up trust relationship from contributories and to reduce out of pocket expenditure for worker and to offer better health care service.

5.12 Strategic plans for requirement of contracting

In this phase, it will be discuss both perceptions from contractor and provider for some contracting terms. Finally, it can summarize for each terms which possible and

acceptance from both sides. It will be included management and evaluation, contract duration and contract formality.

5.12.1 Monitoring and Evaluation (M & E)

There are some opinion for monitoring and evaluation from contractor side.

After interview to contractor side, they have plan for management and evaluation in future.

The C1 explained that “we need third party which includes doctors to check whether the treatment is correct or not. The medical providers should send the medical records to the third party. This team exists in Japan and Thailand. If those parts become settled, we can start contracting. I told to Ministry of Health (MOH) to organize the national health committee. If Ministry of Health (MOH) does not set the team, we will set by ourselves. Then, this team must be responsible for correct procedures for claims processing. It will be formal way which observes for reward and sanction.”

C2 said that “we will check from pharmacy service as well because the pharmacy side will twist wrong amount, for example 7 medicines instead of 5 medicines, claiming from other patients’ medicine who are not insured workers and check medical record whether valid treatment or not. So we need to organize a team for monitoring and evaluation which is not sensitive in regionally.”

Therefore, it clear that the contractor side well known how importance for management and evaluation in contracting services whether general or specific services.

On the other hand, the provider opinion for contracting will describe provider own management and attitude of monitoring and evaluation for contracting.

P1 said that “for external body, I prefer dealing with the team for monitoring and evaluation. I won’t change my management plan but I will try some way to fit in the frame. I accept monitor & evaluation for contracting by negotiating both sides for including facts.”

P2 said that “we apply ISO guideline but not 100%. Normally, we start with rules and regulations, i.e. on the legal side. We accept internal audits, so we welcome monitoring and evaluation. Currently, we discuss for patient complain at meeting. The better way is M & E team spot check without informed to provider services.”

Thus, it is clear that there is not a big difference answer for management and evaluation team for both contractor and provider side. Most of the providers are welcome for M & E.

5.12.2 Contract duration

Regarding contract duration, both contractor and provider prefer short time as 1 year contracting. Some providers are saying that it could be negotiated later. Thus, in this part also seems quite easy for both sides. The reason they choose 1 year is that the initial stage for both sides. Base on the first contract year, they can observe and decide for the contracting. This is some answer from contractor and providers.

C1 comment that “Contract duration will 1 year at beginning.”

C2 explain that “contract duration, ‘currently we set 6 months for contract MMU (Medical Mobile Unit) which include X-ray, Ultra sound, ECG & Lab.’ We adjust the situation and decide for continuing.”

P1 express that “I think, it is better for contracting year at least 2 or 3 years for realize as evaluation. It will be 1 year in first contract later we increase.”

P2 also comment that “For contract duration, we negotiate for it.”

5.12.3 Payment mechanism

For the contracting services, the payment mechanism for provider is main important part. There are many types of payment mechanism for contracting as capitation, co-payment, pre-payment and case-base payment. However, at the initial stage for contracting, both provider and contractor prefer reinvestment system for contracting. It means that the provider will invest first then claim from contractor. Again, there is need to share more information for those contracting terms both contractor and provider because some people misunderstanding often claiming period and payment

system. Actually, there are some private companies and some International Non-Government Organization (INGO) are arrange medical care for their worker as type of co-payment system. This is some example from providers experience for payment system.

The P1 said that “currently, I give service for company in the form of giving service for worker then the owner gives the fees. For example, the cost is 120,000 kyat. The company will pay 100,000 kyats then the worker will pay 20,000 kyat. The company will deduct from salary by according to worker position. It is clear for us. We no need to do money matter.”

Also, another provider who works in INGO explains how they arrange for worker health services as follows.

“For medical contract, it will be ceiling price, even ceiling will vary as minor illness is quite OK, but it become major case, how they will consider for individual as inclusion and exclusion criteria. Even, inclusion, for example, here we offer medical benefit for worker but limit amount per time. The cost set 10,000 kyat for individual but set 3,000,000 kyats for one year.”

Therefore, to facilitate for those development part, it still need information as much as possible because people consider payment mechanism is important for contracting services and pros and cons of each payment system. At the initial stage of contracting, there are many things to set up including payment mechanism. The C1 said that “Payment System will continue reinvestment. In Myanmar, no one has started capitation yet. Capitation may be test through contracting. But this payment will lead to low standard and poor service, next fee for service will be better but it will increase volume which makes burden for us. We will adjust gradually for payment system by testing.”

From both side of opinion for payment mechanism, it will continued reimbursement also it could be possible because the contracting service will start big city as Yangon. Therefore, it could be closely observe the services but it expense the whole country level, the payment system necessary to consider in contracting.

5.12.4 Relationship between contractor and provider

In this sector, the contractors prefer formal way of contracting with private the saying that formal way which observes for reward and sanction. However, some private providers are difference attitude for contract formality. Some are agree to formal relationship with contractor whereas some prefer informal way as negotiate during the contracting process.

In this case, the contractor could deal with those people for adjusting the time period because currently, contractor start contract service with private as a pilot test for observing. It is also possible negotiate with contractor and provider.

From the strategic plan for requirement of contracting, both contractor and provider seems positive way for those management and evaluation, contract duration, contract relationship and payment mechanism. Most of the provider and contractor express their feeling repeat the word as the negotiating for payment, contract duration and contract formality.

5.12.5 Referral System

This is important for practical work in contracting rather than agreement with oral or written paper because it is important service link between primary, secondary and tertiary care in contracting service. Here, some private provider opinion for their hospitals service as below.

P1 said that “We also have economy class as well as high class but I can’t fix for room. Currently, we run for service if room available for patient, they can admit here. But if unavailable we can’t accept patient. It is impossible to fix room for SSS patient permanent. Also, drug list can’t separate for SSS because no standardized medicine in Myanmar. Next, doctor, we can’t set fix doctor for SSS also price for those doctor because of different specialist fees.”

P3 also explain current their service the way they offer “Even inpatient, we can’t offer for SSS patient as permanent room, if we have vacancy, they can get. Otherwise, they transfer to other contracting hospital.”

From the provider side, it will be challenge for private sector as room boarding. Many of them are express that impossible to fix with room for Social Security patients. In this regard, if Social Security starts the hospital contracting, it will be a main part of discussion between both contractor and provider.

Regarding the current process of medical service in Social Security Scheme, the CP1 explains as follows.

"The insured workers need to go clinic for medical treatment. If they are not recovering from clinic, the clinic doctor transfers to Worker Hospital in case the patient can move to government hospital as necessary. This is the current process of Social Security health service."

Also, C1 added the process of medical care from Social Security Scheme.

"In primary care, SSB clinics offer medical care, for secondary refer to worker hospital or general hospital & tertiary can go specialist hospital as cancer hospital."

Here, the contractor thinks for contracting hospital service.

C1said that "we supposed to contract for secondary & tertiary services. We will discuss first to provider as essential drug not luxury, accommodation classify etc. For example, our services for maternity will about 60,000 kyats but it will high in SSC hospital as 100,000 kyat, so the provider deals with patient to pay for partial money."

Thus, it will be negotiate with both contractor and provider for referral system, also the contractor side thinks that they need to negotiate and to standardized for contracting service in future.

5.13 Primary care service (clinic contracting)

In this phase, it needs to explain the current responsible from Social Security for primary care service as more similar curative care for worker because of lack of preventive care for patient. Primary care will consider preventive, promotive and rehabilitative. However, it will be complete offer in new law. From the group discussion, Pt2 explained for primary care plan in new law.

"In new law, individual account will include cost for prevention which will include the procedure as necessary for condition. The cost will include health education as hand washing, health talk for preventive care."

Regarding contracting clinic service, there are two level of clinic what is called outpatient clinic which give treatment for minor illness without investigation and polyclinic which include investigation and minor surgery. In order to classify the level,

they need difference requirement. The C2 comment for those services requirement as follows.

“For clinic contracting, it needs to think types of medicine and medicine price. But some clinics as polyclinic level, we need to consider for service charges for minor surgery.”

It appears quite easy for contracting with clinic but here some provider comment for some difficult part for clinic contracting as follows. P1 has clinic and hospital including investigation.

P1 said that “drug list can’t separate for Social Security patient because no standardized medicine in Myanmar.” Next, doctor, we can’t set fix doctor for SSS also price for those doctor because of different specialist fees.

P3 added that “for clinic the specialist will be main person. We just rent the room and service only. If SSB want to contract for clinic, the specialist fees will difficult because those people are not permanent worker in hospital, just come and see the patient for a while and take different charges among different specialist.”

However, the Social Security need to find out the customer needs. For example, they need to conduct on-site visits. When interviewing in Hmawbi which situated in Northwest of Yangon, where some garment factory is located, it became apparent that there are poor health facilities as some clinic and a few medical doctors.

The Ee1 comment that “I do not encourage contracting private service because is the situation will remain unchanged because here even the private sector has insufficient facilities. For example, even big population, only one doctor takes care for those people. How the service will improve?”

Er2 suggest that “they should contract broadly as geographical location. For example, contract with sub-urban area which factory worker reach easily for use those service. At least, it should be polyclinic level. Then, they should choose the class for services.”

Therefore, it could be easy to contract with clinic rather than polyclinic.

5.14 Secondary care (hospital contracting)

Regarding hospital contracting, C2 explained that “If contract with private hospital, ‘it will be four standardized things as services charges, procedure, choose the types of medicine & medicine price.”

For setting the ceiling price which set the level for maximum price of cost for hospitalization , P1 comment that “I heard meeting from SSS, for contracting but no one can answer from provider side for it thus need to do often workshop. One time, they said that they would set the ceiling price. But for setting ceiling price in private is difficult because of different setting, different price among private hospitals thus the possible way is organize the same level of hospitals setting then set the price .”

However, it will take time due to many requirements as inclusion and exclusion criteria, celling price, referral link. There are some hospital interests for contract with Social Security but without preparing for those outlines, Social Security still considering for hospital contracting.

5.15 Pharmacy contracting

This pharmacy contracting is the Social Security want to start contract with private sector. Last time, the Social Security buys medicine and distribute again for Social Security clinic. In this service, the Social Security find out several weak point as transportation fees, parking fees, expiry of medicine and limited amount of medicine. To escape for those processes, the Social Security wants to contract either distribution pharmacy for Social Security clinic or contracting pharmacy shop. Also, it easy for worker by using card as well as reduce out of pocket money for them.

However, this service also has weak point. Pt2 comment that “this service also has weak point. Sometime, those services will suspect as provider used poor quality from border region then show the high price. Also, it could be suspected provider & doctor together saying that the using for poor quality medicine. But those medicines are already in patient stomach. We cannot see far from our observation.”

5.16 Quality issue for contracting health service

The main purposes of contracting are increase utilization, improve quality and assess. Thus, the quality is important in contracting health service. The Social Security also supposed to emphasize quality issue. However, many things to deal with external organization, the Social Security worry for quality care for their patient.

Pt2 said that "If we contract with private, we request specialist fees but we worry it will discriminate our patient. We are unable to contract very famous hospital because they have already full patient with their price. Thus, they will not interest to contact with us."

Also, the Ee1 worry the discriminate the Social Security patient and other patient as giving poor quality medicine. In addition, the Er1 believe that the contracting health service could not achieve the quality care because of current practice of health care provider. It is confirm that the CP1 explain as following.

"In foreign country, the doctor has private room, salary so apart from duty hours, this doctor can rest. But here even our colleagues off duty from hospital, they still need to work outside private hospital. Anyway, the quality service will reduce even private set up international standard ratio for job satisfaction because we are human."

Thus, the contracting health service will not reach the full standard quality care for worker as mention from some stakeholders. It will discuss when group discussion for quality issues.

5.16.1 Summary for analyzing the problems

For summarized the problem of contracting, there are two types of problems to improve quality and ability internal organization and to deal with terms for contracting external sector which can solve out gradually all changes. Anyway, all problems as we find out above are necessary face when the Social Security Board starts the contracting. Also, if we see roughly, the problems are rather than potential for contracting. It is clear that without institution, without preparing infrastructure and

underline costs, there are many problems to start contracting. At the meantime, the Social Security Board wants to start specific contract rather than general contracting. From analyzing the each specific contracting which Social Security supposed to do in future, every contract has problems because of as I mention above lack of preparing requirements at current situation. Thus, it can classify all specific contracting in order to their requirements. This is the results from analyzing the problem.

Table 15: Summary for analyzing the problems

Reforming internal organization ➢ to change the mindset ➢ to upgrade their workers ability
Negotiating with external organizations **Contracting with public sector** ➢ Used to the same payment system ➢ To deal for service charges
Contracting with private sector Most of the providers negotiate for contract. ➢ Accept M & E ➢ Prefer short duration ➢ Prefer reimbursement ➢ Interest formal way ➢ Negotiate for referral system

5.16.2 Potential for contracting

The following table shows the types of contracting which Social Security Board.

Table 16: Potential for contracting

(1) Pharmacy contracting • Set the drug list & price • Deal with pharmacy shop • Monitoring and Evaluation	**(2) Clinic contracting** • Set the essential drug list & price • Set the visit fees • Set the salary • Monitoring and Evaluation
(3) Polyclinic contracting • Set the essential drug list & type • Service charges • Specialist fees • Investigation fees • Monitoring & Evaluation	**(4) Hospital contracting** • Set the essential drug list & type • Services charges • Investigation fees • Specialist fees • Room boarding • Referral system

Therefore, it seems the pharmacy contracting is the fewer requirements to deal with private owner. In Myanmar, there are no standardized medicines thus it is a bit challenge to set the medicine type. However, the Social Security thinks to set the certain type for medicine, apart from the list of medicine the insured worker needs to spend cash. Then claim from Social Security. It will reduce out of pocket expenditure for insured worker.

Following that the clinic contracting, currently the Social Security has survey for visit fees but haven't settle yet for salary for doctors. Therefore, it could be delay to start for this service.

Next, Polyclinic, it more requirement as dealing specialist fees, services charges, investigation.

Last, hospital contracting, currently, the Social Security hasn't prepared yet for inclusion & exclusion criteria, case per cost, referral link etc. Even to set the ceiling price for hospital cost also not easy because of unexpected of medical problem.

Therefore, according to current situation of Social Security Board and country, it probably contract for pharmacy contract. Also, there are still need to give information to insured workers for all processing as describe clearly how they can get service and how much they can get from the contract service.

5.17 Outcome from group discussion

Actually, the group discussion is look like bran storming because some participants are already past the in-depth interview. Generally, the outcome of group discussion will describe the requirements for changing current organization. Then it will find the way for contracting services.

Regarding the requirements for changing current organization, there are some facts are need as follows.

- To change the mind set of worker
- To set rule and regulation for health services
- To work together other departments for effective and efficient outcomes

Here, it can get some useful answer from sharing experience from participants. Firstly, regarding setting to objective, there are some answer come out how to set the objective in order to insured worker needs following that it can find out Social Security need to do research for insured worker needs. Then, the department of planning and research become important role in Social Security Board. As a result, Social Security need to change the mind set of their workers. Here, some participants discuss for setting objective.

Pt1 mention that "After finding needs it will be one or more than there, currently, for contracting specific health services , SSB haven't find yet for needs also even they

know haven't develop yet. For finding needs, we need much research as we currently find the way."

Following that the requirement finds out to change the internal reforming as mind set of office workers to motivate in work.

Pt4 said that "If we do work shop, we should invite to whom? Thus, I ask MDRI Apart from policy maker, I has another problem as even the foreigner give lecture, I has no qualify worker to learn it. Thus, I repeat a few person, other are no interest in those thing."

Therefore, to set the objective for contracting, the Social Security must find the needs of insured workers. Also, Social Security recognizes the important of research for setting objective. Following that change the mindset of worker to motivate and support for technical knowledge for worker.

Next, the contractor gets profit for information which could apply in new law how to manage the medical checkup time with contributors because there are two process for to become Social Security. First, the worker needs pre- employment assessment for medical checkup. If become employee in company, need to do medical checkup again to become Social Security worker. The problem is no pre-social security assessment. Also, regarding medical checkup, the Social Security needs to set the time for annually or 6 months. In this phase, Pt1 suggest that as following.

"Foreign country, there are using request form as well as deny form for medical checkup. So, the employer refuse to follow regular checkup, they should submit deny form meaning that responsible if worker something happen at that time. We should go this way as 6 month or annual. By doing this the cost of prevention also will be reduced."

Related with prevention, it could be complete care for primary because last time, Social Security stands clinic service as curative without prevention. Now, Pt2 plan in new law to deliver for primary care as follows.

“In new law, individual account will include cost for prevention cost which will include the procedure as necessary for condition. The cost will include health education as hand washing, health talk for preventive care.”

In addition, the contractor noted that from Thailand experience as Social Security working together Occupational safety which check for safety environment in work area. So, it will less cost for medical treatment Social Security because the occupational safety responsible for checking the working environment for worker. This is also contractor share the experience from other country. However, Social Security in Myanmar is responsible for not only for medical but also for social in current.

Thus, the Pt1 comment that “So you can say that pros & cons to add two departments because it couldn’t say exactly we will get benefit only, actually if we could do occupational safety, the SSS side less to treat the worker.”

Regarding contracting services, there are some participants discuss for possible way because some problem are mention already above sections. Thus, in this part, it will describe the way of approach for some contracting. Also, it will present step by step for all contracting which Social Security plan in future. In the first phase, regarding pharmacy contracting, some participants are discusses as follows.

Contracting pharmacy, it could be check related disease for monitoring and evaluation. Also, no standardization medicine in Myanmar, thus Pt2 think that to set the certain drug list. Apart from that list of medicine, the insured worker needs to pay cash but it will spend less than before. Other participants also agree this idea because this is relevant with current situation.

Pt2 think that “For contract pharmacy as Yangon, according to location, we contract pharmacy suitable township, so the patient can take medicine easily less spend cash pay then patient can claim later.. We think as least as out of pocket from patient.”

Pt6 suggest that “So we need essential drug list.”

As ranking the requirements to deal with the level of service, the clinic contracting follows after pharmacy. Regarding clinic contracting, some participants are discusses as follows. Apart from requirement for clinic contracting, the participants discuss the standard of clinic facilities.

Pt1 describe that " As clinic level, we should standardize as doctor who give management & diagnostic only, so no need to consider for injection, it will responsible nurse. Then, the pharmacy should close the clinic. Thus, we should guideline as primary, secondary which plan exclusion & inclusion criteria, referral system, price etc."

Also, Pt1 who own the clinic propose for clinic as full facilities as 1 doctor, 1 nurse and 1 pharmacist or pharmacy close with clinic for smooth service.

However, the contractor should consider as customer needs as well as geographical location and population as patient per doctor.

Next, the participants are considers for hospital and polyclinic contracting. In this case, it will describe the possible way for contract because all requirements are mention above hospital contracting already.

The Pt2 consider that for contracting hospital service as "The one solution is we fix amount for hospital cost. So, the contract hospital will get full cost from our fix cost and additional from patient. Patient should choose which one suitable with them."

Pt6 recommend that "Currently, it is the easy way because different hospital has different price. So it will be different when patient choice as living hall or private room."

However, Pt2 concern hospital contracting hospital service as follows.

"If we contract with private, we request specialist fees but we worry it will discriminate our patient. We are unable to contract very famous hospital because they have already full patient with their price. Thus, they will not interest to contact with us."

It will directly effect to quality care of service in contracting. Thus, all discussion above for contracting whether primary or secondary, some participants comment as follows.

In this case Pt1 think that “Regarding contracting health service primary or secondary, all procedure and process should give information to customers openly. The rest are their choice because of people nature. By doing this, the problem will reduce for service.”

Pt6 also comment that “I understand what you mean. After 2010 update health care system, patient should be decision maker. Others doctors and medical person are giving advice only. Just explain disease, procedure, consequences.”

To concluder for contracting specific services, there are needs for setting for some necessary as M & E, inclusion & exclusion criteria and standardization of procedure etc. Also, the way of delivery health service also important because different education background. It is quite useful facts for contractor when they deal with provider as well as awareness to contributors for contracting service.

For quality issue, some participants share their opinion as follows.

Pt1 comment that “If we compared with other country, our hospital both private and public hospital are poor organization setting because for 7 days must has permanent 7 specialist doctors & assistant. No need to do other outside work. Here, hospital has only part time specialist. So, SSB should settle first.”

However, Pt2 said that the idea is impossible in current. Also, Pt2 mention that private service is better than private.

In group discussion, Pt4 discuss regarding maximum or minimum net income for Social Security doctor. Pt4 explained that the first step, the Social Security will stand independent organization then the Social Security can set the salary for doctors. It must be higher than government salary for motivation.

Regarding this question, Pt4 explain that “We have plan for the rule of finance because the SSB was 1956 to 1962 in independent then 1963 to 2012 SSB become under government. Now, we want to change independent body after 2012 but there are no document for the independent organization of the rule and regulation of finance. Thus, I consider for international as how they settle the rule and regulation of independent organization, standing order by doing research, hire expert person as understanding law, finance, statics then we draw our own. After that we could set the salary for our doctor & worker. It will be higher than government salary. Anyway, the salary is must higher to motivate worker. So, the more patient increase, the more doctors earn money. So, the performance will improve.”

Pt1 suggest that to limit the number of patient per doctor to keep the quality control.

However, private service is better than private service. In group discussion, the participants agree this point. In addition Ee2 also comment the quality care improve in Myanmar compare with previous time.

Thus, it seems contracting service could improve quality care service even though it could not reach the international level.

Regarding quality care, Pt2 and Pt4 explain the plan for future.

Pt2 continued that the plan "*We have 2 plans. The first plan is contract with outside provider & the second is we will run the service not from contribution from the person who can invest the service. Thus, we have survey from them as some are 500 kyat, some are 1000 kyat for consultant fees. So I decide 1000 kyat as consultant fees. For other additional service will add in as injection.*"

Therefore, the Social Security Board will run service not only contracting out with private but also franchise service which

Pt4 said that "*As international, the contracting system is succeeding, the situation in here, we can't stop immediately our service but we upgrade those clinic & hospital while we contract those services with outside provider. We will reduce clinic one by one, by doing this we could increase doctor for quality service as in our left clinic.*"

The conclusion from the quality issue, the Social security plans not only contracting service to set the M&E team but also for their current service. Even though, the quality is can't compare with other countries, it will better service and treatment in private sector.

Moreover, the results are the same for strategic plan for contracting term as contract duration, contract formality, M & E and payment mechanism. In this part, only Pt4 discuss the all things. Therefore, the answers are the same before as in-depth interview. As contract duration is one year, formal way will contract service; it will set M & E team in future and reinvestment for provider payment mechanism. It seems that the participants think that those things will negotiate later.

5.18 Strategic steps for contracting

Figure 3: Infrastructure for contracting of Social Security Scheme

From the analyzing the answers from all stakeholders, there are three main things the Social Security Board need to set as mention in figure. As long standing organization in Myanmar, this organization has many week points due to political and economic situation in Myanmar. However, it could be roll out for those things if Social Security Board gradually change step by step resolution by setting short term and long term plan as Philhealth.

This is the result base on the analyzing the problems for contracting. From the table, we could see easily that at the first step the Social Security should start firm and warm relationship with contributories to earn their trust. The Social Security need to give information more and service for the contributories as setting for call center or phone number to enquiry for available service and information of Social Security. At the same time, the Social Security needs to re-design the internal organization as technical training and workshop. Another important thing is Social Security should set the rule and regulation for contracting plan how to manage the process, then negotiating with external organization to develop the contracting plan. Base on this, it could be reached the contracting.

However, for develop all stages, the Social Security will take time because it is the initial stage, nevertheless Social Security could start some changes when contracting specific services.

CHAPTER 6

CONCLUSION

From this study, it is main finding for what problems for contracting services and how to find the possible way for contracting which relevant current situation. Generally, Social Security can responsible for low coverage about 2.1% for total workforce and 250 cases per month for insured workers as using reimbursement system for outside services in current. Thus, contracting is alternative health care service for Social Security Board for solving this problem. This study is useful for Social Security Board which finds the perception for all stakeholders about 26 people by using secondary and primary data. Base on this, it could analyze the problems and looks forward for possible way for contracting.

From the discussion, there are a couple of problems both internal and external for the Social Security Board. It is no doubt that the organization which wants to renew and introduce new system will face those problems. Generally, the current situation and weak organization makes challenge for the Social Security Board. However, it should see our neighbor country experience and could apply well for introduce contracting health service to insured workers.

However, it could be possible to contract as pharmacy contracting and clinic contracting. Even though quality care is poor in Myanmar, the private health service and treatment is better than public sector. Also, contracting private for clinic health service will reduce burden for time consuming for workers. Anyway, we should think possible way which relevant current situation because the Social Security also could not start full facilities at the moment.

6.1 Suggestion from other country experiences

This is the one example from Cambodia with similar situation of poor health facilities as well as the highest out of pocket health care expenditure as Myanmar. The author Jacobs B, et al., (2009) showed that the case study of public to private and back again: sustaining a high service-delivery level during transition of management authority. In this study the performance of contracted health facilities is linked for consideration of financial incentive to administrator. Also, the way of keep back

management strategy is need and tidy because of already experience from first contract, the back again for health delivery is quite improve because of systematic strategic plan for delivery health.

Also, another case study (Soeters, 2003) found out from the improving government health services through contract management from Cambodia. Again, this is also mention that the utilization of health of health services increased after introduction of cast-sharing and incentive payments. In addition, even the office uses obviously increase following that the utilization also increase too. However, this cost is still lower than informal pay for patients. As I mention above case studies are contract with district health facilities to NGO and INGO.

Another experience from Philippines health insurance for contracting was written by (Bultman J, 2008). In this study, the PhilHealth insurance re-designs the contracting for developing capacity. There are two steps which re-design current situation and develop other plan by setting short term and long term. This is the way for probably could apply re-design for internal organization.

Actually from this study, we can see others country payment system as co-payment from Korea, Northlands and America. The way of contract as specific contract cataract surgery and pharmacy contract which easy to reimbursement for services. Korea, they use co-payment ceiling. By doing this, it could protect over enrolling the member as well as escape the catastrophic payment for household.

6.2 Key findings

To review from others countries as Cambodia experience (Jacobs B, 12 August 2009), it probably could apply in Social Security health services. By contracting INGO, there are benefits left for keep output health care level as well as good management skill for contractor. Another experience from Cambodia also point out the increase utilization (Soeters, 2003) by using incentive, the health workers are motivate in work place as a results the utilization level significantly increase. In addition, it is less informal pay to health worker because of the increase paid for contracting is still less the informal pay. This is the way of not only increase utilization but also improve quality for health workers by contractor side. In addition, it is study from (Bultman J, 2008), the way of re-design internal organization as well as setting systematic approach for future plan as short term and long term plan. It is quite similar situation

in Social Security Board current facing problem. Thus, it could operate for reforming internal and external dealing with private sector for contract term.

To determine the strategies for Social Security Scheme regarding contracting public and private sectors, it is impossible to contract with public in meanwhile because of payment system and services charges which exclude in public whereas private include for it. However, it could contract private sector starting specific contract as pharmacy contracting. Without standardization medicine in Myanmar, the Social Security Board considers to set the some medicine which has standard for insured worker. For this service, the insured worker impossible to get medicine from the doctor prescription but it could get some amount of medicine which contract with pharmacy shop. Anyway, it is the way of reduces out of pocket from insured worker. The Social Security will continue other services when the pharmacy contract succeeds.

To identify the perception of stakeholders for possible impact of contracting, firstly, it revises again 5.9.2 among those responds 13 stakeholders except contractor side, the majority people 9 are level 2 represent agree with condition and 3 persons are stand for level 3 total agree for contracting health service. Again, the result from group discussion, it comes out the suggestion the way of how to approach the contracting as clearly identify contracting service all stakeholders. To be more detailed, the consumers and providers will know what service they can get from contracting, how much they can get from contract service. Without inclusion and exclusion criteria in current situation, the participants are considers to set the certain amount for cost of medical service. Base on this, the insured worker could choose the accommodation and service by themselves.

Base on the responding the objectives, the current situation of health service in Social Security Scheme are insufficient for insured worker. Thus, even though the contracting service could not reach maximize health quality, utilization and access; it could solve out the present problem which insured worker face time limitation for to get health services. From group discussion, private service is better than public which increase quality and utilization in certain level. Anyway, it is necessary for insured worker to get a better health service at the moment. It could gradually approach for

contracting health service from specific contracting to general contracting. This is all objective answers from this study.

Now, this following paragraphs will present the identification the problems and potential for contracting then it will approach the way for strategy for contracting services. Again, from the contractor side, even though they fill up the work force in current, there are still need to upgrade their staff quality because financial and management capacity is vital role for contracting services. Thus, Social Security Board should consider as an internal problem for contracting.

In addition, there are other problems for negotiating with external parts as providers and others professionals. For setting contracting terms, the Social Security Board needs to prepare as inclusion and exclusion criteria, monitoring and evaluation team, treatment guideline and standardized procedure. Meanwhile, the Social Security asks to MOH to organize monitoring and evaluation team and set up for standardized procedure. Therefore, this process will take time due to depend on others organization. As well as that Social Security should negotiate with providers for contracting terms. From the in-depth interviews and group discussion, most of the participants are prefer short term contracting as one year, reimbursement system, formal way for contracting by accepting reward and sanction. However, referral system will negotiate between contractor and provider because it is need to go detail for next process which considering registration and room boarding.

From analyzing the problems, there are possible contracting with private sector in mean while because private can invest for cost then claiming from Social Security. For contracting with public is impossible in current because public can't invest the cost for insured workers and public service is free for patient whereas private sector take for service charge for patients. For these two reasons, the public and Social Security Board can't start contracting with public sector.

Again, without setting contract formality and infrastructure, the Social Security consider specific contracting as pharmacy contracting by setting some medicine cost because of no standardization in Myanmar. Thus, Social Security Board consider set the amount for cost is possible contract with providers. Also, the Social Security

Board think to contract clinic, polyclinic and hospital contracting by setting fix amount for insured workers. This is the way of Social Security think to contract with outside providers. Actually, it is just reduce the out of pocket for insured worker because apart from include items, the insured workers will pay the cost then claim from the Social Security Board. Also, for hospital services, the Social Security Board considers the same way but in this case the Social Security will clear up providers and customers for setting amount. If customers spend over the limit amount, they need to pay for extra charges. For example, the Social Security Board set the amount for economic class but insured worker use private room. In this case, the insured workers must pay extra charges to hospital because of their choice. Anyway, this is relevant and possible way to contract for insured workers at present.

6.3 Limitation

This study is a qualitative and focuses on using in-depth interview among stakeholders mainly for the purpose of finding problems and possible potentials for contracting. However, as a subjective answer from some stakeholders are not willing to answer my question. As a consequence, it makes less information for analyzing situation as contractor side, some departments are not willing to answer and some departments are go for training. Also, some private providers even though make appointment, it less answer to contracting services especially as famous hospital because they think that Social Security is impossible to contract with their hospital.

Thus, some information is insufficient for this study. Also, this is the first study for contracting in Myanmar. Thus, some parts of question are not familiar with interviewees especially payment mechanism. This is also one of the barriers for this study. It can't find clear answer from interviewees.

In addition, there are some other useful findings that came out that are beyond the limits this study. These other findings include quality of services and low level of utilization of services. It is therefore imperative for Government to explore with further studies on the factors that affect quality and utilization of services of the Social Security Scheme in Myanmar. This is analyzing from 26 stakeholders for regarding contracting health services. Thus, it should continue other quantities study for contracting services as utilization and efficiency. Therefore, to become a

complete picture, the further study should extend the contracting service for utilization purpose or quality.

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APPENDICES A

Guideline questions

For in-depth interview for contractor side, it will be mainly focus on the question as follows;

- Why do you think the Social Security Scheme should expand in future?
- Do you think the Social Security Scheme should contract health services from outside providers?
- What would be the objective for contracting?
- Will you contract the whole institution for health service from provider as general services, specific services and facilities?
- Will you consider the link between referral system and patient registration for hospital? If yes, how will you arrange for it under a contracting arrangement?
- How will you target the population for coverage geographical location in contracting services?
- What are the criteria for choosing primary health care provider?
- What are the criteria for choosing hospital provider?
- Do you have management strategy for your financial side? If yes, how will you maintain your financial management capacity?
- Do you have strategy for contract management capacity? If yes, how will you control your management system?
- How will you manage monitor and evaluation system with provider during the contract process?
- How long will you contract for each contracting?
- What kind of payment method will suit to contract?

For provider/contractee side

- How do you think the Social Security Scheme functions?

- How do you think the Social Security Scheme contract health services from outside providers?
- Do you think current health capacity is enough to contract for health service? If yes, how will you arrange the health capacity?
- Will you include the referral system in your service? If yes, how will you consider the referral system and hospital registration system in contracting?
- What would be the objective for contracting?

- What facilities are includes in primary health services contracting?
- What facilities are includes in hospital services in contracting?
- Do you think management is important for contracting? If yes, how will you manage and evaluate your contracting process?
- How will you motivate to the health workers for the quality care of service? How will you arrange it?
- What kind of payment system is suitable for you?
- How will you consider the duration of contract for each contracting?
- What kind of relationship should involve between contractor and provider in contracting? Why?

For contributors side

- How do you think current health services in the Social Security Scheme?
- Do you think contracting health service will benefit for insured worker? If yes, how will be the service you expect?
- Are you willing to pay for contribution for a better health care service? If yes, how much will you increase the contribution?
- What kind of quality service you expect from contracting?
- Do you think contracting health service improve health facilities? If yes, what kind of facilities will improve?

For current providers

- How do you think the current health care services in the Social Security Scheme?
- What kinds of qualities are important for contracting services?
- Do you think contracting health service is a better for insured worker? If yes, in which way?
- Do you think contracting health service will increase utilization? If yes, how will improve the utilization?

APPENDICES B

SUMMARY OF LITERATURE REVIEW

Author (year)	Topic	Methodology	Finding
Liu, et al.(2007)	The effectiveness of contracting-out primary health service more in developing countries	A wide range of research designs included experimental controlled designs; non-randomized controlled designs; pre-designed before and- after designs without controls; retrospective before-and after study designs (i.e. based on provider records); and cross-sectional study designs with controls.	There are positive effects on access of health services and improved the equity in access although little evidence on the impact on the quality and efficiency among different countries.
Macq J, et al, (2008) Soeters R, 2003	Public purchases contracting external primary care providers in Central America for better responsiveness, efficiency of health care and public govenance Improving government health services through contract management: a case	Two stage process that the initial analytical framework bases on literature and interlinking characteristics the contractual relationship with health system performance criteria. Another step is the use of this framework in four case of cross-cutting issue. Individual performance bonus of health staff 30% of agreed incentive method base on the percentage achievement of financial target. A comparison of the during one year from 1999 to 2000 output statistics	Responsiveness takes a vital role that refers to the capacity of health services to react to the patient's demand then public entitlement refer to the correspond to a balance between the needs for medical care. The officer user fees significantly

	from Cambodia.	showed that the utilization of health services increased considerably before and after the introduction of cost-sharing and incentive payments.	increase but it is reasonable price for patients instead of paying for informal way of the government health workers. Next, the result of monitoring performance-base-incentive makes decrease for family health expenditure.
Arur A.et al.,2009	Contracting for health and curative care use in Afghanistan between 2004 and 2005.	This study gets data from a national facility survey or donor and Ministry of Public Health (MoPH) records, and the routine information reporting system from The Health Management Information System (HMIS) constitutes. For data analysis, the author used Principal Components Analysis (PCA) methods in each province to create a wealth index based on the asset ownership, housing characteristics and primary source of income for each household surveyed in 2004.	The government was able to manage contracts effectively although there was no experience in early stage, and that contracting has helped to improve utilization of basic health services. It gives the information in term of scale of contract, performance- base payment as part of bonus, contract management responsibility and monitoring

			process.
Jacobs B, et al., 2009	From Public to Private and back again: sustaing a high service -delivery level during transition of management authority a Combodia case study.	Using four sources of data from the contractor to the senior management, and consequent impact on performance by facilities as cross-sectional surveys, monthly HMIS reports, quarterly performance results, then data from the contractor for performance management and salary supplement payment, and financial reports from the facilities. For a pilot test for pretested structured questionnaire, 4 interviewers were trained. Data analyzed by Epi-Info version 6.04 of the statistical software package.	The performance of contracted health facilities is linked for consideration of financial incentive to administrator. The results for case study, the government sustained well the process of health care delivery especially, the service delivery increase when the bonus system was modified.
Mostafa MM, 2005	An empirical study of patient's expectactions and satisfaction in Egyptian hospitals	The cross-sectional questionnaire survey to 332 patients for 12 hospitals in Egypt that the measure service quality are Tangible, Reliability, Responsiveness, Assurance and Empathy. SERVQUAL model for determine the both private and public hospitals, it might categorize for different variation. The author develops three components as factor 1 contains items similar in nature	As a result, Total variance explained (67.4 percent) by these three components exceeds the 60 percent threshold commonly used in social sciences to establish satisfaction with the solution. Among these three

		of responsiveness and empathy factors labeled “human performance quality”. Factor 2 items relating to the reliability was called “human reliability”. Factor 3 contains items relating to the tangibility of the service what is called “facility quality”.	components, the factor one got the highest total variation about 49.6 percent, meaning that both patients seem hospitals services offer a better responsiveness and empathy to serving patients.
Millis A, (1998)	To contract or not to contract? Issues for low and middle income countries.	All information is represents the design of contract contain the facts that the extent of competition which mean the method of pricing, quality indicators and monitoring of contract performance in which contract duration and sanction for poor contractor performance. Then, compared with the quality of contract out and directly provided service among different countries. Then analysis could be done gathering with information on the capacity which include the level of development of the private sector.	For non-clinical services, contracting showed a better value than direct provision contract services for diet but it leads to poor quality services due to the contractor pay a low wage and poor management. For clinical services, it is a positive result for quality service because of a better maintains and reduces time but the cost of contract hospital

			is higher than direct provision due to the price is substantial difference between the contract and thus, the cost increase of the contractor providing the services.
Mills A, et al., (1997)	Improving the efficiency of district hospitals: is contracting an opinion?	A detailed cost analysis was done to calculate unit costs of in-patient, out-patient care and productivity levels. In South African study, a very large number of quality indicators were produced, covering structural, process and outcome aspects of quality where as those detailed and time-intensive investigation was impossible in the other study, which collected a limited list of quality indicators covering aspects of structural and process quality.	Southern African, contractor hospitals provided care at significantly lower unit costs even though insignificant differences in quality between the two set of hospitals. But the cost of the government contracting was close to the direct provision, indicating that the efficiency gains were captured almost entirely by the contractor. In Zimbabwean

			study, the two mission hospitals served the similar services for two government hospitals but the cost was at substantially low.

APPENDICES C

Transcriptions

PROVIDER 1

I am provider 1. I responsible Executive Director also I'm share holder as well as Medical Superintendent. This hospital started 1998 now 15 years. We extended hospital in 2000.We opened hospital 2004. This hospital has 100 bedded capacity and 300 workers. In my opinion, SSS isn't broadening in Myanmar just set the organization. Even though I'm not knows well. I just know as SSS accept some government servant not include private. For enroll SSS, need to apply again. So the awareness is very low thus less interest from people. In fact, the facilities also insufficient even in Worker hospital. Some private company arrange by themselves for their worker. Actually, the expansion of SSS is good for people but need to systematic plan for approaching.

In addition, I heard meeting from SSS, for contracting but no answer thus need to do often workshop. One time, they said that to set the ceiling price. But for setting ceiling price in private is difficult because of different setting was different level, different price thus the possible way is to organize same difference group. Some foreign company gives even family member. I'm also responsible as chairman in private hospital organization. We also give service multiple as factory, company etc. I think, the SSS objective is more important than us, we will follow as much as we can by negotiated when the SSS plan for health service. I think, it seems as insurance system. Even our country has life insurance, it just include medical checkup. For deal with government sector, we will reduce the price. If contract with clinic, we aren't even though we can offer the service because in my opinion, we are possible to contract the whole service also I think it is easy for worker which can get service in one place without pickup from different places. We also have economy class as well as high class but I can't fix for room. Currently, we run for service if room available for patient, they can admit here. But if unavailable we can't accept patient. It is impossible to fix room for SSS patient permanent. Also, drug list can't separate for SSS because no standardized medicine in Myanmar. Next, doctor, we can't set fix doctor for SSS also price for those doctor because of different specialist fees.

For me I prefer formal way with SSS but internal body I run in formal way but not totally without rule & regulation. For external body, I prefer terms as negotiate. I won't change my management plan but I will try some way to fix in the frame. I accept monitor & evaluation for contracting by dealing & adjustment both side. I think, it is better for contracting year at least 2 or 3 years for realize as evaluation. It will be 1 year in first contract later we increase. I prefer as fast as possible because of I'm invest person for service for quarterly or yearly payment. May be government sector, they also safe for financial side but I'm worry claiming time is not take time too much. In payment, it will be amount, time problem. Currently, I give service for company as giving service for worker then the owner gives the fees as their designation. For example, the cost is 120,000 kyat. The company will pay 100,000 kyats then the worker will pay 20,000 kyat. It is clear for us. We no need to do money matter. It is a type of co-payment. I like it because of a better life for people. Actually, health sector is broadening. For hospital side, it is possible case-base payment as long as they have to pay for extra body.

PROVIDER 2

I have clinic & hospital. I am responsible here as general manager. We have 19 years. If SSB can do for contract, it is good but it very difficult. Also, for this service, we should awareness to worker because to more understand for service. It depends because some are really don't know but some are can sue. It can develop the contracting plan, it is good for secured for worker life. It should balance between leader and follower. For objective contracting, it we need to deal what they need and what can we offer. It will be limit range. We apply ISO guideline but not 100%. Normally, we start rule & regulation as a legal. We accept internal audit so we welcome monitor & evaluation as meeting for patient complain. Better check as usual way without waning to come & check for service. For contract duration, we negotiate for it.

For payment mechanism, without granny in current, we use one month clearance. For security reason, we prefer pre-payment. For clinic, I seem capitation & co-payment is more suitable for contract because as a human nature they appreciate when they get something amount. It will be basic fees, so we will add in additional cost depend on changes. For pharmacy, it varies so control with minimum stock control. We regular take monthly for some medicine & technical equipment. I think,

case-based payment is suitable for hospital because we can adjust the cost as low as possible. As following the international code term (ICT), all disease are will just take the code.

PROVIDER 3

I'm provider 3 responsible as Medical Superintendent. When I work in public, it is easy to deal with public to public because in public some cost is free. But I can't think how SSS will contract to private? Because if SSS contract, how they can effort for it as investigation, drug etc. It will be OK for minor illness but it will be difficult major case. For my side, we need to pay many to government thus it isn't easy to reduce pay as well. Even SSS make standing order as all worker need necessary to insured, in my opinion, it will be difficult currently, we can offer our worker sufficient for health care. It's enough. As far as I know, for SSS, they offer medical leave, sickness benefit, injury etc. If they can do contracting for worker, it is good for factory. I have no idea for SSS because I never heard SSS do successfully something in my life. Actually, they should do workshop and explain to provider information. We suppose to deliver good service to everyone.

Currently, we run service as good as possible for example, when we treat patient isn't recover well, then the cost also become high, so we tell to MD the patient situation to reduce the cost. For inpatient, we can effort it but for clinic the specialist will main person we just rent the room and service only. If SSS want to contract for clinic, the specialist will not permanent as part time, in service etc. Even inpatient, we can't offer for SSS patient as permanent room, if we have vacancy, they can get. Otherwise, they transfer to other contracting hospital. For management, we can do enough management for our service. We train good management to our worker thus I think it is enough. SSC is 200 bedded capacities and it stands around 16 years. I have no idea to say contract duration and contract way. Even, we contract with SSS, we need to deal with room boding. I have no idea for payment mechanism it will depend on our MD and owner. Because as specialist, how will deal with them, they are not our worker. Our current finance, we are very busy for ourselves. It is better after deal with the upper level. For monitoring and evaluation, we are welcome for it, no problem. Main objection is good but need to do plenty systematically. I just manage and implement only if MD agree with SSS.

PROVIDER 4

I'm provider 4 working as administrator also shareholder in hospital. We start as polyclinic then increase as hospital. Now this hospital is 25 years. We offer investigation, operation & diagnostic. We has permanent worker about 40. We have 25 bedded capacities. We can offer outpatient, inpatient and diagnostic. For specific contract, it will better for us because we have limited ability. We interest the contracting with SSS, it is good for both side as well as for workers. We currently offer the maternity case the most. For medical checkup, it will be OK. Our hospital is close factory zone. We interest for management upgrade. We have no incentive for worker but we have plan as vacation for annually and health care for worker. We currently contract some company for medical service as investigation. Monthly basic pay for us without deposit but it depend on amount which not much for us. For payment, we can adjust later not fix. Currently, we go one year contract for service. I can't say exactly which way I use for contract with SSS in current.

PROVIDER 5

I'm MO in here. The workers are 20 and the hospital is about 16 years. Currently, we have no specialist for night time also we can't call specialist night time. We open clinic until 9 pm thus insured worker can come that time for inpatient we has OG specialist also we has operational room. Normally, we transfer to government hospital if we can't recover for patient. We are not offer 24 hours service. We have own lab also we link with outside lab for our patient. For management side, we have no incentive. In my opinion, we should start as adjusting then next step we could continue formal way.

PROVIDER 7

I'm provider 7 responsibility MD in this clinic. My clinic is 3 years. It is good for contracting if they have enough budgets. They give the treatment list for set the standardized for medical treatment from head to toe we have many detail for set the treatment procedure because we can't say exactly what will be the next. Sometime medical problem is unexpected. Also, they ask the list for medicine to standardized medicine. Currently, we run the Medical Mobile Unit (MMU) for insured worker for the purpose of upgrade the level of insured worker. In fact, we see many

difficult things when we run the service as insufficient health worker from SSB. I want to informal way first because we run not only contract service but also our own service. Actually, the contract should at least one year but we start 6 month, from 6 month we set 3 month for pilot test. We have over 48 workers for health service side as assign because we have in charge for each department as lab, X-ray, nurse. Thus they have routine as weekly.

For financial side, we just traditional way separately in order to different. By doing this, we know which service is get profit or loss depending cost and income. I have plans to increase my management capacity as win-win situation because we both sides get the benefit. Currently, we run re imbursement system we invest first then SSB will pay after 40 days. We can't decide yet which way is suitable in current. We are welcome if they come as monitor & evaluation for check. It's really good for worker because they are more awareness for health knowledge. Others country, SSS stand independent organization but in Myanmar SSB is under government. Thus, it delay claim system for worker as waiting process. As worker, they has problem for current pay.

PROVIDER 8

Our polyclinic is one year. I'm work here as administrator. We mainly offer medical checkup, general health care & consultation for people. We plan to increase hospital in future. For worker as international standard, we want to offer for worker as international standard just using card without pay cash. We will contract as low as possible for contract for worker. We will arrange for transport for worker. Currently, we offer medical checkup for company worker as code system. We have 35 workers different department as physiotherapy, dental, pharmacy and lab. We run service 9 am to 10 pm. For financial management, we accept payment as depend on time or population. We have agreement with the customer company management. Currently, I think better start investment rather than payment system. Personally speaking, I prefer formal way for contracting. For contracting duration, I can't say now. It will be negotiated with SSB. I'm welcome for the third party to check our service.

PROVIDER 10

I'm provider 10. I have 8 years services. At present, I responsible in health service department as operational deputy director department. We offer TB, Malaria, Diarrhea, RH, HIV & STI and we plan for future for child survivor which is immunization & water sanitation. If we think last time, we understand government body. How they will do for contracting as donation from others or government fund? If they will do contract from worker's contribution, it will be challenge for sustainability for long term. If they will get support from others, it will be possible. If they can develop, it is good. If contracting in public, the cost is quite high so how can survive for service? For medical contract, it will be ceiling price even ceiling will be varies as minor case is quite OK, but it become major case, how they will consider for individual as inclusion & exclusion. Even, inclusion, for example, here we offer medical benefit for worker but limit amount per time. The cost set 10,000 kyat for individual but set 3,000,000 kyats for one year. For operational management, we run the target during limit cost, amount & time as we run 2 to 3 program by one township instead of running one program. We paid incentive by spending worker each program or trip. Also, we pay salary plus contribution which incentive for TB. We assign all level for management as transport, training etc. Thus, we stand 1200 workers for 7 or 8 projects in here.

For financial management, we deal with as giving input cost & discuss with finance side for how to pay the line item as different budget. For example, we buy something for which program. Even, current we run service for worker with contract. For outsider, we contract franchise clinic without comment clinic own business except affect to program agreement as one month notice what we called formal way. We carry on project over one year & clinic contract is long term except their behavior is seriously effect to program. We set third party for observe clinic which represent among township clinic member. One day, even though we stop franchise, this team will stand as their wish. I think, the third party view is more suitable for organization. We include performance-based payment for worker base on program and monthly paid. We will decide which proposal from worker suggestion depends on different program and procedure. It is difficult to guess future as time, period. It is depend for setting payment. For example, some clinic owner pays the patient for investigation then claim later from us. But for some volunteer, we set the fund to use some amount then refill again end of the month.

EMPLOYEE 1

I work in shoe factory about 6 years. I get 107,000 kyat per month. I got SSB card after I work one month. We have 1200 worker in our factory. I never use SSB service but I heard from our colleagues because I'm worker leader. From my colleagues, we just hold SSB card but for using service it is not effect because they open office hour even 9 am open clinic, in real clinic open 10 am, sometime nurse and doctor come late so we need to wait. We want to escape deduct our salary thus we go SSB clinic lunch time but they take break time. So after 4pm we go SSB clinic, the clinic is close. I never heard SSB give some benefit like as worker get injury work place, only owner pay for their worker. I am happy for this contracting plan but beforehand they deduct increase salary, we will get problem even though I am happy to get contracting with outside provider. At present, we get nothing from SSB. If contracting private sector, whether we can get same service compared with other. I'm worry they will decimated other patient and SSB patient like giving poor quality medicine. 2012, the custom tax worker 1200 kyat, so worker protest in Hlaing Thayar. In April, they will start new law, I am worry high deduct, we will get more problem. If private contract run 24 hours health service for worker, we could use this service as go clinic before we go work.

EMPLOYEE 2

I work sun flower manufacturing factory about 2 years. I get salary 89,000 kyats. Normally, they give injury worker for use SSB service, just sickness is difficult to get leave to go clinic. I rarely use SSB card because the supervisor don't want to send clinic. For example, my friend even sick can't leave finally, they allow when my friend admit hospital. Thus, even we have SSB card, it is very difficult. For contracting health service, I am happy to use because it is a chance to use health service. I feel that if we can get convenience service from contracting health service regardless of time consuming even deduct from our salary. I think, all workers also will happy for it.

EMPLOYER 1

In my opinion, the better way is SSB should stand alone social organization. As around Myanmar, the real workforce is may be about 50% only which is not includes

other sector as farmer. Thus, for social organization SSB should stand as separate organization. If compared with other country the health facilities is very poor. For link with other private, I think it could be failure both system or become good thus, I feel better settle all new by SSB. The cost isn't difference, I think. It is difficult to change the system because transforming period especially, I rare to talk to think for people changing. SSB card change the computer card, for my garment factory, I emphasis health for my worker because 1 or 2 worker get sick it really effect the step by step manufacturing process. We have 1,500 workers. We set the factory since 1996 so about 18 years which we passing the difficult situation as totally responsibility health for worker instead of SSB. We start about 150 workers in factory. The army clinic set opposite of our factory thus we ask help from them. Last time it is take time for claiming now it a bit first just waiting about a month. But it is not much money. It will obvious those system change.

I'm not encourage settle contract private service because it is unchanged because even the private sector also in sufficient facilities in here. For example, even big population, only one doctor takes care for those people. How the service will improve? I am share holder as well as worker in this factory. The workers who live the location is quite close, those worker will go there. Even though SSB contract the health facilities in here is nothing changes because here even health worker is not enough. Thus, the best way is SSB set totally health service by them. Even we go private and public hospitals, we still wait long time for specialists. Because those medical doctors are working in government hospital then working again outside private, so how quality service will improve? Thus, I want to suggest that SSB clinic & hospital should and could compare with private as settle by themselves. They should start MMU is better than contract service in here.

EMPLOYER 2

For worker is 15 kyats & owner 25 kyat. MMU service starts because both worker and owner show seriously their desire. We discuss in meeting, thus tell the truth openly about the real situation. Last 10 year, we aren't believed & trust SSB. If something happen for our worker, we do by our way. Nowadays, we change both sides as we contribute the right amount by showing correct the number of worker. The SSB also start up grate their service as smart card. For better life of worker, we are welcome.

This trust relationship must have and do between us and SSB. For long term plan, there are problem as fund, contribution etc.

They need to observe from other country. In Thailand, any disease is 30 baht. In meeting, I say clearly my attitude. Who will be short term contribute & long term contribute for SSB. They should contract broadly as geographical location. For example, contract with sub-urban area which factory worker reach easily for use those service. At least, it should polyclinic level. Then, they should choose the class for services. This is my opinion, long term plan as housing plan, it is necessary for workers. By doing this, we born strong & trust relationship. Employer will participate for those services. Next, prevention is better than cure. I absolutely believe that if SSB can deliver better health care service, the worker will use more those service. For quality care service, it a bit change in my country compared with last time. Nowadays, SSB should produce as come & give health care rather than saying that come & get service. I am director. This factory around set at 2000 may be around10 years. We have between 500 & 600 workers. Nowadays, our country a bit change for quality compared with last time. It will direct response and ratio of private contract provider.

VITA

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