

VIDEO TRANSCRIPT FOR “REFORMING MYANMAR’S HEALTH SYSTEM”

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On-screen text:

Reforming Myanmar’s Health System
a discussion with Dr. Phyu Phyu Thin Zaw

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Dr. Phyu Phyu Thin Zaw
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Phyu Phyu Thin Zaw: When we talk about a health system, we have certain components that we should look at. Historically, Myanmar’s health system has been shaped by different political systems and regimes. From 1885 to 1948 is a colonial period; Myanmar’s health system is developed based on [the] British health system. From 1948, Myanmar gained independence, as I said before, and Myanmar’s health system is temporarily interrupted due to armed conflicts in the area, in the country. Then, from 1962 to 2011 [Myanmar] is [a] military regime. Due to lack of investment in health, Myanmar’s health system has deteriorated over time. This is just a brief history.

When we look at details of Myanmar’s health system, we have 5 components to look at. For example, leadership. Myanmar’s health system is run by Ministry of Health, Myanmar. During [the] military regime, the leadership is totally bureaucratic. The policies came from above. There is almost no autonomy or transparency concerning budget allocation to policymaking.

Another component we have to look at is healthcare financing. Myanmar spent very little on health in the past almost 60 years. Government health expenditure in Myanmar is the lowest in the Southeast Asian countries; it is around 2.4 percent in 2012. In the United States, the government spent 17 percent to 20 percent of its GDP for health. So Myanmar spent very little on health. Another important thing is [that in] Myanmar, people had to pay [for] everything out-of-pocket concerning with health. To simplify, the majority of the population in the country has to take care of their own health by their own means. The out-of-pocket health expenditure in Myanmar is the highest in [the] Southeast Asia region, and probably the highest all over the world. There is no health insurance system in the country, so the majority of the population [is] not covered by any social security system.

The third component we have to look at is healthcare personnel and health infrastructure. There is not enough healthcare personnel in the country. It is far below the global standard of 2.3 health personnel per 1000 population. Essential medicines and other essential healthcare infrastructures like hospitals and hospital beds are also very limited in the country.

The fourth component we often look at is health system information and technology. Concerning this issue, Myanmar’s health information system is very weak. The population survey—a nationwide survey—cannot be carried out as frequently as needed, and so policymaking is very difficult when we don’t have enough data to base [it on]. The habit, the culture of evidence-based policymaking is very limited—not very developed—in the country.

The fifth component that we should look at is service delivery. Myanmar health system’s service delivery has two components: the curative and preventive. To simplify, the availability of the services depends on where you live in the country. If you live in a rural area, all you can get is a midwife or a rural health center. In the urban area, you can go to hospitals, private hospitals,

etcetera. This is also the rural-urban gap. But anyway, as long as you have enough money to travel and to pay the service fee, you can go to any service delivery places, because there is no gatekeeping mechanism, and almost everything you have to pay [for] out of your pocket.

On-screen text: What health systems can serve as models for Myanmar?

Phyu Phyu Thin Zaw: The good example that Myanmar should follow is Thailand's universal health coverage scheme. Of course this scheme has its own drawbacks, but it is still worth learning from Thailand, because Myanmar and Thailand have very similar backgrounds.

Another good example that I should give is Cuba's health system. Cuba is also an isolated country. Cuba has very limited natural resources and it is under sanctions by the United States for almost half a century. However, Cuba was able to manage to achieve universal health coverage since very [early on]. Cuba's health system is based on preventive medicine, and Cuba's research and information technology concerning health is very developed. As WHO put it, limited resources should not be an excuse to provide low healthcare to the population; it is just the outcome of the lack of political will. So Cuba is a good example that Myanmar should follow.

On-screen text: What progress has Myanmar's healthcare system made in recent years?

Phyu Phyu Thin Zaw: My research looks at the current changes made by the Ministry of Health starting from 2011 to date. When we look at the changes, the most obvious change is government expenditure. Government expenditure has increased from 2.4 percent in 2012 to 3.8-something percent in 2015. It is really a prominent increase. But still it is below the ASEAN standard of government health expenditure. This is the first change.

Another change is concerning universal health coverage. Myanmar set a goal to achieve universal health coverage in 2030. To achieve this goal, Myanmar carried out so many reforms from 2012 to date. For example, they increased payroll tax financing to give social security and health insurance to government employees and some corporate employees. But 70 percent of the population is living in the rural area. This is a big problem still; we don't know how to cover this population—how to collect the premiums from this group, etcetera. So there is a social security policy enacted in 2014 to find ways to cover this population. Still it is under discussion.

Another improvement is [that] there are some private health insurance systems recently launched in the country so that the people who can buy health insurance [are] able to do so.

Another good change is that Myanmar has started to collaborate with international organizations in the health sector. Previously, Myanmar received very little international aid due to political constraints. Now Myanmar has started to open up to international organizations, and I think this is very positive. Lots of NGOs are now starting to work in the country. The only problem is how the government will make those organizations adhere to the Paris Declaration on Aid Effectiveness.

On-screen text: What consequences will these changes have for the people of Myanmar?

Phyu Phyu Thin Zaw: This is a very important transitional period. The changes being made [during] this particular period will affect millions of lives in the country. If the policymakers and health personnel in decision-making positions—if they do the changes right, millions of lives will be saved, and millions of lives will have a [much] better quality of life. So this is a very sensitive transitional period. What I would like to conclude about these changes is not to make any mistakes and to learn from the past.

Another important issue that I should highlight here is the disparities in the allocation of healthcare services between rural and urban, as well as between conflicted areas and non-conflicted areas. This is a very sensitive issue, but we should not ignore the fact.

This is the time to review the healthcare resources and budget allocation very intensively. We should provide [to] those areas which received least in the past, and we should review the very pressing health needs of each state and region. The budget allocation and healthcare resources should be allocated based on those pressing needs. There should be a very strong principle on this issue because it is an equity issue. Without equity, Myanmar will never go forward—not only in the health sector, but also in every sector.