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Introduction

With the growing relaxation of political conditions in Myanmar, many communities—some for the first time—can look forward to the prospect of free, life-saving primary health care. After two decades of very low public spending on health, the challenges for universal coverage remain enormous. Many remote populations are entirely cut off from health services; rates of tuberculosis, malaria and maternal and child mortality are among the highest in Asia; and the country’s rapid urbanisation is already posing new challenges related to unhealthy lifestyles.

However, the recent political reforms, including decentralised governance structures and a more enabling environment for civil society, provide a strong platform for rebuilding the primary health care system and for introducing more equitable financing. Overseas aid and investment

KEY MESSAGES

• Fifty years after Myanmar pioneered free primary health care, the current collapse of social sector investment has cut off significant sections of the population from all health services. Today, the country has one of the highest rates of out-of-pocket health expenditure in Asia.

• Myanmar is confronted by a triple burden of disease, including persistent communicable diseases, an unfinished agenda for maternal and child health and an alarming rise in conditions such as diabetes and cardiovascular disease as the country gradually urbanises.

• Promising political and constitutional reforms present major challenges for the capacity of health managers in terms of decentralisation, private sector regulation and coordination with growing international aid programs and civil society activities.

• The expansion of public health services to politically and geographically isolated areas will require significant national and international investments in infrastructure, human resources and essential medicines and equipment, as well as social protection measures for both rural and urban poor.
are skyrocketing, and the business optimism pervading the country promises a flood of domestic tax revenues. Bolstered by these developments, the government quadrupled health spending in its 2012-13 budget, with ambitious targets for medicines and equipment, staff training and recruitment and the development of rural health infrastructure—all critical foundations for reaching and sustaining long-term universal health coverage (UHC).

This brief describes the situation based upon nine visits between 2007 and 2012 for health systems planning and assessment, in areas including immunisation, health system strengthening, health financing and post-Cyclone Nargis recovery planning.

**Background**

The new constitution enacted by the Union of Myanmar in May 2008 provided the legal framework for a series of institutional and policy reforms to advance the country’s nascent democratisation, including a core commitment for the state to ‘strive earnestly’ to improve the health of its people. This issues brief identifies some of the key policy challenges and prospects for moving towards UHC.

As early as 1953, the country had laid the foundations for a comprehensive primary health care system, establishing a network of township hospitals and rural health centres that, by the mid-1960s, covered every administrative district. Over the next 20 years, with health accounting for more than 10 per cent of government expenditure, life expectancy increased rapidly and infant mortality dropped by a third.

After 1988, a series of free-market macroeconomic reforms led to sharp reductions in social sector and health spending. A new National Health Policy in 1993 introduced health financing models based upon community cost sharing (user fees), hospital trust funds and drug revolving funds to raise additional revenues for the health sector.

**Declining Health Spending**

By the year 2000, spending on health had fallen to 1.2 per cent of total government expenditure, and many health indicators—particularly maternal and child mortality, tuberculosis and malaria prevalence—were lagging far behind regional norms. Poor national health investment was matched by very low rates of official development assistance (ODA), which was equivalent to between one-tenth and one-sixth of that for Laos and Cambodia.

Over the past 20 years, this lack of investment has been reflected in the very low growth of health personnel and rural health infrastructure relative to population. Dwindling expenditure has also resulted in low access to health care services, with more than 80 per cent of women delivering their infants at home. According to the World Health Organization, Myanmar suffers some of Asia’s highest rates of childhood malnutrition and under-five mortality (56,000 deaths per year) and high (though improving) maternal mortality (200 per 100,000 live births). WHO also estimates that Myanmar has one of the highest rates of out-of-pocket health expenditure in Asia.

**Changing Demographics**

Communicable disease remains a major public health concern in Myanmar, with more than 18,000 deaths attributable to HIV/AIDS reported in 2009. As the country urbanises, the health sector is also confronted by a growing challenge from non-communicable diseases (NCDs) such as cardiovascular disease, diabetes and cancer. The urban population rose from 24 per cent of the total in the 1980s to 35 per cent in 2012, with significant impacts on social and demographic structures. While the population is in general still very young, reduced fertility rates, improved life expectancies and changing lifestyles are all contributing to this epidemiological shift; 40 per cent of the total disease burden is now attributable to NCDs.

Myanmar today confronts persistently high caseloads of communicable diseases, an unfinished agenda for women’s and children’s health and the early stages of an NCD epidemic. Widespread inequities in health care access result in high rates of maternal and child mortality, particularly in areas of conflict and displacement along the country’s borders. The high and variegated disease burden, combined with a 20-year decline in social sector spending, presents formidable health policy challenges, particularly for extending services to hard-to-reach populations in conflict zones, in mountainous states and among the burgeoning class of urban poor.

**The Context of Universal Health Care**

Twenty years of underdevelopment: Given the low levels of investment in health personnel and infrastructure, Myanmar’s UHC strategy must focus on a gradual
expansion of the primary health care delivery system, particularly to remote and hard-to-reach areas. Investment in the hospital sector at the expense of rural health has resulted in serious challenges for recruiting and retaining rural staff, and significant imbalances in the workforce composition, including very low numbers of trained midwives.

Social and political reforms: Guided by the 2008 constitution, government investment in the social sectors and the concepts of UHC and social protection are now back on the policy agenda. The trend towards decentralised governance—with the appointment of state and regional legislatures and social affairs ministers with responsibility for health—will increase pressure for the development of efficient state, regional and township management systems.

Demographic and epidemiological transitions: In response to the country’s triple burden of disease, greater focus will be required in designing essential health care packages that address the prevention and management of NCDs and accidents and injuries.

Regionalism and ethnic diversity: With more than 100 different ethnic groups, Myanmar is divided into regions (where the Bamar majority is resident) and states (where the various ethnic groups, such as Shan, Rakhine, Mon and Karen, live). Recent political reforms, while at an early stage, are likely to encourage a period of ‘identity politics’ in which ethnic groups reassert their desire for autonomous administration. This will accelerate decentralisation and underscore the need to address demand-side barriers to health care access, such as traditional beliefs, language, cultural practices and affordability.

Health inequities: The social gradient for mortality rates is very steep, with child mortality rates in the lowest socio-economic quintile up to six times higher than in the highest quintile. Sharp regional variations in poverty and mortality rates also exist, the poverty rate in Chin state, for example, standing at 73 per cent, compared to a national average of 26 per cent.

International development partners: With positive changes in the political context and international relations, there has been a sharp rise in ODA, as demonstrated by the recent start of the multi-donor Three Millennium Development Goals Fund, targeting child mortality, maternal health and communicable diseases. Myanmar is also a recipient of targeted AIDS, TB and malaria support from the Global Fund, and an expanding program of vaccines and immunisation services from the Global Alliance for Vaccines and Immunisation. A major consideration for UHC will be the efficient coordination of these investments with national planning and aid management systems.

**Options for Universal Coverage**

System strengthening: The shifting demographic and epidemiological landscape, coupled with rapidly increasing health investments, points to the need for significant supply-side health system strengthening, particularly for primary care. As occurred in Thailand in the 1970s and ‘80s, this will require carefully coordinated investments in health infrastructure, personnel recruitment and flexible management, information and financial systems to extend health coverage equitably and efficiently to remote and previously unreached populations.
Social health protection: Due to prolonged under-investment in the health care system, the poorest and most remote populations and those affected by conflict will be the last to be reached in the move towards UHC. To mitigate this, state and ODA investment in township-based social protection schemes will be required, along with targeted community programs to reduce the costs of health care and lower access barriers related to culture, language and distance.

Increasing revenues and funds pooling: With the adoption of a Foreign Direct Investment Law and the removal of international sanctions, Myanmar is likely to experience rapid economic growth, which will have positive implications for the tax-based financing of its health services. With both the formal sector and the urban population poised for growth, one option in the medium term is to reinvigorate social security laws and mechanisms, including social health insurance and private health insurance, as a means to move towards UHC.

Conclusions and Recommendations

Myanmar is at a turning point, with far-reaching implications for its health sector. Progress towards decentralised governance, economic growth, privatised services and a proactive civil society has taken place. However, years of under-investment in health, a widespread lack of social protection, continuing internal conflicts and shifts in demography and epidemiology all reinforce the need for prolonged investment and close collaboration between national health planners and their local and international counterparts over the coming decades.

The policy options for UHC in Myanmar remain stark. Most immediately, significant investments will be required to rebuild the primary health care system and expand its geographical coverage. Simultaneously, extensive social protection measures are required to ensure that the poorest sections of the population are guaranteed access to at least a basic package of health services. The government has demonstrated an early commitment by significantly boosting its health expenditure in the latest national budget. It is hoped that this political commitment will be accompanied by the managerial efficiency and transparency required to lay the foundations for an effective, well-resourced and truly democratic health care system.

Further reading


