What are the challenges facing Myanmar in progressing towards Universal Health Coverage?

Policy Note #1

Myanmar Health Systems in Transition
Policy Notes Series

Asia Pacific Observatory on Health Systems and Policies

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Policy Note #1

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The Government of the Republic of the Union of Myanmar is committed to achieving universal health coverage (UHC) by 2030. In practice, this means that over the next 15 years the aim is to progressively ensure that all people in all parts of the country have access to the health-care services they need – both preventive and curative – without suffering financial hardship when paying for them. This ambitious goal is seen as a desirable end in itself, and as a means to achieving people-centred development.

This policy note is the first in a set of four. It provides an overview of the challenges to be overcome in making progress toward UHC and sets out recommendations for how they can be tackled. The other notes look in more detail at three specific issues: how UHC can improve equity, and how strengthening the township health system and expanding financial risk protection contribute to UHC.

1. What are the challenges?

There are two fundamental challenges to be addressed, if the ambitious objectives of UHC are to be achieved.

Health has been a low priority

Health has lacked clear leadership. Despite a National Health Policy (1993) and national health development plans for the period 2000–2016, which included UHC as an overarching goal, political and economic stability has taken precedence over social and human development. Overall levels of funding for health have been insufficient to make the idea of health-for-all and financial protection a reality. The Government has seen health as the sole responsibility of the Ministry of Health and other parts of government with an influence on health outcomes fail to see health as relevant to their mandate. In part because of lack of evidence and in part through active opposition (e.g. from tobacco growers) health is seen neither as a contributor to peace nor to economic growth. The net result is a substantial gap between goals and objectives, the funding needed to achieve them, and the partnerships needed for effective implementation.

Health services function poorly

The second set of challenges is related to the first, but concerns the health system itself. Inadequate public financing means that too many people cannot access the services they need. There are several reasons for this, which together create a vicious cycle. Deterioration of health service infrastructure (clinics and hospitals) contributes to a decline in the standard of services. This is exacerbated by inadequate and unreliable supplies of essential medicine and equipment, and further compounded by inadequate numbers and maldistribution of staff. On top of this, a continuing reliance on out-of-pocket payments for health

care deters the poor from seeking health care or exposes them to unaffordable payments. The combination of these factors results in a public sector in which people have little faith, and a for-profit private sector that offers low quality care, too often at high prices. Breaking this vicious cycle requires action on several fronts.

2. What do we know?

There is a growing body of evidence that illustrates the magnitude of these challenges.

- **Primary care takes second place to hospital services:** Despite being one of the first countries in the South-East Asia Region to develop a primary health care approach, training of health workers and development of health facilities have focused more on doctors, nurses and hospitals, as opposed to health workers at primary facility and community level. Evidence shows that there has been little or no change in the number of primary health care facilities – station hospitals, rural health centres, maternal and child health centres, and school health teams – since the late 1980s. Myanmar national health accounts suggests that government health spending has been directed more towards high-end tertiary services located in big cities, which offer limited access to the rural poor.

- **Access to services remains highly inequitable:** Despite policies to expand services to rural and hard-to-reach areas, monitoring data indicate that disparities still exist in service availability and health outcomes across regions and across socio-economic groups. Coverage of basic services in regions and states with significant hard-to-reach areas is thus considerably lower than in other parts of the country, despite their greater health needs. In some areas non-state actors have established ethnic health authorities and community-based organizations have opposed expansion of government services, seeking instead for recognition of their own work. Shared understanding of this situation is growing but interventions to strengthen alignment are hampered by slow progress in the peace process.

- **The poor rely on private providers:** Most poor households rely on private health-care providers because of their physical proximity, shorter waiting times, availability of staff and drugs, and perceived quality of care. The use of private health care is made additionally necessary by the scarcity of public health services in peripheral areas of the country. The lack of

adequate private sector regulation means that the poor are vulnerable to overpriced services, which are often of very poor quality.

- **User charges discriminate against the poor:** Household out-of-pocket payments became a dominant source of health service financing following reforms in the 1990s. As a result, utilization of services depends more on capacity to pay for medical care and transport costs than health needs. Measures taken to protect the poor and support the destitute have been found to be ineffective.

- **Deployment and retention of staff are major challenges:** A range of factors including, but not limited to, low salaries affect the motivation of all public health staff. However, this is particularly problematic when it comes to placing and retaining health workers in less-secure and hard-to-reach areas. Hardship allowances have had little impact and have been judged to be financially unsustainable. The result is that vacant posts are not filled, making it impossible to ensure adequate services in those areas. Alternative approaches such as contracting local nongovernmental organizations (NGOs) to provide services have yet to be tried on a large scale.

- **New graduates cannot find jobs in the health service:** Despite a manifest shortage of human resources, it is assumed that budget constraints mean that many new professional graduates cannot find positions in the health service, but more evidence is needed to determine whether this is the main issue. Whatever the reason, many doctors either migrate abroad or work in private practice, usually in the main towns and cities. A similar situation exists for nurses and other health and paramedical professionals.

- **Scarce resources are allocated inefficiently:** The priority given to hospitals means that the government is not achieving good value for money. Similarly, procurement reform for pharmaceuticals (which is now underway) has the potential to result in significant savings. Reallocation towards primary care, which allows for prevention and promotion as well as treatment, will result in far better health outcomes even at low levels of investment. Of equal concern is the fact that money spent on hospitals is also being used inefficiently. A study conducted in 2011 showed that 60% of hospitals surveyed performed poorly in terms of bed turnover ratio, bed occupancy rate and average length of stay.

3. What needs to be done?

This Policy Note makes three closely linked sets of *recommendations*, namely to:

A. Increase financial investment in health as a cornerstone of people-centred development;
B. create the partnerships and governance mechanisms needed to ensure that better health is an outcome of policies and programmes in all sectors; and
C. strengthen the township health system (THS) with a new focus on equity and efficiency.[1]

These recommendations are interdependent if UHC is to be achieved. Thus, seeking to strengthen the current health system without a *significant* increase in resources is likely to achieve little. Relying purely on the health sector to produce a more healthy population, in the absence of addressing the other determinants of ill health, will pay limited dividends. And strengthening the health system as it currently operates, without fundamental reform that focuses on significant and measurable efficiency gains, will result in deepening inequity and continuing waste.

A: Increasing investment in health

It is important to note that the Government has taken steps to increase the health budget, but has done so from a very low base.[2] Myanmar still spends less as a proportion of gross domestic product, and as a proportion of overall government spending, than its neighbours and other countries in the South-East Asia Region. The key message is that without significant increases it is unlikely that even current plans for staffing, facilities or commodities will be affordable.

The first step is to systematically review opportunities for increasing the fiscal space for health. Here, there are several options to consider. To date, most of the increase in health spending has resulted from overall economic growth. In other words, health has maintained a constant share of a growing pot of resources. The next obvious step therefore is to assess the potential for reallocation to health from other sectors (increasing the *share* of the overall pot), using the evidence that shows how health can significantly contribute to economic growth as a compelling part of the business case. Reallocation is likely to be more acceptable as overall fiscal space increases through tax reform, more effective tax collection, and new revenue streams (from natural resources, for example).

1 **Policy Note #3:** *How can the township health system be strengthened in Myanmar?* provides more details on strengthening township health systems.
2 The 2015/2016 budget of US$602 million is 8.7 times that of 2011/2012.

A further option to be considered is using so-called "sin taxes" – imposing a levy on items such as tobacco, alcohol or sugary drinks – that can be used in whole or in part to finance health expenditures. Such taxes or levies have a direct public health benefit as well as generating additional resources.

With the opening up of the country, Myanmar will continue to attract external development assistance, and for many donors health is a priority.[3] It is important that external funding does not displace domestic resources, so that external funding is *additional* to domestic spending.

In summary, there is a political window of opportunity during the upcoming general election to increase health spending, as a key to achieving UHC.[4]

B: Health in all policies

Better health cannot depend on health services alone. While the case for greater investment in health rests in part on the contribution that health makes to national economic development, health is a significant beneficiary from good policy in other sectors. Moreover, the role that other sectors play is now an increasingly important element of UHC, particularly as the proportion of death and disability attributable to road traffic accidents and noncommunicable conditions like cancer, diabetes and cardiovascular and respiratory disease increases.

The health sector must be an advocate for policy change, but real progress will depend on actions in other sectors and will require high-level political support. In this sense, health becomes a governance issue, requiring a careful assessment of how each sector can make a difference. The urgency of the issue is compounded by the evident speed of private sector investment in Myanmar.

In many areas, new investments in sectors such as communications, rural transport, financial services and telecommunications can have a positive impact on health and health systems. At the same time, the increasing availability of fast food, tobacco products and alcohol, combined with risk factors such as more sedentary lifestyles and environmental degradation, are likely to have a negative effect on people's health.

3 Recent developments suggest that this may no longer be the case as Australia, the European Union and DANIDA plan to discontinue health funding.
4 **Policy note #4**: *How can financial risk protection be expanded in Myanmar?* provides additional details on health financing and social protection.

Policy coherence across government is equally important in relation to health financing. For example, while the Ministry of Social Welfare, Relief and Resettlement is taking the lead on introducing formal social protection, the Ministry of Labour, Employment and Social Security is concurrently expanding social security coverage. Given the importance of financial protection as one component of UHC, it is critical that different arms of government approach social protection in ways that are well aligned and synergistic. Health will also benefit from investment in disaster preparedness, prevention of road traffic accidents and water and sanitation.

The Ministry of Health has a key role in generating the evidence that policy-makers need to weigh the positive and negative impacts of policies in other sectors. It will also require a careful assessment of the governance instruments (legal, regulatory, public communications, target setting and monitoring) that are needed to ensure that health is a beneficiary and not a casualty of developments in other sectors.

C: Strengthening township health systems

Firstly, the key message is that making health systems more equitable, effective and efficient requires action on many fronts. Like any system, the different elements are dependent on each other: human resources, supplies and logistics, financial management, leadership, health information, planning and budgeting, public engagement and communications, monitoring and evaluation. Any actions to be taken need to be strategic, sustained and consistent. Taking into consideration the many bottlenecks that require urgent attention, both immediate and long-term measures are needed. Secondly, it is vital to recognize that strengthening the system is not an end in itself. It is a means to ensure people have access to quality health care that delivers good health outcomes. With this in mind, a number of actions need to be considered.

- **Declaring a decade for township health systems development (2016–2026) sends a powerful message:** The THS is the vital strategic front. A declaration focusing on the township will signify strong political leadership and long-term sustainable financial commitment. While greater decentralization of financial authority is a prerequisite, support from regional/state authorities in the form of policy frameworks, technical guidance, monitoring and supervision will be essential[5].

- **Reducing inequity is of paramount importance for the health sector as a whole:**[6] However, progress in reducing inequities will require major reforms at township level and

5 **Policy note #3**: *How can the township health system be strengthened in Myanmar?* provides more details on these points.
6 See **Policy note #2:** *How can health equity be improved in Myanmar?* on health equity provides more details.

below to ensure health-care services reach the poor and disadvantaged groups. This is particularly so for minority groups and people in conflict-affected areas.

- **Upgrading close to client services is urgent:** Priority should be given to increasing the quality of care provided at rural health centres, sub-rural health centres and station hospitals in rural areas, before upgrading secondary and tertiary urban hospitals.

- **Up-to-date service mapping will reveal the current maldistribution of facilities:** Service-delivery infrastructures should be equitably distributed across the country. The most needy areas should be prioritized through rapid assessment and adequate supply of essential medicines and basic medical equipment, made available on the basis of level-of-care needs of individual localities. Service delivery mapping should include all providers including the private sector, NGOs, and ethnic health organizations.

- **Monitoring equity is key to ensuring accountability:** Regular monitoring of how health equity has improved, stagnated or regressed is a priority for sound policy-making. Evidence on all dimensions of health inequity – geographical, socioeconomic, ethnicity and maternal educational level – provides a platform for holding different stakeholders to account. Support will be needed to build the capacity for effective equity monitoring.

- **The Health Management and Information System (HMIS) needs to be strengthened:** While the HMIS should be able to generate adequate indicators of acceptable quality, the system needs to be further strengthened if it is to generate more reliable evidence. The HMIS currently collects data only from public facilities. With the upcoming Demographic and Health Survey now is the time to explore inclusion of the private sector in data sharing.

- **The township health system includes all health providers:** The purpose of coordination at township level is to ensure that different departments and programmes deliver health services responsively and effectively. The THS (and township health plans) must include all providers of health care: public, private and NGOs.

- **Station hospitals can become more efficient:** Many station hospitals do not perform well and provide poor-quality services. Inadequate staffing, insufficient supplies and outdated equipment exacerbate this situation. Station

hospitals can save lives; ensuring that they have the means to do so is a priority, given their importance to the rural poor.

- **A more systematic approach to the work of Basic Health Staff is needed:** Basic health staff are the backbone of the THS: making the best use of their skills and enhancing their motivation is critically important. A systematic review of roles, responsibilities and workloads is required. This review should determine how the tasks should be distributed among rural health team members; what potential tasks should be shifted to others such as auxiliary midwives and community health workers; how the productivity of basic health staff should be assessed; and what skill mix is required to deliver services in line with the health needs of the population. The review should take into account changing patterns of disease, notably the growing prevalence of noncommunicable diseases.

- **Interim measures should be introduced prior to an essential package of care:** The Ministry of Health is in the process of developing an essential package of health services that will be covered (and also fiscally sustainable) under UHC. Reaching consensus on this package will take time. In the interim, it is desirable to agree on a more limited range of cost-effective interventions, based on international experience and evidence, that target selected services such as maternal, newborn and child health care.

- **Free access to medicines for all now would demonstrate political commitment to UHC:** One immediate action the Government should consider is to ensure free access to essential medicines for the whole population as a signal of its commitment to UHC. This is not only ethically sound, given high levels of poverty, but also politically strategic. The Government has already increased spending on free essential medicine significantly since 2012. There is some evidence, however, that poor supply and logistic systems have meant that medicines have not always reached facility level. An expansion of this programme would therefore benefit from a rapid assessment of progress to date, to ensure that existing measures are effective, equitable and sustainable, and that supply bottlenecks have been overcome.

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