8 Conclusions

Based on guidelines provided by the Health Systems in Transition (HiT) template and given the available data, this report offers a clear description and honest assessment of the past and current health system of Myanmar. It also identifies successes and failures, and current and future challenges to stimulate further policy formulation. As this report was written soon after democratic reforms took place after the 2010 national election, most of the data in the report may serve as a baseline for future updates and assessment of the progresses made by successive democratic governments and more reforms that are expected to take place.

Among the various reforms in the past, during the first four decades after Independence in 1948 priority was given (to some extent) to improving equity in health and health care in Myanmar. This was reflected in policies attempting to narrow the gap in health and health care between rural and urban areas, and commitments made to the primary health care (PHC) approach. Detrimental effects on equity subsequently followed with meagre government budget (average 549.08 kyat per capita in 2011–2012), a majority of which was allocated to extending hospital-based secondary and tertiary care services at the expense of PHC [MOH, 2013].

The effect on equity in health care was further worsened with introduction of user charges under the banner of community cost sharing (CCS) and revolving drug fund (RDF) in the 1990s at the public health facilities, though measures for protecting the poor are said to be included but do not take place as intended – there is no clear budget line for subsidizing the poor, surplus from RDF sales are grossly inadequate to cross-subsidize free services for them. The government budget for essential medicines was reduced and household out-of-pocket (OOP) expenses became the major source of health financing, a major barrier for the poor to access essential services.
In spite of this situation, achievements in health status of Myanmar could be observed: life expectancy at birth has increased for both males and females; infant mortality rate (IMR) shows a declining trend; under-five mortality rate (U5MR) has decreased; and there are improvements in maternal mortality rate (MMR). On the other hand, Myanmar at the moment is: one of the countries with highest rates of OOP health expenditure; needing much more to be done for achieving and sustaining Millennium Development Goal (MDG) targets for 2015 and beyond; and being challenged with a triple burden of disease (BOD), with noncommunicable diseases (NCDs) contributing to approximately 40% of all deaths setting the scene for an NCD agenda for Myanmar. A focus on universal health coverage (UHC) could accelerate progress on the health-related MDGs, address the growing burden of NCDs, and move towards achieving equitable health coverage for all (Oxfam, 2013). With the new Constitution adopted in 2008, and a new government coming into power in 2011, the concepts of UHC and social protection are now back on the policy agenda.

The concept of equity has been included as part of the basic principles in successive Constitutions of the country. The Constitution of the Republic of the Union of Myanmar (2008) article 367 stipulates that, “every citizen shall, in accord with the health policy laid down by the Union, have the right to health care”. Translating the health equity concept into practice is a real challenge requiring political and financial commitment.

In connection with the financial commitment, the Government of Myanmar should ensure that adequate proportions of national budgets are allocated to health; and look for more efficient, equitable and sustainable ways of raising revenue for health through tax reform. Public financing has to play a key role in Myanmar for funding UHC, taking the example of success stories in other low- and middle-income countries. Myanmar needs to explore how to generate more tax revenues for health while the contributory payroll tax financed social health insurance for the formal sector employees should be scaled up rapidly.

Ideas and policies to face the challenges, however well thought out and developed, will remain hollow and empty if they are not backed up by adequate funding. Social health insurance and government financing through tax revenue are among the options available for reducing household OOP with prepayment mechanisms. The fact that the economy is mainly informal in nature impedes the introduction of employment-based compulsory health insurance, and the need to overcome the technical and
managerial constraints for implementing it in the country, indicates that public financing remains a core option to be considered. The big question is: does Myanmar really have the political commitment to increase public spending for health, because the implications following the commitment go beyond health and extend into tax reform considering the need to increase fiscal space for health measured by the ratio of general government health expenditure to general government expenditure and fiscal space in general, measured by the ratio of tax to GDP. As the Joly Report on Taxation for the EU argues (Council of the EU, 2010):

“Mobilization of domestic resources for development through efficient and fair tax systems is crucial for sustainable growth, reducing aid dependency, poverty reduction, good governance and state building, including the provision of public services required to achieve the Millennium Development Goals. Efficient and fair tax systems are integral to democracy, promote state legitimacy and strengthen the social contract and accountability between government and citizens.”

The recent increase in government spending for health is an encouraging development and the health sector is also required to ensure that more money coming in for health is spent in a way to get more health for money. The Ministry of Health (MOH) needs to develop well-devised interventions with prospects of value for money.

A lucid clear policy in providing financial-risk protection for the poor in the informal or self-employed sector should be introduced in parallel with introducing, by law, a comprehensive Social Security Scheme for the formal sector. Ample international experiences have shown that extending contributory social health security to cover the sheer size of informal sector is almost impossible. Deliberate policies on health financing sources for the poor and the informal sector have yet to be introduced, but are urgently needed.

An immediate action that the government may consider is to ensure free access to essential medicines to the whole population as a key entry point in moving closer to universal coverage; this is not only an ethical imperative (given the high level of poverty), but politically strategic. This could be an effective quick-win policy for the Government of Myanmar (Yates & Tangcharoensathien, unpublished information, 2012). A quick win would help get the health programme up and running with minimal cost and resources.
With growing expectation and eagerness of the people for better health and the need to show substantial gains to those providing financial support within a reasonable period, it may be tempting, with valid reasons, for the health sector to look for a so-called quick win. Sound judgment is essential at this juncture to strike a good balance between achieving a quick win and achieving and sustaining long-term objectives. This quick win needs to be integral to the main and long-term objectives (not a standalone or once-and-forget) and introduced as a starter or kick-off of the main programme in consideration. On the other hand, a quick win needs to be thoroughly differentiated from a quick fix.

There is no doubt that emphasis should be put on the social determinants of health as the most influential factors for people’s health. There is also a need to ensure effective medical care services. People who fall ill and encounter medical emergencies will need medical assistance, so everyone should have equal access to the whole spectrum of preventive, curative and rehabilitative health services when needed, with financial risk protection being ensured.

Addressing health inequities is of paramount importance for Myanmar. Myanmar is in need of a major reform that will ensure that health services reach the poor and disadvantaged groups (minority groups in particular), and those in conflict-affected areas, through the effective functioning of township health systems. Equity considerations are to be given priority in the plans and policies, not only of health, but also of related sectors. From an equity perspective, movement along PHC concepts and practices is clearly a step in the right direction.

Strengthening RHCs, Sub-RHCs and station hospitals in rural areas rather than upgrading secondary and tertiary urban hospitals is a correct endeavour to improve equity in health care, as these close-to-client PHC services are better accessed by the vast majority poor rural people. RHC, Sub-RHC and station hospitals have been the only promising source of rural health services for hard-to-reach populations. These service-delivery infrastructures should be equitably distributed across the country and adequate supply of essential medicines and basic medical equipment made available on the basis of level of care needs of the localities. Improving technical efficiency of the station hospitals through appropriate corrective measures could save the lives of rural poor.

The township health system (including township hospital, station hospitals, maternal and child health units, RHC and Sub-RHC, as well as the associated
community health workers and auxiliary midwives in the villages) in Myanmar can be regarded as the means to achieve the end of an equitable, efficient and effective health system based on the principles of a PHC approach. The township health system is a strategic hub in translating national health policies into high-level and equitable health outcomes. A township hospital provides medical care at the second referral level. Under the leadership and management of a head of the township health department (previously known as township medical officer, TMO), basic health staff (BHS) deployed in RHCs and Sub-RHCs play key roles in providing PHC services for the rural population, where the majority of Myanmar’s population resides. The practice of transferring TMOs every three years and the rapid turnover of BHS has negative effects on health system development in the locality. Policy considerations on these issues should be given importance in human resources for health management.

As the responsibility for PHC services for rural populations falls in large part on these BHS, further strengthening of their skills and enhancing their motivation need to be priority policy considerations. As the past two decades focused strongly on strengthening and expanding hospitals, rural health services need to be reviewed to develop a scientific evidence base for policy-making. This review should involve determining how the tasks could be distributed among rural health team members; what the determinants of productivity of these BHS are; and what skill mix is required for equitable coverage with essential (cost-effective) health services in rural areas.

Under decades of authoritarian rule, data sensitivity was a political culture. It has been suggested that it is now time for Myanmar to move towards improving the quality, accuracy, credibility, reliability, timeliness and availability of economic and social statistical data and information as a first step in building a modern developed nation (U Myint, 2010). Though the Health Management Information System (HMIS) is said to be able to generate adequate indicators of acceptable quality, the system needs to be further strengthened for generating evidence for policy-making in a transparent way, as well as the capacity to provide inequity profiles on a regular basis. The Multiple Indicator Cluster Survey (MICS) is one of the most useful evidence-based platforms for MCH policy development. Incorporation of services provided by the private sector into the HMIS should also be a priority.

As the research departments under the MOH and some NGOs are conducting health-related research, this large of body of research should
be exploited for evidence-based policy-making, closing down the so-called know–do gaps (e.g. Pablos-Mendez et al., 2005). For a country like Myanmar where poverty is deep and over 130 nationality groups reside (and with minorities inhabiting within the geographical areas of other minorities), the evidence used for policy-making should be able to address health inequities. Despite the existence of research departments for public-health research, there is minimal evaluative research incorporating cost-effectiveness analysis and there is inadequate capacity. Such studies could provide information for policy-making, this is an area where the health sector in Myanmar needs development, to sustain and institutionalize these capacities in the country.

Monitoring how equity has improved or regressed is a priority undertaking for sound policy-making in a poverty-stricken country like Myanmar. Myanmar should develop the Gini index, one indicator to serve this purpose. A major entry point would be strengthening national representative household surveys in collaboration with the Central Statistical Organization and other private and public agencies, for equity monitoring of impact of reforms on households. As disability adjusted life years (DALY) signifies Myanmar’s priority disease profile and effectiveness of health interventions, DALY calculation, healthy life expectancy and disability-adjusted life expectancy estimates should be performed on a regular basis.

As formation of regional/state legislatures and governments according to the new 2008 Constitution raises expectations and a prospect for more decentralization, the central authority at MOH will have to assume the functions of setting rules and standards as included in the provisions of respective health laws. Regional/state and local health departments could then take monitoring and enforcement roles as well as service provision and management of a health workforce. Shaping this decentralization will be a challenge for future health-sector reforms. It is a salient fact that this decentralization would require massive capacity development at local level. In addition, it is important to pay attention again to the “minorities-within-minorities” issue. This will be a challenge for health governance of the regions and states from the perspectives of minority rights.

Improvements in access to safe water and adequate sanitation have been reported. However, diarrhoea remains one of the top causes of DALY. This indicates the need to further investigate the extent to which the drinking
water and sanitary facilities that people access are safe and sanitary, respectively. In big cities like Yangon and Mandalay, making improvements in the hygienic conditions of roadside food stalls through appropriate positive measures such as financial incentive and reward measures for safe food handling in compliance with standards and safety requirement, without risking the jobs of the food-stall owners, should be a priority policy consideration from a health perspective.

Although Myanmar has made serious efforts to monitor the situation of the risks inherent in tobacco smoking as well as essential intervention combating tobacco consumption (by adopting National Tobacco Control Law, 2006), it still needs to establish a surveillance system for NCD and actions to be taken for all determinants such as unhealthy diets, physical inactivity and high salt consumption. Many of the most important determinants of health lie in sectors other than health. Thus, the health sector needs to look into other policy fields like trade, agriculture, transport, environment, and rule of law. It is whole-of-government approaches and partnerships that enable health governance to take responsibility for the determinants of health. The MOH will need to be in the driver’s seat to steer this approach.

In Myanmar, for many decades, health policy-making has been top-down with directives given by government, or generated by technocrats. Listening to the voices of the people, particularly the poor and marginalized, and reflecting their views and interests in policy-making never happened. This monopolistic policy process has to be changed from the point of view that a participatory approach to policy-making is necessary to render the process more democratic. Civil society organizations can play a great role as advocates for communities’ issues of concern.

Generally, health professionals tend to be more versed with supply-side changes of delivering health services, with insufficient attention being paid to the demand side. It is to be noted that only when health-related actors – beneficiaries, civil society, private providers, development partners and professional organizations – are involved, will health governance be able to function. This kind of participation is referred to as the whole-of-society approach. Good governance means giving groups a voice in policies and services. Beneficiaries and civil society groups also need to be strengthened so that they are able to exercise demand in effective ways. These issues will remain key governance challenges for the health sector of Myanmar beyond 2015.