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Moving toward UHC

Myanmar

NATIONAL INITIATIVES, KEY CHALLENGES, AND THE ROLE OF COLLABORATIVE ACTIVITIES

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Myanmar's snapshot

UHC Service Coverage Index *(SDG 3.8.1, 2015)*

61%

Catastrophic OOP health expenditure incidence at the 10% threshold *(SDG 3.8.2)*

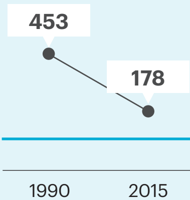
NO DATA

Results of Joint External Evaluation of core capacities for pandemic preparedness *(JEE, 2017)*

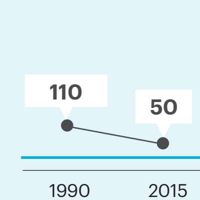
Score (for capacity)		# of indicators (out of 48)
5	Sustainable	0
4	Demonstrated	2
3	Developed	16
2	Limited	17
1	No capacity	13

Health results

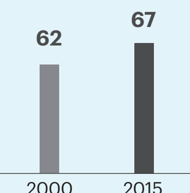
Maternal Mortality Ratio *(WHO)*
Per 100,000 Live Births



Under-Five Mortality Rate *(WHO)*
Per 1,000 Live Births



Life Expectancy at Birth *(WHO)*



Wealth Differential in Under-Five Mortality *(PHCPI)*

NO DATA

More deaths in lowest than highest wealth quintile per 1,000 live births

Performance of service delivery – selected indicators *(PHCPI, 2014-2015)*

	Myanmar	LMIC average
Care-seeking for symptoms of pneumonia	58.2%	61.5%
Dropout rate between 1st and 3rd DTP vaccination	5.3%	7.5%
Access barriers due to treatment costs	34%	47.4%
Access barriers due to distance	23.4%	35.8%
Treatment success rate for new TB cases	87%	80.1%
Provider absence rate	NO DATA	28.9%
Caseload per provider	NO DATA	9 per day
Diagnostic accuracy	NO DATA	47.9%
Adherence to clinical guidelines	NO DATA	33.6%

See page 8 for References and Definitions.

Existing national plans and policies to achieve universal health coverage (UHC)

SERVICE DELIVERY REFORMS

In 2017, the government of Myanmar endorsed the National Health Plan (NHP) of 2017–2021, which aimed to increase equity and financial protection and extend access to the basic Essential Package of Health Services (EPHS) for the entire population by 2021. It is the first of the three phases envisioned to reach UHC by 2030, a goal which has the highest level of political commitment in Myanmar. The Plan sets forth many service delivery reforms. The basic package of services is explicitly stated and covers a wide range of interventions for reproductive, maternal, newborn, child, and adolescent health (RMNCAH); nutrition; communicable and noncommunicable diseases; and emergency conditions. Though the package is broader than RMNCAH, the NHP aims to improve health and nutrition for women and children in line with the Reproductive Health Strategic Plan of 2014–2018 and the National Strategic Plan for Newborn and Child Health Development of 2015–2018.

The NHP recognizes the important role of the private sector in expanding access to services. The involvement of ethnic health organizations (EHOs) and improvements in access to services in conflict-affected areas position health as a bridge to peace, for example, by certifying providers in border areas in basic emergency obstetric care. Furthermore, human resource reforms are being initiated, which include assessing the role of Voluntary Health Workers and revising the job descriptions of Basic Health Staff in the context of delivering a basic package of services for UHC. Other components, such as infrastructure development, health information systems, and public financial management, are also identified and prioritized for strengthening to ensure that health facilities at the township level and below have all required inputs to deliver services that are geographically accessible and affordable for all.

HEALTH FINANCING REFORMS

Progress toward UHC and achieving the goals of the NHP will not be possible at Myanmar's current low level of public spending. Despite a substantial increase in public health spending over the past five years, the public share of spending remains low relative to other countries at a similar income level. The NHP advances new health financing models and systems, including the introduction of risk pooling and active purchasing of services to reduce financial barriers to care. The Parliament has agreed to proceed with the drafting of a Health Insurance Bill, and broader public financial management reforms are under way in financing of provider services. Myanmar's 2016/17 Budget Policy Statement identifies increasing the allocation to health and education as fiscal policy objectives. The NHP also laid out a vision for strategic purchasing of health services in the public sector, which would help provide access to health services more effectively and efficiently, including through private sector providers. Details on purchasing arrangements still need to be established and defined in the Health Financing Strategy.

The National Health Plan 2017–2021 aims to increase equity and financial protection and extend access to the Essential Package of Health Services (EPHS) to the entire population by 2021.

GOVERNANCE REFORMS

The Myanmar Health Sector Coordinating Committee (MHSCC), chaired by the Minister, is the country-led multi-sectoral coordination platform for health, first established as a reform of a Global Fund Country Structure in charge of overseeing the national response to AIDS, malaria, and tuberculosis (TB). MHSCC has evolved to improve oversight, promote collaboration, and increase accountability for ongoing and new initiatives and policies. For example, the implementation of maternal and child health strategies was discussed at the MHSCC to prevent duplication of efforts and reduce additional administrative strain on the government. The Committee has representatives of government ministries, United Nations agencies, international organizations, donors, international and local nongovernmental organizations (NGOs), and the private sector. The reorganization of the Ministry of Health and Sports, including the remerging of the Departments of Public Health and Medical Services, helps to facilitate seamless oversight and decision making across the continuum of care.

Key challenges on the way to UHC

WEAKNESSES AND BOTTLENECKS IN SERVICE DELIVERY

Coverage of essential health services. Rates of maternal mortality, infant mortality, and stunting in Myanmar are high compared to other Association of Southeast Asian Nations (ASEAN) countries. For most reproductive, maternal, newborn, child, and adolescent health indicators, rates in the best-served regions are double those in the least-served regions. Service delivery is constrained by difficult terrain, conflict in border areas, health systems challenges, particularly inadequate distribution of human resources, poor physical infrastructure, insufficient financing, and low absorptive capacity. In remote and hard-to-reach areas, it is difficult to deploy and retain health workers. Despite an increase in the number of health workers per capita since 2010, that number still falls below the threshold recommended by WHO. There are significant inequities in both health status and coverage (i.e., rural/urban, state/region, income groups, etc.). Children in conflict-affected and hard-to-reach areas are especially vulnerable. Health staff are deterred from conducting outreach visits in some remote areas due to high transportation costs, which they often even pay out of their own salaries. On the demand side, women and girls face obstacles to seeking care and information about reproductive health due to gender norms and traditional beliefs and practices around birth, feeding, and rearing.

Quality of care. A recent health facility assessment identified limited clean water accessibility for patients, inadequate regular cleaning, limited staff training on infection prevention and control, and limited budgets for facility maintenance and operations. The private sector is a major source of primary and ambulatory care, providing the majority of these services. However, Myanmar's regulatory bodies and frameworks for overseeing quality of care and the competency of providers, particularly in the private sector, are nascent. Access to affordable medicines is a critical proxy for quality of care due to being a significant contributor to out-of-pocket (OOP) spending, but this has not been addressed strategically.

Pandemic preparedness. A 2017 Joint External Evaluation (JEE) of International Health Regulations (IHR) core capacities revealed that Myanmar's overall level of pandemic preparedness is low. The only two areas for which there is currently demonstrated capacity are national vaccine access and delivery, and indicator-based and event-based surveillance systems. In addition to other specific gaps, Myanmar currently has limited capacity in preparedness, medical countermeasures and personnel deployment, chemical events, and radiation emergencies.

THE STATE OF HEALTH FINANCING

Overall funding for health. Total health spending per capita in 2014 was estimated to be US$20, about 2% of GDP (WHO Global Health Expenditure Database—GHED, 2017). Out-of-pocket (OOP) spending is the dominant source of health financing, comprising 51% of the total in 2014 (GHED, 2017). Bottlenecks in the flow of funding at the central level hinder effective program implementation at subnational levels and financial allocation inequities between state/regional administrative units require additional consideration.

Major financial protection schemes. There is a long history of social health insurance/social security in Myanmar, but no comprehensive health insurance system; health coverage remains extremely low. The social security system established in 1956 covers predominantly private sector employees in the formal workforce—coverage does not even extend to the families of insured employees. The scheme covers less than 2% of Myanmar's population, and social health insurance spending amounted to just 1% of government health spending in 2014 (WHO GHED, 2017). Employees contribute 1–6% of their salary and obtain benefits such as medical treatment, maternity leave, and cash benefits for the sick. There are currently no financial protection schemes for the poor and informal sector—indigents were meant to be exempt from user fees when they were first introduced in Myanmar in the 1990s, but there are no mechanisms in place to ensure user fee exemption.

Free and subsidized care. Since 2012, in theory, care for all emergency, maternal, and childhood illnesses has been provided free of charge in all public hospitals due to increases in government health expenditures. A free medicine policy was introduced in 2011/12, but there remains a lack of clarity and poor communication on the scope of the policy, and an overall lack of awareness on what services are non-chargeable versus those that continue to have an element of "community cost-sharing." The EPHS will be introduced progressively in three phases over the next fifteen years (a basic package accessible to all by 2021, an intermediate package by 2025, and a comprehensive package by 2030). This package will also define cost-sharing ratios, if any, for nonpoor segments of Myanmar's population, providing clarity on expected costs when seeking care and reducing uncertainty about out-of-pocket fees.

GOVERNANCE CHALLENGES

Rural-urban divide. Disparities in service availability, quality, and health outcomes exist across Myanmar's regions, conflict-affected areas, and socioeconomic groups. In rural and hard-to-reach areas, coverage of basic services is lower, despite greater needs, and in some areas ethnic health authorities directly provide primary care services. Financial incentives to retain health workers in less-secure, hard-to-reach areas, such as special consideration for postgraduate studies, promotions, and studying overseas, have been implemented. However, retention of health workers remains a challenge, resulting in coverage gaps. Other priorities include strengthening implementation capacities at the subnational level, moving beyond curative care alone, and increasing multi-sectoral leadership at the central level.

Conflict and health. Myanmar, under the leadership of the State Counsellor, is embarking on an inclusive peace dialogue and process. However, in some conflicted-affected areas, overall underdevelopment affecting communities is compounded by ongoing tensions and restricted movement of people and providers.

Health results and coverage of essential services vary greatly by region – with coverage significantly lower in rural and hard-to-reach areas.

Collaborative efforts to accelerate progress toward UHC

EXISTING INITIATIVES SUPPORTED BY EXTERNAL PARTNERS

External partners are engaged in Myanmar to build national capacity and strengthen the health system, in line with the priorities of the National Health Plan. The Tokyo Joint UHC Initiative, supported by the government of Japan and led by the World Bank (WB), in collaboration with the Japan International Cooperation Agency (JICA), United Nations Children's Fund (UNICEF), and the World Health Organization (WHO), is supporting the government of Myanmar and strives to accelerate progress toward UHC. This support will enable nationally-led strategic health system strengthening to achieve UHC, as well as pandemic preparedness.

To improve sustainable financing and strengthen regional and cross-sectoral cooperation in the East Asia and Pacific (EAP) region that includes Myanmar, the government of Australia, the World Bank, WHO, the Food and Agriculture Organization (FAO), the World Organization for Animal Health (OIE) and other partners are supporting the following objectives: (i) increasing diplomatic and policy engagement, advocacy for sustainable and efficient domestic and external financing, and generating evidence on financing and capacity gaps; (ii) improving regional collaboration to address transborder transmission of infectious diseases; and (iii) providing technical support for knowledge generation and sharing, and capacity building in national and regional institutions. In line with the Sustainable Development Goals agenda and the need for universal, equitable access to high impact interventions, UNICEF, the United Nations Fund for Population (UNFPA), WHO, the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the World Bank/Global Financing Facility (H6 working group) are committed to data-driven planning and implementation to address maternal and child mortality, including policy development and ensuring the supply and quality of RMNCAH services, in accordance with international norms and standards. The H6 working group will support the National Health Plan 2017–2021 with joint technical expertise, ensuring appropriate prioritization, and mobilization of resources.

PLANS FOR FUTURE COLLABORATIVE WORK

Policy and Human Resources Development (PHRD)-funded advisory support

The work under the Tokyo Joint UHC Initiative falls within four key objectives: (1) conduct a situation analysis, review existing preparedness capacities, and identify stakeholders; (2) supply a cost national preparedness plans; (3) develop a financing plan to address financing gaps; and (4) strengthen a framework for governance and institutional arrangements. Fulfilment of each of the objectives will produce a relevant national plan, while the fourth objective is also intended to produce a governance framework for training and capacity building at the state/regional levels. Furthermore, the joint work will closely cooperate with other investments in health, such as those by the Global Fund and Gavi, to contribute to health system strengthening. Considering that nutrition and water and sanitation compose the foundations of heath for all, challenges in these fields also will be considered under the joint work.

These advisory activities will complement other development partners' investments, supporting the implementation and achievement of key system strengthening milestones. For instance, they will support the achievement of key pandemic preparedness targets or milestones, such as the preparation of pandemic preparedness plans that are linked to disbursement of funds under the Essential Health Services Access Project under IDA18. Future efforts can further build on PHRD-funded pilot activities to generate evidence for mobilizing resources under IDA18 to better support the UHC agenda.

H6 support

Given Myanmar's participation in the Global Financing Facility (GFF) as a recipient of the GFF Trust Fund, the H6 will use this opportunity to facilitate the development of an investment case to analyze, plan for, and implement prioritised efforts to promote financial sustainability in the context of accelerating progress on UHC. It will also support government-led mechanisms to convene inputs from civil society, the private sector, and multilateral and bilateral agencies. H6 support will build on existing MHSCC governance structures while ensuring that these embody the two key principles of inclusiveness and transparency.

References & Definitions (page 1 indicators)

UHC Service Coverage Index (2015) – WHO/World Bank index that combines 16 tracer indicators into a single, composite metric of the coverage of essential health services. For more information: WHO/World Bank (2017). Tracking UHC: Second Global Monitoring Report.

Catastrophic out-of-pocket (OOP) health expenditure incidence at the 10% threshold (Single data point, year varies by country) – WHO/World Bank data from Tracking UHC: Second Global Monitoring Report (2017). Catastrophic expenditure defined as annual household health expenditures greater than 10% of annual household total expenditures.

Results of the Joint External Evaluation of core capacities for pandemic preparedness (2016/17, year varies by country) – A voluntary, collaborative assessment of capacities to prevent, detect, and respond to public health threats under the International Health Regulations (2005) and the Global Health Security Agenda. 48 indicators of pandemic preparedness are scored using five levels (1 is no capacity, 5 is sustainable capacity). https://www.ghsagenda.org/assessments

Life Expectancy at Birth (2000-2015), Maternal Mortality Ratio (1990-2015), Under-five Mortality Rate (1990-2015) – WHO Global Health Observatory: http://apps.who.int/gho/data/node.home

Wealth Differential in Under-five Mortality (Single data point, year varies by country) – Indicator used by the Primary Health Care Performance Initiative (PHCPI) to reflect equity in health outcomes. For more information: https://phcperformanceinitiative.org/indicator/equity-under-five-mortality-wealth-differential

Performance of service delivery – selected indicators (Single data points, years vary by country) – Indicators used by the Primary Health Care Performance Initiative (PHCPI) to capture various aspects of service delivery performance. PHCPI synthesizes new and existing data from validated and internationally comparable sources. For definitions of individual indicators: https://phcperformanceinitiative.org/about-us/our-indicators#/

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