

MYANMAR HEALTH CARE SYSTEM

Myanmar health care system evolves with changing political and administrative system and relative roles played by the key providers are also changing although the Ministry of Health remains the major provider of comprehensive health care. It has a pluralistic mix of public and private system both in the financing and provision. Health care is organized and provided by public and private providers.

Evolution of Organization and Administration of Health Services

Following complete colonization of the country by the British in 1886, Health Services Administration, a centralized body responsible for both the curative as well as the preventive health services was set up and a post of Sanitary Commissioner was created. Later in 1889, the two services were separated and a new post of Inspector General of Hospitals was created for administration of hospital services. In addition to the control of government hospitals, the Inspector General of Hospitals controlled the following government institutions, the Chemical Examination Laboratory, the Pasteur Institute (a large bacteriological laboratory) and the Burma Government Medical School. The Sanitary Commissioner, renamed Director of Public Health Services was responsible for the public health aspect of the administration. These two centralized bodies controlled the health services.

At the peripheral level where the geographic regions were called districts, health services under the central control, was managed by senior doctors called Civil Surgeons. In the larger districts curative and preventive services ran parallel and the latter was managed by senior medical officer called the District Health Officer. The post did not exist in smaller districts and both services were managed by the Civil Surgeons.

Hospitals were then divided into two categories by virtue of ownership. These were Governmental and Local Fund Hospitals. The former hospitals included the Rangoon General Hospital, the Rangoon Dufferin Hospital, the Tadagalay Mental Hospital, the Mandalay General Hospital, the Maymyo Civil Hospital and the Myitkyina Civil Hospital. Virtually all other hospitals in the districts and the townships belonged to the local fund group of hospitals. All financial commitments of the government institutions and hospitals were the responsibility of the Government while the local fund hospitals were financed from a collection of funds called the "Hospital Finance Scheme." The sources of income for this scheme were; funds from respective

local bodies, government contributions and subscriptions and donations from the public. These Local Fund Hospitals were managed by Hospital Management Committees the members of which were determined by the Divisional Commissioner.

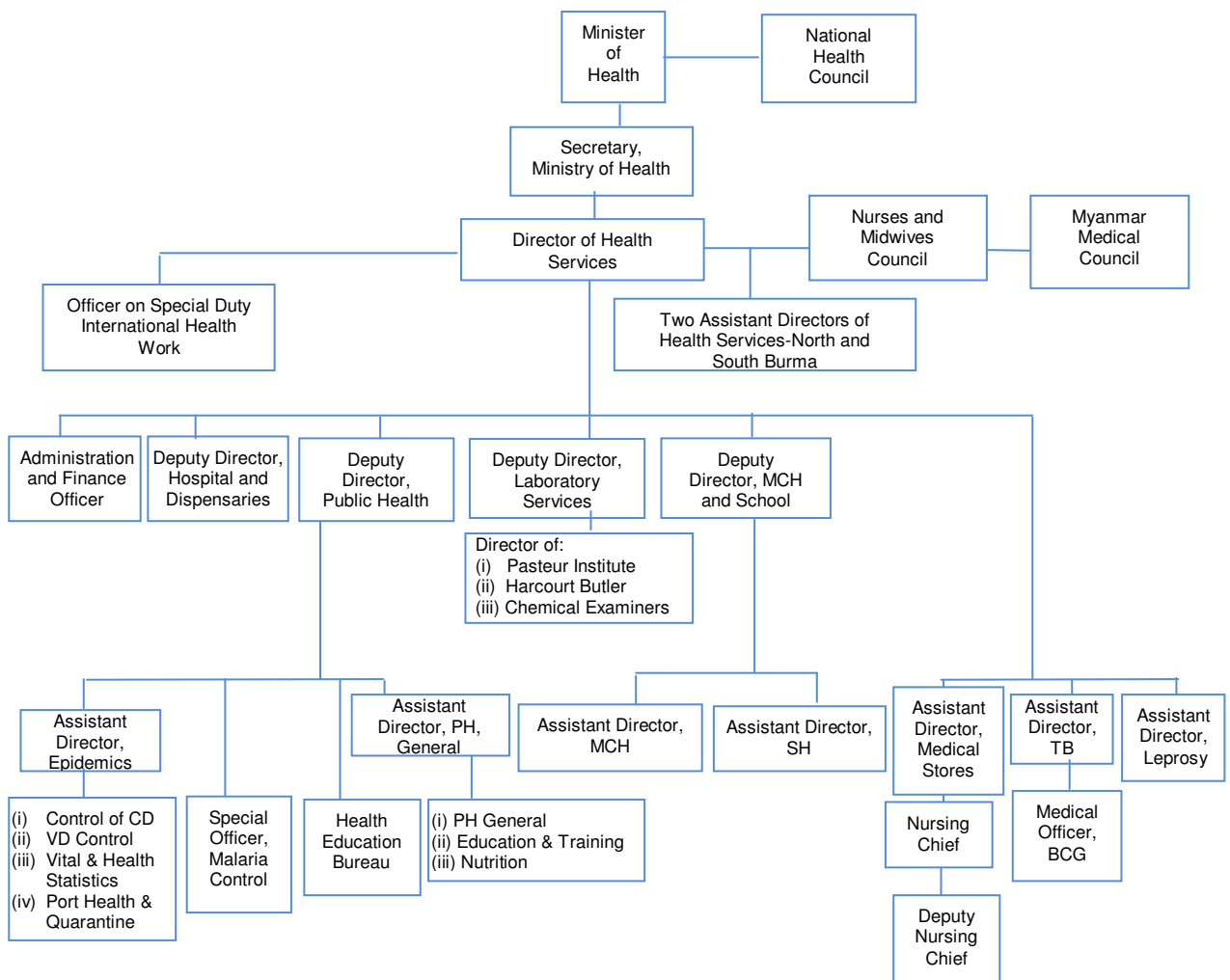
During the Japanese occupation the general administration remained the same though new posts namely, Director of Medical Services and the Director of Public Health Services replaced the two earlier posts. With return of the British administration the health services were reintegrated under a single director called Director of Medical and Health Services. Another directorate was set up, called the Directorate of Women and Child Welfare, previously the Women and Child Welfare Board. Following the Independence and in 1951 a Directorate of Child Health Services was formed. This directorate functioned as a separate body and was responsible for both the social welfare (including control of juvenile delinquents) and health of the children. Consequently there was some overlapping of work with incompetency in administration.

Following reorganization of health services in 1953, with the assistance from the World Health Organization which assigned an advisor in Public Health Administration, these shortcomings were redressed. Consequently these independent directorates were unified into a single directorate called “the Directorate of Health Services”, fore-runner of the current “Department of Health”. The directorate was headed by a Director of Health Services. In 1953 all local fund hospitals were nationalized by the Government. But at the peripheral level, hospitals still remained separate from public health services.

In 1965 the Directorate of Health Services was again re-organized to expand the coverage of health services to reach the rural areas, to ensure a uniform increase in the level of health of the Union, to integrate health services, to eliminate duplication of work through unification of different sections of the health services and to decentralize health administration by delegation of authority to the Divisional and Township Health Departments. In addition to undertaking re-organization at central level, an intermediate level of health administration was introduced in six among nine of administrative regions in the Union. These were; Rangoon Special Division, the Central Division, the North Western Division, the South Western Division, the South Eastern Division and the Eastern Division. They are now called State/Division (State/Regional) Health Departments. Township became the basic health unit at the peripheral level and Township Medical Officers were assigned responsibilities for all health services (curative and preventive). Organization and administration of health services by levels at different administrative period are shown by organization charts in the following pages.

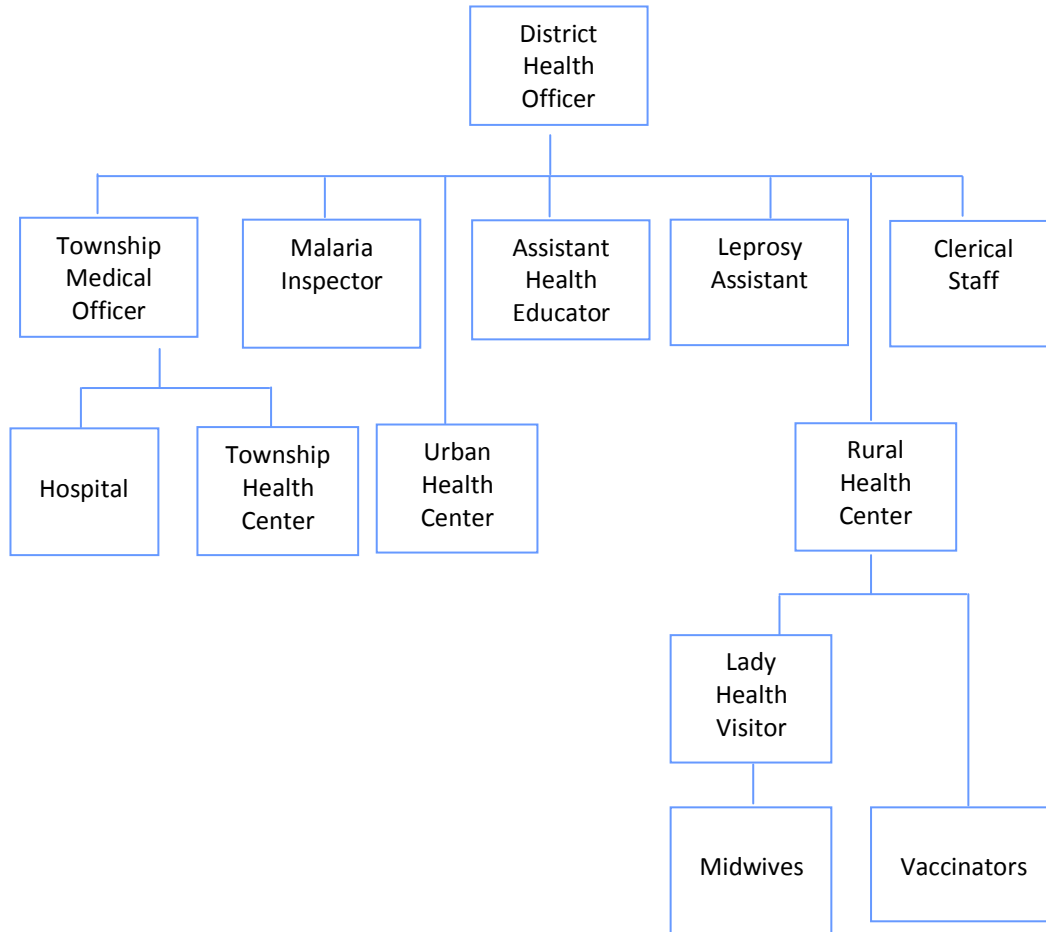
**Organization and administration of health services
from the period following Independence
to the period of Revolutionary Council Government**

Central Health Organization



Source: Annual Health Report of the Director of Health Services, Burma, 1955

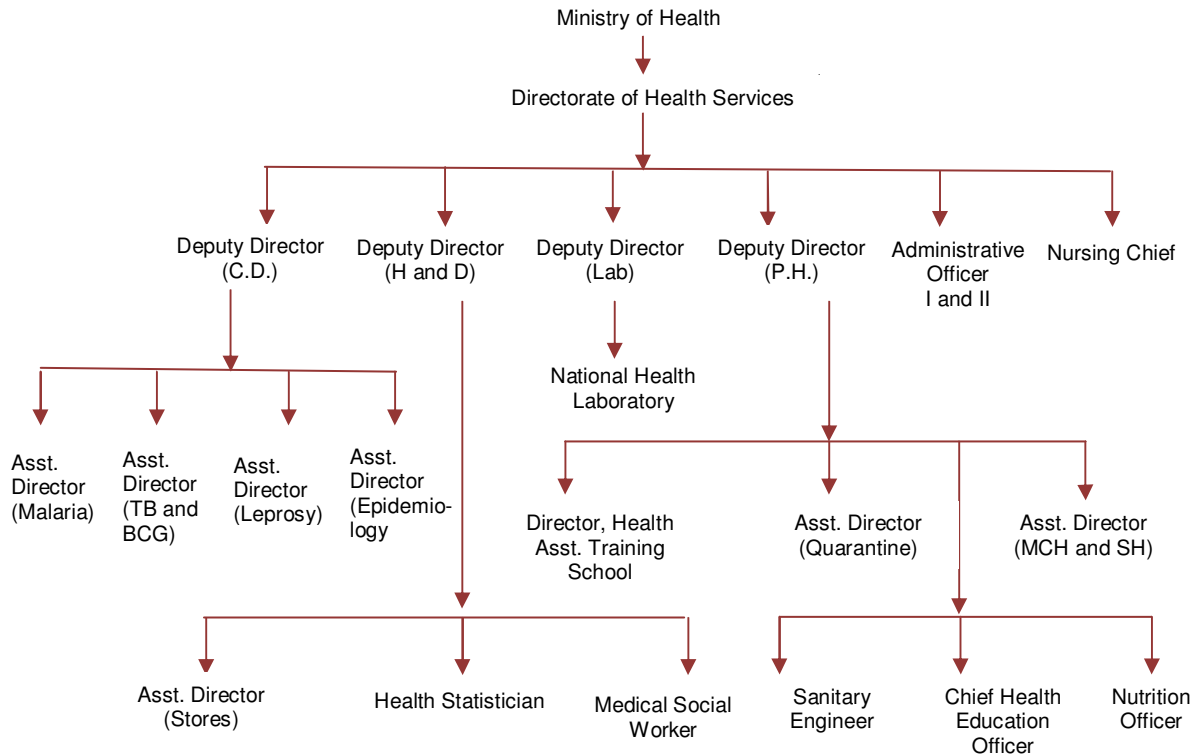
District Health Organization



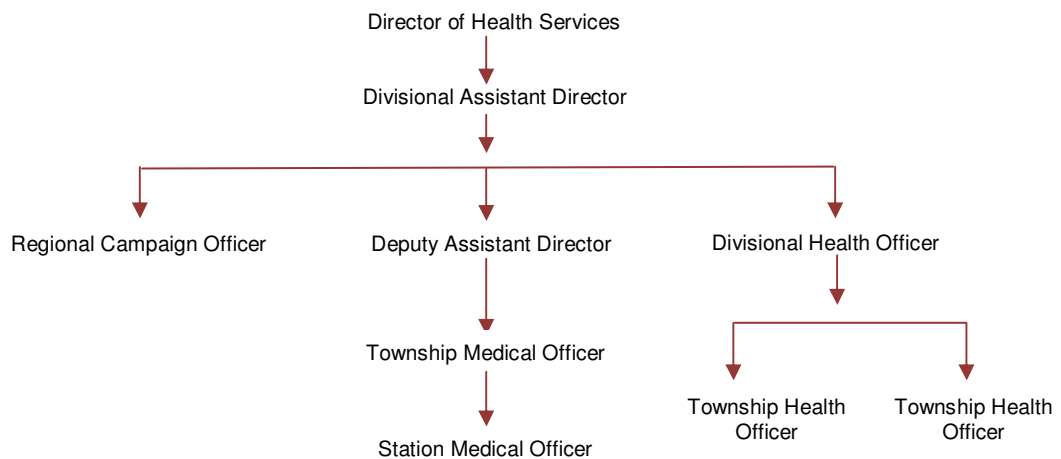
Source: Annual Health Report of the Director of Health Services, Burma, 1955

Organization and administration of health services from the late 1960s to 1973

Central Health Organization

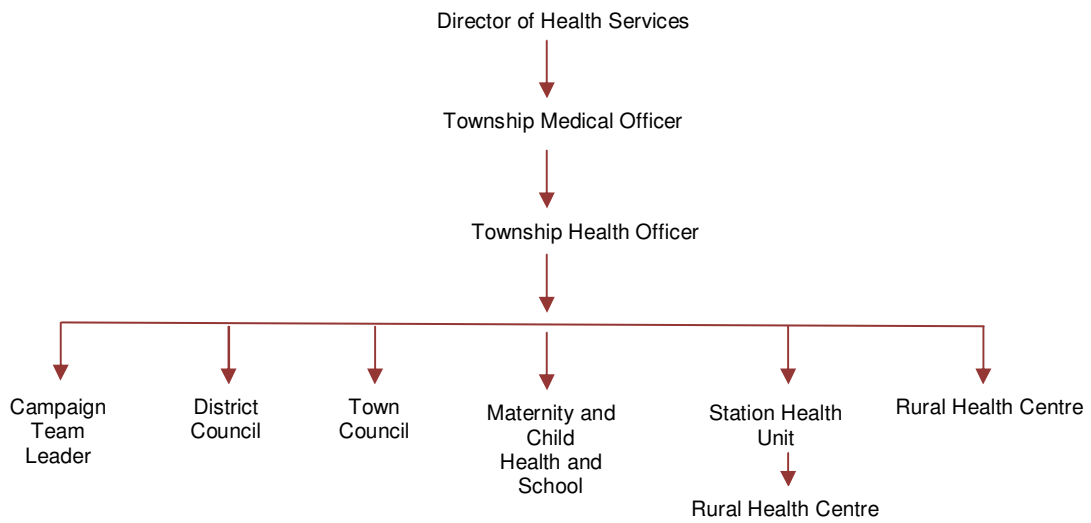


Divisional Health Organization

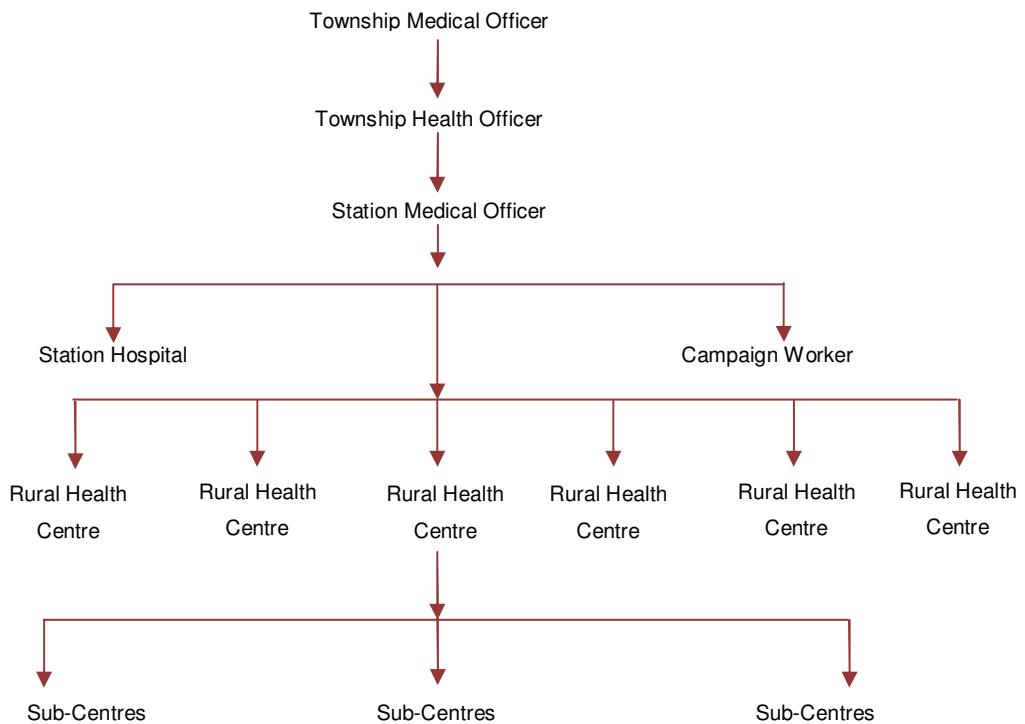


Source: Annual Health Report of the Director of Health Services, Burma, 1955

Township Health Organization

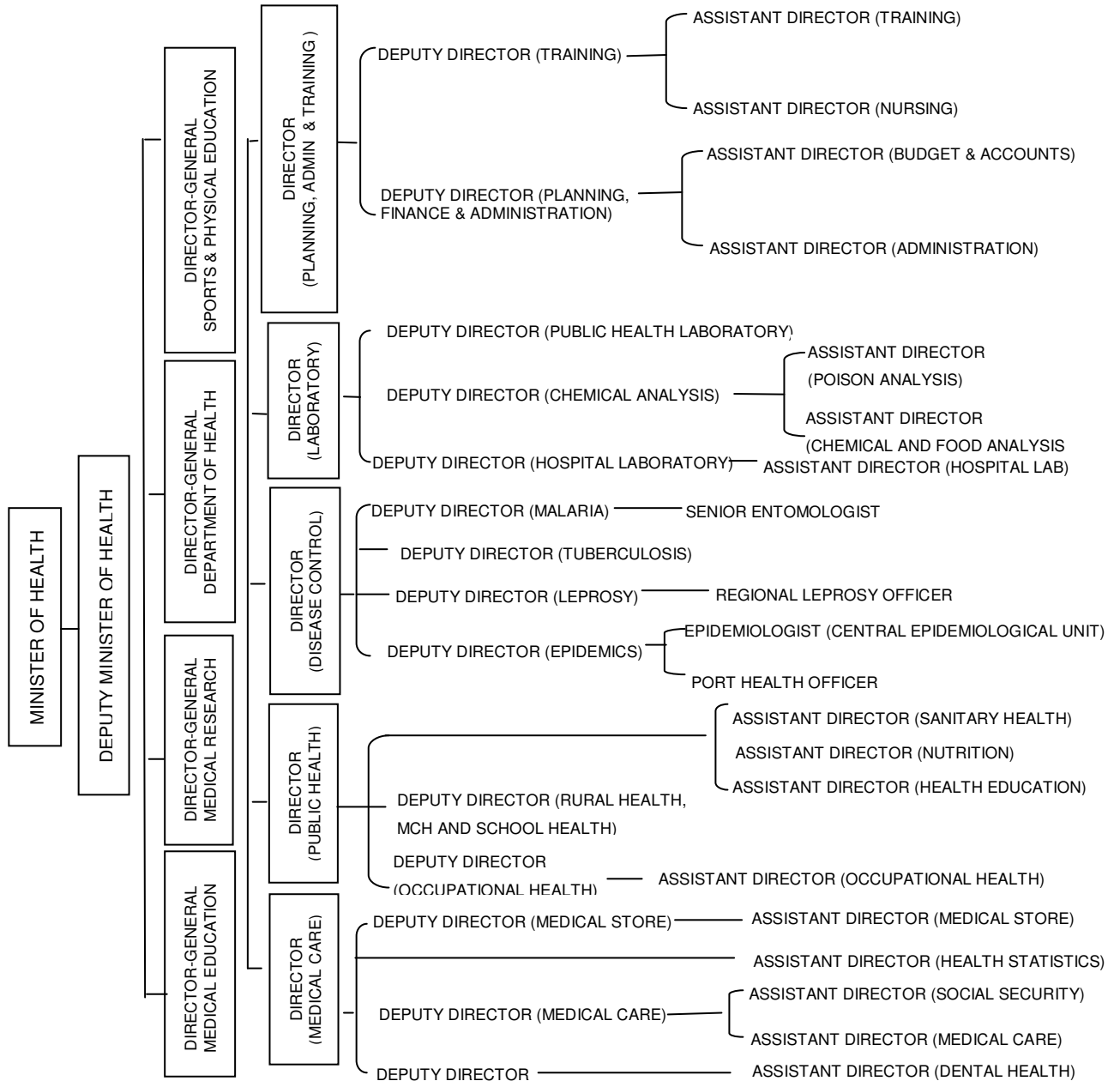


Station Health Unit Organization



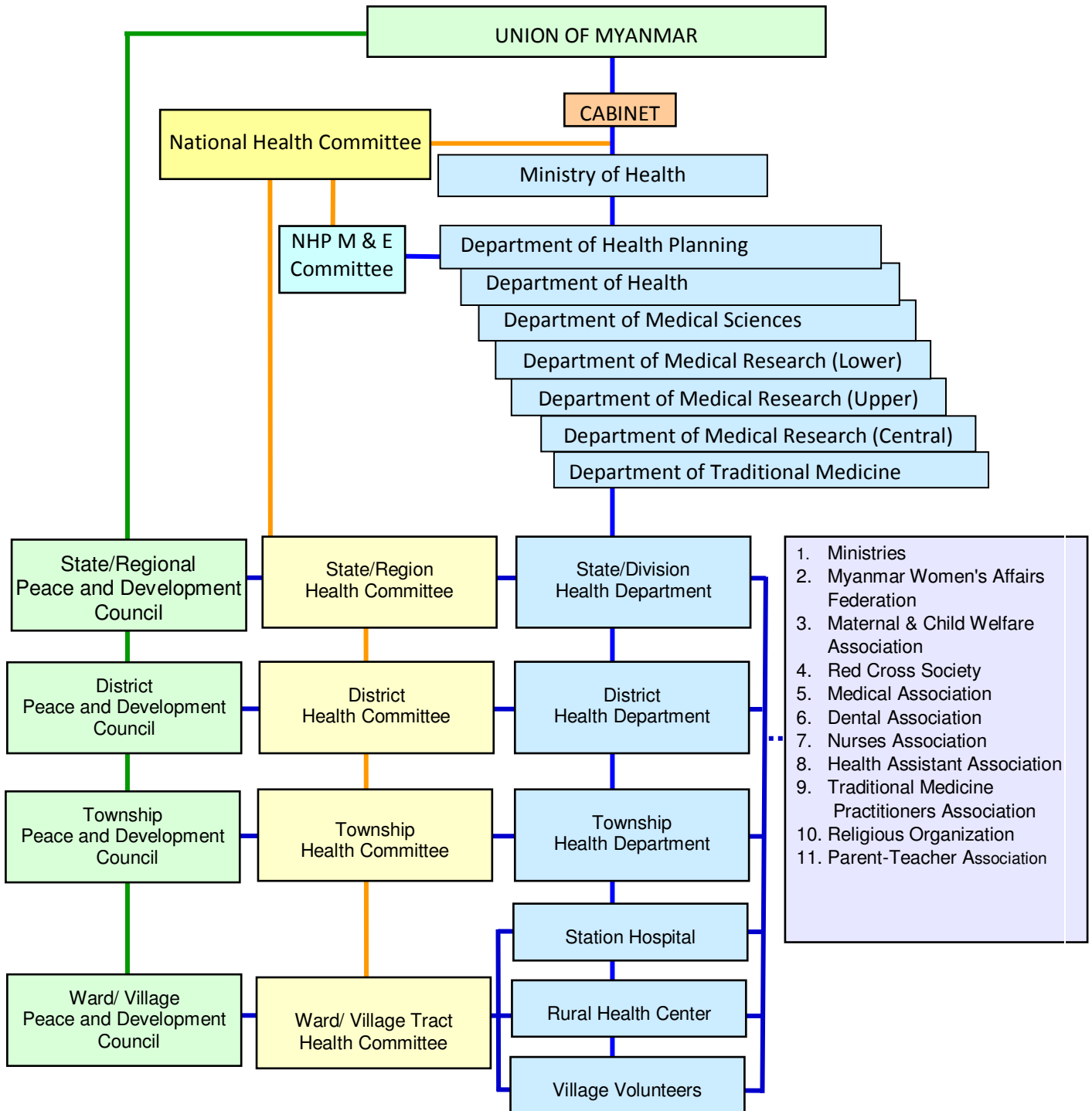
Source: Health Report of the Director of Health Services, Burma, August 1971

Organization and administration of health services from 1974 to 1988



Source: Country Profile, Department of Health, Burma, 1979

Organization of Health Service Delivery during the period of the State Peace and Development Council Government



Current Health Care System

In implementing the social objective laid down by the State, and the National Health Policy, the Ministry of Health is taking the responsibility of providing promotive, preventive, curative and rehabilitative services to raise the health status of the population. Department of Health one of 7 departments under the Ministry of Health plays a major role in providing comprehensive health care throughout the country including remote and hard to reach border areas. Some ministries are also providing health care, mainly curative, for their employees and their families. They include Ministries of Defense, Railways, Mines, Industry I, Industry II, Energy, Home and Transport. Ministry of Labour has set up three general hospitals, two in Yangon and the other in Mandalay to render services to those entitled under the social security scheme. Ministry of Industry (1) is running a Myanmar Pharmaceutical Factory and producing medicines and therapeutic agents to meet the domestic needs.

The private, for profit, sector is mainly providing ambulatory care though some providing institutional care has developed in Yangon, Mandalay and some large cities in recent years. Funding and provision of care is fragmented. They are regulated in conformity with the provisions of the law relating to Private Health Care Services. General Practitioners' Section of the Myanmar Medical Association with its branches in townships provide these practitioners the opportunities to update and exchange their knowledge and experiences by holding seminars, talks and symposia on currently emerging issues and updated diagnostic and therapeutic measures. The Medical Association and its branches also provide a link between them and their counterparts in public sector so that private practitioners can also participate in public health care activities. The private, for non-profit, which is another sector also providing ambulatory care though some providing institutional care has developed in large cities and some townships.

One unique and important feature of Myanmar health system is the existence of traditional medicine along with allopathic medicine. Traditional medicine has been in existence since time immemorial and except for its waning period during colonial administration when allopathic medical practices had been introduced and flourishing it is well accepted and utilized by the people throughout the history. With encouragement of the State scientific ways of assessing the efficacy of therapeutic agents, nurturing of famous and rare medicinal plants, exploring, sustaining and propagation of treatises and practices can be accomplished. There are a total of 14 traditional hospitals run by the State in the country. Traditional medical practitioners have

been trained at an Institute of Traditional Medicine and with the establishment of a new University of Traditional Medicine conferring a bachelor degree more competent practitioners can now be trained and utilized. As in the allopathic medicine there are quite a number of private traditional practitioners and they are licensed and regulated in accordance with the provisions of related laws.

In line with the National Health Policy NGOs such as Myanmar Maternal and Child Welfare Association, Myanmar Red Cross Society are also taking some share of service provision and their roles are also becoming important as the needs for collaboration in health become more prominent. Recognizing the growing importance of the needs to involve all relevant sectors at all administrative levels and to mobilize the community more effectively in health activities health committees had been established in various administrative levels down to the wards and village tracts. These committees at each level were headed by the responsible person of the organs of power concern and include heads of related government departments and representatives from the social organizations as members. Heads of the health departments were designated as secretaries of the committees.

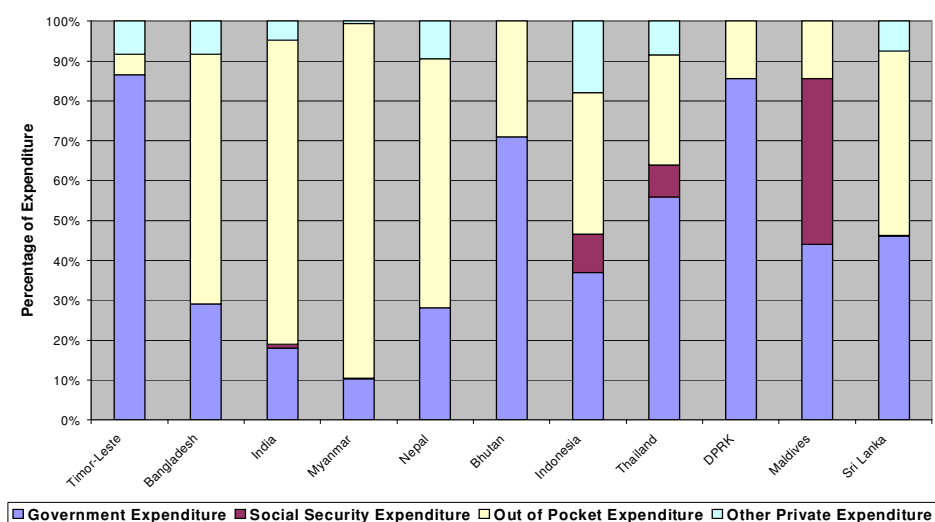
Health Financing aiming towards Universal Coverage

Promoting and protecting health is essential to human welfare and sustained economic and social development. This was recognized more than 30 years ago by the Alma-Ata Declaration signatories, who noted that “Health for All” would contribute both to a better quality of life and also to global peace and security. There are many ways to promote and sustain health. Some lie outside the confines of the health sector. The “circumstances in which people grow, live, work, and age” strongly influence how people live and die. Education, housing, food and employment all impact on health. Redressing inequalities in these will reduce inequalities in health. It determines whether people can afford to use health services when they need them. Recognizing this, the countries committed in 2005 to develop their health financing systems so that all people have access to services and do not suffer financial hardship paying for them. This goal was defined as *Universal Coverage*, sometimes called universal health coverage.

Globally, about 150 million people suffer financial catastrophe annually while 100 million are pushed below the poverty line. Health financing is an important part of broader efforts to ensure social protection in health.

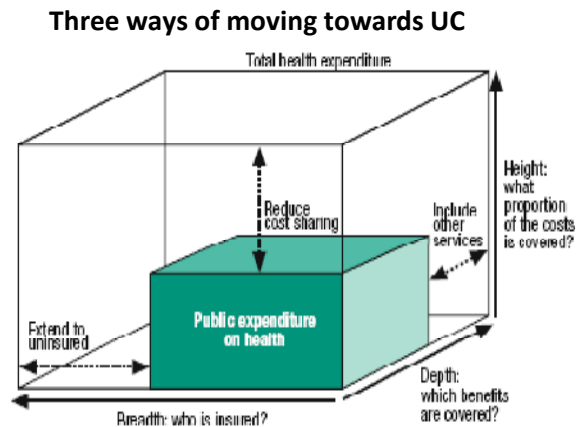
Countries in the South-East Asia Region are at different levels in terms of equitable financing through a mix of government expenditure and social insurance.

Health Financing in South-East Asia Region (2009)



Source: Health Financing Strategy for the Asia Pacific Region (2010-2015)

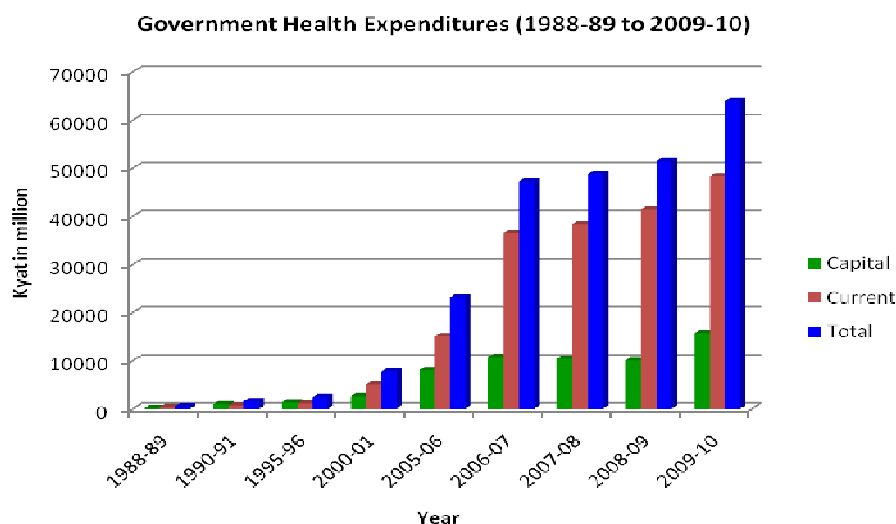
The approach to universal coverage allows three reinforcing strategic choices for countries to advance toward equity in health: in the choice of the benefit package, in the selection of priority populations and in public subsidy of cost of care. Countries must raise sufficient funds, reduce the reliance on direct payments to finance services, and improve efficiency and equity.



The health system has been plagued by much inefficiency in terms of financial, poor management, human resources among others. There are irrational practices being carried out with regard to use of medicines, overuse of medical services with unnecessary use of technologies. There is a need to strengthen the public health systems in the countries.

Health Financing in Myanmar

The major sources of finance for health care services are the government, private households, social security system, community contributions and external aid. Government has increased health spending on both current and capital yearly. Total government health expenditure increased from kyat 464.1million in 1988-89 to kyat 64001.2 million in 2009-10.



As spending by Ministry of Health as a financing agent constitutes the major share in the public spending on health and also taken into account the availability of data, estimates on public expenditures on health by financing entities were based solely on spending by the ministry. By functions curative and rehabilitative services accounted for around 32 to 38 % followed by 30% to 34% of spending devoted to health related functions. Prevention and public health accounted for about 22% to around 33% and Health Administration & Health Insurance accounted around 3% to 4%.

Governmental Health Expenditures by Functions (2006-07 to 2009-10)

Functions (%)	2006-07	2007-08	2008-09	2009-10
Curative & Rehabilitative	37.03	37.72	32.05	31.64
Ancillary Services	0.28	0.24	0.37	0.63
Medical Goods Dispensed	3.73	3.44	3.60	3.16
Prevention & Public Health	21.62	24.03	30.59	32.29
Health Administration & Insurance	3.68	3.86	3.63	2.86
Health Related Services	33.66	30.71	29.76	29.42

Social security scheme was implemented in accordance with 1954 Social Security Act by the Ministry of Labour. According to the law factories, workshops and enterprises that have over 5 employees whether State owned, private, foreign or joint ventures, must provide the employees with social security coverage. The contribution is tri-partite with 2.5% by the employer 1.5% by the employee of the designated rate while the government contribution is in the form of capital investment. Insured workers under the scheme are provided free medical treatment, cash benefits and occupational injury benefit. To effectively implement the scheme branch offices, workers' hospitals, dispensaries and mobile medical units have been established nation-wide.