How can health equity be improved in Myanmar?

Policy Note #2

Myanmar Health Systems in Transition
Policy Notes Series

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How can health equity be improved in Myanmar?

1. What are the challenges?

Myanmar is a country in which people's access to health services is determined more by where they live than their need for care – a situation that is fundamentally inequitable. The challenge is to reduce levels of inequity between different groups in the population and different geographical areas, and most particularly to ensure that health services reach poor and disadvantaged groups, including minorities and those living in conflict-affected areas.

2. What do we know?

There is a growing body of evidence about the extent and dimensions of health inequity in Myanmar.

- **Overall mortality rates disguise significant inequities:** In 2012 the national infant mortality rate (IMR) and under-five mortality rate (U5MR) were 41 and 52 per 1000 live births, respectively. However, the Multiple Indicator Cluster Survey (MICS) shows consistently higher infant and child mortality in rural than urban areas. In addition, while mortality rates *increased* in rural areas between 2000–2001 and 2004–2005, urban areas showed consistent reductions over this same period. The survey also showed disparities by gender, mother's education level and wealth quintiles. Both IMR and U5MR are highest among males, children born to mothers with primary education only, and children from the poorest households (see Figures 1a, 1b and 1c).

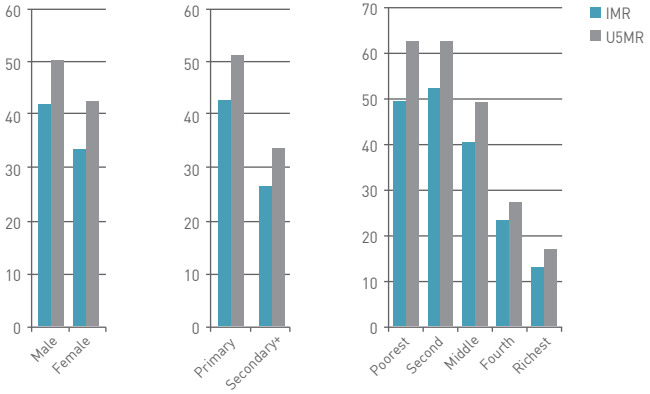

Figure 1a: IMR and U5MR disparity between male and female

Figure 1b: IMR and U5MR disparity between mother's education level

Figure 1b: IMR and U5MR disparity between wealth quintiles

Source: MNPED, 2011[1]

1 Ministry of National Planning and Economic Development (MNPED), Ministry of Health (MOH) & United Nations Children's Fund (UNICEF) (2011). Multiple indicator cluster survey 3009–2010. Nay Pyi Taw: MNPED. Graphs constructed by the author.

- **Poor nutritional status shows similar patterns:** More children in rural areas are underweight and stunted than children in urban areas. Undernourishment was also more common among children whose mothers were less educated and those from the poorest households.

- **Overall rates of maternal mortality have fallen consistently, but there are significant differences between different parts of the country:** Maternal mortality rates fell gradually between 1990 and 2013, but the rates vary significantly and are much higher than the national average in the Delta region and central plains.

- **Inequitable mortality rates are linked to low service coverage and utilization:** Coverage of basic services such as access to oral rehydration and treatment of pneumonia are much lower in regions and states with significant hard-to-reach areas – notably Sagaing Region and Chin, Kayin, Kayah and northern Rakhine states – than in other parts of the country.

- **The MICS report documented systematic inequities in antenatal care:** Antenatal care coverage and attendance by a skilled provider is higher in urban than in rural areas. It is lowest in Shan (North) and Chin states, where more than one woman in 10 delivers without any skilled attendant.

- **The poor rely on private providers:** In the absence of adequate public facilities, most poor households – particularly in Shan, Kachin, Chin, Rakhine, Mon and Kayin states – rely on private health providers, including drug shops, quacks and traditional healers. The reasons behind their choice are complex and can include issues of trust and language as well as shorter waiting and travel times, and better availability of staff and drugs. The key point, however, is that the poor end up paying out-of-pocket for services which are often over-priced and of poor quality.

- **Primary care takes second place to hospital services:** From 1988 to 2011 there was a 22% increase in the number of rural health centres, compared to a 60% increase in the number of hospitals.

- **The impact of low levels of health spending and priority for hospitals is made worse by the impact of user charges:** Between 2011 and 2012 health expenditure per capita was

about 550 kyat (less than US$1 per person), with the majority allocated to extending secondary and tertiary hospital services. Access to care, particularly by the poor, has been further compromised by the introduction of user charges. Schemes to exempt the poor from payment have had little impact due to inadequate financing.

- **There have been recent improvements:** Public budget allocations for health care have increased in the last few years. However, no data are yet available on whether these increases have resulted in improvements to equity and access to health services.

3. What needs to be done?

The *recommendations* in this Policy Note seek to address the root causes of health inequity. As solutions cannot depend on the health sector alone, it is important that an "equity lens" be used in assessing the impact of policies in all sectors.

- **Poverty is a cause of health inequity in its own right:** A wide range of socio-economic determinants, all linked to poverty, influence people's health as well as their demand for health services.
  - Food and nutrition insecurity results in malnourishment and low birth weight, both of which are closely linked to poor health outcomes. Lack of access to education is associated with early marriage and greater risks during pregnancy. Low levels of literacy result in lack of health awareness and low demand for health care.
  - To address inequities, health policies and programmes must therefore aim for synergy with other sectors that contribute to poverty reduction – notably education, labor and employment, agricultural outreach, economic and rural development, and social welfare.
- **Health inequity results from low levels of investment and inappropriate policies:** Lack of investment in the health sector, combined with a shift in priorities towards tertiary hospital care, has resulted in inadequate primary care capacity. The introduction of user charges in public health services has made the situation worse, particularly for the poor. The situation is exacerbated by the fact that Government is unable to oversee and regulate private providers.
  - Resource allocation needs to more closely match health needs in different parts of the country. Therefore,

strengthening rural health centers, sub-rural health centers and station hospitals in rural areas, rather than upgrading secondary and tertiary hospitals, should now be the priority, ensuring also that facilities are more equitably distributed geographically. Within this overall strategy, ensuring that station hospitals are more effective and efficient can save many lives among the rural poor.

- **Primary care facilities have been starved of resources and supplies:** When facilities do exist, their effectiveness is limited if they do not have trained staff, medicines and equipment. This has been a particular problem in hard-to-reach areas.

    - The Ministry of Health is in the process of developing an essential package of health services that will be covered under universal health coverage (UHC). In the interim, it is desirable to agree on a limited range of cost-effective interventions.

    - An immediate action is to ensure free access to essential medicines to the whole population, as a signal of the Government's commitment to UHC. An expansion of the program that started in 2012 would benefit from a rapid assessment of progress to date, to ensure that existing measures are effective, equitable and sustainable, and that supply bottlenecks have been overcome.

- **People's voices are not being heard:** There has been insufficient participation and representation by several key actors, including civil society and marginalized groups, in the decision-making processes that determine health policy.

    - To develop a more equity-oriented health system, potential clients of that system, particularly the poor, must be empowered to play a more central role in the design and operation of systems, especially at the township level and below. Equally government officials must be prepared to respond to concerns. Civil society groups can help the poor, marginalized and other minorities make their voices heard by decision-makers. In this regard, experience from other countries suggests that mechanisms that involve people (through consultation, participation on committees and client surveys) help significantly in reaching underserved populations, reduce barriers to access and increase satisfaction with services.

- **Reducing health inequity needs better monitoring to ensure accountability:** Poor data, weak accountability

mechanisms and a lack of transparency have undermined efforts to reduce inequities in health. Capacity building especially in quantitative skills is urgent in the health sector.

- Reducing health inequity should be declared a national health priority. This will require that both officials and the public become aware of what needs to be done to close the equity gap.

- Clear national targets, a few easily understood indicators, and regular monitoring of how equity has improved or regressed are now essential. A key element of the strategy will be strengthening nationally representative household surveys, in collaboration with the civil society organizations and other private and public agencies, to monitor the equity impact of reforms on households.

- Since the MICS survey in 2009 on which much of the evidence in this policy note is based, further efforts have been made to improve health data in Myanmar. The census has been completed and reports, which will provide greater detail on mortality, are being prepared. A demographic and health survey (DHS) will be completed in 2015.

- While the Health Management Information System (HMIS) should be able to generate adequate indicators of acceptable quality, the system needs to be further strengthened if it is to generate more reliable evidence. The HMIS currently collects data only from public facilities. With the upcoming DHS now is the time to explore inclusion of the private sector in data sharing.

- Many research departments, nongovernmental organizations and academic institutions conduct health-related research. They should be encouraged to increase their focus on analyzing the different dimensions of health inequity.


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