Than Tun Sein et al. 2014: 18). The use of alcohol and drugs – including to an increasing extent amphetamine-type stimulants (ATS) – gives rise to significant problems, especially for the male population and in rural, peripheral and mining areas where the range of employment opportunities is limited; in addition, new, frequently young consumers in urban areas are turning to methamphetamines (Blickman 2011).

HEALTH-RELATED INFRASTRUCTURE

Health care is delivered via dual channels: there is a public and a private health system. Of the country’s 32,861 doctors, 14,050 work in the state service and 18,811 in the private service. In addition there are 3,413 dental surgeons, 32,609 nurses, 22,258 midwives, 1,033 indigenous medical practitioners and 4,980 veterinary doctors (2014/15; MoPF 2016: 38). Primary health care coverage is relatively comprehensive and is provided through regional and sub-regional health centres (RHCs/sub-RHCs), the majority of which were built between 1970 and 1990. Their availability, number and distribution in the parts of the country is based largely on the focal points of population. In the mountainous areas there is therefore a large number of facilities for a relatively small population, in order to ensure that the centres and sub-centres can be accessed even in areas with little transport infrastructure.

For the country as a whole, there are 61 doctors, 100 nurses and 7 midwives within the public health care system per 100,000 population, which places Myanmar below the ASEAN average (Nyi Nyi Latt et al. 2016: 128). The country has 1,056 public hospitals with a total of 56,748 beds, including two general hospitals with more than 2,000 beds, 55 regional/state/district hospitals with 200-500 beds and 330 township hospitals with 25-100 beds for curative and rehabilitative services. Facilities are distributed virtually countrywide, but the majority – including specialist clinics and by far the highest doctor-hospital ratios – are to be found in Yangon, Nay Pyi Taw, Mandalay and a few regional cities. The 2,199 facilities for preventive and public health services include 348 maternal and child health centres and 1,684 rural health centres. There are also 16 traditional medicine hospitals and 243 traditional medicine clinics (all figures: MoH 2014: 142-151). In the urban centres there is one midwife for more than 10,000 people; in the rural areas – especially in the more inaccessible parts of the country – the ratio is significantly higher. All the statistics quoted exclude the medical facilities operated by various ministries (such as the Ministry of Defence, the Ministry of Mines and the Ministry of Energy) for the use of employees and their families (Nyi Nyi Latt et al. 2016).
The availability of statistics relating to private medical facilities is limited; statistical analysis of the health infrastructure must therefore be treated with caution. Ni Nyi Latt et al. (2016: 126) quote figures for the country as a whole of 193 private hospitals, 201 specialist clinics, 3,911 private general clinics and 776 private dental clinics. The number of private medical institutions has been rising rapidly in the last few years, especially in the cities; frequently owned by foreign providers, they are often outposts of major hospitals in neighbouring Asian countries. In places where public health care provision is not comprehensive and there are no commercial private providers, community-based organisations and religious communities step in, usually in support of charity-oriented initiatives. Traditional medicine is important, especially in rural areas: nationwide 6,963 private traditional practitioners are registered (2014; Nyi Nyi Latt et al. 2016: 125) and there are also many healers who practice informally.

The public and private health care systems overlap in that many doctors working in public health care institutions also provide services in private institutions outside their official working hours, in order to boost their salaries and have access to better equipment (dual practice in off-hours). In cases of serious illness and when transport and treatment can be funded, patients are transferred to hospitals in other countries – usually hospitals in Thailand or Singapore that meet international standards and have specific specialist expertise.

A particular problem is the care of the sick and elderly when the family has no social security system in place (Knodel/Bussarawan 2016). With 2,898,000 members of the population aged over 65, the national dependency ratio is 8.8, but in some regions it is significantly higher – e.g. in Magway Region it is 10.9, in Rakhine State 10.7 and in Mon State 10.4 (MoPF 2016: 19).

**FINANCE AND TRAINING**

The funding of health care services presents a major problem. Household out-of-pocket payments (OOP) are extremely high at 75% (Than Tun Sein et al. 2014: 70). This means that patients must pay most, if not all, of the costs of diagnosis and treatment themselves, including the costs of drugs and hospital stays. Around a third of households cannot afford these costs or must borrow money and sell property to do so, thereby often driving the family into poverty and debt. Charities and donations from relatives, friends, neighbours and religious communities play an important part in meeting the costs of treatment.

Training is provided in 15 medical universities and 46 nursing and midwifery training schools; in addition, the military has its own training centres (Nyi Nyi Latt 2016: 128). Many doctors complete at least part of their training abroad; since they can often earn more money in the countries in which they train, this not infrequently results in the emigration of medical workers.

**CHALLENGES IN THE HEALTH SYSTEM**

The greatest challenge in improving the health system is that of reducing health inequities in relation to the availability of and access to health services across the country. In the light of the Constitution of the Republic of the Union of Myanmar of 2008 (Article 367: ‘Every citizen shall … have the right to health care’), this means that there is a particular need to improve provision for poor and disadvantaged population groups, minorities and the inhabitants of conflict-affected and hard-to-reach-areas in the peripheral and mountainous regions. In addition, adequate funding of health care provision must be ensured and the expansion of a basic social security system encouraged (Than Tun Sein et al. 2014: 155-170). An approach based solely on the support of foreign donors is beset with difficulties: ‘Challenges emerge when donor funding is managed by nonstate actors through numerous parallel programmes often not in line with government policy priorities and not sustainable in the long term’ (Than Tun Sein et al. 2016: 61; see also Morrison et al. 2013: 9).