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Adapting to Social and Political Transitions - The influence of history on Health Policy Formation in the Republic of the Union of Myanmar (Burma)

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**Abstract**

The Republic of the Union of Myanmar (Burma) has a long and complex history characterized by internal conflict and tense international relations. Post-independence, the health sector has gradually evolved, but with health service development and indicators lagging well behind regional expectations. In recent years, the country has initiated political reforms and a reorientation of development policy towards social sector investment. In this study, from a systems and historical perspective, we used publicly available data sources and grey literature to describe and analyse links between health policy and history from the post-independence period up until 2012. Three major periods are discernable in post war health system development and political history in Myanmar. The first post-independence period was associated with the development of the primary health care system extending up to the 1988 political events. The second period is from 1988 to 2005, when the country launched a free market economic model and was arguably experiencing its highest levels of international isolation as well as very low levels of national health investment. The third period (2005 – 2012) represents the first attempts at health reform and recovery, linked to emerging trends in national political reform and international politics. Based on the most recent period of macro-political reform, the central state is set to transition from a direct implementer of a command and control management system, towards stewardship of a significantly more complex and decentralized administrative order. Historical analysis demonstrates the extent to which these periodic shifts in the macro-political and economic order acts to reset the parameters for health policy making. This case demonstrates important lessons for other countries in transition by highlighting the extent to which analysis of political history can be instructive for determination of more feasible boundaries for future health policy action.

**Key words:** Myanmar, Burma, health systems, health policy, health history

## **1. Introduction**

In recent years, the Republic of the Union of Myanmar has been exposed to a number of political and societal upheavals. Following cancellation of a democratic mandate in 1988 and the introduction of a free market system, a period of economic sanctions and international isolation followed. The promulgation of a constitution in 2008 (Taylor, 2009a) and elections in 2010 demonstrated some capacity to transition from authoritarian to more open semi-democratic rule (International Crisis Group, 2011). The introduction of global health initiatives and bilateral partnerships between 2006 and 2011 accelerated the pace of change, with new ideas emerging in the areas of poverty alleviation, decentralization and, more recently, social protection. (Tin et al., 2010) Despite initial setbacks and tensions, the post Nargis recovery efforts in 2010 has heralded in a new phase of government and civil society partnerships.

### **1.1 Current Health Status in the Union of Myanmar**

Myanmar (population 47.9 million) (WHO, 2012a) is confronted by a triple burden of communicable and non-communicable diseases, and high child and maternal mortality rates. Malaria, tuberculosis and HIV/AIDS are significant public health problems, especially in the border areas with Thailand and China and the western regions of Myanmar, including Rakhine and Chin States. (Smithuis et al., 2010) Myanmar is one of the world's 22 high disease burden countries for tuberculosis with 525 cases per 100,000 in 2009. (Thu et al., 2012) , (WHO, 2012 b). In the same year, there were 17,000 new HIV infections (second only to India in the South East Asian region) and 18,000 AIDS-related deaths. (Sabapathy et al., 2012) Malaria is also a serious public health problem, with 37% of the population residing in high transmission areas (i.e. areas with > 1 case per 1000 population). (WHO, 2013). High maternal and child mortality rates persist, especially in conflict zones and other

areas with low levels of socio-economic development. (Teela et al., 2009) There are 200 deaths per 100,000 births, and an expected rate of 2000-2500 maternal deaths per year, with estimates of approximately 60,000 child deaths under the age of five each year. (WHO, 2011a)

Continuing high mortality rates are linked to poor access to health care services and persisting problems with poverty and under nutrition. A Living Standards Survey demonstrated a poverty rate of 23%. (MOP, 2009) This is comparable to other countries in the region (e.g. Cambodia and Laos), but poorer road communications, insecurity, and the absence of an extensive health financing strategy means that the impact of low incomes on health access is likely to be very much higher in Myanmar.

Encouragingly, there have been recent reductions in child mortality. Some national health programs, particularly immunization, (Myanmar Ministry of Health, 2007) tuberculosis, (Maung et al., 2006) and malaria control (Myanmar Ministry of Health, 2010) have achieved impressive reach and coverage, demonstrating the extent to which vertically managed disease control programs can have an impact in the context of distance, insecurity and poorly resourced health systems.

**[Insert Table 1 Main Health and Demographic Health Indicators (WHO, Global Health Observatory 2012b)]**

## **1.2 Health Systems Structure**

Despite these challenges, the country maintains an extensive health care structure with vast reach and coverage across central plains, delta regions and mountainous States. The health system is organized according to the boundaries of the administrative system, which position Township hospitals at the Township level of administration, and rural health centres (RHC) within the catchment areas of the Township. Beneath the RHC, there is a network of sub rural health centres (SRHC) staffed by midwives, and midwife auxiliaries. The Township

catchment area comprises between 100,000 and 300,000 people, and even smaller population catchments occur in remote State areas. National Regional and State levels of the system technically guide, administer and resource the Township health authorities to implement programs in the Townships.(Tin et al., 2010)

**[Insert Figure 1: Administrative Map of the Union of Myanmar (Burma) (Nations on Line, 2013)]**

Inequities in access to health care are widespread, with the health system still subject to the effects of conflict, displacement and the inequitable allocation of resources and decision-making authority. There are widespread reports of low levels of health sector development in the States and border regions. For example, up to 800,000 people without citizenship are located in Northern Rakhine State (NRS) – a geographic area bordering Bangladesh, with social sector services provided in the form of humanitarian assistance that are principally coordinated through UNHCR.(UNHCR, 2012) In Kachin State, conflicts continue, with up to 50,000 internally displaced persons located in parts of the State. In other areas, particularly along the border areas with Thailand and China, conflicts with the Wa and Karen minority groups over the last 60 years have resulted in very limited development of the health and education systems.

### **1.3 Framework for Analysis of Health and Health Systems in Transition**

The experience of other countries in the region undertaking similar transitions demonstrates the link between reforms to the economic and political order and related shifts in direction in health policy. Systems that loosen political and economic control are frequently challenged to introduce new decentralized systems of management. This is characteristic of the health contracting models trialed in Cambodia and the subsequent

program of health system reform. (Soeters and Griffiths, 2003) In post-communist Mongolia in the 1990s, radical shifts were required in the way the health sector was planned and financed to account for a transition towards market based and decentralized models of administrative governance (Hindle and Khulan, 2006). In the Philippines and Indonesia, health sectors struggled to manage the complexity of decentralized institutional arrangements in the post centralist Marcos and Suharto eras (Heywood and Choi, 2010), (Lakshminarayanan, 2003), (Espino et al., 2004). Bloom (2008) argued that the main lessons from China's health sector experience relate to the management of institution building in a complex and rapidly changing environment, and suggested that actors in the policy process co-construct new institutional arrangements and rules to accommodate changes instigated by market reforms (Bloom, 2011). The notion of health systems being highly path dependent is seen as a result of the accretion of learned behaviors and cultural norms. This is somewhat analogous to the concept of health policy trajectory described by Walt. (Walt et al., 2008). Sturmberg and Martin (2010) also indicate the extent to which the health policy and planning agenda is set by the "grand attractor" of larger reforms to the political and social landscape.

The increased complexity of institutional arrangements as countries undergo political reform presents significant challenges to change management. Bourdieu (1977) suggests the notion of "habitus" to theorize the co-responsibility of current behaviours with national history. The increased complexity of institutional arrangements as countries undergo political reform presents significant challenges in terms of adaptability of these durable behaviors to change. Huntington (Huntington, 2006) similarly notes this notion of durability by defining institutions as stable, valued and recurring patterns of behavior. Fukuyama (Fukuyama, 2011) defines institutional "coherence" as the measure of the extent to which the roles and functions of emerging institutional or constituency interests (such as decentralized

government, civil society and the private sector) are well defined and agreed upon as societies adapt to social change. (Fukuyama, 2011)

A common thread discernible through these various theoretical standpoints is the degree to which health systems and policy formation are subject to the influence of a wider field of political and social relations that are context specific and that are changing through time. That is, managerial constructs are both *technically* and *socially* constructed. According to the systems view, health systems (which are often classified or segmented into technical health system building blocks) (WHO, 2009), are in themselves sub systems of political and social systems that transition through time. Hence there is a wider “ecology” to health policy making (Capano 2009), consisting of both the technical construction of administrative systems, along with the wider field of social and political relations within which these health systems are located. The main question to be examined in this case study is the degree to which these periodic macro reforms to the system of socio-economic and political relations contributed to key turning points in health policy history.

This case study adopts this systems and ecological standpoint to describe and analyse the links between health and history in Myanmar between 1962 and 2012, and, on the basis of these findings, to reflect on the manner in which an understanding of history can contribute to health policy analysis in transition settings.

The specific objectives of this case study are as follows:

1. To examine the level of influence of social and political history including international relations in shaping the development of health policy and systems in Myanmar ;
2. To consider the implications of these findings for the health policy and organizational landscape in Myanmar , and
3. To reflect on lessons learned for health policy analysis in other transitional contexts.

## **2. Methods**

### **2.1 Data Collection**

Three methods of data collection were applied to address the research question:

- (a) Policy and Planning Participation: The principal method of data collection was the participation by the primary author in health system development initiatives between 2006 and 2012. The main activities undertaken included development of national immunization strategies and plans, (Myanmar Ministry of Health, 2007), (Myanmar Ministry of Health /UNICEF, 2009), post Nargis disaster recovery planning (Myanmar Ministry of Health/WHO, 2009), and development of health system strengthening strategy. (Tin et al., 2010) These field activities included advisory roles in Township level health planning in Post Nargis affected areas in the Delta region of the country, as well as with health system and immunization strategy development with central planners. This enabled a wide level of participation of the field level situation, Township management and planning processes, and development cooperation, as well as facilitating access to the grey literature on health policy and planning.
- (b) Literature Review: The health literature about Myanmar was searched (PubMed database) as well as social sciences databases (social science citation) using search terms of “Burma” and “Myanmar.” Documentation on policy and planning was sourced in relation to health system strategy, immunization plans and Post Nargis Recovery planning as well as publicly available data sources and documents through the Ministry of Health. The terms “Myanmar”, “Burma and “Health Systems” were searched in social citation index data base in order to identify historical accounts of the evolution of the health systems in Myanmar.
- (c) Health and Demographic Data: Data on health, socioeconomics and demography of the country was sourced through the database of the World Health Organization

(Global Health Observatory) (WHO, 2012) and the most recent Living Standards Survey in Myanmar conducted in 2010. (UNDP, 2011)

The principal reason for selection of the case study approach was to address the complexity associated with the impact on health status and health systems of external factors resulting from a changing social and political environment. Holmes (Holmes, 2006) suggests that the “web of causation” associated with complex social situations increases the risk that observations will be biased by the author’s own assumptions on the nature of social reality. This risk can be minimized by posing a single research question and through the systematic categorization of data using an analytical framework. (Rosenberg and Yates, 2007) We have also attempted to minimize selection bias in categorization of data according to historical era by searching and referencing information of historical accounts of the development of the health systems from the early 1960s, in order to balance the availability of data on the current period through grey literature sources. .

### **3. Results**

Figure 2 describes the health and history timeline in Myanmar between 1962 and 2012.

#### **[Insert Figure 2 Timelines of Health and History Myanmar 1960 - 2012]**

Three major periods are discernible. The first is the post-independence period of development of the primary health care system extending up to the 1988 political upheaval. The second is from 1988 to 2005, when the country launched a free market economic model and was arguably experiencing its highest levels of isolation. The third period (2005 – 2012) represents a further attempt at health reform and recovery, linked to emerging trends in national and international politics and development assistance.

#### **3.1 Period 1: From Colonial Health Systems to Primary Health Care**

Following assumption of full colonial control of Myanmar in 1886 after three Anglo-Burman Wars, the British continued to rationalize the central functions of the State, through the establishment of line technical administrative systems. In 1899, hospital administration was separated from prison administration. A “Sanitary Commissioner” was appointed in 1908, which led to establishment of the Public Health Department. (Taylor, 2009c) After Japanese occupation from 1942 to 1945, independence was finally granted in 1948, and experiments with democracy continued until 1962. The health sector evolved during this post-independence period and continued through Ne Win’s Burma Socialist Programme Party rule between 1964 and 1988. Myanmar was one of the pioneering countries in developing a primary health care system. In 1953, a system of Rural Health Centres (RHC) was established, and by 1964 there was a rural health centre in every administrative district. (Ko Ko, 2006) As early as 1967, contemporary accounts were documenting the establishment of rural health care system, including a network of Township Hospitals, Station Health Units and rural health centres and sub centres. The reorganized health services were inaugurated on 1 January 1965 with the aim of “extending their frontiers to the rural workers and farmers”, with “preventive and social medicine .....based at hospital centres.” (Woodruff, 1967 Page 552) At that time, the population of 23 million was already served by 2,100 doctors (1 per 11,000 inhabitants).

Another contemporary account observed that investment in health and education was one of the bright spots of the early Ne Win socialist period (Cook, 1970, Butwell 1972). Between 1961 and 1971, government expenditures on medical establishments more than doubled with hospitals increasing in number from 269 to 374 and hospital beds from 11,035 to 20,587. The number of doctors grew from 1,778 to 3,073, and rural health centers from 555 to 909 in this 10 year period (Butwell, 1972)

Another indication of the pace of development of the PHC system prior to 1988 was the establishment of 1337 RHC. Despite significant population growth, this had only expanded to 1565 facilities by 2011-12 (MOH, 2012). Expenditure on health was 10% of government expenditure from 1962 to the mid-1980s. Between 1964 and 1983, life expectancy for men increased from 45 to 61 years, and for women from 48 to 65 years. Infant mortality dropped by one third, and literacy increased from 57% in 1963 to 81% in 1985. (Taylor, 2009b). Despite these early investments and gains in health and in medical education (Cook, 1970) several decades of economic stagnation had contributed to a marked decline in the quality of health and education infrastructure by the 1980s (Khin Maung Kyi).

### **3.2 Period 2 The Emergence of the Free Market Era from 1988 to 2005**

The first steps towards economic liberalization took place in 1987, which was also the year when the United Nations first classified Myanmar as a “least developed country” in order to ease debt burden. In 1988, the government officially declared it would depart from 30 years of central planning and adopt an “open door policy”. (Cook and Minogue, 1993) The economy became focused on tourism and extractive industries, an expedient measure to earn foreign exchange at the expense of long term social and environmental planning. (McCarthy, 2000) This move to the free market was a trigger for health policy reform in the early 1990s. In 1993, the Ministry of Health through a new National Health Policy began exploring alternative financing mechanisms (in the form of Hospital Trust Funds, User Fee Systems, and Drug Revolving Funds) to reduce the impact of user fees on utilization of health care services by the poor, and to support recurrent financing of the health system.

By 2000, expenditure on health as a percentage of total government expenditure had declined to 1.2%. (WHO, 2011b) In the same year, the World Health Report measured the dramatic decline in the quality and coverage of the Myanmar health system by ranking it 190th for health system performance, significantly lower than Cambodia (ranked 174) and

Laos (ranked 165).(WHO, 2000), a finding which acted as a galvanizing force for the reconsideration of health policy.

### **3.3. Period 3 Early Evidence of Recovery and Reform 2005–2012**

#### **3.3.1 Challenges for the Reform Era**

Myanmar has faced many human resource barriers that are common to developing countries. These include over-investment in the hospital sector at the expense of rural health, difficulty in placing and retaining a health workforce in rural and remote areas, an imbalance in the mix of the health care workforce, and ongoing problems with rural health workforce motivation and remuneration. (GAVI Alliance, 2008) Lack of infrastructure, logistics systems, equipment, lifesaving essential medicines, transport availability, and weak supervision systems in these rural and remote areas were additional factors contributing to inequities in access to quality health care. (Myanmar Ministry of Health, 2006)

One of the fundamental challenges to health system development and health care access in Myanmar has been the lack of both State and international investment in health care. This is evident in the population's high rate of out of pocket expenditure for health care; the highest in the region according to data from the Global Health Observatory (92.4% of total health expenditure).(WHO, 2012c).

Figure 3 illustrates per capita total and government health expenditures for selected countries in the region.

**[Insert Figure 3 Total Expenditure on Health per Capita 2009 South East Asia (WHO, 2012a)]**

In response to these challenges, within the last 7 years, there has been gradual progress in health reform and a recovery linked to shifts in the national and international political context. Reforms include health planning, international partnerships for health, and the exploration of social sector policy options.

#### **3.3.2 Health Planning and Health Financing Reforms**

At Township level and below, there is no system of comprehensively costed plans that include inputs in an integrated planning and service delivery framework. There is no defined operational budget of any significance, other than line project financing. To address this, the Ministry of Health has developed a trial model of Co-ordinated Township Health Planning (CTHP), with a view to incorporating all project and program inputs into a single costed annual plan for the Township. (Tin et al., 2010), thereby addressing in part the fragmentation of health systems attributable to an over reliance on vertical management of projects and programs. The transition to decentralized and integrated planning models will be accelerated by political reforms, as decentralized States and Regions gradually take up the role of financing and management of health care.

Political reforms are once again effecting the direction of health financing reforms. Tax based finance for health care is planned to increase by a factor of four from the previous financial year 2011-2012. Recent commitments to Universal Health Coverage (UHC), reinvigoration of social health insurance, and trialing of community based health insurance and social safety nets (Myanmar Ministry of Health 2012) are all reflective of the recent political openness that recognizes the poverty alleviation challenge associated with very high rates of out of pocket expenditures on health.

### 3.3.3 The Development of International Health Partnerships

Despite the challenges in governance and health financing and the impact of weak international relations on health aid flows, there have been some promising recent developments in international health commitments. In 2005, following concerns about independent monitoring of investments in a major global health initiative, (Parry, 2005) funds to support the fight against malaria, tuberculosis and HIV/AIDs were halted. In their place, bilateral donors established a “3 Diseases Fund” to support program improvements for disease prevention and control with additional essential medicines support through the Global

TB Drug Facility. (Three Disease Fund, 2010) In 2010, Myanmar was successful in reapplying for Global Fund grants. The Global Alliance for Vaccines and Immunization has been influential in supporting the introduction of new childhood vaccines and in providing cash grants to support immunization services and health system strengthening (GAVI Alliance, 2011).

Following the Nargis disaster in 2008 that resulted in over 173,000 dead or missing there was a sustained national, regional and international response. Although the government was criticized initially for the delayed response, a substantial effort was mobilized to implement programs in emergency and recovery phases of operations. (Taylor, 2009a) This is significant given the tensions associated with the initial Nargis response, when US and European warships were positioned off the coast of the Delta region accompanied by an international discussion about the forcible implementation of an aid agenda, based on the “responsibility to protect” doctrine. (Taylor, 2009a) Ultimately, the emergency and recovery effort was coordinated by a regional mechanism known as the Tripartite Coordination Group, with government, ASEAN and civil society representatives. (The Tripartite Core Group, 2008)

Despite tensions in international relations after 1988 and the fall in international aid flows, the Government of the Union of Myanmar, in partnership with international colleagues, has found a pathway to increase external financing of the health sector particularly since 2008. The main approach has been to source funding through global health initiatives including the Global Fund and GAVI. There has also been greater involvement of non-government organizations following the Nargis disaster, where civil society groups (both national and international) have played a pivotal role in the emergency and recovery effort. (Htwe, 2011), (Myanmar NGO Contingency Working Group, 2011)

#### 3.3.4 Consideration of Social Sector Policy Options

In 2008, steps were taken to initiate reforms in the social and political system. A new constitution was enacted, elections were conducted, a parliament convened, and a presidency established (International Crisis Group, 2011), (Taylor, 2009a). A key theme in the reforms is the promotion of the concept of decentralization.

These reforms also provide an opening for the expansion of poverty alleviation programs. There was publication of a Living Standards Survey in 2010 (MOP, 2010) and renewed discussions on social protection and health financing. New strategic directions for development, education and health were outlined at the Development of Policy Options Conference (UNIC, 2012) held in Nay Pi Taw in February 2012. These directions emphasize social sector investment and human resource development, providing a counter balance to the traditional focus on economic policy, internal security and natural resource extraction. The shift in focus is reflected in the planned reallocation of budget resources from defense to the social sectors, as reported at a conference (UNIC, 2012), and announcement of a \$300 million Millennium Development Goal Health Fund in 2012 (3MDG Multi Donor Fund, 2012).

#### **4. Discussion**

The interrelationship between political and historical narratives and health system evolution presents major challenges for institutional and policy reforms in the health sector. The emergence of a revived civil society and developing private sector, the development of market forces, shifts in international relations, and widened decision making authority for local government all serve to introduce a level of complexity into institutional relationships that will require highly adaptive policy responses (Bloom, 2011), (Fukuyama, 2011).

Emerging themes in health policy and planning in Myanmar and their likely trajectory in the next decade are illustrated in Figure 4, and are discussed in more detail in the sections that follow.

**[Insert Figure 4 Health Policy Landscape Myanmar]**

#### **4.1 Economic Policy and Trends in Health Financing**

Health financing reform has been driven principally by the emergence of free market economic reforms since 1988 (Cook and Minogue, 1993). Township health care systems have struggled to manage with limited operational budgets since this time. In the event of a shortfall of health commodities (equipment and medicines) patients are asked to pay for these commodities, in addition to financing their food and travel costs. This locks a significant proportion of the population (particularly the 23% below the poverty line) out of the system.

The policy of free market development and low social sector investment is also affecting workplace placement and retention. The public sector has lost its competitive edge in attracting new members into the workforce, particularly in remote areas. While no clear data is available on the growth of the private medical sector, anecdotal evidence suggests a similar pattern to other developing countries. As observed elsewhere in the region, (Dieleman et al., 2003) the phenomenon of “double job holding” is becoming prevalent, with staff reportedly attending public facilities in the mornings, and in the afternoons or evenings, opening home based private clinics.

In order to arrest the decline in the public sector, and support wider efforts for poverty alleviation (now designated as a higher order government objective), financing approaches in the health sector will increasingly focus on models of risk pooling through maternal and child health subsidies and cash transfer “voucher schemes”, hospital health equity funds, increased tax based financing and the strengthening of social health insurance and even broader social protection schemes (MOH, 2012). To ensure coverage of the poorer and more remote

sections of the population, a significant level of supply side investment in health sector development will be required, including health provider incentives and salary adjustments for remote area placement and improved civil society and private sector partnerships. Experience from the region demonstrates that it can take up to 20 years to develop the institutional capacity to achieve universal coverage (WHO Western Pacific Region and South East Asia Region, 2009).

#### **4.2 Decentralization Policy and Health Systems Strengthening**

The political reforms and constitutional changes now taking place will result in a higher level of political and administrative decentralization. Previously, military commanders governed States and Divisions. Under the reforms, there will be a transition of management to Chief Ministers and the appointment of Social Affairs Ministers in the renamed “Regions” (formerly Divisions where the Bamar ethnic group predominates) and the States (where the various ethnic minorities reside). Inherent within the decentralization concept is a delegation of powers and resources to middle and lower levels of the administrative systems (States, Regions and Townships), which has implications for both the management and resourcing of the health sector.

The need to develop decentralized and integrated health planning systems, to place and retain human resources in remote or post conflict affected areas and to develop capacity for health financing and health insurance all point to a need for a systems rather than a project based approach. This will require the development of integrated management teams, information and financial flows in contrast to line management of projects with vertical decision-making. The transition from “project thinking” to “systems thinking” (WHO, 2009) will require significant reorientation of management culture, given the long term dependence

on central command and internationally funded projects and programs including those for immunization and disease prevention and control.

### **4.3 Governance and the Emergence of Civil Society and Private Sector**

#### **4.3.1 Constituencies**

A high level of voluntarism in communities and through religious institutions is evident in Myanmar. During the more democratic era between 1948 and 1962, a vibrant civil society was active in urban areas, and re-emerged in 1988 during the pro-democracy movements for change. (International Crisis Group, 2001) With the opening up of free markets from 1988, developments following the Nargis emergency in 2008, and the relaxing of political control from 2010, the re-emergence of civil society is becoming evident.

Despite the initial tensions around the management of emergency aid, (Seekins, 2009) the NGO sector (both national and international) has begun to flourish in the regions affected by the emergency, where NGOs have formed joint plans with Township Health Authorities to improve maternal and child health and emergency preparedness capacity. (Myanmar Ministry of Health/WHO, 2009) National NGOs have publicly reported that the disaster was a trigger for the professional development for a civil society sector. (Htwe, 2011) There are now 101 National NGOs in Myanmar, and 17 national Health NGOs, concentrated mainly in water and sanitation, the three diseases (TB, Malaria and HIV), medical services and disaster response. (Myanmar NGO Contingency Working Group, 2011)

The current trend is towards strong growth of a private medical sector in the cities and towns, including village based general practitioners in more economically prosperous areas of the country. Research has confirmed that the private sector is the sector of choice for management of TB, despite the fact that services are free in the public domain, with clients citing convenience as the main determinant of seeking out a provider type. (Saw et al., 2009)

Private public partnerships are being initiated, including social franchising for selected health care services (Loannroth et al., 2007), (O'Connell et al., 2011) and public private collaborations for both TB (Maung et al., 2006) and malaria management in Upper Myanmar. (Tun et al., 2009).

In addition, Myanmar has been identified as being one of five countries in the Asian Pacific Region with the highest health profession emigration factors (along with the Philippines, India, Pakistan, and Sri Lanka) (Connell, 2010). The main reasons for this are that population ageing in most OECD countries and the related increase in health care requirements have led to increased demand for medical personnel from developing countries. Recent political reforms will present many opportunities and challenges as a result of the potential re-engagement of the health care system with an expatriate health care workforce.

The complexity of the decentralized planning systems and civil and private sector constituency emergence as described above will present difficulties for central managers in transitioning from a command and control of program management function to that of a regulator in a more decentralized and multiple provider service delivery and administrative context.

#### 4.3.2 International Relations and Social Sector Aid

The inequities in international aid flows to the Union of Myanmar are increasingly well documented.(Grundy and Biggs, 2012) However, development partnerships with National and Township health authorities have been formed in recent years as a result of national and international civil society partnerships and increased Global Health Initiative support through the Global Fund and GAVI. A '3MDG Fund 'will be supported through a pooled donor fund. Donor commitment is likely to be in the range of US\$250 to \$300 million

over 5 years.(3MDG Multi Donor Fund, 2012) The scale of this investment, associated with the recent political openings and easing in international relations, will lead to a reversal in trends in international aid flows, but will represent significant governance challenges in coordinating much larger health investments. The most promising opportunities for management of multiple and diverse sources of funding will be through strengthening of coordinated health planning systems (Tin et al., 2010), although coordination mechanisms related to increased development assistance are still in the early stages of development. The development of such coordinated planning, financing and monitoring systems at National, State, Regional and Township levels is likely to be the critical intervention for the reform of health policy and planning systems in Myanmar.

#### **4.4 Regional Lessons in Health Policy and Planning Responses to Social Transition**

This case study demonstrates the extent to which the evolution of a health system is guided and shaped by critical historical events in national politics and international relations. The socialist military era of the Ne Win administration assisted initially with the development of a primary health care system with a broad network of facilities and health providers across the Union. Cancellation of the political mandate of the NLD in 1988 and the introduction of free market reforms from the early 1990s contributed to a key turning point in health policy history, whereby the Ministry of Health initiated its first health financing reforms through introduction of user fees with the National Health Policy of 1993. The reforms to the political sector commencing in 2008, have once again substantially altered the parameters for health reform, with the health sector now in the early stages of health planning and health financing reforms.

This study of the inter-relationship of political and health policy reform is mirrored by the historical experience of other countries of the region. As evidenced by market reforms in

China, policy makers are being confronted by multiple reform and institutional challenges in order to adapt to shifts in the system of market relations. (Bloom, 2011) In Cambodia, adapting to political and social reform has required substantial investments in capacity development in middle level management to adapt to new roles and functions, and in oversight of social protection initiatives including hospital equity funds. (Okamoto et al., 2009) In Mongolia, the transition from a former central command political system in the early 1990s to a liberal democratic free market regime has required highly reflexive policy responses including establishment of public private family group practices and national health insurance schemes. (Hindle and Khulan, 2006) .

These regional cases are highly illustrative of the extent to which macro-political reform acts to reset the parameters for health policy formation, setting in train a series of health reforms encompassing decentralization, health financing, health planning and human resource management. Critically, the trajectory of these reforms would have been otherwise if not for the influence of the macro-reforms in re-defining the legitimate boundaries for health systems development. In this sense, rather than health systems being viewed solely as a set of technically engineered and interconnecting managerial classifications or “building blocks” (WHO, 2009), health systems can also be viewed as dynamic social constructs that are being continually re-shaped by periodic shifts in the design of economic and political systems.

Even taking into considerations these policy responses to social and political transitions, it nonetheless remains the case that many of these responses still lag well behind the pace of change, as demonstrated by persisting health inequities of access and outcomes across the region. (Boerma et al., 2008) This illustrates the policy challenge of moving ahead with institutional reform in the context of the “durable dispositions” (Bourdieu, 1977) of command and control management cultures, and the need to negotiate more “coherent” (Fukuyama, 2011) responses to an increasingly complex social and institutional context.

These trends would suggest the need for more emphasis by central planners and development partners on regulation, coordination and middle level management systems and capacity development in order to successfully manage the transition. The capacity of the Myanmar health sector institutions and other nations in the region undertaking similar transitions to effectively respond will depend on what Huntington (2006) refers to as the adaptability, coherence and autonomy of institutions as new actors appear and political, economic and social conditions continue to shift.

## 5. Conclusions

We have highlighted the extent to which health system evolution has been influenced by social and political transitions and by national politics and international relations. Health policy processes (and the institutions within which they are embedded) are subject to historical forces. Therefore sound policy analysis should be more cognizant of historical events and current boundaries set by the national and international political context. The impact of international relations in recent years, changes in economic policy in the 1990s, the response to the Nargis Disaster, shifts in the political order and administrative decentralization all demonstrate the extent to which the health policy and planning agenda is being influenced by larger reforms to the political and social superstructure. Historical perspective can assist in determining the trajectory of health policy analysis, (Walt et al., 2008), and in doing so, enables a more realistic determination of future health policy options.

Myanmar is on the verge of a new social policy and human development journey. As in Mongolia, Cambodia, Indonesia and the Philippines, it will be increasingly difficult to turn back the clock once reforms are set in motion. In spite of the need for caution in relation to the nascent stages of any political or social reform, there is also a sound basis for optimism. The challenge for health policy makers and planners will be to carefully track these new opportunities, and to put in place practical measures to protect vulnerable populations from

the ongoing impacts of social and economic transition. This will require a higher level of political commitment, as measured by increased domestic financing for the health sector, as well as increasing levels of management openness, adaptability and capacity to change. These elements of political commitment and management response will in all probability be the decisive factors in guiding effective and equitable health policy responses to social transition.

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**Highlights**

- The Union of Myanmar (Burma) has a long and complex history characterized by internal conflict, tense international relations and health indicators lagging well behind regional expectations
- Post-independence health history has been characterized by periods of primary health care development, subsequent health system decline, and a more recent moderate recovery
- In response to the most recent period of reform, the central state is set to transition from a direct implementer of programs towards stewardship of a more complex and decentralized administrative system.
- Historical perspective can assist in determining the trajectory of health policy and planning, and in doing so, enables a more realistic determination of future health policy options.

**Table 1. Main Health and Demographic Indicators in the Union of Myanmar (WHO GHO, 2012c)**

<b>Indicator</b>	<b>Result</b>	<b>Year, Source</b>
<i>Demographics</i>		
Population	47,963,000	2010, WHO
% living in urban areas	33%	2009, WHO
Life expectancy at birth	64 years	2009, WHO
<i>Health</i>		
Under 5 mortality rate	66 per 1,000 live births	2010,WHO
Number of under-5 deaths annually	56,000	2010, WHO
Maternal mortality ratio	200 per 100,000 live births	2012, WHO
Births attended by skilled health personnel	70.6%	2010, WHO
Measles immunisation coverage among 1-year-olds	88%	2010, WHO
No. of reported cases of malaria	420,808	2010, WHO
Prevalence of HIV among adults aged 15 to 49	0.6%	2009, WHO
<i>Financing</i>		
Total health expenditure as % of GDP	2%	2009, WHO
Out of pocket expenditure on health as % of total health exp.	95.5%	2009, WHO

Figure 1 Administrative Map of the Union of Myanmar (Burma) (Nations on Line, 2013)

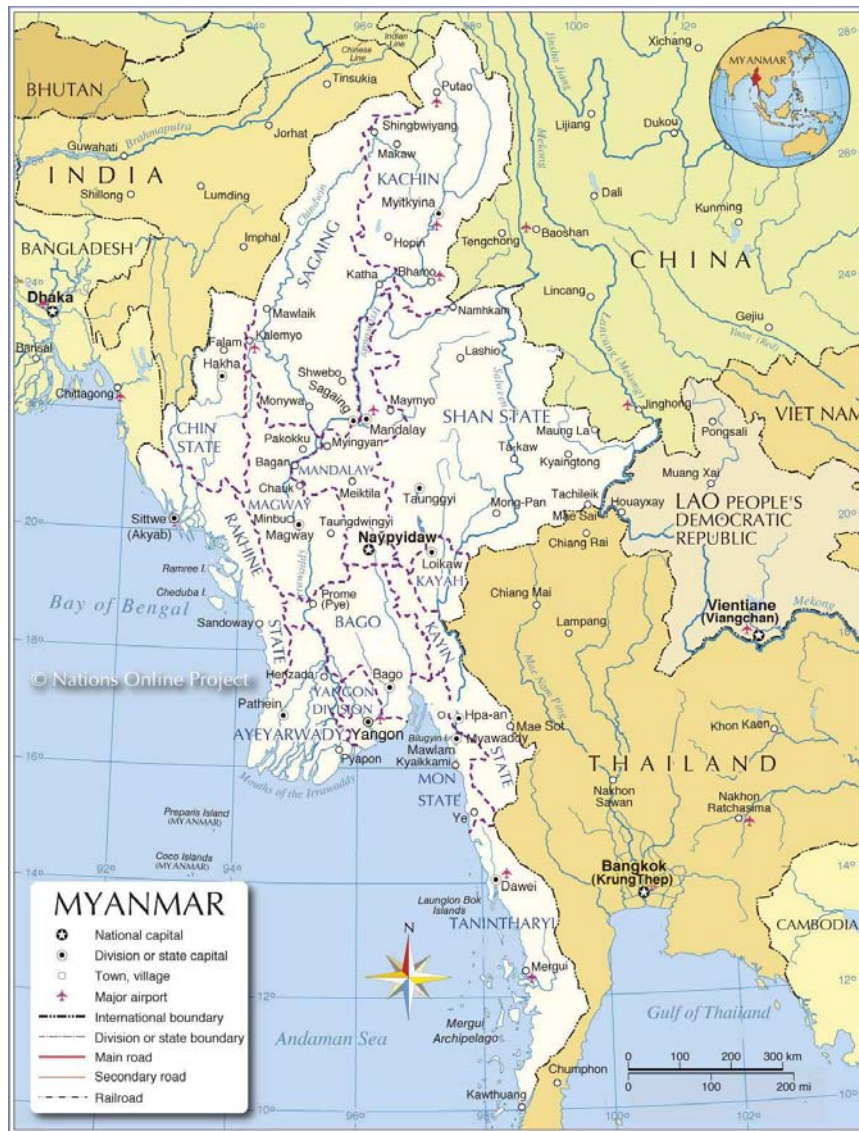
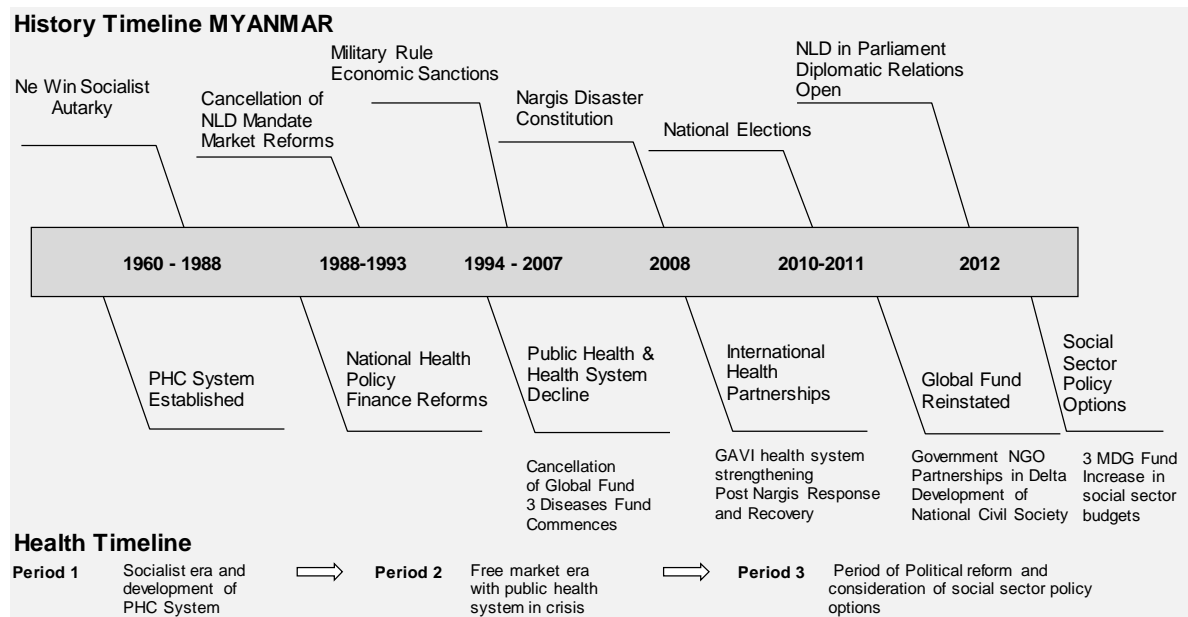
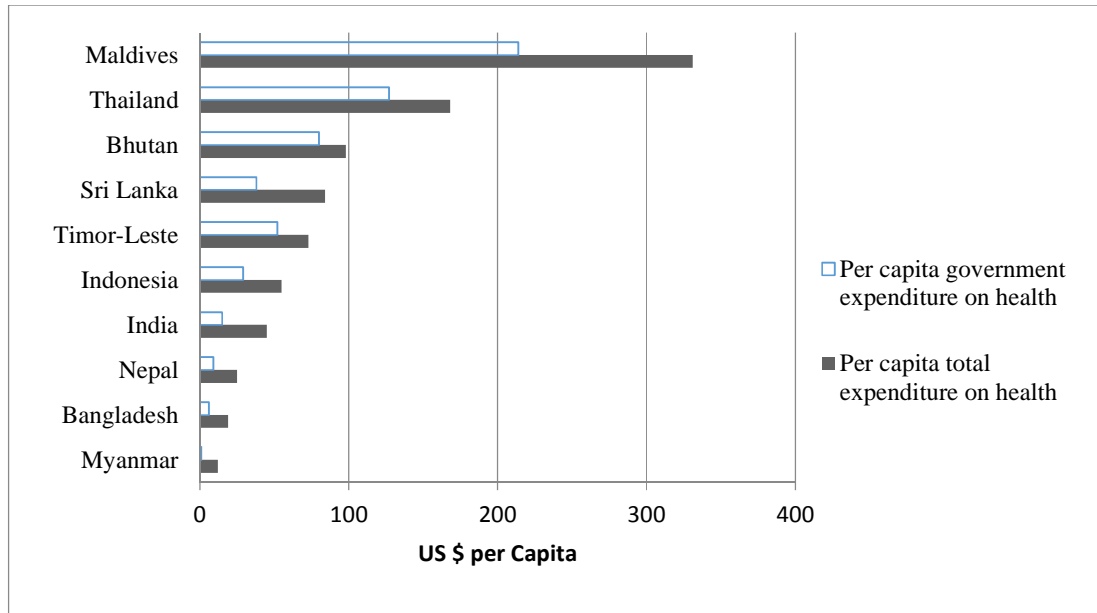


Figure 2 Timelines of Health and History Myanmar 1960 - 2012



**Figure 3 Total Expenditure on Health per Capita 2009 South East Asia (WHO, 2012a)**

**Figure 4 The Health Policy Landscape of Myanmar**