International Labour Organization

Social Protection in Action: Building social protection floors for all

Country Brief: Myanmar

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Extending Social Health Protection in Myanmar: Accelerating progress towards Universal Health Coverage

1. Introduction

As a country in transition, Myanmar has been striving to improve its development outcomes and overcome a past characterized by authoritarian rule. The country's overarching development framework is laid out in the Myanmar Sustainable Development Plan 2018–2030 (Myanmar Ministry of Planning and Finance 2018), in which social protection has been outlined as a priority. One of the country's social development strategies is to "expand an adaptive and systems-based social safety net and extend social protection services throughout the life cycle" (Myanmar Ministry of Planning and Finance 2018, p45). The health sector policy framework is outlined in the National Health Plan (NHP) 2017–2021 (Myanmar Ministry of Health and Sports 2016), which aims to strengthen the country's health system and move towards Universal Health Coverage (UHC) by 2030 through the implementation of pro-poor health protection policies. In addition to the provision of a range of tax financed public health services to the population, social health protection in Myanmar is delivered through the Social Security Board (SSB) which administers the National Health and Social Care insurance scheme and provides insurance and income security to contributing workers.

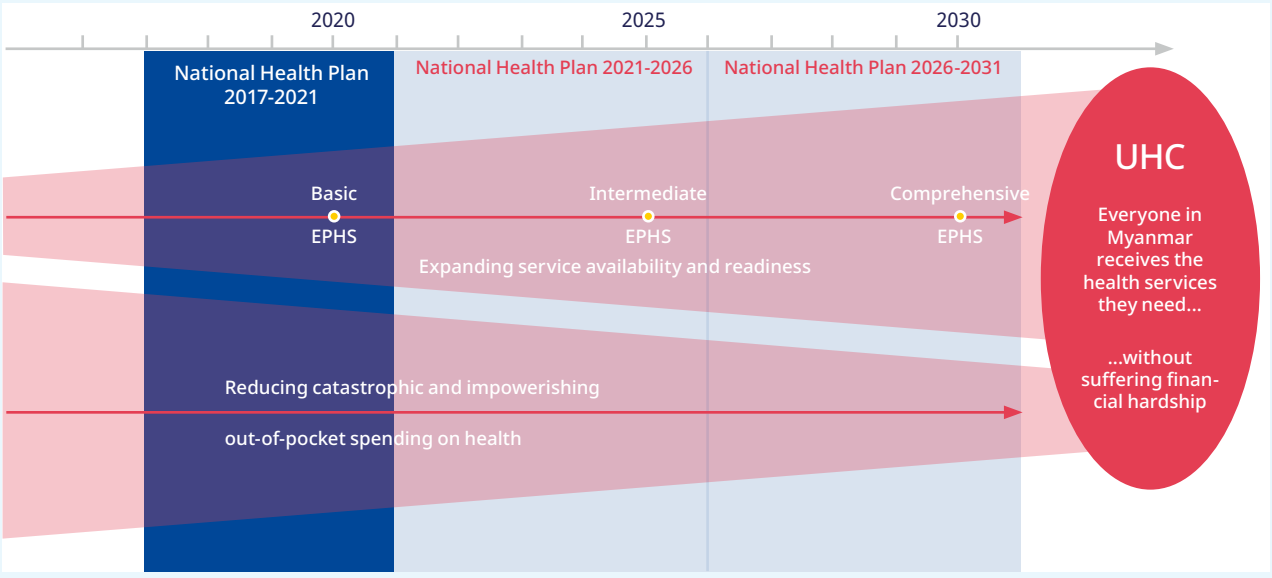
Efforts to strengthen Myanmar's social health protection system are ongoing, and tangible progress has been made over the years. Alongside steady increases in health spending, life expectancy rose from an average of 56 in the year 1990, to 66 in 2016. Moreover, in line with regional trends, the country has experienced notable declines in maternal and child mortality rates and a marked decrease in the prevalence of malaria, tuberculosis, HIV/AIDS and other communicable diseases. However, with out-of-pocket (OOP) health expenditure In Myanmar among the highest in the region, significant challenges remain. To sustain and accelerate momentum in the context of emerging health challenges, enhanced investment in social health protection and the health system as a whole is needed.

2. Context

The health system in Myanmar has evolved in accordance with political regime changes. Following the independence of Myanmar in 1948, the country followed a publicly financed services model, wherein government taxation and international assistance were major sources of health financing. Health care services were then nationalized and expanded to rural areas under the one-party ruling of the Burma Socialist Programme Party, in power from 1962–1988 (Sein et al. 2014). During this time, primary health care was implemented and set as a priority. However, health care during this period remained under-resourced and mismanaged (Sein et al. 2014). Due to a lack of government investment in the health sector in the late 1980s and mid-1990s under the military Government of Burma (otherwise known as the State Peace and Development Council), from 1988–2011, there were major health financing reforms which encouraged households to assume greater responsibility for their own health care. Fee-for-service hospital rooms and wards were introduced in all government hospitals, and user fees were charged for selected medicines and services. These mid-1990s reforms resulted in a significant increase in the proportion of OOP financing for health care.

Today, Myanmar's social health protection system builds from two existing mechanisms: (i) the tax-funded health care system meant to be free for all (non-contributory) and; (ii) the contributory social health insurance scheme managed by the Social Security Board (SSB). The SSB Health and Social Care scheme (hereafter the SSB scheme) is the only social health insurance scheme in the country. In line with the National Health Plan 2017–2021, the Government envisions providing a Basic Essential Package of Health Services (EPHS) to the entire population, while increasing financial protection. The Basic EPHS emphasizes the critical role of primary health care and the delivery of essential services and interventions at township level and below. The National Health Plan envisages a stepwise approach, progressively expanding service availability and readiness until a comprehensive EPHS is attained. The goal is to reduce catastrophic and impoverishing OOP spending on health, and to achieve UHC by 2030.

Figure 1. National Health Plan strategy



Source: Adapted from Myanmar Ministry of Health and Sports (2016).

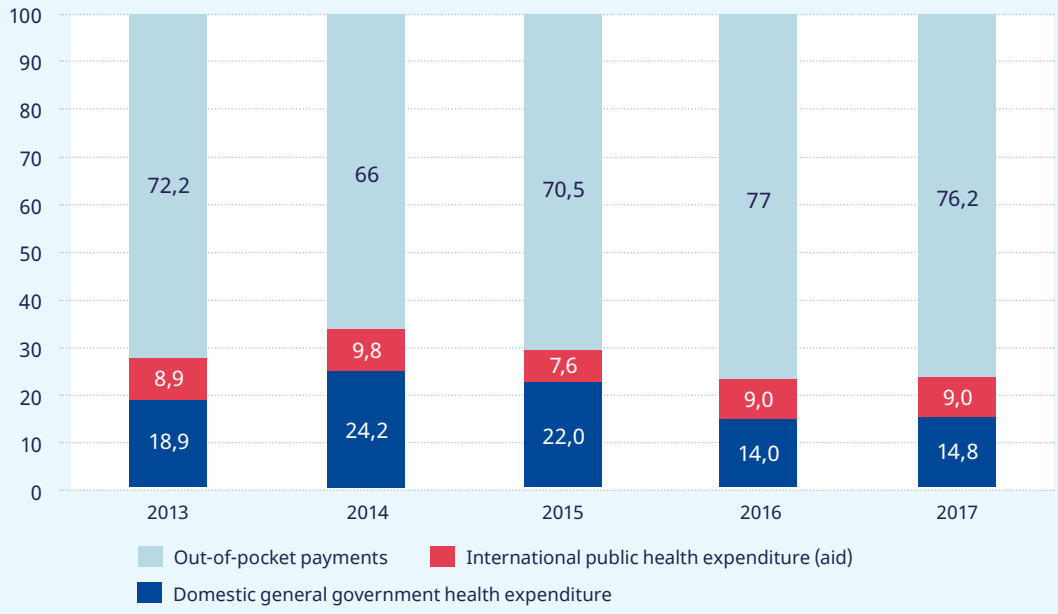
3. Design of the social health protection system

- Financing

Since Myanmar's transition to a civilian government in 2011, investments in the health sector have increased (Han et al. 2018). Budget allocation for health grew from less than 3 per cent during 2011—2012 to 8 per cent in 2015 (Myanmar Ministry of Health and Sports 2019). However, investment in health in Myanmar remains low compared to other countries of the same income level. Myanmar's total health expenditure was 3.6 trillion kyat in 2015, equal to 70,100 kyat or US$54 per capita, which is less than half of the US$136 average among lower middle-income countries (Myanmar Ministry of Health and Sports 2019). Current health expenditure in 2018 accounted for just under 5.0 per cent of GDP (World Bank n.d.). Despite increased investments in health care, Myanmar's health system is still under-funded.

Due to limited government funding for health as well as limited health insurance coverage, OOP payments remain the dominant source of health financing in Myanmar. OOP spending by households accounted for 76.2 per cent of health expenditure in 2017. In 2015, 14.4 per cent of households incurred catastrophic spending (at the threshold of health spending totalling more than 10 per cent of total household consumption) (WHO n.d.). Figure 2 below illustrates the share of health care financing sources that comprised the total health expenditure for the period 2013–2017.

Figure 2. Health financing sources as a percentage of total health expenditure from 2013 2017



Source: Adapted from WHO Global Health Expenditure Database.

In 2017, tax revenue accounted for around 21 per cent of total health expenditure, while the SSB health insurance scheme only accounted for 0.42 per cent. The main revenue source of the SSB takes the form of contributions paid by registered employees and their employers. The health contribution rate to the SSB is 4 per cent, which is split as follows: 2 per cent of the salary from the worker and 2 per cent from the employer (if the insured person is less than 60 years old at the time of registration). If the insured is 60 years of age or older, the rate is 2.5 per cent each from the worker and the employer. [1] The employer also contributes an additional 1 per cent of the worker's salary

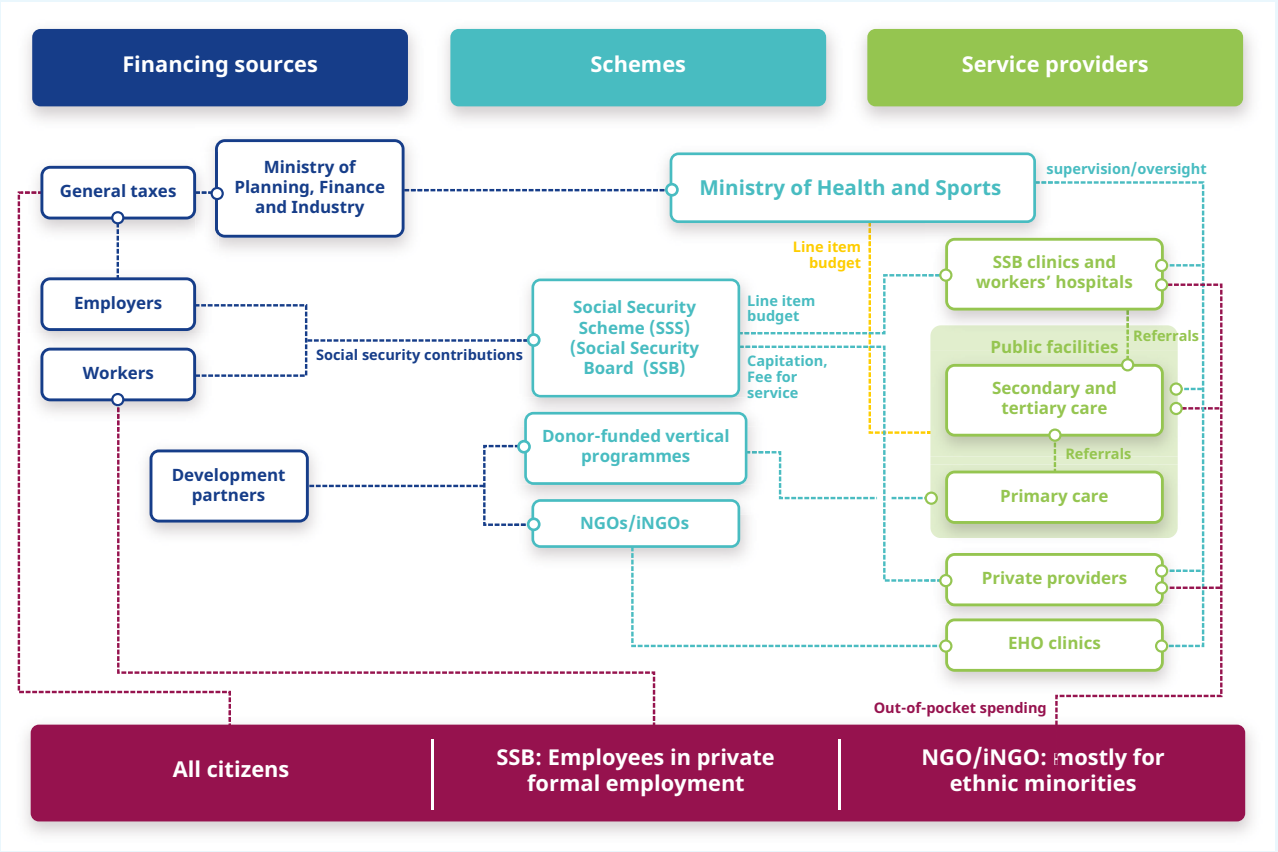
[1] In accordance with The Myanmar Ministry of Labour, Employment and Social Security Social Security Rules of 2014, available at: https://www.mol.gov.mm/en/wp-content/uploads/2016/10/The-Social-Security-Rules-E.pdf

to the employment injury insurance scheme. A worker's salary is defined as consisting of: (i) basic salary or basic wages; (ii) subsistence allowance; (iii) overtime wages; and (iv) other monthly additional payments paid to the worker by the employer. Cash benefits such as sickness benefits, maternity benefits, temporary disability benefits, permanent disability benefits and unemployment benefits are not counted as insurable salary. Contributions to the SSB are collected through a payroll deduction, and the employer is responsible for deducting the employee contribution from payroll and remitting it to the SSB.

Several vertical funding pools are distributed through different ministries and agencies, with most pooled funds sourced from tax revenues and managed by the Ministry of Health and Sports (MOHS) (Teo and Cain 2018). Pooled funds for health in Myanmar (both the SSB health fund and other tax funded and donor funded pools) are small and fragmented, which limits the redistributive capacity of the health financing system. Currently, multiple financing agents, including the MOHS, other related ministries, the SSB and NGOs (including Ethnic Health Organizations), purchase health services on behalf of different sub-populations in Myanmar. The same service provider could therefore be receiving multiple sources of revenue from different programmes (for example, maternal and reproductive health programmes, nutrition programmes and so forth). This fragmentation negatively affects the efficiency of the system, which is already facing financial constraints. The prepaid or pooled share of total health spending in Myanmar in 2014 was 23 per cent, compared to an average of 76 per cent in low and middle-countries in East Asia.

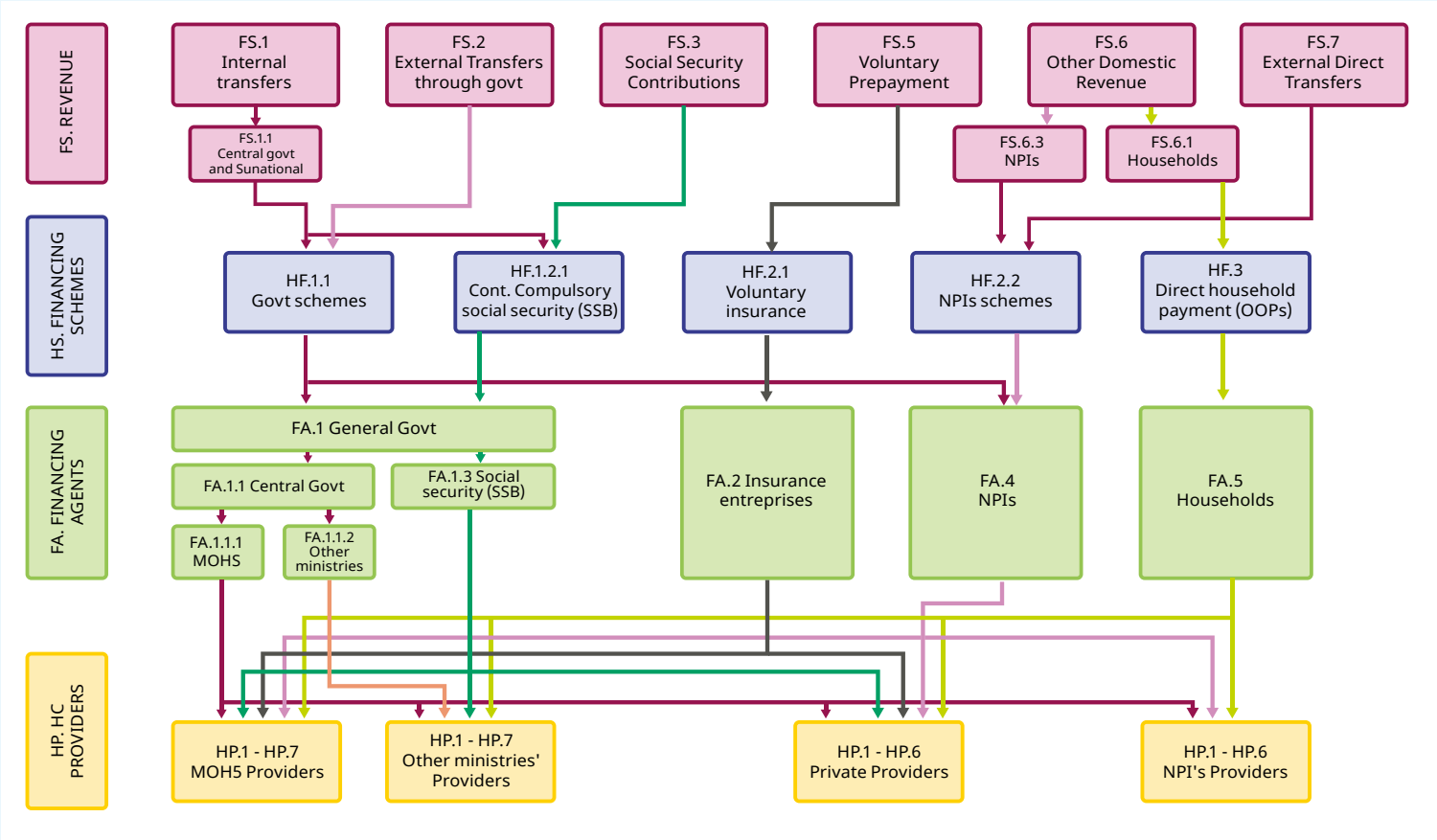
Figure 3 summarises the financing flows of the social health protection system in Myanmar.

▶ **Figure 3. Overview of main financial flows of the social health protection system in Myanmar**



Source: Authors.

▶ Figure 4. Financing flows in Myanmar Health Accounts 2016 2018



Source: Adapted from Myanmar Ministry of Health and Sports (2020, 3).

The MOHS finances public facilities through budget line-items for redistribution among different sub-line-items (Myanmar Ministry of Health and Sports 2019). The budget lines are generally rigid, and although funding passes through regions, states and townships, sub-national entities have no authority to reallocate the funds. Public finance arrangements for budget allocation to the health sector lead to inequities and inefficiencies in resource utilization and in health service delivery (Teo and Cain 2018). Insufficient resources to provide free health care, including funding, equipment, commodities and staff, limit the ability of providers to deliver free services of sufficient quality. In addition to low levels of government financing, budget execution is poor, including under-spending, over-spending and poor budget accuracy. This is symptomatic of broader challenges in the public financial management system, which in turn affects health service delivery (Teo and Cain 2018).

Addressing these issues by extending access to an essential package of health services to the entire population while increasing financial protection is the main goal of the National Health Plan 2017–2021. In late 2019, the Strategic Directions for Financing UHC in Myanmar (Myanmar Ministry of Health and Sports 2019) outlined how resources will be mobilized to finance progress towards UHC and how risk pooling mechanisms will be strengthened to increase affordability of care and address barriers to accessing care, especially among the poor and vulnerable.

- Governance

Health policies are developed by the Ministry of Health and Sports. The SSB health insurance scheme is governed by the Social Security Law of 2012, adopted by the Assembly of the Union of Myanmar. The law builds on the 1954 Social Security Act (No. LXVII), and aims to expand

mandatory and voluntary coverage. The SSB manages the overall implementation of the 2012 Social Security Law and related Social Security Rules of 2014.

The SSB is supervised by the Ministry of Labour, Immigration and Population (MOLIP), and overseen by a Tripartite Board, chaired by MOLIP. The National SSB provides guidance and manages any disputes related to the 2012 Social Security Law. The Social Security Appellate Tribunal hears appeals against decisions of the regional or state social security office. The Medical Advisory Board, formed by the SSB, provides advice on implementing the medical duties of the SSB. [2]

- Legal coverage and eligibility

The right to free access to public health services in not embedded into the legal system. SSB Registration is compulsory for businesses with a minimum of five workers and voluntary for the self-employed and companies with fewer than five workers. This applies to formal private sector enterprises and state-owned enterprises, as well as government enterprises which generate revenues, in accordance with the 2012 Social Security Law. Dependents are not covered by the SSB.

- Benefits

The public health system provides promotive, preventive, curative and rehabilitative services, including traditional medicine, which, in theory, are subject to small user fees according to the fee-schedule established by health facilities. In reality, patients often have to pay informal user-fees or purchase medical supplies from private pharmacies. Prices are not necessarily determined in advance, and the total amount of OOP spending is often unpredictable for the patient.

The Social Security Law 2012 specifies the SSB medical scheme benefits. The package is relatively extensive, covering out-patient and in-patient care, medicines, laboratory tests and transportation costs in cases of referral outside urban areas. In addition, medical care is provided for the first year of a new born's life (Tessier and Guillebert 2015). The SSB benefit package for medical care is the same for all SSB beneficiaries.

As part of the scheme, the SSB also provides access to sickness benefits, maternity and paternity benefits, family benefits (including assistance in the occurrence of natural disasters), disability benefits, funeral grants and survivors' cash benefits, in accordance with the Social Security Law. Employment injury insurance is provided through a separate scheme, and an unemployment insurance scheme is currently under development.

As mandated by the Social Security Law of 2012, any insured person has the right to access medical care and obtain a medical certificate if they are registered and have paid contributions. Sickness cash benefits can only be claimed for those who have been registered for at least six months and paid four months' worth of contributions prior to the first commencing day of sickness. The insured have the right to obtain maternity cash benefits provided they have paid six months of contributions and were registered with the social security office at least 12 months before the commencement of maternity leave (or miscarriage).

- Provision of benefits and services

The public health system comprises a network of facilities at all levels, including specialized hospitals, with a total of 11,726 facilities, comprised of 1,177 hospitals and 10,549 rural and urban health centres. The SSB scheme provides free health care for SSB beneficiaries, without co-payment, through its own health facilities, which include 96 SSB clinics, 3 workers' hospitals and 58 enterprise clinics. Workers' hospitals and SSB clinics are concentrated in urban areas, consistent with the distribution of insured workers (Sakunphanit et al. unpublished). Workers registered with the SSB and who make regular contributions may access secondary, tertiary and outpatient services in SSB hospitals through a referral system from SSB clinics (Sakunphanit et al. unpublished). SSB members are also entitled to seek care in public facilities and selected private facilities. In such cases, co-payment applies to all insured workers and are implemented in line with a sliding scale. The SSB is currently piloting the contracting of private facilities to provide outpatient services to test a purchaser-provider split (PPS) mechanism. The SSB finances its own clinics through direct budget allocation. In the case of private facilities, different contract modalities are used. Capitation has been tested in Kachin, Southern Shan and Tanintharyi, while fee-for-service has been tested in the Yangon region for outpatient care (Sakunphanit et al. unpublished).

[2] The social security Law 2012, available at: https://www.mol.gov.mm/en/wp-content/uploads/2016/10/Social-Security-Law-2012-E.pdf

4. Results

- Coverage

In theory, the entire population is entitled to free tax funded health care in public facilities. However, while a range of public services is already accessible to the entire population of Myanmar in line with the National Health Plan, the EPHS is not yet defined and not yet embedded within law (Teo and Cain 2018). Due to limited supply-side availability and quality, the benefits package of the public health system is rather limited and unpredictable. Overall, the readiness of public health care facilities to deliver essential health services remains very limited, due to years of chronic underinvestment in the health sector.

On the contributory side, the SSB is intended to cover 8 million formal sector workers, which is equal to 15 per cent of the total population of Myanmar. According to SSB administrative data, currently, the SSB covers about 1.4 million workers and 34,000 companies, which is only equal to 17.5 per cent of the target group. About 4,000 workers have registered on a voluntary basis. While the law provides for coverage of dependents, this measure has not yet been implemented. This low coverage rate is mainly due to a lack of enforcement of the scheme.

- Adequacy of benefits/financial protection

Among the general population (excluding insured SSB beneficiaries), financial protection is limited due to low government spending on health and the lack of a clear definition of free health care services, combined with the absence of a legal framework for the provision of free services (Teo and Cain 2018). The current tax funded health services available do not protect uninsured persons from falling into poverty as a result of health care payments. Interventions to provide financial protection, for example through trust funds for poor patients, were introduced in the mid-1990s but were not effective (Sein et al. 2014).

As a result, OOP payments in Myanmar are alarmingly high, accounting for 76.2 per cent of total health expenditure in 2017, which is one of the highest rates in the world. In a recent study, the issue of catastrophic health care expenditure in Myanmar was highlighted and evidenced through various indicators and thresholds of catastrophic health care spending (Myint, Pavlova, and Groot 2019b). According to a study that drew from the Myanmar Demographic and Health Survey 2016, around 2 per cent of non-poor households were pushed into poverty due to OOP payments for health care (Han et al. 2018). As noted above, only a small portion of the population is benefiting from the SSB social health insurance scheme, meaning that coverage of workers remains limited. This is due to the limited mandate of the SSB (most public service officials are not covered) and partial implementation of the Law (dependents are not yet covered). Those covered by the SSB face limited access to health facilities due to the limited network of health care providers and low quality of services under the scheme. This leads many SSB-insured patients to opt for services outside of the scheme, even though they have to pay out-of-pocket (Myint, Pavlova, and Groot 2019a).

SSB beneficiaries are therefore not exempt from the impact of OOP spending. A recent survey conducted in the three most industrialized townships in Myanmar (Yangon, Mandalay and Bago) show that more than 90 per cent of surveyed SSB members had to pay out-of-pocket when seeking care because they used services outside the SSB system (Myint, Pavlova, and Groot 2019a). The survey also found that around 13.7 per cent of surveyed respondents who were uncovered by the SSB had to borrow money to pay for health care services or medicines, compared with 12.7 per cent of SSB beneficiaries. 2 per cent of persons not enrolled in SSB and 3.6 per cent of SSB beneficiaries had to sell their assets to cover medical costs associated with their most recent experience of illness or injury (Myint, Pavlova, and Groot 2019a).

While SSB beneficiaries still incur OOP spending, they nonetheless benefit from better financial risk protection than those not insured through SSB, despite the fact that the coverage and utilization rate is low. Indeed, evidence shows that, among those who pay out-of-pocket, SSB members are paying up to eight time less than the general population. As noted, the share of respondents among the general population who needed to borrow money or sell assets to cover health care expenditures is similar to the proportion of surveyed SSB beneficiaries. However, both the mean amount of money borrowed and the mean amount of money gained from sold assets to cover health care expenditure among SSB beneficiaries is significantly lower than that of the General population (five times lower and one and a half times lower, respectively) (Myint, Pavlova, and Groot 2019a).

- Responsiveness to population needs

  o Availability and Accessibility

Despite the Essential Health Care package policy, services and medical supplies provided by public facilities are often limited, unavailable and unpredictable. Limited access is particularly problematic in rural areas and hard-to-reach regions due to a lack of resources and infrastructure, and gaps in access to and utilization of health care services are noticeable across geographic regions (Sein et al. 2014; Teo and Cain 2018). Inequalities across income groups are also evident, as the richest quintiles benefit from better health care access and utilization (Han et al. 2018; Sein et al. 2014; Teo and Cain 2018).

Primary care services are more readily available at SSB clinics and at workers' Hospitals for secondary level care. However, the number of SSB clinics and workers' hospitals is too limited to ensure equitable access for all registered members across geographic regions; the need to travel a long distance to reach SSB clinics and workers' hospitals, combined with inconvenient opening hours are additional barriers to health care access (Tessier and Guillebert 2015). In light of this limited access, the utilization of health care services is determined by many other factors besides care needs (Sein et al. 2014). In addition to geographic barriers, perceived quality of care and medical costs are the most important determinants of health care utilization (Myint, Pavlova, and Groot 2019a), suggesting that there are both physical and financial barriers to access in Myanmar. Such factors may lead SSB beneficiaries to opt for a nearby clinic over an SSB facility which would have provided them with free health care (Myint, Pavlova, and Groot 2019a).

  o Acceptability and Quality

Due to the historical dominance of socialist ideologies and autocracy in Myanmar, citizens have not traditionally been accustomed to participating in their own care, with health policies predominantly implemented from the top-down. However, alongside increasing calls for transparency and accountability in government, there are growing expectations among citizens on their entitlements (Sein et al. 2014). Despite this shift, the quality of care in Myanmar remains somewhat limited, with patients often receiving incomplete care in public facilities, which is a direct consequence of consistently insufficient funding (Teo and Cain 2018). As a result, all public facilities face inadequacy of service readiness, caused by a lack of inputs and a shortage of medical staff (Tessier and Guillebert 2015). Another consequence of insufficient funding is manifested in concerns over the perceived quality of medicines used at public facilities, which leads many people to resort to private pharmacies when seeking care (Tessier and Guillebert 2015).

SSB members are generally dissatisfied with the quality of care received at SSB facilities due to concerns over the quality of drugs used, inconvenient opening hours, long waiting times and cumbersome reimbursement processes in the case of referrals (Tessier and Guillebert 2015). Despite this, there is no motivation to improve the quality of care in either public or SSB facilities due to a range of system-level inefficiencies. For example, the budgets of public hospitals and SSB facilities are not linked to effective service provision or patient satisfaction. According to research supported by the ILO Vision Zero Fund, given the lack of a provider-purchaser split, there is no incentive for quality improvements among service providers because there is no direct link between service delivery (outputs) and what is paid for (inputs) (ILO 2019). The study also found that the lack of equipment and resources at public and SSB facilities may dampen motivation for innovation among medical staff.

▶ 5. Way forward

With health outcomes in Myanmar lagging behind regional averages, a population facing high risks of health-related impoverishment, and persisting health inequities, the need to design and implement comprehensive health reforms is urgently needed. Success in improving the overall health status of the population requires the implementation of combined strategies to strengthen the overall health system and improve financial risk protection. Today, after years of under-investment in health care, the Government of Myanmar is accelerating reforms towards the achievement of UHC. To achieve this, mobilizing financial resources for the health sector to address limited health care access and poor quality of care in Myanmar is key.

The National Health Plan recognizes the urgent priority of strengthening overall health systems. To do so, more public investment in health is needed, which is challenging given the impact of the global pandemic on the macro-fiscal

environment. Based on the latest statistics, the public share of total health spending is only 23.0 per cent, or about 1.1 per cent of GDP, which is among the lowest shares compared to countries at a similar level of development (Teo and Cain 2018). Prioritization of the health sector in the Government budget or allocation of additional resources to the health sector (earmarked taxes) are among the political decisions to be made to ensure increased fiscal space for health. As a first step, the Health Financing Strategy identifies complementary strategies for resource mobilization, including "increasing Government allocation to Health, introduction of sin taxes, expanding contributions collection to all formal sector workers and improving budget utilization".

To achieve better pooling and more strategic purchasing, the Government is looking into addressing the fragmentation of funding flows to improve the efficiency of the whole health system. Policy directions to progress towards UHC were laid out in the "Strategic Directions for Financing Universal Health Coverage in Myanmar" document, formulated in 2019. The strategy initiates the development of a vision and identifies options for establishing a strategic purchasing function in the public sector (Teo and Cain 2018). Presently, the MOHS is planning to realize this vision by establishing a semi-autonomous agency to purchase health services from accredited state and non-state health providers (Myanmar Ministry of Health and Sports 2019). A key intermediate step is to ensure that the purchasing entity has a sustainable source of revenue, systems and staff needed to manage and track expenditures (Teo and Cain 2018). In the meantime, a number of pilots are on-going to test various payment mechanisms with private facilities.

Expanding population coverage is another key priority moving forward. The establishment of a strategic purchasing agency is expected to bring coherence across various social health protection instruments, to provide better financial protection to the entire population of Myanmar and improve health equity. In May 2020, the MOHS proposed a draft National Health Insurance Law in this direction. Scenarios outlined include the provision of public subsidies to cover poor and vulnerable households. In parallel, the SSB has set in motion efforts to expand coverage of its health and medical schemes to dependents, and an actuarial assessment has been initiated, which is expected to lead to a decision to expand coverage in 2021.

6. Main lessons learned

- Institutional arrangements are not good predictors of the performance of social health protection systems. Neither the tax funded health system nor the SSB scheme have been able to reduce the financial burden currently on the shoulders of households in Myanmar. This is due to low government spending, poor quality of care, gaps in the legal framework and inadequate implementation of policies. Addressing these issues in an integrated manner is essential to the provision of universal health protection.
- Currently, the SSB health Insurance scheme seems to provide better financial protection than the tax funded system. However, coverage of the SSB is very low, and SSB members still incur health costs. Indeed, despite a comprehensive benefit package without co-payments, limited access to SSB facilities translates into OOP expenditures, indebtedness and obligations to sell assets among beneficiaries.
- Successful implementation of the social health protection system requires major investments to strengthen health systems. In Myanmar, limited quality of care caused by inadequate funding, a lack of physical infrastructure, limited qualified human resources and other system-level inefficiencies are detrimental to the successful implementation of both contributory and non-contributory social health protection mechanisms, and hinder the achievement of UHC.
- Strong inter-ministerial collaboration with active participation of social partners is needed to further advance the reforms in preparation, and ensure the rapid development of a comprehensive social health protection system, to the benefit of the entire population. The existing policy framework is conducive to the development of a comprehensive social health protection system and the attainment of UHC in Myanmar. Translating this into practice requires a sustained and resolute political commitment at the highest level.

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