EVOLUTION OF UHC IN

MYANMAR

Countries learning from each other to achieve and maintain Universal Health Coverage (UHC)

Capital	Naypyidaw (Nay Pyi Taw) 19°45'N 96°6'E
Official language	Burmese
Ethnic groups	68% Bamar 9% Shan 7% Karen 4% Rakhine 2% Mon 10% others
Area	• Total 676,578 km² • Water 3.06%

GENERAL INFORMATION

Myanmar, officially known as The Republic of the Union of Myanmar, is a lower-middle income country in Southeast Asia. The country is bordered by India and Bangladesh to its west, Thailand and Laos to its east and China to its north. The population is estimated to be 54,4 million, with a life expectancy of 67 years and a poverty headcount of 32,1%.

Myanmar's health care systen was largely shaped by different administrative regimes and political systems and reached a new political phase since the military government was officially replaced in 2011.

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NATIONAL UHC DYNAMICS CARD
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towards SDG 3.8.2

1886 - 1948

The Colonial Period

Ayuvadic indigenous practitioners received no status and credibility.

Hospital care was introduced by the colonial medical department.

Most doctors were non-natives.

1948 - 1956

THE PARLIAMENTARY PERIOD

1948
Maynmar gained independence from the British Colony.

1954
Inception of the Soial Security Act.

Implementation of the Pyidawthar Plan (a long-term programme for economic and social development for the country) which included a National Health Programme.

1956
Implementation of a Social Security System mandatory for enterprises with more than five employees.

1962 - 1978

THE REVOLUTIONARY COUNCIL AND BURMA SOCIALIST PROGRAMME PARTY PERIOD

1962
Complete nationalization of health services.

1963
Abolition of private wards in hospitals.

1966
Nationalization of private hospitals.

1975
Readjustment of health administrative levels.

1978
A series of four-year People's Health Plans (PHPs) were drawn up in accordance with Primary Health Care concepts.

1989 - 2011

SLORC

THE MILITARY-LED STATE LAW AND ORDER RESTORATION COUNCIL (SLORC) AND THE STATE PEACE AND DEVELOPMENT COUNCIL PERIOD

1989
Formation of a National Health Committee as a supreme Health Authority above the Ministry of Health.

1990
Piloting of the Revolving Drug Fund.

1991
Adoption of the first National Health Policy to transition from a socialist-based PHP.

1993
Introduction of user fees for certain diagnostic services.

1994
Introduction of user charges for selected items of medicines with the intention of full cost recovery.

1996
Introduction of a Community Cost Sharing model.

1998
Creation of a National Health Account.

1993-2011
Series of different National Health Policys.

2012 - 2019

THE DEMOCRATIZATION PERIOD

2012
Implementation of a new Social Security Law.

The Social Security Board (SSB) leads the social security scheme and operates its own three hospitals, 92 clinics and 42 enterprise clinics countrywide under other ministries. For tertiary health services outside these facilities, the members will have their medical bills reimbursed by the SSB. Under the new law, the SSB purchases services from existing MOH hospitals as well as from private pharmacies.

2014
>1%

The SSB covered less than 1 % of Myanmar's population.

2016
Implementation of a National Health Plan until 2021, that contains the main goal of attaining UHC by 2030 through a progressive rollout of the Essential Package of Health Services.

2017
Adoption of a Private Health Care Services Law.

Formation of a National Health Plan Implementation Monitoring Unit (NIMU) under Minister's office of the Ministry of Health and Sports (MoHS).

2019
Development of the new Myanmar Health Financing Strategy.

3%

Myanmar's Social Health Insurance covers 3% of the population (1.6 millions beneficiaries).

OUTLOOK

Remaining challenges to create a comprehensive health insurance in Myanmar:

- Low levels of health spending despite a general increases in government spendings.
- Large informal sector (~25% of total population) and large proportion of poor.
- Weak tax infrastructure and regressive tax.
- Poor coordination across various health programs and lack of intersectoral collaboration.
- Absence of guaranteed minimum health services from public health facilities.
- Inflexible arrangements in government budgeting.
- Weak political support (still no legal framework).

TOTAL HEALTH EXPENDITURE

2001-2011

2.4%

Total health expenditure as % of GDP increased from 2.0 to 2.4% (still remained the lowest among countries of WHO South-East Asia and Western Pacific Regions).

2019

Out of pocket payments remain high

(~74% of total health expenditure).

Dr. Thant Sin Htoo
Ministry of Health and Sports
Myanmar

"The way to UHC is context specific and there is no short cut to get there. Every country has their own issues and difficulties in the UHC journey where Myanmar is of no exception. But we try our best to achieve it."

For reference, please visit: https://p4h.world/en/myanmar | Maps are an approximation of actual country borders.