Social Science & Medicine 107 (2014) 179–188

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Adapting to social and political transitions – The influence of history on health policy formation in the Republic of the Union of Myanmar (Burma)

John Grundy [a,b], Peter Annear [b], Shakil Ahmed [b], Beverley-Ann Biggs [c,*]

[a] Deakin University, Melbourne, Australia
[b] Faculty of Medicine, Dentistry and Health Sciences, Nossal Institute for Global Health, University of Melbourne, Carlton, Victoria 3010, Australia
[c] Department of Medicine, University of Melbourne, Royal Melbourne Hospital, Parkville, Victoria 3050, Australia

ARTICLE INFO

Article history:
Available online 10 February 2014

Keywords:
Myanmar
Burma
Health systems
Health policy
Health history

ABSTRACT

The Republic of the Union of Myanmar (Burma) has a long and complex history characterized by internal conflict and tense international relations. Post-independence, the health sector has gradually evolved, but with health service development and indicators lagging well behind regional expectations. In recent years, the country has initiated political reforms and a reorientation of development policy towards social sector investment. In this study, from a systems and historical perspective, we used publicly available data sources and grey literature to describe and analyze links between health policy and history from the post-independence period up until 2012. Three major periods are discernable in post war health system development and political history in Myanmar. The first post-independence period was associated with the development of the primary health care system extending up to the 1988 political events. The second period is from 1988 to 2005, when the country launched a free market economic model and was arguably experiencing its highest levels of international isolation as well as very low levels of national health investment. The third period (2005–2012) represents the first attempts at health reform and recovery, linked to emerging trends in national political reform and international politics. Based on the most recent period of macro-political reform, the central state is set to transition from a direct implementer of a command and control management system, towards stewardship of a significantly more complex and decentralized administrative order. Historical analysis demonstrates the extent to which these periodic shifts in the macro-political and economic order acts to reset the parameters for health policy making. This case demonstrates important lessons for other countries in transition by highlighting the extent to which analysis of political history can be instructive for determination of more feasible boundaries for future health policy action.

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Introduction

In recent years, the Republic of the Union of Myanmar has been exposed to a number of political and societal upheavals. Following cancellation of a democratic mandate in 1988 and the introduction of a free market system, a period of economic sanctions and international isolation followed. The promulgation of a constitution in 2008 (Taylor, 2009a) and elections in 2010 demonstrated some capacity to transition from authoritarian to more open semi-democratic rule (International Crisis Group, 2011). The introduction of global health initiatives and bilateral partnerships between 2006 and 2011 accelerated the pace of change, with new ideas emerging in the areas of poverty alleviation, decentralization and, more recently, social protection. (Tin et al., 2010) Despite initial setbacks and tensions, the post Nargis recovery efforts in 2010 has heralded in a new phase of government and civil society partnerships.

Current health status in the Union of Myanmar

Myanmar (population 47.9 million) (WHO, 2012a) is confronted by a triple burden of communicable and non-communicable diseases, and high child and maternal mortality rates. Malaria, tuberculosis and HIV/AIDS are significant public health problems,

* Corresponding author. Fax: +61 (0)3 9347 1863.
E-mail addresses: babiggs@unimelb.edu.au, chaji@unimelb.edu.au (B.-A. Biggs).

http://dx.doi.org/10.1016/j.socscimed.2014.01.015
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especially in the border areas with Thailand and China and the western regions of Myanmar, including Rakhine and Chin States (Smithuis et al., 2010). Myanmar is one of the world's 22 high disease burden countries for tuberculosis with 525 cases per 100,000 in 2009 (Thu, Win, Nyunt, & Lwin, 2012; WHO, 2012b). In the same year, there were 17,000 new HIV infections (second only to India in the South East Asian region) and18,000 AIDS-related deaths (Sabapathy et al., 2012). Malaria is also a serious public health problem, with 37% of the population residing in high transmission areas (i.e. areas with >1 case per 1000 population) (WHO, 2013). High maternal and child mortality rates persist, especially in conflict zones and other areas with low levels of socio-economic development (Teela et al., 2009). There are 200 deaths per 100,000 births, and an expected rate of 2000–2500 maternal deaths per year, with estimates of approximately 60,000 child deaths under the age of five each year (WHO, 2011a).

Continuing high mortality rates are linked to poor access to health care services and persisting problems with poverty and under nutrition. A Living Standards Survey demonstrated a poverty rate of 23% (MOP, 2009). This is comparable to other countries in the region (e.g. Cambodia and Laos), but poorer road communications, insecurity, and the absence of an extensive health financing strategy means that the impact of low incomes on health access is likely to be very much higher in Myanmar.

Encouragingly, there have been recent reductions in child mortality. Some national health programs, particularly immunization, (Myanmar Ministry of Health, 2007) tuberculosis, (Maung et al., 2006) and malaria control (Myanmar Ministry of Health, 2010) have achieved impressive reach and coverage, demonstrating the extent to which vertically managed disease control programs can have an impact in the context of distance, insecurity and poorly resourced health systems (Table 1).

Health systems structure

Despite these challenges, the country maintains an extensive health care structure with vast reach and coverage across central plains, delta regions and mountainous States. The health system is organized according to the boundaries of the administrative system, which position Township hospitals at the Township level of administration, and Rural Health Centres (RHC) within the catchment areas of the Township. Beneath the RHC, there is a network of Sub Rural Health Centres (SRHC) staffed by midwives, and midwife auxiliaries. The Township catchment area comprises between 100,000 and 300,000 people, and even smaller population catchments occur in remote State areas. National Regional and State levels of the system technically guide, administer and resource the Township health authorities to implement programs in the Townships (Tin et al., 2010) (Fig. 1).

Inequities in access to health care are widespread, with the health system still subject to the effects of conflict, displacement and the inequitable allocation of resources and decision-making authority. There are widespread reports of low levels of health sector development in the States and border regions. For example, up to 800,000 people without citizenship are located in Northern Rakhine State (NRS) – a geographic area bordering Bangladesh, with social sector services provided in the form of humanitarian assistance that are principally coordinated through UNHCR (UNHCR, 2012). In Kachin State, conflicts continue, with up to 50,000 internally displaced persons located in parts of the State. In other areas, particularly along the border areas with Thailand and China, conflicts with the Wa and Karen minority groups over the last 60 years have resulted in very limited development of the health and education systems.

Table 1
Main health and demographic indicators in the Union of Myanmar (WHO GHO, 2012c).

Indicator	Result	Year, source
Demographics		
Population	47,963,000	2010, WHO
% Living in urban areas	33%	2009, WHO
Life expectancy at birth	64 years	2009, WHO
Health		
Under 5 mortality rate	66 per 1000 live births	2010,WHO
Number of under-5 deaths annually	56,000	2010, WHO
Maternal mortality ratio	200 per 100,000 live births	2012, WHO
Births attended by skilled health personnel	70.6%	2010, WHO
Measles immunization coverage among 1-year-olds	88%	2010, WHO
No. of reported cases of malaria	420,808	2010, WHO
Prevalence of HIV among adults aged 15 to 49	0.6%	2009, WHO
Financing		
Total health expenditure as % of GDP	2%	2009, WHO
Out of pocket expenditure on health as % of total health exp.	95.5%	2009, WHO

Framework for analysis of health and health systems in transition

The experience of other countries in the region undertaking similar transitions demonstrates the link between reforms to the economic and political order and related shifts in direction in health policy. Systems that loosen political and economic control are frequently challenged to introduce new decentralized systems of management. This is characteristic of health contracting trials conducted in Cambodia and the subsequent program of health system reform (Soeters & Griffiths, 2003). In post-communist Mongolia in the 1990s, radical shifts were required in the way the health sector was planned and financed to account for a transition towards market based and decentralized models of administrative governance (Hindle & Khulan, 2006). In the Philippines and Indonesia, health sectors struggled to manage the complexity of decentralized institutional arrangements in the post centralist Marcos and Suharto eras (Espino, Beltran, & Carisma, 2004; Heywood & Choi, 2010; Lakshminarayanan, 2003). Bloom, Standing, and Lloyd (2008) argued that the main lessons from China's health sector experience relate to the management of institution building in a complex and rapidly changing environment, and suggested that actors in the policy process co-construct new institutional arrangements and rules to accommodate changes instigated by market reforms (Bloom, 2011). The notion of health systems being highly path dependent is seen as a result of the accretion of learned behaviors and cultural norms. This is somewhat analogous to the concept of health policy trajectory described by Walt et al. (2008). Sturmberg and Martin (2010) also indicate the extent to which the health policy and planning agenda is set by the "grand attractor" of larger reforms to the political and social landscape.

The increased complexity of institutional arrangements as countries undergo political reform presents significant challenges to change management. Bourdieu (1977) suggests the notion of "habitus" to theorize the co-responsibility of current behaviors with national history. The increased complexity of institutional arrangements as countries undergo political reform also presents significant challenges in terms of adaptability of these durable behaviors to change. Huntington (Huntington, 2006) similarly notes this notion of durability by defining institutions as stable,

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