"Exploring Available Data and coordination Mechanisms in Myanmar to Examine How Ageing and Older Adult Populations are included in Health and Social services as Part of Achieving UHC by 2030"

Ageing and older persons care have been neglected in the country for several years. This report finds out the current situation of older persons and ageing population; review policy documents; mapping policy and research studies to identify the best intervention that can be adopted by the country. The study has tremendous no. of consultation with variety of stakeholders and findings and recommendations from the older person led workshop.

"Exploring Available Data and coordination Mechanisms in Myanmar to Examine How Ageing and Older Adult Populations are included in Health and Social services as Part of Achieving UHC by 2030"

Contents

Acronyms

ADB	Asian Development Bank
CBOs	Civil Based Organizations
EHCH	Enhance Health Care Home
EHO	Ethnic Health Organization
EPHS	Essential Package of Health Service
GPs	General Practitioner
LTC	Long Term Care
LTCMI	Long-Term Care Medical Insurance
ONS	Organization for National Statistics
OPSHGs	Older Person Self-Help Groups
PHC	Primary Health Care
MAS	Myanmar Aging Survey 2012
MDGs	Millennium Development Goals
MOH	Ministry of Health
MOLSF	Ministry of Labour and Social Welfare
MSWRR	Ministry of Social Welfare, Relief and Resettlement
NCDs	Non Communicable Diseases
NGOs	Non-Governmental Organizations
NHS	National Health Services
NHP	National Health Plan
NIMU	NHP Implementation and Monitoring Unit
NLD	National Leagues for Democracy

SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
WHA	World Health Assembly
WHO	World Health Organization

CHAPTER 1

1.1 Background and rationale

Myanmar's economic and political reforms since 2011 have contributed to considerable changes in the county's economic and social realities. One manifestation has been the rise in GDP per capita to US$1299 as of 2017 from US$410 in 2007 (The World Bank, 2018b). New political and social pressures have resulted in an increase in public expenditures on health services, moving from 1.9% as recently as 2012 to 4.9% in 2015 (The World Bank, 2018a)with the Parliament approving more spending on health in the 2018-2019 budget (The Myanmar Times, Issue 897, Friday 12 October 2018). While there is no definitive expenditure estimate for achieving Universal Health Coverage (UHC) in a country, two WHO reports from 2010 (World Health Organization, 2010) and 2013 (World Health Organization, 2013), argued for governments to target spending of between 5-10% of GDP.

The provision of health and social care services across Myanmar is a challenge: there are 135 ethnic tribes living unequally distributed across the country, with 70% of total population residing in rural areas. Myanmar has a population of nearly 52 million, with those aged 60 years and above accounting for about 9.1% (Spoorenberg, 2015). The population density is generally low, with higher terrain and topographic barriers in rural areas and many ethnic States, where service provision is lower than in regional hubs or urban settings. Systems will be additionally challenged by the ongoing epidemiological and demographic shifts. It is expected that the proportion of older adults (60+ years) will increase to 30% of the total population by 2030 and to 50% by 2050 – driven by decreasing fertility and mortality. There is considerable scope to improve health and social protection systems, especially when comparing Myanmar to other neighbouring countries. According to the 2014 Myanmar Census, life expectancy at birth (both sexes combined) is 66.8 years, which is low compared with the ASEAN member country average of 68 years for males and 73 years for females(Department of Population, 2017a).

Population ageing in Myanmar will have profound implications for the burden of disease and social and health-care systems. At present in Myanmar, older people not only rely on their children for economic support, they also often live with them or very close for the physical support(Knodel, 2014). Moreover, Myanmar faces important challenges, including changes in demographic dynamics that will likely reduce the availability of family support for older adults despite projected increases in care needs from an increasing burden of chronic illness (Knodel and Teerawichitchainan, 2017). The coverage of formal social protection systems for older persons in Myanmar is improving, and the responsibility of the Ministry of Social Welfare, Relief and Resettlement, but currently covers less than 2% of the total population. Out-of-pocket health expenditures are extremely high, so the financial protection component of achieving UHC will be a challenge.

The other main component of UHC, equitable access to quality services will also be a challenge. Health services are highly fragmented, often of poor quality, and highly dependent on out-of-pocket payments. For Myanmar to achieve UHC, it is recognized that it will need to rely on a mix of public, private for-profit, private not-for-profit and ethnic health organization (EHO) providers.

> *"In Myanmar public sector alone can't reach to entire population with basic Essential Package of Health Services. Public sector is not a single actor but there are private for profit providers, non-profit providers like NGOs and Ethnic Health Organizations involving in health service delivery. Weak policies and regulations, limited enforcement and lack of clarity in existing guidelines pose further challenges."(Ministry of Health and Sports, 2016)*

Since Myanmar committed to achieving UHC by 2030, it is important to review the service areas defined in the current NHP 2017-2021, which is the first of three 5-year plans that progressively frame the work needed to achieve UHC. During consultation process for NHP 2017-2021, health and social care for older adults was emphasized by all stakeholders, noting that this is an underserved population. In some ways, the mention of services for older adults in the National Health Plan is ground-breaking. Yet, much work remains, and we recognize that achieving UHC will require more than the health system – so we plan to examine a set of other plans and policies that will contribute to UHC.

This includes the Myanmar National Social Protection Strategic Plan 2014, under the responsibility of the MoSWRR, and a number of other key plans and policies. Each plan and all ministries will require data to inform progress against the plans. Where possible, we will attempt to curate an analysis from available data – or else clearly identify data gaps. We know gaps exist – including an essential component to maintain political support, which is economic data to make a case for investments aimed at older adults. These economic arguments will be crucial to maintain and grow support for policy development and planning services within the National Health Plan and other plans across different ministries.

The challenge is to extract and interpret existing data, propose concrete and sustainable mechanisms to collect needed data for policy reformulation, engage with the various ministries to use the results, and better understand how data and cross-ministry collaboration can be used to inform policy into the future. The proposed work will begin to a process of better using research to inform policy, and policy evaluation to identify how to best to deliver efficient and quality services for older populations at costs that do not lead to delays in accessing services or impoverishment.

Though responsibilities for older adults are spread across different ministries either directly or indirectly, there are considerable bottlenecks and gaps to address to fully engage social and health services across ministries. We will also look at how "universal" may exclude those with higher need levels – such as frail or disabled older adults, and particularly those with no family support. According to the 2014 Census, the number of people living with a disability constitutes around 4.6% of the total population. This equates to about 2.3 million people, of whom adults aged 60 years and older represent about 45% of this total (Department of Population, 2017a). The Census Disability Report also presented estimates that pointed to over 60% of the older adult population in the country has some degree of disability.

1.2 Project goals and objectives

Goals:

To generate needed evidence from available data, policy assessment and mapping of gaps in both to inform future planning of social and health care for older adults and ensure their full inclusion in the next National Health Plan 2022-2025 and as part of achieving universal health coverage by 2030.

With this goal in mind, the body of this work aims to: develop policies related to population ageing and older adults in the area of social and health services for older adults aligned with National Health Plan (2017 to 2021) and the National Social Protection Strategic Plan in light of UHC.

Objectives:

1) To investigate currently available data sources to examine the health and economics of ageing, cost of illness and quantity and quality of health and social services accessible to persons aged 60 years and older across Myanmar;

2) To conduct mapping and analysis of available research studies;

3) To review a set of existing plans, polices and legislation in the area of social and health services for ageing populations, identifying gaps and challenges;

4) To examine current plans, policies and legislation in comparison to neighbouring countries (Thailand and Malaysia) with available reports on older adult social and health care services;

5) To develop the mapping of older adult care stakeholders and institutions that provide older adult care services; and,

6) To consult with a range of stakeholders and investigate the national coordination mechanism for older adult inclusion in the move to UHC, sector coordination and public services for older adults and examine the role of EHOs and the private sector in health and social services out-reach.

1.3 Geographic scope of project

The project includes:

1) Review of existing studies and data in Myanmar, studies covering issues related to Universal Health Coverage, older adult social and health care, ageing and health, social protection, including the Situation Analysis on Elderly Care. A literature review will be conducted, and snowball techniques for identifying unpublished work as part of the consultations listed in #3 below.

2) Mapping and evaluation of plans, policies and legislation related to healthy ageing and universal health coverage.

3) Consultation with key stakeholders (Ministry of Social Welfare, Relief and Resettlement at central level); State/Regional Implementers (public and private at State/Regional level and EHO and private sector representatives about how care services are being provided to older adults, how they are addressed and perceived under individual institutions in each State/Region

In addition, the study will attempt to consult with stakeholders from Non-State Actors, ethnic health organizations and other private sector organizations and groups in a selection of States/Regions.

1.4 Structure of the report

This project target data and policy that addresses the inclusion of older people in health and social services in Myanmar. An additional focus is extracting any data on the economics of ageing- noting the limited amount of data currently available to generate cost of illness estimates or to cost out sustainably supplying age-friendly essential health packages.

This project aimed identify and map available data for descriptive and economic analyses that will begin the process of identifying returns on investments in ageing, but there is no economics studies related to the health and social care for elderly in Myanmar except the out of pocket (OOP) expenditure. This project primarily try to identify data to examine the economics of ageing, cost of illness and quantity and quality of health and social services accessible to persons aged 60 years and older across Myanmar. This study highlights the gaps in how evidences are used in policy development. According to the available of the

data and limited study and report related health and social care for elderly in Myanmar context;

(a) Chapter 2 presented to understand and oversee the context of Myanmar health system and health financing system; and International elderly care situation

(b) Chapter 3 of this review is mapping the available main source of study (national level) that focus on and or related to the elderly area from the perspective of UHC outcomes; which are in terms of study related to (a) the financial protection (b) equity (c) access and (d) quality;

(c) Chapter 4 is the policy review/analysis and bottleneck analysis from the available evidence and validated by consultation with various stakeholders who are included in the elderly related policies and law development process. In the meantime, the international published literatures that are supporting in the informing/developing elderly health and social care policies are also reviewed. In implementing UHC, the essential health services (EHS) are needed to be from the evidence-based interventions. Moreover, prioritizing a high-functioning primary health care system, which is costed, funded and implemented, the essential health care service package is a cornerstone for UHC. Therefore, the systematic review of international published literatures related to the health economics study of the health/social care interventions on elderly in Asia was applied. The grey literature and other sporadic studies conducted in Myanmar also outsourced and reviewed accordingly. Review of National Health Plan (2017-2020) and National Social Protection Strategic Plan (NSPSP) is presented as a case study.

(d) Chapter 5 details the findings from consultation with different level of stakeholders along with the quantitative and qualitative study in Mudon Township.

(e) Chapter 6 discusses the challenges and gaps in Myanmar elderly policy and recommendations for the stakeholders and policy makers based on the findings and lessons learnt from other countries.

(f) Chapter 7 is the recommended elderly inclusive policy framework for Myanmar in moving toward UHC 2030

CHAPTER 2

2.1 Myanmar Country Context

2.1.1 Myanmar General Health Profile

According to the 2014 Census, Myanmar had a population of 51.48 million, of which 51.78% were female. The health status of the Myanmar population is poor both in absolute terms and by comparison to other countries in the region. Life expectancy at birth in Myanmar is

64.7 years, the lowest among ASEAN countries(Ministry of Health and Sports, 2016). The maternal mortality ratio (MMR) is the second highest among ASEAN countries at 200 deaths per 100,000 live births. The under-five mortality rate (U5MR) is 51 deaths per 1,000 live births, as compared with 12 in Thailand and 29 in Cambodia. Malnutrition is highly prevalent with over a third of children under-five stunted(Ministry of Health and Sports, 2016). Human Immunodeficiency Virus (HIV) prevalence (361 per 100,000), and TB incidence (373 per 100,000) are the third and second highest respectively among Association of Southeast Asian Nations (ASEAN) countries(World Health Organization, 2016a). Despite little available data, rates of non-communicable diseases (NCDs) are believed to be increasing rapidly with an estimated 40% of mortality attributable to NCDs.

Approximately 70% of the Myanmar population live in rural areas. To serve this population the health system is networked by 1,815 rural health centres (RHCs) under the administration of Township Medical Officers. Each township serves approximately 100,000 to 300,000 people and is responsible for providing primary and secondary care services.

Urban areas are served by township hospitals, urban health centres, maternal and child health centres and school health teams. In rural areas, township health departments oversee 1-3 station hospitals and 4-9 RHCs. Each RHC has 4-7 satellite sub-rural health centres; each of which is staffed by a midwife and a public health supervisor grade-II (PHS- II). Outreach services are provided by midwives supported by volunteer auxiliary midwives (AMWs) and community health workers (CHWs) (Ministry of Health and Sports and UNFPA, 2017).

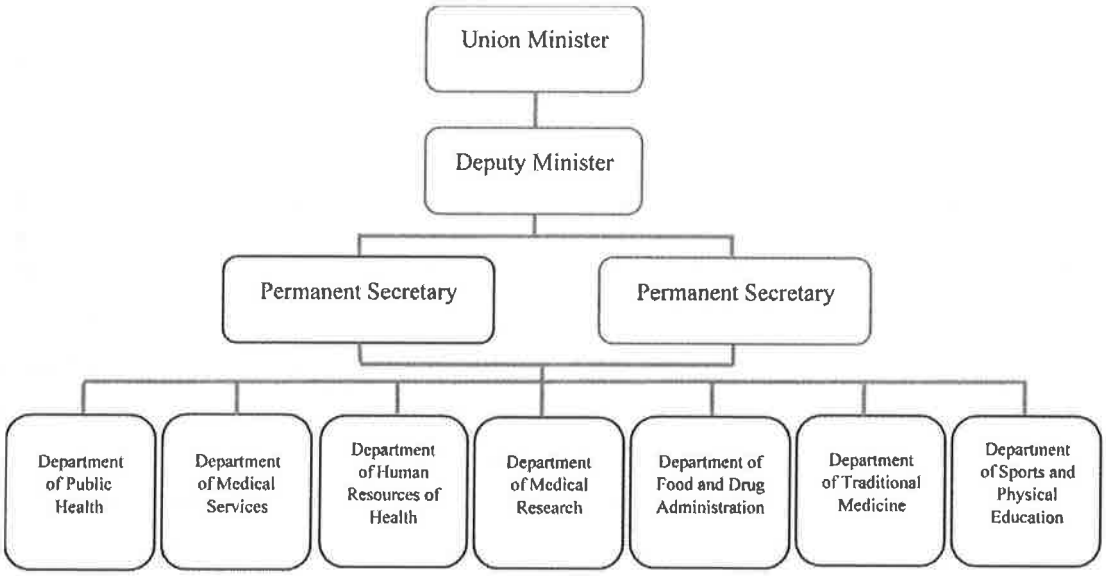
Substantial health disparities exist along geographic, ethnic and socio-economic lines. MMR ranges from 357 (in the Chin State) to 213 (in Yangon) per 100,000 live births, and U5MR ranges from 108 (in Magwe) to 48 (in Mon) per 1,000 live births. The 2014 Census demonstrated that children from poorer households were more than twice as likely to be malnourished compared to better-off households. Only 69.5% of the population have access to improved drinking water (2014 Census) and 74.3% have access to improved sanitation(Department of Population, 2015).

Overall and generally, Myanmar has made good progress on health indicators but did not fully achieve the health related Millennium Development Goals (MDGs), so inequities in health outcomes and coverage remain. The burden of disease is now towards non-communicable diseases, an emerging challenge for future health planning and actions in Myanmar. Out-of-pocket personal spending constitutes a disproportionately large share of

total health spending in Myanmar; and public investment remains low for achieving the UHC vision. The availability and distribution of human resiurces and health infrastructure is unequal across the country. Information for evidence-based decision making is limited both in its availability and use. Moreover, there are increasing complex influences on health status and outcomes, with both causes and effects beyond the health sector, requiring a multi-sectoral approach to population health and sector development.

2.1.2 Health care organization and delivery

Private and public sectors provide health care services in Myanmar. The National Comprehensive Development Plan (NCDP) is implementing by the Ministry of Health and Sports (MOHS), and the main body for healthcare provider is served by the Department of Health – a department of the Ministry of Health and Sports, facilitating all aspects of health for the whole population with 6 departments (Figure 1)(Ministry of Health and Sports, 2019). The public health department is responsible for primary healthcare and basic health services.



Source: MoHS Website

Figure 1. Organization chart of Ministry of Health and Sports

Conforming to the National Health Policy, NGOs such as MMCWA and MRCS are providing a share of service provision. Local CBOs and other religion-based societies are also providing healthcare nationwide (Figure 2).

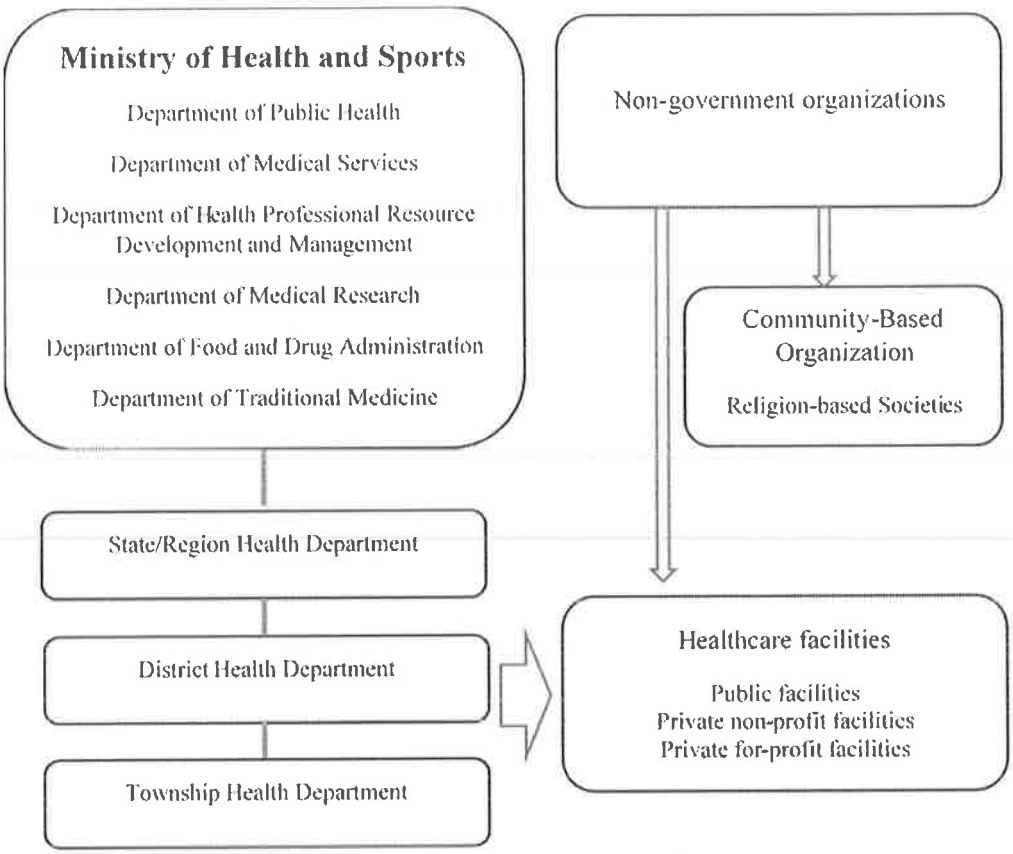


Figure 2. Administrative structure of Healthcare in Myanmar

2.1.3 Healthcare facilities

Public hospitals are the main source for major poor population even though there are numbers of private facilities that are for the wealthy peoples. Public hospitals are categorized into general hospitals (up to 2000 beds), specialist hospitals and teaching hospitals (100-1200 beds), regional/state hospitals and district hospitals (200-500 beds), and township hospitals (25-100 beds). In rural areas, sub-township hospitals and station hospitals (16-25 beds), rural health centres (no beds), and sub-rural health centres (no beds) provide health services, including public health services.

According to the latest statistics of 2019, there are 33 Specialist hospitals, 9 teaching hospitals, 11 (500 beds) hospitals, 3 (300 beds) hospitals, 28 (200 beds) hospitals, 2 (150 beds) hospitals, 40 (100 beds) hospitals, 115 (50 beds) hospitals, 150 (25 beds) hospitals, 150 (16 beds) hospitals and overall total 1144 hospitals across the Union in public sectors (Ministry of Health and Sports, 2019). In addition, the distribution of hospitals in Myanmar is based on geographic situation and population.

Table 1. Health Facilities under Ministry of Health and Sports (July 2019)

Health Facilities Under Ministry of Health and Sports

July 2019

NO.	State/Regions	Specialist Hospital	Teaching Hospital	500 beds	300 Beds	200 Beds	150 beds	100 Beds	50 Beds	25 Beds	16 Beds	Station Hospital	Total Hospital	Total Permitted Beds	Station Health Unit	RHC	SRHC
1	Kachin	2		1		1		2	5	13		34	58	2144	22	54	307
2	Kayar			1					1	5		10	17	835	7	21	119
3	Kayin					1		3	2	7		24	37	1159	16	48	273
4	Chin					2		2	4	1		20	29	1145	18	71	369
5	Sagaing			1	1	2		6	11	19		102	142	4457	45	203	1201
6	Thanintaryi					2		1	3	5		28	39	1223	8	42	242
7	Bago			2		1		3	10	14		81	111	3646	35	161	855
8	Magway		1			3		3	8	14		69	98	2954	31	162	898
9	Mandalay	11	2		1	3		3	16	8		65	109	8265	41	122	768
10	Mon	1		1				2	4	3	1	29	41	1655	18	49	306
11	Rakhine			1		1		4	8	4		49	67	2384	21	108	582
12	Yangon	14	3	2		4		1	12	10	4	33	83	11460	11	81	435
13	Shan		2	1		2	2	6	16	34	4	97	164	5766	48	174	921
14	Ayeyarwady			1		5		2	10	12		96	126	4036	93	171	1306
15	Naypyitaw	5	1		1	1		2	5	1		7	23	4137	2	27	166
	Total	33	9	11	3	28	2	40	115	150	9	744	1144	55266	416	1494	8748

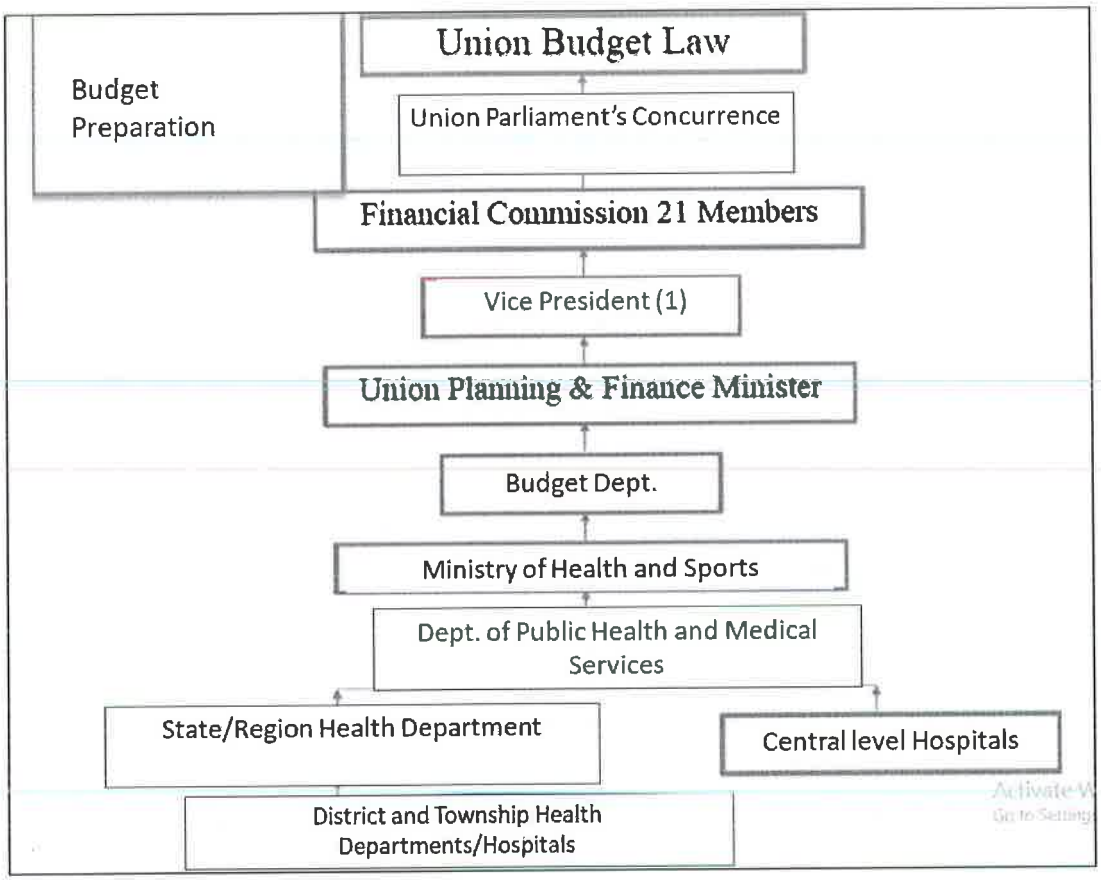
Source: MoHS

In 2016, Beds occupancy for Station hospitals is the highest proportion followed by 25 bedded and 50-bedded hospitals. Specialist hospitals and general hospitals are accounted only for 2.9% and 4.6% among the 1144 hospitals(Ministry of Health and Sports, 2018a). Private sectors also run non-profit clinics for the poor as well. The CBOs and religion-based societies also run the non-profit clinics and it provides ambulatory care. But the facilities for the rich and the poor is limited as the hospital statistics report covers only public facilities (Ministry of Health and Sports, 2018a).

2.1.4 Universal health coverage (UHC)

Ministry of Health and Sports is implementing the UHC program over the whole country and it is aim to achieve its goals in 2030; with the 3 UHC components; (1) population coverage (2) service delivery and (3) financial protection. Firstly, Myanmar government set priorities in the access to health care improvement through a better and efficient referral system i.e. strengthening the primary health care in township levels. Secondly, ensuring all levels of populations in health system could get safe, effective and quality generic medicines. Achieving the UHC goals for Myanmar is very challenging because of the shortage of qualified medical staff, inadequate medical equipment, the healthcare infrastructure is weak, and the insufficient of public expenditure in health. Moreover, UHC in Myanmar is still far away to be achieved as the health service coverage is still low, out of pocket expenditure is high, and access to care is also inequity (Han et al., 2018).

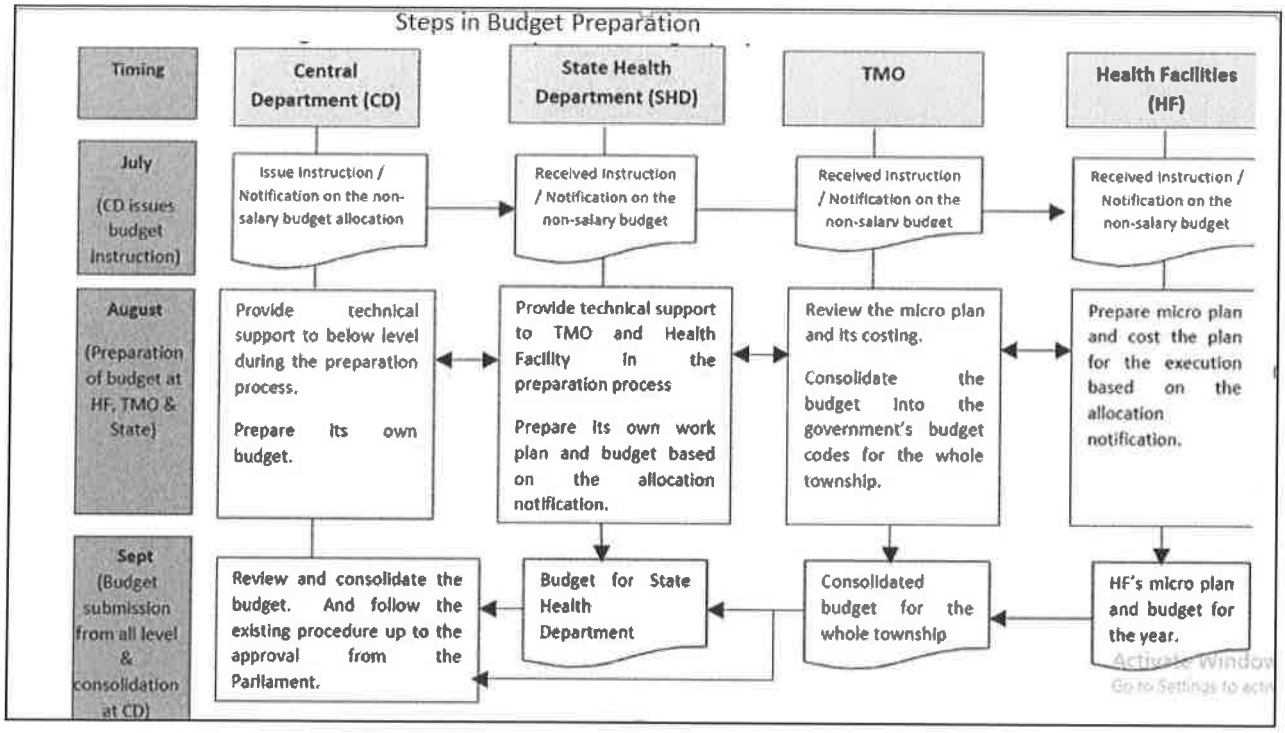
2.1.5 Government Budgetary Preparation, Approval Mechanism and Spending for MoHS



MoHS=Ministry of Health and Sports

Figure 1: Budget Preparation, Approval and Spending for MoHS

Budgeting Preparation Steps (Ministry of Health and Sports)



CD=Central Department; HF=Health Facilities, TMO=Township Medical Officer

Figure 2: Budget Preparation Steps

Fund flow mechanism, allocation, risk pooling

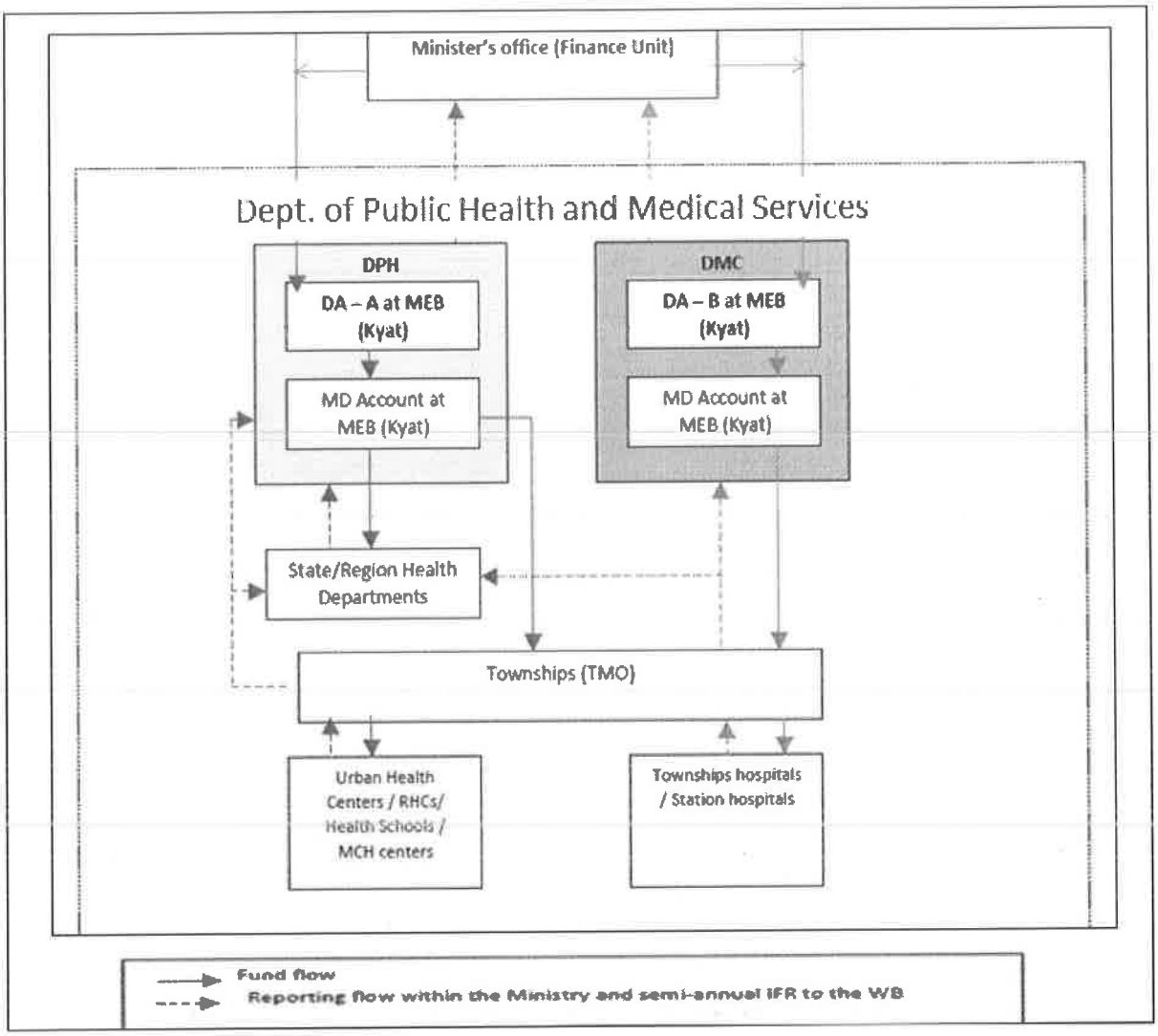


Figure 3: Ministry of Health and Sports Fund Flow Mechanism

2.1.6 Human resources

Human Resources for Health (HRH) is the foundation of a health system (Anyangwe and Mtonga, 2007) that improves the coverage of health services and enables people to enjoy the right to health (World Health Organization, 2016a), (Campbell et al., 2013). Good management on the HRH also promote healthcare quality (Campbell et al., 2013), (Ramadevi et al., 2016). The worldwide demand for an available, accessible, acceptable, and high-quality healthcare workers have been higher than ever (World Health Organization, 2016a), (World Health Organization, 2006) since the WHO has at first evaluated the crisis of labor shortages in healthcare more than ten years ago in the World Health Report 2006(World Health Organization, 2006). The availability, accessibility, acceptability and quality of healthcare workforces are equally important(Latt et al., 2016).

Health services in Myanmar are provided by public, private and non-governmental organizations (NGOs) and ethnic health organizations (EHOs). The health system is decentralized, with patients at the station / village, in the municipality, in the district, state / regional and national level.

The essential of HRH in Universal health Coverage (UHC) and the Essential Package of Health Services (EPHS) has been highlighted in the Myanmar National Health Plan (2017-2021)(Ministry of Health and Sports, 2016). Particularly, in the 2017-18 Annual Operations Plan (AOP), the formulation of an HRH strategy to strengthen primary health care is prioritized to provide a baseline package for EPHS in the current NHP planning period; and lay the foundation for later expansion to the next phases of EPHS.

An important and ongoing problem is the lack of a central HRH database and the lack of private sector information that makes it difficult to track current trends and predict future healthcare professional needs. Myanmar is developing a Consolidated Human Resources for Health Information and Planning System (CHiPS) system for the healthcare community, but this is not yet complete(Ministry of Health and Sports, 2018b). The National Health Plan 2017-2021 points out that there are 1.33 healthcare workers per 1,000 population in Myanmar compared with WHO's recommended threshold of 4.45 per 1,000 population required for Universal Health Coverage(World Health Organization, 2016a).

2.1.7 Service availability

The median age of the Myanmar population is increasing due to lower fertility and mortality(Worldometer, 2019b). With the increasing number of older people, there is a growing demand for public health systems and medical and social services(Worldometer, 2019a). Chronic illnesses that disproportionately affect the elderly contribute to disability, poor quality of life, and increased costs for health and long-term care. The increasing of life expectancy, in part, reflects the success of public health interventions, but public health programs are now driven by this achievement, including chronic illnesses, injuries, disabilities, psychological disorders and increased concerns about future care and the issues arise must be addressed as well as the medical costs.

Geriatric medicine, or geriatric care, is a specialized field focused on the health management of the elderly. It aims to promote health by preventing and treating illnesses and disabilities in the elderly. As people age, their physical health becomes fragile. Their psychological health is also increasingly at risk due to the effects of negative life events such as accumulated traumatic experiences and poor social and economic factors. Therefore, elderly health care must address these conditions in order to provide elderly-friendly services.

In order to fulfil these services, it is essential to identify how many facilities are ready and how many services are available in the country including private sectors. These data are also crucial for development of policy and strategy for elderly health care. Historically, nationwide service availability and readiness assessment was conducted in 2014 for the overall area of health care services using WHO SARA tools but there is no elderly specific SARA(Ministry of Health and Sports, 2015). However, so far, there has been little information about geriatric facilities available at public and private medical institutions.

Therefore, to better understand Myanmar's health facilities and inform its policies, strategies, and plans for health care for the elderly; it is still needed and important to obtain baseline data and evidence-based information; of assessment on service availability and

readiness for elderly care, and on scaling up interventions to improve service delivery in the healthcare area.

2.1.8 Health service utilization

A recent study revealed that 60% of elderly has at least one morbidity and more than 30% of elderly people are with multi-morbidity(Aye et al., 2019). The elderly who live in rural areas and those who are not educated were less likely to report multi-morbidity. Older women, and who self-reported poor health status were more likely to have multi-morbidity. For the older people who living in rural areas has less access to health care than the urban areas residing elderly as their chronic conditions may have gone undetected. The majority of elderlies in rural area where there is no project cover are still facing several challenges for their health care(Moe et al., 2012). This means that there might be a difficulty in access to health services for elderlies. Moreover, rural elderly people has possibly low health care seeking and unsafe socio-demographic condition. Poor elderlies are reported to be more likely to skip getting treatment than those elderly with income above the poverty line are. In addition, those with low education status are more likely to skip getting treatment than those with higher education status. However, there are significant differences in health care utilization pattern were found in upper and lower Myanmar. Moreover, the most frequent health-seeking place was rural health center, which is common in rural population, and the second most was private practitioners(Moe et al., 2012). Although health service utilization is not so poor, it is important to raise awareness among urban families to improve healthcare utilization (SoeAung et al., 2016).

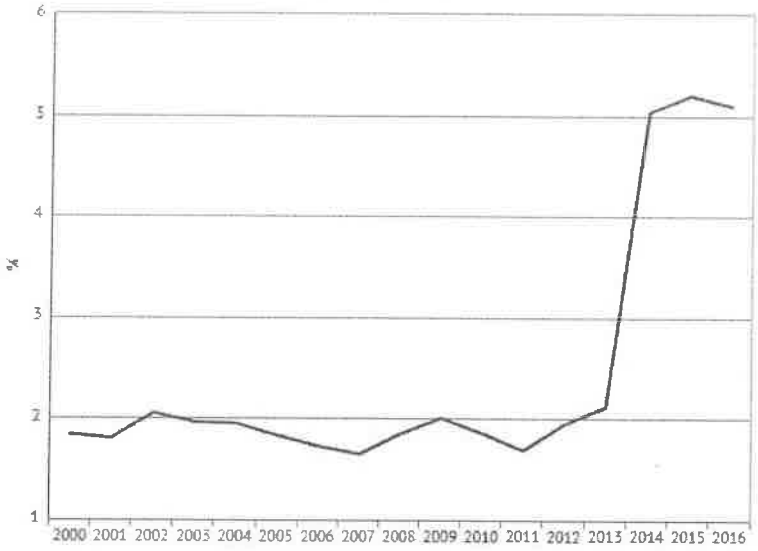
2.1.9 Health financing

Myanmar is the highest out of pocket expenditure rates among ASEAN health care spending, 73.98% as of 2016 (The World Bank, 2019). Although public hospitals provide such proportion of treatment charge, it is slightly improved but the out of pocket expenditure is still considerable high comparing OOP from the past few years ago. There were healthcare subsidies from public hospitals and the hospitals is overcrowded as the infrastructure is still weak, and numbers of patients were unable to stay in hospital rooms. People who have considerable high income tend to use private hospitals in hoping of getting better healthcare services.

Myanmar government has been increasing the public budget for health and education sectors since 2011. Government health expenditure increased from USD 279 million in 2012-2013 to USD 789 million in 2017-2018, but this still represents just over 1% of Myanmar GDP(Chang et al., 2019). And these funds are earmarked 11 for purchasing health technology, providing government employees provision of cares and other infrastructure developing activities.

Government Expenditure on Healthcare (2012-2018), USD Millions graph

What is Myanmar health expenditure as a share of GDP?



DATE	VALUE	CHANGE, %
2016	5.1	-2.04 %
2015	5.2	3.26 %
2014	5.0	138.28 %
2013	2.1	8.50 %
2012	1.9	15.32 %
2011	1.7	-9.11 %
2010	1.9	-7.42 %
2009	2.0	8.60 %
2008	1.8	11.97 %

Figure 4: MM Health Expenditure as Share of GDP (Ref: World Bank World Indicator Report 2018)

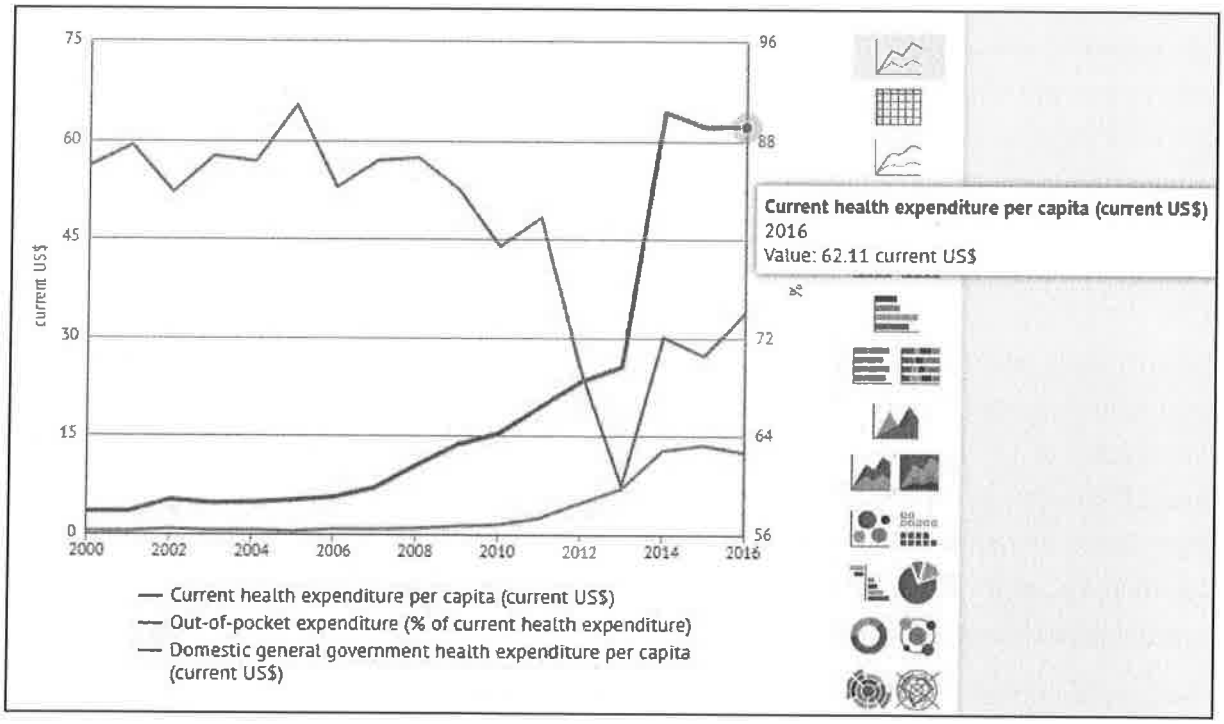


Figure 5: Myanmar Health Expenditure Domestic Government, Current Health and OOPE

(a) Insurance and OOP spending for health

73% of Myanmar's health services paid through out of pocket by citizens (The World Bank, 2015, World Health Organization, 2015b). In 2012, the Ministry of Health of Myanmar estimated that the amount of government funding is only 23% of total health expenditure. Government spending on health is low compared to neighboring countries such as Thailand, Vietnam and India (World Health Organization, 2015a). The Ministry of Labor is currently offering the only health insurance in Myanmar, the so-called Social Security Scheme (SSS), which was introduced in 1956. Of the 53.7 million people in Myanmar, only about 600,000 individuals are covered, meaning that these individuals make a percentage contribution to

their income and entitlement to certain categories from employees of state-owned enterprises, civil servants and employees of public and private companies with more than 5 employees(De la Puente, 2014). Citizens who are not enrolled in the social security scheme have to pay for the health services out of their own pocket. Due to the high percentage of disbursements in Myanmar, poor and other disadvantaged groups, who often seek medical help, are particularly vulnerable to catastrophic financial consequences if they need medical help. To protect these groups and middle-income groups, there is an urge to design and implement a national health insurance mechanism that can provide universal protection. Myanmar government has devoted to provide general health insurance by 2030(World Health Organization, 2011).

The need to design and implement a nationwide health insurance system with an appropriate package of benefits and cost sharing is one of the strategies to consider. In order to improve the availability of health services, efforts will be made to develop a national health financing policy aimed at adequate funding, resource efficiency, financial sustainability and capacity for better management of available resources. The establishment of a universal risk-pooling mechanism to allocate health costs and reduce disbursements will help to prevent catastrophic health expenditure for poor and disadvantaged people and to ensure access to health services (Smith and Witter, 2004, Majumder, 2012). There is no study conducted to find out which type of health financing system is most appropriate although the need for general health insurance in Myanmar is recognized.

2.2 Global Policy review on aging

Demographic transition of aging and its imminent threat to health and wellbeing of elderly population is a stimulus to the global health community. Consequently, rights on health care and quality of life has been considered for aging population. In September 2011, the UN Special Rapporteur on Right to Health submitted to the Human Right Council in Geneva on importance of rights-based approach to health care of elderly people towards active and dignified aging. In 2012, WHO devoted the World Health Day to aging with emphasis on improving health and quality of life of elderly people.

Policy amendment to adept transition of aging has been significantly noticeable in many developed countries. Norway, Sweden, United States, Netherlands and Japan are top five countries according to the aging society index score (Chen et al., 2018). In Norway, the new equality and anti-discrimination law for aging was approved by Parliament in 2017 to forbid age discrimination in working life (MLSA Norway, 2017). In Japan, the parliament voted in early 2000 to raise the retirement age to promote productive lives of elderly. In the United States, more proportion of GDP was devoted to social security by Congressional Budget Office and budget allocation to Medicare and Medicaid will improve up to 17% by the year 2040 (Hinrichsen et al., 2010). Such policy initiatives would improve dignity, quality of health care and encourage self-resilient of elderly population in the effluent societies.

In contrast to the developed countries, many developing countries are simply unprepared for policy formulation or amendment for aging population, because there has been a massive disconnect between the Millennium Development Goals (MDGs) and aging in their development agenda (Shetty, 2012). The complacency and system limitation towards ageing in developing countries is reflected in how health systems cater to older people. Consequently, developing countries are fast running out of time to formulate and implement adequate policy solutions to cope with their rapidly growing ageing populations.

2.2.1 World Health Assembly Resolutions related to Aging and Elderly Care

The World Health Organization is a leading agency for providing elderly health care policies to its Member States. Recalling resolution WHA52.7 (1999) on active ageing resolution and WHA58.16 (2005) on strengthening active and healthy ageing, both resolution encouraged Member States to take measures that ensure the highest attainable standard of health and well-being for the rapidly growing numbers of older persons. Furthermore, WHO changed broader paradigm for elderly health care beyond 2010. WHA65.3 (2012) on strengthening non-communicable disease policies to promote active ageing, WHA67.19 (2014) on strengthening of palliative care as a component of comprehensive care throughout the life course and WHA64.9 (2011) on sustainable health financing structures and universal coverage to increase assess quality of elderly care.

2.2.2 Global strategy and action plan on ageing and health WHA69.3

In May 2016, the *Global strategy and action plan on ageing and health* was adopted by World Health Assembly (WHA 69.3) in order to ensure both longer and healthier lives of elderly people. This Strategy focuses on five strategic objectives to achieve Healthy Ageing for all. The principles of global strategy focused on dignity and human rights, including the right that older people have to the best possible health. The strategy was accountable for gender equality, equity in economic status and social determinants, non-discrimination on aging, progressive realization and intergenerational solidarity, which enabling social cohesion between generations.

2.3 The Universal Health Care (UHC) for aging population

Universal health coverage (UHC) is defined as all people having access to quality health services without suffering the financial hardship associated with paying for care is the overarching vision for health sector development (WHO, 2013a). In 2016, UHC: Moving Towards Better Health, an action framework was developed to support countries in realizing vision of better health through UHC. It outlines shared principles of UHC and reflects the values of the WHO Constitution, the Health for All agenda set by the Alma-Ata Declaration in 1978 and multiple World Health Assembly resolutions. The health system attributes for UHC include quality, efficiency, equity, accountability, sustainability and resilience (World Health Organization, 2016b). Achieving a sustainable UHC requires action in three broad

policy areas: adequate financial coverage for cost-effective services, right tools to diagnose financial sustainability and innovative service delivery to maximize the efficiency of health spending (Pearson et al., 2016).

Major innovations are underway that accelerate progress in attaining UHC for older populations. The renewed commitments under the Sustainable Development Goals to achieve UHC offer a unique opportunity to invest in the foundations of the health system of the future (Barber and Rosenberg, 2017). In order to achieve UHC pathway for elderly care the following issues has to be considered.

- Chronic diseases are common in elderly, which need early investment in cost-effective public health policies.
- A shift from focusing on diseases-specific programs to health system strengthening and investing the foundation for health system is required to achieve UHC.
- Benefit package under UHC is required to determine whether the package will promote healthy gaining and respond to the needs of older people.
- Patient-centered service delivery design is essential because older people demand services for continuous management of NCDs.
- Implementing a strong primary care system requires shifting investments in infrastructure and deployment of human resources to primary facilities and health networks.
- Health care for older persons goes beyond doctors and health facilities and the new technologies are required to save cost, engage older persons, family and their caregivers.
- Older persons require not only health care but also social interaction, physical activities, and non-medical help to enable them to stay in their homes.

2.3.1 UHC and elderly care in UK

In UK, more than one in five citizens are over 60 and people over 60 is expected to increase from 14.9 million in 2014 to 18.5 million in 2020 (ONS, 2015). Majority of elderly people over 75 years old have long term condition which need comprehensive elderly care and the National Health Services (NHS) was struggle to meet the increasing demand for resource as well as changing patient needs. UHC approach is one of the solution for aging crisis, which is essential for elderly to support to remain health and independent as possible in the community and they received the highest quality of care when need without financial hardship (Alderwick and Dixon, 2019). NHS developed Long Term Plan in January 2019 designing the new service model for the 21st century. The new NHS elderly care policy sets strategy to;

- Reframe infirmity as a long term condition to be prevented by promoting proactive case finding and managed to target prevention strategies (aging with multiple long term conditions)

- Support public services to work together to support older people (such as rescue, social welfare, safe home visit to identify common health and other hazards)

- Enhance Health in Care Homes (EHCH) Vanguards services and support older people live with multiple long term condition (dementia, delirium) in care homes and those who require support to live independently in the community.

- Extend primary and GPs network to provide elderly care in the community and provide toolkits for General practices (GP) and practice staff to support older people.

- Promote community based care for elderly by developing a practical guide to health aging for self-care of elderly and guideline to healthy caring for family members and caregivers.

- Identify unpaid care givers, and strengthen support for them to address their individual health needs by introducing best-practice quality market for primary care

2.3.2 UHC and elderly care in Japan

Japan symbolizes the development of policies speedy and high aging society and become a model for all aging countries in Asia. The country succeeded in developing UHC through social security system that costs half as much and often achieves better medical outcomes than its American counterpart (Wang, 2018). In order to harmonize the goal of UHC, the government increased budget on medical care to developed medical technology and balanced pricing mechanism by imposing regulations on medical facilities.

Japan has invested proportionately in primary, secondary and tertiary prevention, especially for hypertension and diabetes in elderly, and therefore has both long and healthy life expectancy even in old age (Barber and Rosenberg, 2017). Japan focused on three steps to develop carrying system for elderly by paying attention to political pressure on health system in formulating strategies based on;

- Improving efficiency of health care system by improving effective network of care
- Building up and integrated home-based healthcare system,
- promoting the long-term care for elderly,

This reduced the rate of un-necessary growth of hospital services, empowered PHC stakeholders on decision making and supported the health system to formulate long-term care strategies for aging people (Bloom, 2019). Furthermore, Japan demonstrated the success of patient-centered models by identification of workforce needs to achieve the right skills mix, including the recognition of the general practitioner as central to the system. Integrated and routine services for older patients, such as, ensuring medication, appointment adherence, identifying early warning sings and ensuring appropriate nutrition and exercises are provided by allied health workers within a network of supportive care.

Japan also ensured the public-private partnership investments for elderly care, where there is a long history of private hospitals using social health insurance and state budget funding to advance hospital-based contributions to UHC (Chu et al., 2019). The role of the private sector in the provision of health care services dominates the hospital and primary health care (PHC) sectors in Japan. It is important to ensure two-way referral, so that PHC facilities can ensure continuity of care when people are discharged from hospital. In some cases, hospitals establish outreach clinics to reduce the pressure on outpatient departments (World Health Organization, 2018a).

At the other end of the health care spectrum, Japan promoted innovations for elderly care, such as tools for decision aids to empower multiple treatment and telemedicine to expand access to specialists for elderly care (Garvelink et al., 2016). With increasing income and levels of health awareness, these tools may facilitate discussions with patients and family about their ability to comply with treatment recommendations, personal preferences, and impact on quality of life(Barber and Rosenberg, 2017).

2.3.3 UHC and Elderly care in China

There are four main challenges to addressing the health and social care needs of older people: (a) access to affordable health care, (b) equitable distribution of health-care resources, (c) efficient and quality care, and (d) adequate coverage for health expenditure(World Health Organization, 2015a). China's experience illustrated that several policy reforms were being encountered to improve elderly care in UHC approaches (Bloom, 2019). Those includes

- increased hospital beds and promote long-term care
- introduced new insurance scheme to cover rural and urban residents,
- (re)-training health personnel for elderly care
- changing inappropriate financial incentives and
- strengthening monitoring of performance, and
- ensuring better coordination, including private sectors.

National policy attention is turning to Long-term care (LTC) policy in China, which represent new frontier of public response to aging and economic development. Recent government policy documents (No. 80 of the Ministry of Human Resources and Social Security, June 2016, and No. 200 of the Ministry of Civil Affairs, July 2016) both encouraged LTC systems. LCT used to be primarily a family responsibility is now the subject of systematic policy. Long-Term Care Medical Insurance (LTCMI) programme has been adopted by central and local government. LTCMI was designed to deliver medical services outside a hospital environment, redistributing health resources and utilization from top- to lower-grade hospitals/clinics. Under this policy, about 500 urban institutions had acquired qualifications to provide services to recipients by the end of 2016(Lu et al., 2017).

In China, hospitals generate majority of revenue from payments by patients and insurance schemes and have had many flexibilities in the investment decisions (WHO, 2015b). Policy on hospital reform strengthened the governance arrangement by specifying hospital mandates on quality of care, integration of inpatient and outpatient care and establishment of mechanism for monitoring performance on elderly care. Government improved the capacity of hospitals to provide cost-effective inpatient care by training hospital managers and establishing hospital management system. This reduced unnecessary use of diagnostic equipment, drugs, and surgical interventions and to reduce the length of hospital stays (World Bank Group et al., 2016).

The experience of China illustrates managing major health system reform to promote elderly care in rural area by village doctors, the first contact for most rural residents in the county. Evidence-based clinical pathways for stroke and chronic obstructive pulmonary disease demonstrated that clinical practice can be altered by retraining health workers and monitoring their performance (China National Health Development and Research Centre and National Institute for Health and Care Excellence (NICE) International, 2018). In the 2000s, township health centers were responsible for monitoring and improving the

performance of village doctors. In the late 2000s, the government earmarked funds for PHC services, including the management NCDs and elderly care.

The Government changed financial incentives mechanism by removing the opportunity to earn money from selling drugs and by increasing allocation of government funds. Some intervention focused on modifying payment mechanisms that reward costly styles of medical care (Jian et al., 2015). Innovative approach in Henan Province demonstrated that combination of treatment guideline at different levels of care, case-based payments and provider performance monitoring mechanism in PHC leads to better control of NCDs and strengthen local service for elderly (Shi et al., 2015).

Furthermore, development of digital health services and private-public partnership was improved for elderly in China. In 2014, MOH set policy to outline specific areas for private-sector growth, including premium services, rehabilitation and geriatric care (Cowley and Chu, 2019). These services include online pharmacies with door-to-door delivery, online medical advice services, and support for the management of chronic health problems using digital devices to monitor health indicators. The private investment in this sectors amounted to 15.75 billion RMB (2.5 billion USD) in 2015 (Mehl and Labrique, 2014).

2.3.4 UHC and elderly care in Vietnam

Economic development and innovative policy interventions lead to large gain in health outcomes and access to health care in Vietnam. Between 1991 and 2010, government health spending increased 13 times in real terms. Funding for health care of elderly dramatically increased by Ordinance on the Elderly (2000), Law on the Elderly (2009), and Law on the Disabled (2010). The Law on Social Health Insurance (SHI) was passed in 2009 and established a nationwide social health insurance program in attempt to achieve UHC(Matsushima and Yamada, 2014, Somanathan et al., 2013).

Although multiple funds and schemes were created over the course of the reforms, Vietnam consolidate these into a national insurance program to enhance harmonization and redistribution as benefit packages. A set of policy measures and quick actions, including prioritization of government expenditure and proactive consolidation of insurance schemes expended the coverage expansion and financial protection (Barroy et al., 2014). The enrolment rate of SHI has been increasing gradually and the coverage rate reached 71 % in 2014 (Somanathan et al., 2014).

Under Decree 93/2014, public health facilities are allowed to use joint venture or cooperate resource to improve the facility. The move towards autonomous public hospital is one aspect of Vietnam social mobilization policy that lead to improve public-private-partnership in elderly care (Cowley and Chu, 2019). This attempt improved not only technical efficiency of elderly care in hospital, but also controlling the costs of hospital-based care, especially through the use of case-based reimbursement methodologies, such as diagnostic-related group bundled payments, which may help increase the quality of medical care.

Elderly people over 60 are more-likely to choose higher level public hospital where they could receive more advance and better treatment. In addition, most of the elderly over 80 years old received health insurance from the government for free (MOROOKA et al., 2017). The private sectors contribute toward the attributes of quality, accountability, equity, and efficiency of service provision, in order to best support a mixed health care system moving to achieve UHC (Morgan et al., 2016).

Despite sizable investments to strengthen service delivery, human resources for health remain a core concern for effective health coverage on elderly care in Vietnam. Recent policy initiatives on allowing public professional to practices in private sectors helped to increase the availability of practicing health professionals, particularly in poorer regions. The first initiative provided financial incentives to health workers in rural areas and the second was the "rural pipeline" strategy, which provided training for assistant doctors from rural areas who wished to become medical doctors in rural areas. A similar policy was used for pharmacists and nurses from disadvantaged and minority groups (Barroy et al., 2014).

The National Assembly played a key role in refining the provisions of the law. Consequently, the law passed in November 2008 was different from the initial draft on reform of co-payment rates and decentralized number of target groups. Prime Ministerial Decision 538, of March 29, 2013, approving the project to implement the roadmap toward universal health insurance coverage for the period 2012–15 and 2020 (Somanathan et al., 2013). Such decentralization allowed new actors to emerge in the policy development process for UHC and elderly at the province and district levels. Furthermore, International agencies can play an important part in exposing the Vietnamese to new ideas to expand UHC and elderly care.

2.3.5 UHC and elderly care in Malaysia

According to the department of Statistics Malaysia, number of older person will increase to 3.3 million, 11% of total population. The Ministry of Women, Family and Community Development formulated National Policy for Older Person in January 2011 through 5 dimensions Frameworks: healthy aging (health), active aging (social), positive aging (spiritual), supportive aging (environment) and productive gaining (economy). 6 strategies were outlined in this policy, namely: (i) Promotion and Advocacy; (ii) Life-long Learning; (iii) Safety and Security; (iv) Governance and Shared Responsibility; (v) Intergenerational Solidarity; and (vi) Research and Development.

In view of the need of a more effective, coordinated and comprehensive health care in UHC for active aging the Ministry of Health developed the National Health Policy for Older Person in 2008. The NHP adopted the following guiding principles for elderly by maintaining autonomy and self-reliance, recognizing the needs of elderly, supporting care givers, promoting healthy aging, providing continuity of care and maintaining the rights of elderly to quality of life and death. Through this Policy, the Government has made a commitment to

ensure older persons will achieve the optimal health through integrated and comprehensive health and health related services. Under this policy, 7 strategies were identified as follow;

- Health Promotion;
- Provision of a Continuum of Comprehensive Health Care Services;
- Human Resource Planning and Development;
- Information System;
- Research and Development;
- Interagency and Inter-sectoral Collaboration; and
- Legislation.

The social insurance has played important role in attempt to implement Malaysia's elderly strategy. The country has a well-established government PHC service and many private medical clinics that serve urban residents. The MOH issued national protocols for NCD management in PHC clinics (Yiengprugsawan et al., 2017). It is mandatory to link PHC services and national protocol with other measures aimed to improve performance of NGO's service provider in order to meet the demand of elderly. The combined measures were taken to reorient government PHC facilities to meet the needs of an aging population more effectively and to improve the performance of private health service providers (Mustapha et al., 2014).

2.4 UHC and National Health Planning processes in Myanmar

Among the 2.3 million persons who reported having a disability in Myanmar, 1.8 million live in rural areas, amounting to a rural share of persons with a disability of 77%. Furthermore, the country is facing a critical shortage of health care staff fewer than 23 heath-workers per 10,000 people (Help Age report, 2018). Currently, LTC policies for health do not exist in Myanmar. However, the government is keen to invest in social protection programs directed to the most vulnerable in society, including frail older persons in need of LTC (Knodel and Teerawichitchainan, 2017). Therefore, access to health care for elderly and disability is required to be addressed at township health systems through UHC pathway.

In 2016 December, the Ministry of Health and Sports launched the National Health Plan 2017-21 (NHP) which aims to strengthen the country's health system and pave the way towards Universal Health Coverage (UHC). The NHP defined UHC as all people having access to the needed quality health services without experiencing financial hardship. The main goal of NHP 2017-2021 is to extend access to the Basic Essential Package of Health Service (EPHS) to entire population by 2020 while increasing financial protection. The NHP focuses on system building on human resources, infrastructure, service delivery and health financing to provide EPHS through government sectors, ethnic health organizations, NGOs and private general practitioners.

Several actors participated in series of workshops and consultation on building blocks of health system and UHC in the process of formulating NHP. Those actors included

representatives from parliaments, from the various Departments and Programs of MOHS, health authorities at State/Region and Township levels, from the NLD Health Network, from Ethnic Health Organizations, from the various Councils and Professional Associations, from civil society, from private sector, from development partners, as well as independent experts and academics. During the NHP formulation process, actors actively involved in series of consultative discussions to link target group, the health system building blocks and specific disease control programme, including elderly care.

As the NHP aims for provision of EPHS through public and private service providers, cohesion of existing MOHS health programme, NGOs, ethnic group and private sector for provision of EPHS is crucial for NHP implementation. Elderly care is one of the project under lifecycle programme and it is cross cutting with other health programme. However, it was not practice widely by other service provider apart from the national programme. Strengthening other building blocks, such as, human resource, infrastructure and procurement were discussed during NHP formulation to provide comprehensive elderly services.

The NHP Implementation and Monitoring Unit (NIMU) was established by the MOHS to oversight NHP implementation and harmonizing provision of EPHS with various service providers. The NHP monitoring framework was developed to monitor the progress. However, there were no specific indicators for the elderly health care included in the NHP monitoring framework. Linking SDG and inclusion of indicator for elderly care is required for next revision of NHP monitoring framework.

2.4.1 The law for Senior Citizens Myanmar (No 44/2016)

Myanmar needs comprehensive national strategy addressing multidisciplinary aging care to ensure effective implementation and coordination of programs for older persons. The National Social Protection Strategic Plan launched in 2014 by the Ministry of Social Welfare, Relief and Resettlement is particularly promising. It incorporates two programs directed to older adults involving establishing social pensions and promoting Older Person Self-Help Groups (OPSHGs) (Knodel and Teerawichitchainan, 2017).

The new law for Senior Citizens (No 44/2016) was promulgated in December 2016 by Union Parliament. The law addressed the rights of elderly, responsibility of relatives, responsibility of community and states. The law covers health and social protection, creating enabling environment, participation in civil societies and institutional care for elderly. In addition, the law includes governance issues, IDs and registration for aging, recognition of INGOs for elderly care and trust fund for aging population.

Under this law, the government established the highest committee for senior citizen care chaired by Ministers for social welfare with nine relevant ministries, representatives from municipal committee and 3 civil based organizations. The committee will oversight enforcement and implementation of the law and coordinate with the Ministry of Health and

Sports for provision of quality medical for elderly, either free or subsidize, and promote elderly health literacy and researches for elderly health care.

2.5 Why elderly health policy in Myanmar?

Myanmar confronts important challenges including demographic shifts and socio- economic transitions during the past few years. In line with the global trend of ageing, the proportion of older persons will be gradually increased due to longer life expectancy and low fertility rates. Majority of elderly care in Myanmar society is home-based family care. As influenced by religious teachings, cultural traditions, and social norms, Myanmar people hold older people in high regard, and take care of them with pride and respect. Therefore, taking care of older people did not constitute a serious social issue in Myanmar till the recent decades(Han, 2012).

However, this situation is subject to change with economic, social, and cultural transitions, which might shift towards a disadvantageous situation in taking care of elderly. Trending situations in the society such as migration of adult children to urban area and leaving old parents at home, coping with rising living and healthcare costs, shrinkage in family size, and engagement of women in paying jobs to support household income rather than being stay home housewives, have caused negative impact on taking care of elderly including the extent and forms of family support. Recent survey stated Myanmar elderly heavily depend on their sons and daughters for financial and material supports, and those without adequate family support are engaged in hard work such as farming to support themselves (Knodel, 2014). As the country's social pensions schemes and health systems are not adequate, financial burden will be heavier if they get sick.

Unfortunately, health status of many older persons in Myanmar is relatively poor comparing to neighbouring country such as Thailand. According to 2012 Myanmar Ageing Study, only one-third (34%) of elderly perceived their health as good or very good, as compared to 43% in Thailand (Knodel, 2014). Non-communicable diseases (NCDs) are also prominent health problems that disproportionately affected elderly population(Department of Population, 2017b). WHO estimates that NCDs account for 68% of all deaths in 2016(World Health Organization, 2018b). This alarming social and health care needs of elderly has called for the Myanmar Government to initiate a strong policy on health protection, social welfare protection and legal protection of elderly population.

In addition, Myanmar has committed to increase cooperation, participation and communication between regional, international and institutional organizations which has brought favourable improvement to elderly health policy since the political reform, took place in 2010. In 2014, Myanmar adopted international guidelines towards the social and economic protection of the older population in its Action Plan on Ageing. In conformity with the 2002 Madrid International Plan of Action on Ageing (MIPAA), and in light of population ageing, Myanmar passed the Law Relating to Older Persons on the 30th December 2016 and