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.

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).

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