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PRIVATE SECTOR PARTICIPATION IN PUBLIC HEALTHCARE SECTOR IN MYANMAR

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A thesis submitted in partial fulfillment towards the requirements for the Degree of Master of Development Studies (MDevS)

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ABSTRACT

When large-scale investments are being considered, especially for Universal Health Coverage (UHC), the role of public and private sector which in turn public-private partnerships (PPPs) have been touted as a valuable option. This thesis examines the strength of established involvement, current operating status and future prospect of private sector participation in public healthcare in Myanmar. The objectives of this study are to examine the participation of private sector in public healthcare under implementing National Health Plan and financial contribution of private sector on healthcare and strengthening of health system in Myanmar. The study used descriptive method and secondary data is collected and extracted from Government of Myanmar official websites and publications. There are four key findings are being presented such as both sectors lack of responsible implementation on its own role, inadequate capacity especially financial contribution, inadequate regulation and weak enabling environment.

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LIST OF ABBREVIATIONS

ASEAN	Association of Southeast Asian Nations
BOT	Build Operate-Transfer
CSO	Central Statistical Office
CSO	Civil Society Organization
EIB	European Investment Bank
EPHS	Essential Package of Health Services
GDP	Gross Domestic Product
ICD	International Statistical Classification of Diseases and Related Health Problems 10th Revision
INGO	International Non Government Organization
IPD	In-Patient Department
LNGO	Local Non Government Organization
MIL	Myanmar Investment Law
MIR	Myanmar Investment Rule
MOHS	Ministry of Health and Sports
MSDP	Myanmar Sustainable Development Plan
NGO	Non Government Organization
NHP	National Health Plan
NIMU	National Health Plan Implementation Monitoring Unit
NLD	National League for Democracy
OECD	Organisation for Economic Co-operation and Development
OOP	Out-Of-Pocket
OPD	Out-Patient Department
PAPRD	Project Appraisal and Progress Reporting Department
PPP	Private Public Partnership
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
UN	United Nations
UNDP	The United Nations Development Programme
UNECE	The United Nations Economic Commission for Europe
UNFPA	The United Nations Population Fund
UNICEF	The United Nations Children's Fund
WHO	World Health Organization

CHAPTER 1
INTRODUCTION

1.1 Rationale of the Study

The country's station of healthcare services can be determined by how harmonized working public and private sector executing the National Healthcare System according to The National Strategies and Polices. The health sector plays an important role in attaining and cross-cutting with every Sustainable Development Goals (SDGs) either directly or indirectly. Since the present government was prescribed Myanmar Sustainable Development Plan 2018-2030 (MSDP), private sector participation in the provision of basic infrastructure in nationwide provides a solid foundation for enhancing national development agenda especially for health and education which had been reaching the lowest level among ASEAN countries. For every nation, healthcare is not only the basic needs but also contribute in national economy through health and well-being labour (workforce) in the aspect of preventive to curative as well as physical and mental wellness.

After sequential reforms in post 1988 period, private participation in providing primary, secondary and tertiary healthcare has been dramatically increased. Private participation can be seen in various forms, from fully privatized services to a range of Private Public Partnership (PPP) measures with the government institutes from the various stakeholders such as UNs, NGOs (local and international), Investors (local and foreign), Civil Society Organizations and even community led organizations and individuals (healthcare personnel).

Therefore, this thesis explores, analyses and examines the strength of established involvement, current operating position and future prospect of private sector participation in public healthcare in Myanmar. The Government of Myanmar is committed to improve the access and quality of health as part of its National agenda aimed at raising the overall level of social and economic development in the country.

After sequential reforms in post 1988 period, private participation in every aspect of healthcare system become allowed and enhanced. Private participation can be seen in various forms, from fully privatized healthcare to a range of PPP measures with the

Government which envision to addressing health inequities is of paramount importance for Myanmar.

Private sector healthcare delivery in low- and middle-income countries is sometimes argued to be more efficient, accountable, and sustainable than public sector delivery. Conversely, the public sector is often regarded as providing more equitable, affordable and accessible.

1.2 Objective of the Study

The main objectives of this study are to examine the participation of private sector in public healthcare and to present financial contribution of the of private sector on strengthening of health system under implementing National Health Plan

1.3 Method of the Study

Descriptive method is used in this study based on secondary data. Secondary data were be collected from the publications of Ministries; National Health Plan Implementation Monitoring Unit (NIMU), Department of Planning from Ministry of Health and Sports (MOHS) and Central Statistical Office (CSO) from Ministry of Planning and Finance and other reliable data source The World Bank and World Health Organization (WHO), UNs, NGOs and Profit organizations which are the main service providers of healthcare system in Myanmar. Previous studies relating to Myanmar's healthcare were also studied.

1.4 Scope and Limitations of the Study

In this study, the collaborative participation of selected private sectors (healthcare providers) in public sector is studied. Study period is the post 1988 reforms particularly 2008-2009 (after Cyclone Nargis) to 2018 (latest data available). Among the various participation and partnership stages and forms, the lowest level of health ranking in WHO data.

Therefore, the study conceptualized on the WHO health systems framework consists of six building blocks, namely (1) Service Delivery, (2) Health workforce, (3) Health Information, (4) Medical Technologies (including medical products, vaccines, and other relevant technologies), (5) Health financing and (6) Leadership and governance. All those six points will take into the aspect of economics, social, political, environmental and other development factors.

1.5 Organization of the Study

This study is organized by comprehensive five chapters. Chapter (1) is the Introduction which includes Rationale, Objectives and Method of the study together with Scope and Limitations. Chapter (2) is literature review about effectiveness of PPP and incudes definition and WHO framework of health sectors and its services. Chapter (3) includes Private and Public participation in Myanmar healthcare system. Chapter (4) becomes the main component of this thesis and it is composed of explore, analyse and examine the strength of established involvement, current operating status and future prospect of private sector participation in public healthcare in Myanmar against the two major components of Policy and Financial participation. Chapter (5) is the final chapter consisting findings and suggestions.

CHAPTER 2
LITERATURE REVIEW

This chapter reviews literature on effective partnerships of public and private sector. It contains Literature on Concepts and scope of Public Health Care System, Role of Public health care in Country Economy, Public and Private Partnership, Private Sector Participation in Health Care services, Review on Previous/Empirical Studies. It also presents gaps to be filled by the study and the conceptual framework.

2.1 Concepts of Public Health Care System

Public health is the art and science of averting disease, lengthening life, and promoting health through the organized efforts of the social order. The goal of public health is the biologic, physical, and mental well-being of all affiliates of society. Public health is concerned with the process of mobilizing local, state/provincial, national and international resources to assure the conditions in which all people can be healthy. To successfully implement this process and to make health for all achievable public health must perform the scope and functions listed as below.

2.2 Scope and Functions of Public Health[1]

1. Stop disease and its development, and injuries.
2. Encourage healthy regimes and good health customs.
3. Recognise, measure, monitor, and forestall community health needs.
4. Verbalize, encourage, and enforce vital health policies.
5. Unify and ensure high-quality, cost-effective public health and health-care facilities.
6. Lessen health disparities and ensure access[1] to health care for all.
7. Endorse and protect a healthy environment.
8. Distribute health evidence and mobilize publics to take appropriate action.

[1] https://oxfordmedicine.com/view/10.1093/med/9780199661756.001.0001/med-9780199661756-chapter-1

9. Strategy and concoct for natural and man-made catastrophes.
10. Decrease interpersonal violence and aggressive war.
11. Conduct study and evaluate health-promoting/disease-preventing policies.
12. Develop new methodologies for research and evaluation.
13. Train and ensure a capable public health workforce.

2.3 Role of Public and Private Sector in Health Care Services

In every democratic country's economy, there would be needed to work harmonically public and private sector vital for attaining economic growth and wellbeing of the country. Public sector contains of governments and all publicly controlled or publicly funded activities, initiatives and other objects that deliver public programs, goods or facilities. They are part of an economy concerned with providing rudimentary government facilities which mainly constitute of services such as national safety, public transports, education, healthcare, etc. The public facilities are in the nature of non-excludable and non-rivalry and encouraging justice.

Healthcare can be provided through public and private providers as well as local and international. Public health care is usually provided by the government through national healthcare systems. Private health care can be provided through "for profit" hospitals and self-employed practitioners, and "not for profit" non-government providers, including civil society organizations (CSOs) including UNs, Development Partners and NGOs.

There is substantial ideological debate around whether low- and middle-income countries should reinforce public against private healthcare amenities, but in reality, maximum low and middle-income countries use both types of healtcare delivery for the better coverage. Recently, as the Myanmar elected government has put major restrictions and deficiency on government budgets meanwhile implementing the universal healthcare coverage policy which makes the big burden of budget deficit. However, no doubt that this public healthcare provision is of most benefit to poor people and is the only way to achieve universal and equitable access to health care.

Public healthcare entities may have many disadvantages and which lead to government system disappointment. For instance, inadequacies of public sector may lead to herding out effects, rent seeking and some regulatory risk on economy. It is significant to ensure that governments deliver the application of promised policies

effectively whatever the problems exist. By doing so, public sector is its propensity to enlarge whilst not being able to deliver its directive to the satisfaction of its people. Public healthcare services should be delivered within a quality pledge framework. In particular, there should be commitment to build in quality by those who delivering services.

As for public sector, economic development and effective delivery of services become the most powerful challenges especially for the developing countries. Malfunctioning and poor responses in providing public goods and services erode the trust and face destabilizing effects in public sector.

2.4 Role of Private Healthcare Sector in Country Economy

Private healthcare sector is a part of the economy which is operated by private individuals or associations regardless of for profit or non-profit objectives. In every country economy, strong and active private sector is a vital component for economic development of a country, efficient market is necessary. There are many benefits of private sector such as creation of jobs, access to new technologies, improves productivity and raises incomes. These are the direct contribution of private sector in economy.

As a relation of private and public, through the payment of taxes by private sector, it enables government to invest in public goods and services and in turn provide social services which needs for the general public.

2.5 Public and Private Partnership (PPP)

PPP is a relationship between public and private entities that are responsible for the delivery of an infrastructure asset and /or associated services (servicing, operations, and maintenance). PPP is between the level of pure public sector and privatization. Major purposes for the PPP are to increase efficiency in project delivery, operation and management, to enhance availability of additional resources to meet the growing needs of investment in the sector and to access advanced technology. They enable the government to invest without liabilities and limitations.

According to the definition of PPP, it is necessary to distinguish it from other types pf public and private sectors interactions. By separating tasks, responsibilities and risks, it can be more cost-effective and can provide better delivery of service. Under PPP, each party draws its own benefit, proportionate to its interest.

Table (2.1) Major Partners in PPP (Types of PPP)

PPP partners		
Public sector	**Private sector**	**Civil Society**
- Municipal officials. - Politicians and decision makers. - Interested parties at higher levels of government	- Chambers of commerce. - International companies - National companies - Small-scale providers.	- Consumers ad users. - Community based organisations - Other representatives / leaders of the poor - Nongovernment organizations - Unions

Source: https://pppknowledgelab.org/partners

2.5.1 History of Public-private Partnership (PPP) and Permutations

A public-private partnership (PPP) means a specialised procurement process employed by government for the delivery of public goods and infrastructure facilities to the private. PPPs and contracts have been broadly used by ASEAN member countries since early 1980s and be distinguished from conventional procurement methods such as project and construction contracts. PPPs may take many forms and the PPP Rules adopt a provisional approach whereby member nations in the procedure of drafting a new PPP policy may contain all forms of infrastructure procurement in every stages of the program and change to more precise contractual forms. PPP contracts are long-term arrangements featuring private capital at risk and the allocation of transactional risk to the private party, including responsibility for lifecycle costs which is the essential difference between a PPP contract and conventional procurement.

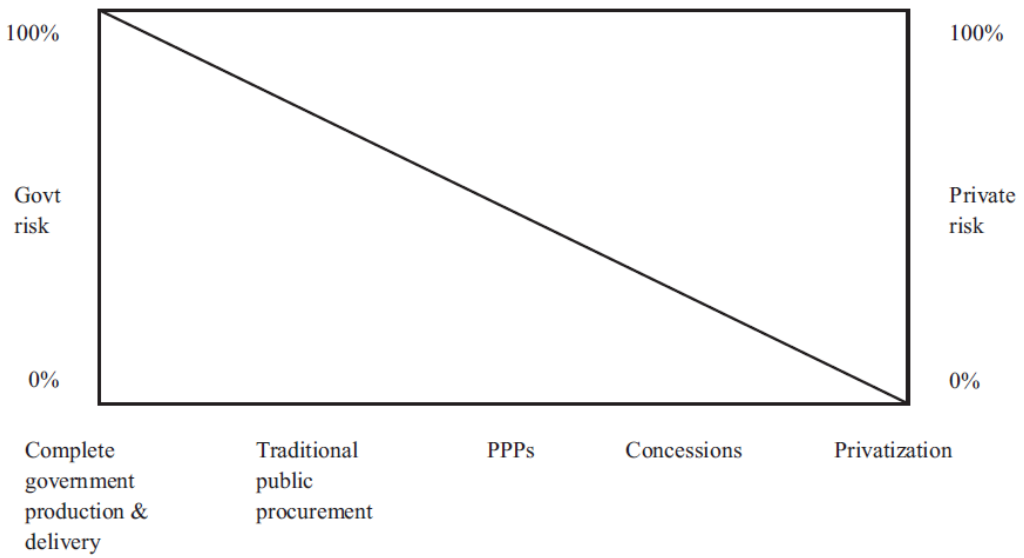
In this era, PPP could be seen in many of infrastructure development (roads and hydropower), social community development (education and health), economic development (mining, production). Major causes of operating PPP are rise in efficiency and capital, enhance organization, broader variety of funding, access to additional investment, faster application, risk distribution, lower budgets of service through specialization and added price to consumer and community.

When the government competence is limited and public prospects are far beyond, like in developing nations, have been encouraged, by international financial institutions (such as the International Monetary Fund and the World Bank), to use additional methods of service delivery in corporation with the private sector (domestic and external). These processes maintain privatization, quasi-private arrangements, and PPP). It is claimed that the needs of developing countries are truly vast, and hence ought to be addressed through various combinations of partnerships between charitable or faith-based organizations, non-government organizations (NGOs), community-based organizations, businesses (domestic and external), and government units. Preferably, these partnerships should include win-win situation for the government and private providers as well as for the public in the community. They agree profits for private providers, increased income for the government, while improving the lives of people who do not have suitable access to basic health-care, safe and clean water, power, all-season roads or other physical infrastructure or community services.

2.5.2 Spectrum and Environment of Public-private Partnership (PPP)

According to the European Investment Bank (EIB, 2004: 2), PPPs are "relationships formed between the private sector and public bodies often with the aim of introducing private sector resources and/or expertise in order to help provide and deliver public sector assets and services."

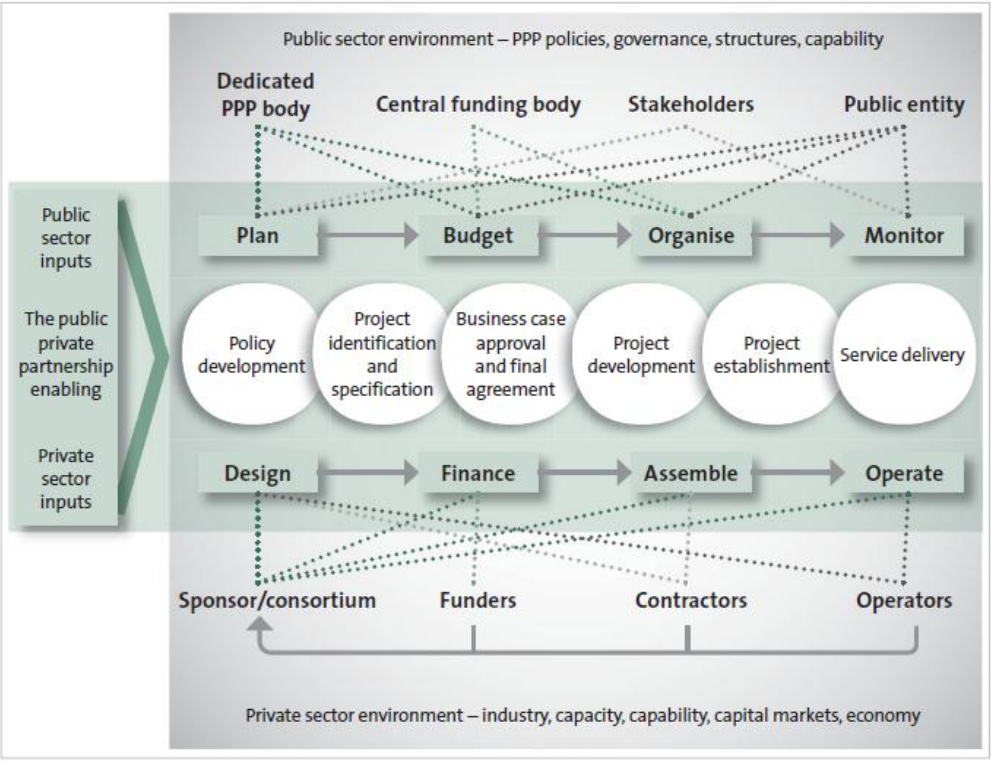
Figure (2.1) Spectrum of Combination of Public and Private Partnership



Source: OECD (2008)

The spectrum of partnership decides PPPs from Government retained to privatization and from 100% Government risk to full percent Private risk. Privatization includes no such alignment of objectives since the government is not always participated in output specification for the privatized entity while allowing the privatized unit to maximize profit. In PPP, the government usually requires the quantity and quality of the service provided, and both partners agree on the value. The private firm seeks to maximize profit at the agreed price with their greatest inventions.

Figure (2.2) Public and Private Sector Environment



Source: https://ppp.gov.ph/ppp-program/what-is-ppp/

According to the figure (2.2), although some form of contractual procedure will be essential to organising the progression and the parties, the ultimate achievement or value of these companies will depend on whether each sector has the ability, capacity, and institutional buildings to sustenance and sustain the project/ programme, the members, and the procedure.

2.5.3 Advantages and Disadvantages of PPP

As for the literature review, there are many publications and reviews list stated regards with advantages and/or disadvantages of PPPs. These lists are usually based on long-term infrastructure contracts, which include a large element of private financing. In many cases, these are used to debate the perceived value-for-money and efficiency differences between the PPP approach and traditional ways of procuring. However, in Myanmar context, it would be difficult to state since the country economy starts growing lately when the neighbouring countries are already matured PPP policy and structure.

For this thesis, it highlights that healthcare is public provision although private sector participation would be inclusive approach to achieve the Nation's goals and objectives. When the Act comes out for the greater use PPP, there would be needed to consider the advantages and disadvantages for the public sector.

One of the major benefits for both sectors is that the public sector uses the private sector to help achieve this innovation and change by supporting the relationship and the process by clearly specifying these innovative benefits, how they are rewarded, and then by monitoring their progress in a transparent and accountable way.

Table (2.2) Advantages and Disadvantages of Public Private Partnership

Advantages for Public Sector	Related Disadvantages for Public Sector
Greater risk transfer to those parties best able to manage that risk	Difficulties in specifying, pricing, and the ownership of risk There is a monetary cost to the public sector in transferring that risk (directly proportionate) Ultimately, the public sector is responsible for delivering core or essential services
Related to the greater risk transfer, there can be more certainty in costing and timing of projects or programme	Longer, more detailed, and more costly procuring

Table (2.2) Advantages and Disadvantages of Public Private Partnership

(Continued)

Advantages for Public Sector	Related Disadvantages for Public Sector
Not having to find the money to pay for the project or programme immediately	Need to pay for the project or programme cost over the operational stages
Being able to spread the cost of services over the lifetime, meaning greater intergenerational equity	Less flexibility through a long-term contract to manage the overall business in response to agreed or changing needs and policies Future users could be disadvantaged if the level of service quality changes over time
Greater third-party scrutiny and accountability through funders, sponsors, and stakeholders	More complex contract, higher procurement costs Different parties with differing motivations and incentives (greater overall governance needs)
Brings together (bundling of) various activities (such as design, construction, maintenance, and operations) to allow a whole-of-life perspective	Reduces the options available to manage the project or programme in discrete steps over time Can create difficulties when the service quality (or outcome) requirements cannot be defined clearly Can encourage upfront choices that reduce future costs at the expense of future service quality
Less project or programme management required	Greater contract and performance management required
Potential innovation and change in the way the project, programme, or service is planned, structured, and delivered (from private sector involvement)	The potential risks in achieving innovation and change will depend on the maturity of the sectors and the relationship between the parties

Source: pppknowledgelab.com

2.6 Features of Common PPP Models in Healthcare

PPPs in healthcare provide opportunities for governments to leverage private sector resources and expertise, to enable investment in large-scale projects that advance national and local public health goals, such as improving quality of service delivery, and expanding access to care.

Historically, governments have engaged the private sector to deliver services through healthcare PPPs to achieve one or more of six functions:

(1) Finance – financing or co-financing of the project

(2) Design – design of the project, including design of the infrastructure and delivery model

(3) Build – construction or renovation of facilities included in the project

(4) Maintain – maintenance of hard infrastructure (facilities as well as equipment as applicable)

(5) Operate – supply of applicable equipment, IT and delivery/management of nonclinical services

(6) Deliver – delivery and management of specified clinical and clinical support services

There is some debate about whether clinical services PPPs fall under the definition of a PPP. Given its rise in service delivery, and other qualities of risk sharing and performance management, it has to consider when partnering.

The majority of facility-based PPPs bundle these functions into three models:

1. Infrastructure-based model – to build or refurbish public healthcare infrastructure
2. Discrete Clinical Services model – to add or expand service delivery capacity
3. Integrated PPP model – to provide a comprehensive package of infrastructure and service delivery by means of financial assistance

These models comprise the focus of this report, and are described in greater detail, below. iii Each government's decision of which model to pursue is driven largely by local health needs and environmental (e.g., political, social) factors. The threshold of risk and responsibility that the government seeks to allocate—and that the private partner is willing to accept—are also major determining factors.

2.7 The WHO Health Systems Framework

There is power balancing on transformation in the health system as the state on one side and markets, civil society and social media networking of public on the other side. In this 21st century, the role of non-state actors like private sectors including international society become taking part in significant role especially in the delivery of health services which heading to the In the era, health system and its governance are not the exclusive preserve of the states globally. For the effective partnership for Universal Health Coverage (UHC), "ensuring that all people have access to needed promotive, preventive, curative, and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services." (World Health Organization), the collaborative system must be needed to fosters and leverage the nation's health status which means private including both health actors and non-health actors come together for one and only aim which is health system strengthening.

When considering private sector for healthcare, it includes multiple layers such as Civil Society Organizations (CSOs), Individual non-governmental organizations (international and local), professional organizations, philanthropic foundations, trade associations (such as pharmaceutical traders association), the media, national and transnational corporations, individuals and informal diffuse communities have a certain level of power in reforming the health sector.

2.6.1 Conceptualizing Health System by using Six Building Blocks

Conceptualizing Health Systems Pragmatic solutions already exist to address many of the greatest global health challenges, yet progress remains frustratingly slow because many health systems are constrained and cannot fully operationalize them. Achieving better health internationally thus requires the effective cooperation of Private and Public health providers for both the tackling health challenges as well as the health policies and systems strengthening to actually deliver them.

Health systems have been defined in many ways. The most widely-used definition is from the World Health Organization's World Health Report 2000, which defines health systems functionally as "all the activities whose primary purpose is to promote, restore or maintain health." These activities are often grouped into six categories or "building blocks", namely 1) service delivery, 2) health workforce, 3)

health information systems, 4) medical products, vaccines and technologies, 5) health systems financing and 6) leadership and governance.

Health systems have also been defined at least in part in terms of contributing actors. The European Observatory for Health Systems & Policies, for example, defines health systems as the "people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health." 7 The Tallinn Charter from the 2008 WHO European Ministerial Conference on Health Systems defines health systems as the "ensemble all public and private organizations, institutions and resources mandated to improve, maintain or restore health" which "encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health."

Figure (2.3) Six Building Block of Country Health System

Source: http://www.who.int/healthinfo

2.6.1.1 Service Delivery of Health Care

In any of health system, the main output is to ensure the delivery of health services that are accessible, equitable, safe and responsive to the users. Service delivery is the backbone of any system especially in health. For reaching this delivery

to the required community, it is depending on the availability of health facilities, health workers, diagnostics, drugs and other supplies including provision of financing. In any country, the health systems interventions are measured improvement indicator by increasing in coverage of health services as best as possible.

For the either of one or partnerships of public and private, one of the key objectives of the health system effectiveness and strengthening is to increase equity in access to health services for those in need, regardless of their social and economic status. The effectiveness can be measured by overall trend of improvement of equity in access and outcomes due to many health systems interventions. For example, Universal Health Coverage (UHC) that services are free at the point of delivery of health services, engaging all communities and decentralization of services not only in health institutions but also health care personnel.

2.6.1.2 Health Financing

Health financing is fundamental to the ability of health systems to maintain and improve human welfare. At the extreme, without the necessary funds no health workers would be employed, no medicines would be available and no health promotion or prevention would take place. Health financing refers to the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system… the purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal (private) health care" (WHO 2010). [2]

Moreover, it has three key factors namely, collection of revenue, pooling of funds, and purchasing. In many countries, financial protection and access to needed health care are becoming the most priority especially for the low and middle income. By diversifying the sources of revenue, variety of health financing systems are introduced including private and public partnerships in order to strengthen health systems.

[2] https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_section5_web.pdf?ua=1

2.6.1.3 Governance and Leadership

Leadership and governance in building a health system involve ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability. Governance in health is a cross-cutting theme, intimately connected with issues surrounding accountability, political stability, government effectiveness, regulatory quality, rule of law and control of corruption. It involves three main components namely State actors, Health service providers and health services users, and the General public. The most important factor in good governance and leadership system is to deliver the effective health system by engaging and regulating both public and private sector actors to achieve the country's health mandates.

The effectiveness of partnerships between state, citizens and providers influences the performance of quality, efficiency and sustainability.

2.6.1.4 Health Workforce (Human Resource)

Human resource for the health system is the vital of the whole system. A knowledgeable, skilled and motivated health workforce such as doctors, nurses and supportive staff like managers, ambulance drivers etc are needed. Skilled health workers are unable to deliver services effectively without appropriate physical capital such as adequate facilities, equipment and consumables such as medicines. Thus, health system budgets need to balance these three vital demands – human resources, physical capital. If underfinancing, health education system becomes fragmented, outdated and not-in line with the international standards which in turns producing under qualified human resources.

In reality, health human resources migrate from developing to developed countries. The shifting of human resources so called 'brain drain' exacerbates the burdened in health system of low socio-economic countries. The consequences of this brain drain leads the worse burden for those countries in such a way that health systems have been weakened including failure to do the needed public health interventions and financial loses.

2.6.1.5 Health Information System

Well-functioning and reliable health information system is the foundation of decision-making across all health system building blocks. It is essential for health

system policy development and implementation, governance and regulation, health research, human resources development, health education and training, service delivery and financing.

The health information system provides the underpinnings for decision-making and has four key functions: (i) data generation, (ii) compilation, (iii) analysis and synthesis, and (iv) communication and use.

Data from health facilities can provide immediate and ongoing information relevant to public health decision-making, but only if certain conditions are met. The data must be of high quality, relate to all facilities (public and private), and be representative of the services available to the population as a whole. When considering partnerships between private and public, the availability and accuracy of data is one of the main challenges. The information system coordination and leadership; it would be needed to train human resources at all levels of system for the production of health information and infrastructures.

2.6.1.6 Medicines and Technologies (Supply Management)

To provide all the health-related goods and services needed by general public, combined the various sectors providing services together make up the total healthcare marketplace. These services, delivered by multiple public and private providers, depend on effective management and delivery of health products. A well-functioning health system supply management ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness. In this era, even the developed countries, there is an increase in demand for medicines and technologies and have difficulties ensuring that health products are available in the current global manufacturing and product sourcing environment.

To minimize shortages and strengthen efficiency, private and public must work together optimally to ensure effective, reliable, and agile supply chains that help to provide equitable access to health services for all people.

CHAPTER 3
HEALTH SYSTEM OF MYANMAR

3.1 Health Coverage

Universal health coverage (UHC) is a global health priority, and a essential component of the Sustainable Development Goals (SDGs) implemented by the UN in September, 2015. Goal 3 sets a determined agenda to "ensure healthy lives and promote wellbeing for all at all ages". The aim of UHC is to confirm that all people could access good-quality health services without suffering financial hardship. WHO and the World Bank's goal for UHC is minimum 80% coverage of essential health services and 100% coverage of financial protection in the entire population. To measure growth towards UHC, WHO developed a framework that contains of three scopes: financial risk protection, essential health service coverage, and population coverage (equity). Like other WHO member countries, by 2030, the Myanmar Government has committed to achieving UHC. The Ministry of Health and Sports launched the 5-year National Health Plan (2017–21) in December, 2016. The major goals are to ensure access to a basic essential package of health services (EPHS) for the whole population by 2020, and to rise financial risk protection. The Myanmar health system is a multicultural mix of public and private systems in terms of both financing and service delivery. After the transition to a civilian government in March, 2011, investments in the health sector have improved. The Myanmar Government increased the budget allocation for health to 3·4% of total government expenditure in the 2014–15 fiscal year, a substantial improvement from the 1% allocated in 2010–11. However, this allocation remains the lowest in the Asia-Pacific region. External funding, mostly in the form of official development assistance channelled through governmental and not-for-profit organisations, is also a source of finance. Official development assistance funded 21·8% of total expenditure on health as of 2014. Public spending on health has increased from 0·2% of the gross domestic product (GDP) in 2009, to 1% in 2014. However, despite this substantial increase in health investment, public spending on health in Myanmar is lower than that in all other

countries of the Association of Southeast Asian Nations. Because of an absence of health insurance and cost-sharing policies, out-of-pocket payments are the main source of health financing in Myanmar. Alongside increases in health sector investment, out-of-pocket health expenditure as a proportion of total health expenditure decreased from 79% in 2011, to 51% in 2014. However, the proportion of health expenditure that out-of-pocket payments comprise in Myanmar is still one of the highest in the region. Other key challenges in Myanmar's health system include the insufficient health workforce, limitations in decentralisation of health services, and a lack of infrastructure. The health worker density in 2016 was 15 per 10 000 population, 61% lower than the southeast Asian regional estimate. Despite the introduction of health-sector decentralisation, financial and human resources are still centrally managed. Only 0·6 hospital beds are available per 1000 population, the second lowest availability in the southeast Asian region. Additionally, inequality in access to health services and financial risk protection as a result of geographical, ethnic, and socioeconomic differences is a major concern in Myanmar. The path to UHC differs between all countries on the basis of variations in demographic and socioeconomic characteristics. Thus, measurement of progress is both necessary and informative. This study provides a baseline measurement of UHC in Myanmar both nationally and subnationally, against which subsequent measurements can be compared to monitor progress. In view of the current situation, understanding of progress towards UHC at a subnational level assessment is very important for identification of states or regions that are failing to meet targets for health service coverage and financial risk protection.

3.2 Population and Birth Rate

According to the Myanmar Population and Housing Census 2014, the population in the Republic of the Union of Myanmar was 51,419,000 (24,821,000 males and 26,598,000 females) as of March 29, 2014, which includes an estimated population of 1,206,000. Yangon was the most populated area (7,355,000, 14.3%), and the capital, Nay Pyi Taw, had 1,158,000 (2.3%).

According to the Union Report, 28.6% were aged under 15 years, 65.6% were aged 15 to 64 years, and 5.8% were aged 65 years At the same time, another source, the World Factbook, reports that the estimated population for July in 2015 is 56,320,000; 26.1% for those aged 0–14 years, 68.6% for those aged 15–64 years, and

5.4% for those aged 65 years or over. Based on the Census 2014, the government estimated that the crude birth rate in the previous one year was 18.9 per 1,000 population. The annual population growth rate was estimated to be 0.89% between 2003 and 2014.6) Despite the government historically encouraging population growth and adopting a laissez-faire policy towards fertility in the past, fertility has been steadily falling. Myanmar's total fertility rate estimated by the Census 2014 was 2.29, which down from 6.1 in 1965. Fertility rates in the urban areas were low (1.7 in Yangon Region and 1.9 in Mandalay Region), and those in the surrounding regions were hovering just above replacement fertility (2.1 in Magway Region, 2.1 in Nay Pyi Taw Union Territory, 2.2 in Bago Region, 2.6 in Ayeyarwady Region, and 2.3 in Sagaing Region). Further away from the urban areas, the rates were relatively high (2.4 in Mon State, 2.7 in Shan State, 2.8 in Kachin State, 3.0 in Tanintharyi Region, 3.3 in Kayah State, 3.4 in Kayin State, and 4.4 in Chin State). While providing direct support to family planning in order to improve women's reproductive health, it has only been in the last 20 years that the government has taken actions with regards to fertility, seeking to maintain replacement-level fertility.

3.3 Administrative Structure

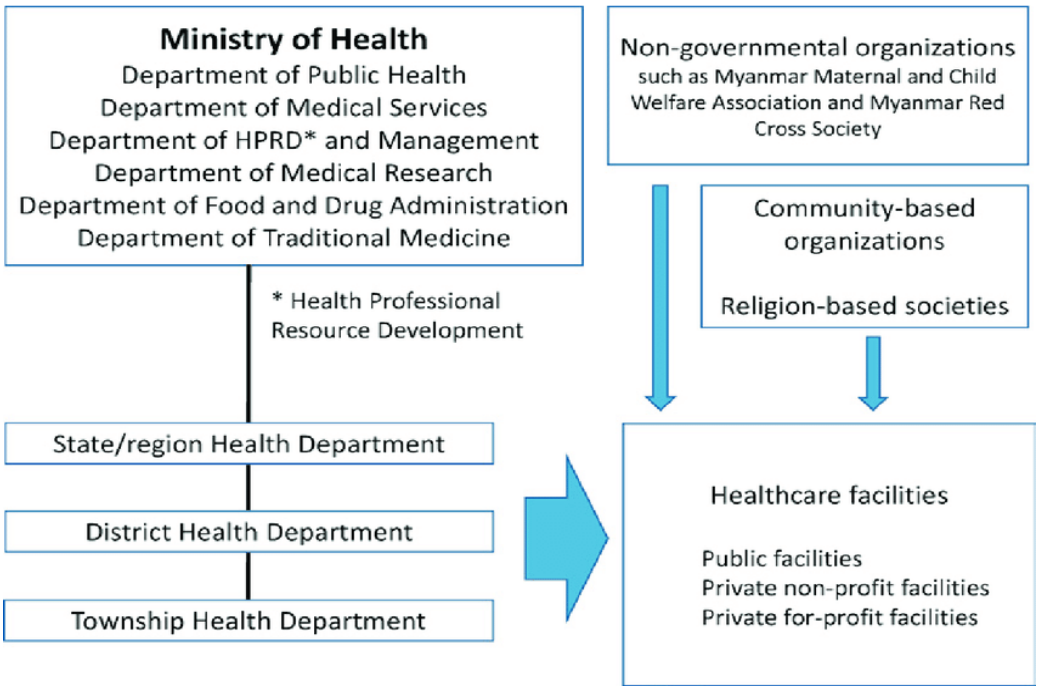
Myanmar healthcare systems have drastically evolved with recent changes of political and administrative systems. Although the healthcare systems are a mixture of public and private sectors both in the aspects of finance and supply, MOHS remains the major provider of healthcare services. As shown in Fig. 3.1, there are 6 departments in the MOHS, which facilitate all aspects of health for the whole population.

The Department of Public Health is mainly responsible for primary healthcare and basic health services; nutrition promotion, environmental sanitation, maternal and child health, school health, and health education. The Disease Control Division and Central Epidemiology Unit under this Department cover prevention and control of infectious diseases, disease surveillance, outbreak investigations, and capacity building. The Department of Medical Services provides effective treatments and rehabilitation services. Curative services are provided by various categories of health facilities under the control of the Department. The Department of Health Professional Resource Development and Management is mainly responsible for training and production of all categories of health personnel, except for traditional medicine

personnel, to attain equitable healthcare for the whole population. The Department of Medical Research conducts national surveys and research for evidence-based medicine and policy making. The Department of Food and Drug Administration ensures safe food, drugs and medical equipment, and cosmetics. The Department of Traditional Medicine is responsible for the provision of healthcare with traditional medicine, as well as training of traditional medicine personnel. There were 6,963 private traditional practitioners in 2014. Most of them were trained at the Institute of Traditional Medicine until 2001, and at the University of Traditional Medicine from 2002 onwards.

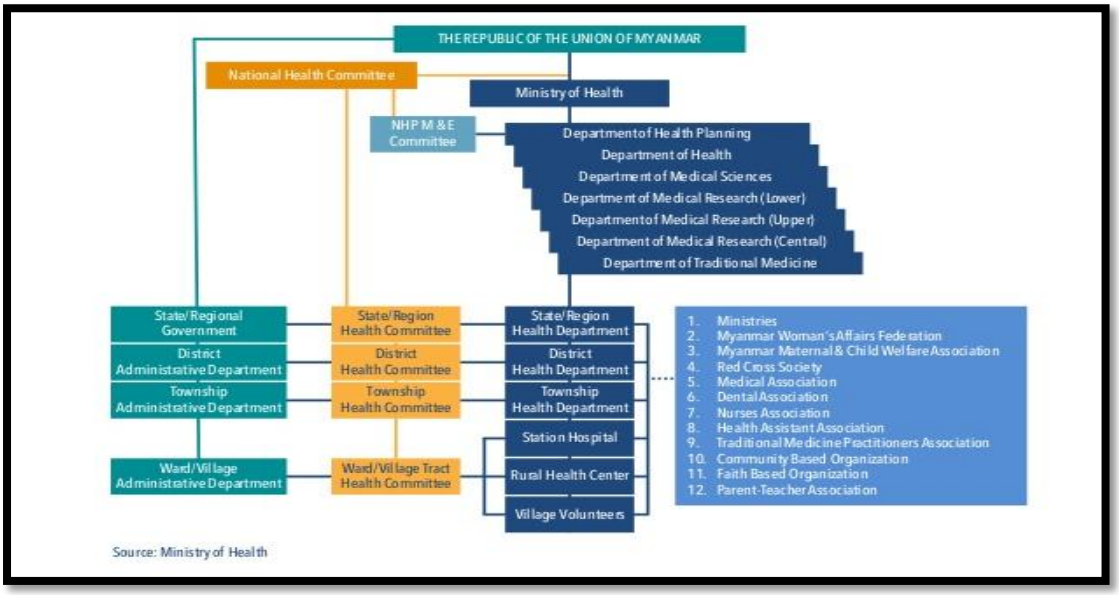
In line with the national health policy, semi-governmental organizations such as the Myanmar Maternal and Child Welfare Association and the Myanmar Red Cross Society are taking a share of service provision. Nation-wide non-governmental organizations, as well as locally acting community-based organizations and religion-based societies, also support and provide healthcare services.

Figure (3.1) Administrative Structure of Healthcare System



Source: Ministry of Health and Sports - www.mohs.com

Figure (3.2) Organization Structure of Ministry of Health and Sports



Source: Ministry of Health and Sports

The private healthcare sector in Myanmar includes hospitals, clinics, drug importers and wholesalers, pharmacists, informal drug sellers, and a large and growing number of medical practitioners working primarily, or exclusively, in private practice. These for-profit entities are complemented by a number of local and international non-governmental organizations.

Therefore, the area of private in healthcare has 2 major segments (1) for-profit entities and (2) non-profit organizations including Civil Society Organizations such as LNGOs and INGOs.

Coordination both within government and with a range of professional organizations, local and international investors, voluntary organizations, self-regulatory authorities, and healthcare purchasers could be seen in three main contexts as below. In fact, any areas of public and private partnerships provision are under regulated, leading to both the potential for inefficiency and missed opportunities for health system.

1. Primary care

Myanmar, like four of its neighbouring countries (Cambodia, Indonesia, Laos, and Vietnam), has a shortage of doctors, nurses, and midwives measured by the 2.28 per 1000 population WHO minimum. A large and growing number of the providers that do exist work primarily, or exclusively, in private practice. The work of these

clinicians is supported by multiple cadres of community health workers in the public sector, a small but important number of local and international non-governmental organizations, and a very large number of pharmacies, some licensed, some not. There is also an extensive range of informal medical practitioners ('quacks'), and drug vendors whose practices are unregulated.

2. Hospital/specialty care

There are currently 150 private hospitals, all registered since the 2007 law on private medical practice, although some have existed as private clinics before that time. The number of new hospitals is growing rapidly, with foreign investment a key driver in urban centers. Fully private, foreign-staffed hospitals are currently under consideration for licensure. Private cosmetic treatment, dental, and optometry centers exist in cities. As in other countries in the region, skilled personnel tend to be concentrated in the urban areas.

3. Financing

Approximately 80% of health expenditure in Myanmar is in the form of private direct, Out-Of-Pocket (OOP) payments for medical services, often in the form of purchasing medicines for self-treatment. Private insurance is growing, but still very limited, and while government financing is growing rapidly—with a commitment to increase from 2% of government expenditure to 5% of gross domestic product in the next three years—concurrent growth in private expenditure means that financing is expected to remain largely OOP for some time.

Regulating dynamic health markets requires many forms of engagement, and assuring effective healthcare across a health system requires attention to all forms of service provision including partnership structure and strategy for both public and private. Setting in place structures to plan an appropriate, safe, and positive role for the private sector within the larger health system is both urgently needed and, at this period of rapid growth, particularly open to effective action.

3.4 Opportunities for Public Private Partnerships (PPP) in Myanmar Healthcare

Opportunities for PPPs have been identified based on the following principles: PPPs need to be in line with public health/ government priorities including National Healthcare Policy and other national plans; responsibility for meeting public health goals rests with the government with PPPs playing a supplementary role; leverage the strengths of the public and private sectors and reflect lessons learnt. PPP opportunities can be grouped into two broad categories:

Table (3.1) Categories of PPP Opportunities

Category 1: PPPs with limited implementation but with potential	Category 2: PPPs with some acceptance
• Outsourcing management of Primary, Community and Universal healthcare coverage Government hands over the infrastructure of the facility on a "as is where" basis to a NGO / Private investor who brings in their own HR and manage provision of range of services. The government reimburses costs. Private sector capacity is not clear to take over. The necessary capacity would merge or could be built.	• Mobile Medical Unit
• Diagnostic centre Partnership organization has to contract in and finances the entire capital and operating costs and provides the diagnostic services at rates determined by the government and free of charge for low income patients. Current private sector in this industry is highly fragmented with many laboratories, although very few are accredited.	• Purchase of clinical service

Table (3.1) Categories of PPP Opportunities (Continued)

• Medical education No clear strategy. PPP for establishment of a medical education was tried out in Myanmar officially, but did not take off and no official law stated. Foreign and local private companies have plans to offer not only pure medicine courses but nursing, dentistry, and other paramedical courses as well.	• Health insurance
• Secondary and tertiary care hospital The government provides land at nominal cost per month on a long term lease which same model as Petrol companies. The investor covers all capital and operating costs and keeps a fixed number of beds and a certain percentage of IPD and OPD services for government patients free of cost. Private foreign hospital groups have plans and they have reached to Union Minister MOHS. Private sector is seeking land and requesting opportunity to venture the existing state-owned hospitals.	• Referral transport

Source: Ministry of Health and Sports

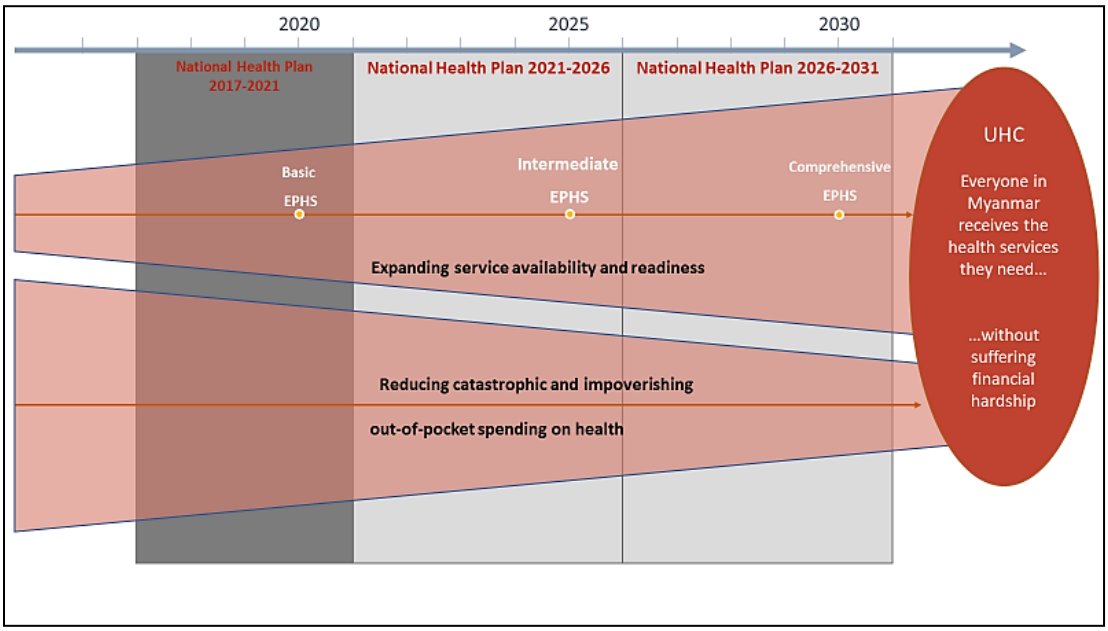
CHAPTER 4
ANALYSIS ON PRIVATE SECTOR PARTICIPATION IN PUBLIC SECTOR HEALTH FINANCING

4.1 Introduction of National Health Plan

"The formulation of the National Health Plan 2017-2021 presents a unique opportunity to outline a new path for the health system that will help the country move towards UHC in an equitable, effective and efficient manner… The NHP aims to strengthen the country's health system and pave the way towards UHC, choosing a path that is explicitly pro-poor"

The main goal of NHP 2017-2021 is to extend access to a Basic Essential Package of Health Services (EPHS) to the entire population by 2020 while increasing financial protection.

Figure (4.1) National Health Plan 2017-2030 Against Universal Health Coverage



Source: National Health Plan Implementation Monitoring Unit (NIMU) MOHS

In Chapter (3), it is already mentioned and internationally accept that WHO Six Building Blocks are the main source that enhance the nation's health system to improve. In this Chapter (4), according to the Myanmar National Health Plan (2017-2021), clearly stated the two main strategies which are Supply Side Readiness and Financial Protection.

4.1.1 Supply Side Readiness

Supply Side Readiness is capacity to deliver from basic EPHS to all national level commitment provisions in each facility level regardless of type of provider (private or public). To implement it, there would be required to progress the Baseline Nationwide Health Facility Assessment which has to cover Townships, States and Regions Health Plans inclusively.

4.1.2 Financial Protection

Financial Protection means developing alternative acquiring mechanism for guaranteed minimum services (Basic EPHS) and executing Health Financing Strategy such as Revenue Raising, Pooling, Purchasing, Quality assessment. There is needed to grow the legal framework for alternate health financing system. By doing so, there would be set objective as reducing catastrophic impoverishing by out-of-pocket spending on health.

Health financing systems are critical for attainment UHC to WHO Six Blocks. Health financing raises to achieve to UHC lie in three interrelated sectors: reducing financial barriers to access through prepayment, raising funds for health; and subsequent pooling of funds in preference to direct out-of-pocket (OOP) payments; and allocating or by means of funds in a method that promotes efficiency and equity.

4.2 Service Delivery of Health Care

In 2007 the government allotted "The Law Relating to Private Health Care Services". Private Health Statistics 2015 by the Department of Medical Services reported that there were 169 private hospitals, 201 private specialist clinics, 3,911 private general clinics, and 776 private dental clinics. In Myanmar, many charity hospitals run by private sectors are functioning for the poor. There are private non-profit clinics run by community-based civil society organizations and religion-based

societies, which also offer ambulatory care. Among them, some have advanced to provide inpatient care in Nay Pyi Taw, Yangon, Mandalay, and other large cities in recent years, although the funding and provision of care were still fragmented.

Table (4.1) Public Health Facilities in Myanmar (2014)

Public Health Facilities in Myanmar (2014)	
Facility	**Number**
Curative and rehabilitation services	1056
General hospitals	4
Specialist/teaching hospitals	50
Regional/state/district hospitals	55
Township hospitals	330
Station hospital	617
Preventive and public health services	2199
Primary and secondary health centers	87
Maternal and child health centers	348
Rural health centers	1684
School health teams	80
Traditional medicine	259
Traditional medicine hospitals	16
Traditional medicine clinics	243

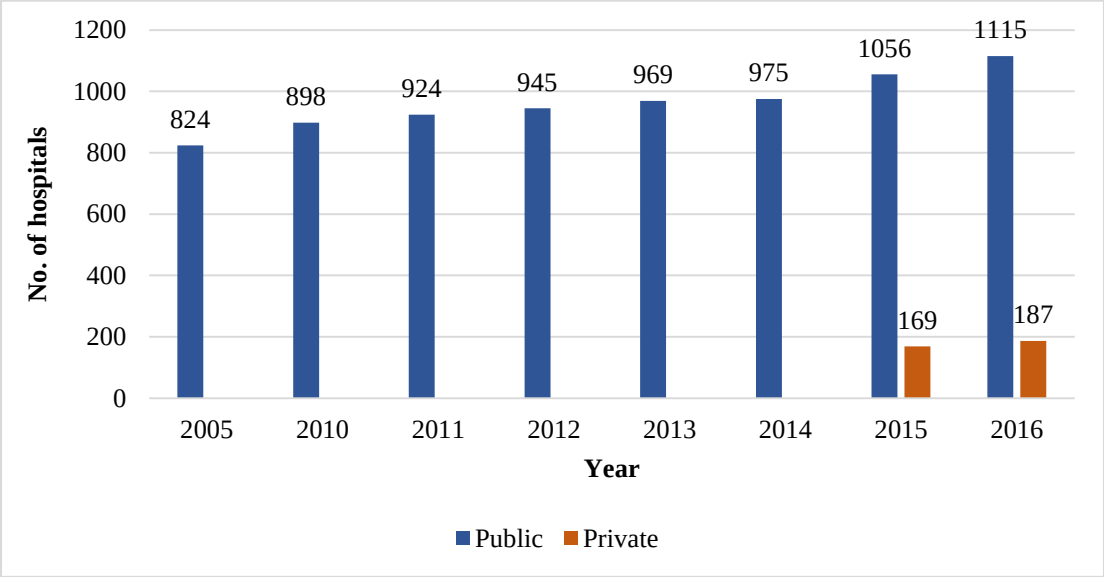
Source: Data from Health in Myanmar 2015

Table (4.1) shows the number of public healthcare facilities in Myanmar in 2015. There were

- 1,056 public hospitals with 56,748 beds in total. These facilities mainly provide curative and
- rehabilatitive services. There are 87 primary and secondary health centers, 348 maternal and

- child health centers, 1,684 rural health centers, and 80 school health teams which are
- mainly responsible for preventive services and public health activities.
- The Ministries of Defense, Railways, Mines, Industry, Energy, Home and Transport also
- provide healthcare for their employees and families with their own medical facilities and budget.

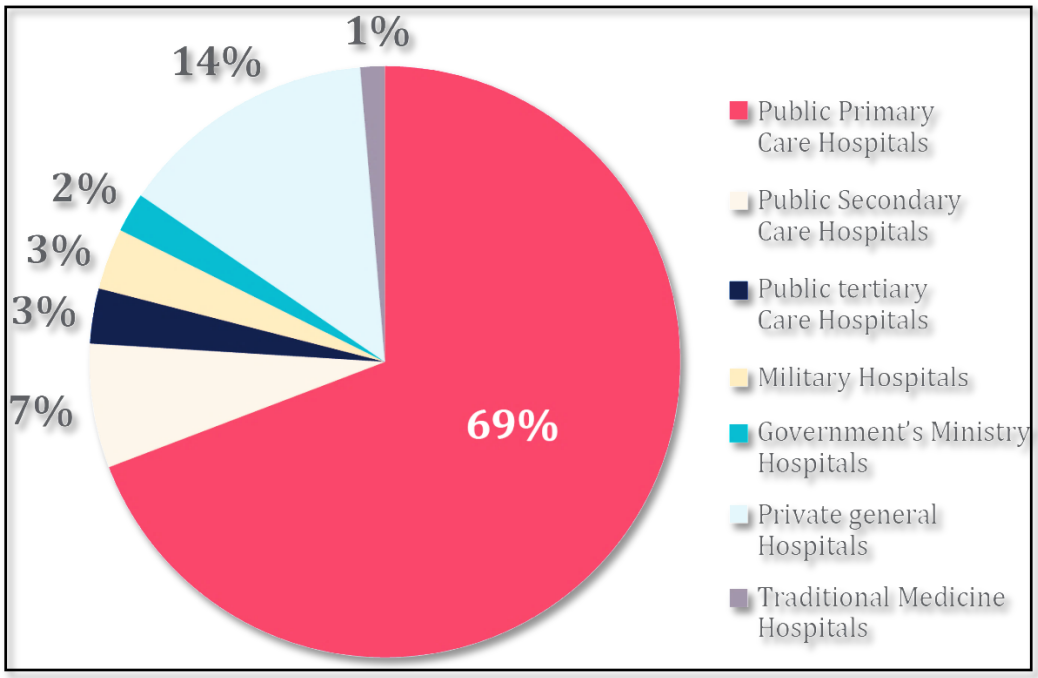
Figure (4.2) Number of Public and Private Hospitals in Myanmar



Source: Ministry of Health and Sports (MOHS)

The number of hospitals is dramatically growing over the years. According to the obtainable data, there were (824) public hospitals in 2005 and which was expressively going up to (1056) in 2015 and (1115) in 2016. There is no data available for number of private hospitals former 2015, however the informed private hospitals were (169) in 2015 and (187) in 2016. There has been an ~10% rise in the no. of private hospitals between 2015 and 2016.

Figure (4.3) Percentage of Hospitals by Level of Care (2015)



Source: Solidiance Research & Analysis, World Health Organisation (WHO), Ministry of Health and Sports (MOHS).

Public hospitals account for ~86% of entire hospitals, but are far behind local quality standards, while private hospitals account for 14% of whole hospitals and contribute to 7% of total beds in Myanmar. In public hospitals, selected basic medicines and lab tests are being well-ordered free of charge for poor as well as emergency patients subsequently late 2014.

4.3 Health Financing

Developments in these key health financing areas will regulate whether health services happen and are obtainable for everyone and whether people could have enough money to use health services when they need. When considering health financing system, the below questions has to answer

- Where will the budget for health come from?
- Stirring away from out-of-pocket expenditure: How to make aids to health care develop more pre-paid?
- Who could pay?
- How should the budget be collected and succeeded? How would the risk be shared?

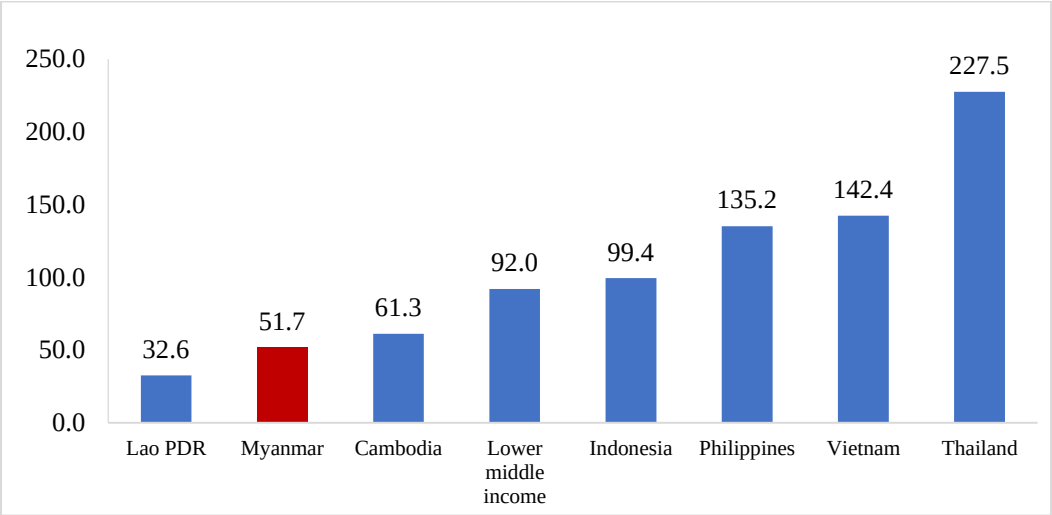
- How will the money be used to pay for health services that persons utilize?

To make sure everyone has better contact to quality services and has more financial protection, more capitals would be needed.

4.3.1 Health Spending and Expenditure

Health expenditure per person per year in Myanmar: (51.7 USD) 62,048 Kyat, in 2014. Related to other countries in the region and at a comparable level of income, Myanmar's level of spending on health is the second lowest.

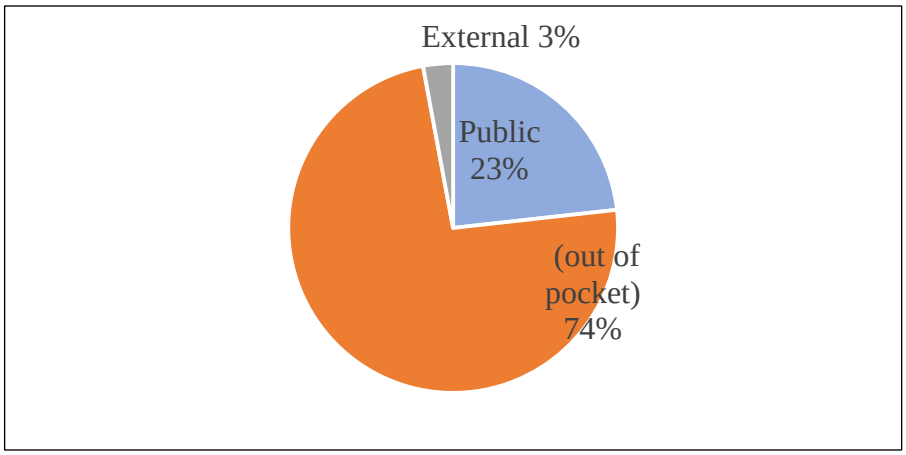
Figure (4.4) Health Spending per Person per Year (US$ equivalent in 2014)



Source: Myanmar MOHS National Health Accounts 2014/15, World Development Indicators for other countries

4.3.2 Health Expenditure by Source

Figure (4.5) Sources of Financing for Health in Myanmar, 2014



Source: Myanmar MOHS National Health Accounts 2014/15, World Development Indicators for other countries

Analyzing "where will the budget for health come from". Reducing requirement on OOP expenditures – and increasing the share of public financing for health -- is key for achievement of National Health Plan. This is the obligation to pay directly for services at the instant of requirement – whether that payment is made on an official or unofficial basis – avoids millions of people receiving health care when they prerequisite it. For those who do need treatment, it can result in most financial hardship, even impoverishment. OOP is best be less than 15-20% of total health spending, in order to prevent financial hardship for families as per WHO recommends.

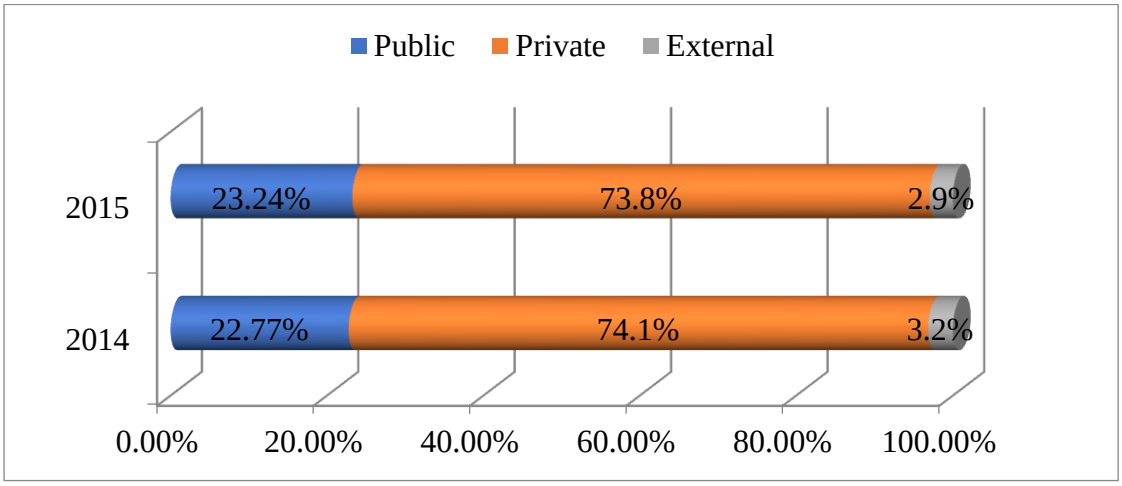
In presenting characteristics of any health care system, it is significant to have reliable estimations of "who d paying for health care?" and "How much of it?". In other words, two connected questions need to be answered (1) How much public and private resources can be spent on health care? and (2) how much of public resources are keeping utilized by various units of the population?

In Myanmar, for every $10 spent on health, $7 originates directly from public, when they drive to hospitals and clinics (out of pocket spending). Less than $3 comes from government rendering to the MOHS data.

Public expenditures comprise costs by the MOHS, other ministries providing health care to their workforces (including Yangon, Mandalay and Nay Pyi Daw City Development Committees (YCDC etc) and Ministry of Defence,) and the social security scheme. Expenditures were recorded and made according to definite budget headlines for the period under implementation.

Private expenditures mainly include OPP for health care made by the households, which is supplemented by expenditures by employers and non-profit organisations. Estimation of private household OPP expenditures includes two parts. The first is those made in hospitals under the MOHS. Data for these were accessible from the department of health - medical care division. The second main component is the household health expenditure in overall, estimation for total number of which was based on GDP, national annual consumption, private sector contribution in the GDP, share of household expenditure in the private consumption and share of medical care expenditures in the total household expenditure. Data were accessible from the International Health Division of the Ministry of Health covering UN agencies like WHO, UNICEF, UNDP and UNFPA and International NGOs working in Myanmar.

Figure (4.6) Health Expenditure by Source



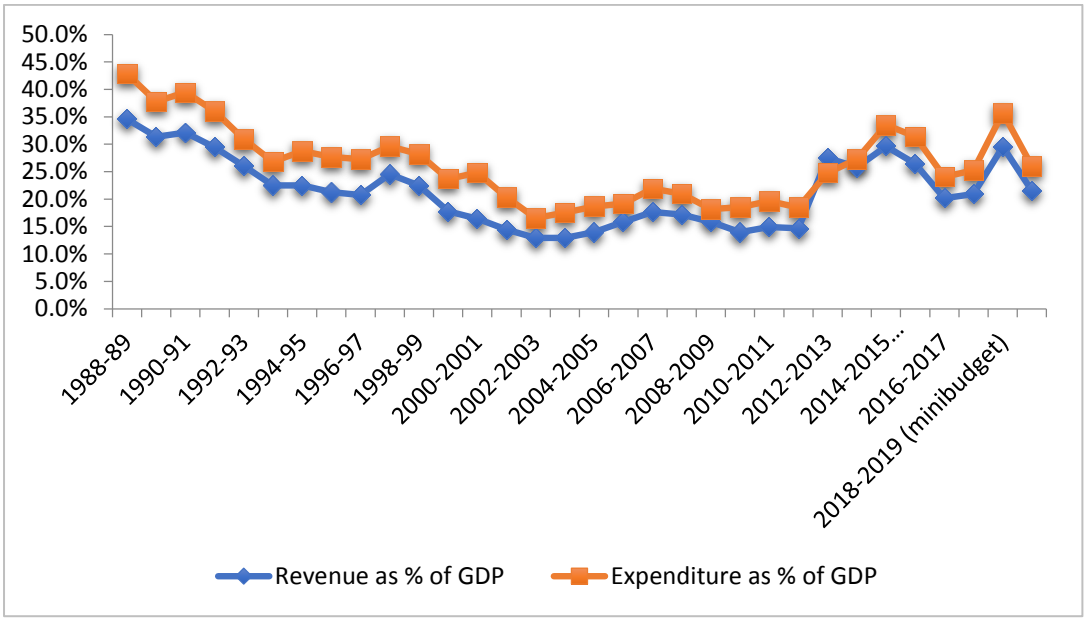
Source: National Health Plan Implementation Monitoring Unit (NIMU), MOHS

The proportions of public expenditure were 22.77% and 23.24% of total health expenditure in 2014 and 2015 respectively. It was observed that by type of provider hospitals accounted for one third of total spending. As mentioned in Chapter (3), Primary care (public health) devoted 20-30% and Hospital care (curative and rehabilitative) was 60-70%. The proportions of private expenditure were 74.1% and 73.8% of total health expenditure in the same period. According to the MOHS data, over 77% of private health spending (Orange bar) was made by the hospitals (inpatient and outpatient), about 20% on ambulatory care and just 3-4% was for dispensing medical goods.

Although it was observed that all components namely public, private and external sources are responsible for the rise in total health spending, higher spending was mainly noted in external and private mechanisms. Private health spending establishes the major share of total health spending and at the same time growing share by external sources was well noted since major causes of financial aids for health are coming from the government and has increased health expenses yearly by yearly both on current and capital. By seeing this health expenditures from private and public, the implementation of health programs is needed to provide the systematic and effective collaboration and coordination mechanism. This coordination has to cover issues relating to not only Six blocks of WHO health system also legal environment for health, partnership for health, HR and Financing, health research, equitable

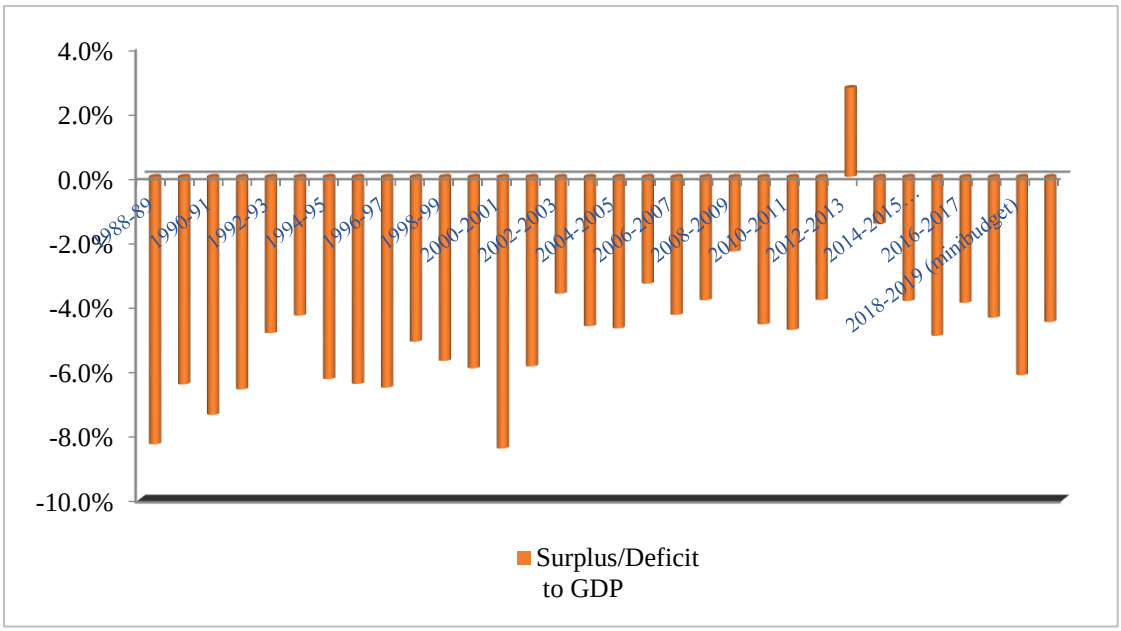
coverage of health services, response on emerging health problems and international collaboration.

Figure (4.7) Government Revenue and Expenditure Trend (1988-2018)



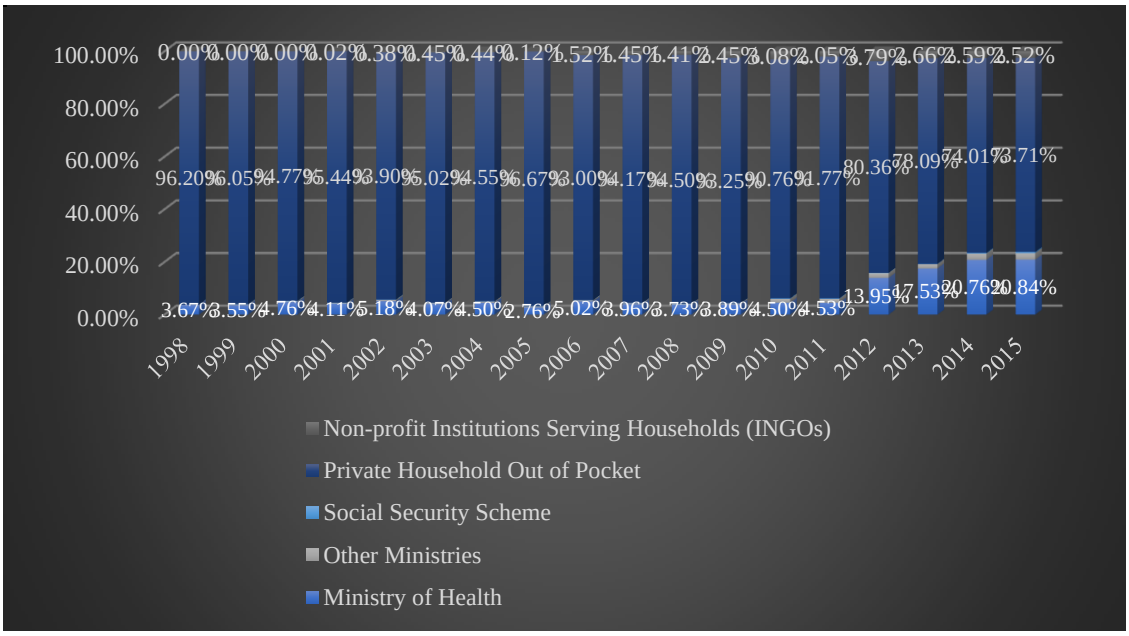
Source: National Health Plan Implementation Monitoring Unit (NIMU), MOHS

Figure (4.8) Government Expenditure Surplus / Deficit to GDP (1988-2018)



Source: tradingeconomics.com. Central Statistics Organization, Myanmar

Figure (4.9) Proportions of Total Health Expenditure



Source: National Health Plan Implementation Monitoring Unit (NIMU), MOHS

As the above figures, there was special occurrence in 2012 -2013. It had happened the Revenue was more than Expenditure, Budget surplus occurred as well as the Ministry of Health increased the significant percentage of Total health expenditure (THE) (from 4.5% to 13.95%).

Total health spending is the sum of public and private health expenditures as a ratio of total population in the nation. Health expenditure measures the final consumption of health care related goods and services (i.e. current health expenditure) including personal health care (curative care, rehabilitative care, long-term care, ancillary services and medical goods) and collective services (prevention and public health services as well as health administration), but excluding (not counting) spending on investments. Health care is financed through a mix of financing arrangements including government spending and compulsory health insurance ("Government/compulsory") and voluntary health insurance system is not strongly established in Myanmar (and private funds means households' OOP payments, NGOs and private corporations ("Voluntary").

Table (4.2) Total Expenditures on Health at Current Prices (2012-2013)

Kyat in Million

Indicator	2012	2013
Total Health Expenditures (THE)	1197024	1351869
Gross Domestic Product (GDP)	51060279.2	56680145.3
THE as % of GDP	2.34%	2.39%

Source:

Table (4.3) Per-capita Health Expenditures at Current Prices (2012-2013)

Kyat in Million

Indicator	2012	2013
Per-capita Health Expenditure	23019.7	25997.5
Per-capita Gross Domestic Product	1001181.95	1111375.4
As % of per capita GDP	2.30%	2.34%

Source:

Recognition of the importance of population health and investment in health continue to improve there were no significant changes on THE as % of GDP 2.34% (2012), 2.39% (2013) and 2.3% (2014).

It is important to note a key point here is that the overall per capita public expenditure on health is far below private (OOP) expenditure.

4.4 Governance and Leadership

Since only three regions in Myanmar are able to offer adequate healthcare services for public, Myanmar's healthcare system is still faced with many challenges which result in an overall miserable healthcare governance system. In April (2016) The National League for Democracy (NLD) took the Office and stressed the health care is a priority of party's governance. The NLD started the National Health Network to offer basic health care services and its manifesto assured to improve and expand the country's medical services and lessen the level of OOP spending by those who are seeking treatment which is the main target of Universal Health Care (UHC) by 2030.

4.4.1 Current Governance and Leadership

The Ministry of Health and Sports MOHS has ultimate accountability for Governance and Leadership. They are welcoming the door to the private and international community to fill the gaps in health care establishment. The most significant gap of current governance system is that the lack of linkage with health governance structures from national strategies to community level in the aspect of accountability and ownership. This involves determining which facilities need to be available on a continuous system within a community and also which services can be providing on a scheduled basis through the existing outreach services, in order to be most feasibly and effectively delivered to meet community health needs. It comprises Inclusion in national level policy frameworks, plans and budgets at all plans.

The collective actions required by implementing good and strong governance system together with private sector are

- Ultimate UHC as National Agenda & Everyone's concern access to quality health without suffering any of financial hardship,
- Poor inter-ministerial collaboration and involvement and implementing legal framework and highest political commitment,
- Responsiveness on UHC/ insurance and ownership from GoM - Cabinet, MOHS, MP, MOPF & other ministries, SSB, INGO, CSO, EHO, Private sector, BHS, Community, Media and so forth.

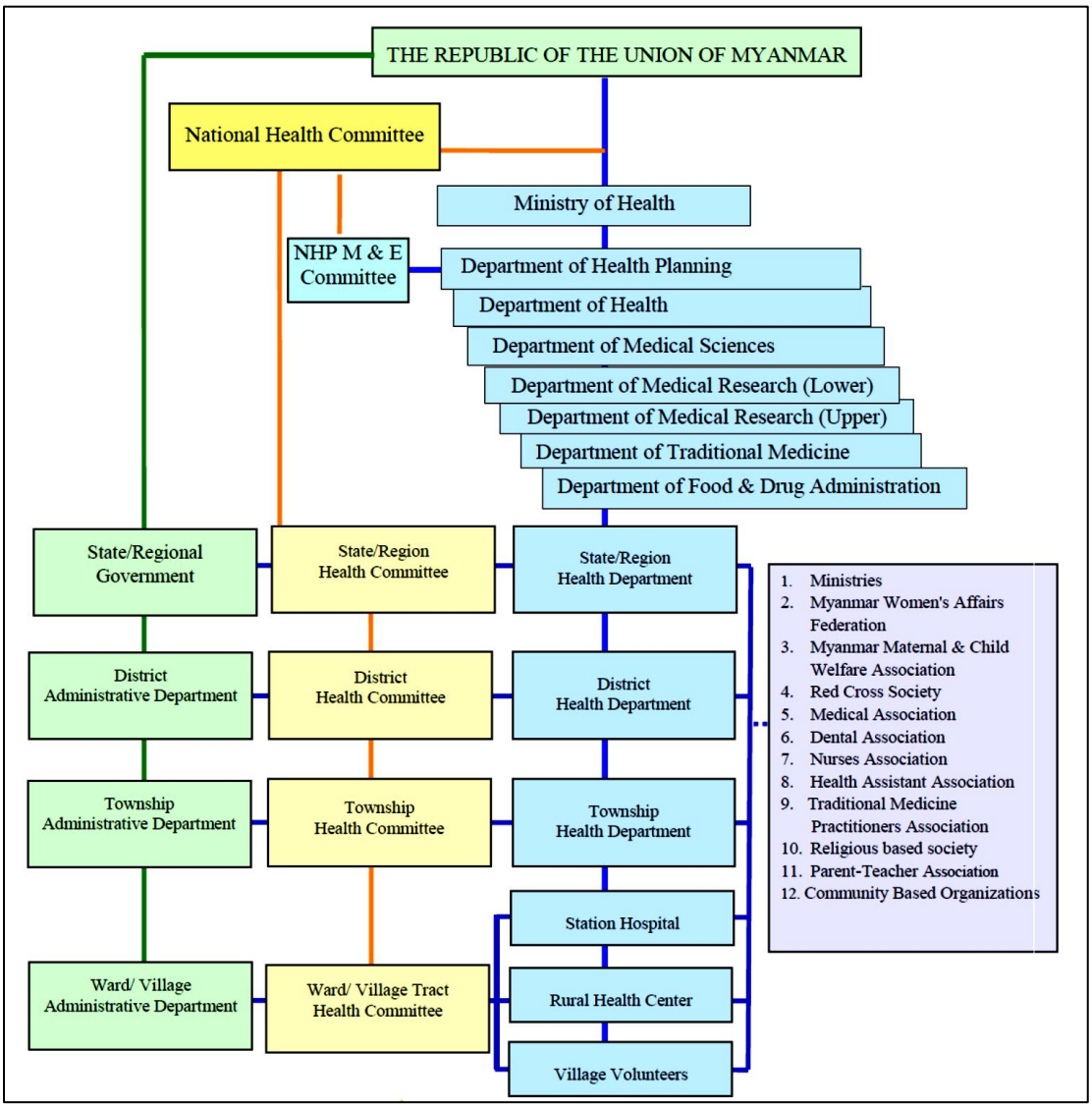
4.4.2 Private Sector Participation in the Governance of Health Care

The governance system has to be reinforced activities for promoting health, preventing illnesses, providing effective treatment and rehabilitation to increase the health status of the population. Ministry of Health takes part a major role in providing all-inclusive health care throughout the whole country including remote and hard to reach border areas. The private, for profit and non-profit, sectors participated in many years but it has significantly developed in current years. Although funding, profit and provision of care are really fragmented. They are regulated in conforming with the provisions of the law and regulation relating to Private Health Care Services and Agencies.

The basic and major connection of health governance system from the private sector is General Practitioners (GPs) and their clinics. General Practitioners' Section of the Myanmar Medical Association (MMA) with its branches in townships provide

these practitioners the opportunities to update learning and exchange their knowledge and experiences by holding conferences, talks and symposia on currently emerging issues and updated diagnostic and therapeutic measures. The Medical Association and its branches agencies provide a link between public sector and private practitioners by facilitating continuing clinical knowledge, primary community health and epidemiological data.

Figure (4.10) Myanmar Health Governance Structure



Source: Health in Myanmar (2014)

4.5 Health Workforce (Human Resource)

As an integral component of the long-term visionary plan, the National Comprehensive Development Plan (NCDP) (Health Sector) (2010-2011 to 2030-2031) has been articulated based on changing condition. The formulation of the NCDP must link with related sectors as well as also link with the States and Regional Comprehensive Development Plans. This long-term visionary plan with its objectives will be a guide on which further short-term national health plans are to be developed. Aiming towards the health sector development, the strategies for the human resource and capacity building is very critical for the future.

Human Resources for Health Development Programme

- Produce different categories of health professionals according to the human resources for health needs
- Development of infrastructure, teaching/learning materials, technology, libraries, upgrading laboratories to meet the international standard
- Regular review, revise and update of curricula for relevance to the changing trends in medical education
- Strengthening of human resource information and research activities

Myanmar has a chronic shortage of doctor and medical persons as most practicing doctors want to be located in or around big cities which is major concern. The availability of doctors in tier-2 cities is extremely low and the doctors attending to the sick are mostly underpaid.

Table (4.4) No. of Students Attending in Universities and Training Schools under Department of Medical Science (2014)

No.	University/ Training Schools	Number of Students
1	University of Medicine(1), Yangon	3454
2	University of Medicine, Mandalay	2881
3	University of Medicine(2), Yangon	2945
4	University of Medicine, Magway	1984
5	University of Dental Medicine, Yangon	940
6	University of Dental Medicine, Mandalay	744
7	University of Pharmacy, Yangon	554
8	University of Pharmacy, Mandalay	348
9	University of Medical Technology, Yangon	551
10	University of Medical Technology, Mandalay	426
11	University of Nursing, Yangon	776

12	University of Nursing, Mandalay	771
13	University of Community Health, Magway	677
14	Nursing Training Schools	4331
15	Midwifery Training Schools	2436
16	Lady Health Visitor Training School	NA

Source: Health in Myanmar (2014)

According to the Table, there are more than 28000 health care persons are producing from the range of Doctor to Basic Health Staff. To produce qualify Medical doctors, the annual student intake to Medical Universities from 2400 to 1200 and to increase the study period from 6 years to 7 years. As a short-term program, the student intake was reduced but for achieving the target of long term National development plan it is still needed to produce more doctors. So, Department of Medical Science established the New Medical University in Taunggyi, Southern Shan State starting from 2013-2014.

Table (4.5) Health Manpower Production as of February 2014

No.	Degrees/ Certificates Total Number of Production	
1	M.B,B.S	37154
2	B.D.S	3695
3	B.Pharm	2983
4	B.Med.Tech	3091
5	B.N.Sc	5320
6	B.Comm.H	1613
7	Nursing Diploma	27864
8	Midwifery	34009
9	L.H.V	4371

Source: Health in Myanmar (2014)

As of February 2014, there were 37154 medical doctors and few thousands of other health workforce. For the wider coverage of health system till the village level, Nursing and Midwifery.

4.6 Health Information System

Health information is one of the six building blocks of Health System and which in turn plays a vital role for decision making as strong indication. Health information services in primarily for Public Health Services and Hospital Care Services.

Morbidity and mortality statistics in hospitals depend on the quality of disease coding and thus, training of medical record technicians as well as medical doctors on ICD (International Statistical Classification of Diseases and Related Health Problems 10th Revision) is very important for quality statistics in recent years. Data quality assessment on hospital statistics was performed in five hospitals in 2013, those were sending softcopy of ICD-10 coding in Hospital Report Form II to central. Generally, the quality of data on ICD-10 coding was 67.6% and Medical record documentation was 71.4%. Myanmar cover ICD-10 trainings of medical record technicians and health staff. Trainings of BHS on HMIS data set and data dictionary were conducted to 1348 basic health staff from 22 townships in 2013 and 876 basic health staff Training of trainers approach for BHS training on HMIS at Region/State level was provided according to country plan of COICA; it covers eight Regions and States of health authorities. Altogether 290 township training team members from 124 townships of right such Regions and States attended and actively participated in the training.

Data collection from private health sector (licensed private hospitals) was happening at January 2013 to figure out the whole picture of nation-wide data. Orientation and training on private health sector data collection was conducted for two days with the collaboration of private hospital association; manual was also distributed.

For quality improvement of public health statistics, understanding of data description with definition and application of indicators in real time situation are essential in this stage.

CHAPTER 5
FINDINGS AND SUGGESTION

This thesis briefly describes the current situations of various aspects especially financial and health expenditure of healthcare in Myanmar, based on the most up-to-date data sources. Though the private sector participation in national public health sector in Myanmar have been refining as demonstrated by Global indicators, there is a serious lack of by law and private sector partnerships with public health system. A new attempt to introduce a health insurance is being expected to further improve the conditions of health system. National and international support is needed for continuing implementing UHC and success and improvement to be shown.

According to The World Bank Survey "Procuring Infrastructure Public-Private Partnership 2018 in Myanmar", there is no exact and detailed regulatory framework for Public Private Partnerships (PPP) at the national or local level. However, general tendering procedures are administered by the terms of Directive No. 1/2017 ("Tender Rules"). The Tender Rules are commonly used as a standard for PPPs at this moment. And Union Departments noted as the procuring bodies for national procurement processes. Union, Region, or State Departments or Organisations become the procuring bodies for State or Region procurement processes.

Further, where the private party or parties have some international connection, the regulations on investment, which are the Myanmar Investment Law (MIL) promulgated in 2016 and its rules (MIR) apply. Restricted investment activities are outlined in the notification 15/2017 of the Myanmar Investment Commission (10 April 2017) and the List of Restricted Investment Activities (Notification 15/2017).

The notification no. 49/2014 of Myanmar Investment Commission (14 August, 2014) for the Myanmar Citizen Investment Law - The Pyidaungsu Hluttaw Law No. 18., is stated as above.

Private participation can be conceivable and be controlled by sectoral notifications prepared by health ministry which intend to MOHS in this thesis. However, these are released independently and should be considered in relation to the

business of each specific plan (for example, a medical doctor rendering for Ministry of Transport project would be ruled by notifications from the Ministry of Transport and Communications MOTC).

The Ministry of Planning and Finance has published the Project Appraisal and Progress Reporting Department (PAPRD) as a PPP Unit in November 2016 and PAPRD will commence to prepare its PPP related functions. (www.mopf.gov.mm) However, the scope of PARD as to PPP project and policy management have not been visibly outlined and stated. There are no PPP Unit to oversee, no capacity building mechanism or technical supporting for public authorities, no PPP promotion plan in local and international level like forums, no identification and selection criteria of PPPable projects from the national plan, no review of fiscal risks born by the Government system, no consultation mechanism delivered on PPP project's impacted local communities and no history of official announce PPP approved and undertaking projects.

5.1 Findings

There are 4 key challenges to exploiting and sustaining the above category 1 and 2 opportunities:

1. Lack of shared understanding of role of private sector in meeting national health priorities; this has led to ad-hoc for PPP without a felt need for a policy and a well thought out strategy for undertaking with the private sector.
2. Inadequate capacity to manage PPPs has led to lack of precision on performance parameters and methods of measurement leading to complications in monitoring and evaluation. Lack of reliable data or resource in the aspect of cost of services and agreement on fair rate of return to private organizations again subsidize to government's distrust of the for-profit private sector.
3. Lack of capacity on regulations of PPPs arising due to lack of quality assurance systems/ accreditation and difficulties in enforcing contracts.
4. Weak enabling environment: Lack of enabling environment by way of incentives/ viability gap funding, etc.

Based on the findings, there are a few major points for the attention in private and public partnership:

(1) The overall health status at national level has improved expressively since 2011.

(2) While the network of public institutions has been expanding, the overall dependence on or private sector participation has been increasing with the lead of democracy government transition;

(3) Public expenditure and External assistants on healthcare has been abruptly increased over 4 folds after 2011. Private spending (out of pocket expenditure) on health care has been gradually decreasing over the years;

(4) However, increasing financial spending, is implementing to obtain significant improvements in health care financing. There is no reliable health insurance system, lowest ranking in WHO data and a poor overall national health system. In 2011, 91 percent of Myanmar's total health expenditure came from out-of-pocket financing. This figure decreased to 73 percent in 2015, which indicating the general public that government has attention to the issue and trying to sort out. Out-of-pocket payments in Myanmar far exceed the global average of 32 percent of a country's total health expenditure. Recent government health policy has set an aim of reducing out-of-pocket expenses to 25 percent of overall health expenditure according to National Health Plan which would be possible opportunity as well as challenges for the private sector.

5.2 Suggestions

(1) Development of PPP Law / Policy at National Level

a. Successful PPP implementation needs many supporting institutions, both public and private. PPP policy should be prepared with a good understanding of the supporting institutions required to deliver successful and sustainable projects.

(2) Thresholds and Tests to guarantee effective PPP

a. Three methods usually used with PPP projects are: value for money benchmarking and the last but not least the scope ladder. For the initial development of PPP policy, benchmarking and value for money might not be able to apply in a systematic way, although this will change as

policies are developed and transactional experience produces. Value for money would be a measure of the quantitative (cost) and qualitative (qualitative aspects) of PPP proposals and may be used in periods of the PPP procedure. Benchmarking enables a planned PPP to be measured against a number of current projects to evaluate cost correspondence. The scope ladder is for availability payment projects & is one of the methods for ensuring that bids not exceeding the government's capacity to pay for the service delivered over the terms of the contract. A target sum is organized and used to relate and check with the bidder proposals.

(3) PPP-Lite

a. While there is no world-wide agreement on the minimum project size appropriate for PPP, some countries such as Australia set AUD50 mil as the minimum project scale. Actually, projects smaller this size are recognized as inefficient to be run under PPP criteria. For Myanmar, the efficient minimum size for a PPP project scale ought to be set at USD50 mil, and between USD 20-50 mil for a light (small) version of PPP ("PPP-Lite").

(4) Good Governance System for PPPs

a. For an achievable PPP policy that brings benefits to the government, the PPP policy ought to be designed to incorporate with good governance principles. Good governance has multiple benefits for government, private bidders, stakeholders and the community.

b. UNECE - The United Nations Economic Commission for Europe published Guidebook on Promoting Good Governance in PPPs defines governance as "the processes in government actions & how things are done, not as just what is done". All elements of the PPP Framework described in this module deliver to the governance of the PPP programs. UNECE also describes "good governance" as encompassing the following six core principles as below:

    1. Efficiency: apply the resources without waste, delay, corruption, or undue burden on future generation of nation.

2. Accountability: the extent on political actors are responsible to society for their actions as consequences.
3. Transparency: openness and clarity in decision-making process.
4. Decency: development and implementation of rules with no harm.
5. Fairness: equal application of rules to all members of civilization.
6. Participation: involvement of each and every stakeholders.

c. One of the goals of establishing a sound PPP framework is to ensure these principles of good governance are followed in the implementation of PPP projects.

(5) Simple financing structure

The financing structure of projects that are multifaceted and include several types of investor and loan will generate complex procedures and ways to settle arguments or renegotiations. In healthcare PPPs, the major sources of finance for health care services are the government, private households, social security system, community contributions and external aid. If a project is delivering public healthcare to the community, the revenue stream will generally come from government in the form of availability payments based on the quantity and quality of services delivered.

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