Chapter Six
The Public Health System

Introduction

The capacity of the Myanmar public health sector is very limited. This state of affairs is primarily due to government policy on health sector resourcing rather than the lack of government resources to provide health services to the Myanmar people. The status of health within the state system is apparent in the lack of resources allocated to health and the highly centralised control of policy that, despite the rhetoric of inter-sectoral and community consultation, inhibits opportunities for genuine advocacy and initiative. Overall, the selective disinterest of the highest central authorities culminates in a crippling lack of support for the health bureaucracy.

In many respects, the public health system can be classified as ‘underdeveloped’, where ‘the vast majority of the population are quite outside the reach of modern medical care’ (Roemer 1977: 16). In such a system, the ratio of doctors to the population is very low, and the majority of doctors is based in urban areas. The rural population relies on traditional healers in the village, auxiliary health personal with limited training in government health centres, and drug vendors for medication. No social insurance or voluntary insurance programs exist, merely local co-operatives or charity hospitals (ibid.: 16-17). Many of these features are apparent in the Myanmar public health system. However, the health sector is also beginning to display some attributes of what Roemer has characterised as ‘transitional’ systems: a substantial private medical sector catering to the affluent; increasing amounts of imported medicines; modern hospitals and extensive networks of health centres; and highly developed health subsystems for privileged groups, such as military personnel
(ibid.: 17-18). In Myanmar, these characteristics have begun to develop over the last decade, reflecting the expectations of the elite for good quality medical care.

Health planning in any country, but especially one that is resource-deprived, is always an imperfect process.\(^1\) Its success depends on the choices made by the government within the structural constraints of the particular country. This chapter describes how the Myanmar public health sector functions, looking at how the policy agenda is set, financed, translated into documents, and then implemented by the Ministry of Health. The description makes apparent how flaws within the overall state system, resulting in the state’s political incapacity in regards to social development, have produced a problematic and inadequate health system. The chapter also explores the pressures on the public health system that are beyond the control of the regime, but contribute to the weakness of the public health sector. This includes the growth of inequality in the system as the economic transition facilitates the growth of a private system that favours the wealthy, and people’s health care behaviour that favours informal service providers over the public health services, thereby further undermining the reach of the state. Finally, a comparison of health with education places health within the context of the other social sectors, and the context of social development within the wider state system.

The effects of state disinterest on the health system were highlighted by the WHO's annual report in 2000, which ranked Myanmar as having the second worst health system in the world, ahead of Sierra Leone (WHO 2000). WHO's appraisal was calculated by assessing the health status of the population, the responsiveness of the system to people’s expectations, and the fairness of contributions to financing of the health system.\(^2\) On the assessment of health

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1 John M. Donahue (1990: 80) lists some of the reasons for the disparity between health policy and practice in developing countries, including: the nature of the bureaucratic culture, the resistance of local political elites to grass-roots community organisation, the lack of political organisation among traditional practitioners, and fundamental differences between traditional and modern medicine worldviews.

2 After the World Health Report 2000 was released, some bureaucrats in the Ministry of Health, as well as members of the United Nations agencies, questioned the methodology of the WHO rankings, because it is not obvious how accurate statistics could have been gathered. However, it should be mentioned that access to the report was severely restricted, even for employees of
status, Myanmar was ranked 139 out of 191 countries. However, the overall rank was pulled down by the assessment of the financing of the system.

Figure 6.1: World Health Organization Health System Ratings: Myanmar

| Health Status:                     | Level | 139 out of 191 countries |
|                                  | -     |                          |
|                                  | Distribution | 162 out of 191 countries |
| Responsiveness of System:        | Level | 151 out of 191 countries |
|                                  | -     |                          |
|                                  | Distribution | 158 out of 191 countries |
| Fairness in Financial Contribution |     | 190 out of 191 countries |
| Overall Goal Attainment:         | Level | 151-153 out of 191 countries |
|                                  | -     |                          |
|                                  | Distribution | 158 out of 191 countries |
| Performance of Health System on Level of Health |     | 129 out of 191 countries |
| Overall Health System Performance |     | 190 out of 191 countries |


The point being made by the WHO report was that, even with its current resources, the Myanmar state has the capacity to make the health system much better than it is, especially in terms of fairness of financial contributions by private households to health care. This was an implicit criticism of the government’s lack of political commitment to make substantial improvements in the public health sector, and was unsurprisingly not well received by the Myanmar government. An editorial in the state-run newspaper said:

Even mildly put, the wanton manner in which the report’s section on Myanmar has been pieced together from dubious sources is to be put down as an insult on the integrity of our health workers, the Ministry and the nation itself....Myanmar as a nation is aggrieved that its unrelenting efforts to improve health system performance have not been given the recognition it deserves but is [sic] instead discredited (New Light of Myanmar, 2 July 2000).

The government’s reaction to the World Health Report 2000 highlights the way in which the health crisis in Myanmar goes beyond the usual problems of underdevelopment. The nature of the state system, centred on military priorities and practices, produces an administrative culture of neglect, denial the international organisations. Myanmar was not the only country that was greatly offended by the WHO report. WHO received criticism that some of the data on which the ranking had been calculated was extrapolated from other countries’ data or taken from small, unrepresentative samples (Brown 2002). Consequently, the WHO has postponed the release of
and selective action, which produces an adverse effect on the delivery of health services.

**Figure 6.2: Cartoon from State-Run Newspaper**

![Cartoon Image](image)

Caption: “It is not natural, how the wrong data got into the World Health Report 2000”

Source: Kyemon (23 August 2000).

**Policy Formulation**

Like all major decision-making in Myanmar, health policy comes directly from the top. The principal policy-making body is the National Health Committee (NHC), an inter-sectoral organisation that was formed in December 1989.\(^3\) An official publication from the Ministry of Health states that ‘the high level policy making body is instrumental in providing the mechanism for inter-sectoral collaboration and co-ordination. It also provides guidance and direction for all health activities’ (Myanmar Ministry of Health 1999: 19).

The NHC is chaired by General Khin Nyunt,\(^4\) and originally consisted of six members: the minister of Social Welfare, Relief and Settlement, the minister of National Planning and Economic Development, the minister of Health, the mayor of the Yangon City Development Committee, the deputy minister of

\(^3\) The National Health Committee existed in a less formal manner before 1988, as a coordination committee within the Pyithu Hluttaw (Aung Kyaing and Naing Oo 1988: 3). In addition, an intersectoral Joint Committee on Health met annually from 1983 (ibid: 7).

\(^4\) Khin Nyunt also chairs the Myanmar Naing-Ngan Education Committee, which was formed in 1991.

One of the first acts of the NHC, in 1993, was to develop the fifteen-point National Health Policy (see Box 6.2), on which subsequent policy documents have been based. Beyond this task, the Committee was not active for the first few years of its existence. It was not until the mid 1990s, when aid donors began giving considerable funding for HIV/AIDS and other communicable disease programs, that the NHC became active (personal communication 78, February 2002). The first major meeting was not held until 1 April 1995, and the membership was formalised only on 24 July 1996, under Notification 8/96. Five more major meetings were held between then and November 1997. A government publication states that ‘[t]he meetings dealt with ensuring that health programmes and activities are in line with the National Health Policy, issues arising from the implementation of the National Health Plan, formulating and promulgating health-related laws and regulations’ (Myanmar Ministry of Information 1999: 55).

In February 1998, the NHC was reorganised, and its membership increased to sixteen (Myanmar Ministry of Health 1999: 19). This, presumably, reflected the restructuring of government the previous November. The level of activity has increased considerably in the last few years, with more regular meetings. By 8 February 2001, the NHC was up to its 31st meeting (The New Light of Myanmar, 9 February 2001).

The first point of the National Health Policy outlines a continuation of the primary health care approach to raising the country’s health status. Other

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5 In November 1997, around the same time as the upgrading of the National Health Committee, the size of the Myanmar Naing-Ngan Education Committee was increased, and its policy-making role strengthened as a precursor to a new process of reform. Previously, the Education committee had held only four meetings between 1995 and 1997. The majority of policy decisions made during this time were related to tertiary education, such as the upgrading of various regional colleges to university level (Myanmar Ministry of Information 1999: 52). The upgrading of both committees indicates a shift in the leadership’s attitude to social development in the late 1990s.
points, though, indicate the change in direction by SLORC. Commitment to developing alternative health care financing, and the encouragement of a greater role for the private sector and NGOs are both part of the government’s withdrawal from complete responsibility for the health sector. The other significant change in health policy is the emphasis on expanding health services to the border areas. An update of the National Health Policy is said to be on the government agenda, probably due to UN pressure (interview 21, Rangoon: March 2000), but there is no sign of when this might happen.

**Box 6.3: National Health Policy (1993)**

1. To raise the level of health of the country and promote the physical and mental well being of the people with the objective of achieving “Health for all by the year 2000” goals, using primary health care approach.
2. To follow the guidelines of the population policy formulated in the country.
3. To produce sufficient as well as efficient human resource for health locally in the context of board [sic] framework of long term health development plan.
4. To strictly abide by the rules and regulations mentioned in the drug laws and by-laws which are promulgated in the country.
5. To augment the role of co-operative, joint ventures, private sectors and non-governmental organizations in delivery of health care in view of the changing economic system.
6. To explore and develop alternative health care financing system.
7. To implement health activities in close collaboration and also in an integrated manner with related ministries.
8. To promulgate new rules and regulations in accord with the prevailing health and health related conditions as and when necessary.
9. To intensify and expand environmental health activities including prevention and control of air and water pollution.
10. To promote national physical fitness through the expansion of sport and physical education activities by encouraging community participation, supporting outstanding athletes and reviving traditional sports.
11. To encourage conduct of medical research activities not only on prevailing health problems but also giving due attention in conducting health systems research.
12. To expand the health service activities not only to rural but also to border areas so as to meet the overall health needs of the country.
13. To foresee any emerging health problem that poses a threat to the health and well being of the people of Myanmar, so that preventative and curative measures can be initiated.
14. To reinforce the services and research activities of indigenous medicine to international level and to involve in community health care activities.
15. To strengthen collaboration with other countries for national health development.

The National Health Policy broadly informs the direction of the national health plans, which are drawn up every four years. The first NHP under SLORC predated the Policy, running from 1991 to 1992 as a transition from the last socialist-based People’s Health Plan. This has been followed by NHPs from 1993 to 1996, 1996 to 2001, and the current plan, which is intended to run until 2005.\(^6\)

The process by which the NHPs are formulated remains much the same as during the socialist era (Myanmar Ministry of Health 1996: 6). The detail of policy formulation remains with the Ministry of Health. A National Health Plan Steering Committee exists under the direction of the National Health Committee; its membership reflects the stated values of inter-sectoral cooperation and community participation. It is chaired by the Minister of Health, and consists of the director-generals of the departments within the Ministry, as well as seventeen director-generals from other ministries.\(^7\) Given the size of the committee, it appears that its role is mostly consultative, and that the input of the members outside the Ministry of Health is limited, their presence being primarily related to the need to meet the government’s demand for inter-sectoral cooperation. More significant, perhaps, is the presence of the chairpersons from six health-related GONGOs that are closely tied to the state. These are the MMCWA, the Myanmar Red Cross Society (MRCS), the Myanmar Medical Association (MMA), the Myanmar Health Assistant Association, the Myanmar Nurses Association, and the Myanmar Dental Association. The first two are involved in large-scale health projects throughout the country, while

\(^6\) I was unable to obtain a copy of the current National Health Plan, so the following information is based on the 1993-1996 and 1996-2001 NHPs, as well as interviews with people involved in the development of the most recent NHP at the time of my fieldwork.

\(^7\) The full government membership of the committee is as follows: minister of Health, deputy minister of Health, director of Defence Medical Corps, director-generals of Department of Health, Department of Medical Research, Department of Medical Science, Department of Traditional Medicine, and the Department of Planning and Statistics (who acts as the committee secretary), the director-generals of the Department of Sports and Physical Education, Department of Agricultural Planning, Office of Development of Border Areas and National Races, Department of Planning and Statistics in the Ministry of Forestry, Department of Basic Education, Department of Higher Education, Department of Water Resource Utilization, Department of Foreign Economics Relations, Myanmar Pharmaceutical Industry, Directorate of Trade, Department of Social Welfare, Department of Planning, Department of Budget, Department of Project Appraisal and Progress Report, and the chairman of the Social Security Board (Myanmar Ministry of Health 1996: Annex 4).
the other four are professional organisations. These organisations play a significant role of mass mobilisation and control over certain sectors of the population. In terms of advocacy some of these may have just as much influence as the high-level bureaucrats, as, in many ways, they operate as de facto government departments. This will be explored further in the following chapter.

Figure 6.4: Health Policy Planning Process

The work of formulating the National Health Plan is undertaken by the Formulation Sub-Committee. It is here that the policy is actually written. The committee is chaired by the director-general of Planning and Statistics, and consists of director-level bureaucrats within the ministry, the majority of whom are responsible for policy implementation. Once the implementation process is underway, the National Health Plan Supervisory and Implementation Committee and the National Health Plan Monitoring and Evaluation Committee are responsible for ensuring it follows the National Health Policy. Overall, apart from opportunities for advocacy from the UN and GONGOs (see below and Chapter Seven), the policy planning process appears to be largely a

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See Chapter Seven for a full analysis of MMCWA and MRCS, and Chapter Eight for more detail on the MMA.
The Public Health System

top-down process. Exactly how much, however, was not possible to assess during my research.

International influence on the NHP seems to be considerable. As mentioned in Chapter Five, the policy priorities of all health plans since 1978 have been based on WHO’s campaign of ‘Health for All’. As most countries were unable to meet the Health For All targets by the original date of 2000, WHO’s new global policy is ‘Health For All in the Twenty-First Century’ (WHO 1998c), which is basically a reformulation of the original principles. The WHO Southeast Asian Regional Office localised this policy, and consequently the National Health Plan for 2001 to 2005 is based on the ‘Declaration on Health Development in the Southeast Asian Region in the Twenty-First Century’ (WHO-SEARO 1997), which was a reaffirmation of commitment to developing universal access to health care, made at the meeting of Southeast Asian health ministers in 1997. In addition, the WHO’s country office in Myanmar has an advocacy role, as part of the Joint Government/WHO Collaborative Programme (WHO 1995b: 1).

The detail of the programs that make up the NHP is heavily influenced by the joint UNICEF and Ministry of Health Master Plan of Operations (MPO), which is drawn up before the NHP is formulated, and is implemented concurrently.9 This is an indication of how important the UN agencies are to assisting in the implementation of health policy. The 1996-2000 MPO outlines the ‘program of cooperation, intended to combine the policy frameworks of the government and UNICEF’ (UNICEF 1995). The document is based on the goals of the government’s ‘National Programme of Action for the Survival, Protection and Development of Myanmar’s Children in the 1990s’ (NPA). Many of the goals in the NPA, such as the commitment to reduce the infant mortality rate to no more than 50 per 1000 live births, are ambitious in the current context. However, UNICEF maintains that ‘[t]he adoption of such an ambitious set of

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9 The current MPO for 2001 to 2005 was signed in Yangon on 24 July 2001. As with the NHP, I have not seen a copy of this, and base my analysis on earlier plans.

Following UNICEF’s emphasis on providing for children and their families, the MPO contains six programs: Health and Nutrition, Water Sanitation and Environment, Education and Early Childhood Development, Child Rights and Protection, Advocacy, Information and Communication, and Policy, Planning and Monitoring for Children. Because this requires coordination with a number of ministries, the Foreign Economic Relations Department (FERD) of the Ministry of National Planning and Economic Development is responsible for coordinating and monitoring the implementation of the Country Programme. The FERD is ‘the principal aid coordination agency through which all foreign loans and grants to the country are channelled’ (Cowater International Inc. 1993a: 5-29).  

The details of the MPO make it clear that the programs are not just UNICEF programs. For the 1996-2000 plans, UNICEF committed US$32.5 million, while the government pledged to contribute Kt1,826,175,000 and to consider the allocation of foreign exchange on an annual basis: ‘the Government will provide all personnel, premises, supplies, technical assistance and funds, recurring and non-recurring, necessary for the implementation of this Master Plan of Operations’ (UNICEF 1995: 18).

The development and implementation of the UNICEF programs that cover health matters involve a close working relationship with the Department of Health. The Health and Nutrition Program includes six projects: Universal Child Immunisation, Control of Diarrhoeal Diseases and Acute Respiratory Infections, Women’s Health, HIV/AIDS Prevention, Nutrition, and Border Areas Primary Health Care and Development. UNICEF does not implement...

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10 Some of the Department’s main functions are ‘to maintain a continuing dialogue with multilateral and bilateral institutions for the purpose of tailoring external assistance to the development needs and priorities of the country, to participate in aid negotiations and aid agreement preparations, to monitor implementation of projects financed with foreign assistance, [and] to maintain and monitor implementation of projects financed with foreign assistance’ (Cowater International Inc. 1993a: 5-30).

11 In December 1996 the black market rate was approximately Kt180 to the US dollar. By December 2000, the kyat had devaluated to approximately 420. It is likely that the
these projects directly, seeing its role as ‘assisting the project managers to plan, implement, monitor and evaluate mutually-agreed activities’ (UNICEF 1998b: 11).

The joint agreements between the government and UNICEF, and with the other UN agencies, involve a process of trying to reconcile the two different agendas, as the implementation of the government programs relies a great deal on the financial and technical assistance of the UN agencies.

The NHP for the period 1993 to 1996 consisted of six broad programs: community health care, disease control, hospital care, environmental health, health systems development, and organisation and management. For implementation, the programs were divided into 47 projects. Written in the same year as the National Health Policy, the orientation of these programs reflects the attempts to move away from the socialist emphasis of placing sole responsibility for social welfare on the state. The NHP document says: ‘the most important feature of this National Health Plan is community involvement, which is also a major concern of the National Health Policy (Myanmar Ministry of Health 1993: 11).

This NHP also contained the official reasoning behind the policy to develop alternative health financing:

The escalating cost of health care, the emergence of private business enterprises and joint venture commercial undertakings are creating an affluent social class which can afford to pay for medical care.….It is felt that sharing the cost of medical care should release funds for enhancing promotive, preventive and rehabilitative health services and improve medical care for those who cannot afford to pay (ibid.: 2).

The programming is also determined by a ranking of health problems, which are determined by objective (mortality rates, morbidity data, and health trends over a ten year period) and subjective criteria as defined by the government (political concern, community concern, availability of preventative

government’s projected annual contribution in kyats is not adjusted for inflation over the course of the plan (personal communication 78, February 2002).

12 As well as bureaucrats in the Ministry of Health, UNICEF’s project managers consist of members of INGOs and GONGO, religious groups and community-based organisations (UNICEF 1998b: 11).
technology, availability of curative technology and socio-economic impact) \textit{(ibid.: 7).} Malaria has been ranked as the top health priority. As of the last NHP, tuberculosis is ranked second, followed by AIDS, diarrhoea and dysentery, and protein energy malnutrition. The sixth priority is sexually transmitted diseases, then drug abuse, leprosy, abortion and anaemia. These priorities are an accurate reflection of the main elements of the health crisis in Myanmar, yet, as will be shown below, the fact that they are priorities in official policy does not necessarily mean that high-level political support exists to address problems that are seen as culturally sensitive.

The NHPs have become increasingly detailed and sophisticated. The 1996-2001 NHP is essentially a continuation of its predecessor, although the programs are outlined in greater detail. The six broad programs remain the same, but the Ministry of Health maintains that detailed planning is adjusted according to local needs and changing conditions (Myanmar Ministry of Health 1996: 7). Subsequently, the specific projects have been expanded to fifty. The Ministry of Health states that ‘[t]he most salient characteristic of this National Health Plan is inter-sectoral approach including health related departments, NGOs and community participation’ \textit{(ibid.: 9).}

This process produces policy that is closely in line with international norms.\textsuperscript{14} However, beyond the form of the policy process, a number of fundamental flaws in the system hinder the possibility of policy being put into practice as intended. The formulation of health policy in Myanmar formally involves consulting with other parts of the government and various external and non-government agencies, although, given the hierarchical nature of the political system, it is unlikely that this process is fully consultative. In addition, the programs of the 1996-2001 NHP and previous NHPs were not converted

\textsuperscript{13} For example, UNICEF ‘remains virtually the sole provider of items such as vaccines, drugs, cold chain and other basic PHC equipment’ (UNICEF 1999b: 12).

\textsuperscript{14} A UNICEF (1998b: 6) document states: ‘The systemic problems which hamper the delivery of a good quality and affordable minimum package of health services are known by the policy makers, and efforts are currently being made in Myanmar to analyse the causes, design corrective strategies and decide on policy implications....Myanmar has therefore embarked upon a process of reorganisation of the public health services combined with their decentralisation, while at the same time dealing with the issues of privatisation and community cost sharing.’
into detailed plans of action (interview 13, Yangon: March 2000). This is logically the final step of the policy process. After the Formulating Sub-Committee has submitted the document for approval, Working Committees for Implementation of each program are formed, consisting of the project managers of each of the sub-programs (Myanmar Ministry of Information 1999: Annex 4). This implies that the bureaucrats in the Department of Health are given the task of directly implementing their programs according to the goals and broad strategies outlined in the National Health Plan for each program. But again, the reality of the bureaucratic culture (such as ‘the clerk mentality’), along with the limited resources available, tends to discourage anything more than adherence to formalities.

Related to the lack of detailed and substantive planning is the prevailing culture of self-censorship that runs through governance of the state. In regard to the social sectors, it has been alleged that any issue that Secretary-1, who oversees health policy, is known to dislike, or even suspected of disliking, is not raised (interview 40, Rangoon: July 2000; interview 46, Rangoon: August 2000). In terms of writing program policy, it would be unacceptable for bureaucrats to counter any of the official government rhetoric about the progress in dealing with certain diseases (for example, cholera does not exist in Myanmar), or reports of achievements that have been made. Therefore it is in the interests of policy writers within the government to remain as vague as possible, and simply repeat the official government line, a common feature of all authoritarian systems.

15 A paper on human resource management by the deputy director general of the Department of Health Manpower outlines some of the problems lack of detailed planning at the policy level causes, such as the ‘lack of rational and systematic approach[s]’, which results in shortages of some categories of health personnel, imbalances in skill mixes and geographic maldistribution, and ineffective coordination with the private sector (Thein Maung Myint 1996: 22).

16 Interview 20 (Yangon: March 2002).

17 In Indonesia, health policy is also a predominantly top-down process. Bureaucrats in the Ministry of Health have no channels through which to contribute ideas to the policy-making process, and the local government is purely an implementation body (Achmad 1999: 12). Further, within the government as a whole, the ministry is very weak (ibid.: 17)
Health Financing

However, the primary indication that the policy process is predominantly rhetorical is that the budget allocated to health is barely enough for the Ministry to cover salaries, let alone implement programs. For example, malaria prevention and control activities by the Department of Health were estimated to cost US$511,000 in 1996. However, the annual budget in that year for the Vector Borne Disease Control program was only US$69,000. Part of the difference was made up through WHO support, but the program is still significantly underfunded (Murthi 1998: 3).

Health policy means little unless it is intimately connected to the budgeting process. In the latter half of the 1990s, health policy was formulated to fit in with the second five-year short-term economic plan (1996/97-2000/01), which is part of the SPDC’s strategy of economic transition, and reflects the way the social sectors fit into the overall economic planning process. The plan states as an objective ‘the creation of a more diversified economic structure conducive for the emergence of a modern market economy’ (Myanmar Ministry of National Planning and Economic Development 1996: 4), with agriculture as the leading priority. The declared targets for the development of the health sector over the five year plan were: the building of 61 hospitals, 383 rural health centres, 35 primary health care centres, 10 maternal and child health centres, and 3 indigenous hospitals; the opening of 37 indigenous medicine dispensaries; and the appointment of 2466 doctors, 251 dental surgeons, 5035 nurses and 2260 midwives (ibid.: 19).

By the end of the Five Year Plan and the 1996-2001 NHP, the government was claiming substantial achievements in funding, facilities and manpower (Myanmar Ministry of Health 2000). Yet, like most government statistics in

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18 An indication of how budgeting occurs comes from a report on the education sector. Along with the other ministries, the Ministry of Education draws up annual estimates for its recurrent and capital expenditure to submit to the Ministry of Planning and Finance, which then submits a state budget to the cabinet in March of each year, for final approval by the SPDC. Each school, university and institute contributes its estimates of their expenditure requirements (Nyi Hla Ng, Nyunt Hlaing et al. 1992: 3). One flaw in this system is that ‘departments just draw up their budgets based on their requirements with no idea of how their expenditures will be met (Khin Ohn Thant 1992: 10).
Myanmar, the impressive figures did not match up with the reality. By 1996 the political situation was relatively stable, but it was becoming apparent that the economy was in dire shape. With the end of a brief economic boom in 1998, continued economic growth, on which the health policy documents seemed to have been based, was replaced by stagnation.20

Since the end of the socialist economy, the government has reduced its role in health financing. While central government expenditure overall has declined significantly, this decline has been concentrated in the social sectors (US Embassy Rangoon 1997: 36). The decline in overall spending was marked by a decrease in the ratio of recurrent expenditure (salaries, essential drug supplies, etc.) to capital expenditure (physical infrastructure) (Abel-Smith 1994: 4). Whereas in 1990/91 recurrent expenditure on health was approximately 72 per cent of capital expenditure, in 1997/98 – the last year in which detailed figures were made public – it had increased to almost 85 per cent (Central Statistical Organization 1998: 202). In 2000, the Ministry of Health and other ministries account for 17.1 per cent of health sector spending, while private expenditure on health accounted for 82.9 of total health expenditure (WHO 2002).

As mentioned earlier, after a decade of SLORC/SPDC rule, public expenditure on health as a share of GDP had declined to 0.1 per cent (EIU 2002a: 22). In comparison, health expenditure is three times higher in Cambodia, and six times as much in Laos (ibid.). One of the largest drops in health expenditure occurred between 1986-1988, when real per capita health spending more than halved. The government did increase spending in the following two years, and partly recovered these losses, but from 1990 health spending has steadily declined. By 1996, real per capital government spending on health was Kt6.9, which was a decline of 60 per cent from 1983, when real health spending was at its height under military rule, at Kt16.66 per capita (UN

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19 The government’s development of an institutional structure for state-sanctioned indigenous medicine, including hospitals and clinics, is discuss later in the chapter.
20 See Zaw Tun (2000). The surge in GDP reported in 2000 and 2001, if accurate, is possibly partly due to the initial payments to the government for gas and mining projects.

**Figure 6.5: Real per Capita Annual Government Expenditure on Health (kyats)**


The sharp decline in real health expenditure in the mid-1980s, and again from the early 1990s, is demonstrated in Figures 6.5 and 6.6. This decline has continued as cuts in health and education expenditure are used to reduce the government budget deficit (EIU 2003a: 3).

**Figure 6.6: Capital, Current and Total Government Expenditure on Health as a percentage of Total Government Expenditure**


In contrast, Figure 6.7 shows the increases in health spending according to official government figures, which have not been adjusted for inflation. The government uses figures such as these to support its claims that it is dedicated to the ‘uplift’ of the country’s health status.
Further, within the context of the social service sectors overall, low spending on health is to the advantage of education. The allocation from the state budget to social service sectors (health, education and social welfare) in 1997-98 was Kt 10,713 million for recurrent expenditure, and Kt7,635.7 million for capital expenditure.\(^{21}\) This represented 3.8 per cent and 11.7 per cent of government expenditure (Myanmar Ministry of National Planning and Economic Development 1999: 323). Three points, however, must be noted. First, education receives the major portion of the budget allocation to social services. The 1997/98 Financial, Social and Economic Report listed provisional expenditure on health at Kt1,175 million for current expenditures, and Kt1,651.8 million for capital expenditures, totalling Kt2,970.1 million (Central Statistical Organization 1998: 202). Expenditure on education was estimated at Kt5,365.3 million (recurrent) and Kt4,355.4 million (capital), a total of Kt9,720.7 million (ibid.: 190). Secondly, this amount includes ‘contributions’, which is reported as financial aid from the UN, especially WHO; this may actually cover the major share of the expenditure (interview 5, Yangon: February 2000; interview 22, Yangon: March 2000). It has been reported that external aid was 85.8 per cent of government health expenditure in 1997. Seventy per cent of this came from UN contributions, which totalled US$12 million in 1996, with the remainder coming

\(^{21}\) According to a Myanmar economist, budget figures are rarely converted into hard currency. Rather, the amounts given in kyats are relative, reflecting budgetary trends (personal communication 77, August 2001).
from NGO and bilateral sources (figures cited at Workshop on Aid Coordination for Health, 18-20 March 1998, Yangon). Thirdly, over this period, the share of the social sector in total government expenditure declined as money was poured into the expansion of general infrastructure and other economic sectors (Department of Medical Sciences 1998: 4).

A UNICEF (1998b: 28) document states that

the Government budget allocations for the social sector are not enough to match the minimal needs for health, education and social welfare….The support provided by the UN system and donor community is only partial and major challenges remain for long-term sustainability.

Thus, as argued in Chapter Four, the ‘narrowness’ of the regime’s view of development, which in reality places a low priority on developing the health services, is borne out by the pattern of health financing. As such, the situation of health care that is described in this chapter can be traced to the political factors, such as regime illegitimacy, that reduce the political capacity of the regime to undertake reform in this area.

Even with the new market-based strategy of shifting the burden of social welfare onto the community and the private sector, the government has been able to achieve little in the health sector. This raises the question of why the regime bothers to put effort into the appearance of taking action for sectors that are low priority to the state. Without a doubt, much of the policy-making is directed internationally, in response to pressure from the UN agencies working in the country, and to regional allies that run joint health programs. How much of the effort is directed toward domestic legitimacy is less easy to determine, although it is certainly characterised by inconsistent and reactionary motivations.22 Token commitment to the health sector to placate external donors is not likely to mean much to the Myanmar people. What counts for them is the implementation of policy that increases their access to health services.

22 See the case studies on the Expanded Programme on Immunisation and the HIV/AIDS Prevention and Control Programme in Chapter Seven.
Policy Implementation

As in most other countries, the implementation of primary health care in Myanmar has had some successes, but the core principles of the PHC approach have not become ingrained in the public health sector, regardless of how often they are emphasised in official policy. This is partly because the concept of comprehensive primary health care is too ambitious to be realistic for most developing countries, requiring as it does ‘a substantial reorientation of political thinking and resource allocation’ (Mull 1990: 36). Even in the context of what is possible, many governments are not prepared to create the circumstances necessary for bureaucrats to implement the policy and to facilitate community participation.

The ambitious nature of the PHC policy, the bureaucratic culture that has developed under military rule (described in Chapter Three), and the lack of resources allocated to health combines to make the work of the Department of Health in implementing health policy extremely difficult. Dedicated bureaucrats and external support can overcome these obstacles locally, but systemic problems make the task of combating the health crisis without adequate funding especially difficult.

The political incapacity of the regime to concentrate development efforts in the social sectors, combined with long-term governance problems of the state and the disruptive process of economic transition, is manifested in the health sector in a number of ways. For example, at the same time as government funding of health care has markedly declined, since the late 1980s, the cost of

23 The primary health care strategy has been criticised for ‘ignoring fundamental barriers stemming from inequities in power and wealth, exclusion of local communities from effective participation in decision making, and inadequate access to services by the most needy’ (Coreil 1990: 12). The Alma Alta Declaration of 1978, where the principles of PHC were formally established, was based on recognition that health status could be improved only by addressing the environmental, social and economic determinants of underdevelopment, through an intersectoral approach that focused on social equity. The strategy to implement the original PHC principles is known as comprehensive PHC. However, this was too idealistic for most developing countries, and was replaced by a lesser-definition, known as selective PHC strategy, which targeted specific health problems - particularly maternal and child health (Asthana 1994b: 182-183). However, the selective PHC approach has been criticised as not able to address the root causes of ill health, and ‘represents a return to a technologically and cost-oriented approach which denies local initiative’ (ibid.: 183-184). In Myanmar, as in many other countries, PHC has become more and more distant from the concepts of social justice and equity.
health care has been greatly increased by a number of other factors. The cost of imported medicines and equipment has been significantly increased by the government’s maintenance of a multiple exchange rate, which greatly complicates trade and makes imported goods increasingly expensive. More importantly, the quota of foreign exchange allocated by the government for health and medical imports is insufficient and has created serious shortages of essential drugs and equipment.

Two factors already mentioned in Chapter Two, the substantive increase in both high-level and low-level corruption, and the substantive decrease in the real value of civil service salaries, have increased the direct expenses of health care, and are the main contributors to WHO’s assessment of the unfairness of health care financing. Although these factors are not related to health policy directly, they stem from the government’s macro-economic decisions (and considerations of political expediency), which have had consequences for many parts of the state that were never intended, but nonetheless have to be attributed to the government’s policy failure. Specifically, this stems from the regime’s priorities of spending on defence and large infrastructure, as well as resisting much-needed economic reform.

There are now approximately 8000 private doctors, concentrated in the urban areas, compared to about 5600 public doctors (Poverty Reduction and Economic Management Unit 1999: 119).24 Most public sector doctors also spend a good part of their day in private practice, which causes a drain of resources from the public sector and greatly decreases the quality of care available for people who cannot afford to go to a private practice.

Lastly, the governance of health, along with all other sectors that do not directly contribute to the GDP, is characterised by centralised control of all aspects of policy and implementation, combined with financial self-sufficiency. In order to compensate for the lack of public funding, most functions of the government below central level are directed to be self-supporting. This is

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24 In the early-1990s, an average of 500 doctors were graduating from three medical schools. At the time, the Ministry of Health employed 20 per cent of the graduates, and the remainder were employed in the cooperative and private sectors (Mattock and Abeykoon 1993: 42).
simultaneously a consequence and contributing cause of state incapacity. Even army battalions are expected to provide their own food, although they have a much greater capacity to appropriate resources than doctors and teachers. This policy is manifested in the health sector by ‘community cost-sharing’, described below. The burdening of the poor with the cost of health services is why, for most of the population, illness is synonymous with debt, and high mortality rates are accepted as normal.

**The Ministry of Health, Health Infrastructure and the Hierarchy of Policy Implementation**

Within this context, the Ministry of Health attempts to implement the policy developed by the National Health Committee. It has two stated objectives: ‘to enable every citizen to attain full life expectancy and enjoy longevity of life; [and] to ensure that every citizen is free from disease’ (Myanmar Ministry of Information 1999: 283). The ministry claims substantive achievements in the pursuit of these objectives under the SLORC/SPDC regime. An official government publication states that for females, life expectancy has increased from 63.0 years in 1987 to 64.5 years in 1996, and for males, from 58.9 years to 60.6 years. It also declares:

Maternal Mortality and Infant Mortality have declined, disease morbidity rates have decreased and recurrent infectious diseases have been controlled....These achievements have been made possible by ensuring universal access to health care delivery right down to the grass-roots level (ibid.: 283).

The government presents an extensive list of activities, including ‘widespread disseminations of health education’; extensive disease prevention activities, especially the National Immunisation Days, which achieve over 90 per cent coverage of children under five within the country; ‘mass eradication campaigns’ for the elimination of flies and mosquitos; modernisation of hospitals; and expansion and upgrading of health facilities (ibid.: 284-285). The two tables (6.8 and 6.9) below list the current status of health facilities and

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25 This comes from a government publication listing the achievements in nation-building under the rule of SLORC. Publications from the Ministry of Health tend to be more modest.
health manpower in the country, which show significant increases since 1988. However, the public health sector operates much less effectively than the Ministry of Information puts forth, as will be shown below.

Table 6.8: Health Facilities

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Government Hospitals</td>
<td>631</td>
<td>745</td>
</tr>
<tr>
<td>Hospital Beds</td>
<td>25,309</td>
<td>30,868</td>
</tr>
<tr>
<td>Dispensaries</td>
<td>247</td>
<td>349</td>
</tr>
<tr>
<td>Primary and Secondary Health Centers</td>
<td>64</td>
<td>84</td>
</tr>
<tr>
<td>Maternal and Child Health Centers</td>
<td>348</td>
<td>348</td>
</tr>
<tr>
<td>Rural Health Centers</td>
<td>1,337</td>
<td>1,402</td>
</tr>
<tr>
<td>School Health Teams</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>Traditional Medicine Hospitals</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Traditional Medicine Clinics</td>
<td>99</td>
<td>200</td>
</tr>
<tr>
<td><strong>Border Area and Special Regions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>8</td>
<td>49</td>
</tr>
<tr>
<td>Dispensaries</td>
<td>6</td>
<td>78</td>
</tr>
<tr>
<td>Rural Health Centers</td>
<td>n.d.</td>
<td>26</td>
</tr>
<tr>
<td>Sub-centres</td>
<td>n.d.</td>
<td>43</td>
</tr>
</tbody>
</table>


Table 6.9: Health Manpower

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Public</td>
<td>12,268</td>
<td>14,626</td>
</tr>
<tr>
<td>- Co-operative and Private</td>
<td>7,891</td>
<td>9,505</td>
</tr>
<tr>
<td>Dental Surgeons</td>
<td>857</td>
<td>1,033</td>
</tr>
<tr>
<td>- Public</td>
<td>328</td>
<td>296</td>
</tr>
<tr>
<td>- Co-operative and Private</td>
<td>529</td>
<td>737</td>
</tr>
<tr>
<td>Nurses</td>
<td>8,349</td>
<td>12,821</td>
</tr>
<tr>
<td>Dental Nurses</td>
<td>96</td>
<td>103</td>
</tr>
<tr>
<td>Health Assistants</td>
<td>1,283</td>
<td>1,709</td>
</tr>
<tr>
<td>Lady Health Visitors</td>
<td>1,557</td>
<td>2,202</td>
</tr>
<tr>
<td>Midwives</td>
<td>8,121</td>
<td>11,195</td>
</tr>
<tr>
<td>Health Supervisor (I)</td>
<td>487</td>
<td>515</td>
</tr>
<tr>
<td>Health Supervisor (II)</td>
<td>674</td>
<td>1,047</td>
</tr>
<tr>
<td>Traditional Medical Practitioners</td>
<td>266</td>
<td>539</td>
</tr>
</tbody>
</table>

The current Minister of Health, Professor Kyaw Myint, was promoted from deputy minister in early 2003, replacing Major General Ket Sein. Replacing a former military commander with the new minister, who is a well-respected former chest physician, indicates an attempt to improve the government’s image in social development. Yet, the position of a minister is generally not very powerful, as the tight central control of the system ensures that anything but a routine decision is effectively decided by the SPDC.

The minister is supported by the deputy minister, currently Professor Myo Oo, who is a retired military doctor and former rector of the Institute of Medicine (1). Beneath these two, the Ministry is divided into five departments, each headed by a director-general. These are the Department of Health Planning, which is responsible for policy formulation, supervision and monitoring of policy implementation, and the collection and dissemination of health data; the Department of Medical Research; the Department of Medical Sciences, which oversees the training of health manpower; the Department of Traditional Medicine, which formalises and regulates the practice of indigenous medicine; and the Department of Health. The Department of Health is the largest component of the Ministry of Health, employing over 40,500 people (Department of Medical Sciences and Department of Health Planning 1999: 9); it has the task of transforming the National Health Plan into workable programs and administers the hierarchy down to the village level (Myanmar Ministry of Health 1999: 11-16). The other four departments, and the Minister’s office, contain only a small number of the personnel in the Ministry.

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26 Before serving as health minister, Major General Ket Sein was the regional commander of South East Command at the time the KNU headquarters of Manerplaw was captured.
27 The health ministry has room for two deputy ministers, but Professor Kyaw Myint was not replaced when he was promoted.
28 The Ministry of Health also contains the International Health Division, which liaises with foreign agencies and International NGOs.
As Figure 6.10 indicates, the public health sector is organised in a rigid hierarchy directly from the central government to the village. The excessive centralisation of the Ministry of Health contributes to implementation problems, because

[i]mportant decisions require prior approval by several layers of authority. Though some staff may take initiative to carry out some activities to reach the planned goals, most usually waiting [sic] for instructions and are inhibited to act or work on their own initiative (UNICEF 1998b: 29).

Each department operates independently, causing problems with coordination across departments and the management of projects (Royal Institute of Public Administration 1991: 13). The 1996–2001 NHP placed emphasis on decentralising the system (Myanmar Ministry of Health 1996: 291, 301, 336-7). The aim is to decentralise management, procurement and data collection from the central level to the control of the state/division and district
health departments (interview 29, Yangon: May 2000). However, it is not apparent how this will be effectively carried out.

Below the central level, the administration of the health sector comprises fourteen state/division health departments. These have a mainly supervisory role over the district and township health departments, as well as coordination of training for health volunteers, ‘technical support’ (such as distribution of essential drugs and equipment), and evaluation (effectively, channelling the monthly reports up the hierarchy) (Myanmar Ministry of Health 1999: 29). The state/division health department also administers the state/division hospital, which is defined as ‘tertiary level’, and contains twelve specialties (Department of Medical Sciences and Department of Health Planning 1999: 12). A large amount of the time of officials in the state/division departments is reportedly occupied with managing the rotation of postings (Royal Institute of Public Administration 1991: 22). For example, the Mandalay Division Health Department (which is probably bigger and better equipped than most) (see Figure 6.11) consists of a divisional health director, two deputy health directors, an assistant director of nursing, five medical officers, and technical and clerical staff. This department is responsible for 75 hospitals, ranging from the 800-bed Mandalay General Hospital to station hospitals in thirty townships (Mandalay Division Health Office 1999).

An emphasis on decentralised administration also exists in the Department of Basic Education, which appears to be more successful than its counterpart in the Ministry of Health. A working paper in 1992 described the Ministry of Education as ‘a mixed type of centralisation and decentralisation’ (Hla Kyu and Myint Thein 1992: 7). A government report states: ‘The administration process throughout the education sector is centralized but shared amongst several ministries. The education planning process is also centralized; but decentralization of control and responsibility has been developed and community participation is active. Education decisions and initiatives are largely the province of central ministerial department’ (Myanmar Ministry of Education 1998: 3). What this means is that the budget, and quotas for primary school teachers for each state or division, are set at the central level. Education officers working at the state/division level are responsible for all matters of basic education in that area, including the appointment, transfer and training of staff. The direct administration of schools takes place at the township level, by the township education officer.

For example, the Health Management Information System Program created new forms for the chain of monthly reports, which starts with the midwife, and travels up the hierarchy through the rural health centre, the township, and the state/division health department. The new forms were designed to save time by setting predefined parameters for the data. However, when it was initiated, the basic health staff were not given training in how to calculate their information into the new categories, such as percentages and calculated prevalence (Bhatnager 1996: 81).
However, as mentioned earlier, the health departments must coordinate with the twelve military regional commands, which hold the real power at regional level and operate with significant autonomy. The ministries, which operate parallel to general administrative bodies, must coordinate with the office of the regional commander, who is the supreme authority in his respective area. This local authority often has a different set of priorities from that of the central government (see Chapter Three); often the Department of Health and INGOs sponsored by the Ministry of Health are prevented from carrying out activities sanctioned by the central government. However, in some cases where the local authorities are more progressive, on issues like
HIV/AIDS, it is possible to achieve more than central government policy approves (interview 22, Yangon, March; interview 67, Yangon: October 2000).

There are also district health departments, although these are rarely mentioned. The district level of administration (also called the township zone) was recreated in 1989 as part of an attempt to decentralise governance, and consists of an area covering three to five townships (Myanmar Ministry of Health 1999: 31). Each district has a district medical officer, who seems to constitute the district health department. One of the main responsibilities of the medical officer at this level is to administer the district hospital, which is intended to provide public health services and curative services, as well as four speciality services (Department of Medical Sciences and Department of Health Planning 1999: 12). The district-level health department is meant to supervise the townships, although in practice this extra layer of administration is probably just a formality. Many of the district-level health offices are actually run out of the township health department, which operates with a dual function (Royal Institute of Public Administration 1991: 14). One of the aims of the 1996-2001 NHP was to progressively complete the establishment of the district health system (Myanmar Ministry of Health 1996: 337).

The bulk of the public health infrastructure is based in the township health department, which is the main implementer of health policy at the local level. This manages the township hospital, and coordinates – to the best of its ability – the network of basic health staff and voluntary health workers that administer to the villages. In reality, this is mostly composed of the township medical officer, who is sometimes assisted by a township health officer (THO) who supervises the rural health centres (UNDP 1993: 8). The TMO is responsible for administering the hospital, performing surgery, attending monthly coordination meetings with the TPDC, participating in the township branches of NGOs, such as the MRCS, and supervising the rural health centres. In addition to this, the TMO normally runs a private practice to support his/her family (interview 20, Yangon, March 2000). Not surprisingly, all these functions are performed in order of priority, so that functions within the urban centre of the township, where the demands are the most immediate, tend to take
precedence over duties in the rural areas; most of the TMO’s time is spent dealing with administrative and clinical hospital work (ibid.). The fact that the TMO or THO often has to personally pay for transport to the rural health centres for meetings and supervisory visits is a considerable deterrent to carrying out these duties. The township health staff may visit the more remote centres only about once a year (UNDP 1993: 11). Thus, the only regular contact the basic health staff have with the township health department occurs when they come each month to collect their pay (interview 20, Yangon: March 2000). The lack of supervision and support from the hierarchy above has been shown to be detrimental to the performance of the basic health staff (UNICEF 1995: 25; 1998: 29).

Figure 6.12: General Organisational Set-up of Township Health Department

The township health department is responsible for organising the hierarchy beneath it, which consists of station hospitals, rural health centres, and volunteers in the villages. The station hospital usually has 16 beds, and is the first level of referral for serious cases. However, due to under-resourcing these hospitals are very constrained in their operations (personal communication 78, February 2002). The only contact that the majority of the population has with the public health sector is through the basic health staff. The rural health centres cater to around 45 to 50 villages (approximately 23,000 people) (UNICEF 1995: 24). They are headed by a health assistant, who is trained in a four-year Bachelor of Community Health, or a one-year condensed
course (Department of Medical Sciences and Department of Health Planning 1999: 19). If the rural health centre is fully staffed, a public health supervisor (Grade I and II) is responsible for implementing the Department of Health’s programs on environmental health and disease control, while a lady health visitor is responsible for maternal and child care, including supervision of the midwives.

Below the RHCs are sub-rural health centres. These are run by a midwife, who is responsible for a wide range of activities, including basic curative care, referrals, supervision and training of volunteer workers, and implementing the tenets of PHC, such as health education and immunisation. This makes the midwife the ‘backbone of the primary health care system’ (UNICEF 1995: 24). Training schools for midwives, in each state and division, provide an eighteen-month course (Department of Medical Sciences and Department of Health Planning 1999: 19). The construction of the sub-RHC and housing of the midwife must be provided by the community.

Sub-RHCs ideally cater for three to five villages, although in fact it tends to be more like five to ten, and sometimes as many as twenty-three villages (UNICEF 1995: 24). The midwife is supposed to spend two or three days of the week at the sub-RHC, and the rest visiting the villages under her jurisdiction. However, usually she is preoccupied by curative care and administrative work, and can only undertake other duties in the village she resides in (UNDP 1993: 10). As much as 35 per cent of the midwife’s time is spent on data collection (Department of Planning and Statistics 1992: 4). Further, a study of the workload of midwives found that productivity was below 50 per cent of an assumed standard workload (Bayarsaikhan 1995: 48). The sub-RHCs are most

31 In 1999, 9524 midwives catered to the rural population (Department of Health Planning 1999a: 2).
32 A study conducted by UNDESA (1999b: 50) indicated that the main benefit in some villages of having a health centre is information about birth spacing and the sale of contraceptives.
33 The Ministry of Health examined its information system in 1992, and found: ‘The existence of a one way information flow with virtually no feedback to any level of management other than the central; information used is demand based and not user based; most of the information is reported without proper analysis or interpretation; lack of an interlinking mechanism among the various departments leading to work overload for the collector and duplication of information (Department of Planning and Statistics 1992: 2).
effective in places where a village health committee is formed to support the midwife and to mobilise funds for transport and referral cases (UNDP 1993: 8).

The overburdening of health staff contrasts with the Ministry of Health’s claims that resources and manpower in the health sector are steadily expanding. There is in fact a large gap between the capacities of the health sector on paper (see Tables 6.8 and 6.9 above) and what exists in reality. Many of the Department of Health staff posts included in official statistics have either never been filled or are allocated to personnel who refuse to go to remote areas (Morse 1994: 2). In January 1998, of the 40,547 positions approved by the Department of Health, only 37,737 had been filled. Of the positions that had been filled, over fourteen per cent were unoccupied by the staff that had been assigned (Myanmar Ministry of Health 1999: 9-15).

As a result, public health services rely a great deal on volunteers. The basic health staff that work out of rural health centres and sub-rural health centres are supplemented by volunteer health workers who are recruited to provide first aid and health education in their own villages. These workers fall into four categories: community health workers (CHW), auxiliary midwives (AMW), ‘ten household’ health workers, and trained traditional birth attendants (Basic Health Section 2000: 1). These categories were launched in 1978 under the Volunteer Health Scheme, as mentioned earlier. The role of the CHW is to give basic first aid, promote nutrition, sanitation and immunisation, and keep records of births and deaths. The AMWs are trained to attend to maternal and child care, particularly ante-natal and post-natal care, deliveries, and referrals of dangerous pregnancies into the government health system, plus promoting health education. These positions include training, four weeks for the CHW and six months for the AMWs, but are unpaid (Win Naing, Trasey Sein et al. 1991: 2). At the time they were introduced, the assumption was made that

The tradition of volunteerism in Burmese society, the prestige that accompanies the role of VHWs, coupled with the expected in-kind remuneration, was considered sufficient to make the VHWs a viable enterprise and valuable asset (O’Brien, Mays et al. 1985: 22).
This turned out to be true to an extent for the AMWs, who benefit from the custom of gifts or payment from the family when they deliver a baby, but the record of the CHWs has not been as successful, as they were not tapping into a community role that already existed. Moreover, the attrition rate is high for both categories: 36 per cent of CHWs that have been trained (Bhatnager 1996: 119), and 24.5 per cent of AMWs (Basic Health Section 2000: 2).

Although voluntary health workers tend to come from the better-off families of their community, most are farmers (Bhatnager 1996: 120). Usually, they are selected to apply by the local community (Basic Health Section 2000: 9). Many spend around two hours per day on their volunteer duties (Win Naing, Trasey Sein et al. 1991: 18), however they suffer from the same lack of supervision and support as the basic health staff, and are often diverted by more pressing needs like harvesting (interview 33, Kachin state: June 2000). After the initial training is completed, refresher training is very rare, and the AMW has to restock her kit through her own resources (Basic Health Section 2000: 22).

Another component of primary health care is the attempt to integrate indigenous medical practitioners (IMPs) into the public system. The government is trying to regulate IMPs, through enforcing registration and by drawing up lists of approved medicines (interview 37a, Yangon: May 2000). The SPDC enacted the *Traditional Medicine Law* and *Traditional Practitioners Association Act*, to draw indigenous medicine into the realm of the state (Myanmar Ministry of Education 1999: 68). Fifty-bed indigenous medicine hospitals have been built in Yangon and Mandalay, and a 16-bed hospital in Pathein. The government also operates indigenous medicine clinics, of which there were 102 in the country in 1998, trains doctors at the Mandalay Institute of Indigenous Medicine (opened in 1976), and runs factories that produce indigenous medicines (Myanmar Ministry of Information 1999: 150). The government requires IMPs to take a one month course to meet its registration requirements, which cover physiology, Myanmar indigenous medicines, pathology and astrology.
Chapter Six

The government’s patronage of indigenous medicine follows WHO’s push for integration of traditional medicine into the mainstream. However, a senior bureaucrat sees it as a mistake to try to shape indigenous medicine into a Western infrastructure, as it belies the main benefits of indigenous medicine, such as the willingness of IMPs to take their services to the patient’s home, and flexibility of payment (interview 37a, Yangon: June 2000). The WHO’s promotion of indigenous medicine has been criticised as a substitute for the lack of community participation in primary health care (Velimirovic 1990: 54-55).

The impact of resource deprivation

Another impact of resource deprivation is evident in the limited supply of essential drugs available. The Central Medical Stores Depot (CMSD) distributes drugs only once or twice each year; these usually run out after a few months. As a result, many midwives buy supplies from private sources with their own money, and charge the cost to each patient. Otherwise, patients have to buy medications themselves from drug vendors. In addition, much equipment in the health centres is old and broken, or alternatively lies unused if it is of little relevance to the main work of the midwife (interview 32, Kachin state: June 2000).

While the allocation of public expenditure to health overall has declined, the allocation of funds to providing essential drugs has decreased within the declining health budget: from 9.8 per cent in 1993 to 8.5 per cent in 1995 (Bayarsaikhan 1995: 14). To address the inadequate supply of pharmaceutical drugs to the public health sector, the government and WHO began an Essential Drugs Pilot Project in 1989. One of the main problems was that ‘there was no

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34 See also discussion later in chapter on attitudes to traditional practitioners.
35 For another analysis of integration of indigenous and modern medical systems, see Hyma and Ramesh (1994).
36 The CMSD is the chief government procurer and distributor. Its functioning is hindered by the shortage of non-essential drugs, uncertainties of supply, and lack of initiative and conservatism of the staff, who are mostly medical graduates. A 1990 report noted how the CMSD’s tendency to stockpile drugs for emergencies has given it a reputation as a hoarder, and led hospitals to encourage their patients to buy drugs on the open market (Perti 1990: 1).
37 At the same time, some of the drugs remain unused because of the lack of knowledge of the midwife and a preference for treatment by injections, which most patients believe are more effective (Videl 1994: 6).
The Public Health System

comprehensive and coordinated approach to drug supply management’ (WHO 1995a: 19). Therefore, the project aimed to procure quality drugs at an economic cost, to provide them to health care facilities in amounts appropriate to need, and promote rational prescribing by health staff (WHO 1995a: 6). However, an evaluation report in 1995 found that although a list of essential drugs was drawn up, many of the drugs that had been distributed by the CMSD were still in the non-essential category. More importantly, drugs being sold and used in the private sector remained unregulated (ibid.: 50-51). Finally, a major obstacle to the supply of essential drugs and medical equipment is the lack of foreign exchange allocated to import them. The Myanmar Pharmaceutical Factory produced approximately 40 per cent of the country’s needs in essential drugs, but was reliant on allocations of foreign exchange for raw materials. As the factory is run by the Ministry of Industry, its production priorities do not always match those of the Ministry of Health, especially as about half of the factory’s operations are jointly run with private companies. As a result, the CMSD is often out of stock of many drugs (Bayarsaikhan 1995: 16-17).

It is at the level of basic health services that the government’s health financing policy has the greatest ramifications. It is not surprising that bureaucrats find it so difficult to implement policy: in 1995, 61.9 per cent of recurrent health expenditure went to salaries, and only 8.5 per cent to the purchase of essential drugs. Furthermore, these amounts were declining (ibid.: 14). The official solution to these deficiencies is the cost recovery programs that have been initiated over the last decade, such as user fees at hospitals, community cost-sharing, and revolving drug funds. The income generated by these schemes goes to maintenance, the purchase of further drugs, and staff incentives (Abel-Smith 1994: 9). However, generally these measures have not increased utilisation of public health services, as people prefer to buy cheaper

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Essential drugs are those that are considered to be high priority to fulfil the country’s drug supply needs, and ideally should be given precedence in importing and domestic manufacture according to the list drawn up by the government.
drugs on the private market, even if the quality is sub-standard (Bayarsaikhan 1995: 26).

Table 6.13: Health Care Cost for Consumers by Service

<table>
<thead>
<tr>
<th>Health Care Service</th>
<th>Number of People (n=743)</th>
<th>Mean (Kyats)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>161</td>
<td>93.09</td>
</tr>
<tr>
<td>CHW</td>
<td>8</td>
<td>340.62</td>
</tr>
<tr>
<td>Midwife (sub-RHC)</td>
<td>86</td>
<td>128.37</td>
</tr>
<tr>
<td>RHC staff</td>
<td>96</td>
<td>414.62</td>
</tr>
<tr>
<td>General practitioner</td>
<td>220</td>
<td>560.86</td>
</tr>
<tr>
<td>Hospital</td>
<td>38</td>
<td>1285.13</td>
</tr>
<tr>
<td>Other*</td>
<td>134</td>
<td>348.47</td>
</tr>
</tbody>
</table>

*‘Other’ includes home medicine, quacks, indigenous medical practitioners and auxiliary midwife services.


Thus, the lack of financing from the government to sustain public health services means that, in reality, they are user-pay (see Table 6.13). It has always been the case that individuals have had to informally contribute towards their health care. However, under economic transition this has become much more overt. The retreat of the state from direct health financing is manifested in the policy of community cost-sharing. This was initiated as a method of creating revolving funds for essential drug supplies, where the midwife is supplied with a starting amount, and replaces stock by making a small charge to patients (Khin Kyi Kyi 1993). Policies such as this have formalised the user-pay nature of the health system. Any public health service requires a financial contribution from the patient, especially for medicines. While this contribution is usually relatively small, it is enough of a burden for the many people who barely have enough to eat each day. Patients are required to provide everything for their treatment, down to suture thread (interview 5, Yangon: February 2000).

39 The policy of community cost sharing in Myanmar is derived from UNICEF’s Bamako Initiative, which was developed to respond to the lack of national resources to address the health crisis in Africa. The success of the Initiative has been subject to debate, with critics opposing its promotion of the shift to market-driven health care where ‘efficiency is emphasized over equity’ (Asthana 1994a: 60).
Although the very poor are meant to be exempt from such fees, the mechanisms to identify the poor are seldom effective.

Overall, the effectiveness of the public health sector is limited by the serious lack of supervision, medical supplies and even training given to basic health workers and volunteers. Combined with inadequate salaries, this contributes to a high rate of attrition and absenteeism (UNDP 1993: 10). Even if a sick person is able to reach a health centre relatively easily, it may not be staffed, and probably will not have sufficient supplies of drugs and equipment. Of course, there are many very competent and committed health workers who go beyond the call of duty and are greatly trusted by their community. Unfortunately, they appear to be the exception rather than the norm.

Urban health services face many of the same problems, and the experience of the poor with the public health sector is not much different. Although the majority of health sector resources, both public and private, are based in urban areas, there is still a large disparity of accessibility to health services for the population in the cities. The urban poor face many of the same problems of gaining good quality and affordable health care. The process of urbanisation exacerbates this; the urban population increases by 2.8 per cent annually (UNICEF 2002: 30).

However, the disparity of health services between urban and rural areas is due to more than service utilisation patterns. Approximately 40 per cent of health expenditure goes to the greater Yangon area, which covers about 10 per cent of the population (Abel-Smith 1994: 8).

There are limited social security and charity arrangements in place to help people compensate for the cost and inefficiency of health care. The Social

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40 The lack of training and supervision in the health sector is mirrored in the public education sector. A World Bank research team reported that ‘over two-thirds of all primary schools are understaffed, and two-thirds of all teachers currently in service are untrained’ (Poverty Reduction and Economic Management Unit 1999: 125). Many teachers teach multiple grades and double shifts of classes, usually without adequate teaching materials.
41 Accessibility has increased during the 1990s, with over 83 per cent of the population living within an hour’s walk of a RHC – the maximum distance from which health care is defined as accessible – and 95 per cent, able to reach a sub-RHC in the same time (Department of Health/UNDP/WHO 1994: 1). Lack of accessibility to health services is greater in border areas. See Chapter Seven for an analysis of regional disparities.
Security Board of the Ministry of Labour operates a limited social security scheme. In 1997/98, this covered 378,333 workers in a variety of state-owned, co-operative and private enterprises (Central Statistical Organization 1998: 186). The Scheme covers sickness, maternity, death, temporary and permanent disability and survivor’s pension. The government reported that contributions made by the employers and employees amounted to Kt150.6 million, 91 per cent of which was returned in benefits to the workers (ibid.: 186).

In addition, the Ministry of Defence, the Ministry of Transport and Communication, the Ministry of Mines, the Ministry of Labour and the Ministry of Finance provide health care to their employees through their own system of hospitals and dispensaries (McConville 1995: 17).

Otherwise, the main formal support networks available are local health care co-operatives, run through the Ministry of Co-operatives. Co-operative health clinics that exist in some parts of the country form an alternative to public health clinics and general practitioners. Members pay a small joining fee, and are able to get health care for less than the cost of seeing a private doctor, and with more convenience than utilising public services (Abel-Smith 1994: 6).

**Health and Society: the ‘other’ health system, and how people survive**

The deficiencies of the public health sector are only one aspect that shapes the health system. Sociocultural factors shape the health system just as much as political and economic factors. The role of the state in promoting health transitions is not merely to build rural health centres, but to facilitate a combination of modernising social forces, such as urbanisation, economic development and education, and modern medical interventions, such as childhood immunisation and village health systems (Caldwell, cited in Christakis, Ware and Kleinman 1994: 275). But ‘the effect of both modernizing social change and medical interventions upon health status in the developing world are mediated by local-level processes, in particular, illness behavior’ (ibid.: 276). Thus, it not only the political and economic decisions of the military
regime that account for the nature of the Myanmar health system, but the way in which government policy is affected and is impacted on by social organisation.42

This section describes the parts of the health system that exist outside of state structures. The combination of popular attitudes to health care, and the bureaucratic nature and low capacity of the public health system, causes people to use the health sector only as a last resort. This reflects the lack of embeddedness of state-society relations. Specifically, individuals and societal forces may counter the impact of government policy and implementation, through avoidance of the public health system and by compensating for its deficiencies through informal health care providers.

First, avoidance of the public health sector is a common phenomenon, relating to community distrust of government authority and its attempts to organise everyday life and attitudes, as well as political and resourcing constraints on public health service delivery. The health system is subject to struggles for power and authority, no less than any other aspect of life. Yet, by choosing to treat illnesses outside of the public health care system, individuals place themselves outside the ambit of the state in this sector.

Avoidance is demonstrated by utilisation rates of the public health system, which have been decreasing under the rule of the current regime. The use of hospitals and dispensaries declined 20 per cent in the 1990s, reinforcing the claim that there is more to access to health care than the distance the population lives from health facilities.43 Over the same time, there has been a four-fold increase in the use of indigenous health clinics (Poverty Reduction and Economic Management Unit 1999: 117).44

42 In respect to health, social organisation accounts for the way that individuals and households interact with the health system. Coreil (1990: 12) explains that health outcomes are ‘dependent on multiple dimensions including socioeconomic conditions, means of subsistence, household composition, dietary factors, child care patterns, and resource allocation strategies, as well as the specific health-related behaviour practices’.

43 The decline in utilisation of public health facilities has particularly applied to station and township hospitals. However, tertiary general hospitals and specialised hospitals have high utilisation rates (Myanmar Ministry of Health 1993: 4). The decline in utilisation may be higher; a source cited by Steinberg puts utilisation at 80 per cent (Steinberg 2001a: 173).

44 Weak demand for public health services is not unique to Myanmar. In Indonesia, another country with a poor public health record, low utilisation rates of health centres and hospitals...
Further, a desire to avoid the public health sector is reinforced by the existence of alternative sources of health care. Although international norms of state responsibility for delivering social services are firmly established, and acknowledged by the rhetoric of SLORC/SPDC, the failure of the state as a provider is not generally considered a loss by most rural communities and urban poor, who never expected that the state would provide for them in the first place. Rather, life goes on as always, and needs are met to the best of abilities by informal health care providers and local survival networks.

**Popular Attitudes Towards Health**

The Myanmar government adopts WHO’s definition of health, which explains it as ‘a state of complete physical, mental, and social well-being, and not merely the absence of disease’ (Preamble to the Constitution of the World Health Organization, 1946). This definition is an ideal which fits the holistic aims of Health For All, but is not necessarily useful in accounting for how health is relevant to a society, especially in a context where the attainment of such health is not at present a realistic proposition.

A relativistic alternative ‘conceives of health as a dynamic, constantly varying condition of the individual or the group’ (Dunn 1976: 133). This definition derives from a perception of health that changes over time, according to a group’s experience of changes in quantity and quality of health status. Therefore, rather than being an absolute value, ‘ill health corresponds to a substantive diminution in health’ (*ibid.*). This definition is more useful for explaining the health and illness behaviour of individuals in underdeveloped countries. It is revealing that the Myanmar word for health is *kyan ma ye*, which is a combination of the words ‘strong’ and ‘hard’.

The most appropriate and well-implemented health policy is of little use if it is not applied at the local level. One problem with a community relying on its own resources is that health is considered important only when ill-health is apparent. This is a long way from WHO’s definition, and is more closely have been found to be linked to poor quality of services, again due to resource constraints
approximated by the relativist definition of health. Consequently, preventative health measures are rarely practiced, because of both lack of resources and lack of knowledge.

A number of different factors contribute to the health behaviour of an individual (health behaviour being actions that may prevent or cause illness, and actions taken by individuals when morbidity occurs). These include individual attitudes, knowledge and values, social support and cultural norms, environmental factors, the availability and accessibility of health services, the financial costs, and political and legislative factors (Hawe, Degeling and Hall 1990: 32).

While financial and political factors are important contributors to the health crisis in Myanmar, the health-seeking behaviour of individuals, which makes the public health sector relatively insignificant in their lives, also a pertinent factor. The population relies mainly on household and community resources to deal with illness. This is not only a reaction to the poor quality of health services provided by the state, but in turn contributes to the difficulty of implementing government health policy.

The fact that people regularly avoid public health services stems from the failure of state-run health systems to effectively penetrate into society. Generally, people use modern medicine when it is economically and geographically accessible but cultural and ideological obstacles remain (Donahue 1990: 86). Health education campaigns seldom address popular conceptions about cause and treatment of disease. Superstition and myth are powerful determinants of illness behaviour. Even where effective modern medical facilities exist, the patient may perceive that type of medicine as being inappropriate for a particular illness, or mistrust of health staff from a different part of the country will prevent it from being used (Christakis, Ware and Kleinman 1994: 280-281). As agents of the government and practitioners of

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(Corner and Raharjo 1995: 80-81). For an in-depth look at conceptions of illness in the private sphere, see Kendall (1990). Also, for a historical analysis of health and health-care in Southeast Asia under colonial rule, see Owen (1987).
Western bio-medicine, basic health staff often have difficulty in gaining the trust of the villagers. This is compounded if the health worker is an outsider, or a young woman, as many of the volunteers are (interview 22, Yangon: March 2000). Lack of trust can apply to private doctors as well, especially when the doctor does not inform patients about their treatment (Clawson and Keller 1999: 29).

Thus, a large part of the problems of the health sector stems from the inability of the system to overcome the gap between the modern medical system and the lay community, who, lacking understanding and trust, as well as experiencing inefficiency and low quality of service, do not utilise the public health system to its full capacity.46

In turn, lack of public demand prevents the improvement of health service quality in the public sector. Januar Achmad argues that if sufficient public demand is present,

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\text{[t]he clients of the health system, acting directly or through the political process, can raise the level of accountability and responsibility of the system to the people it serves. This route of influence can only work, however, if the people affected are aware that performance can be improved and if they are able and willing to make their voice heard and exert some pressure to make that happen (Achmad 1999: 142).}
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Thus, differences in health service quality in developing countries can be partly explained by differing levels of grassroots pressure. In Indonesia, which Achmed studies, and in Myanmar, such pressure is very weak, because of low levels of formal education, and intolerance of criticism by the government (ibid.: 142-149).

The Hierarchy of Health Care: What People Do When They Get Sick

Generally, people use the government health services as a last resort. The low quality and high cost of care in the public system is a deterrent to its utilisation, except in emergency cases, and a substantial portion of people

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46 Even when a service such as clean water is available in a village, it may not be used. David Chandler points out that "without sufficient training, community members view latrines as unnecessary devices that must be kept clean for use by visiting VIPs. In addition, people tend not to boil water because the fuel costs are high" (Chandler 1998: 253).
instead seek treatment outside the public health sector (see Table 6.14). Low quality of care was demonstrated in a study of the quality of case management of children with respiratory problems in public health facilities which found that of children with a very severe disease, only 50 per cent were diagnosed correctly, and only 50 per cent of those diagnosed were given the correct treatment (Department of Health/UNDP/WHO 1994: 10). Low utilisation of the public health sector was shown in a study conducted in 1989, that found ‘only 3 per cent of people consulted a community health worker, while 38 per cent consulted a private doctor, and 23 per cent consulted a traditional practitioner’ (Mattock and Abeykoon 1993: 42). As mentioned earlier, the utilisation of public health services has declined significantly since then.

### Table 6.14: Source of Health Care Services

<table>
<thead>
<tr>
<th>Health Care Provider</th>
<th>People in Study</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self care</td>
<td>161</td>
<td>21.4</td>
</tr>
<tr>
<td>CHW</td>
<td>8</td>
<td>1.1</td>
</tr>
<tr>
<td>Midwife (sub-RHC)</td>
<td>86</td>
<td>11.4</td>
</tr>
<tr>
<td>RHC staff</td>
<td>97</td>
<td>12.9</td>
</tr>
<tr>
<td>General practitioner</td>
<td>223</td>
<td>29.6</td>
</tr>
<tr>
<td>Hospital</td>
<td>43</td>
<td>5.7</td>
</tr>
<tr>
<td>Other*</td>
<td>135</td>
<td>17.9</td>
</tr>
<tr>
<td>Total</td>
<td>753</td>
<td>100</td>
</tr>
</tbody>
</table>

*Other* includes home medicine, quacks, indigenous medical practitioners and auxiliary midwife services.


The process of illness behaviour\(^{48}\) is much the same for the rural and urban poor, who attempt to deal with their illnesses through self-care. The first measure will be to visit one of the small drug vendors, invariably unlicensed and unqualified, who are relied on to give advice. Throughout the developing

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\(^{47}\) The study was based on a survey of 714 households in 34 villages, and a questionnaire sent to all 50 RHC and sub-RHC in seven townships representing different parts of the country. The findings were based on health care behaviour during the most recent illness episode of the respondent.

\(^{48}\) As a component of health behaviour (which is a range of behavioural risk factors) illness behaviour is the individual’s response to sickness and suffering, such as deciding what medical services to use and the perceptions of those services (Christakis, Ware and Kleinman 1994: 277-278).
world, drug vendors are perceived as similar to doctors, offering diagnosis of illnesses and prescribing medicines (Christakis, Ware and Kleinman 1994: 289). Vendors are popular because they usually have a wide variety of medicines (interview 34, Kachin state: June 2000). However, although common ailments, such as malaria, will probably be identified, much of the medication sold is of poor quality, beyond its use-by-date, or a useless counterfeit. Even the smallest drug shops in the villages are well stocked with a variety of medicines, but many of these are smuggled into the country or unregistered. Of the medicines produced by the state-owned pharmaceutical plant, and a few small-scale private manufacturers, a WHO study found that none complied with Good Manufacturing Practice requirements (Wondermagegnehu 1999: 15). Further, the majority of tested drugs from vendors in Yangon either contained ingredients other than what was claimed, or insufficient quantities of active ingredients. The drugs tested had a failure rate of 16 per cent (the same study found a failure rate of 8 per cent in Vietnam) (ibid.: 19). However, anecdotal evidence from doctors suggests that the amount of substandard drugs sold by vendors may be higher (interview 24, Yangon: April 2000; interview 51, Yangon: August 2000).

If self-care fails, the next step is to consult a practitioner of ‘traditional’ medicine. Each village seems to have a couple of elderly men who practice some sort of indigenous medicine or healing (Technologies Development Group 1998: 12). While Western bio-medicine is popular, traditional medicine has the advantage of costing less and being more flexible to the needs of the patient.49 In fact, often people can only afford traditional treatments (UNDESA 1999b: 93). The status and importance of indigenous medical practitioners in the village is often underestimated by health planners (Akhtar 1991: xii).

Many of the IMPs of today are not trained in the Ayurvedic tradition,50 and considerable scepticism exists in Western medical circles about their

49 Many IMPs will accept payment by barter, such as some rice or bananas (interview 7, Yangon: March 2000).
50 The diversity of IMPs makes definition difficult, as formal medical systems have become corrupted, or absorbed into a plurality of systems. Carl E. Taylor (1976: 287) points out that
effectiveness. A comparative health specialist argues that ‘their overall impact today on the health of the people must be considered negative’ (Roemer, cited in Velimirovic 1990: 53). Some IMPs are highly skilled, and utilise localised treatments and drugs which can be surprisingly effective. Generally, indigenous doctors in Myanmar have a good reputation for treating broken bones and sprains.51 There are also herbal remedies and some other treatments, often quite localised, which are very effective for common ailments. In one part of the Shan state, the traditional treatment for malaria is to prick the tips of all fingers and toes every two hours; this treatment is reported by a community development expert to work (interview 36, Yangon: June 2000). Apart from this, most of the traditional doctors are not trained in any recognised school of medicine, but practice treatments learnt from an elder which, often being based on superstition, can do more harm than good.52 This is why trained medical personnel, like their colonial counterparts, often refer to IMPs as quacks (interview 7, Yangon: February 2000).

It is often only after the failure of self-help and local healers that someone will enter the public health system, provided their family can afford to transport them to the health centre, and ultimately the township hospital. By the time people are admitted to hospital, it is usually too late to treat them (interview 7, Yangon: March 2000).

In some cases, even when government health workers are present, only part of the village has access to their services. For example, villagers in the dry zone told of how ‘[a]n 18-year-old woman has just given birth to a son 20 days before, but instead of a midwife, her sister-in-law came to help her delivery. A midwife...visits the village residential area, but marginal areas where this woman lives are usually ignored’ (UNDESA 1999b: 29-30).

‘when we [use] the term “indigenous practitioner”, we are really talking about indigenous practitioners of medicine, not practitioners of indigenous medicine’.51 This generalisation is based on anecdotal evidence from different parts of the country.

51 A volunteer health worker in the Kachin State described how a young boy in the village had sustained a serious head injury during a fall. She was unable to treat it, because her main role was health education and basic first aid. The community health worker at a nearby health unit was away from the village, so she took the boy to the local IMP. However, he did not know how to stop the bleeding and the boy died, having been failed by both the formal and informal health systems (interview 33, Kachin state: June 2000).
The hierarchy of illness behaviour as described above specifically applies to the very poor. Different socio-economic groups have different illness behaviour. For example, in a village in Bogalay Township, in the delta region, the better-off in the village will get medical treatment in Bogalay (a small town) or Yangon. Middle-level income villagers will get treatment from the health assistant in a nearby village. The worse-off in the village must make do with local healers (UNDESA 1999b: 108). Similarly, in a village in Pindaya Township in the Shan state, the better-off and middle households see a doctor in the town when sick, but the poor households only have access to traditional medicine (ibid.: 40).

The experiences of the urban poor are similar to those of their rural counterparts. Again, they will first go to the drug vendors and IMPs. If they need to go to the health centre or hospital, they will not have such a large transportation problem as those living in rural areas, but will still be disadvantaged by the poor quality of care. The main difference for health care access in the cities is the availability of private doctors, for those who can afford to pay.

A study of maternal and child health needs in Dawpon, an impoverished suburb of Yangon where squatters were resettled from the inner city in the early 1990s, found that choice of health services ‘is influenced by quality of care, availability of medicines, cost of transport, and access to clinics at convenient times’ (McConville 1995: 1). Although treatment at the health clinic is free, while private doctors charge Kt20-50 per consultation, ‘there is...no point in travelling to the health centre to be given the name of medicines to be purchased, when other health providers who live nearly can do the same at a cost equal to or lower than, the cost of transport (and time inconvenience) to the health centre’ (ibid.: 32).

53 In Dawpon, apart from the government health services, there are 32 general practitioners, and about 100 unregistered IMPs plus 30 traditional birth attendants who were trained in 1988 by the Ministry of Health but are considered by the community to be informal service providers (McConville 1995: 17). Fifty-five per cent of mothers with children under five, interviewed in the study, sought treatment from the general practitioners, while 15 per cent were treated at home, 5 per cent used IMPs, and only 5 per cent used the government health centre (ibid.: 30). However, the government health clinic is more popular for antenatal care, being used by 21 per
Most of the very poor families simply have no capacity to pay for health care. Only 1.8 per cent of monthly income is spent on medical care, which in 1999 was an average of Kt249.13. Rural areas spend slightly more on health than urban areas, probably because of the higher cost of accessing health care services (Central Statistical Organization 1999: Table 4.12.1).

Sometimes, medical care is not an option at all. Some poor people in a village in the southern Shan state report that ‘[i]f they are not feeling well, they have to stay to take a rest at their home because they can’t afford the expense of medicine’ (UNDESA 1999b: 61). Likewise, in the urban suburbs, ‘a health issue proves an insupportable expense within the family budget. A family member’s medical needs may go without being addressed, or the cost of the treatment may send the children into the workforce and the parents to the moneylender’ (Clawson and Keller 1999: 30). Poverty-stricken households have a precarious everyday existence, and the loss of daily income through sickness can be critical. A common consequence of illness is indebtedness, as families must borrow from relatives, or a pawnshop or moneylender to get by. Most moneylenders charge around 20 per cent interest (interview 24, Yangon: April 2000).

Health Care Transition: the private and parallel health sectors

The attitudes that make many people reluctant to encounter the public health system, and the inadequacy of care often received if they try to, might suggest that communities would attempt to compensate for the lack of essential health care. However, in respect to health matters, it seems that genuine volunteerism is limited and localised, taking the form of individual acts of charity, or in some exceptional cases of grassroots community development (see cent of women. McConville notes that different services are used for different illnesses. For example, ‘it is a common belief that children with measles should be treated with indigenous medicine’ (ibid.: 25).

The non-food categories with higher levels of spending than health are: transport; fuel and light; charity and ceremonials; clothing; cleansing and toilet; house rent and repairs; and personal use goods (Central Statistical Organization 1999: 100).

Government and UN rhetoric maintains that the Buddhist culture in the country creates a culture of community volunteerism (UN Working Group 1998: 36). However, the emphasis on community participation by the government and the UN leads to risk of overburdening communities (Poverty Reduction and Economic Management Unit 1999: 113).
Chapter Five. For the most part, compensation for weak state capacity has been channelled into the commercial realm. Since the end of the socialist era, the move away from the public health sector has also been facilitated by the government’s encouragement of the private health care sector; this is one of the key impacts of the economic transition on the sector of health.

The Ministry of Health assumes that the proportion of household expenditure on health will rise, and expects rapid growth of private sector health provision (Department of Medical Sciences and Department of Health Planning 1999: 6). This has certainly occurred; private expenditure on health is 800 per cent higher than public expenditure (1.6 per cent of GDP as opposed to 0.2 per cent) (World Bank 2001). However, the growth of the private health sector has drained the already limited resources of the public health sector, exacerbating the inequities of the health system.

For the small percentage of wealthy urban dwellers, a very high quality of health care is available through the private sector. This includes a growing number of well-equipped hospitals and specialist clinics. The private sector also accounts for the numerous general practitioners in urban areas who provide services to the middle class and poorer parts of the population. The growth of the private sector since the ending of the socialist economy has been demand-driven. Even at the lower end of the market, where the private sector is of similar cost to the public sector, private health services are of much greater convenience (Abel-Smith 1994: 8; see also Chapter Eight). Additionally, the growing entrepreneurial classes, who can now afford quality services, are not content to rely on deteriorating public services.

The availability of high-quality private health services to the rich is one of the largest impacts on health of the economic transition. In 2000, 189 polyclinics were advertised in Yangon, including international medical centres catering to the foreign population, specialists and dentists (Anon. 2000). A number of these clinics include facilities for inpatient services, and have up-to-date medical technology. The clinics are owned by doctors, who lease the equipment from private businessmen, or owned by families or businesses who hire doctors and specialists on a commission basis (Mya Maung 1998: 250). A
WHO consultant describes a visit to one of the private clinics in a central Yangon suburb in 1994. Although registered as a clinic, it was in fact a small hospital, with 60 beds and three operating theatres, as well as laboratory, x-ray, ultrasound, EEG facilities and a pharmacy. At that time, the charges were Kt1000 per day for a first class room with air-conditioning, television and a refrigerator; Kt550 for a room with only air-conditioning, and Kt400 for a basic room. Major operations cost Kt1000, minor operations Kt400, and use of the labour room Kt500 (Abel-Smith 1994: Annex A1). The costs quoted by Mya Maung (1998: 251) a few years later are even higher (even when taking into account the depreciation of the kyat to over half its 1994 value): Kt20,000-50,000 for child-birth and maternal services, and as much as Kt300,000 for the services of a specialist with a foreign medical degree. These costs restrict use of the private clinics to the well-off.

The government’s main form of control over the private medical sector is the Myanmar Medical Association. Private medical practitioners are required to register either with the MMA or the TPDC (interview 48, Yangon: August 2000). Like other health-related GONGOs (see the next chapter), the MMA is run in a top-down, hierarchical fashion by a 30-member executive committee which is assisted by branches at each administrative level. It has over 6000 members, spread through 65 branches and 17 specialist sections.56 The MMA’s main function is to further the medical knowledge of its members through training courses, seminars, clinical demonstrations, a quarterly journal and an annual conference (Myanmar Ministry of Information 1999: 421). The MMA is closely involved in government policy formulation and implementation. Representatives of the MMA also participate in drafting the National Health Plan, and the Association assists in the implementation of the NHP through participation in Department of Health and UNICEF projects covering HIV/AIDS, birth spacing, child survival and the like (ibid.: 422-423).

56 The MMA organises social and cultural activities, as well as providing health care and other assistance for members who are retired (Myanmar Perspectives, May 2000).
Nevertheless, neither the MMA nor the government is in the position to influence the commercial decisions of private doctors.

As argued in the previous chapter, although the government has encouraged the growth of the private sector, it has not been through careful application of policy. As a result, because the private sector grew so rapidly, the mix of public and private is badly regulated. Not only is quality control of private services almost impossible to achieve, but the great disparity of public health services between urban and rural areas has been underscored by the almost exclusive concentration of private health sector services in the towns and cities. Although the government can compel public sector doctors to serve time in remote rural areas, private doctors set up their practices to suit their own needs, rather than the needs of the patients. Thus, although the growth of the health sector has offered a greater variety of health services to the population, except for the rich it has not addressed the basic deficiencies of the health system. The Ministry of Health is well aware of these problems, but does not have the capacity or political backing to do anything about them. (interview 37a, Yangon: May 2000). Thus, while the demand-driven growth of the private health sector reflects the limited capacity of the state, and, by draining resources from the public sector, further undermines the state’s capacity, the growth of the private sector is characteristic of the economic transition in Myanmar. That is, the regime’s survival instincts have hindered the ability of the government to counteract structures that exacerbate social inequality and impoverishment, as well as maintaining a lack of state capacity to implement such policies.

The growth of inequity through the private sector is accompanied by a more marked division within the public sector. The system described above, caters to people who have little connection with, or influence on, the regime. However, the military, being the basis of regime power, is too important for SLORC/SPDC to be subject to inequitable and low quality health services. Instead, the military and their families are catered to by the defence medical health system. The Ministry of Defence runs two large Defence Services hospitals in Yangon, as well as hospitals in Mandalay and major regional towns. These hospitals are well-supplied and well-equipped, presumably
having a greater allocation of foreign exchange than those run by the Ministry of Health. The Defence Services Medical College in Yangon trains doctors who are given greater access to research and specialisation (Smith 1996c: 24-25).\textsuperscript{57} A number of these facilities have been newly built under SLORC/SPDC.

The private health sector and the privileged defence medical system certainly existed during socialism, but did not provide such a blatant contrast with the services available to the rest of the population. They represent the divisions that have been emphasised by economic transition. Therefore, the change in health policy under SLORC/SPDC, in which compromises on social issues have been made to shore up the power of an illegitimate regime, has also initiated a gradual change in some parts of the health system from ‘underdeveloped’ to ‘transitional’, as defined above. Yet this change does not reach across the board, remaining restricted to the upper end of the health system, producing a mix of ‘underdeveloped’ health services with those in transition to a more modernised system. The processes within the current political system indicate that this disparity is more likely to increase than decrease.

**Prospects for Reform**

The Myanmar public health system is in need of major reform and capacity building. Under the current regime, that is very unlikely. Because the nature of the state determines the nature of each sector within it, any attempts to reform health service delivery in isolation from the wider system it exists in will have only minor success. For that reason, while resource deprivation and a lack of development assistance aggravate the health crisis, merely increasing resources would not be an adequate solution to the problems in a system that

\textsuperscript{57} Defence personnel and their families also have privileged access to education. In the case of tertiary education, medical, engineering and technical institutes have been opened under the Department of Defence during the rule of SLORC/SPDC. These are much better maintained and equipped than the public system. Because the students are military personnel, and therefore not a political risk to the regime, education is not restricted by priorities of social control to the same extent. In an effort to bring the education of the leadership up to par with its ASEAN counterparts, senior officers undergoing postgraduate work are given access to comparative political and economic knowledge that is not available elsewhere in the country.
has been operating at a very low capacity for decades. It has been recognised for years that ‘spending more on health services does not necessarily generate better health for the country as a whole’ (Abel-Smith and Leiserson 1976: 220). Some health care professionals already working in Myanmar have doubts that the current system could absorb an influx of funds.

A World Bank research paper stated that ‘aid has a positive and significant impact only in countries with sufficiently reformed policies and institutions’ (Knack 2000: 1). High levels of aid can erode bureaucratic quality and the rule of law, and increase levels of corruption. For example, foreign aid can reduce state capacity by implementing projects that were formally the responsibility of local governments, luring the most talented public servants away from the civil service, and potentially providing funds to be used for patronage (Knack 2000: 5). In many cases, foreign aid has reduced state accountability for development.

This is not to say that the lives of individuals would not be improved by an increase in aid. The state of development in most of the country is so bad that even badly delivered aid is better than none. However, to make a sustainable impact on development, more fundamental problems need solving. For example, Martin Smith (1996c) ties the inadequacies of the health system to human rights problems that are manifested in censorship, distortion of statistics, misreporting of health problems, and other by-products of the authoritarian system. These are ingrained features in the operation of the state. Smith maintains that the solution does not lie with grassroots NGOs, whose current contribution is ‘a drop in the ocean’; rather, he says that the first step in any health reform program is the need to strengthen and upgrade the delivery capacity of the Ministry of Health (ibid.: 117).

This is what the UN agencies in Myanmar are attempting to do, under the premise, expressed in a report for UNDP, that ‘the civil service at the higher levels is impressive in its technical capability and is probably capable of policy formulation given a more liberal environment and access to quality information’ (Agrodev Canada Inc. 1995: 49). Some success has been claimed,
such as the streamlining of training and publications for overlapping programs (interview 29, Yangon: May 2000).

However, improvements in health rely on ‘flows’, such as income or recurrent expenditure on health, in combination with ‘stocks’, of knowledge, infrastructure and social institutions that are built up over decades (Murray and Chen 1994: 18-19). It is these ‘stocks’ that the political situation has suppressed. Thus, the public health system remains reliant on reform of the wider political system.

**Health and Education: a comparative policy analysis**

Up to this point, the discussion of social policy and practice has focused on the health sector. But education and other social development activities have been equally affected by the changing role of the state. The education system provides an interesting contrast to the health system. It is also a sector that is neglected by the government and greatly affected by the poverty of the population. On the other hand, the greater value placed on education by the government and the community, and the more straightforward manner of policy formulation and implementation, demonstrates how the Myanmar state can work differently across sectors. Ultimately, however, the basic characteristics of governance in Myanmar apply across the board. By contrasting the experience of the education sector and the health sector, it is possible to place health within the broader context of the social sectors, and to place the social sectors within the context of the Myanmar state system.

The allocation of public expenditure to the social sectors was only 3.1 per cent in 1988-89, after declining more than 1 per cent since the mid-1980s. Although this percentage rose briefly in the early 1990s, by 1995-96 it had declined even further, to 2.2 per cent of public expenditure (UN Working Group 1998: 29). Expenditure on education had followed this trend (see Figure 6.15).
As detailed above, the amount of public expenditure allocated to education is around double that allocated to health. This is not unusual. Across the Southeast Asian region, governments give greater priority to education than health, and social security receives less emphasis than either (Ramesh and Asher 2000: 81). From 1989-1992, when government expenditure on education increased briefly, education absorbed the majority of public expenditure allocated to the social sectors as a whole: around 60 per cent of current expenditure, and 75 per cent of capital expenditure (Fredriksen and Jourdan 1992: 59). The new resources going into education were drawn from the already low allocations to the social sectors overall, and came at the expense of the health budget, which declined significantly over the same period (ibid.).

The education sector receives more attention than health for three reasons. First, a high cultural value is placed on education, even by the very poor. At an individual level, literacy is seen as the key to social mobility and prestige. Where the resources exist even to a very limited extent, it is not unusual for a village to build a school, subsidise the salaries of government

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58 The increase was due to the doubling of civil service salaries in 1991 (Evans and Rorris 1995: 12). In the early 1990s, 82 per cent of recurrent expenditure went to salaries (Department of Basic Education 1992: 8).
59 Social Welfare activities receive even less funding than health activities. As an example, capital expenditure of the Department of Public Works in 1991/92 was Kt24.8 million on education, Kt11.7 million on health, and Kt400,000 on welfare (Cowater International Inc. 1993b: 6.4).
teachers, and even pay for extra teachers.\textsuperscript{60} Secondly, education is the most straightforward of the social sectors to provide for. The desired ends of policy are easily measurable, which makes planning resources much simpler (Ramesh and Asher 2000: 133-134).

Thirdly, education represents a more contentious political issue than most other sectors, because students are historically one of the most politically active groups in society (Silverstein 1970). Secondary and tertiary students have always been closely associated with political activism, being at the forefront of the nationalist movement against the colonial government, major protests against the military government in 1962 and 1974, and the 1988 pro-democracy movement. Consequently, they have suffered greatly from the repression of these anti-government protests.\textsuperscript{61} Governments have always been wary of the student population, and since 1988, SLORC/SPDC has dealt with this potential threat by shutting down the universities to deal with political instability; since 1988, the universities have been closed more than they have been open.\textsuperscript{62} At the same time, the government has been developing and modernising the universities, seemingly in order to appease the student population and encourage depoliticisation.\textsuperscript{63} This strategy is working, as political activism is guaranteed to deprive individuals of opportunities for advancement in the current system, and is increasingly seen as futile.\textsuperscript{64} The

\textsuperscript{60} However, the quality of education varies between villages, and between years, according to the fluctuating economic status of the village (Evans and Rorris 1994: 2). Payment of extra teachers by the community is often dependent on the success of the harvest (Wheeler, cited in Poverty Reduction and Economic Management Unit 1999: 125).

\textsuperscript{61} Hundreds of students were killed during military repression of student demonstrations in 1962 and 1998, and hundreds more have been imprisoned, or forced to flee into exile. Further, John Brandon has noted that in the 35 years between 1962 and 1997, the universities have been closed for 20 per cent of the time (Brandon 1998: 235).

\textsuperscript{62} Given the failure of the higher education system, the young people in Myanmar have often been referred to as ‘the lost generation’. Many students put their lives on hold, waiting to be able to finish their degrees. The boredom and disillusionment have been destructive for many, with drug addiction having become common among the children of Yangon’s elite (Skidmore 1998: 266). Others abandon their education altogether, losing the valuable opportunity of tertiary education. But even after graduation, the current society holds little prospect for students with ambition, due to limited employment prospects.

\textsuperscript{63} Under SLORC, the tertiary sector has been going through a process of expansion and upgrading. Eight new universities and three colleges have been built, and thirty-nine institutions have been upgraded (Myanmar Ministry of Education 2000a: 13).

\textsuperscript{64} Rather than fighting the system, most young people (in urban areas at least) seem to place emphasis on making the most of their lives, getting a decent job, and having fun. The most popular option, for those whose families are rich and influential enough, is to study overseas.
consequence for social policy overall is that tertiary education is overtly politicised and given special attention. In fact, despite the official policy emphasising basic education, the priority of tertiary education within the education sector as a whole increased during the 1990s. Basic education still dominates education expenditure, but its share has declined from 78.1 per cent in 1983/84 to 71.9 per cent in 1992/93 (Evans and Rorris 1994: 14). This trend has probably continued over the last decade, due to the government’s emphasis on activities such as the development of electronic-learning and post-graduate teacher education.65

Of course, although education is in a better situation than health and social welfare,66 the advantage is only relative, and education has faced the

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65 For example, the government runs 203 e-learning centres around the country, to transmit lectures to high-school students studying for matriculation (Myanmar Times, 12-18 November 2001, Vol 5(89)). Also, the Institute of Education introduced a PhD in education in July 2001 (Myanmar Times, 19-25 November 2001, Vol 5(90)).

66 The Ministry of Social Welfare, Relief and Resettlement is even lower in the pecking order than the ministries of Education and Health. The ministry consists of three departments, as well as being closely affiliated with the National Committee on the Rights of the Child, and the Myanmar National Committee for Women’s Affairs, which are both chaired by the minister. The Department of Social Welfare covers a variety of child, women and rehabilitative welfare services. The department directly runs nurseries for orphaned children, pre-schools and day care centres, women’s development centres and vocational training schools, schools for the disabled, and drug rehabilitation centres. Most of these schools and institutions are operated by voluntary and non-government organisations, supported by grants and training from the Department (Myanmar Ministry of Information 1999: 325-329). The department also has projects for Children in Especially Difficult Circumstances, Prevention of Juvenile Delinquency, social and cultural exchange programs, and programs targeting beggars and lepers. Several of these projects are run in cooperation with UNICEF (ibid.: 326-329). The lack of resources allocated to the department is reflected in the conditions of government-run orphanages and institutions, which follow the model of institutional care inherited from the colonial government. A UNICEF consultant noted that ‘in all the institutions visited, children displayed symptoms of serious disturbance or trauma’ (Boyden 1991: 10).

The Relief and Resettlement Department is established to give ‘emergency relief to the people who lose their property and houses in such calamites such as fires, floods, storms and earthquakes as well as insurgency’ (Myanmar Ministry of Information 1999: 332). The provision for insurgency was added when SLORC came to power, as part of the material incentives provided to ceasefire groups. It also applies to resettlement of squatters in satellite towns, reception camps for returning refugees, and assistance to the border area development projects (ibid.: 333-335).

The final component of the Ministry is the Fire Services Department, which consists of government fire stations, staffed by trained and paid personnel, and voluntary fire stations. The Fire Services Department covers more than just fire-fighting and fire prevention activities. It has also been given a development and security role. As described by the Ministry of Information, ‘[t]he FSD and its State/Division and Townships FSDs have carried out works such as taking part in development activities, in ensuring general security, cleaning up hospital
same downward trend under SLORC/SPDC rule. In 1989-90, government expenditure on education accounted for 2.7 per cent of GDP, and 20 per cent of official public expenditure (Department of Basic Education 1992: 8). This had declined to 1.1 per cent of GDP by 1995-96 (UN Working Group 1998: 31), and 0.3 per cent of GDP in 1999/2000 (EIU 2002a: 22). While official budget figures state that public expenditure on education has doubled in the last decade (Mya Than 2000: 151), public expenditure in real terms decreased from 13.4 per cent of total government expenditure in 1996, to 8.4 per cent in 1999 (Asia Recovery Information Center December 2001). Translated into real per capita expenditure, public support for each child in the primary school system declined over 90 per cent in the decade after SLORC took power (Poverty Reduction and Economic Management Unit 1999: 124).67

Education policy under SLORC/SPDC is clearly shaped by the World Conference on Education for All, which was held in Jontiem, Thailand, in 1990. The purpose of Education for All (EFA) is to make primary education more accessible in developing countries.68 The SLORC committed to EFA, and established a National Programme of Action for EFA and EFA Central Coordinating Committee. This commitment stimulated a short-lived government interest in education, before a return to declining resources and quality. No national education plans were formed, possibly because a general plan of action for EFA was established at the Jontiem conference.69

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67 Part of the reason for this decline is the inability of public expenditure on education to keep pace with increasing enrolments (Evans and Rorris 1994: 6).

68 The Jontiem Declaration states: ‘Every person – child, youth, adult – shall be able to benefit from educational opportunities designed to meet their basic learning needs. These needs comprise both essential learning tools (such as literacy, oral expression, numeracy and problem solving) and the basic learning content (such as knowledge, skills, values and attitudes) required by human beings to be able to survive, to develop their full capacities, to live and work in dignity, to participate fully in development, to improve the quality of their lives, to make informed decisions, and to continue learning’ (World Declaration on Education For All 1990: Article 1).

69 Other education policy goals came from the Convention on the Rights of the Child, which Myanmar acceded to in 1991. With the passing of the Child Law (1993) and the development of
After almost a decade of implementing Education for All, the government claimed that the school enrolment rate had increased to 91 per cent, and the students completing the five years of primary school had increased from 25 per cent in 1991 to more than 50 per cent in 1999 (Myanmar Ministry of Education 2000a: 10). The adult literacy rate had also improved, officially standing at 91 per cent in 1999 (ibid.). However, in 1999, significant quality and efficiency problems in the education system were still being reported (Poverty Reduction and Economic Management Unit 1999: 123-127; UNICEF 1999a: 79-84). The various government policies to ensure universal primary education have had little effect in moving the majority of children through this system. To start with, 39 per cent of children never enrol in school (UNICEF 1995: 112). Of those that do, up to 25 per cent drop out in the first couple of years (UNICEF 1999a: 7). The failure of the basic education system is confirmed by UNICEF’s estimate that only 25 per cent of children in the country complete primary school (ibid.: 3). Therefore, it is likely that the situation has not changed much since the early 1990s, when it was reported that ‘much of the school-age population fails to acquire basic skills in reading, writing, and arithmetic’ (Myanmar Education Research Bureau 1992: ii).

In addition to the lack of government funding to improve education, the failure of the basic education system reflects a combination of poverty and structural barriers within the education system. The structural problems fall into two categories, low quality of education provision and lack of affordability (Poverty Reduction and Economic Management Unit 1999: 123). This combination of problems places a burden on individual households that often prevents them from keeping their children in school, and a burden on communities, who are required to compensate for the lack of government funding.

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a National Program of Action, the government committed itself to giving every child the opportunities and right of a free basic education (UNICEF 1995: 115). However, UNICEF estimated that the literacy rate in the mid 1990s was probably 55 per cent, due to the low primary school completion rate and the shortage of reading materials at community level for neo-literates (UNICEF 1995: 3).
By 2000, the country had almost 36,000 primary schools, along with 2111 middle schools and 952 high schools. The schools built under the Border Areas Development Programme accounted for 433 of these (Han Tin 2000: 148). This is reported as an 11.4 per cent increase from 1990 (Myanmar Ministry of Education 2000b: 7), and represents approximately one primary school for every two villages, an increase from the ratio of one school to three villages in 1983 (Evans and Rorris 1995: 5). This increase has occurred over the same time that public expenditure on education has been declining. The reason is that, as in other sectors, the government has been unable to address the fundamental problems facing the education system, and has encouraged the private sector and community to take up the burden of providing education services. The basic public/private division in education has been described:

[b]roadly speaking…the government trains some of the teachers, provides the curriculum and pay most teachers’ salaries. The community is responsible for most other aspects of primary education (Evans and Rorris 1994: vii).

Since 1998, the education sector has been undergoing a process of reform. The Education Promotion Programme, a series of national seminars, began in mid-1998 to assess basic and higher education. This resulted in the formulation of the first integrated education policy document under the economic transition, known as the Special Four-Year Plan for Education, which runs from January 2000 to December 2003 (Myanmar Ministry of Education 2000a: 8-13). A government document states that the aim of the Four-Year Plan is to create an education system that is on par with that of [sic] international standard and that can generate a learning society capable of facing the challenges of the Knowledge Age (Myanmar Ministry of Education 2000b: 1).

The initiative for the reforms appears to have come from the civilian Minister of Education, U Than Aung, who was appointed in 1998 (interview 47, Yangon: August 2000).

71 The drop-out rates reflect the disparity of access to primary education. ‘The majority of those who abandon or are rejected by the school system belong to the most vulnerable population groups, specifically the poorest and/or those living in remote areas’ (UNICEF 1999a: 81).

72 In addition, a 30-year plan for basic education was initiated in 2001/02, to be implemented in six five-year phases (Ximuha, 9 July 2003).
The reforms outlined in the Four-Year Plan are comprehensive, and directly address the flaws in the education system. In basic education, the plan aims to abolish learning by rote, the reintroduction of pre-service teacher training, the revision of the school curriculum and the introduction of continuous assessment procedures, in order to reduce the high repetition rate and cut the average number of years taken to complete primary school (Myanmar Ministry of Education 1999: 7-8). For higher education, the emphasis of reform is on adjusting tertiary education to meet the labour needs of the country, and developing a more flexible approach to education (Myanmar Ministry of Education 2000b: 9).

Some minor successes have been reported, such as positive results in reforming early childhood education. However, as has been illustrated in terms of the health sector, policy is rarely implemented effectively. What will make this set of education reforms any more effective than previous ones, such

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73 As described by the Ministry of Education, the plans for basic education are ‘a discernable shift from existing education programmes and practices...a movement from subject-centred to child-centred approach, exam oriented to continuous assessment and progression system, lecture discussion method to active participation method and pipeline approach to initiative, creative and productive approach’ (Myanmar Ministry of Education 2000b: 3).

74 The effect of this program was apparent very quickly, with the kindergarten repetition rate being reduced to 15 per cent (UNICEF 1999a: 79). However, it is possible this was due to an official policy that all children automatically pass each year of primary school (Poverty Reduction and Economic Management Unit 1999: 125). The government also claims that the enrolment rate has increased to 91 per cent in 1999, and the completion rate to 50 per cent (Myanmar Ministry of Education 2000b: 3).

75 One component of this is the Human Resource Development Programme, established by the Ministry of Education in 1998. Under this programme, income-generating courses have been established at various universities, institutes and colleges, running parallel to the regular system. The fees are used as additional remuneration for the staff. Courses offer certificates, diplomas and degrees, and cover the subjects of foreign language studies, computer science, computer engineering, accounting, business management, environmental studies, multi-media arts, gemology, cosmetic technology, and teaching (Han Tin 2000: 150-151).

76 In the last few years, pre-school education has progressed from a state of ‘almost benign neglect’ (Han Tin 2000: 154). Pre-school education is provided by private centres, which mainly cater to the middle class, and by the Department of Social Welfare, which caters to children of civil servants. It consists of alphabet learning to give children an advantage in the difficult first year of formal schooling. Children who start school without knowledge of the alphabet are given less attention by the teacher, and are usually set aside to automatically repeat. Therefore, this puts great pressure on children as young as three, who are pressured to begin learning early in order to better their chances when they start school (interview 46, Yangon: August 2000). Consequently, pre-schools tend to ‘emphasise the cognitive development of the child at the expense of his or her psycho-social development (UNICEF 1999a: 77-78). The emphasis of the reforms has been on childhood development, such as the introduction of play into preschools. However, the reason this seems to be working is not because of the reforms per se, but because of the dedication and motivation of the teachers and bureaucrats involved, assisted by the expertise of an international expert in early childhood education working for an INGO based in Yangon (interview 50, Yangon: August 2000). This is a case where a degree of policy leniency can be utilised to make changes which all involved see as advantageous.
as the New Education Plan in 1984? A 1992 report on the education sector noted that ‘frequent changes in the Education System had hardly been preceded [sic] or followed by a systematic review of the situation’ (Khin Saw Naing 1992: 2). After producing the basic outline of the reforms, it seems that it has fallen to the implementing agency, the Ministry of Education, to translate the reform package into concrete plans of action. However, over the same period, there is no indication that the trend of declining public expenditure on education has changed. That is the most telling fact about what chance the reforms have of succeeding. Already, the usual problems of implementing the reforms without a strong political capacity are apparent. For example, some reforms are not being implemented effectively because the stakeholders, especially teachers, are not being given incentives to integrate new methods of teaching and assessment into their classrooms. To the contrary, the high-level directions to implement reforms without corresponding funding increases, means that the burden of reform falls on already overburdened teachers. Without extra resources being allocated, inertia and conservatism of government staff will prove to be big obstacles to reform success, yet again.

For the reforms overall, the same gap between policy intention and implementation effectiveness that affects most areas of governance in the country, particularly the social sectors, is likely to keep the education system in its current state.

When compared to the health system, the analysis of the education is revealing of the way the state system is run, by highlighting the variations in the operation of the state system. While the nature of the state system produces a pattern common to all sectors, the lower status of some sectors, such as health, can be explained by the more subtle variations in between sectors. For example, the political connotations of education policy, and the greater community demand for education relative to health, has made the public education sector a

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77 One objective of the curriculum change under the New Economic Plan was to abolish learning by rote. A report five years later stated that ‘efforts have not been entirely successful’ (UNESCO 1989: 10).

78 The proposed curriculum change will also face a problem of its predecessors, namely producing new textbooks in a system where shortages of materials have been commonplace for decades.
higher priority for the state than health. In addition, comparative examination of the Ministry of Health and the Ministry of Education can reveal differences, relating to the different working cultures of the two departments, levels of conservatism, and degree of centralisation, which all have implications for the ability of the ministries to interpret and implement policy.

However, on a larger scale, the analysis also reveals significant parallel trends in the health and education sectors. Historically, both sectors were privileged under socialist rule, but suffered from lack of resources and implementation problems. Both have lost government support under SLORC/SPDC rule, as the new emphasis on economic growth has led the government to shift the responsibility for social services to the private sector and the community, and to significantly reduce the allocation of public funds.

However, within this overall trend, state attitudes to health and education have shifted. Particularly notable is the change in policy in health and education around 1997 and 1998, mentioned in Chapter Five, when the respective national policy committees were rejuvenated, and began operating regularly for the first time in their existence. It is around this time that the policy reforms in education were initiated, and, more subtly, the regime began to play a more active role in health policy. It is possible that these shifts were related to Myanmar’s entry into ASEAN in 1997, and the image-conscious shift from SLORC to SPDC at the end of that year. In this context, the minor changes in social policy could be part of an effort by the regime to improve its position within the international community. At this time, also, it became increasingly difficult for the regime to ignore the fact that its economic reforms had not achieved sustainable economic growth, which might have caused the SPDC to adjust its development strategy. Whatever the catalyst, the late 1990s saw a shift from the regime’s neglect of health and education, apparent since the beginning of economic transition, and an apparent realisation that the poor

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79 For example, the Ministry of Health, because it works with many international partners, has the reputation of being quite open. Other ministries, such as the Ministry of Education, are considered to be conservative and resistant of outside influence (interview 29, Yangon: May 2000). Another source notes that the Ministries of Health and Education are keen to increase
state of health and education was a hindrance to any kind of development and growth. The significance of this shift has been limited, however, by the fact that policy reforms have not been matched by redistribution in public expenditure; policy implementation thus remains ineffective.

**Conclusion**

It is unlikely that the health crisis will be addressed while military rule continues in Myanmar. It is not only the regime’s restriction of public expenditure on the health sector that is responsible for the country’s poor health status. As this description of the public health sector reveals, the lack of resources for health exacerbates a combination of political, economic and social factors that are detrimental to state capacity in this sector. The reality of the situation is not reflected in the quality of policy, which generally adheres to international standards, but in the government financing of public health, that has declined steadily under SLORC/SPDC. Policy made in the framework of a top-heavy state, and the context of an inhibiting bureaucratic culture, means that the intention of policy is difficult to translate into implementation, and the state is rendered ineffective.

The problems that existed throughout the socialist era remain, and the processes of economic transition have put even greater pressure on the government resources available to health care, as well as the encouragement of a more equitable system. In particular, inequity is being reinforced by the development of an unregulated private sector. Another impact of the transition is increasing reliance on, and influence by, international agencies such as the UN. As such, the examination of the health system in Myanmar details the results of the maldistribution of resources in a dysfunctional and inequitable state system.

Moreover, the disparity between popular attitudes towards health, and government strategies of health improvement, exemplifies the nature of state-measures to control the HIV epidemic, but are constrained by the conservatism of the ministries of Information and Social Welfare (ICG 2002a: 7).
society relations in Myanmar. The provision of government health services that are not effectively synchronised with the needs and attitudes of the community, reflecting a lack of embeddedness of the state in society, is a significant contributor to the incapacity of the state to reach its goals – in this case, the desire of the political leadership to provide public health services with a minimum amount of resources. A broad societal refusal to accept an inadequate standard of state services, where informal, private and charity spheres meet the demand for alternative health providers, reinforces the ineffectiveness of the state at the community level, and its irrelevance to people’s health care behaviour.

However, the informal health providers must exist in the restricted operating space open to them in the strongly controlled state system. This is currently the antithesis of a structure that could cultivate the sociocultural conditions for behavioural change, which is the key to improvements in health status (Coreil 1990: 9). Public health services, regardless of quality, will never be effective if they do not address the sociocultural behaviour of the community, and enable a strong role for women and community participation (ibid.: 7).

The contrast between the education and health systems makes particularly apparent that the ingrained defects in the state system that prevent essential reforms apply across the sectors. As such, the problems faced by the health sector are not particular, but form part of a broader pattern.

While there are some indications of adjustments in social policy to improve state effectiveness, these changes are too small-scale, and under-resourced, to have more than minor impact. Attempts to reform are undermined by the impact of long-term resource deprivation, which has crippled the health system. At this stage, even an increase in resources is not enough to fix the problems faced by the public health sector, but would need to be part of a larger system of reform – to rebuild the capacity of the health system, and of the state itself.

Meanwhile, the underdevelopment of the Myanmar state contributes to its diminished ability to address either traditional health threats, such as
malaria, or new health threats, such as the HIV/AIDS epidemic, which requires thorough and appropriate state intervention.

The next chapter looks more closely at the regime’s attempts to take short-cuts in building up the ‘stocks’ of the health system (knowledge, infrastructure and social institutions), which are the basis for strong state capacity. For example, public information, even of health matters, has been censored to achieve social control, or because of the cultural conservatism of the military leadership. One manifestation of such policies is the rapid spread of HIV. In terms of infrastructure, government money continues to be poured into major projects that are of limited use to most villagers. Although villagers benefit from new roads and bridges that offer easier transportation to markets or hospitals, the community is burdened with building local health centres and schools. Further, the military regime has concentrated on suppressing genuine social institutions, replacing them with closely controlled organisations. As the next chapter will show, even where certain aspects of health are compatible with the political priorities of the regime, substantial state capacity does not exist, as the political barriers to social development and good governance in the state system remain too ingrained to overcome.