Comprehensive HEALTHCARE SECTOR STUDY on Investment and PPP Environment in Myanmar

Investment Promotion and PPP Environment in the Healthcare Sector of Myanmar

Project: Support to the Initiative for ASEAN Integration

March 2018
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**Acronyms**

<table>
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<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
</tr>
<tr>
<td>AFAS</td>
<td>ASEAN Framework Agreement on Services</td>
</tr>
<tr>
<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
</tr>
<tr>
<td>ATISA</td>
<td>ASEAN Trade in Services Agreement</td>
</tr>
<tr>
<td>BOT</td>
<td>Build-Operate-Transfer</td>
</tr>
<tr>
<td>CLMV</td>
<td>Cambodia, Lao PDR, Myanmar and Vietnam</td>
</tr>
<tr>
<td>CPI</td>
<td>Community Partners International</td>
</tr>
<tr>
<td>CSO</td>
<td>Central Statistical Organization</td>
</tr>
<tr>
<td>DICA</td>
<td>Directorate of Investment and Company Administration</td>
</tr>
<tr>
<td>DISI</td>
<td>Directorate of Industrial Supervision and Inspection</td>
</tr>
<tr>
<td>EHO</td>
<td>Ethnic Health Organization</td>
</tr>
<tr>
<td>EPHS</td>
<td>Essential packages of health services</td>
</tr>
<tr>
<td>EuroCham</td>
<td>European Chambers of Commerce</td>
</tr>
<tr>
<td>FDA</td>
<td>Food and Drug Administration</td>
</tr>
<tr>
<td>FESR</td>
<td>Framework of Economic and Social Reform</td>
</tr>
<tr>
<td>GIZ</td>
<td>Deutsche Gesellschaft für Internationale Zusammenarbeit</td>
</tr>
<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
<tr>
<td>JICA</td>
<td>Japan Investment Cooperation Agency</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MIC</td>
<td>Myanmar Investment Commission</td>
</tr>
<tr>
<td>NCDP</td>
<td>National Comprehensive Development Plan</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-Governmental Organizations</td>
</tr>
<tr>
<td>NHP</td>
<td>National Health Plan</td>
</tr>
<tr>
<td>PAPRD</td>
<td>Project Appraisal and Progress Reporting Department</td>
</tr>
<tr>
<td>PPP</td>
<td>Public-Private Partnerships</td>
</tr>
<tr>
<td>RHC</td>
<td>Rural Health Centers</td>
</tr>
<tr>
<td>TIPRA</td>
<td>Transfer of Immovable Property Restriction Act</td>
</tr>
<tr>
<td>UHC</td>
<td>Universal Health Coverage</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
1. Introduction
1.1. Context and Objectives of the Comprehensive Sector Studies

The Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH (GIZ) has been supporting the development of the service sectors healthcare and tourism in the CMLV countries – Cambodia, Myanmar, Lao PDR and Vietnam in the project “Support to the Initiative for ASEAN Integration”. Within the project scope, GIZ identified a common need in the target countries for an identification of suitable models for effective public and private sector cooperation and for ways how the respective governments may actively promote the growth of the private sector in the tourism and health sector to mutual benefit.

Given the extensive network of the European Chambers of Commerce (EuroCham) to both, the private and public sector in the CMLV countries, GIZ provided commenced collaboration with the different EuroCham offices in the region to undertake this research. Furthermore, EuroCham will engage in respective dialogue activities to contribute to an enhancement of the investment conditions in the tourism and health service sector of Myanmar and the other countries.

This report covers the healthcare sector and provides hereby an analysis of the policy environment supportive or inhibitive to the provision of healthcare services by or in cooperation with the private sector – through the government-led promotion of private investments in health or through PPPs. Consequently, objective of this report is to inform the Government of Myanmar about opportunities on a national or ASEAN level to addressing health-related needs of population through the enabling and promotion of private sector engagement in the sector.

In summary, the report is seeking to answer the key research question: “How can the Government of Myanmar in the current policy environment address health-related needs of the population through (a) Public Private Partnerships (PPP) and (b) investment promotion initiatives to fulfill national health development objectives under budgetary constraints?”

1.2. Research Methodology

The research team acknowledges that significant gaps in Myanmar-specific literature covering the role of in particular the private as compared to the public sector exist. Such gaps in terms of a limited coverage of the role of the private sector in tourism sector in Myanmar equally are observed in key policy documents of the government as well as publications of international development partners.

In addition to desk-based secondary research, primary research is required to fill existing gaps in literature. The research team hence conducted semi-structured interviews with a diverse range of stakeholders: This includes e.g. the line ministries and government departments involved in economic governance (e.g. DICA) as well as health-related aspects, international development partners (e.g. IFC, GIZ) and numerous private companies involved in e.g. tour operators, investors, hoteliers and tourism development consultants. The research team requested in particular the private sector to articulate immediate opportunities for a meaningful collaboration of public and private sector as well as business-inhibiting barriers to the delivery of tourism development in Myanmar.
1.3. Overview over Myanmar’s Economic Development

Myanmar is an economy in transition. The previous Thein Sein administration began a policy of economic reform and liberalization in 2012 that has continued under the National League for Democracy administration, which assumed office in 2016. Myanmar’s GDP increased at an average rate of 7.2%\(^1\) between the 2012-13 and 2016-17 fiscal years\(^2\), making it one of the fastest growing economies in the region and the world.

Economic growth slowed to 5.9% in 2016-17, although the IMF expects this to recover to 7%-7.5% in the medium term. The slowdown was due mainly to the impact of devastating flooding on the agriculture and food processing sectors and a global drop in natural gas prices that reduced export revenues.

Various economic sectors are also showing improvement. Inflation fell from double digits in recent years to 6.8% in 2016-17, the fiscal deficit declined to 3% of GDP and the trade deficit — although still considerable — dropped from 9% of GDP to 8.5%. GDP stood at $67.4bn in 2016 and GDP per capita at $1,275\(^3\). Although these factors allowed Myanmar to be formally classified as a lower middle income country, however, income per capita growth has been very uneven across different states and regions and shows no signs of converging\(^4\).

Per capita income differences across states and regions range from K1.7 million in Yangon to K400,000 in Chin State\(^5\) (equivalent to $1,259 and $296 respectively using December 2017 exchange rates).

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1 IMF data
2 The Myanmar fiscal year runs from April 1 to March 31, though from 2018 this will change to October 1 to September 30
3 World Bank estimates
4 World Bank, Myanmar Economic Monitor October 2017 (data from 2014)
5 World Bank, Myanmar Economic Monitor October 2017 (Ministry of Finance and Planning, 2014 Census)
In terms of the economic structure, Myanmar is shifting away from agriculture towards more a more diversified set of sectors including services (e.g. telecommunications) and industry (e.g. food processing). During the period 2000-2004 agriculture accounted for 54% of GDP, but only 32% over the period 2010-2015. The share of GDP of services shifted from 34% to 39% and the share of industrial value creation increased from 11% to 28% over the same time period.

The distribution of employment across those three sectors, however, remained broadly stable between 2004 and 2014. Agriculture still accounts for more than half of all workforce, with just over a third employed in services and the rest in industry. The formal modern sector makes up only 11% of total jobs in Myanmar, according to the World Bank, and labor productivity in agriculture and in manufacturing is among the lowest in the region. According to IMF data of 2016, in terms of GDP contribution, the service sector is most significant contributing 46% of the GDP, while industry and agriculture generate 28% and 26% of GDP respectively.

The country has also struggled to make progress on the World Bank’s ease of doing business index, falling from 170th to 171st in the 2017 report. This was despite making slight improvements in some areas, including access to electricity and paying taxes. Myanmar’s closest ranked Association of Southeast Asian Nations peers are Laos at 141st and Cambodia at 135th.

(Source: World Bank Open Database)

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6 World Bank Myanmar Economic Monitor – October 2017
1.4. Overview over Policies, Regulations and Stakeholders

List of horizontal policies, regulations and stakeholders

Most of the efforts undertaken in investment promotion are not essentially codified in policy papers, but are typically implemented through laws, regulations and the institutionalization of necessary structures with particular support of the Directorate of Investment and Company administration. Only in the area of PPPs, currently a cabinet paper is being formulated.


List of policies, regulations and stakeholders in the healthcare sector

In the health sector, policy directions under the current Government have been summarized and streamlined in the National Health Plan.

1.5. Framework for Investment Promotion and Facilitation in Myanmar

Among the aforementioned laws, in particular the Myanmar Investment Law (2016) and the currently revised Myanmar Companies Law (formerly “Myanmar Companies Act”) with respective implementing rules and regulations are primarily governing investments also in the respective service sectors. A fundamental change in the enterprise-related legal and regulatory framework will be the implementation of the new Myanmar Companies Law, as the law will permit foreign ownership in a Myanmar company up to a sector-specific threshold percentage up to which the entity will not be considered foreign.

The subsequent figure illustrates the three possible cases in the application process for an investment project in Myanmar. As a measure of simplification of the processes, non-strategic investments (e.g. investments below a threshold of USD 5 million) may be realized only with the endorsement of MIC or the subnational investment committees that have been established by DICA throughout 2017.

Table 1: Application process for investment projects in Myanmar

<table>
<thead>
<tr>
<th>Step 1: Inquire information from DICA</th>
<th>Step 2: Preparing the application documents</th>
<th>Step 3: Review by the DICA</th>
<th>Step 4: Review by the MIC/ region &amp; state Investment Committee</th>
<th>Step 5: Obtaining results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seek advice and request information from DICA (optional).</td>
<td>Buy the Investment permit application form 2, fill in the form and submit it to DICA.</td>
<td>Attend the PAT meeting and give presentation.</td>
<td>Attend the MIC meeting and give presentation.</td>
<td>Receive the decision of MIC. If accepted, pick up the MIC Permit.</td>
</tr>
<tr>
<td></td>
<td>Buy the Investment endorsement application form 3 A, fill in the form and submit it to DICA.</td>
<td>Review by the Investment Divisions of DICA</td>
<td>Review by the MIC, no presentation and no need to attend the meeting.</td>
<td>Receive the decision of MIC. If accepted, pick up the MIC Endorsement.</td>
</tr>
<tr>
<td></td>
<td>Buy the Investment endorsement application form 3 B, fill in the form and submit it to DICA.</td>
<td>Review by the region/state DICA offices</td>
<td>Attend the region/state Investment Committee meeting and give presentation.</td>
<td>Receive the decision of region/state Investment Committee. If accepted, pick up the region/state Investment Endorsement.</td>
</tr>
</tbody>
</table>

(Source: GIZ/DICA 2018)

Overall, it can be noted that the Directorate of Investment and Company Administration has not yet developed sector-specific investment promotion strategies in the healthcare, tourism
or other sectors. Efforts of DICA to date have predominantly targeted at a strengthening of the organization-internal capacity, the expansion of DICA in the states and regions of Myanmar, legal and regulatory reform and rather overarching sector-independent instead of sector-specific investment promotion.

1.6. Framework for Public-Private Partnerships in Myanmar

While the general benefits of an inclusion of the private sector in the delivery of services for the government as well as the need for conduction of competitive tender processes have been realized, different modi of collaboration with the local and international private sector coexist in different ministries.

Common practice in various ministries (e.g. Ministry of Construction) has been to utilize tenders for the identification of interested private sector parties for the implementation of a project. Hereby, the utilized tender documents often solely have included fundamental parameters of the project deliverables without any particular technical details. Equally, it could be observed that the supervision and effective quality assurance measures by the government in private sector implemented projects have been limited. Exemplarily, lessons may be learned from the Build-Operate-Transfer (BOT) PPP system of road construction in Myanmar by Ministry of Construction, in which it the local private sector has frequently failed in delivering roads of a certain width (with shoulders) favoring lower-cost solutions at the expense of quality and road safety.

As part of the comprehensive socio-economic reform process under the Thein Sein government, various international development partners including particularly ADB, IFC and JICA have started providing technical assistance in the area of PPP. The Thein Sein government hence included reform measures for the development of a framework and legal basis for PPPs in the Framework of Economic and Social Reform (FESR) as well as in the National Comprehensive Development Plan (NCDP). In the PPP pilot initiative of the construction of the Myingyan gas-fired power plant, a framework for PPPs - not only limited to the power sector - has been established. The Project Appraisal and Progress Reporting Department of the former Ministry of National Planning and Economic Development (currently: Ministry of Planning and Finance) became a central focal point for the PPP initiative along with other tasks in the area of privatization and the appraisal of major projects essential for national economic development (see www.pppmyanmar.gov.mm).7

Based on this, the following fundamental challenges in the policy area of PPP have evolved: There is a fundamental discrepancy in the level of sophistication in the tender management and PPP arrangements of the different ministries in Myanmar and the best practices in PPPs advocated for by international development partners and financial institutions. Partially, the activities of international development partners in the PPP space are not fully coordinated (e.g. between ADB, JICA and World Bank Group), so that partially no a clear roadmap and timeline for reform in the area of PPPs had been visible previously.

The limitation of the work of international development partners on PPPs in particular sectors only (primarily power, infrastructure and transport) with respective governmental counterparts in different ministries limit the chances for an interministerially uniform approach in the handling of PPP arrangements. The healthcare service sector has not yet been covered by any PPP-related project of international development partners, while equally Ministry of Health and Sports has not yet commenced any broader PPP initiative.

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7 See GIZ 2017a
As part of an organizational restructuring process around the establishment of an office supporting the work of the Permanent Secretary of Ministry of National Planning and Economic Development, the Project Appraisal and Progress Reporting Department had been dissolved during a certain period, until the department was re-established after the return of the officials from their postings.

Despite the efforts under the Thein Sein Government, the legal framework for PPPs could not yet be established, while even not yet an aligned approach of major ministries with regard to PPP arrangements exists. After the commencement of the work of the NLD Government in 2016, the newly formed Ministry of Planning and Finance delivered a draft policy paper on the necessary steps for the creation of a PPP-enabling environment as part of a UNDA / UNESCAP supported project. Subsequently, also the ADB took up technical assistance to the government on PPPs in particular in the transport sector. In this context, ADB also supported the drafting of a cabinet paper on PPPs, which has been still unpublished and is under review by the cabinet. (GIZ)

1.7. Regional Commitments of Myanmar under the ASEAN Framework Agreement on Services (AFAS)

With the core objective of a facilitation of freer trade in services within the ASEAN region, ASEAN member states including Myanmar have committed to the implementation of the ASEAN Framework Agreement on Services (AFAS). In the negotiations, AFAS have covered general commitments for the facilitation of trade in services as well as sector-specific commitments. In the AFAS, national legal and regulatory issues limiting (1) market access and (2) national treatment in differently supplied services (i.e. (A) Cross-border supply, (B) consumption abroad and (C) commercial presence) have been flagged for elimination or improvement of market access and treatment. The AFAS will in the future then be taken up in the context of renewed negotiations of the ASEAN Trade in Services Agreement (ATISA) for the further strengthening of regional integration.

In the case of Myanmar, the legislation around the incorporation (e.g. Myanmar Companies Act 1914, Partnership Act 1932, Special Companies Act 1950, Myanmar Companies Regulation 1957), the taxation including income tax and withholding tax (now mitigated) and particular legal issues (e.g. Transfer of Immoveable Property Restriction Law 1987, practice of foreign lawyers, establishment of a commercial presence of a company) are particular issues to be mentioned in the AFAS.
2. Introduction – Healthcare in Myanmar

As part of the political and economic transition of Myanmar over recent years, the Government of Myanmar has shown continuous and important efforts to strengthen the access of citizens to public services including healthcare: The National Health Plan 2017-2021 is expression of these ambitious reform plans targeting an achievement of Universal Health Coverage (UHC) - access to essential health services for everyone in Myanmar within the shortest possible timeframe. Initial target is to provide in an "equitable, effective and efficient manner" basic primary healthcare to the population at township level and below. Hereby fundamental is that healthcare providers outside Ministry of Health and Sports shall be constructively involved in the healthcare service provision.

Elementary challenges though remain in the healthcare sector, as indicated e.g. by the short life expectancy at birth at only a level of 64.7 years in Myanmar momentarily, while various communicable diseases such as malaria, tuberculosis and HIV/AIDS are prevalent in the country. The healthcare sector is also just recovering from a phase of severe public underinvestment during the time of political isolation - the share of public budget spend on healthcare is currently at around 3.65% - increasing, though among the lowest of ASEAN peers. In the case of other ASEAN economies (e.g. Vietnam, Thailand and Singapore), the percentage of the GDP spent on public healthcare ranges at a level of 5-6% despite the nominally higher GDP in the other economies.⁸

The limitations in governmental funding and its allocation have in the past led to a concentration of skilled human resources predominantly in the Yangon - Nay Pyi Taw - Mandalay corridor, an underdevelopment of the physical health infrastructure and the limited availability of essential medicines etc. in public hospitals. Given only nascent steps taken towards a health insurance system, out-of-pocket spending by households remains the dominant source of financing for health services.

It is apparent that Myanmar’s healthcare challenges can only be tackled through the close collaboration of all stakeholders concerned including Ministry of Health and Sports and facilities under its auspices, Ethnic Health Organizations (EHOs), international development partners and the private sector. Purpose of this research is in particular to assess the potentials for a stronger involvement and facilitation of the private sector in contributing to the achievement of healthcare reform objectives.⁹

This report will in particular focus on the opportunities for the public sector and (local and international) private companies to join forces with the Government as part of Public-Private Partnerships (PPP) as well as on ways to promote investments in the healthcare sector of Myanmar. Such measures represent important, though still underused levers available to the Government of Myanmar to mobilize additional funding and to accelerate the modernization and expansion of healthcare service provision in the whole of Myanmar. Currently, mostly the local private sector only has been involved in the operation of private hospitals and e.g. the distribution of pharmaceuticals.

Objective of this research is to map the status quo of the involvement of the private sector in healthcare services in Myanmar along with the opportunities through PPPs and investment promotion initiatives to raise quality and accessibility of health-related services to the population.

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⁸ See IFC 2016  
⁹ Myanmar National Health Plan (2017 - 2021)
3. The Status of Health in Myanmar at a Glance

A substantial improvement of the medical situation of the population still requires committed and strategically coordinated efforts of all relevant stakeholders.

The prevalence of a range of communicable and non-communicable diseases in combination with the previously limited public budget allocation for healthcare indicates the challenging and ambitious character of the reform path that the Government of Myanmar has embarked on. The indicator “life expectancy at birth” of 66 years (males: 65, females: 68) in 2015 shows both - the need for accelerated and committed efforts for healthcare improvements as well as the successes of previous healthcare reform efforts: While the life expectancy at birth increased by three years between 2000 and 2012 in Myanmar, the country is still significantly lacking behind in any comparison on an ASEAN level (e.g. as compared to Singapore, Vietnam etc.).

Table 2 shows the development of several Millennium Development Goals (MDG) indicators in the recent past.

Table 2: Data of the World Health Organization on the status in selected MDG indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Statistics</th>
<th>Baseline*</th>
<th>Latest**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-five mortality rate (per 1000 live births)</td>
<td></td>
<td>109</td>
<td>51</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100 000 live births)</td>
<td>580</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td>Deaths due to HIV/AIDS (per 100 000 population)</td>
<td>17.3</td>
<td>21.6</td>
<td></td>
</tr>
<tr>
<td>Deaths due to malaria (per 100 000 population)</td>
<td>7.1</td>
<td>5.4</td>
<td></td>
</tr>
<tr>
<td>Deaths due to tuberculosis (if HIV-negative) (per 100 000 population)</td>
<td>135</td>
<td>49</td>
<td></td>
</tr>
</tbody>
</table>

\*1990 for under-five mortality and maternal mortality; 2000 for other indicators
\**2012 for deaths due to HIV/AIDS and malaria; 2013 for other indicators

(Source: World Health Organization)

Despite improvements, in particular the mortality among mothers and children under the age of five remains high also in comparison to the progress reached in other ASEAN economies (see Figure 1).

![Figure 3: Maternal mortality ratio and under-five mortality in Myanmar and other ASEAN countries in 2015](Source: IFC 2016)

The prevalence of vector-transmitted diseases (e.g. Japanese encephalitis and malaria), tuberculosis as well other typical water and food-borne diseases in low-hygiene environments

\(^{10}\) See IFC 2016
represents a severe challenge in the healthcare sector. In addition to the regular disease control challenges, partially overall developmental deficits in Myanmar (e.g. limited infrastructural access to areas requiring “backpack doctors”), limitations in stable power supply (e.g. affecting refrigeration) also the access to healthcare services. Equally, various diseases (around 59% of deaths) are caused by non-communicable diseases.\textsuperscript{11}

Over recent years, though general progress in terms of the status of health could be achieved in line with the general advancement in medicine: For instance the maternal mortality rate at a level of 520 per 100,000 live births in 1990, decreased to around 200 in 2013 and is standing at a level of 178 in most recent figures of 2015. The introduction of diagnostic tests for Malaria led to a decrease from 12.6 to 1.3 deaths per 100,000 between 1990 and 2010. Progress equally could be achieved in terms of the greater level of detection of tuberculosis raised from only 8.0% in 1990 to a level of 71.0% in 2010. The greater level of detection now equally allows the appropriate treatment of the disease (at a success rate of 85% in 2009).\textsuperscript{12}

4. Policy Environment for Healthcare

4.1. Governance of the Public and Private Healthcare Sector of Myanmar

The overall governance structure in the health sector of Myanmar does not in any particular way reflect in its organizational structure the need to regulate and support the private healthcare sector. Figure 4 illustrates the departmental structure under relevant ministries involved in the governance of the sector.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{departmental_structure.png}
\caption{Departmental structure of ministries in Myanmar as contact points of a private sector engaged in healthcare}
\end{figure}

(Source: MIMU [modified])

The activities of the departments under Ministry of Health and Sports are primarily targeted towards public service provision – e.g. reflected in the lack of even data collection on private

\textsuperscript{11} See OBG 2017
\textsuperscript{12} See Nyi Nyi Latt, et al. 2016
healthcare provision – and the approval and supervision of medical facilities. Ministry of Health and Sports, however, functions also as the primary regulator for private sector activities in the healthcare sector. Ministry of Health and Sports is equally in charge of ensuring the compliance of healthcare facilities with existing laws, regulations and standards. Furthermore, Ministry of Health and Sports used to provide licenses and recommendations for import of equipment and manufacturing and registration of products medical use. (MoHS)

Under Ministry of Health, the Food and Drug Administration (FDA) is likely to be the unit of the ministry in closest contact with the private healthcare sector, in particular pharmaceuticals. FDA is primarily tasked with the approval of the drugs, medical devices as well as food items of any kind to be distributed in Myanmar. Equally, FDA is to approve changes to existing products (e.g. packaging), the licensing of manufacturers and wholesalers and e.g. the advertisement of drug etc. The FDA hereby controls central functions necessary for the assurance of the required level of product quality (e.g. laboratory testing and monitoring of adverse drug reactions). Despite the presence of FDA in the border areas and close collaboration with Ministry of Commerce, the Customs Department of Ministry of Planning and Finance as well as with the Myanmar Police Force the influx of abundant unregistered pharmaceuticals may hardly be disrupted.

Under Ministry of Industry Myanmar Pharmaceutical Industries has governed in particular the state economic enterprise activities in the sector. Furthermore, the Directorate of Industrial Supervision and Inspection (DISI) is in charge of the technical supervision of various types of facilities to be found e.g. in a hospital (e.g. elevators). For both, the establishment of hospitals or manufacturing facilities, Ministry of Industry would approve construction plans, environmental plans and partially the import of equipment according to the needs of the project.

The Directorate of Investment and Company Administration (DICA) under Ministry of Planning and Finance and the related Myanmar Investment Commission (MIC) are facilitating the incorporation of any type of company and the approval of a particular project equally in the healthcare sector. In the case of investments in the healthcare sector, DICA will refer investors then to the relevant other ministries, local authorities etc. to obtain further approvals. Through a one-stop shop arrangement, DICA is seeking to essentially streamline and shorten the investment process significantly, whereby in particular foreign investments in the health sector nonetheless often appear to face challenges throughout the process of obtaining necessary additional permissions from the side of Ministry of Health. In addition, DICA has not yet developed any particular sector-specific investment promotion strategies (i.e. for the healthcare sector). Certain subsectors in healthcare have been included in the list of promoted sectors (see Myanmar Investment Commission Notification No. 13/2017) eligible for tax exemptions for a period of three, five or seven years in dependence on the location of the investment (see Myanmar Investment Commission Notification No. 17/2017). (DICA website)

Under Ministry of Planning and Finance - in addition – a specific unit, the Project Appraisal and Progress Reporting Department (PAPRD), has been established in particular to rapidly appraise the implementation of projects with significant project budget exceeding a threshold amount, projects of importance for national development and projects to be carried out in a PPP arrangement. This department, however, has not yet carried out a PPP project in the health sector yet. (PPP Framework ADB)

Certain other line ministries are equally sustaining a certain number of hospitals for their staff and dependants. Beyond military hospitals under Ministry of Defense, the other ministries for instance in the areas of industry, mining and transport have also sustained facilities for the provision of healthcare services. Ministry of Labor, Immigration and Population equally is operating three hospitals at locations in Yangon and Mandalay for individuals with entitlement under social security schemes.
4.2. Policy Objectives of the National Health Plan

The Myanmar National Health Plan (NHP) has been launched for the period from 2017 to 2021 by the Union Minister of Health and Sports with endorsement of the State Counsellor Daw Aung San Suu Kyi. In the plan, it is envisioned to achieve Universal Health Coverage (UHC) until 2030 meaning to allow “all people [to have] access to needed health services of quality without experiencing financial hardship”. In this respect, the NHP is adopting a pro-poor and inclusiveness perspective as a central motive. Despite its ambitious underlying vision, the NHP remains predominantly a policy plan without a comprehensive set of actions determined as a contribution to its technical implementation. Primarily two strategies for the achievement of UHC until 2030 have been provided as an “expansion of service availability and readiness” as well as a “reduction of the catastrophic and impoverishing out-of-pocket spending on health”. Principle of the NHP is hereby to expand the coverage of healthcare services in utilization of all available resources, which “need to meet the same minimum standards of care”, though irrespective of the party providing them.

On an implementation level, Ministry of Health and Sports is currently defining the three different levels of essential packages of health services (EPHS): Basic EPHS, Intermediate EPHS and Comprehensive EPHS. In order to provide such standardized packages, the ministry is currently determining the costs of such packages to then subsequently identify financial requirements for the implementation of the package delivery on a nationwide scale – hence, a costing of the NHP.

While the NHP is recognizing the need for an involvement of the private sector in the delivery of healthcare services to reach a viable path to UHC by 2030, the NHP does not define the way in which the private sector may particularly be encouraged to engage in collaboration with the government.

Figure 5: Visualization of fundamental principles of the Myanmar National Health Plan

(Source: Myanmar National Health Plan)
In the NHP, for an achievement of “service availability and readiness”, the private sector is only considered under the term of the “general practitioners”. Hence it remains unclear in the NHP, which role other private medical service providers e.g. as defined in the “Law Relating to Private Health Care Services” from 2007 may adopt in the implementation of the NHP. This comprises e.g. private general and specialist hospitals, private general and specialist clinics, private maternity homes, private nursing homes and private diagnostic services.

5. Healthcare Financing

Public and private expenditure for healthcare have significantly increased in Myanmar over the past years in absolute and relative terms. The government is still to develop a sustainable financing strategy for the coverage of healthcare expenses.

Certain indicators of healthcare service availability immediately correlate with the public expenditure, for instance the bed count or equipment of hospitals with certain medical devices. The ASEAN countries covered in a regional IFC study overall are characterized by an under-capacity of available hospital beds in the range of 0.7 and 2.5 beds per 1,000 inhabitants as compared to the recommended value of 3.5 beds per 1,000 people by WHO. (IFC) An explanation for the undersupply of hospital bed may also be that the medical systems of the respective countries primarily sought to address acute treatment necessary in response to infectious diseases or individual accidents. With rising life expectancy, however, also the elderly may also require a more extended period of care within on average the nine years of life beyond the healthy life expectancy. Challenges of the future may hence be the treatment of chronic diseases and the preparation for an aging society with though demands and needs within the healthcare system. It is in this context encouraging that the Government of Myanmar has realized the need for greater public investment in healthcare. A recent analysis of the budget expenditure of the Government of Myanmar indicates the significant relative increase in budget allocation for health and education system development (see Figure 6).

![Governmental expenditure in FY 2009/10 vs. FY 2013/14](Image)

Figure 6: Analysis of public expenditure in Myanmar by sector in FY 2009/10 vs. FY 2013/14 against the benchmark of similar economies

(Source: World Bank Group)

Figure 7 also shows the relative increase in healthcare spending, while it indicates both, public and private sector spending. It is noteworthy that while investments in the health sector have increase on the public and private side, the private sector has only emerged at scale within the previous five years. This indicates the dynamic and potential for the achievement of UHC
- at the most rapid possible pace - through effective private sector involvement and the collaboration between public and private sector.

Figure 7: Public and private healthcare expenditure in Myanmar from 2010 to 2015

(Source: Solidiance [modified])

The social security scheme - implemented according to the 2012 Social Security Law - is the most comprehensive structure in Myanmar to insure against different health-related risks and e.g. the risk of inability to carry out the profession after an accident. While the scheme is particularly targeted at workers, also care for dependant family members may be covered. (NICB)

In July 2015, in addition, a first health insurance initiative has been launched, wherein Myanmar Insurance as well as a set of private insurance service providers may offer a basic coverage of cost incurred in publicly run healthcare facilities. Such health insurance scheme, however, does not allow coverage for treatment in private hospitals and other private facilities. Hence, the current setup of insurance and social security system in Myanmar does not effectively allow patients to utilize healthcare run by the private sector to seek higher-priced medical care. In consequence, patients seeking treatment in the private sector often remain therefore suddenly be confronted by major expenses in case of an emergency without any insurance scheme that would flatten health expenditure to a regular insurance premium. (VDB Loi)

Particularly transformative initiatives regarding the financing of healthcare sector reform of Myanmar are currently under implementation by the World Bank as well as PSI. Hereby, the World Bank is supporting Ministry of Health and Sports in a financing strategy for health services and in the delivery of analytical pieces for the determination of the reasonable pricing for the essential services. PSI is supporting Ministry of Health and Sports in the development of a strategic purchasing mechanism for the procurement of healthcare services from general practitioners (GPs), public hospitals and clinics. The PSI project is aiming at reforming the current system of direct budget allocation of different departments under Ministry of Health and Sports e.g. to individual GPs and out-of-the-pocket spending of patients. E.g. general practitioners would in the current system in particular be discouraged from overspending particular budget lines, even if the total allocated budget to the practice would allow for a budget reallocation. In particular in the case of e.g. an epidemic outbreak, GPs hence would be unable to react to patient’s needs beyond the budget allocation for the particular measure. PSI is seeking to support the government in the establishment of an independent central body as a pool of funding from the public budget, international development partners and e.g. health insurance or social security contributions. Such central body would then plan strategic purchases and handle relevant procurement processes centrally to achieve lower costs.
6. Health Service Providers

6.1. Overview: Public Medical and Health Facilities in Myanmar

In general, it is encouraging to note that the increasing government spending on healthcare has been translated into an expansion of the number of facilities available: The number of both, public medical and privately run health facilities has expanded in the pursuit of UHC. It is noteworthy though that the growth of healthcare facilities publicly provided of around 30% between 2000 and 2015 is in contrast to the doubling of in-patient numbers and tripling in outpatient numbers in the same timeframe though. Hence, it is likely that – under an assumption of continued growth of the demand of health services by a growing proportion of the population – facilities especially in urban agglomerations will though reach their capacity in the near future.

The significant proportion of the population in rural areas is primarily served by Rural Health Centers (RHC) and its usually four subcenters. A RHC is staffed by a Public Health Supervisor (Grade I) at the RHC, four Public Health Supervisors (Grade II) at each subcenter), five midwives available in the RHC and all four sub-centers as well as a Lady Health Visitor and a Health Assistant at the RHC.13

Table 3: Development of the number of medical and health facilities between 2000/01 and 2014/15 in absolute values

<table>
<thead>
<tr>
<th></th>
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</tr>
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<tbody>
<tr>
<td>GOVERNMENT HOSPITAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(1) Specialist Hospital</td>
<td>19</td>
<td>20</td>
<td>24</td>
<td>25</td>
<td>30</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>Bed: Scheduled</td>
<td>5.850</td>
<td>5.950</td>
<td>7.400</td>
<td>7.500</td>
<td>9.450</td>
<td>8.150</td>
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<tr>
<td>(2) General Hospital</td>
<td>731</td>
<td>804</td>
<td>874</td>
<td>899</td>
<td>919</td>
<td>941</td>
<td>947</td>
</tr>
<tr>
<td>Bed: Scheduled</td>
<td>25.770</td>
<td>28.116</td>
<td>33.513</td>
<td>34.304</td>
<td>35.119</td>
<td>35.896</td>
<td>35.983</td>
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<tr>
<td>Available</td>
<td>33.512</td>
<td>36.092</td>
<td>39.098</td>
<td>39.197</td>
<td>38.568</td>
<td>41.025</td>
<td>41.278</td>
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<tr>
<td>HOSPITAL ACTIVITY</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) In-Patients (000)</td>
<td>831</td>
<td>1.003</td>
<td>1.311</td>
<td>1.322</td>
<td>1.520</td>
<td>1.785</td>
<td>2.084</td>
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<tr>
<td>(2) Out-Patients (000)</td>
<td>2.119</td>
<td>2.755</td>
<td>3.627</td>
<td>3.660</td>
<td>4.166</td>
<td>5.519</td>
<td>7.276</td>
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<td>DISPENSARY</td>
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<td>388</td>
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<td>INDIGENOUS MEDICINE</td>
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<td>(1) Indigenous Hospital</td>
<td>10</td>
<td>14</td>
<td>14</td>
<td>14</td>
<td>17</td>
<td>17</td>
<td></td>
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<td>(2) Indigenous Medical Centers</td>
<td>209</td>
<td>237</td>
<td>237</td>
<td>237</td>
<td>237</td>
<td>254</td>
<td>247</td>
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<tr>
<td>(3) Patients Treated (000)</td>
<td>1.271</td>
<td>1.142</td>
<td>2.300</td>
<td>1.459</td>
<td>1.080</td>
<td>1.487</td>
<td>1.484</td>
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<td>HEALTH CENTRE</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(1) Rural Health Centre</td>
<td>1.402</td>
<td>1.456</td>
<td>1.558</td>
<td>1.565</td>
<td>1.635</td>
<td>1.684</td>
<td>1.696</td>
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<tr>
<td>(2) Primary and Secondary</td>
<td>84</td>
<td>86</td>
<td>86</td>
<td>87</td>
<td>87</td>
<td>87</td>
<td>88</td>
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<tr>
<td>(3) Maternity and Child Health</td>
<td>348</td>
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<tr>
<td>SCHOOL HEALTH TEAM</td>
<td></td>
<td></td>
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<tr>
<td>(1) Number of Teams</td>
<td>80</td>
<td>80</td>
<td>80</td>
<td>80</td>
<td>80</td>
<td>80</td>
<td>80</td>
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<tr>
<td>(2) Schools visited (000)</td>
<td>32</td>
<td>35</td>
<td>38</td>
<td>38</td>
<td>37</td>
<td>38</td>
<td>41</td>
</tr>
<tr>
<td>(3) Children examined (000)</td>
<td>4.651</td>
<td>5.332</td>
<td>5.908</td>
<td>6.097</td>
<td>4.332</td>
<td>4.661</td>
<td>4.602</td>
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6.2. Distribution of Publicly Run Medical and Health Facilities in Myanmar

Table 3 illustrates the geographic distribution size and coverage of the public medical and health facilities of the population in the different states and regions. These statistics, however, do not take into account private sector facilities (i.e. practices of general practitioners, private hospitals and clinics) as well as the degree of utilization of the facilities. Despite the – in statistical terms – high availability of medical services in the ethnic border states (e.g. 484 inhabitants per scheduled bed in Chin State and 527 inhabitants per scheduled bed in Kayah State), the mountainous terrain and resulting inferior accessibility of areas explain the differences.

Table 4: Geographic distribution of public medical and health facilities throughout Myanmar

<table>
<thead>
<tr>
<th>Region</th>
<th>No.</th>
<th>Scheduled beds</th>
<th>Population</th>
<th>Population-facilities ratio</th>
<th>Population-bed ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNION TOTAL</td>
<td>975</td>
<td>44133</td>
<td>50279900</td>
<td>51569</td>
<td>1139</td>
</tr>
<tr>
<td>Ayeyarwady Region</td>
<td>103</td>
<td>3143</td>
<td>6184829</td>
<td>60047</td>
<td>1968</td>
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<tr>
<td>Bago Region</td>
<td>96</td>
<td>2706</td>
<td>4867373</td>
<td>50702</td>
<td>1799</td>
</tr>
<tr>
<td>Chin State</td>
<td>24</td>
<td>990</td>
<td>478801</td>
<td>19950</td>
<td>484</td>
</tr>
<tr>
<td>Kachin State</td>
<td>51</td>
<td>1823</td>
<td>1642841</td>
<td>32213</td>
<td>901</td>
</tr>
<tr>
<td>Kayah State</td>
<td>17</td>
<td>544</td>
<td>286627</td>
<td>16860</td>
<td>527</td>
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<tr>
<td>Kayin State</td>
<td>30</td>
<td>986</td>
<td>1504326</td>
<td>50144</td>
<td>1526</td>
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<tr>
<td>Magway Region</td>
<td>82</td>
<td>2673</td>
<td>3917055</td>
<td>47769</td>
<td>1465</td>
</tr>
<tr>
<td>Mandalay Region</td>
<td>111</td>
<td>9057</td>
<td>6165723</td>
<td>55547</td>
<td>681</td>
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<tr>
<td>Mon State</td>
<td>33</td>
<td>1077</td>
<td>2054393</td>
<td>62254</td>
<td>1908</td>
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<tr>
<td>Rakhine State</td>
<td>49</td>
<td>1387</td>
<td>2098807</td>
<td>42833</td>
<td>1513</td>
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<tr>
<td>Sagaing Region</td>
<td>113</td>
<td>3384</td>
<td>5325347</td>
<td>47127</td>
<td>1574</td>
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<tr>
<td>Shan State</td>
<td>151</td>
<td>4774</td>
<td>5824432</td>
<td>38572</td>
<td>1220</td>
</tr>
<tr>
<td>Tanintharyi Region</td>
<td>33</td>
<td>1127</td>
<td>1408401</td>
<td>42679</td>
<td>1250</td>
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<tr>
<td>Yangon Region</td>
<td>82</td>
<td>10462</td>
<td>7360703</td>
<td>89765</td>
<td>704</td>
</tr>
</tbody>
</table>

Nay Pyi Taw has not been included in the statistics of the Department of Public Health, whereby literature suggests a high status of development of healthcare facilities and sufficient availability of healthcare services in Nay Pyi Taw.

(Source: Department of Public Health, 2014 Population and Housing Census)
6.3. Distribution of Private Medical and Health Facilities in Myanmar

An analysis of the private sector involvement in Myanmar will need to start from the definition of “the private sector”: The structure of the statistical record maintained by the Central Statistical Organization (CSO) as well as wording chosen in the NHP suggest that there is limited recognition of the private clinics and hospitals as stakeholders in the national health system. Furthermore, other health-related sectors with significant development potentials in Myanmar from the pharmaceutical industry to diagnostic devices and the insurance sector are not covered in the NHP and other related strategic policy documents.

The greatest level of recognition as private sector actors in healthcare by the Government of Myanmar has the group of GPs. In contrast to other regional economies, the practices of the 3911 registered GP practices are typically small in size – often solely comprising the doctor and e.g. a nurse, medical assistant or receptionist or administrative staff. 444 private polyclinics existed in the country according to the APO Myanmar Health System Review 2014, while it needs to be noted that the Myanmar Private Hospitals Association is the only entity gathering publicly available data on e.g. such clinics.

![Distribution of general clinics and general dental clinics by state / region in 2015](image)

(Source: Department of Public Health)

Figure 6 shows the overproportional concentration of GPs in Yangon Region, predominantly Yangon itself. According to the combined data set of CSO and the Myanmar Private Hospitals Association, the distribution of private hospitals throughout the country equally shows concentration in Yangon Region. However, private hospitals increasingly have also opened in Mandalay and second-tier cities. Currently, around 13.8% of the hospitals in Myanmar are privately operated. (Solidiance)
6.4. Other Stakeholders with Involvement in Healthcare Provision in Myanmar

The National Health Plan explicitly also mentions the fundamental role of two other stakeholder groups in the provision of healthcare in Myanmar:

- Ethnic Health Organizations: The health organizations of non-state actors involved in the border areas are often operating in a similar way to NGO project and partially receive funding from international donors. The facilities contribute significantly to reaching the objective of universal coverage of EPHS. Non-Governmental Organizations (NGOs) such as Community Partners International (CPI) have continuously supported ethnic health organizations throughout the country.

- NGOs, also comprising UN agencies, private charitable initiatives: International development partners active in the healthcare sector of Myanmar are delivering important contributions to the development of access to and the quality of health services during an interim period, before more effective revenue collection mechanisms for the government are available or a comprehensive health insurance system or other sustainable financing mechanism has been developed.

- Religious Leadership: Several initiatives of religious organizations and religious leaders in the construction and operation of hospitals and clinics could be found (e.g. an eyecare clinic established by Buddhist monks in Sagaing Region).
### 7. Segmentation of Usership in Healthcare

Several key segments of healthcare users in Myanmar can be identified as (a) users of rural healthcare facilities, (b) users of urban public healthcare, (c) users of private urban healthcare in Myanmar and (d) medical tourists from Myanmar.

In consideration of the segmentation of the healthcare users it is noteworthy that in the current socio-economic structure of Myanmar there is room for complementarity and cooperation instead of competition between public and private healthcare service providers in delivering for a particular user segment. Hence, the promotion of private sector involvement in healthcare provision constitutes a clear win-win situation in the efforts of fostering universal healthcare service accessibility. Regional disparities between urban, semi-urban and rural areas and the formation of different socio-economic classes have led to different demands of these groups for healthcare service.

In recent years, more accessible entrepreneurial opportunities (e.g. in IT, gastronomy) and the expansion of the operations of local- and foreign-invested companies in Myanmar have allowed the growth of a “new” middle class. Such improvement of the income situation of particularly urban population now shapes an promising opportunity for the private sector to serve such healthcare user segments in a commercially viable and sustainable way. Therefore a liberalization in healthcare service provision (within a sound and transparent legal and regulatory framework) and an active call for private sector involvement by the government may well repeat the transformative societal and economic change of the “digital leapfrogging” following the telecommunication sector liberalization under the administration of U Thein Sein.

(a) **Users of Rural Healthcare**

In rural areas of Myanmar outside of the Yangon - Nay Pyi Taw - Mandalay corridor and outside of second-tier cities, access to healthcare services remains limited and challenging. In rural areas, a mix of governmental funding, support of international donors and the work of ethnic health organizations has allowed a certain limited level of access to healthcare services. In rural areas, the involvement of the private sector is still rudimentary. Private telemedical, app-based or mobile healthcare services may well though be an important solution for remote diagnosis, referrals and efficient resource utilization, in which e.g. general practitioners, doctors in urban public hospitals etc. may well collaborate with the private sector providers. Particular constraints are the limited accessibility of communities due to the underdevelopment of infrastructure as well as rural poverty in an setting of high out-of-pocket spending.

(b) **Users of Urban Public Healthcare**

Yangon and the two other urban centers of Mandalay and Nay Pyi Taw have seen significant development in terms of the expansion of healthcare facilities and services. Univocally, interviewees in this research stated that public healthcare facilities were predominantly utilized by low-income households, who would otherwise not be able to afford treatment. Although the treatment is provided mostly free-of-charge in non-private rooms, various costs for e.g. laboratory-based testing, linens etc. are still to be borne by the patient. In addition, given the widespread socio-economic hardship in Myanmar, public hospitals are often operated at their capacity limits. Due to the low salary for doctors in the public sector, e.g. medical specialists often spend afterhours in private hospitals.
(c) Users of Urban Private Healthcare

Likewise to most business sectors, the healthcare sector is predominantly concentrated in the primary city and commercial capital Yangon: The majority of general practitioners are located in Yangon Region, while also in particular international private hospital projects primarily target Yangon. In an analysis, Solidiance segmented the private hospitals according to the per-night prices and the socio-economic classes targeted: Low-cost hospitals (around USD 20 per night) primarily target segments up to the lower middle class, medium-priced hospitals (around USD 50 per night) an upper middle class, while high-priced hospitals (around USD 90 per night) would target such wealthier patients, who would previously have travelled abroad to Thailand or Singapore for medical purposes. For instance, Pun Hlaing Hospital as rather a high-end hospital has undertaken attempts to broaden the range of patient segments reached by introducing low-cost treatment: Cost savings would hereby not be generated at the expense of the quality of the treatment, but through a denser configuration of beds etc. similarly to the situation in public hospitals.\(^\text{14}\)

(d) Medical Tourists

Medical tourism is a common phenomenon among Myanmar nationals: According to the Royal Thai Embassy, a majority of the Myanmar visitors to Thailand enter the country for medical purposes. Given this high-demand by Myanmar nations, Thai hospitals have reacted through the availability of Myanmar-Thai translators, representative offices and partner hospitals in Yangon and even the arrangement of discounted air travel for in-patients (see Figure 8).

Main destinations of medical tourists from Myanmar are Thailand, Malaysia, India and Singapore. According to market research of IPSOS, it is suggested that typical types of treatment sought in foreign hospitals comprises medical for instance check-ups, cardiac treatments, orthopedics and oncologic treatment. Due to a more favorable legal framework, organ transplants are frequently undergone in India. In particular in the case of possibly fatal diseases, Myanmar nationals prefer an evacuation over domestic medical treatment.\(^\text{15}\)

\(^{14}\) See Solidiance Research and Analysis 2018  
\(^{15}\) See Ipsos 2013
The situation of medical tourism shows the high demand for treatment at international standards and the opportunity to constructively engage the foreign and local private sector as well as foreign medical professionals within Myanmar in the future. Equally, the outbound medical tourism from Myanmar shows the deeply entrenched mistrust of the population in the quality of healthcare services in Myanmar.

8. Human Resource Development in the Healthcare Sector

A severe undersupply in qualified human resources persists in Myanmar - mostly in terms of the low number of nurses, medical assistants and pharmacists. The possibilities for involvement of foreign medical professionals in Myanmar are still limited nonetheless.

The staffing of the public medical and health facilities is showing both systematic strengths and weaknesses of the public healthcare sector of Myanmar: The number of medical doctors in state service could be significantly increased, nearly tripled, so that currently 14050 medical doctors in state service are available for the 975 medical and health facilities at a capacity of 44133 scheduled beds. However, remarkable is the considerably low number of nurses, midwives and health assistants. The number of doctors of 32861 in 2015 even exceeds the number of nurses of 32609 in Myanmar, which explains anecdotal evidence that medical doctors would – beyond diagnosis and immediate treatment – engage in a number of supportive activities that would in other country contexts be supported by nurses. Interviews with key informants equally univocally identified a systematic lack of medical technicians e.g. trained in the operation and maintenance of equipment as a major challenge.

Table 5: Development of the number of medical and health personnel between 2000/01 and 2014/15

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>(i) state service</td>
<td>5.421</td>
<td>6.941</td>
<td>10.450</td>
<td>11.675</td>
<td>12.800</td>
<td>13.099</td>
<td>14.050</td>
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<td>(ii) private practice</td>
<td>10.046</td>
<td>11.643</td>
<td>15.985</td>
<td>16.402</td>
<td>17.032</td>
<td>18.443</td>
<td>18.811</td>
</tr>
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<td>Dental Surgeon</td>
<td>1.072</td>
<td>1.594</td>
<td>2.562</td>
<td>2.770</td>
<td>3.011</td>
<td>3.219</td>
<td>3.413</td>
</tr>
<tr>
<td>Health Assistant</td>
<td>1.717</td>
<td>1.771</td>
<td>1.883</td>
<td>1.893</td>
<td>2.013</td>
<td>2.026</td>
<td>2.074</td>
</tr>
</tbody>
</table>
Myanmar is far below the recommendation of the World Health Organization (WHO) for the achievement of coverage for essential healthcare services of 2.28 skilled health workers per 1,000 population. In statistical terms, Myanmar has as an anomaly an undersupply of skilled health workers in comparison with its ASEAN peers: Per 100,000 population, Myanmar is supplying 61 doctors (SE Asia: 59), 100 nurses / midwives (SE Asia: 153) and 7 dental surgeons (SE Asia: 10). Despite the relatively high number of doctors available, there is a substantial lack of specialists: Research for instance quantified the number of practicing oncologists in the entire country as 17 only. Particularly alarming in this context are the persisting barriers of entry to foreign medical specialists (e.g. visa, charges) that allow public and private hospitals not to satisfy the demand for specialized care.

These limitations in the availability of qualified medical specialists also lead to a situation, in which in particular Myanmar Medical Council is facing a significant burden of constant workload: Myanmar Medical Council is tasked with the registration of any foreign and local medical practitioner active in Myanmar, whereby the council tends to only permit both foreign doctors and former Myanmar citizens (who adopted other nationalities) to operate in Myanmar on a short-term basis. Typically, approval is only given to non-Myanmar nationals for a particular schedule of e.g. operations / treatments throughout a period of a few days. Even former Myanmar citizens with specialist medical expertise and excellent international credentials and intentions to contribute to the advancement of the Myanmar’s healthcare sector typically face challenges in being permitted to return on a longer terms basis. In addition, any non-Myanmar national medical practitioner needs to seek a letter of endorsement by any of the few licensed Myanmar specialist doctors throughout the registration process of Myanmar Medical Council, which represents another bureaucratic effort for the local specialists. An additional unnecessary responsibility of medical specialists under Myanmar Medical Council is the provision of formal letter of recommendations for any pharmaceutical product (including different packages of the same product) to be approved by the Department of Food and Drug Administration for a limited period of time. The prevalence of counterfeit products on the Myanmar market provides a certain rational for additional checks, while the current approval procedures for pharmaceuticals by specialists under Myanmar Medical Council and FDA may create a moral hazard issue for the pharmaceutical private sector in the process of gaining the confidence of the limited number of medical specialists in a certain field.

Key informants explained that the daily workload of medical specialists in Myanmar is exceeding any sustainable scope: As graduates from Myanmar’s medical universities are required to work in the public medical sector at comparatively low salary levels, medical specialists tend to work in the medical public sector during daytime and in private hospitals during the nights. Only the combination of remuneration from public and private sector appears to allow the medical practitioners to be able to sustain their lives.

While the Philippines and Myanmar show similarities in terms of the high number of nationals working in service sectors abroad (e.g. global placement of seamen, hospitality workers in the Middle East), this does not apply to the medical service sector. Myanmar is considerably undersupplied e.g. with nurses, midwives, qualified caregivers, medical technicians and capable
healthcare administrators. Despite the challenges caused by the shortage in Myanmar’s healthcare sector itself, it is noteworthy that also employment opportunities in the export of services against the receipt of remittances remain unexplored.\textsuperscript{16}

9. Legal and Regulatory Framework for Domestic and Foreign Investment in Healthcare

The most comprehensive law concerned with in particular the definition of possible private sector activities in healthcare provision is the aforementioned Law Relating to Private Health Care Services (2007). In addition, the Public Health Law (1972) has before already provided fundamental definitions on the relationship between e.g. hospitals or clinics and the numerous practices of general practitioners.

The following laws primarily govern the provision of private health services (mostly WHO):

\textbf{Table 6: Key legislation relevant to healthcare provision and the private sector}

<table>
<thead>
<tr>
<th>Law</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competition Law (2015)</td>
<td>It prohibits any agreements and e.g. pricing strategies that would be based on an abuse of market dominance, hence prescribes the requirement for competition in business transactions.</td>
</tr>
<tr>
<td>Dental and Oral Medicine Council Law (1989, revised in 2011)</td>
<td>The law fundamentally regulates the provision of dental care in Myanmar and assigns responsibility to the Oral Medical Council with regard to the representation of the medical professionals active in this sector.</td>
</tr>
<tr>
<td>Insurance Permission Law (2015)</td>
<td>It allows the engagement of private sector insurances other than the regulator and monopolist Myanmar Insurance in the market.</td>
</tr>
<tr>
<td>Law Relating to Private Health Care Services (2007)</td>
<td>The law is fundamental for the operation of any private sector company the healthcare sector, as it initially legitimizes the delivery of healthcare services by the private sector. It defines the different types of facilities (e.g. hospitals, clinics) wherein private companies may involve as operators.</td>
</tr>
<tr>
<td>Law relating to the Nurse and Midwife (1990, revised in 2002 and 2015)</td>
<td>The law fundamentally regulates nursing and midwifery practices in Myanmar and assigns responsibility to the Nurse and Midwife Council with regard to the representation of nurses and midwives.</td>
</tr>
<tr>
<td>Myanmar Companies Act (1913) / Myanmar Companies Law (2017)</td>
<td>The Myanmar Companies Act has been the most basic law regarding the definition, establishment, governance and management as well as liquidation of a private sector company in Myanmar. In 2017, the law that is dating back to British colonial times has been updated through the Myanmar Companies Law. A major novelty of the revised law will be the permissible foreign ownership in a company treated as a local entity up to a certain percentage.</td>
</tr>
<tr>
<td>Myanmar Investment Law (2016)</td>
<td>The Myanmar Investment Law is unifying the previously separate Foreign Investment Law (2012) and the Citizens Investment Law (2013) in a single legal document. Furthermore, the revised law includes streamlined investment approval procedures, investment tax incentives in promoted sectors as well as underdeveloped townships of the country.</td>
</tr>
<tr>
<td>Myanmar Medical Council Law (2000, revised in 2015)</td>
<td>The law establishes the Myanmar Medical Council Law as a key entity in the definition of standards, rights and duties for medical practitioners, for the development of human resources in the medical sector and the registration of doctors.</td>
</tr>
</tbody>
</table>

\textsuperscript{16} See Nyi Nyi Latt, et al. 2016 and OBG 2017
It relates to the production, storage and commercialization of safe and efficacious drugs and assigns responsibility to a supervisory body of the sector (currently the Food and Drug Administration).

The law stipulates the responsibility all actors of the healthcare system to control communicable diseases and to minimize the risk of their spreads through measures of hygiene, sanitation and necessary care.

**Public Health Law (1972)**
It outlines fundamental standard to adhere to in terms of hygiene, sanitation, disease control etc. in hospitals and clinics.

(Source: World Health Organization)

10. **Framework for Investment Promotion in the Healthcare Sector**

The Myanmar Investment Commission has emphasized the importance of private sector involvement in the healthcare sector. In Myanmar Investment Commission (MIC) Notification No. 13/2017, therefore certain key sectors have been prescribed as promoted sectors, among these various sectors that directly or indirectly relate or may relate to the private healthcare sector (see Table 7).

**Table 7: Promoted sectors for investments according to MIC Notification No. 13/2017**

<table>
<thead>
<tr>
<th>(P) Education services</th>
<th>1 Private schools</th>
<th>ISIC 85</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 Schools which apply international curriculum</td>
<td>ISIC 8530</td>
</tr>
<tr>
<td></td>
<td>3 Technology and vocational institutes</td>
<td>ISIC 8530</td>
</tr>
<tr>
<td></td>
<td>4 Higher education services</td>
<td>ISIC 8530</td>
</tr>
<tr>
<td></td>
<td>5 Sport education services</td>
<td>ISIC 85419</td>
</tr>
<tr>
<td></td>
<td>6 Training for civil aviation</td>
<td>ISIC 85</td>
</tr>
<tr>
<td></td>
<td>7 Training and developing health service support human resources</td>
<td>ISIC 85</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(Q) Health services</th>
<th>1 Hospital service</th>
<th>ISIC 861</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 Medical laboratory service</td>
<td>ISIC 861</td>
</tr>
<tr>
<td></td>
<td>3 Traditional hospital service</td>
<td>ISIC 86101</td>
</tr>
<tr>
<td></td>
<td>4 Private clinic service</td>
<td>ISIC 86</td>
</tr>
<tr>
<td></td>
<td>5 Manufacturing of veterinary medicine</td>
<td>ISIC 7500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(T) Science research development business</th>
<th>2 Research for medical education and medicine</th>
<th>ISIC 72103</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6 Research on traditional medicine and laboratory service</td>
<td>ISIC 72103</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(D) Manufacturing</th>
<th>28 Production of coffee, tea and traditional medicinal plants</th>
<th>ISIC 1076</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>54 Production of medicine, chemical products for medicine and botanical products</td>
<td>ISIC 2100</td>
</tr>
<tr>
<td></td>
<td>91 Production of traditional medicine</td>
<td>ISIC 10762</td>
</tr>
<tr>
<td></td>
<td>92 Production of medical equipment and supply</td>
<td>ISIC 3250</td>
</tr>
</tbody>
</table>

(Source: Myanmar Investment Commission)

The inclusion of a certain healthcare-related subsector among the list of promoted sectors allows investors to profit from tax exemptions between three and seven years in dependence on the status of development of the respective township wherein the investment is undertaken: In “less developed townships” (predominantly in the border areas) the tax exemption is granted for a period of seven years, in “moderately developed township” for five years and in “developed townships” for three years (see Figure 12). *(MIC)*
Figure 12: “Development Zones” according to MIC Notification No. 10/2017
(Source: MIMU, Myanmar Investment Commission)

11. Exemplary Investment Process Map
The establishment of a new hospital or clinic at a certain location would though not be guided by policies and identified healthcare development needs of Ministry of Health and Sports. In most cases, an unsolicited proposal is developed by private sector parties and escalated to the Government.

Typically, the following broad steps will be performed by the developer of a new private medical facility such as a polyclinic (see right).

In addition to the licensing process on a township and level, obvious other processes including for instance the incorporation or the obtaining of the Myanmar Investment Commission are to be initiated by the investor. For the establishment of most healthcare-related facilities (e.g. hospitals, clinics, facilities for human resource development and pharmaceuticals production), typically a percentage of up to 80% foreign ownership is permissible by default. Hence, the establishment of a medical facility in Myanmar requires joint venturing with a local partner, whereby the partnership may also profit from the local standing of the Myanmar partner company.\(^\text{17}\)

Equally may parties desirous to purchase or sell equity in an existing company operating a healthcare facility do so with respective permission, if land would not be held - only be used - by a foreign party due to the restrictions in foreign ownership of land according to the Transfer of Immovable Property Restriction Act (TIPRA) of 1987.\(^\text{18}\)

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\(^\text{17}\) See VDB Loi 2016
\(^\text{18}\) See VDB Loi 2016
12. Relevant AFAS Commitments in the Removal of Barriers to Trade in Services in the Healthcare Sector

As part of the AFAS negotiations, Myanmar has in the healthcare sector only agreed to permit a commercial presence of entities of “up to 70% foreign equity participation […] in accordance with The Law relating to Private Health Care Services, 2007” in the following sectors beyond horizontal commitments:

- General medical services (CPC 93121),
- Specialized medical services (CPC93122),
- Dental services (CPC 93123),
- Deliveries and related services, Nursing Services, physiotherapist and paramedical personnel (CPC 93191),
- Hospital services (CPC 9311),
- Ambulance services (CPC 93192),
- Laboratory Services,
- Residential health facilities services other than hospital services (CPC 93193) and
- Other human health services (CPC 93199).

13. Key Opportunities for Private Sector Involvement in Healthcare

In this section, different key opportunities for private sector involvement, investments and public-private partnerships in different areas of healthcare and related industries will be presented. It is attempted to illustrate opportunities and challenges from a private sector angle and to share hands-on perspectives on procedural bottlenecks. It is important to understand that these opportunities have been selected for illustration purposes only and that this report cannot cover all of the abundant sub-sectors in healthcare.

**Opportunity 1: Establishing further healthcare facilities by the private sector to reach universal coverage.**

In order to reach the targets of the National Health Plan for universal coverage and meet healthcare quality demands by patients in particular in urban areas, the establishment of private facilities is apparently highly desirable.

Opportunities lie not only in the establishment of private general hospitals or clinics, but equally in the opening of private specialized medical centers.

**Opportunity 2: Permitting the manufacturing and distribution of medical drugs**

The import and distribution of medical drugs is currently restricted to Myanmar-national companies only. Predominantly, the demand on the Myanmar market is satisfied to around 35-40% by Indian pharmaceutical supplies, which tend to cross the land border formally and informally. Other imports originate in China, Thailand and other regional economies. (IP-SOS) The pharmaceutical distribution system is only rudimentarily developed, whereby
imported pharmaceuticals are mostly initially sold on Yangon’s Mingalar Market to distributors, wholesalers and dealers. Typically, the pharmaceuticals are distributed to the end user either e.g. through micro-scale pharmacies or pharmacy outlets integrated into retail businesses. A key challenge to the healthcare system is the limited capacity and training of such e.g. pharmacy sales staff. Anecdotal evidence suggests that pharmacy staff in Myanmar tend to hand out pharmaceuticals such as antibiotics freely - e.g. increasing the risk of the occurrence of multi-resistant bacteria.

Only two foreign-backed companies DKSH (Switzerland) and Mega Life Science (Thailand) have managed to operate in the Myanmar market in the pharmaceutical distribution. Domestic production capacity for pharmaceuticals has not yet been built up to any significant extent, so that the country relies predominantly on imports. In particular, an expansion of the domestic production of pharmaceuticals and a strengthening of the supply chain of pharmaceuticals appear essential.

A fundamental simplification of the (regularly to be repeated) approval process of every single pharmaceuticals package design (of even an already approved drug) by the Food and Drug Administration and Myanmar Medical Council is an essential basis to create a basis for the operation and job creation of pharmaceutical companies in Myanmar.

Opportunity 3: Developing human resources in medical professions

As aforementioned, the availability of in particular qualified professionals in rather supportive and technical roles (e.g. nurses, midwives, medical technical professionals, pharmacists, healthcare administrators) is a bottleneck rather than any shortage of doctors. Also, income opportunities through an export of services through the (temporary) migration of Myanmar nationals to other economies short of healthcare personnel are not utilized as in the case of the Philippines and other service sectors in Myanmar (e.g. Myanmar seamen).

Major barrier to overcome for improvement of the quality of healthcare services in Myanmar is a certain level of “protectionism” inherent to the medical system of Myanmar. Instead of hindering the small number of e.g. nurses from migrating in case of a mutual recognition of their qualification by Myanmar and regional countries and of operating in a situation of a shortage in the listed types of medical professionals, the private sector may be engaged in a constructive way to expand the base of qualified professionals in a commercially viable model or in a PPP arrangement.

In addition, the limits to the operation of foreign medical specialists endanger the availability of specialized medical services in the private (and public) healthcare sector. Other developing countries have implemented schemes of providing gratis visa to medical specialists, exempt these required specialists from income taxes or provide similar benefits. In this context, a reform of the mandate of Myanmar Medical Council (in legal and practical terms) is imperative.

19 See Ipsos 2013
Opportunity 4: Leapfrogging through telemedicine and mobile health services

While Myanmar has – following the liberalization of the telecommunications sector – experienced substantial economic growth in ICT-based industries, opportunities through telemedicine and mobile health services have not yet sufficiently been explored.

According to a developer of an mHealth application, an initial key challenges appears to be the limited understanding among the government as well as international development partners of the procurement of an intangible asset as a mobile application (e.g. costs of development, development cycle, usability considerations, pricing). Furthermore, challenges exist due to the yet limited adoption rate of digital payment solutions (e.g. Wave Money) and the significant share of unbanked population.

Opportunities in the telemedical sector / eHealth / mHealth sector exist in particular through the collaboration of the government with developers of such solutions. Hereby, the Ministry of Health and Sports and other related line ministries would be required to allow app developers a piloting and testing of the developed solutions with support of the government.

Opportunity 5: Health Insurance Sector Liberalization

The insurance sector had in the past been solely dominated by the state owned enterprise Myanmar Insurance that adopted a dual role as a monopolistic market actor and regulators of the sector. Under the recent liberalization policies in the insurance sector, twelve local private insurance companies could enter the market, though only offer the same policies without any possibilities for a variation of pricing according to the risk profile of the insured party. (VDB Loi) Only recently, basic packages of a health insurance became available, which, however, do not allow cover treatment in the private healthcare sector. Hence, it can he concluded that the insurance product does not satisfy the demand of e.g. medical tourist seeking high-quality medical treatment.

The liberalization of the health insurance system offers opportunities for reaching other market segments and for ensuring that medical expenditure of all – including these demanding higher-priced services – is covered.
### 14. Key Barriers Limiting Private Sector Involvement in Healthcare

Partially, the identification of barriers, opportunities for improvements and recommendations have immediately been adopted from the Mapping of Barriers to Trade in Services in CLMV Countries (DRAFT) of GIZ from May 2017.\(^{20}\)

<table>
<thead>
<tr>
<th>#</th>
<th>Barrier</th>
<th>Opportunity</th>
<th>Challenge (for local and intl. investors)</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The role of the private healthcare sector in contributing to reaching targets of health services coverage is not specifically referred to in e.g. the National Health Plan.</td>
<td>Exchange between public and private sector for a better shared understanding of aligned and differing perspectives and the inclusion of private sector needs in policy documents would be most beneficial.</td>
<td>Private sector investments will not be undertaken in a scenario of highest uncertainty on the position of the Government of Myanmar on the private-sector led expansion of healthcare services.</td>
<td>Organization of an initial public-private sector forum in Myanmar to discuss the current and potential contribution of the private sector to reach the objectives of the National Health Plan and to share best practices from strongly private sector based healthcare systems (e.g. Singapore).</td>
</tr>
<tr>
<td>2</td>
<td>Limited sector-wide consultations between public and private sector, leading to opaqueness of private sector (and lack of relevant and up-to-date statistics on private sector size, services).</td>
<td>Ministry of Health and Sports and the Central Statistical Organization may gradually exchange data with and collect data from the private healthcare sector for a better monitoring of the Government of the dynamics in the private sector.</td>
<td>Data not readily available to potential new entrants (domestic and foreign), which limits investment options. Promotes medical tourism instead of improving local facilities through better public-private consultations.</td>
<td>Commencement of data sharing between public and private healthcare sector.</td>
</tr>
<tr>
<td>3</td>
<td>Myanmar national users appear to have very low confidence in the quality of public and private health services in Myanmar and prefer medical tourism at any occasion possible.</td>
<td>The delivery of healthcare services in the country to users willing to accept these services is essential to treat patients in critical stages, to save costs of the utilization of health services for users and to create local employment.</td>
<td>The Myanmar private sector operating hospitals at international standards is facing a challenging environment to market healthcare services to Myanmar customers due to the inferior public perception of the medical system in Myanmar.</td>
<td>Public awareness raising campaigns on the progress in the development of the public and private healthcare sector and discouragement of out-bound medical tourism.</td>
</tr>
</tbody>
</table>

\(^{20}\) GIZ 2017b
| 4 | Competition of private and public health sector around human resources persists: Doctors trained at medical universities in Myanmar are not permitted to work in solely the medical private sector, but are required to work (during daytime) in the hospitals of the public sector. | A fundamental agreement on sharing of the human resources between public and private sector may formalize the current informal practice that specialist doctors work in the private sector in night shifts after daytime work in the public sector. | Medical specialists are in a precarious situation of often two simultaneously performed jobs at daytime and during the night, which apparently is not sustainable and feasible in long run. | Dialogue between medical specialists, Ministry of Health and Sports and the private sector is to be facilitated to identify feasible options for a sharing of time of the specialists between public and private healthcare sector within regular working hours. |
| 5 | Foreign and former Myanmar national medical specialist doctors remain barred from entering the country (in a feasible effort) despite the essential shortage of medical specialists. | The health system of Myanmar is strongly in need of extending its human resource base and may only be able to function properly, if the exorbitant lack of specialist doctors can be addressed. | The entry barriers to foreign medical specialists (including former Myanmar citizens) provide harm to the medical system of Myanmar and inhibit the delivery of needed health services and the operations of public and private healthcare facilities. | The role, capacity and incentives of Myanmar Medical Council and affiliated local specialist doctors in the selection of foreign medical specialists admissible for a long term stay in Myanmar are to be reviewed independently. Dialogue and cooperation with in particular the newly established “Kan Thar Yar International Specialist Hospital” in Yangon is to be sought in addressing this fundamental issue. |
| 6 | A supply-demand gap in various medical professions (e.g. specialized doctors, nurses, medical technicians) exists, while immediate potentials even for an export of services remain unexplored. | A fundamental expansion of skill development in mentioned healthcare-related professions is essential for the domestic health service provision. In addition, Myanmar may – like e.g. the Philippines – foster the export of services through skill development of qualified healthcare personnel temporarily relocating abroad (e.g. Japan) for additional training, gaining of international experience and high contributions to family incomes through remittances. | Skill development efforts through public and private institutions in the domestically and internationally demanded healthcare professions are in essential need to be fostered. | Development of a national skill development vision in healthcare identifying: • the current supply of medical personnel / staff / assistants / administrators, • the internationally scope of foreign / former citizen healthcare specialists potentially available to operate in Myanmar, • under the assumption of realistic national development scenarios delivery of a forecast of the |
| 7 | Pharmaceutical companies face major market entry and operational barriers due to the frequent and time-consuming FDA approval processes as well as due to abundant counterfeit products available on the market. A streamlining of processes at FDA may substantially improve the operational situation of the pharmaceutical industry in Myanmar and allow the future development of a stronger pharmaceutical sector in-country. Furthermore, qualified FDA staff – currently engaged in administrative tasks in Naypyitaw – may rather support the control of shipments at the land border posts, where greater capacity is needed. The limited production volume of pharmaceutical products in Myanmar opens up paths for an entry of mostly informally traded pharmaceutical products that may comprise counterfeit products. A study may identify the potentials to … • identify potentials to transform FDA into a financially self-sustaining independent agency based on a revised revenue system, • automatically accept pharmaceuticals that are accepted in reference countries or that contain the same dosage of an already approved pharmaceutical substance, • reduce the burden of medical specialists to recommend on behalf of FDA certain pharmaceuticals, • expand the capacity of FDA to mitigate issues around the prevalence of counterfeit products in Myanmar. | number of professionals required by 2025 or 2030 domestically, • the scope and distribution of international demand for qualified healthcare specialists, • the domestically available network of public and private institutions able to deliver skill development training. |
15. Key Recommendations for Follow-up by Ministry of Health and Sports

**Suggestion 1:**
*Preparation of Policy Dialogue Format on the Role of the Private Sector in Reaching Targets of the National Health Plan*

The National Health Plan does not essentially give credit to healthcare investors, operators of private hospitals, pharmaceutical distributors etc. It is hence suggested to conduct a rapid appraisal of the current role of publicly and privately sector run healthcare facilities in delivering healthcare services in particular highlighting areas in which publicly and privately offered services complement each other (e.g. due to different user / income groups, by mobilizing additional private funding for the health sector etc.). In the policy dialogue format a broad spectrum of private sector representatives from different subsectors in healthcare, regional experts for a sharing of international best practices in private sector involvement in healthcare delivery shall be included as well as international development partners and governmental counterparts in the formulation of the NHP shall be invited to provide a basis for constructive dialogue.

**Suggestion 2:**
*Review of the Mandate and Structure of Myanmar Medical Council in its Regulatory and Advisory Function in the Healthcare Sector of Myanmar*

The scope of competencies and the extensive legal mandate of the Myanmar Medical Council shall be assessed. There might be options for reducing the workload of the Myanmar Medical Council through liberalization efforts in certain core areas (e.g. licensing of foreign medical specialists in Myanmar, FDA-related procedures).

**Suggestion 3:**
*Preparation of a Targeted Investment Promotion Strategy in the Healthcare Sector*

DICA and MIC are prioritizing investments and business development in the healthcare sector of Myanmar for sustainable economic growth and an improvement of the living conditions of the population through access to healthcare services. Despite the inclusion of the aforelisted medical subsectors among the promoted sectors, DICA has not yet had available capacity to develop a targeted investment promotion strategy in a particular sector (such as healthcare). The healthcare sector may hence well be utilized for the determination of a functionable pilot approach for the development of a sector-specific investment strategy. The development of the strategy is to be closely coordinated with the DANA Facility, the DICA Japan Desk of JICA, the World Bank health sector engagement and IFC. The list of promoted healthcare subsectors may be utilized as a starting point (1) for consultations with Ministry of Health and Sports on suitable investment projects in line with health development objectives in each sector, (2) for engagement with the locally active private sector and all foreign chambers of commerce in Myanmar on opportunities and potential interest of particular companies in investments in the respective subsectors, (3) for a gathering of representatives from the national and subnational governments to articulate desirable investment opportunities in the states and regions in all promoted subsectors and (4) for an investment forum format with all stakeholders to present the opportunities in the sector.
**Suggestion 4:**

*Conduction of an Assessment and Delivery of an Estimate for Human Resource Requirements in the Healthcare Sector of Myanmar in 2025/2030*

It can be stated that the requirements in the number of differently qualified medical professionals in Myanmar of today may not be sufficient to cover the healthcare requirements of the future, as the country is growing and urbanizing, while its middle class is rapidly expanding. It is hence suggested to engage the government and private sector in the preparation of an estimate in the scope of human resource requirements to allow for an adjustment of the healthcare sector. The current number of available medical professionals active in different areas and current capacity of e.g. educational institutions (e.g. universities, vocational training centers) available for their qualification should be mapped to identify gaps in the supply of skilled professionals.

**Suggestion 5:**

*Development of an Approach for the Delivery of Healthcare Infrastructure through PPPs*

In dependence on progress of ADB in the advancement of the development of the cabinet paper on PPPs, Ministry of Health and Sports may be supported in identifying healthcare-related projects that may be implemented in a PPP model. It is not advisable to commence activities unaligned with the approach of ADB in the promotion of PPPs.

**Suggestion 6:**

*Promotion of Telemedical / mHealth / eHealth Solutions in Myanmar as a Case Study within the Development of an eCommerce Strategy*

In line with the currently ongoing development of an eTrade strategy by Ministry of Commerce and other related ministries, it may be advisable to present and promote telemedical and mHealth / eHealth solutions under development in Myanmar to enhance the recognition of such solutions by the government and to enhance the capacity of the different ministries to effectively facilitate the operations of such companies in Myanmar.

**Suggestion 7:**

*Improving the Approval Processes of Investments at Ministry of Health and Sports*

Investment proposals that have been submitted for approval typically require a certain time for processing. A streamlining of the process and enhancement of the transparency of the necessary steps involved in the process would be desirable.
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