elderly and some have small scale health services provided by practitioners and volunteers; but they are not there in all home for the aged; the home for the aged are managed by independent private body and the department of Social Welfare under the committee of elderly can only provide some financial and social support to some home for the aged.

Chapter 5

Historical Process of Elderly Health Policy

5.1 Historical process of Elderly health policy in Myanmar

Government of Union of Myanmar recognise the fact that successful ageing requires balanced and parallel development in economic, health and social dimensions of older people. Therefore, elderly care programmes were structured under the arms of social welfare provision and healthcare provision in the country's Social Protection Strategic Plan. Care of the elderly is traditionally perceived as the responsibility of the family, community, and the state, but is subsequently recognized as an integral part of the primary health care system as the context changes(The Republic of the Union of Myanmar, 2014).

The **National Health Policy** formulated in 1993 stated ***'Health for All'*** and equitable access to basic health services by those needed. This acts as a main guiding principle towards health and health system development to meet the overall needs of the country, including rural and border areas. Elderly healthcare was first introduced formally in the second National Health Plan (1993 - 1996) as a "***Healthy Ageing programme***" under the category of Community-based Health Care programme. Some initiatives for healthy and active ageing have been introduced as community-based programme with technical support from WHO and partners(World Health Organization, 2014). Before that era, relatively little policy attention was given to elderly health at national level, except provision of homes for the aged for the minority of vulnerable people.

In the succeeding NHP (1996 - 2000), "Healthy Ageing" was also included, and subsequently the idea was continuously recognised as integral part of primary healthcare in the following NHPs till the current one. The general objective of the programme is to promote health of the elderly in Myanmar and to increase the accessibility of geriatric care services for the elderly(Han, 2012).

In 2001, considering the rapid changes in demographic, epidemiological and economic trends, both nationally and globally, an ambitious 30-year health development plan – **Myanmar Health Vision 2030** – has been drawn up to meet the future health challenges. The long-term visionary plan encompasses the political, economic and social objectives of the country that will guide the planning and implementation of short-term national health plans. With the aim of improving the health status of the people, the objectives include: reducing the public health impact of communicable diseases; ensuring universal coverage of

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health services for the entire nation; training and producing all categories of HR for health within the country; ensuring the availability in sufficient quantity of high-quality essential medicine and traditional medicine(World Health Organization, 2014).

In 2008, the country's Constitution was revised by the last Military government. The 2008 Constitution recognised the rights of elderly to "be cared" by the State, which mentions "the Union shall earnestly strive to improve the education and health of the people; enact the necessary law to enable the population to participate in matters of education and health; provide care for mothers and children, orphans, the fallen Defence Services personnel's children, ***the aged and disabled***; ensure that mothers, children and expectant women enjoy equal rights; and promote the right of every citizen to health care" (World Health Organization, 2014).

Since 2010, Myanmar government has undergone a series of on-going political and structural reforms which has led the government to allocate more resources to the health sector. After many decades of military rule, the first democratically elected government, National League for Democracy (NLD), took office in April 2016. Among the many challenges and priorities of the new government, social sectors including health and education are repeatedly emphasized as critical area that required immediate attention and action.

Significant progress has already been made in economic reforms, including the enactment of the Financial Institutions Law, the passage of the Investment Law, and continued improvements in revenue administration. The country's economy is growing fast. In FY 2015, real Gross Domestic Product (GDP) increased by 7.3%. As a country's economy, social development and health sectors are closely interlinked, progress in one sector such as the economy and security have direct implications for the health sector and vice versa (Ministry of Health and Sports, 2016).

A promising progress towards elderly care was observed in the last five years since 2014. Ministry of Social Welfare, Relief and Resettlement launched **the National Social Protection Strategic Plan in 2014** and subsequently reviewed and scaled-up the program coverage in 2017. National Social Protection Strategic Plan was based on the Framework for Economic and Social Reforms which states:

"Myanmar needs a social protection system that is based on the needs of multiple economic groups, including women, children, ***vulnerable groups, the aged, and people with disabilities****. To this end a high-level national committee for the coordination of social protection, led by the ministry of social welfare, relief and resettlement and the ministry of labour, employment and social security will be established. This committee will work towards rights-based, inclusive and systemic policy development, with due attention given to alleviating poverty and addressing inequities, social exclusion, and emergencies."(The Republic of the Union of Myanmar, 2014).*

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The 2014 National Social Protection Strategic Plan incorporates two flagship programs directed to older adults involving establishment of national social pensions and promotion of Older Person Self-Help Groups (OPSHGs). The former programme is the first national, universal social protection scheme providing financial assistant to persons above 90 years old. The latter program is community-based care jointly run by Ministry of Social Welfare and HelpAge International.

At the end of 2016, the **Elderly and Disability Law** was enacted by the Upper Parliament with the aim of protecting the rights and promoting the welfare of elderly. The law addressed the rights of elderly, social responsibility of the family members, responsibility of community and the state. The law covers health and social protection, providing safe and supportive environment, facilitating transport and mobility of elderly, and also addresses elderly care at different levels such as self, family and community level. Under this law, the government established the national committee for older person 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(Myanmar Government, 2016).

In 2016 December, the Ministry of Health and Sports launched the **National Health Plan 2017- 2021 (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 provide Basic Essential Package of Health Service (EPHS) to entire population by 2020 while providing financial risk protection. EPHS are defined as primary health care services and interventions that the poor and vulnerable need most. Although planning and provision of EPHS facilities are highly focused to deliver on "equity basis" to meet the needs of the country's most vulnerable groups, other guiding principles such as inclusiveness, accountability, efficiency, sustainability and quality of services were also considered in formulating the NHP. The NHP also focus on system building on human resources, infrastructure, service delivery and health financing to provide EPHS through government sectors, or in partnership with ethnic health organizations, NGOs and private general practitioners(Ministry of Health and Sports, 2016).

Elderly care is one of the NHP project under RMNCH+ 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(Ministry of Health and Sports, 2016).

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5.1.1 Social Areas of Elderly in the Process of Policy Development

Myanmar National Social Protection Strategic Plan was launched in 2014 and Elderly People Law was enacted on 31 December, 2016, under the responsibility of Ministry of Social Welfare, Relief and Resettlement. "Elderly People means all Myanmar citizens who are 60 years of age and above", who will be entitled with an Elderly People Identification Card, which is the identification card issued in accordance with the Elderly Law to elderly people to be entitled their rights (Elderly People Law, 2016). The elderly people law claims that the older people in Myanmar have right to claim for their basic needs – social support, care support and financial support, and health care – and they have the rights for civic participation and to be free from any kind of discrimination (Articles 15 & 16, Chapter 5, Elderly People Law).

Basically there are two models of social care, which are the tradition way of caring and international care practices - family care, home-based care services, community-based care services, group home care service and day-care center.

As the ageing of Myanmar's population was slow in the past century and traditional family structure remains largely intact - religion and culture are closely linked and play a central role in care of the elderly – family care system were very common in Myanmar and there were homes for the aged for the minority of vulnerable people in Pre 2000 era (Regional Forum on Policies on Ageing, 20–21 July 2017). Home for the Aged was first established in 1898 by a well-known lady, Daw Oo Zonn, since then many ones have been established in various places in the country. Currently, there are 70 homes for the aged across the country covering over 2300 older people (Mr. Aung Tun Khaing, Regional Forum on Ageing, May 8 – 11, 2012).

As Myanmar agreed the adoption of the Madrid Political Declaration and International Plan of Action on Ageing at the United Nations Second World Assembly on Ageing (MIPPA 2002 – 2022) for handling ageing issue in the 21st century (Madrid, 8-12 April, 2002), and 2005 there was more regional engagement on ageing. MIPPA focuses are on three priority areas: older persons and development; advancing health and well-being into old age; ensuring enabling and supportive environments.

Ensuring the third focus of enabling and supportive environments, the volunteer-based home care program, which is a replication of the home-care model of the Republic of Korea and other ASEAN countries was introduced in Myanmar in 2004. It has been implemented by three phases – First phase from 2004 to 2006, Second Phase from 2006 to 2009 and Third phase from 2009 to 2012 – is now caring for approximately 30,000 older people. These are the places where older people are provided food, shelter, health care, social care and protection and rice, funds for food and clothes are provided by the Department of Social Welfare (Prof Myint Han, 2012). The main activities include recruiting volunteers and training for home care, and to organize get-together for older persons, aiming to improve the health and social conditions of the poor, frail and lonely older persons. The 1st phase

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was two pilot projects, the 2nd phase was in 25 townships and the third phase was with was expanded through DSW ten partner organizations which can reach to 16919 older people in 154 township with the help of 16624 volunteers. Main implementation partner organizations were National YMCAs, HelpAge Korea and HelpAge International, where Ministry of Social Welfare and Ministry of Health stood as Project Advisory Committee in the management structure (Ms.Cho Hyunse, Regional Expert Consultation, 9-10 December 2014, Bangkok).

For rural development on ageing, REVEAL projects (Reducing Economic Vulnerability through an Equitable/ Inclusively Approach to Livelihoods) were Livelihood support to household with older people (in kind and in cash), Home care (social care) and Health care, IGV activities, DRR and Capacity development to the community. It was funded by LIFT fund and implemented by HelpAge International from December, 2010 to June 2015 with local partners – Golden Plains Agric Products Coop Society, Leprosy Mission International (TLMI), NAG (Network Activities Group), The National Council of young Men's Christian Associations (YMCA). It reaches to 10,000 older people and their families in 15 villages in Ayardaw Township and 15 villages in Ma Hlaing Township, contributed to secure livelihoods and better nutrition and hygiene for 4,082 rural households. It was the establishment of sustainable, community-led development groups – Village Development Committees (VDCs) – that include, persons with disabilities, older people, women-headed households and landless families, and developed Integrated Community Action Plans (ICAPs), formed township networks, and linkages with local government.

From the outlook of population aspect, the Department of Population has conducted nationwide Population Census in 1973 and 1983 and the series of Fertility and Reproductive Health Surveys since 1991. "the Elderly Population in Myanmar: Trends, Living Conditions, and Characteristics and Prospects" is conducted in 2004 and "Ageing Transition in Myanmar" in 2009 by Ministry of Population and UNFPA. It found out the features of the ageing in Myanmar are a shift in the distribution of the aged, with an increasing proportion of the aged being found in the oldest of the old age groups; an increasing proportion of the aged that the population of older persons will exceed the population of children around 2040 (Ageing Transition in Myanmar, 2012). According to the Myanmar National Census figures, out of the country's total population of 52 million or so, 4.75 million (9.06%) are aged 60 and above in 2015-2016.

Definitely, it can be that the response to this population change was inter-sectoral and inter-ministerial by looking at the policy process of Myanmar National Social Protection Strategic Plan (MNSPSP). MNSPSP was developed under the oversight of a Social Protection Working Committee, consisting of a broad range of government sectors ministries and non-governmental organizations (MNSPSP, 2014). Social Protection Working Committee was formed at the direction of the Office of the President of Myanmar (Order No. 57/2014), chaired by Union Minister for Social Welfare, Relief and Resettlement. Later, the chair established Technical Support Group (TSG) – consists of government ministries,

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development partners, non-government organizations and a research institute – to assist the working committee with Strategic Plan preparation.

A detailed plan of activities to prepare the Strategic Plan was developed and agreed in January 2014: Strategic Plan launch workshop hosted by DSW and UNICEF in January 2014; Myanmar Development Cooperation Forum organized by Ministry of National Planning and Economic Development on January 25 26, 2014; Social Protection Inventory with the identification of priority gaps by the support of World Bank; Social Protection training by DSW and UNICEF in April 2014; Social Protection Assessment Based National Dialogue (ABND) by ILO; South-South Learning Forum on Social Protection on Designing and Implementing Social Protection and Labor Systems attended by the delegates from DSW in March 2014; Workshops on Policy and Strategy Development from 26 to 28 August 2014 and in September 2014; the Policy and Strategy was endorsed on 29 October 2014 at the Coordination Meeting of SPWC; and final Strategic Plan was approved by the Social Protection Working Committee, drawing on regular consultation with TSG in November 2014 (MSPSP, 2014).

Besides, it can be said that policy, strategies and action plans regards with ageing does not lose on giving an insight on both personal ageing and population ageing, as Myanmar National Social Protection Strategic Plan includes two flagship programmes; Social Pension and promotion of Older People's Self-Help Groups (OPSHGs). Also, one of the duties and responsibilities of Myanmar Elderly People Committee is to introduce the measures of preparation for elderly people's lives to the younger generation, carrying out appropriate social welfare programmes and encouraging the youths to participate in these programme (Chapter III, Elderly People Law, 2016). Ministry of Social Welfare, Relief and Resettlement includes a number of other key plans and policies related to elderly people.

Since 2015, Myanmar's policy situation on ageing was changed sharply, particularly with the country's new interest in social protection and initiatives on an ageing law and policy. Since April 2014, HelpAge International implemented a 3-year project in collaboration with the MSWRR, and with support from Livelihoods and Food Security Trust Fund (LIFT). The project was designed two distinct objectives: To build the capacity of MSWRR to define its mandate on social protection and to make informed decisions in choosing and designing specific social protection instruments, and to support the Ministry in delivering national policies on ageing and building related capacity. Besides, this project piloted one-year Social Pension Pilots in 2015 - 2016 to test the delivery mechanism of social pension, was implemented by HelpAge and Department of Social Welfare, which was funded by LIFT.

Consecutively, nation-wide One-off cash transfers to older persons above 100 years and 90 years by government. In 2017 the government initiated a social pension, the first national, universal social protection scheme, and the First National Universal Social Pension was commenced in June for older persons above 90 years with government budget for FY 2017-18 of approximately 4.2 Billion MMK (Ms. Khin Thuzar, Deputy Director, DSW, MSWRR).

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Similarly, OPSHGs (Older Persons Self Help Groups) model was funded by KOICA, introduced by HelpAge International (HAI), from January 2015 to December 2017. Aiming to help older people to lead dignified, active, healthy and secure lives, these are multifunctional community-based organizations formed by older women and men through a democratic practice. OPSHGs are designed to be sustainable and to have a strong informal social protection mechanism, aiming to strengthen older people's participation and have their voice heard in township and national level.

With the main activities of OPSHGs – fundraising, livelihood and income generation ventures, health care and home care – there are one main committee with five sub-committee (fundraising, livelihood and income generation ventures, health care, home care and DRR). This model can reach to about 20,000 Ops and their families. Projects were in ten villages in Pyi Oo Lwin, 8 villages in Patheingyi in Mandalay Region; 5 in Pathein, 10 in Kangyidauk, 18 in Kyaik Lat and 10 in Shwe Thaung Yan stubtownship in Ayeyarwaddy Region; 2 wards in East Dagon Township in Yangon Region.

Likewise, Elderly People Law was enacted on 31 December 2016, with the aims of ensuring regular income, care support, social and health care, and promoting the elderly participation in social and community affairs, (Chapter II, Elderly People Law). Myanmar Elderly People Committee also has the responsibilities of arranging part-time job opportunities and the jobs capable of doing by elderly people; arranging to get loans to do the livelihoods; providing vocational and professional training for elderly people; and taking measures for appropriate tax reduction or exemption for the employers who give job opportunities to elderly people (Chapter II, Elderly People Law). 7. In Addition, in New Pension Law (2012), Article 34 enacted as, "The age for superannuation of the Insured shall be as stipulated by the Ministry of Labour in Coordination with the SSB with the approval of the Union Government," though no enforcement and no implementation and the elderly employment is not a policy yet.

Moreover, as well as the International Plan of Action on Ageing (MIPAA) includes the older people and development, advancing health and well-being of older people, ensuring and enabling the supportive environment, the National Plan of Action on Aging focus on the following nine sectors are being drafted; Income security, Health and health care, Natural Disasters and other Emergencies, Security of Care during Periods of Dependency, Home and Environment, Care and Support, Education and Advocacy, Implementation System, Monitoring and Evaluation (Background on Taking Care of Older Persons in Myanmar, Country Report on "The 11th ASEAN & Japan High Level Officials Meeting (HLOM) on Caring Societies").

Thus, Union Government forms the Myanmar Elderly People Committee with Union Ministers and Deputy Ministers of different ministries, three representatives from City Development Committees, Chairpersons of Myanmar Women Affairs Federation (MWAF), Myanmar Maternal and Child Welfare Associations (MMCWA), and Representatives Members from the Internal Non-Governmental Elderly People Organizations, under Elderly

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People Law. The Committee is responsible for the formation of necessary working committees, subcommittees and advisory groups and assigning duties, laying down and implementation work programmes for care support, social and health care without losing an insight on the established family structure based on the traditional paradigm (Chapter III, Elderly People Law).

The Elderly People Law emphasized the rights of the elderly people in its chapter 5; to protect and promote the rights and benefits of elderly people and to prevent discriminations; the right to receive appropriate financial, care and support for physical and psychological development, social and health care support; and, the rights to participate in different associations and social activities.

Another duty and responsibility of Myanmar Elderly People Committee is to establish care centres, recreation centres, day care centres for elderly people, homes for the aged laying down guidelines and regulations, and providing necessary supports (Chapter III, Elderly People Law). As a result of changing family system, the elderly people face the social loneliness. Day Care Center for the Aged was opened by Department of Social Welfare at No(64), corner of Kabaraye Pagoda Road and Parami Road, Mayangone Township, Yangon, on November 20, 2013, in order to reduce the social vulnerability and to have the healthy and active ageing life. To date, the Day Care Center provides support to total 180 older people (Male 125 and Female 55). Besides, this center is the only one center providing the care giver training, started in 2015 and to date, it can generates 9 batches in total.

In health care sector, health care for the elderly was one of the sub-programs under the umbrella of the Community Health Care program in the National Health Plan (NHP) (1993-1996). It was also included in the NHP (1996-2000) and thereafter, as an Integral part of primary health care. The general objective of the program is to promote health of the elderly in Myanmar and to increase the accessibility of geriatric care services for the elderly.

To fulfil the general objective, the Elderly Health Care program aims to provide at least 20% of the ambulatory elderly with geriatric clinical services through the primary health-care approach in the project townships. It also encourages home-based geriatric care through families, health volunteers and nongovernmental organizations. Training programs for health staff, voluntary health workers, family members and community volunteers are also included in the program (Prof. Myint Han, 2012).

An important part of the program is establishing "Wednesday" geriatric clinics in the project areas including the rural health centers. The program also increases awareness on ageing issues in the community. These were implemented by the coordination and collaboration among local NGOs such as Myanmar Mother and Children Welfare Association (MMCWA), Myanmar Red Cross, Fire Brigade, Myanmar Women Federation (MWF), Voluntary Home Care services from Social Welfare Department and various NGOs, both local and international.

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The elderly health-care program has been implemented in (88) townships in various states and divisions covering 20% of the total townships in the whole country including rural areas which has been expanded to four townships yearly.

Another Elderly Health Care program is forming the support group for elderly doctors (SGED), to render help in three identified areas: financial, social and services to elderly doctors above 70 years of age. The SGED is taking care of 617 elderly doctors including those who live on their own. The functions of SGED are: day-care center development and preparation of home-based physiotherapy care project. Research programs, academic training programs and publication of newsletter are the other activities of SGED.

Next, Myanmar National Health Plan (2017- 2022) was drawn to ensure the availability and accessibility of quality essential health services and interventions. Health is not the sole responsibility of the Ministry of Health and Sports (MoHS) and many of the health inequities observed in the country are directly related to social determinants of health (National Health Plan, 2017 – 2022), policies must be linked to mainstream sectorial plans and national development plans that address a broader range of issues such as health and care, social protection, employment and the engagement of older people as a resource in their economies and societies (Regional Forum on Policies on Ageing, 20–21 July 2017).

Like National Health System in the United Kingdom and Health Law for the Philippines, Myanmar National Health Plan is designed to have the universal coverage and reach the whole community at every corner, not only through public health care system but also general practitioners with the development of risk pooling mechanism. Yet there are still challenges and difficulties in health sector for the elderly people in Myanmar at policy level: National elderly health care program is not implemented yet; Low awareness on active and healthy aging concepts; Strengthening of Gediatric Medicine is needed; and only over 8000 senior people are cared and needs more senior people (The 11th ASEAN & Japan High Level Officials Meeting).

In order to create a Convenient Environment for the Mobility of Elderly People, it is necessary to take into consideration the special requirements of elderly people at public places, housings and transportation, and directing and laying down rules and regulations for the private sector and civic organizations (MNSPSP, 2014). Therefore, it is necessary to have a continuous support for sustainability of elderly health care activities, awareness raising for development of healthy public policy ensuring the enforcement and implementation, strengthening and capacity building for elderly care volunteer and having the elderly employment policy and law.

Actors in Policy Process

As stated in the National Health Policy, the successful conduct of elderly healthcare project needs the close collaboration and integration with related ministries, international organizations, non-governmental organizations and the local community. The Health Workforce Strategic Plan (2012-2017) also recognizes that engagement and partnership

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with health professionals outside of the public sector, the private health sector, NGOs, CSOs, EHOs, and DPs should be strengthened to tackle issues around planning and management of the health workforce. MoHS has recently shown interest to recognize non-government health workers in ethnic areas and expected to collaborate with Ethnic Health Organizations to provide health services to hard-to-reach ethnic regions(Ministry of Health and Sports, 2016).

5.2 Timeline and Progress of Elderly Health Policy in Myanmar

1915 -	**Home for the Aged** was first established as the very traditional way of caring older persons by a humanitarian, Daw Oo Zoon
1993 -	NHP (1993-1996) aligned to **WHO - Health for All** initiative
	1993 - **Healthy ageing programme** was first introduced in the 2nd National Health Plan and subsequently included in the succeeding NHPs
	2001 - A 30 years health development plan **Myanmar Health Vision 2030** was formulated
	2008 - The third national **Constitution** recognized the rights of elderly to be taken care of by the State
2014 -	**National Action Plan on Ageing** was established
2016 -	**Elderly and Disability Law** enacted to protect the rights of senior citizens
2017 -	**National Policy on Ageing** was submitted to Cabinet
	Review and scale-up of 2014 Action Plan to extend the scope and coverage of elderly care
2017 to 21 -	current NHP aims towards achieving **UHC by 2030**
	Provision of **Basic Essential Package of Health Service (EPHS)** to entire population by 2020

Elderly care is included as one of the NHP project under RMNCH+ **lifecycle programme**

Case Study 1

5.3 Review of Myanmar National Social Protection Strategic Plan from Social perspective

There are nearly 2.9 million people in Myanmar aged 65 and over and the figure depicts upward trend year by year (Frontier Myanmar 2017). Culturally speaking, these elderly people get respect and priority from the rest of society because of cultural and religious backgrounds in Myanmar. However, from an economic point of view, the majority of this older population encounters with socioeconomic disadvantages including poverty, with about one third living in home without electricity and over half lacking running water, and these socioeconomic hardships are more prominent in rural area where 70% of Myanmar

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people are living (HelpAge 2019). Consequently, in spite of some institutional-wide efforts of governmental and non-governmental organizations, the vast majority of elderly people in Myanmar call for help and support from both government and community. For successful fulfilment of this requirement, there are two critical factors to be considered; **resource and policy**. Ideologically speaking, this article will help to view the **policy outlook** for elderly care in Myanmar, covering both opportunities and bottlenecks ***from social protection point of view.***

By conducting secondary review on currently available studies related to elderly care in Myanmar, the following significant facts are observed. First, there are very limited numbers of researchers and research institutions specialized on aging research in Myanmar, with key players namely Department of Social Welfare, Ministry of Health & Sports, WHO, UNFPA, UNICEF, ILO, HelpAge International and some universities in Myanmar like the University of Public Health Yangon & Yangon Institute of Economic (John K & Bussarawan T 2016). Secondly, there are significant numbers of studies and research articles directly related to elderly care (more abundant in the recent years), addressing a broad range of topics like health seeking behavior & health disparities, living arrangements & long-term care, impacts of family support on wellbeing of older adult, etc., and there are many indirectly related studies for examples studies on Non-communicable Diseases in Myanmar (John K & Bussarawan T 2016). Thirdly, the majority of these elderly studies highlight two main issues related to elderly care in Myanmar, namely ***material wellbeing & income securities*** and ***access to healthcare***, and both are relatively unsatisfactory and lower as compared to other regional countries like Thailand and Malaysia. Lastly, in spite of some limitations and weaknesses in provision of social welfare for elderly people, Myanmar has adopted international guidelines towards the social and economic protection of older population by developing Myanmar National Social Protection Strategic Plan in 2014 (Williamson 2015).

5.3.1 Stakeholders

After making policy mapping, some laws and policies related to elderly care in Myanmar should be analyzed in depth; ***Elderly People Law***, ***Social Security Law*** and ***Myanmar National Social Protection Strategic Plan***. Moreover, with stakeholder analysis for these policy documents, the Department of Social Welfare under the Ministry of Social Welfare, Relief & Resettlement is founded to be the primary stakeholder and other related ministries like the Ministry of Health & Sports, the Ministry of Labour, Immigration & Population, and other non-government organizations like WHO, UNFPA, UNICEF, ILO & HelpAge become secondary stakeholders. After considering two main factors of ***interest and influence***, the stakeholders in the government sector such as the Ministry of Social Welfare, Relief & Resettlement and the Ministry of Health & Sports hold stronger influential power than the non-governmental organizations and this importance of government sector was significantly noted during the policy making process of the two main policy documents called the Myanmar National Social Protection Strategic Plan and the National Health Plan. Furthermore, for legalization of related policies, the Parliament definitely becomes a key

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stakeholder and this significance was clearly found in enactment of the Social Security Law in 2012 and the Elderly People Law in 2016. Meanwhile, non-governmental organization like HelpAge, WHO & UNFPA, UNICEF, ILO have a keen interest in elderly care in Myanmar and have been providing technical and financial supports to the key stakeholders like the MSWRR & the MoHS in both policy making and policy implementation processes. Therefore, detail discussion and consultations with these stakeholders will provide further in depth information in the policy analysis process.

5.3.2 Process and Actors

Regarding with the policy process of the Myanmar National Social Protection Strategic Plan which was published in December 2014, the most important initiating force came from the National Social Protection Conference held in 2012 and opened by the former President U Thein Sein, accepting and committing the universal social protection concept for poverty alleviation(The Republic of the Union of Myanmar, 2014). Moreover, the MNSPP was formulated according to the National Comprehensive Development Vision and National Comprehensive Development Plan, aiming to complement the Framework for Economic and Social Reforms(The Republic of the Union of Myanmar, 2014). The Key Actor for the policy formulation process was the Social Protection Working Committee which was formed at the direction of the Office of the President of Myanmar (Order No. 57/2014), consisting of a broad range of Government Sector Ministries and non-governmental organizations(The Republic of the Union of Myanmar, 2014). Furthermore, a Technical Support Group with 21 members of government and non-governmental agencies was established for policy drafting and the Ministry of Social Welfare, Relief and Resettlement took the steering role(The Republic of the Union of Myanmar, 2014). From the beginning of the 2014, the detailed actions for the policy process was planned and came into action, taking technical inputs and advices from various stakeholders including internal organizations like UNICEF, ILO, HelpAge etc.,(The Republic of the Union of Myanmar, 2014). After conducting nine major activities including workshops, forums and dialogues, the final policy product of MNSPP was endorsed in December 2014(The Republic of the Union of Myanmar, 2014).

5.3.3 Content

Conducting content analysis on the Myanmar National Social Protection Strategic Plan, the following salient facts are going to be highlighted. Firstly, this policy document was developed in the light of general social protection for the whole country and not specifically designed for elderly care in Myanmar. However, the policy did not ignore the elderly care although the issue did not get enough priority in the policy, with introduction of social pension and older person self-help groups (OPSHGs) programs. Secondly, according to country comparison among SEA region, Myanmar ranks the lowest in the social protection expenditure, with less than 0.5 % of GDP, **and it is terrifically lower than the regional average of 2.6% and other countries like Thailand in Singapore both of which spends around 4 % of GDP** (Asian Development Bank 2014). Consequently, this inadequate social protection expenditure called for the need of more government funding on elder care like

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social pension for people aged 65 & above, which will provide 25,000 MMK per month and will cost about 1.39 % of GDP annually(The Republic of the Union of Myanmar, 2014). Thirdly, regarding with the current social protection programs for elder people in Myanmar, only Civil Service Pension Scheme and Social Security Old Age Pension Scheme are currently providing financial assistant for older people in Myanmar. The former scheme covers only civil servant and the latter is applicable only for formal sector workers with voluntary contribution. Since the majority of people in Myanmar are living in rural area and working in the non-formal sector with irregular income, both of these two schemes will not provide an adequate social safety net for financial insecurity of older people in Myanmar. Lastly, the strategy looks the elderly care issue from all four social protection dimensions called protective, preventive, promotive & transformative social protection, and aims to support the interventions for elderly care with the full social protection spectrum, covering family & community-based care, nutrition & health care, job identification & matching, disaster risk management and traditional & cultural aspects, and therefore the MNSPP should be considered as an ideologically sound policy document(The Republic of the Union of Myanmar, 2014). However, currently providing Civil Service Pension Scheme and the Social Security Old Age Pension Scheme of the MNSPP cover only protective and preventive dimensions, while Thailand, Singapore and Malaysia are providing the full spectrum of social protection like social assistance programs, social insurance and labour market programs, covering all dimensions of social protection (Asian Development Bank 2014).

In the meantime, in spite of using universality concept, life cycle approach and system approach in MNSPP currently, social protection initiatives in Myanmar had encountered some resistances in the early stage of MNSPP policy making process. Based on the stakeholder consultations with some important officials from the Ministry of Social Welfare, Relief & Resettlement, the first barrier during the advocacy process of MNSPP was the controversy between universality concept and need-based concept and that was overcome by several discussions among key stakeholders and other important decision makers, finally accepting the universality concept in MNSPP policy making process. Economically speaking, Myanmar ranked the lowest GDP per capita among regional countries, with 1,338 $ and this economic disadvantage become a major limitation for provision of essential social protection services in Myanmar (Adelaida S 2018). This poor economic performance and deficient tax system in Myanmar create limited fiscal space for social protection expenditure and then the unsatisfactory budget allocation for MNSPP becomes another critical issue in its implementation (Ministry of Social Welfare, Relief & Resettlement 2018).

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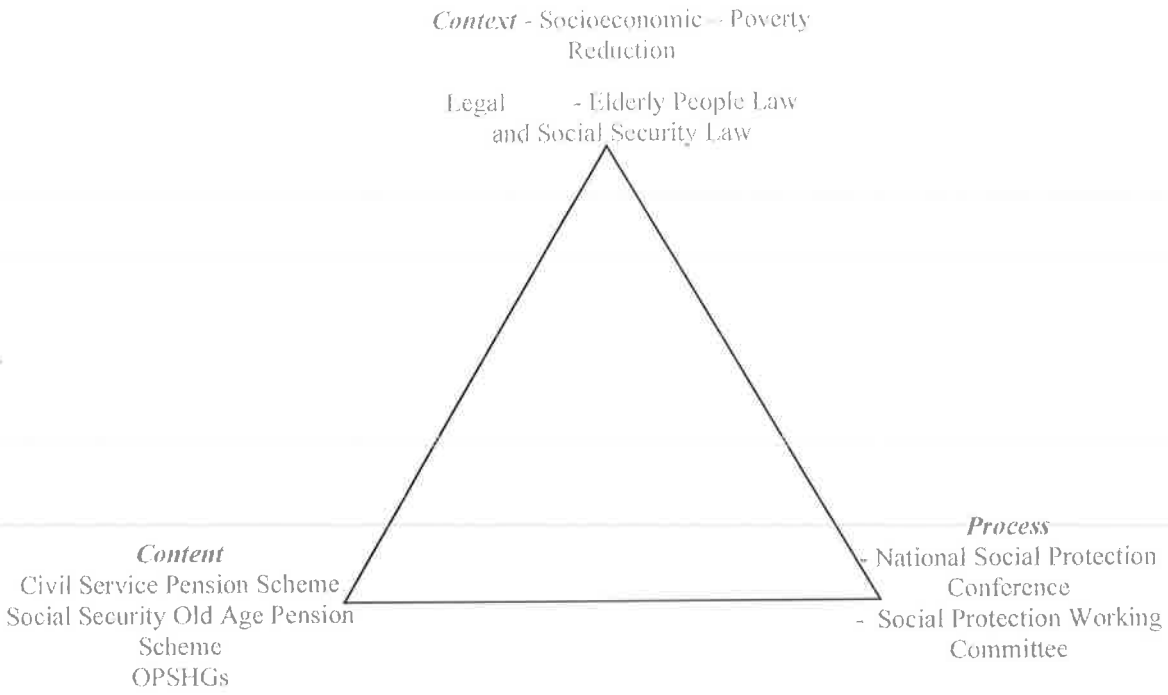

Figure 5: Triangle of Policy Development in the area of Social Protection, Elderly Law, Social Security Law that generate social pension scheme and older person social care services

5.3.4 Context

Contextual analysis on the two laws namely Elderly People Law and Social Security Law, the older people in Myanmar have right to claim for their basic needs including healthcare and discrimination of elder people based on gender, race, religion and socioeconomic status are prohibited (in articles 15 & 16 of the Chapter 5 of the Elderly People Law). However, this Law stresses more on the role and responsibility of descendants, non-government organizations and community less on the government responsibility except duties & responsibilities of the Elderly Committee(Myanmar Government, 2016). Moreover, according to the Chapter 3 of the Law, the National Committee for Elderly People was established and its duties and responsibilities were constituted for effective implementation of the law, aiming to provide sufficient social protection and assistance for the elderly people in Myanmar(Myanmar Government, 2016). According to the Article 29 of the Social Security Law, the retired civil servants of the entitled ministries can claim for their medical expenses and they also have right to get financial compensation in advance or in divided phases when they get retired as mentioned in the Article 35 of the law (Social Security Law 2012). Although these two laws are providing some financial protections for the elderly people, the legal context in Myanmar should be more involved in and directed to elderly care in the light of social protection.

Comparing the social protection and assistant activities for elderly people in Myanmar with those in other regional countries, Myanmar cover only some aspects of social protection as mentioned earlier and the elderly care activities are limited to Community-Based Care

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Services. Meanwhile, some Institutional-Based Care Activities like Civil Service Pension Scheme and the Social Security Old Age Pension Scheme are currently providing for elderly people in Myanmar, but both of the schemes cannot cover the entire elderly population, while other regional countries like Thailand, Singapore and Malaysia are trying to provide social assistant and safety net programs for entire elderly population by formulating sound and comprehensive national aging policies. For examples, Thailand with successful the Universal Healthcare and Universalization of the Old-age Allowance, Singapore with the Holistic and Integrated Affordable Healthcare and Eldercare System, and Malaysia with extending the existing Employee Provident Fund to self-employed group (Research Gate 2009). Although Myanmar lags behind other regional countries in social protection for elder population as mentioned above, current legal support and interest from national level like the Ministry of Social Welfare, Relief & Resettlement and the Parliament become an important opportunity to establish effective and comprehensive social protection system for elder population in Myanmar. Moreover, together with technical and financial supports from the INGOs and local NGOs, Myanmar elderly people are now encountering the brighter future due to formulation and implementation of the National Aging Policy which will be disseminating very soon (Ministry of Social Welfare, Relief & Resettlement 2019).

To sum up, there are some studies, laws and policies related to the elderly care issue in Myanmar and most of them are ideologically sound, contextually valid and operationally feasible in the light of social security protection with prevention of financial insecurity for elderly people. However, there are some limitations and bottlenecks as mentioned above. For better understanding of the underlying and inter-related factors of these obstacles, detail studies and more consultations with relevant stakeholders are necessary. Moreover, international comparison with the regional countries for the elderly care issue calls for further in depth analysis and consultations.

Case Study 2

5.4 Review of National health Plan (2017-2021) from Health care Perspective

This part analyze the health policy especially ***Myanmar National Health Plan 2017-2021 (NHP)*** and identify its gaps and challenges to reach Universal Health Coverage (UHC) by covering the elderly people in Myanmar. In addition, this assignment includes the comparison of health policy with a neighboring country like Thailand how to reach UHC and how to cover the elderly people in their National Health Policy. For policy analysis, a policy triangle of Kent Buse will be applied to find out how policy actors are making the policy process, its content and the contextual factor which effect on the health policy.

5.4.1 Context

Under the **contextual analysis**, there are some ***situation factors*** that drive the Government's health policy and National Health Plan towards Universal Health Coverage in Myanmar. Myanmar has the lowest life expectancy at birth among ASEAN countries, which

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is 67.7 years(National Health Network, 2016, Ministry of Health and Sports, 2016). It is approximately a decade below life expectancy for Thailand, which is 74.6 years (Tejativaddhana et al., 2018, World Health Organization, 2015e).

According to the preliminary estimates from the 2014 census, the maternal mortality ratio (MMR) is 282 deaths per 100,000 live births, compared to 161 in Cambodia and only 20 in Thailand, and the under-five child mortality rate (U5MR) is 72 deaths per 1,000 live births, compared to 29 in Cambodia and 12 in Thailand (National Health Network, 2016). Malnutrition is highly prevalent, with more than one third of the children under the age of five stunted. Both HIV prevalence and TB incidence are second highest among ASEAN countries. The burden of disease from non-communicable diseases (NCDs) is increasing at alarming rates; it is estimated to already account for more than 40 per cent of all deaths. Diabetes and hypertension are particularly prevalent (National Health Network, 2016).

Hidden behind the national averages are wide geographic, ethnic and socio-economic disparities. For example, the maternal mortality rate (MMR) in Chin State is 357, compared to 213 in Yangon, and the U5MR ranges from 108 in Magwe Region to 48 in Mon State. Children from poorer households are more than twice more likely to be undernourished than those from better-off households (National Health Network, 2016).

As the ***structural factors***, the Government of the Republic of the Union of Myanmar is committed to achieving universal health coverage (UHC) by 2030(World Health Organization, 2015e). In addition to being the National League for Democracy party's vision, UHC is also part of the Sustainable Development Goals, to which Myanmar has subscribed. The Programme of Health Reforms proposes a roadmap towards UHC(National Health Network, 2016). After many decades of military rule, the first democratically elected government took office in April 2016, following a landslide victory of the National League for Democracy (NLD) at the November 8, 2015, elections. U Htin Kyaw became the country's new President and Daw Aung San Suu Kyi became the State Counsellor. Among the many priorities of the new government, social sectors including health and education are repeatedly emphasized as being critical(Ministry of Health and Sports, 2016). According to the speech of a Stake Counsellor Daw Aung Suu Kyi, "*Some of the best indicators of a country developing along the right lines are healthy mothers giving birth to healthy children who are assured of good care and a sound education that will enable them to face the challenges of a changing world. Our dreams for the future of the children of Burma have to be woven firmly around a commitment to better health care and better education.*"

As the ***International or exogenous factors***: As the global health priority, UHC is firmly based on the 1948 WHO Constitution, which declares health a fundamental human right and commits to ensuring the highest attainable level of health for all(World Health Organization, 2019a). When all 193 Member States of the United Nations (UN) agreed on the Sustainable Development Goals (SDGs) in New York in 2015, they set out an ambitious agenda for a safer, fairer and healthier world by 2030(UHC 2030, 2019).

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5.4.2 Actors, Process and Content of NHP (2017-2021)

Myanmar National Health Policy has been adopted since 1993 with the initiation and guidance of the National Health Committee (Ministry of Health and Sports, 2014). The policy guidelines related to health sector included in the Constitution of the Republic of the Union of Myanmar (2008). In article 367 of 2008 Constitution, it stated as, 'Every citizen shall, in accord with the health policy laid down by the Union, have the right to health care'. There were 15 policy statements in National Health Policy and the first statement obviously indicated its objective of achieving "Health for All" goal as the primary objective using Primary Health Care approach. Based on Primary Health Care approaches, to achieve Myanmar Health Vision 2030, the Ministry of Health has formulated four yearly People's Health Plans from 1978 to 1990 followed by the National Health Plans from 1991-1992 to 2001-2006. Under the Ministry of Health and Sports (MoHS), the department of health planning is a focal department for formulating the National Health Plans(Ministry of Health and Sports, 2014).

Like many WHO member countries(Marten et al., 2014), the Myanmar Government has committed to achieving UHC by 2030(Ministry of Health and Sports, 2016). Ministry of Health and Sports launched the 5-year National Health Plan (2017–21) in December, 2016(Han et al., 2018). In September 2016, committees and working groups for the formulation of the NHP 2017-2021 were established(Ministry of Health and Sports, 2016). The key actor of NHP is a H.E Union Minister of Health and Sports because he was a chair of a steering committee. Under his guidance, a Technical Advisory Group (TAG-NHP) and a Technical Working Group (TWG) were founded, which were jointly responsible for the NHP formulation process and for the elaboration of the NHP document. After a series of workshops, a panel and various consultations on the first draft of the NHP with UN organizations, INGOs, EHOs and CSOs, a final NHP (2017-2022) was developed and it was for a period of four years. NIMU is the focal committee for implementation of this National Health Plan.

As the content of NHP (2017-2021), the objective is to "strengthen the country's health system and pave the way towards UHC, choosing a path that is explicitly pro-poor" and the main goal is to extend access to a Basic Essential Package of Health Services (EPHS) to the entire population by 2020 while increasing financial protection(Ministry of Health and Sports, 2016). The main strategy of NHP is to extend the Basic EPHS to the entire population, which will require substantial investments by the Ministry of Health and Sports (MoHS) in supply-side readiness at Township level and below, and in strengthening the health system at all levels(Ministry of Health and Sports, 2016). Therefore, during first four years, NHP is conducting the geographical prioritization to expand the Townships' capacity by improving service availability and readiness as well as service prioritization to guaranteed a Basic Essential Package of Health Services for everyone by 2020. As the main focus of NHP (2017-2021) is the health system strengthening and building to obtain supply-side readiness

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especially in four pillars: human resources, infrastructure, service delivery and health financing.

5.5 Gaps and challenges to cover elderly people in Myanmar Health Care System

5.5.1 Myanmar elder people

Due to the improvement in health care technologies and socio-economic conditions, life expectancy becomes longer and elderly population is increasing worldwide. Myanmar's population is beginning to age rapidly. One third of countries in Asia Pacific Region are now occupied with elderly population from 8%, including Myanmar, to 26.4% of total population in Japan. As in other countries across Southeast Asia, the number of older people in Myanmar is increasing rapidly, having virtually quadrupled over the past 60 years. Currently older people account for about 9% of the country's population.(8) In 2030, Myanmar itself is expected to see an increase in population proportion of its older people from 8.9% (4.7 million people) to 13.2% (7.9 million people)(Hernandez and Myint, 2017).

Health can greatly affect quality of life, physical independence and financial security. Only a third of older people in Myanmar say that their health is good or very good. Reports of poor health increase from 17% to over 30% between those aged 60–64 and those aged 80 and older in Myanmar(Ministry of Health and Sports, 2014). Based on the 2012 Myanmar Aging Survey, nearly 40% of persons in their early 60s and 90% of those 80 and older reported at least one physical difficulty (Teerawichitchainan and Knodel, 2018). The survey also found that 28% of older persons in Myanmar reported problems with eyesight, compared to 18% in Thailand(Tun et al., 2019). With significant increase in ageing population, the increased number of people with disabilities and chronic illnesses became recognized(World Health Organization, 2015d). Furthermore, due to the epidemiological transition, there is increasing burden of non-communicable diseases (NCDs). During 1990–2010, deaths caused by stroke, heart disease, diabetes, and kidney disease doubled(World Health Organization, 2015d). From WHO 2011 report, nearly 40% of all recent deaths in Myanmar are due to NCDs(World Health Organization, 2015d). According to STEPS survey (2014), it was found that the prevalence of NCDs was in 25 to 64 years old population in Myanmar. Among them, 26.4% had hypertension, 10.5% had diabetes mellitus, and 22.4% had been categorized as overweight(World Health Organization, 2015d).

5.5.2 Elderly care In Myanmar

To promote the health of the older people and increase the accessibility of geriatric care services for them, Elderly Health Care Project has been formulated. Elderly Health Care Programme is under the Improving Health for Mothers, Neonates, Children, Adolescent and Elderly as a Life Cycle Approach Programme Area of National Health Plan (2011-2016). It has six strategies as follow (Marten et al., 2014):

- Promotion of effective geriatric health care services through proper training of basic health staff and volunteers.

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- Establishing geriatric clinics in the existing health facilities.
- Increasing awareness of healthy ageing among the family and community through various media.
- Promoting community participation through social mobilization.
- Promoting healthy living in older people focusing on behavioural aspect (life styles modification) such as nutrition, physical exercise, cessation of tobacco and alcohol consumption.
- Strengthening the cooperation and collaboration with related sectors, NGOs and INGOs in well- being of older people

As the strengthening community health services to meet the changing health needs of the community, the Union Minister for Ministry of Health and Sports has highlighted the concept of Community Health Clinic (CHC) model in 2018. He encouraged for strengthening implementation of CHC model at all States and Regions(World Health Organization, 2015d). These community clinics so-called "Wednesday Clinics" exist in rural and urban health centers, and sub-rural health centers and follow the guidance provided from WHO's model(Tun et al., 2019). The goal of the CHC is to ensure improved accessibility to effective and efficient health care in community and contribute to reduction of NCDs morbidity and mortality in Myanmar. The CHC is the action oriented public health care activity, providing health care services focusing on screening and treatment of uncomplicated diabetes and hypertension, health care for ageing population and health literacy promotion(World Health Organization, 2015d). The patients are attended by the Basic Health Staff (BHS) who are trained in managing/treating a "Package of Essential Non-Communicable Diseases (NCDs)" (PEN), particularly hypertension and diabetes (Tun et al., 2019).

However, not all BHS in Myanmar have been trained in this package of services aimed at the older people and there are admitted constraints on the use of drug stocks(Tun et al., 2019). In addition, the **pilot model** was conducted in Pyin-Oo RHC in Nga-phe Township, Min Bu District, Magwe region. The Community Health Clinic (CHC) is expected to contribute to achieving Universal Health Coverage (UHC) by improving access to quality health services without financial hardship and improving quality of life which also in line with National Health Plan of Myanmar (NHP, 2017–2021)(World Health Organization, 2015d). In addition, the National Social Protection Strategic Plan launched in December 2014 by the Ministry of Social Welfare, Relief and Resettlement is particularly promising. It incorporates two programs directed to the elderly involving establishing social pensions and promoting Older Person Self-Help Groups (OPSHGs). The latter program is relevant to community-based care. It supports OPSHGs at the village level with key objectives to meet economic and health needs of older persons. Community-based care for the elderly is to be delivered by trained volunteers recruited from OPSHGs. These programs are not yet effective nationwide. At present, the OPSHG program remains in the pilot stage, covering less than 1% of the population aged 60 and older(Tejativaddhana et al., 2018).

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Table 6: Timeline for Myanmar Health Policy, National Health Pan and Elderly Cares with main actors

Timeline	Activities	Main Actors	Remark
1993	Myanmar National Health Policy has been adopted with the initiation and guidance of the National Health Committee	National Health Committee	NHP
1978-2006	To achieve Myanmar Health Vision 2030, Ministry of Health has formulated four yearly People's Health Plans from 1978 to 1990 followed by the National Health Plans from 1991-1992 to 2001-2006.	Myanmar Ministry of Health and Sports	NHP
2011-2016	Elderly Health Care Programme is under the Improving Health for Mothers, Neonates, Children, Adolescent and Elderly as a Life Cycle Approach Programme Area of National Health Plan (2011-2016).		Elderly Care
December 2014	Two programs directed to the elderly are established which were social pensions and promoting Older Person Self-Help Groups (OPSHGs). OPSHGs is the community based cared.	Ministry of Social Welfare, Relief and Resettlement	Elderly Care
December 2016	5-year National Health Plan (2017–21) in December, 2016.	-H.E Union Minister of Health and Sports -Technical Advisory Group (TAG-NHP) and a Technical Working Group (TWG) -NIMU	NHP
2018	The Union Minister for Ministry of Health and Sports has highlighted the	-Union Minister for Ministry of Health	Elderly

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	concept of Community Health Clinic (CHC) model in 2018. (also called "Wednesday Clinics")	and Sports	Care

5.5.3 Challenges and Gaps to reach UHC goal to cover the Elderly in Myanmar

In Myanmar, the biggest challenge to reach UHC goal is health service coverage (including elderly care) and financial protection. WHO and the World Bank stated that the target for UHC is at least 100% coverage of financial protection and 80% coverage of essential health services in the whole population(Hernandez and Myint, 2017, Evans and Etienne, 2010). Public spending on health has increased from 2% of the gross domestic product (GDP) in 2009, to 5% in 2014. Even though there was increased in health sector investment, the proportion of health expenditure that out-of-pocket payments comprise in Myanmar is still one of the highest in the region. The reason is that the out-of-pocket health expenditure as a proportion of total health expenditure decreased from 79% in 2011, to 51% in 2014(Hernandez and Myint, 2017). Therefore, these was a bit far from WHO recommended targets because there should be at least 5–6% of gross domestic product (GDP) on health sector and OOP spending should not exceed 30-40 % of Total Health Expenditure (THE)(Zaw et al., 2015). One study, which access the progress towards UHC in Myanmar, reported that roughly 15% of households in Myanmar incurred financial catastrophe, and 2% of non-poor households were impoverished as a result of out-of-pocket health payments (Hernandez and Myint, 2017, Rodriguez et al., 2014). This study also reported that households with members older than 65 years or members with chronic illnesses were more likely to experience financial catastrophe or impoverishment as a result of health expenditure.

Due to heavily on out-of-pocket payments, a large number of households are into poverty which prevents the accessibility of health care they need, and creates considerable inequities(National Health Network, 2016). Researchers also highlighted health service delivery and interventions by the public sector does not reach the entire population(National Health Network, 2016). One study discovered that the percentage of health service coverage is lower than 60%, both nationally and sub-nationally and these findings are similar to some countries such as Afghanistan, Bangladesh, Nepal, and India(Hernandez and Myint, 2017). Although the aim of NHP (2017-2021) is mainly focus on the strengthening the service readiness, the level of readiness of public health facilities varies widely(National Health Network, 2016). Other researchers also revealed that there is prominent wealth-based inequality in both coverage of health services and catastrophic health payments across all states and regions(Hernandez and Myint, 2017). It is stated that health service coverage was notably low in Rakhine, Chin, and Shan, which are remote, conflicted regions whose populations comprise mostly ethnic groups(Hernandez and Myint, 2017). Another major challenge for increasing coverage of health services, some areas could not access to these services because of frequent conflicts(Zeitzer and Disability Policy

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Solutions, 2018), some areas are under the controlled of Ethnic Armed Group such as Kayin Sate and Shan State and some areas are with inter-ethnic conflict. Furthermore, there is a lack of communication between public and private health sectors to achieve coordinated health coverage(Knodel and Teerawichitchainan, 2017).

Among the health service provision, the elderly care is another main issue in the health care system of Myanmar. A policy mapping study of MOHS also stated that unlike industrialized countries, developing countries have less comprehensive policy and elderly health agenda (Marten et al., 2014). It also stated that elderly programs have many challenges in both technical and resource efficiency as well as there are many unequal facilities in basic health, medical care and social support for elderly those live in rural areas(Marten et al., 2014). In Asia including Myanmar, older people are mostly dependent on their family members especially for health care support. It also depends on the wealth status of households. However, Myanmar confronts important challenges including demographic shifts that reduce availability of family support for older persons and increasing burden from chronic illnesses(Brennan, 2017). Other researchers also supported that Myanmar is facing the demographic transition such as fertility decline, population ageing and increased internal migration, which may be likely challenge the current form of family caregiving for frail older persons(Tejativaddhana et al., 2018). Besides, there are also gaps in long-term care (LTC) for elderly, which are significantly associated with household wealth(Tejativaddhana et al., 2018). Some researchers also suggested that the state should fill this gap of LCT for elderly and social protection policies should include frail older persons who need LTC because there is virtually no official policy or program in place to provide LCT care for older persons in Myanmar(Tejativaddhana et al., 2018).

Other key challenges in Myanmar's health system include the insufficient health workforce, limitations in decentralization of health services, and a lack of infrastructure(World Health Organization, 2015c). Myanmar has less health workers (doctors, nurses, and midwives) than the WHO minimum density threshold of 2.28 health workers per 1,000 inhabitants.(Kanchanachitra et al., 2011, World Health Organization, 2015c, Sein et al., 2014) The health worker density in 2016 was 15 per 10,000 population, 61% lower than the southeast Asian regional estimate(Pyne et al., 2016). Despite the introduction of health-sector decentralization, financial and human resources are still centrally managed(Hernandez and Myint, 2017). Only 0.6 hospital beds are available per 1000 population, the second lowest availability in the southeast Asian region(Hernandez and Myint, 2017). Deterioration of health service infrastructure (clinics and hospitals) contributes to a decline in the standard of services. This is exacerbated by inadequate and unreliable supplies of essential medicine and equipment, and further compounded by inadequate numbers and improper distribution of staff(World Health Organization, 2019a). Additionally, inequality in access to health services and financial risk protection as a result of geographical, ethnic, and socioeconomic differences is a major concern in Myanmar(Hernandez and Myint, 2017).

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5.6 Achievement of Elderly inclusive Universal Health Coverage (UHC) in Thailand

In Thailand, even though decades of health infrastructure development and experimenting with different financial risk protection schemes were launched, Universal Health Care (UHC) did not reach. Nevertheless, when Thailand established an ambitious reform known as the Universal Coverage Scheme (UCS) in 2001, it covered 47 million people: 75% of the Thai population, including 18 million people previously uninsured within one year(Thaiprayoon and Wibulpolprasert, 2017). Thailand also increased the public health spending from 5% of the budget in 1985 to 17% in 2015, which is one of the highest in the world(Thaiprayoon and Wibulpolprasert, 2017).

In the early 1980s, to ensure adequate health services throughout the country, the government emphasized a rural health development programme and prioritized the expansion of infrastructure and increased human resources in district health systems(Tangcharoensathien et al., 2014, Tangcharoensathien et al., 2013, Hanvoravongchai, 2013). From 1982 to 1986, although there was the economic crisis, the government decided to freeze all capital investment in the urban hospitals and shifted the limited resources to build rural district hospitals and health centres with extensive training of community-level health professionals and rural doctors. As a result, there was rapid, nationwide expansion of rural health services and expansion access to essential health services at the community level(Tangcharoensathien et al., 2014). In 1993, the targets of "one hospital for every district and one health centre for every sub-district" had been attained(Tangcharoensathien et al., 2013). Furthermore, Thailand recruited and trained around one million village health volunteers to assist health personnel in providing basic healthcare and health education to their communities. They helped distribute essential drugs and get children vaccinated; they also built sanitary latrines and clean-water reservoirs, and implemented nutrition programmes. This committed rural health development programme met with success in improving access to basic healthcare services and laid down a strong public-health infrastructure, which made the UHC policy possible(Tangcharoensathien et al., 2014).

In 1975, after the "free medical care programme", a few policy elites in Ministry of Public Health (MoPH) started to work towards formulation and implementation of UHC in the mid-1980s(Tangcharoensathien et al., 2014). There were political reform movements during 1996-97 with the promulgation of the new 'People's Constitution' in 1997, resulted in strong political movements demanding public-interest policies. It is stated that the main drives of UHC onto to the political agenda were connections of policy elites with the Thai Rak Thai (TRT) party and Rural Doctor Society movement. TRT party became extremely popular with the motto of "30 Baht treats all diseases", which was to represent the notion underlying their proposed UHC policy. The party won landslide victory in the first election under the new Constitution in December 2000(Tangcharoensathien et al., 2014).

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To ensure 100% UHC, immediately after the formation of the new government, the plan for implementing the UCS was formulated based on evidence and experience. The scheme was modified from the voluntary, publicly subsidized health-insurance systems, proposed during the election campaign, to an entirely tax- based social welfare system, with a minimal co-payment of 30-baht (about US$ 1) per visit(Tangcharoensathien et al., 2014). It covers inpatient and outpatient care, surgery and drugs as comprehensive benefits packages.(Hanvoravongchai, 2013) This 30-baht policy was introduced to address the problem of the health insurance coverage gap between the rich and the poor because millions of informal workers and their families lacked health insurance. Approximately 30% of the Thai population was uninsured before implementation of the UCS. This despite the government establishing several insurance schemes over at least three decades.(Tangcharoensathien et al., 2007) As a reformed policy, the UCS was intended to cover poor and informal sector workers, who are uninsured by Civil Servant Medical Benefit Scheme (CMBS) and Social Security Scheme (SSS). Currently, Thailand's public health protection schemes cover all citizens because 7% of population are covered by CMBS, the SSS covers 15% of population, and the rest (76%) are in the UCS(Sakunphanit, 2006).

'30 Baht policy' was started with a pilot project in six provinces in April 2001 and it later expanded to cover 15 additional provinces in June. In October 2001, the scheme was implemented in the whole country except Bangkok, which was covered in April 2002.(Hanvoravongchai, 2013) '30 Baht policy' provides comprehensive benefits packages for all Thai people excluding those who are covered by CSMBS and SSS.(Pannarunothai et al., 2004) The comprehensive health package covers both basic and catastrophic illnesses excluding cosmetic surgery, haemodialysis and anti-retroviral treatment with the co-payment of 30 baht per visit. The main source of finance is the general tax.(Pannarunothai et al., 2004) The initial phase of the policy implementation was under the execution of the Ministry of Public Health (MOPH). A national wide coverage could not be achieved within a year without the strong leadership of Dr. Mongkol Na Songkhla, Minister of MOPH and active participation of the staff from the Provincial Hospitals.(Tangcharoensathien et al., 2007) The goal of the UC scheme was fully success to cover the whole country during 2001-2002 prior to legislation processes.(Tangcharoensathien et al., 2007, Pannarunothai et al., 2004)

To ensure the sustainability of the policy, a network of civic groups drafted a National Health Security Bill with more than 50,000 signatories of Thai citizens and submitted to Parliament. Hence, the ***National Health Security Act*** was promulgated in 2002, which established the National Health Security Office (NHSO) to manage the UHC systems(Tangcharoensathien et al., 2014). National Health Security Office (NHSO) was created as an autonomous agency with its own governing body (NHSB) to operate the UCS.(Hanvoravongchai, 2013, Tangcharoensathien et al., 2007) As the ***policy content of UCS***, the benefit package of the UCS includes a comprehensive set of health interventions stipulated in a contract between the NHSO and the providers, at every level of health

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service. It covers two components: the health promotion and disease preventive package, and the treatment and care package(Tangcharoensathien et al., 2014). The treatment and care package covers all outpatient and inpatient services, including rehabilitation and palliative and long-term care. However, for medicine coverage, the systems use an 'inclusion' list of National Essential Medicines, which covers around 800 items(Tangcharoensathien et al., 2014). The UCS's health promotion and disease prevention package covers immunizations, annual physical check-ups, premarital counseling, voluntary HIV counseling and testing, antenatal care, family-planning services, and primary and secondary prevention for NCDs(Tangcharoensathien et al., 2014).

Regards to ***UCS policy implementation***, it employed a primary care-based system. Primary care provider Units (PCUs) have been designated as gatekeepers to provide continuous and comprehensive care with a holistic approach. In principle, UCS beneficiaries receive services from their chosen primary providers with clear referral systems. However, in the case of accidents and emergencies, they can go to any health facility contracted under the UCS to seek emergency services(Tangcharoensathien et al., 2014). PHC through the District Health Service (DHS) structure is the first point of contact with the health system where previously community hospitals (CHs) and outpatient clinics were the dominant and preferred entry point for most Thais(World Health Organization, 2015e). At primary health services in Thailand are provided through networks of "Health Centres" and Primary Care Units (PCU) run by the MoPH. The health centres and PCU of the MoPH are usually located in rural areas of other provinces and are mainly staffed by nurses, community health workers whereas PCU are staffed by rotating 1-2 physicians, dentist, nurses and allied personnel. Promotive and preventive provisions are the main functions of these centres. Community hospitals, which are the first referral centres in rural areas, also provide primary health services for people living in their responsible areas(Jitapunkul and Wivatvanit, 2008).

Health facilities under the UCS can be classified into three groups according to the services they provide:

1) ***Contracting Unit for Primary Care (CUP)***: are primary healthcare facilities offering curative, promotive, preventive and rehabilitative services, such as ambulatory care, home care and community care.

2) ***Contracting Unit for Secondary Care (CUS)***: are health facilities that offer secondary care, mainly inpatient health services.

3) ***Contracting Unit for Tertiary Care (CUT)***: provide expensive and specialized care with the aid of high technologies(Tangcharoensathien et al., 2014). Under the UHC policy, all Community Hospitals are assigned to be CUPs(World Health Organization, 2015e).

5.6.1 Elderly Care in Thailand

Since 1982, Thailand had established its first ***National Elderly Council*** while the United Nations held the World Conference of Aged Population in Vienna, Austria, in which a long-

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term international action plan was set with respect to the elderly(Witter and Garshong, 2009). In this conference, member countries were encouraged to develop and implement policies and programming relating to the elderly. In 1991, elderly rights including respect to autonomy, involvement, care, self-satisfaction and esteem were recognized by the United Nations Assembly. Thailand promulgated the new ***Constitution of the Kingdom of Thailand*** in 1997, in which two sections were devoted to the elderly: the first indicating that persons 60 years of age or older who earn no income have the right to receive aid from the State; and the second indicating that the State must support the elderly, the poor, and disabled so that they can have a better standard of living(Witter and Garshong, 2009).

The United Nations declared 1999 as the International Elderly Year in which activities celebrating the elderly would be held throughout the world. At the same time in Thailand, the Office of the Prime Minister push forward the goal of promoting programs and policies concerning the elderly by stabling a permanent committee—the ***National Committee of Senior Citizens (Witter and Garshong, 2009)***. The committee members were from various ministries, departments and organizations as well as qualified individuals from private and public sectors. In 1999, the ***Declaration of Thai Senior Citizens*** was also launched and signified the commitment of the Prime Minister and representatives of all political parties in Thailand to elevating the standard of living of the elderly and protecting their rights (See in Annex 1)(Witter and Garshong, 2009). Among nine declarations, number 5 was directly related to elderly care, which was "the elderly should be taught about appropriate self-care of health, obtained the insurance, accessible to complete health service equally, and be taken care until the end of their lives that they rest peacefully after their values."

In 2003, Thailand preannounced the ***Elderly Act*** (See in Annex 2) and the Cabinet entrusted the Institute of Elderly Medical Science, Department of Medical Service, and Ministry of Public Health, to be the core team working on it. There was a collaboration of Assembly of Woman, Youth, and Elderly Affairs, senators and representatives, Ministry of Labor and Social Welfare, Ministry of Education, Ministry of University Affairs, the National Elderly Council, qualified individuals, academic elites, and private and public organizations(Witter and Garshong, 2009). The ***First National Plan for Older Persons (1982–2001)*** was developed as a guideline for the treatment of the elderly. Although the plan identified general directions for supporting the elderly, there were no specific goals, strategies, action plans, or suggested outcomes. Nevertheless, the Plan's focus on promoting the development of programs and services for Thai senior citizens influenced the development and enactment of the Declaration of Thai Senior Citizens in 1999(Witter and Garshong, 2009).

Therefore, Thailand developed its ***Second National Plan for Older Person (2002–2021),*** partially because it was ready to advance beyond the First National Plan, and partially to respond to the Madrid International Plan of Action according to 2002–2021 The United Nations convened the Second World Assembly on Ageing in Madrid, Spain in 2002(Witter and Garshong, 2009). The second plan focus on four significant issues, which were forced by

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the Act on Older Persons: 1) The Elderly Right; 2) National Mechanism on the Elderly; 3) Tax Privilege for Children Who Take Care of Their Parents; and 4) The Elderly Fund. Furthermore, the implementation of this second plan mainly focused on 3 programs (1) promoting a positive attitude toward aging and older persons; (2) promoting health in the elderly; and (3) social protection for the elderly(Witter and Garshong, 2009).

(1) Promoting a Positive Attitude toward Aging and Older Persons: The Thai government realizes the importance of recognizing older persons who promote Thai culture. The Ministry of Culture gives awards each year to elderly persons, naming them National Artists or recognizing them for their work on culture that has national or international acclaim. The ***Older Persons' Brain Bank*** was established on the occasion of Her Majesty the Queen's Birthday in 2000 as a coordinating and information center linking retired older persons with a particular skill or expertise with organizations and individuals who need these skills and services. As an annual Fair on the ***National Day of Older Persons***, in 1982, the Cabinet approved the 13th of April to be the National Day of Older Persons, coinciding with the Thai new year day national holiday(Witter and Garshong, 2009).

Health Care Service for Elderly: In 1992, the Ministry of public Health started a free healthcare program for Thai elderly in all public hospitals and health centres. All regional/general hospitals in Thailand open ***special clinics*** for elderly, date and services depend on particular hospital, they provide special health care treatment for elderly, including problems of care givers. According to Universal Coverage Policy, all elderly will receive free services. In 2002, the Ministry of Public Health has initiated new strategic approach on ***Healthy Thailand*** in order to use as guideline to reduce behavioral health risk and major health problems in Thailand, including elderly health club. Health promotion services, both primary and secondary, including mental health promotion for elderly also conducted in community level. In Thailand, ***village health volunteer system*** is very strong and effective. There are more than 200,000 volunteers working at the community level. Health centres and Primary Care Unit PCU will support ***elderly club*** activities, volunteers for elderly, ***home visit(Health Age International, 2017)***.

5.6.2 Promoting Health in the Elderly: Ensuring the quality of life of the elderly, including independent living, health and well-being. In 2005, "Healthy Thailand" was announced as a national agenda. In addition, the Ministry of Public Health began to support the establishment of ***elderly clubs***, providing a wide range of health promotion activities (aerobics, lectures on health and mental health care, cultural activities), in every sub-district, with target of a minimum of 50% of older persons in each sub-district becoming members of elderly clubs in their communities. As ***Sports/Recreation and Health Promotion in the Elderly***, the Ministry of Tourism and Sports arranges sports activities to specifically promote health and recreation among the elderly through its collaboration and joint activities with the Offices of Sports and the Institutes of Physical Education. Facilities and equipment are made available, for example, health parks, exercise devices, fitness centers, Petong courts, exercise classes for aerobics/Taikek/ Chigung, aerobics/baton aerobics, and

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sole/foot massage. Older persons are encouraged to get together and form their own exercise group. Medical care centers in communities and elderly clubs coordinate to arrange mobile units to provide information about practicing exercise, checking physical fitness, and assessing the health of older persons in communities. Elderly clubs have been established in almost all sub-districts of all provinces (97%; 12,000 clubs), with nearly 4,000,000 older persons as members (64% of the total older population)(Witter and Garshong, 2009).

Besides, the Department of Health carries out a ***"Health Promotion Temple project"*** with a target of covering all 875 districts in all 75 provinces of the country; one temple in each district is designated for the project. The main purpose of this project is to promote elderly health by integrating health care knowledge into religious activities, as a temple is a community center where people, especially the elderly, gather in large numbers to join in religious activities. In addition, other health promotion projects like ***"Return Smiles to the Elderly"*** which is launched by the Department of Health, Ministry of Public Health in 2005. This project inserted and fixed dentures for 80,000 cases of toothless older persons during the period of 2005–2007(Witter and Garshong, 2009).

5.6.3 Social Protection for the Elderly

As the providing the ***assistance to older persons*** who face social problems, the government provides temporary or long-term assistance to older persons who encounter social difficulties. Assistance includes support for temporary or emergency housing, food, clothing, medical treatment and care and rehabilitation to the ill, consultation and help in legal proceedings, counseling services, and admission to an elderly home for those who have no relatives or caregivers. The agency directly in charge of providing services and assistance to older persons in-need is the Ministry of Social Development and Human Security through cooperation and interaction with the Ministry of Public Health and the Ministry of Justice(Witter and Garshong, 2009).

To ensure a ***supportive environment*** and respect for the elderly, the following three main activities are implementing(Witter and Garshong, 2009):

The Office of ***Family Institution Promotion***, the Ministry of Social Development and Human Security, takes steps to promote and support a national campaign aimed at encouraging families and communities to take care of and support individuals of all ages (including the elderly), and enabling family members to live together with happiness. The campaign called "Sunday, the Family Day", focuses on enhancing love, relationships and care among family members. It has been conducted nationwide since 2006, with budget support to all 75 provinces from the Office of Family Institution Promotion.

1. Developing social services through improving ***Homes for the Elderly***: Homes for the Elderly are the last choice of residence for Thai elders. Previously there were 20 homes for the elderly throughout the country, operated under the supervision of the Department of Social Development and Welfare, Ministry of Social Development and Human Security. The government developed a policy to transfer the

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administration of these homes to local organizations to operate and supervise. The services in the elderly homes include medical services, physical therapy, physical and mental health care, social welfare, recreation, occupational rehabilitation, religious activities and arrangement of funerals. In 2006, these eight homes for the elderly were improved and they became "Social Welfare Development Center(s) for the Elderly, Regular services of the center include health care, physical therapy, social welfare services, income-generating activities, recreation, educational tours, knowledge program, and religious activities. In addition, they provide day care services as needed to those older persons who stay with their families.

2. Providing ***house repair service*** for the elderly in communities. In 2006, the Department of Social Development and Welfare initiated budget support for elderly house repair in the community, including the repair of activity facilities for the elderly. Local administrative agencies collaborate and provide resources for these services.

Table 7. Timeline of activities concerning UHC and aging Thailand activities in relation to UN activities

Thailand UHC activities	**Thailand Elderly Care activities**	**United Nations activities**
1975 — Free Medicare Program		
Early **1980s** —Rural Health Development Program	**1982**— First Elderly Council in Thailand	**1982**—World Conference of Aged Populations
1982-1986 —Investment in Rural District Hospital and Health Centres to strengthen Primary Health Care	**1982**—First National Plan for Older Persons (1982-2001)	
		1991—the United Nations Assembly recognized elderly rights with respect to autonomy, involvement, care, self-satisfaction and esteem.
1996-97—Political reform movements which push UHC on to the political agenda		
1997—New Constitution of the	**1997**—New Constitution of the Kingdom of Thailand, with two	

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Kingdom of Thailand	sections devoted to elderly	
	1999— National Committee of Senior Citizens	
	1999—Declaration of Thai Senior Citizens	**1999**—UN International Elderly Year
2000—Thai Rak Thai (TRT) party won landslide victory with the motto of "30 Baht treats all diseases".		
April 2001 —Universal Coverage Scheme (UCS) pilot project in six provinces		
April 2002—the UCS was covered all provinces	**2002**—Second National Plan for Older Persons (2001-2021)	**2002**—UN Second World Assembly on Aging; led to Madrid International Plan for Action on Aging
2002—National Health Security Act which established the National Health Security Office to operate UCS.		
	2003—Elderly Act	
	2005—Healthy Thailand; one component focused on promoting health of the elderly	

5.7 Policy recommendations to achieve UHC in Myanmar including Elderly Care

To achieve universal coverage, as the starting point of UHC in Myanmar, the three main policy recommendations would like to propose.

(1) Political leadership and commitment for health policy reform and Elderly Care policy

(2) The government needs to improve efficiency in revenue collection and prioritization of government expenditure on health to fulfil the objective of financial protection.

(3) Next step is strengthening of health system especially in Primary Health Care system, enhancing health workforce, infrastructures and governance that would also guarantee elderly healthcare services.

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