MYANMAR NATIONAL HEALTH ACCOUNTS

HEALTH EXPENDITURE REPORT 2019 – 2022

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FOREWORD

Tracking health expenditures is fundamental to effective health system governance. It provides essential insights into resource allocation, highlights financing gaps, and supports strategies to strengthen health systems. The Myanmar National Health Accounts: Health Expenditure Report 2019-2022 presents a comprehensive analysis of health financing during a period of significant challenges. Conducted amid the COVID-19 pandemic and other extraordinary circumstances, this study reflects the resilience and adaptability of Myanmar's health sector, offering a valuable overview of health spending despite these difficulties.

Since 1998, Myanmar has conducted National Health Accounts (NHA) using internationally recognized methodologies, the System of Health Accounts (SHA) 1.0, with the support of World Health Organization. In the previous NHA study for 2016-2018, Myanmar transitioned to the SHA 2011 framework, allowing for a more detailed and standardized analysis. This report marks the second application of SHA 2011, further strengthening our ability to track and evaluate health financing trends.

Moving forward, expanding the scope of health expenditure tracking remains a priority. A key area for improvement is subnational analysis, which is currently limited. A more granular understanding of regional disparities will ensure equitable resource allocation, better addressing the diverse health needs of our population. Strengthening health financial tracking will also support evidence-based policy decisions to enhance health system resilience.

I extend my sincere appreciation to the Ministries, institutions, and partners who contributed to this report. Their collaboration has been instrumental in producing a study that not only captures Myanmar's health expenditure landscape but also provides actionable insights for policymakers.

The findings of this report will serve as a critical reference for shaping future health financing strategies, ensuring a more sustainable and equitable health system in Myanmar. I commend all those involved in this effort and trust that this report will guide stakeholders in addressing both current and emerging health challenges.

Dr. Thet Khaing Win
Union Minister of Health
Myanmar

Myanmar National Health Accounts Report 2019 - 2022

Table of Content

ACRONYMS

CDC	City Development Committees
CHE	Current Health Expenditure
COFOG	Classification of Functions of Government
COICOP	Classification of Individual Consumption by Purpose
CSO	Central Statistical Office
DIS	Disease & health condition
DPs	Development Partners
FA	Financing agents
FP	Factors of Provision
FS	Revenue of health financing schemes
FY	Fiscal year
GFF	Global Financing Facility
GGE	General Government Expenditure
GGHE	General Government Health Expenditure
GHED	Global Health Expenditure Database
HAPT	Health accounts production tool
HC	Health care, health functions
HF	Health financing schemes
HK	Health capital
HIV	Human immunodeficiency virus
HP	Health provider
HRH	Human resources for health
ICD	International Classification of Diseases
IPD	Inpatient day
LTC	Long term care
MDY	Mandalay
MI	Myanmar Insurance
MLCS	Myanmar Living Conditions Survey
MMK	Myanmar Kyat
MNHP	Myanmar National health Plan
MOC	Ministry of Construction
MOD	Ministry of Defense
MOHINGA	Myanmar's Aid Information Management System
MOH	Ministry of Health
MOI	Ministry of Industry
MOL	Ministry of Labour
MOPF	Ministry of Planning and Finance
MOTC	Ministry of Transport and Communications
MOSWRR	Ministry of Social Welfare, Relief and Resettlement
NEC	Not elsewhere classified
NGO	Non-governmental organizations
NHL	National Health Laboratory
NPISH	Non for-profit institutions serving households
NPT	Nay Pyi Taw
OECD	Organization for the Economic Cooperation and Development
OOPS	Out-of-Pocket Spending
OPD	Out-patient-Department
OPV	Out-patient-Visits
MPLCS	Myanmar Poverty and Living Conditions Survey
PR	Principal recipient
QC	Quality control
SHA	System of health accounts
SNL	Subnational

ACRONYMS

SSB	Social security Board
STD	Sexually transmitted diseases
SYB	Statistical Yearbook
TB	Tuberculosis
UCH	University of Community Health
UM	University of Medicine
VHI	Voluntary health insurance
WHO	World Health Organization
YGN	Yangon

1.Executive summary

The second round of Myanmar National Health Accounts using the SHA 2011 standard framework, is generated for the years 2019-2022. The latest estimates suggest that health expenditure as a share of GDP was about 8 percent in 2022, nearly twice compared to 2019. A sharp and significant rise in 2021 and 2022 was on account of the ongoing pandemic related spending and a concomitant decline in GDP due to lockdown and economic restrictions. GDP growth was negatively hit during the pandemic period. The Real GDP Growth (at constant factor prices) which remained a robust 6.6 percent in 2019, dropped to negative -9 percent in 2020-21 and -12 percent in 2021-22. Public spending through budgetary route and external funds appears to be considerable despite a significant drop in economic activities and revenue raising capacity of the government during the pandemic. In 2019, the government health expenditure accounted for a modest 3.25 percent of the total government expenditure. This accelerated to over nine percent in 2021 and 4.8 percent in 2022. Clearly, the government had to step in with significant funds during the pandemic period. External funds as a share of overall health expenditure in Myanmar correspondingly accelerated from 7.41 percent to 13.11 percent in 2022.

In 2022, the Current Health Expenditure (CHE) was estimated to be MMK 5,993,978 million, with a per capita health expenditure of MMK 111, 000 (USD 72.76). Whereas in 2019, per capita health expenditure was estimated to be MMK 81,000 (USD 59.52). As a result, households have been less exposed to the market forces, preventing them from spending high levels of Out-Of-Pocket (OOP) expenditure during the pandemic period. During the period under consideration, the share of OOP spending declined from 76 percent in 2019 to 65 percent in 2022. While the share of social health insurance schemes remains low at 0.8 percent of CHE in 2022. It may also be noted that the health expenditure flowing through non-governmental organisations nearly doubled from 6.4 percent in 2019 to 11.6 percent in 2022.

In terms of functional categories of measured expenditure, the evidence for 2022 reveals that over one third (34.3 percent) of health expenditure is directed towards outpatient curative and rehabilitative care, whereas little less than one third (31.8 percent) is spent towards hospitalization related expenditure. Medical goods, on the other hand, accounted for 16.3 percent of the health expenditure while preventive care alone accounted for 15.5 percent of the health spending in 2022. From the providers side, it may be observed that Hospitals alone (including primary, secondary and tertiary based) took a share of 59 percent in 2022.

Key Highlights, National Health Accounts, Myanmar, 2019-2022

- Current Health Expenditure (CHE) for 2022 is estimated to be MMK 5,993,978 million
- Current health expenditure as a share of GDP is 8 percent in 2022 as compared to 4 percent in 2019
- Per capita health expenditure in 2022 is estimated at MMK 111,000 (USD 72.76) as against MMK 81,000 (USD 59.52)
- Government health spending as a share of overall government expenditure stood at 4.8 percent in 2022
- External funds in 2022 accounted for 13.11 percent as against 7.41 percent in 2019
- During the pandemic period, OOP spending of households declined considerably to 65 percent in 2022 from a high of 76 percent in 2019
- Curative care along with rehabilitative care accounted for nearly two thirds of all health expenditure in Myanmar in 2022
- Preventive care spending in 2022 accounted for 15.5 percent of all health expenditure whereas primary health care that includes curative, preventive and promotive care, accounted for half of all health spending in Myanmar
- About half of all health spending in 2022, was incurred on medicines, vaccines and supplies. Wages and salaries accounted for over one third of all health spending.

Further, a detailed examination of health expenditure by disease conditions shows emerging pattern of resource allocation. As a proportionate share of total health expenditure from all sources, it may be observed that in 2022, infectious diseases accounted for over one third of all spending (34.2 percent), with spending on COVID-19 alone accounting for 13.7 percent. In fact, during 2021, the year in which COVID-19 immunization began, a sharp uptick in vaccination coverage was noted. Therefore, during 2021, expenditure on infectious diseases accounted for a higher share of 45.3 percent of the total health spending, about 30.7 percent alone was allocated to COVID-19 prevention, treatment including COVID-19 immunization. During pre-COVID-19 period, in 2019, the proportionate share of non-communicable diseases accounted for a larger share of 45.9 percent while the same has declined to 37.4 percent in 2022. The observed decline could be a temporary trend, as the disease pattern and the associated expenditure is expected to turn largely towards NCDs in later years. It is also interesting to note that health expenditure for reproductive health, maternal and child health conditions continue to be significant at 14 percent in 2022. Injuries alone, on the other hand, has accounted for 7.3 percent of total health spending in the country.

Emerging evidence further demonstrates that a relatively larger share of health spending goes into procuring pharmaceuticals by the government, households, and other actors. In 2022, about half of all spending was incurred on medicines, vaccines and supplies. This could potentially be an outlier for the year 2022, as the earlier years shows that it was around 30 percent in 2019 and 2020. Another key expenditure category is wages and salaries, which accounted for 34.2 percent in 2022, although in 2019, its share was about 40 percent in the government sector. As far as health expenditure by primary health care, the latest data suggest that half (51.1 percent) of all the spending on health is allocated to primary health care in 2022. However, evidence for 2021 showed that primary health care accounted for 63.1 percent, suggesting it to be an outlier, triggered by significant spending on COVID-19 immunization coverage for a large segment of adult population.

INTRODUCTION

Myanmar remains committed to monitoring health spending on a regular basis following the global standard, the System of Health Accounts (SHA) since 1998. The revised version of SHA 2011 has been applied by an increasing number of countries and by the WHO Global Health Accounts Expenditure Database [GHED] since 2016. Myanmar has initiated the use of SHA2011[1] in the last NHA reports of 2016-2018. This new set of evidence for 2019-2022 is disseminated following the COVID-19 pandemic.

It is expected that the results displayed in this report will contribute to inform relevant decisions and processes:

i) Resources channeled to the health system in Myanmar represent one of the lower levels in the South-East Asian region and it is expected that evidence from health accounts contribute to make the best use of every Myanmar Kyat (MMK);
ii) this report can also provide information to support mobilization of additional resources allocated to the health system in the country;
iii) Health Accounts can also act as a tool to support reducing households Out-Of-Pocket (OOPs) spending; and
iv) to inform the expenditure of health response to the COVID-19 pandemic. This Health Accounts (HA) report aims at showing how much resources were used in the health system and how they were distributed.

A standardized monitoring of health spending in the country ensures that changes are adequately identified and quantified, in a comparable way over time. The key input of the HA is information. Paucity of data often ends up in poor planning and decision-making. An important effort is to obtain, interpret and use the available data to come up with estimates of National Health Accounts. It is not a work for a team, but a collective effort involving all stakeholders with records related to health spending and their use. This effort will be considered relevant if results are useful to inform decisions on resource allocations and efficient use.

This report presents key findings and recommendations. It begins with a summary overview of the key results in selected indicators and continues to inform how much has been spent per year, how this spending was funded and how the resources were used. The final section describes policy implications and recommendations, linking the results with policies currently under discussion in the country, such as the need to scale up government health spending and to reduce out-of-pocket payments. Data sources and methodological description are outlined in the annexure.

[1] OECD/Eurostat/WHO (2017), A System of Health Accounts 2011: Revised edition, OECD Publishing, Paris, https://doi.org/10.1787/9789264270985-en and WHO : http://www.who.int/nha/sha_revision/en/

Summary of Health Financing System in Myanmar

The health system in Myanmar comprises various actors, producing and delivering health care to the population, governed by specific organizational and health system administration bodies. The Ministry of Health (MOH) takes the pivotal role of Myanmar health system and is responsible for the health of the population of Myanmar. The public sector is primarily financed with taxes and public revenues. Within the public sector, expenditure on health by the MOH as well as by other ministries is included. Some of the ministries have their own health facilities and others are using governmental budget for health of their staff mainly under budget line O316 (Medical Expenses).

Health insurance is represented by Social Health Insurance Scheme (SHI), offered by the Social Security Board (SSB), and by private health insurers offering voluntary health insurance schemes [VHI]. Both VHI and Social Security schemes are having an increasing role in health financing and providing health benefits. The social insurance scheme is funded through contributions from employees and employers at 2% and 3% of the employee's monthly salary respectively. The voluntary health insurance scheme is financed through premiums, mostly paid by households.

Not-for-profit institutions (NPIs), including resident external agencies working on health and non-governmental organizations (NGOs), work largely with external resources. While the majority of facilities providing health care are owned by MOH and other ministries, a small portion is operated by NPIs and increasingly by for-profit private providers. Households receive services from all providers, through insurance prepayment or by making out-of-pocket payments (OOPS) at the moment of receiving health care and at the point of contact with the health system.

Various health organizations play different roles within the system. National Health accounts (NHA) identified and analyzed those roles, specifically as resource flows among various organizations. A graphic representation aims at identifying the financing and expenditure flows, associated to the transactions and actors. These flows are simplified and reflected in the flow chart below (Figure 1). To elucidate resource flows in the system, each transaction was classified from the consumption, provision and financing points of view. The flows begin when resources enter in the system (once designed to cover health care) and finishes when these resources are used to generate specific services offered to various population groups. When possible, these services were further linked to the health /disease conditions.

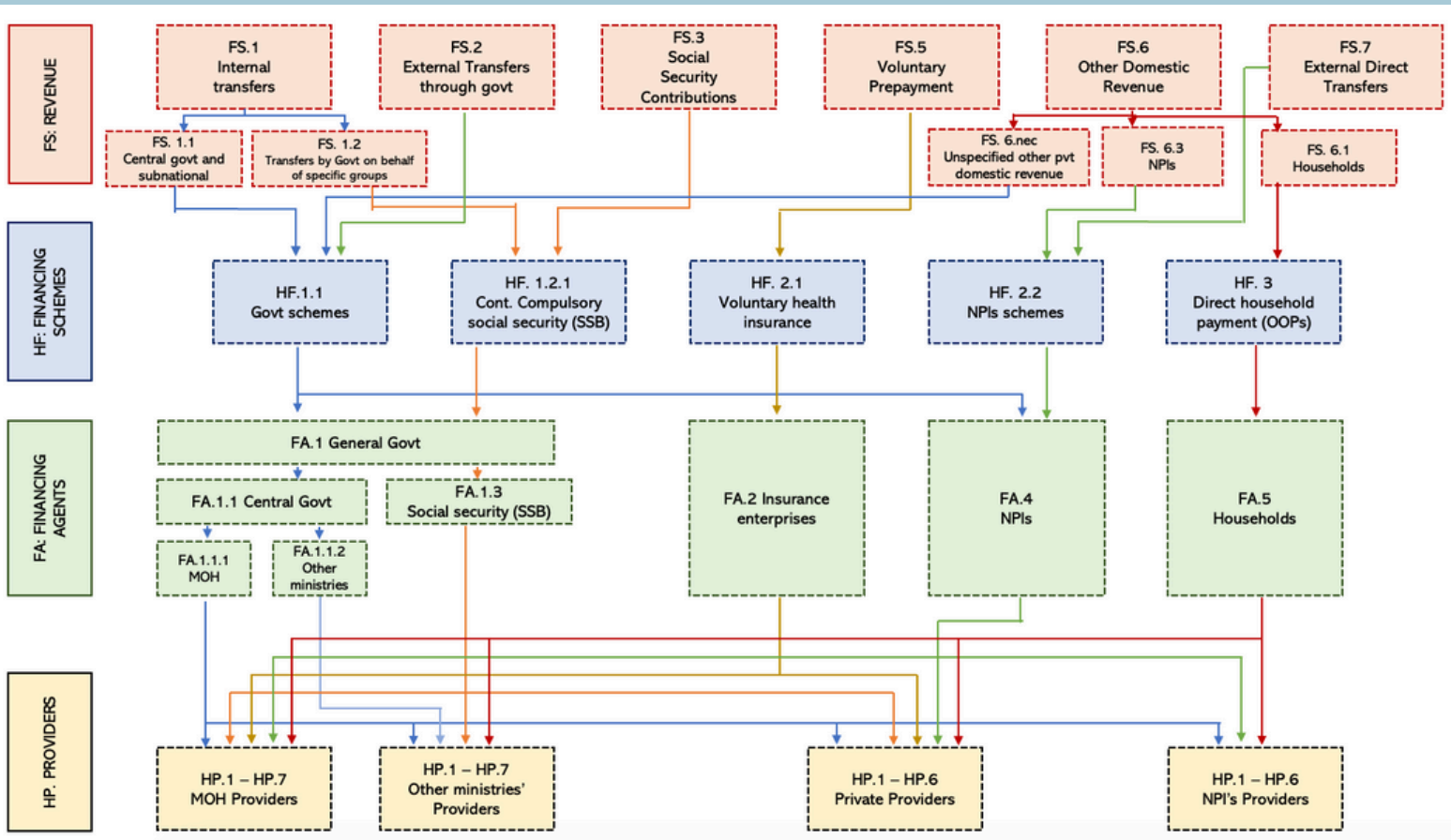


Figure 1. Financing flows in Myanmar Health Accounts 2019-2022

2.KEY FINDINGS

Key indicators related to Total Health Expenditure

This second round of Myanmar National Health Accounts using the SHA2011 standard is generated for the years 2019-2022. The latest estimates suggests that health expenditure as a share of GDP was about 8 percent in 2022, nearly twice compared to 2019. A sharp and significant rise in 2021 and 2022 was on account of the ongoing pandemic related spending and a concomitant decline in GDP due to lockdown and economic restrictions. GDP growth was negatively hit during the pandemic period. The Real GDP Growth (at constant factor prices) which remained a robust 6.6 percent in 2019, dropped to negative -9 percent in 2020-21 and -12 percent in 2021-22. Public spending through budgetary route and external funds appears to be considerable despite a significant drop in economic activities and revenue raising capacity of the government during the pandemic. In 2019, the government health expenditure accounted for a modest 3.25 percent of the total government expenditure. This accelerated to over nine percent in 2021 and 4.8 percent in 2022. Clearly, the government had to step in with significant funds during the pandemic period. External funds as a share of overall health expenditure in Myanmar correspondingly accelerated from 7.41 percent to 13.11 percent in 2022.

In 2022, the Current Health Expenditure (CHE) was estimated to be MMK 5,993,978 million, with a per capita health expenditure of MMK 111, 000 (USD 72.76). Whereas in 2019, per capita health expenditure was estimated to be MMK 81,000 (USD 59.52). As a result, households have been less exposed to the market forces, preventing them from spending high levels of Out-Of-Pocket (OOP) expenditure during the pandemic period. During the period under consideration, the share of OOP spending declined from 76 percent in 2019 to 65 percent in 2022. While the share of social health insurance schemes remains low at 0.8 percent of CHE in 2022. It may also be noted that the health expenditure flowing through non-governmental organizations nearly doubled from 6.4 percent in 2019 to 11.6 percent in 2022 (Table 1).

During the pandemic, there was a sudden and sharp increase of COVID-19 related health care services while there was a drastic reduction of other / usual health care services due to restricted movement and lockdowns. The COVID-19 related services included both preventive and curative care, with new medical products, services and unforeseen budget. The role of several Ministries changed temporarily to cope with emerging needs. It may be observed that local communities in Myanmar are accustomed to charitable donations, including those directed towards the health system, even before the COVID-19 pandemic. However, previous studies did not encompass this aspect. The response to the pandemic witnessed a substantial contribution to health expenditures by charitable donations from individuals, various foundations, and a share of corporate social responsibility (CSR). The new resource flows originated in budget reallocations and new flows from external sources and from private sector donations. Myanmar Government has established the COVID-19 Fund by reallocating the budget from the line Ministries to foster COVID-19 response. As a result, the health system witnessed sharp scale up of domestic and external funding [growth rate of increase 40% and 77% respectively in the analyzed period]. Government spending proportionally increased from 16% to 23% of current health spending, which represents around 2% of GDP in 2022. Government health spending as a share of general government spending [GGE], increased from 3 to 5% [almost 50% growth].

2.KEY FINDINGS

The study spans the fiscal years, beginning 1 April to 30 March[2]. Given that the health spending measured in 2022 represents half of fiscal year, for generating the indicators these results were expanded to represent full financial year.

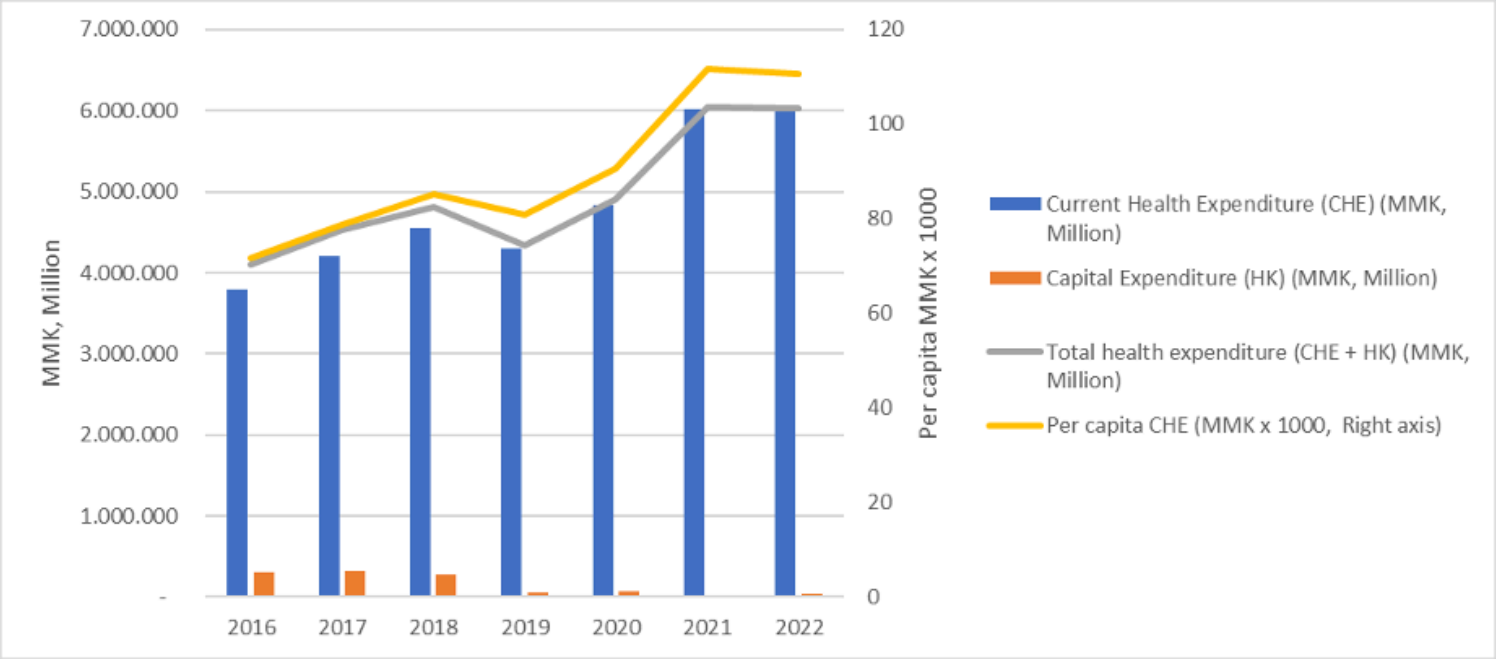
[2] From 2016-2018 there is a fiscal year from 1 April to 31st March. The financial period of 31 March year-end was changed to October 1 to September 30. From the financial year 2018/19 (i.e. from 1 October 2018) for state-owned enterprises and financial institutions and from the financial year 2019/20 (i.e. from 1 October 2019) for all other taxpayers. The financial year-end of 30 September has changed to 31 March again, starting from 1 October 2021. These changes have created two "partial fiscal years" in 2018 and 2022 covering only six months, from October 2021 to March 2022 is specified as an interim budget period that has been analyzed as reported and expanded to represent a full year.

Indicators	2019	%	2020	%	2021	%	2022	%	Change rate in the period
Totals									
Current Health Expenditure (CHE) (MMK(Million))	4,293,530	93	4,836,083	91	6,013,161	96	5,993,978	97	1.4
Capital Expenditure (HK) (MMK(Million))	328,576	7	481,965	9	239,783	4	161,135	3	0.5
Total health expenditure (CHE + HK) (MMK(Million))	4,622,105	100	5,318,049	100	6,252,944	100	6,155,113	100	1.3
Indicators									
Per capita CHE (MMK x 1000)	81		91		112		111		1.4
CHE as share of GDP (%)	4.08		4.20		6.10		7.99		2.0
Capital expenditure as share of GDP (%)	0.31		0.42		0.24		0.21		0.7
Government CHE (GGHE) as share of CHE (%)	16.14		21.28		36.39		22.51		1.4
OOPs as share of CHE (%)	76.56		72.57		54.10		65.14		0.9
External CHE as share of CHE (%) [through government + NPIs]	7.41		6.20		10.07		13.11		1.8
NPIs CHE as share of CHE (%)	6.35		4.91		8.84		11.55		1.8
Social security CHE as share of CHE (%)	0.92		1.21		0.62		0.75		0.8
Voluntary health insurance CHE as share of CHE (%)	0.02		0.03		0.05		0.05		3.4
Government CHE as share of GDP (%)	0.66		0.89		2.22		1.80		2.7
Government CHE (GGHE) as share of Government spending (GGE) (%)	3.25		4.13		9.19		4.80		1.5
Reference values									
Nominal GDP(MMK(Million))	105258501		115105761		98654174		75044663		0.7
General Government Expenditure (GGE) (MMK(Million))	21321136		24917789		23815868		28096694		1.3
Total Private Final Consumption (PFC) (MMK(Million))	54914529		57780891		44892609		34149095		0.6
Exchange rate (MMK)	1360		1525		1520		1520		1.1
Total population (x 1,000)	53040		53423		53798		54200		1.0

Table 1: Key Health Expenditure Figures, Myanmar, 2019-2022

The various health accounts studies have shown that in current values, health spending has progressively increased in Myanmar. The change is also visible in Figure 2 for the 2016-2022 period, to make evident the pace of the increase, radically accelerated with the COVID-19 pandemic, to focus on the emerging care needs in 2020 and consolidated in 2021 and 2022, notably with the acquisition of vaccines. The regular investment plan was modified to allow for the use of resources in the emergency. Observing the trend in current health spending over the complete period, a close to stable increase is visible, with the remarkable fact that there is a significant drop of household spending share (Figure 2).

Figure 2. Health expenditure main components, Myanmar, 2016-2022



Source: Data for macroeconomic-variables were obtained from WHO Global Health Expenditure Database, accessed on May 2024.

Which are the key financing arrangements covering the population's health in Myanmar?

All citizens of Myanmar are entitled to health care delivered by the Ministry of Health (MoH), with similar benefits and covering most conditions. Health spending is distributed among various schemes: the larger financing scheme continues to be the out-of-pocket spending [OOPs], representing 65% of total current health spending [CHE] in 2022, followed by government spending [23%], and NPIs [12%]. The MoH is the major vehicle for delivering tax funded health care services. The smaller schemes display proportionally larger changes, but they are relatively small to change the real financial picture in Myanmar: for instance, Social Security Scheme and Voluntary Health Insurance continued to contribute to a miniscule level with less than 1% funding although they tripled their contribution in the period under consideration.

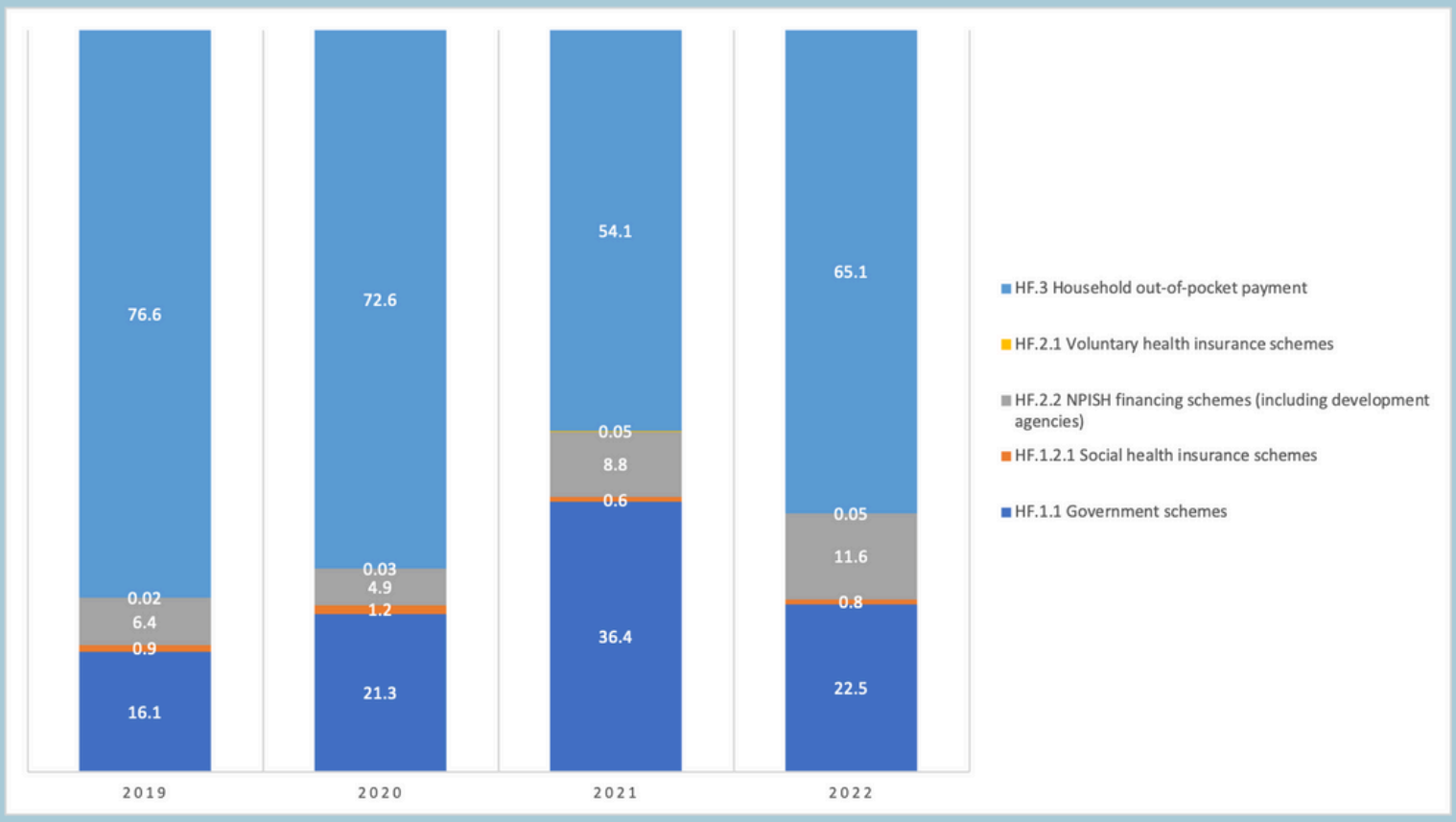
The MOH delivers services through its own facilities, in which most health care is offered without payment to users. However, some services, such as laboratory, imaging and some supplies, are to be paid by patients, within the MOH or outside, e.g. when there is shortage of medicines supply in health facilities, patients need to purchase them in private pharmacies. Other ministries and theCity Development Committees cover their entitled population offering health benefits too, either on-site health facilities, or as reimbursement of health spending. The Ministry of Defense has the largest health spending after the MOH, which is used to cover health needs of its employees and families [parents, children, and spouses] all over the country. In times of need, particularly during disasters and emergency situations, such as in COVID-19 Pandemic, the Directorate of Medical Service of the Ministry of Defense, provided health services to the community at their own health facilities or via mobile clinics (Table 2).

Health care financing schemes	2019		2020		2021		2022	
	MMK (million)	*Share of CHE*	*MMK (million)*	*Share of CHE*	*MMK (million)*	*Share of CHE*	*MMK (million)*	*Share of CHE*
HF.1 Government schemes and compulsory contributory health care financing schemes	732,791	17.1	1,087,496	22.5	2,225,430	37.0	1,394,422	23.3
HF.1.1 Government schemes	693,091	16.1	1,029,083	21.3	2,188,002	36.4	1,349,456	22.5
Of which HF.1.1.1.1 Ministry of Health	608,164	14.2	940,313	19.4	1,639,817	27.3	1,211,392	20.2
HF.1.2.1 Social health insurance schemes	39.700	0.9	58,413	1.2	37,428	0.6	44,967	0.8
HF.2 Voluntary health care payment schemes	273,446	6.4	238,906	4.9	534,523	8.9	695,280	11.6
HF.2.1 Voluntary health insurance schemes	680	0.0	1,644	0.0	2,895	0.0	2,708	0.0
HF.2.2 NPISH financing schemes (including development agencies)	272,766	6.4	237,261	4.9	531,629	8.8	692,573	11.6
HF.3 Household out-of-pocket payment	3,287,293	76.6	3,509,682	72.6	3,253,208	54.1	3,904,276	65.1
CHE total	4,293,530	100	4,836,083	100	6,013,161	100	5,993,978	100

Table 2. Current Health Expenditure (CHE) by Health Financing Scheme, Myanmar, 2019-2022. (Million MMK and percent shares of CHE)

The increase in health spending by the government during the COVID-19 pandemic is about 20%, which contributed to a sharp decline in the pace of OOPs growth between 2019 and 2021. The change is represented in Figure 3.

Figure 3. Current Health Expenditure (CHE) by Health Financing Scheme, Myanmar 2019-2022 (Percent Distribution)



Enterprise schemes are expected to be a minor actor in health spending as in most countries, and it has not been explored in this report.

How is current health expenditure funded?

Resource mobilization from different actors is required to make financial arrangements operational for interventions in health system. In a nutshell, three major mechanisms of funding are identified here. The largest share belongs to household payments [> 60%], followed by government transfers [>10%] and foreign grants routed through government and/or non-government organisations [>10%]. Most foreign grants in the analyzed period are channeled directly, whereas a minimal share are distributed through the government. A large share of foreign grants are from multilateral organizations (table 3).

Local charitable organisations traditionally contributed resources to health system via households, enterprises and domestic NGOs. These donations were relatively low in pre-Covid-19 times, however, during the pandemic they became a key support source channeled to MOH facilities. From less than 1% in 2019, they reached up to 19% of total CHE. These grants are difficult to identify by specific source, thus, given its private nature, they are classified all together as FS.6.nec [see tables 3 and 4].

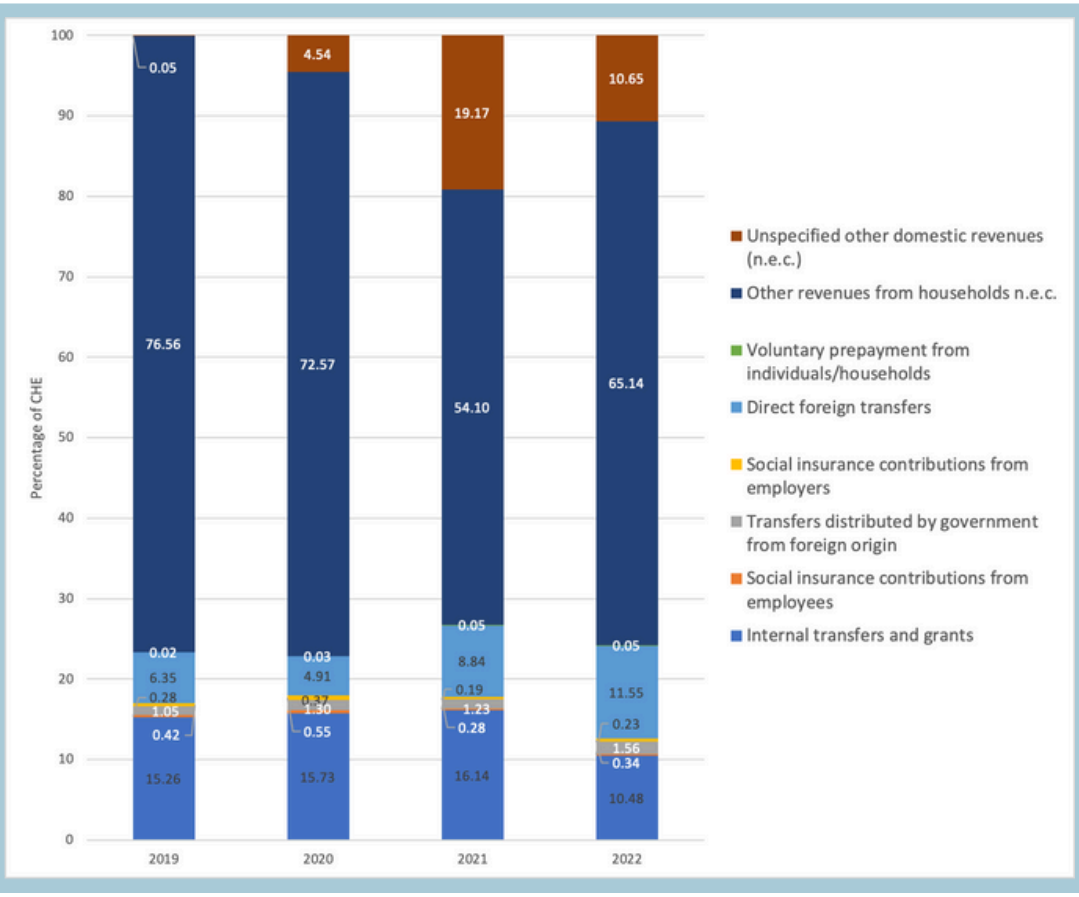
Table 3. Current Health Expenditure (CHE) by Revenue of Financing Schemes. Myanmar 2019-2022. [Million MMK and percent share to total]

Revenues of health care financing schemes Kyat (MMK), Million Financing schemes	FS.1 Transfers from government domestic revenue (allocated to health purposes)	FS.1.1 Internal transfers and grants	FS.2 Transfers distributed by government from foreign origin	FS.3 Social insurance contributions	FS.3.1 Social insurance contributions from employees	FS.3.2 Social insurance contributions from employers	FS.5.1 Voluntary prepayment from individuals/households	FS.6.1 Other revenues from households n.e.c.	FS.6.nec Unspecified other domestic revenues (n.e.c.)	FS.7 Direct foreign transfers	All FS
2019 Total FS	655,006	655,006	45,292	30,223	12,090	18,133	680	3,287,293	2,270	272,766	4,293,530
2019 Share of FS	15.26	15.26	1.05	0.70	0.28	0.42	0.02	76.56	0.05	6.35	100
2020 Total FS	760,865	760,865	62,721	44,469	17,789	26,680	1,644	3,509,682	219,441	237,261	4,836,083
2020 Share of FS	15.73	15.73	1.30	0.92	0.37	0.55	0.03	72.57	4.54	4.91	100
2021 Total FS	970,411	970,411	73,807	28,493	11,398	17,095	2,895	3,253,208	1,152,718	531,629	6,013,161
2021 Share of FS	16.14	16.14	1.23	0.47	0.19	0.28	0.05	54.10	19.17	8.84	100
2022 Total FS	628,216	628,216	93,521	34,233	13,694	20,538	2,708	3,904,276	638,453	692,573	5,993,978
2022 Share of FS	10.48	10.48	1.56	0.57	0.23	0.34	0.05	65.14	10.65	11.55	100

Note: FS denotes to Revenues of Financing Schemes

The relevance of charity donations to the government facilities during the COVID-19 pandemic is visualized in Figure 4. Direct transfers by external agencies almost doubled whereas household direct payments show significant decline in 2021 and 2022.

Figure 4. Current Health Expenditure (CHE) by Revenue of Financing Schemes, Myanmar, 2019-2022 (Percent Distribution)



In general, each scheme sets specific mechanisms to obtain its revenue sources, which is pictured in Table 4, that display the level of contributions of each revenue source: i) Government schemes not only use domestic resources, but also receive external grants, e.g. for disease control programs. ii) Social Health Insurance is linked to specific contributions, from employers and employees, and government transfers, mainly received as salary payments. iii) Voluntary health insurance receives premiums, mostly from households and enterprises. External funds support government intervention (FS.2) but it is also channelled as direct funding to NGOs (FS.7).

Table 4. Revenue Sources by Financing Schemes, Myanmar, 2019-2022 (MMK Million & percent shares)

	Revenues of health care financing schemes Kyat (MMK), Million Financing schemes	FS.1 Transfers from government domestic revenue (allocated to health purposes)	FS.2 Transfers distributed by government from foreign origin	FS.3 Social insurance contributions	FS.5.1 Voluntary prepayment from individuals/households	FS.6.1 Other revenues from households n.e.c.	FS.6.nec Unspecified other domestic revenues (n.e.c.)	FS.7 Direct foreign transfers	Total	% of CHE
2019	HF.1.1 Government schemes	645,529	45,292				2,270		693,091	16.14
2020		746,921	62,721				219,441		1,029,083	21.26
2021		981,477	73,807				1,152,718		2,188,002	36.39
2022		617,482	93,521				638,453		1,349,456	22.51
2019	HF.1.2.1 SSB (Social health insurance scheme)	9,477		30,223					39,700	0.92
2020		13,944		44,469					58,413	1.21
2021		8,934		28,493					37,428	0.62
2022		10,734		34,233					44,967	0.75
2019	HF.2.1 Voluntary health insurance schemes				680				680	0.02
2020					1,844				1,844	0.03
2021					2,895				2,895	0.05
2022					2,708				2,708	0.05
2019	HF.2.2 NPISH financing schemes							272,766	272,766	6.35
2020								237,261	237,261	4.91
2021								531,629	531,629	8.84
2022								692,573	692,573	11.55
2019	HF.3 Household out-of-pocket payment					3,287,293			3,287,293	76.56
2020						3,509,882			3,509,882	72.57
2021						3,253,208			3,253,208	54.10
2022						3,904,276			3,904,276	65.14
2019	All HF	655,006	45,292	30,223	680	3,287,293	2,270	272,766	4,293,530	100
2020		760,865	62,721	44,469	1,844	3,509,882	219,441	237,261	4,836,083	100
2021		970,411	73,807	28,493	2,895	3,253,208	1,152,718	531,629	6,013,161	100
2022		626,216	93,521	34,233	2,708	3,904,276	638,453	692,573	5,993,978	100
2019	Share of CHE	15.26	1.05	0.70	0.02	76.56	0.05	6.35	100	
2020		15.73	1.30	0.92	0.03	72.57	4.54	4.91	100	
2021		16.14	1.23	0.47	0.05	54.10	19.17	8.84	100	
2022		10.46	1.56	0.57	0.05	65.14	10.65	11.55	100	

Note: HF denotes to Health Financing Schemes and FS relates to Revenues of Financing Schemes

Where are the health funds deployed?

Health services are delivered by health facilities which offer both inpatient and outpatient care. Hospitals alone accounted for 50-60% of all health expenditure during the period under consideration. The second largest provider are retailers, notably providing pharmaceuticals (15-20%), and followed by preventive care providers (8-up to 29% in 2021) which includes technical activities of health programs [as HIV, EPI, malaria, TB, etc.]. During COVID-19, preventive providers were strategic in their actions and more prominently performed surveillance, risk communication, early case detection, vaccination and program control. In fact, preventive care providers showed a substantial rise in spending associated with COVID-19 interventions. Ambulatory care providers (6% to 9% of CHE) offer consultations to patients (more often called as General Practitioners). On the other hand, health spending on providers of ancillary services and long term care are negligible [<0.5%]. Laboratories may have offered testing on own initiative during COVID-19, which is not documented here. Providers of administration accounted for 1-3% of total CHE (Table 5).

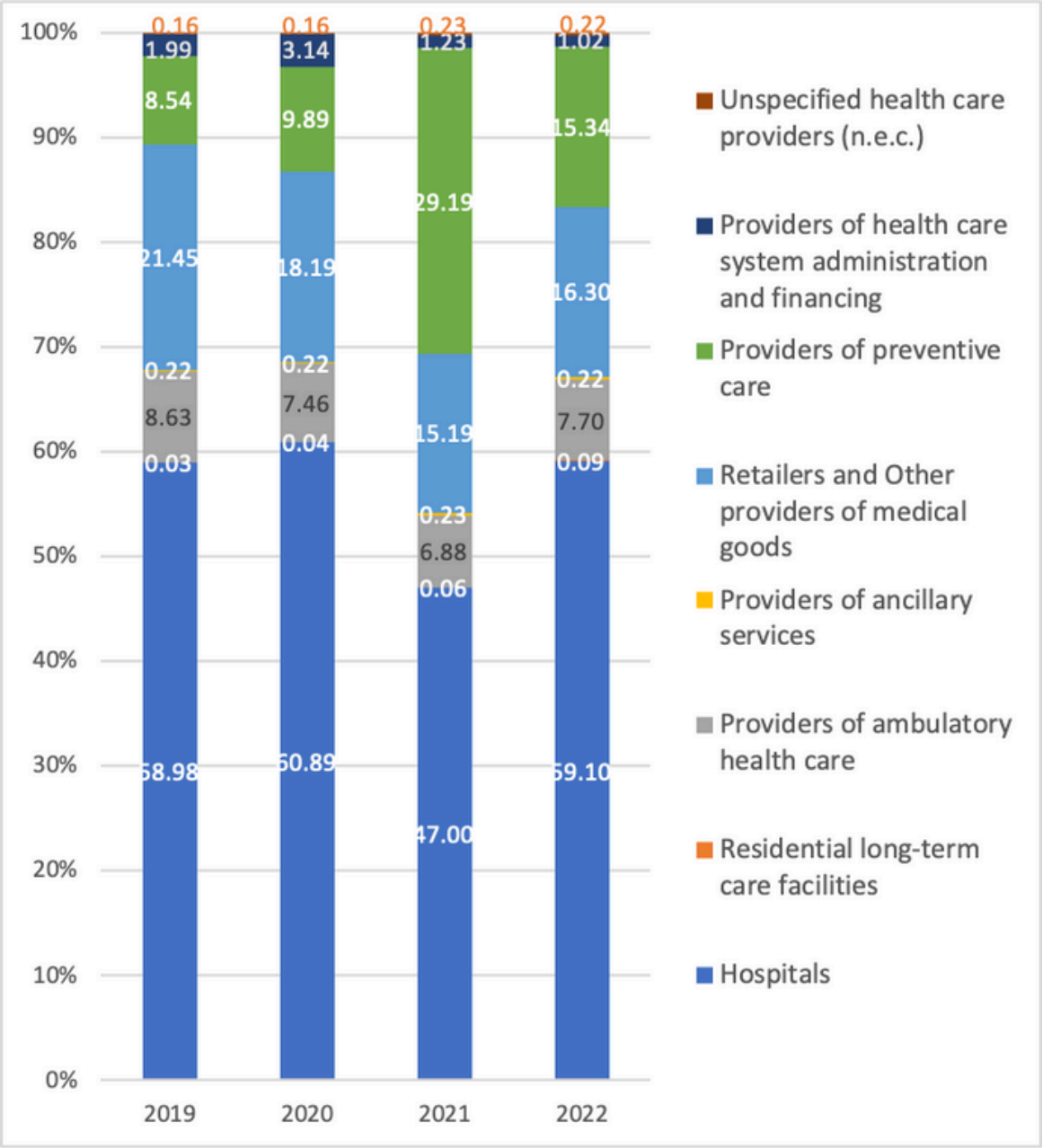
The expenditure distribution witnessed transformation during the COVID-19 crisis, when some ambulatory providers became preventive care providers, along with offering curative care services. Also important is that the lack of gatekeepers to hospital care, which makes it easy for any consultation that can be sought at hospital level, regardless of complexity of cases.

Table 5. Current health spending by type of provider in Myanmar, 2019-2022, (Million MMK and percent shares to total)

Type of provider	2019		2020		2021		2022	
	Million MMK	% of CHE	Million MMK	% of CHE	Million MMK	% of CHE	Million MMK	% of CHE
Hospitals	2,534,693	58.98	2,944,664	60.89	2,825,924	47.00	3,542,290	59.10
Residential long-term care facilities	1,333	0.03	2,045	0.04	3,494	0.06	5,312	0.09
Providers of ambulatory health care	370,376	8.63	360,879	7.46	413,727	6.88	461,801	7.70
Providers of ancillary services	9,518	0.22	10,714	0.22	13,752	0.23	13,421	0.22
Retailers and Other providers of medical goods	920,854	21.45	879,912	18.19	913,338	15.19	977,268	16.30
Providers of preventive care	364,485	8.54	478,157	9.89	1,755,479	29.19	919,514	15.34
Providers of health care system administration and financing	85,275	1.99	152,041	3.14	73,668	1.23	61,178	1.02
Unspecified health care providers (n.e.c.)	6,995	0.16	7,672	0.16	13,779	0.23	13,195	0.22
Total	4,293,530	100	4,836,083	100	6,013,161	100	5,993,978	100

During non-COVID-19 years, hospitals and retailers represented 80% of CHE. Whereas, during the pandemic, specially in 2021, including the preventive care providers, the share of CHE increased over 90% of total current spending. See figure 5.

Figure 5. Current health spending by type of providers in Myanmar Health System, 2019-2022, percent share of CHE



Each financing arrangement is often linked to specific priorities of care, which lead to a specific profile of resource flows to providers. MOH spending is distributed mainly to providers including hospitals, preventive care and administration. The administration of MOH, relates also to governance, including regulation, policy and health system oversight. The Social Security often channels their resources to hospitals and administration. This social security administration relates to contribution management, reimbursements and payments to providers. Whereas, NPIs largest spending is linked to preventive care and ambulatory providers. Community health workers are also funded by NPIs. Voluntary health insurance pays mainly to hospitals. On the other hand, households are the key spenders, with payments reported mainly to hospitals, retailers and ambulatory care providers (Table 6).

Table 6. Financing schemes spending by type of provider, Myanmar, 2019-2022 (MMK Million and percent share)

Financing schemes		Health care providers / Kyat (MMK), Million	HP.1 Hospitals	HP.2 Residential long-term care facilities	HP.3 Providers of ambulatory health care	HP.4 Providers of ancillary services	HP.5 Retailers and Other providers of medical goods	HP.6 Providers of preventive care	HP.7 Providers of health care system administration and financing	HP.nec Unspecified health care providers (n.e.c.)	All HP	Share of HF
2019	HF.1.1	Government schemes	403,115		49,549	4,197	250	164,711	70,050	1,219	693,091	16.1
2020			538,413		42,044	5,315	2,143	301,848	136,635	2,685	1,029,083	21.3
2021			694,510		40,494	2,538	1,630	1,391,250	56,910	670	2,188,002	36.4
2022			837,466		41,449	1,057	522	424,478	41,961	2,523	1,349,456	22.5
2019	HF.1.2.1	Social health insurance schemes	33,320			337			6,043		39,700	0.9
2020			49,026			495			8,892		58,413	1.2
2021			31,413			317			5,697		37,428	0.6
2022			38,122						6,845		44,967	0.8
2019	HF.2.1	Voluntary health insurance schemes	367		49		162		102		680	0.0
2020			934		114		349		247		1,644	0.0
2021			1,842		242		810				2,895	0.0
2022			1,825		206		677				2,708	0.0
2019	HF.2.2	NPISH financing schemes (including development agencies)	12,105	1,333	39,713	4,984		199,774	9,080	5,776	272,766	6.4
2020			10,771	2,045	31,979	4,904		176,309	6,267	4,987	237,261	4.9
2021			27,818	3,494	101,022	10,896		364,229	11,061	13,110	531,629	8.8
2022			33,396	5,312	123,421	12,364		495,035	12,372	10,672	692,573	11.6
2019	HF.3	Household out-of-pocket payment	2,085,787		281,064		920,442				3,287,293	76.6
2020			2,345,520		286,741		877,420				3,509,682	72.6
2021			2,070,341		271,968		910,898				3,253,208	54.1
2022			2,631,482		296,725		976,069				3,904,276	65.1
2019	Total spending by each provider group and all schemes		2,534,693	1,333	370,376	9,518	920,854	364,485	85,275	6,995	4,293,530	100
2020			2,944,664	2,045	360,879	10,714	879,912	478,157	152,041	7,672	4,836,083	100
2021			2,825,924	3,494	413,727	13,752	913,338	1,755,479	73,668	13,779	6,013,161	100
2022			3,542,290	5,312	461,801	13,421	977,268	919,514	61,178	13,195	5,993,978	100
2019	Share of each provider type and all financing scheme		59.0	0.0	8.6	0.2	21.4	8.5	2.0	0.2	100	
2020			60.9	0.0	7.5	0.2	18.2	9.9	3.1	0.2	100	
2021			47.0	0.1	6.9	0.2	15.2	29.2	1.2	0.2	100	
2022			59.1	0.1	7.7	0.2	16.3	15.3	1.0	0.2	100	

Note: HF denotes to Health Financing Schemes and HP refers to Providers of Health Care

Which services are paid for?

A critical dimension in the SHA 2011 is the functional dimension of health care. It indicates a combination of health care goods and services consumed by final users. It may be observed that health care can be consumed in two different ways, namely, individual and collective basis. Most treatment interventions in the health sphere are directed at individuals and therefore consumption of health care is on individual needs. However, collective health care services are directed at the entire or sub-set of population which are intended to improve health status of the community or region or the nation as a whole. Often preventive services, such as, immunization, IEC, disease surveillance, etc. are considered under the collective health care functions[3].

[3] OECD, Eurostat, WHO (2011), A System of Health Accounts, OECD Publishing.
doi: 10.1787/9789264116016-e

Under the SHA 2011 classifications, several functional categories are identified: i) inpatient curative care; ii) outpatient curative care; iii) rehabilitative care; iv) long-term care; v) ancillary care; vi) medical goods and services; vii) preventive services; viii) governance and administration, etc. The structure of spending on health care (HC) in Myanmar is closely associated with the spending distribution by households, given that they are the largest financing scheme. Household spending, is informed mainly by the survey [LSMS]: inpatient care, outpatient care and direct pharmaceutical spending. However, during the pandemic, the changes were largely related to COVID-19 needs, e.g. 25% of increase in hospitalizations in 2020, and 29% on prevention in 2020. Preventive care increased in 2021 almost fivefold compared to 2019 due to vaccination. This functional distribution of health care spending is summarized in Table 7.

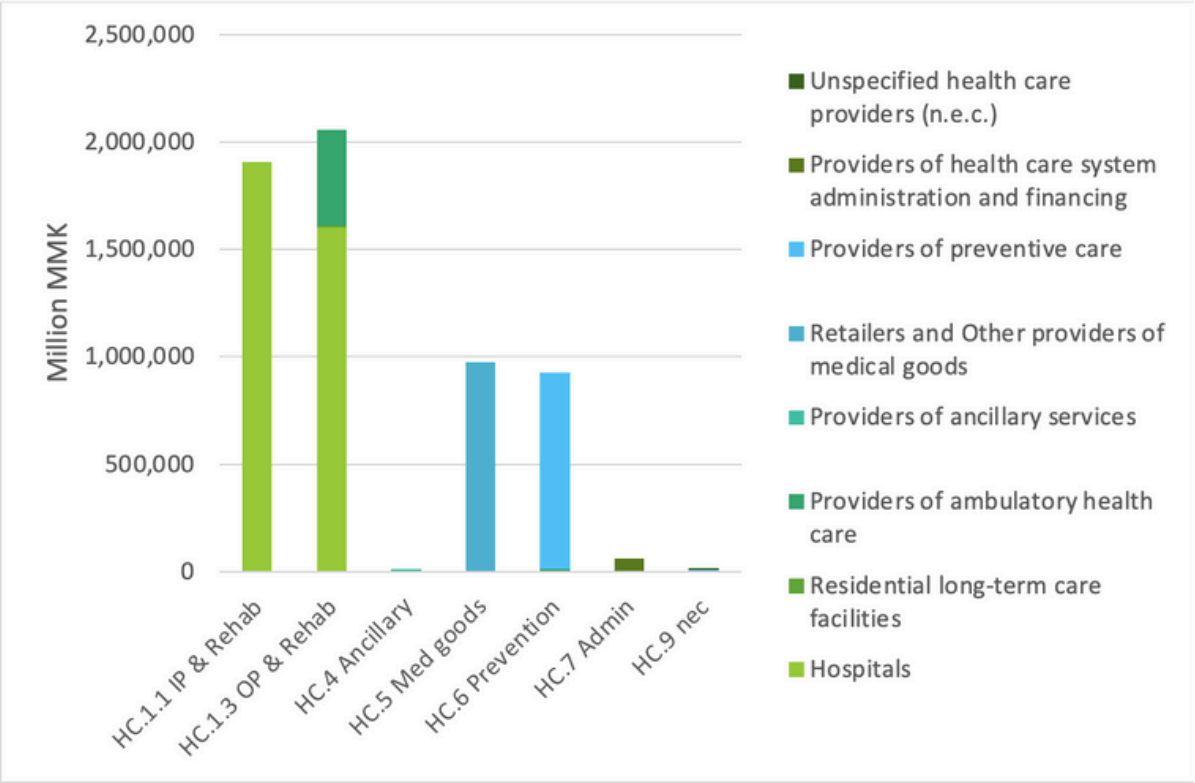
Table 7. Spending on services by health care provider type, Myanmar, 2019-2022 (MMK Million and percent share)

Health care functions		*Kyat (MMK), Million*	Hospitals	Residential long-term care facilities	Providers of ambulatory health care	Providers of ancillary services	Retailers and Other providers of medical goods	Providers of preventive care	Providers of health care system administration and financing	Unspecified health care providers (n.e.c.)	Total	%
2019	HC.1	Curative and rehabilitative care	2,534,630	1,333	353,939					1,492	2,891,394	67.3
2020			2,944,664	2,045	346,523	27				375	3,293,634	68.1
2021			2,825,924	3,494	400,308					982	3,230,708	53.7
2022			3,542,290	5,312	447,619					1,362	3,996,583	66.7
2019	HC.1.1	Inpatient curative and rehabilitative care	1,167,081								1,167,081	27.1
2020			1,462,164			22					1,462,186	30.2
2021			1,506,538								1,506,538	25.1
2022			1,906,584								1,906,584	31.8
2019	HC.1.3	Outpatient curative and rehabilitative care	1,356,487	1,333	352,037						1,709,857	39.8
2020			1,472,309	2,045	346,275	6					1,820,634	37.6
2021			1,318,963	3,494	400,040						1,722,496	28.6
2022			1,604,698	5,312	447,330						2,057,340	34.3
2019	HC.4	Ancillary services (non-specified by function)				9,518					9,518	0.2
2020						10,687					10,687	0.2
2021						13,752					13,752	0.2
2022						13,421					13,421	0.2
2019	HC.5	Medical goods (non-specified by function)					920,854				920,854	21.4
2020							879,912				879,912	18.2
2021							913,338				913,338	15.2
2022							977,268				977,268	16.3
2019	HC.6	Preventive care			16,436			364,485			380,922	8.9
2020					14,356			478,157			492,513	10.2
2021					13,418			1,755,479			1,768,897	29.4
2022					14,182			912,586			926,768	15.5
2019	HC.7	Governance, and health system and financing administration							85,275		85,275	2.0
2020									152,041		152,041	3.1
2021									73,668		73,668	1.2
2022									61,178		61,178	1.0
2019	HC.9	Other health care services not elsewhere classified (n.e.c.)								5,503	5,503	0.1
2020										7,297	7,297	0.2
2021										12,798	12,798	0.2
2022								6,928		11,833	18,761	0.3
2019	Sum of all functions		2,534,693	1,333	370,376	9,518	920,854	364,485	85,275	6,995	4,293,530	100
2020			2,944,664	2,045	360,879	10,714	879,912	478,157	152,041	7,672	4,836,083	100
2021			2,825,924	3,494	413,727	13,752	913,338	1,755,479	73,668	13,779	6,013,161	100
2022			3,542,290	5,312	461,801	13,421	977,268	919,514	61,178	13,195	5,993,978	100
2019	Share of CHE		59.0	0.0	8.6	0.2	21.4	8.5	2.0	0.2	100	
2020			60.9	0.0	7.5	0.2	18.2	9.9	3.1	0.2	100	
2021			47.0	0.1	6.9	0.2	15.2	29.2	1.2	0.2	100	
2022			59.1	0.1	7.7	0.2	16.3	15.3	1.0	0.2	100	

Note: HC denotes to Health Care Functions

Often times, health service and providers are clearly linked [Figure 6]. Inpatient [IP] care reflects a service package including diagnosis [laboratory, image], hospitalization and medicine provision. Outpatient consultation (OP) may include diagnosis and/or medicine provision. When ancillary services and medical goods are obtained outside health care provision, and/or when specifically billed, they are accounted for separately as simple services: [HC.4] laboratory tests, imaging studies, patient transportation, [HC.5] medicines and other medical goods, such as lenses and hearing aids are also key components of health care functional classifications, as outlined in Figure 6.

Figure 6. Spending by services offered by provider in 2022, Myanmar, MMK million



COVID-19 in health function profiles

Clearly, the financial data relating to functional classification has reflected the role of COVID-19, with interventions during the pandemic, prompting significant changes in spending pattern. One such pattern is reduced households' Out-Of-Pocket (OOP) payments, especially for buying medicines from private pharmacies during 2021. Further, due to mobility restrictions, fear of contamination and reduced access to health facilities during 2000, 2021 and 2022, expenditure on curative care component declined sharply in 2021, both inpatient and outpatient. Spending on governance, on the other hand, increased in 2020 due to rise in governance functions. One of the largest rises in expenditure was witnessed for preventive care function, most notably on account of surveillance, testing, early case detection and vaccination (Table 8).

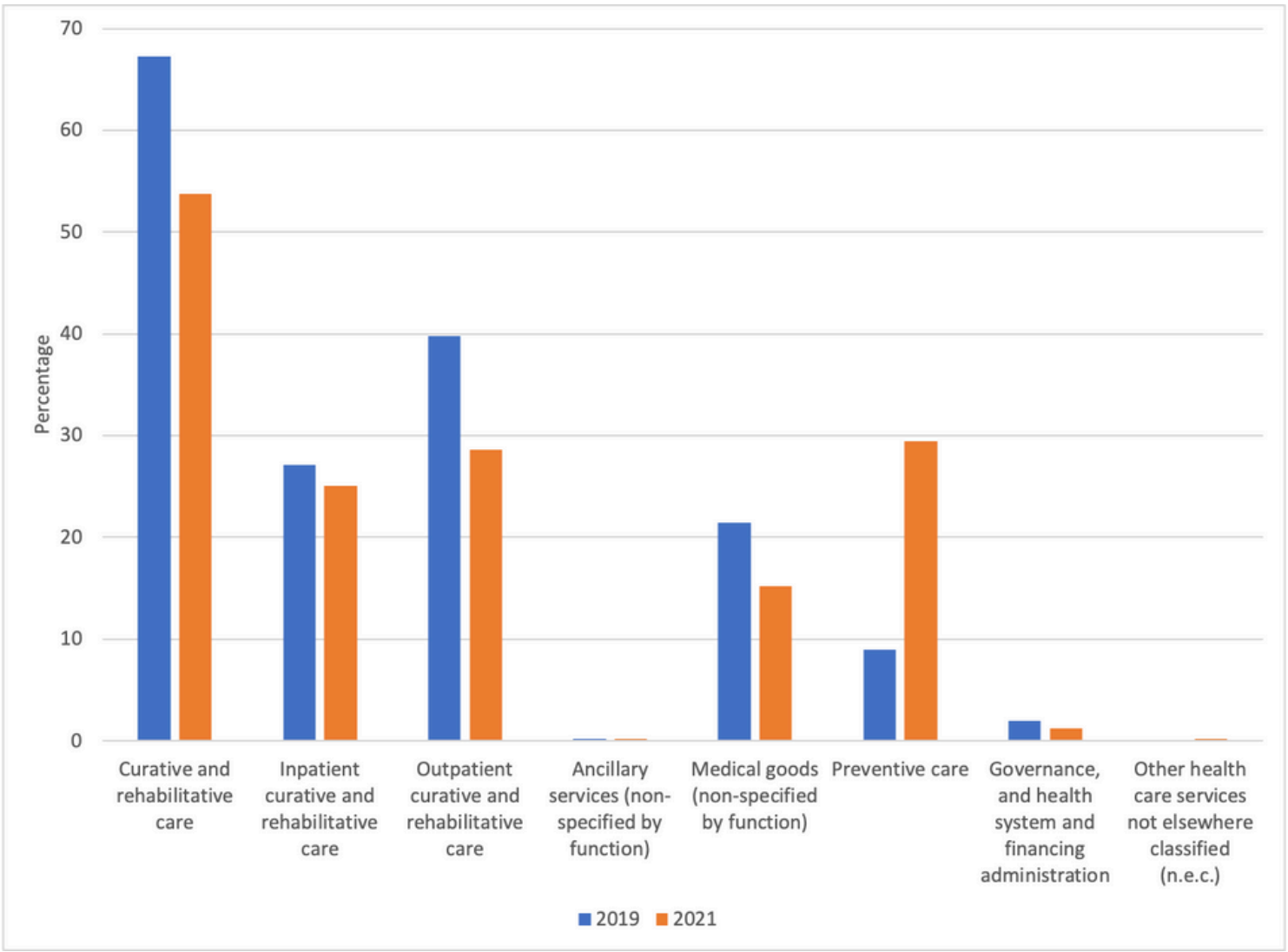
Table 8. Current health spending by type of services [functions] in Myanmar, 2019-2022 (MMK million and shares to total)

Health care functions [% of total]		2019		2020		2021		2022	
		MMK Million	% of total	MMK Million	% of total	MMK Million	% of total	MMK Million	% of total
HC.1-HC.2	Curative and rehabilitative care	2,891,458	67.3	3,293,634	68.1	3,230,708	53.7	3,996,583	66.7
HC.1.1-HC.2.1	Inpatient curative and rehabilitative care	1,167,144	27.2	1,462,186	30.2	1,506,538	25.1	1,906,584	31.8
HC.1.3-HC.2.3	Outpatient curative and rehabilitative care	1,709,857	39.8	1,820,634	37.6	1,722,496	28.6	2,057,340	34.3
HC.4	Ancillary services (non-specified by function)	9,518	0.2	10,687	0.2	13,752	0.2	13,421	0.2
HC.5	Medical goods (non-specified by function)	920,854	21.4	879,912	18.2	913,338	15.2	977,268	16.3
HC.6	Preventive care	380,922	8.9	492,513	10.2	1,768,897	29.4	926,768	15.5
HC.7	Governance, and health system and financing administration	85,275	2.0	152,041	3.1	73,668	1.2	61,178	1.0
HC.9	Other health care services not elsewhere classified (n.e.c.)	5,503	0.1	7,297	0.2	12,798	0.2	18,761	0.3
	Total	4,293,530	100	4,836,083	100	6,013,161	100	5,993,978	100

Note: HC denotes to Health Care Functions

Figure 7 demonstrates potential changes pre-pandemic and during pandemic period involving functional classification of expenditure.

Figure 7. Percentage of spending by type of health service in 2019 and 2021, Myanmar [As shares of CHE]



What diseases and health conditions does Myanmar spend on?

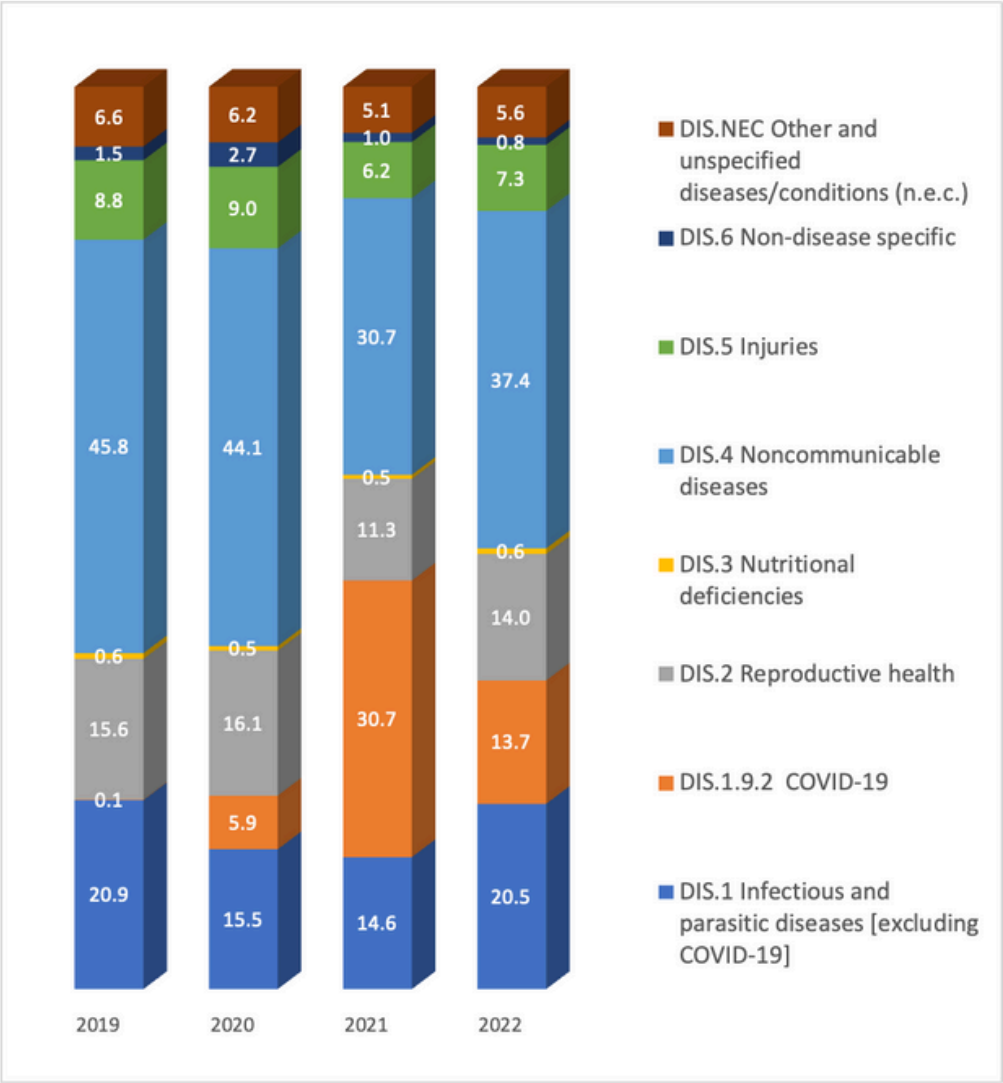
The key focus of the interventions in the health system are related to diseases and health conditions of the population. The interventions and its corresponding use of resources are expected to be aligned with national priorities. Earlier, we noted that the expenditure pattern by functional classification was impacted by COVID-19 related spending. This is also true in expenditure pattern involving disease conditions. Given the mobility restrictions and the reduced health care provision, both in 2020 and to a large extent in 2021, the role of COVID-19 spending is clearly visible. Table 9 demonstrates that in 2019, infectious diseases accounted for relatively less spending, whereas non-communicable diseases [NCD] received a relatively larger share of resources. This pattern was turned upside-down in which infectious diseases remained predominant during pandemic years. During 2022, even as the role of NCDs began to predominate, the share of infectious disease continued to remain relatively large. In 2021, COVID-19 alone took a large share of resources, mainly due to COVID-19 vaccination. The other major categories of disease-specific spending are on reproductive health, followed by injuries.

Table 9. Current Health Expenditure by Disease/Health Condition, Myanmar, 2019-2021 (MMK in million and shares to total).

Health condition [as a share of total]		2019		2020		2021		2022	
		MMK Million	% of total	MMK Millior	% of total	MMK Millior	% of total	MMK Millior	% of total
DIS.1	Infectious and parasitic diseases	899,345	20.9	1,036,833	21.4	2,723,028	45.3	2,050,299	34.2
DIS.1.9.2	*Of which: COVID-19*			287,646	5.9	1,843,069	30.7	819,380	13.7
DIS.2	Reproductive health	670,461	15.6	776,881	16.1	676,812	11.3	839,981	14.0
DIS.3	Nutritional deficiencies	27,025	0.6	24,826	0.5	27,706	0.5	37,364	0.6
DIS.4	Noncommunicable diseases	1,968,799	45.9	2,131,129	44.1	1,843,442	30.7	2,241,168	37.4
DIS.5	Injuries	377,871	8.8	437,005	9.0	373,748	6.2	438,970	7.3
DIS.6	Non-disease specific	65,355	1.5	131,440	2.7	61,772	1.0	48,667	0.8
DIS.NEC	Other and unspecified diseases/conditions (n.e.c.)	284,673	6.6	297,969	6.2	306,653	5.1	337,528	5.6
	Total	4,293,530	100	4,836,083	100	6,013,161	100	5,993,978	100

The change in expenditure by disease conditions during 2019-22 is presented in Figure 8.

Figure 8. Expenditure distribution by disease conditions, Myanmar, 2019-2022 [COVID-19 separate].



Which arrangements cover the payments by disease/health condition?

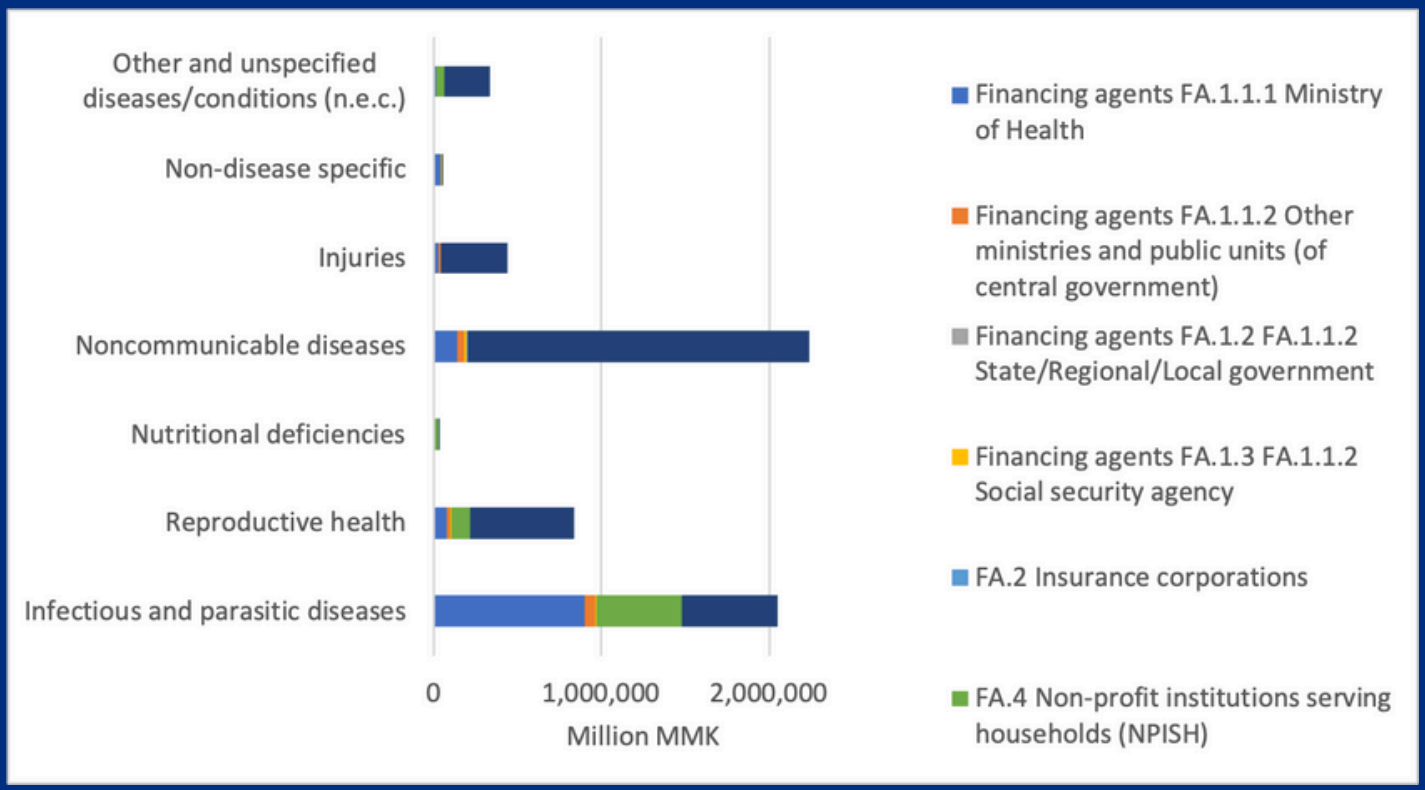
It may be observed that government schemes cover all disease conditions, but more focused on a relatively larger share on infectious diseases and NCDs. For the years 2020-22, this also included COVID-19, for which the government spending appeared to predominate. Whereas the Social Security and Voluntary Health Insurance schemes also appeared to spend on all disease conditions, a relatively smaller amount is spent on malnutrition while largest share is on NCDs. The Not-for-Profit Institutions (NPIs) focus appears to be largely concentrated on infectious diseases. On the other hand, household's out-of-pocket payments went for funding involving injuries and NCD, and they are also the key funding source for reproductive health expenditure. This is captured in figure 9 and table 10, exemplifying the distribution in 2022.

Table 10. Disease-specific expenditures by financing agents, Myanmar, 2022 (MMK Million and shares)

Financing agents		FA.1.1.1	FA.1.1.2	FA.1.2	FA.1.3	FA.2	FA.4	FA.5
Exenditure by disease		Ministry of Health	Other ministries and public units (of central government)	State/Regional/Local government	Social security agency	Insurance corporations	Non-profit institutions serving households (NPISH)	Households
DIS.1	Infectious and parasitic diseases	897,553	62,940	599	6,844	396	511,036	570,930
DIS.2	Reproductive health	77,622	18,366	688	7,735	431	113,516	621,623
DIS.3	Nutritional deficiencies	10,483	281	11	121	4	20,733	5,731
DIS.4	Noncommunicable diseases	138,282	41,422	1,552	18,040	1,415	537	2,039,922
DIS.5	Injuries	31,994	9,998	375	4,326	272		392,005
DIS.6	Non-disease specific	40,777	3	0	6,846	0	478	562
DIS.nec	Other and unspecified diseases/conditions (n.e.c.)	14,681	1,722	108	1,054	190	46,272	273,502

Note: 'DIS' denotes to disease categories and FA refers to Financing Agents

Figure 9. Summary display of financing agents paying for health care by disease conditions, MMK Million, 2022



How are various diseases/health conditions treated?

Three of the five groups of diseases are analyzed below. The tables identify which are the main providers and services associated.

It may be observed that communicable disease conditions are largely treated in health facilities/clinics, followed by preventive care providers [48% and 32% of CHE respectively in 2022]. Services received are mainly preventive care interventions (such as vaccination and IEC), followed by inpatient care [37 and 36% of CHE respectively in 2022]. If outpatient (OP) and inpatient (IP) treatment are considered together as part of curative care, both together account for a higher share than preventive care, except in 2021. In 2021, due to the pandemic, preventive care providers and preventive services were the predominant mode of intervention. In 2019, prevention care along with inpatient and outpatient services were quite similar in their importance (24, 29 and 30% respectively). Table 11 describes communicable diseases/health conditions and its treatment profile in 2019, 2021 and 2022.

Table 11. Service provision of Communicable Disease Conditions, Myanmar, 2019-2021-2022 [MMK million and percentage shares to CHE]

		2019	2021	2022	2019	2021	2022	2019	2021	2022	2019	2021	2022	2019	2021	2022	2019	2021	2022
Health care functions		HC.1.1 Inpatient curative care			HC.1.3 Outpatient curative care			HC.4 Ancillary services			HC.5 Medical goods			HC.6 Preventive care			All HC			Share of HP		
Health care providers [Million MMK]		2019	2021	2022	2019	2021	2022	2019	2021	2022	2019	2021	2022	2019	2021	2022	All services			Share of HP		
HP.1	Hospitals	217,428	699,269	746,900	175,109	130,210	205,604										403,599	829,754	983,405	44.7	30.5	48.0
HP.2	Residential long-term care facilities				563	1,820	2,252										563	1,820	2,252	0.1	0.1	0.1
HP.3	Providers of ambulatory health care				87,242	121,379	143,626							308	11,952	12,631	89,168	133,368	156,302	9.9	4.9	7.6
HP.4	Providers of ancillary services							2,863	7,122	6,847					11,952		2,863	7,122	6,847	0.3	0.3	0.3
HP.5	Retailers and Other providers of medical goods										119,096	90,911	125,439				119,096	90,911	125,439	13.2	3.3	6.1
HP.6	Providers of preventive care													272,994	1,642,392	755,691	272,994	1,642,392	762,619	30.5	60.3	37.2
HP.nec	Unspecified health care providers (n.e.c.)																5,285	13,110	10,672	0.6	0.5	0.5
All HP		217,428	699,269	746,900	262,914	253,409	351,482	2,863	7,122	6,847	119,096	90,911	125,439	273,302	1,654,344	768,322	899,345	2,723,027.8	2,050,299			
Share of HC		24.1	25.7	36.4	29.2	9.3	17.1	0.3	0.3	0.3	13.2	3.3	6.1	30.6	60.8	37.5	100	100	100	100	100	100

Note: HP denotes to providers of health care and HC refers to health care functions

Reproductive care is notably managed in hospitals (e.g. delivery), besides accessing care from pharmacy retailers (contraceptive acquisition) and preventive care providers (antenatal and postnatal care) [65, 16 and 13% respectively in 2022]. Key services include curative care (assisted delivery), considering IP and OP together, followed by preventive care (antenatal, postnatal care and contraceptive services) [71%: 38 IP and 34% OP, 16% medical goods and 13% on prevention in 2022]. Table 12 displays summary distribution of reproductive care services by providers.

Kyat (MMK), Million Health care functions X DIS.2 Reproductive care Health care providers X DIS.2 reproductive care	2019	2021	2022	2019	2021	2022	2019	2021	2022	2019	2021	2022	2019	2021	2022	2019	2021	2022
	HC.1 Curative care			HC.4 Ancillary services (non-specified by function)			HC.5 Medical goods (non-specified by function)			HC.6 Preventive care			All HC			Share of all HC		
HP. 1 Hospitals	403,599	432,323	536,313										403,599	432,323	536,313	0.5	64.6	64.8
HP. 2 Residential long-term care facilities	563	460	1,001										563	460	1,001	0.0	0.1	0.1
HP. 3 Providers of ambulatory health care	88,861	42,006	51,753							308	91	97	89,168	42,097	51,851	0.1	6.3	6.3
HP. 4 Providers of ancillary services				2,863	3,091	4,055							2,863	3,091	4,055	0.0	0.5	0.5
HP. 5 Retailers and Other providers of medical goods							119,096	118,079	131,073				119,096	118,079	131,073	0.1	17.7	15.8
HP. 6 Providers of preventive care										272,994	72,910	103,615	272,994	72,910	103,615	0.3	10.9	12.5
All HP	493,023	474,790	589,068	2,863	3,091	4,055	118,313	118,079	131,073	273,302	73,000	103,712	888,283	668,960	827,908	100	100	100
Share of HC	55.5	71.0	71.2	0.3	0.5	0.5	13.3	17.7	15.8	30.8	10.9	12.5	100	100	100			

Table 12. Selected services delivered by health care providers to patients with reproductive care conditions, Myanmar, 2019-2021-2022 (MMK Million and percentage shares)

Similarly, Non-Communicable Disease (NCD) conditions are mainly treated as curative care [around 76%] of which outpatient [47%], followed by inpatient [38%] and medical goods direct purchases [24%] account for largest share in 2022. Unlike other disease conditions, preventive care accounted for a negligible share. Table 13 displays the summary profile of spending by NCD services for 2019-2022.

Table 13. Services delivered by providers to patients with Non-Communicable Disease Conditions, Myanmar, 2022 (MMK Million and percentage shares)

Kyat (MMK), Million	2019	2021	2022	2019	2021	2022	2019	2021	2022	2019	2021	2022	2019	2021	2022	2019	2021	2022
Health care functions X DIS.4 NCDs	HC.1			HC.4			HC.5			HC.6			All HC			Share of HP		
Health care providers X DIS.4 NCDs	Curative care			Ancillary services (non-specified by function)			Medical goods (non-specified by function)			Preventive care								
HP. Hospitals 1	403,599	1,166,163	1,536,287										403,599	1,166,167	1,536,287	65.7	63.3	68.5
HP. Providers of ambulatory health care 3	88,861	158,271	166,531							308		8	89,169	158,279	166,539	8.1	8.6	7.4
HP. Providers of ancillary services 4				2,863	1,586	563							2,863	1,586	563	0.1	0.1	0.0
HP. Retailers and Other providers of 5 medical goods							119,096	514,854	534,866				119,096	514,854	534,866	25.8	27.9	23.9
HP. Providers of preventive care 6										272,994	1,555	2,241	272,994	1,555	2,241	0.1	0.1	0.1
All HP	492,460	1,324,443	1,702,818	2,863	1,586	563	119,096	514,854	534,866	273,302	1,563	2,249	887,721	1,843,442	2,241,168	100	100	100
Share of HC	55.5	71.8	76.0	0.3	0.1	0.0	0.1	27.9	23.9	0.1	0.1	0.1	100	100	100			

Note: HP denotes to providers of health care and HC refers to health care functions

Investments in the health system

As far as capital expenditure is concerned, the key players involved in investing funds in the health sector include MOH and SSB in Myanmar, accounting to 17-53% depending on the year. The investments relate to acquired buildings, new constructions or major renovations of already existing health facilities. Medical equipment is also another important category, whose share varies from 11 to 29% (Table 14). In 2020, health investments were largely focused on COVID-19 related resources including preparedness of the impending pandemic, such as setting up Intensive Care Units (ICU), oxygen concentrators, etc.

Table 14. Health Expenditure on Capital Goods in Myanmar, 2019-2022 (MMK Million & percentage shares)

MMK million	HK.1.1.1 Infrastructure	HK.1.1.2 Machinery and equipment	of which: HK.1.1.2.1 Of which: Medical equipment	HK.1.nec Unspecified gross capital formation (n.e.c.)	HK.nec Unspecified gross fixed capital formation	All HK
2019	202,015	57,253	41,940	77,851	43,544	380,857
Share	53	15	11	20	11	100
2020	206,373	212,439	148,921	178	82,453	547,850
Share	38	39	27	0.03	15	100
2021	125,841	67,983	56,874	119	50,307	270,730
Share	46	25	21	0.04	19	100
2022	88,685	207,499	90,663	149,106	505.56	536,458
Share	17	39	17	28	0.09	100

Note: HK denotes to health care investments

Which are the inputs used to offer health care?

Concerning health inputs – often termed as Factors of Provision - the SHA 2011 follows budgetary category items, such as human resources, medical commodities, meaning materials and services used to provide health care goods and services. Inputs are central to health care provision which can take the form of both health specific [health care], such as, medicines, diagnostics and non-health specific [to support health care] such as, water and electricity. Non-health goods include e.g. expenditures to operate ambulances, essential for health service provision. Non-health services include expenditures e.g. on security, facility maintenance and cleaning, among others. Besides, other payments may be required, such as taxes (e.g. VAT). The classification of factors of provision accounts for the total value of all resources, in cash and/or in kind, used in health care provision.

Available information on inputs relating to MOH is presented in table 15. The two factors that account for the largest expenditure share are remunerations/salaries for health workforce and medicines & supplies[4]. It may be observed that medicine spending has been increasing and in 2022, the share was relatively higher than expenditure on remunerations/salaries.

Table 15. Inputs used by MOH, Myanmar, percentage shares of current health spending, 2019-2022

FP Categories	2018-2019	2019-2020	2020-2021	2021-2022
FP.1.1 Wages and salaries	40.1%	38.9%	42.8%	34.2%
FP.1.2 Social contributions	0.1%	0.1%	0.1%	0.1%
FP.1.3 All other costs related to emplo	0.8%	0.4%	0.2%	0.3%
FP.3.1 Health care services	1.8%	1.3%	2.4%	1.3%
FP.3.2.1 Pharmaceuticals	29.6%	30.8%	36.4%	49.4%
FP.3.2.2 Other health care goods	7.4%	9.9%	2.7%	1.6%
FP.3.3 Non-health care services	17.4%	14.7%	10.6%	8.3%
FP.3.4 Non-health care goods	2.7%	3.9%	4.7%	4.8%
Total	100%	100%	100%	100%

Source: MOH budget as per SHA 2011 Factors of Provision coding; FP denotes to factors of provision

The strategic role of human health resources

A functioning health care system often requires a fine balance between availability and use of inputs that deliver health care. While Myanmar requires adequate and appropriate mix of health professionals, the composition of its workforce is also key to achieving the desired results.

[4] The value of medicines is higher when measured as inputs for all providers, than as measured as functions or services provided to the population only through pharmacies.

In terms of health workforce, key role is played by the MOH in supporting the formation of human resources, as well as their specialization. Table 16 displays spending pattern on health human resource formation. The strategy is clear, as both allopathic and traditional medicines are covered besides encouraging the growth of various specialties and levels. This refers, e.g. medical, nursing, as well as pharmacy, dentists, etc. The budget allocation often reflects the importance attached to investment in human capital. This set of investment includes resources spent on producing workforce, starting from community health workers, midwives, nurses, dentists, pharmacists, doctors, specialists, etc. These amounts are not included in health care spending but registered as a "memorandum item" given their relevance. However, expenditure that goes into salaries/remuneration and training resources of health workforce is strictly considered as part of health care spending.

Table 16. Public spending on human health resource formation in Myanmar, 2019-2022, million MMK

Human Resource Formation	2018-19 FY	2019-20 FY	2020-21 FY	2021-22 Mini
Stewardship	1,077.988	1,043.870	846.973	444.121
Nursing & Midwifery	8,035.997	6,633.020	3,479.673	1,594.002
Community Health	559.426	573.300	465.317	248.314
Dental	2,479.321	2,611.723	1,434.040	553.672
Medicine	15,743.558	16,039.296	9,260.120	3,964.136
Pharmacy	1,144.989	1,117.258	782.673	359.439
Public Health	316.431	319.903	261.586	139.424
Total	29,357.710	28,338.370	16,530.382	7,303.108

Primary Health Care in Myanmar

Primary health care (PHC) is often seen to be first contact to accessing health care - offering an entry point to the health system[5]. PHC services are expected to potentially focus on people's needs and requirements at the frontline community level and provide health care as early as possible, along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care. This strategy is likely to ensure equity, effectiveness and efficient use of resources, if only by providing preventive care, avoiding unnecessary admissions and ensuring a reduced inappropriate use of antibiotics[6]. Given the high relevance of PHC, WHO has produced a specific and detailed guideline on how to analyse and measure the PHC spending in a standardized way for international comparison. However, at the same time, WHO promotes that countries develop and use their own PHC definition and measures it accordingly[7] Table 17 describes in bold those functions that are agreed as PHC services, as proposed by WHO.

[5] Declaration of Astana: Global Conference on Primary Health Care, Astana, Kazakhstan, 25–26October 2018. World Health Organization, United Nations Children's Fund (UNICEF); 2018(https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf).

[6] OECD. Realising the Full Potential of Primary Health Care,. Policy Brief, 2019. A functioning health care system often requires a fine balance between availability and use of inputs that deliver health care. While Myanmar requires adequate and appropriate mix of health professionals, the composition of its workforce is also key to achieving the desired results.

[7] WHO. Measuring primary health care expenditure under SHA 2011: technical note, December 2021. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.

Table 17. Health care services for inclusion under PHC expenditure

Code	Label of service	Code	Label of service
HC.1	Curative care	HC.2	Rehabilitative care
HC.1.1	Inpatient curative care	HC.3	Long term care (health)
HC.1.1.1	General inpatient curative care	HC.3.1	General long term care
HC.1.1.2	Specialised inpatient curative care	HC.3.2	Dental long term care
HC.1.1.nec	Unspecified inpatient curative care (n.e.c.)	**HC.3.3**	**Unspecified long term care (nec)**
HC.1.3	Outpatient curative care	**HC.3.4**	**Home based long term care (health)**
HC.1.3.1	**General outpatient curative care**	HC.3.nec	Unspecified long term care (nec)
HC.1.3.2	**Dental outpatient curative care**	HC.4	Ancillary services (non-specified by function)
HC.1.3.3	Specialised outpatient curative care	**HC.5**	**Medical goods (non-specified by function) PARTIAL**
HC.1.3.nec	**Unspecified outpatient curative care (n.e.c.)**	**HC.6**	**Preventive care**
HC.1.4	**Home-based curative care**	**HC.7**	**Governance and health system and financing administration PARTIAL**
HC.1.nec	Unspecified curative care (n.e.c.)	HC.9	Other health care services not elsewhere classified (n.e.c)

Source: WHO Measuring primary health care expenditure under SHA 2011 Technical note, December 2021. https://apps.who.int/nha/database/DocumentationCentre/Index/en

As the first point of contact, providing good primary health care involves targeted preventive interventions at the community level and disease management programs. For the purpose of international comparisons, PHC expenditure is expected focus on the type of health care services provided rather than the type of providers, given that the structure of health systems differs among countries. The services outlined above are expected to cover key health care daily needs. In Myanmar, primary health care (PHC) is provided mainly by health facilities at township level and below. This includes outpatient care offered at township & station hospitals, urban health centers, maternal and child health centers, rural health centers, sub rural health centers and ambulatory providers of the non-public health facilities such as GP clinics. In fact, as there is no gatekeeping function to access specialized care, patients accessing secondary or tertiary facility with a PHC need, may be treated accordingly. Thus, it may happen that a certain amount of PHC spending is located in all facilities, irrespective of whether the facility in question is of secondary or tertiary level. Hence, the definition proposed by WHO based on services fits in well with Myanmar health system.

Services considered to be PHC in Myanmar include general (non-specialized) outpatient and home-based services offered by any provider, and preventive care interventions. As per records available, unspecified outpatient care (HC.1.3.nec) in governmental facilities covers only 40% of PHC. Also important, although it is not expected to be included, HC.1.nec unspecified curative care, in the case of Myanmar, contains basically information from NPIs, which are already known to support mainly PHC. Thus, the totality of these spending is included as PHC.

All preventive care is included as PHC. As proposed by WHO, the provision of medicines outside the inpatient and outpatient services, which is mostly comprising medicines purchased in pharmacies, is included although only 80% of this spending. Deviating from the WHO proposal (which is 80% of HC.7 health system , administration), administrative spending linked to PHC was estimated to be equivalent to the share of other PHC services in current health spending: share of PHC [excluding admin] in CHE equals to share of admin on total admin in the year [HC.7] in CHE.

Adequate resources must be allocated on a priority basis to PHC to favor UHC. To interpret the expenditure levels on PHC, the structure of the health system is to be considered: the higher the level of available specialized services, the lower the share of PHC expenditure, and vice versa. In Myanmar, in 2019, during pre-COVID-19 period, the share of PHC was 44%. During 2020 decreased to 42% and escalated to 55% in 2021, returning to 44% in 2022. During the pandemic, the share of government expenditure on PHC spending, increased to 24% while in previous years it was around 8%. A relatively large share of external resources channeled through NPIs are also linked to PHC provision by NPIs. On the other hand, households have disproportionately spent on PHC, with around 30% in 2019 whereas during pandemic it stood around 22%. The purchase of medicines in pharmacies is linked to OOPS, covering the highest amount per function in PHC (Table 18). PHC Expenditure measured in this study, can be represented in a summary table, which is displayed below for the years 2019 and 2021 (Figures 10 and 11, table 18).

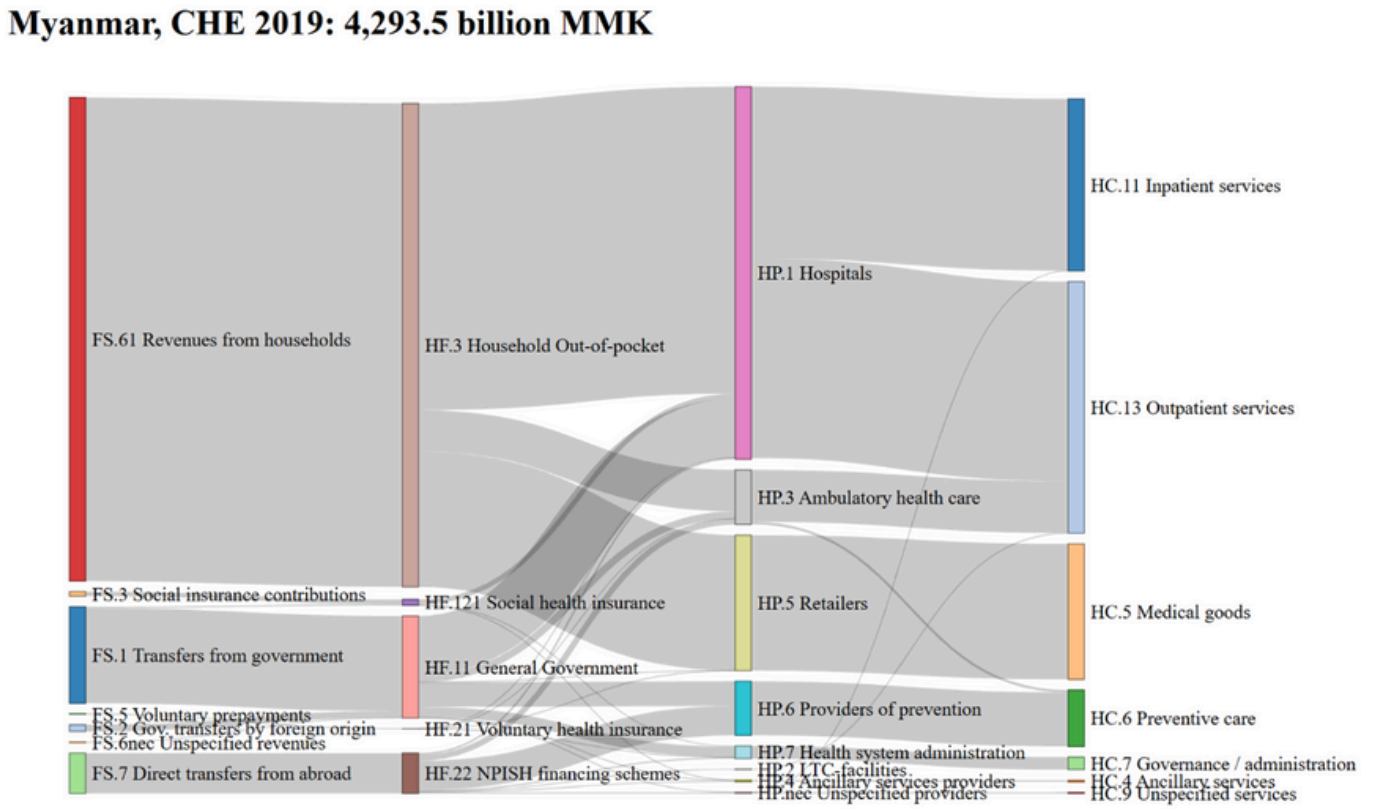
Table 18. Myanmar spending on PHC in 2019-2022 by service and financing component. MMK million

PHC services by scheme Million MMK			HC.1.3.1,HC.1.3.2, HC.1.4 General outpatient curative care, Dental outpatient curative care, Home care	HC.1.3.nec Unspecified outpatient curative care (n.e.c.)	HC.1.nec Unspecified curative care (n.e.c.)	HC.5 Medical goods (non-specified by function)	HC.6 Preventive care	HC.7 Governance, and health system and financing administration	Total
2019	HF.1	Government schemes and compulsory contributory health care financing schemes	36.959	74.599	284	251	181.147	60.875	354.115
2020			574	54.307	566	1.714	316.204	56.005	429.370
2021			24.318	21.809	655	1.304	1.404.668	217.913	1.670.667
2022			21.427	24.737	442	417	438.661	72.853	558.537
2019	HF.2	Voluntary health care payment schemes	17.732	21.805	14.173	163	199.774	7.345	260.992
2020			14.827	7.785	10.248	280	176.309	31.417	240.866
2021			54.410	20.262	982	648	364.229	66.080	506.611
2022			68.538	24.284	32.172	542	488.107	92.046	705.689
2019	HF.3	Household out-of-pocket payment	624.586	0	0	920.443	0	0	1.545.028
2020			666.840			701.936		205.316	1.574.092
2021			618.109			728.719		202.024	1.548.852
2022			741.812			780.855		228.400	1.751.068
2019	HF.2+HF.3	Non governmental	642.318	21.805	14.173	920.605	199.774	7.345	1.806.021
2020			681.667	7.785	10.248	877.700	176.309	263.056	2.016.765
2021			672.519	20.262	982	729.367	364.229	268.104	2.055.463
2022			810.351	24.284	32.172	781.397	488.107	320.447	2.456.757
2019	All HF	Sum	679.277	96.404	14.456	920.857	380.922	68.220	2.160.136
2020			682.241	62.092	10.814	879.414	492.513	319.061	2.446.135
2021			696.837	42.071	1.637	730.671	1.768.897	486.017	3.726.130
2022			831.778	49.021	32.614	781.814	926.768	393.299	3.015.294

Note: HC denotes to health care functions and HF refers to health financing schemes

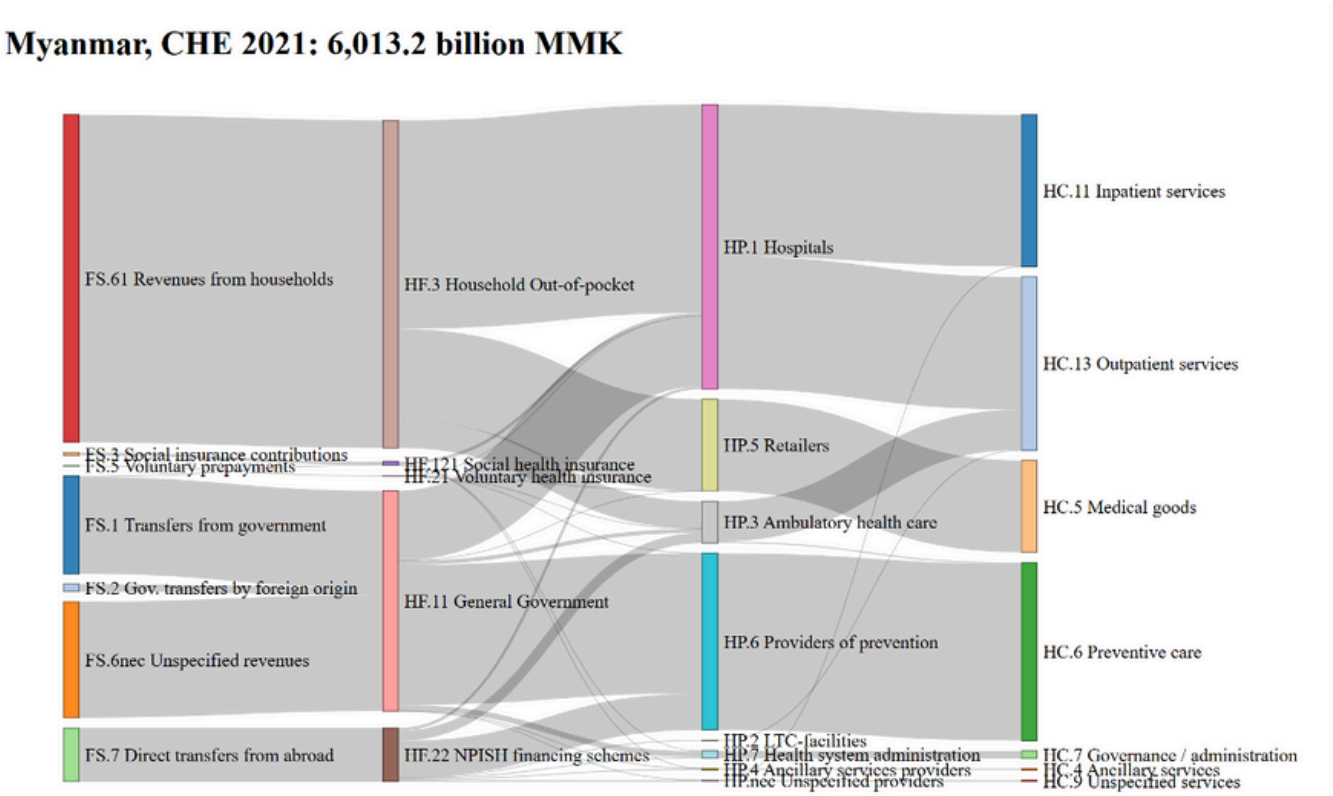
The summary representation of the PHC expenditure flows measured can be made through Sankey charts. It allows to identify the categories being included. Following the paths from one side of the chart to the other, one can identify and focus on the vital values on each side, the widest connecting bands, the connections that create a trend and those that seem to buck the trend. Their width is proportional to the amounts represented. In this case, the household spending is identified as a major source, which is distributed among various services, notably curative care and medicines.

Figure 10. Sankey chart of Myanmar health accounts study in 2019



The main change in the Sankey representation for 2021, compared to 2019, is the increase on preventive care spending related to COVID-19.

Figure 11. Sankey chart of Myanmar health accounts in 2021



3.POLICY IMPLICATIONS AND RECOMMENDATIONS

Increasing government spending on health

The government's priority on health in recent years is reflected in higher budget allocation. Government spending on health has increased as a share of GDP, and as a share of total government spending (GGE) and in per capita values. Adequate levels of government health expenditure and its significant rise is critical to ensure better access to healthcare and financial protection to households. Is current government spending sufficient? While there is no internationally accepted benchmark such as the Abuja target[8], there has been an increasing consensus around a few estimates that have emerged from empirical findings. The two most commonly cited indicators are from a Chatham House Report published in 2014[9], which recommended General Government Health Expenditure (GGHE) to be at least reaching 5% of GDP, or $86 per capita, to ensure essential health service access. In certain regions, the target may be even more ambitious, such as a threshold suggested by Latin American Countries (LAC) for GGHE to be no less than 6% of GDP[10]. In LAC only few countries have reached that level.

The level of health spending has increased in Myanmar compared to previous estimates. The indicators in Table 1 are not fully comparable to the previously estimated, due to COVID-19, which has increased the spending but has also affected the reference values such as GDP, a sharp decline by 30% during the COVID-19 period. In per capita terms, the health spending level accelerated from 85 to 111 thousand MMK, a 30% increase in2022 compared to levels seen in 2018. This increase is no way closer to the target for Myanmar, formulated in 2018 by IMF in its country report of March 2018. In that report, the IMF has estimated for 2015 data that to comply with SDGs, Myanmar government health spending needs to be close to 2.5% of GDP[11] (Figure 12). Our estimates show that the domestic government spending represented 1.8% of GDP in 2022.

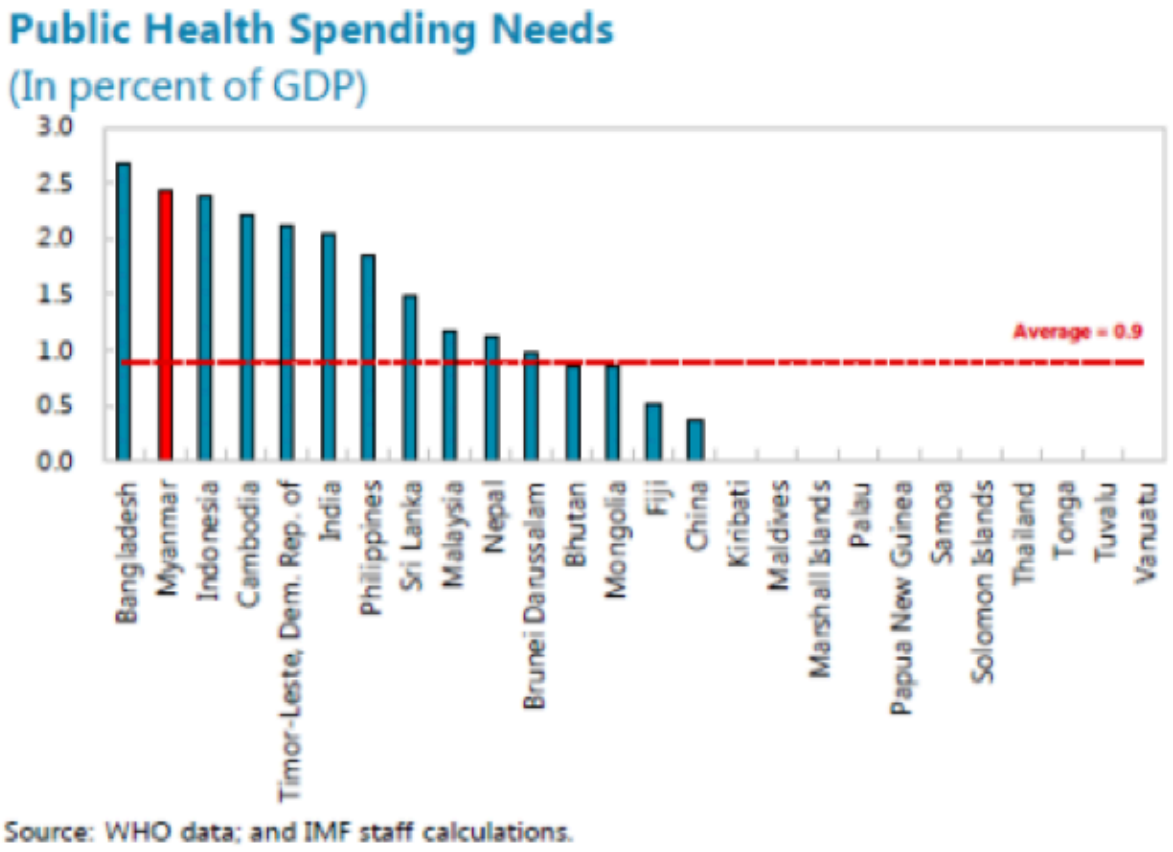
[8] On April 27, 2001, African Union (AU) governments adopted the Abuja Declaration, in which they set a target of allocating at least 15 percent of their national budgets to improve health care. See https://iris.who.int/bitstream/handle/10665/341162/WHO-HSS-HSF-2010.01-eng.pdf

[9] The Royal Institute of International Affairs. Chatham House Report. Shared Responsibilities for Health. A Coherent Global Framework for Health Financing. Final Report of the Centre on Global Health Security Working Group on Health Financing. Chatham House. London, May 2014. https://www.chathamhouse.org/sites/default/files/field/field_document/20140521HealthFinancing.pdf

[10] PAHO. Universal Health in the 21st Century: 40 Years of Alma-Ata. Report of the High-Level Commission. PAHO/WHO, 2019. Washington. Pp 67 https://reliefweb.int/sites/reliefweb.int/files/resources/9789275120682_eng.pdf

[11] IMF. Myanmar. Selected Issues. Country report 18/91. IMF, Washington 2018

Figure 12. Comparative levels of additional public health spending required among countries (2016 calculations)



Source: WHO data; and IMF staff calculations.

Compared to these suggested benchmarks, there is still space for Myanmar government to further increase its health spending from budgetary resources. An increase of tax resources can only result from more allocation from Ministry of Finance and Planning, that is, from the general government (GGE). In the analyzed period, the increase of GGE was 30% while GDP declined by 30%. Experience from other countries highlights that it is important to also increase GGE, in order to accordingly expand resources available for health. Usual means to increase public revenue involve e.g. pro-health taxes (tobacco, alcohol, sugar-sweetened beverages), general taxes, Value Added Taxes, a share of income in a governmental enterprise, a share on personal transfers from abroad, and a share of use of mobile telephone. The changes in governmental spending can be monitored in NHA, as well as the sources of financing, using the below the line or memorandum items.

Primary health care - PHC

Providing adequate resources, a well-staffed primary health care (including community workers, and facility-based health workforce) can reduce the need for more expensive health care and expand access to population in need. PHC includes frequent disease management, thus adequate level of spending on PHC and its distribution across states/regions can help to reduce OOPS. Among other interventions that covers infectious disease and RMNCH care, one other key initiative should be to expand prevention and treatment activities for NCD. Often, we find that the financial burden on households is now largely on paying for NCD treatment. Prevention at appropriate time would have saved the need for treatment for NCDs.
In terms of per capita spending on PHC, global benchmark for government spending has been suggested to be 65 USD[12] and 85 USD to be better covered[13]. In Myanmar, the government spending on PHC, currently represents around 1.3 USD per capita in 2022. To reach the benchmark of 65 USD per capita, it would require a tremendous level of increase. Changes in PHC financing can be monitored through tracking NHA, as well as their uses.
It is vital to strengthen PHC services, while improving the rationale use of secondary and tertiary levels of care. This can be envisaged through a gatekeeper function, which encourages the population to initiate contact with the health system via PHC services.

[12] McIntyre D, Meheus F, Røttingen JA. What level of domestic government health expenditure should we aspire to for universal health coverage? Health Economics, Policy and Law (2017), 12, 125–137 doi:10.1017/S1744133116000414
[13] Stenberg K, Hanssen O, Bertram M, Brindley B, Meshreky A, Barkley S, Tan-Torres Edejer T. Guide posts for investment in primary health care and projected resource needs in 67 low-income and middle-income countries: a modelling study. Lancet Glob Health 2019; 7: e1500–10. https://doi.org/10.1016/S2214-109X(19)30416-4

Reducing OOPS

The households' OOPs level observed in this study is lower compared to previous years, but still is relatively high. Available international evidence suggests that a higher level of OOP – over 20% of CHE - would be a strong indicator of financial risk for households when accessing necessary health care[14].

As per current health accounts results, OOPS is lower among diseases for which other funding sources exist, such as for HIV/AIDS and nutrition. Thus, in order to reduce OOPS, it is required that household payments are substituted by other sources, ideally, via a rise in government funds, to ensure access with financial protection. Besides mobilizing additional resources, efficient utilization of available resources is also called for. To facilitate this process, the analysis on what OOPS is paying for is vital. In Myanmar, a higher level of OOPs is spent on pharmacies, ambulatory care and, to a lesser extent (in relative terms) in hospitals. Reducing OOPs would require increasing operational resources and medicines at health facility level, which are reported to be linked to OOPS and catastrophic spending[15]. Therefore, in order to make a strong dent on financial risk burden on households, public spending must grow faster than the growth in the economy (in per capita GDP terms), to reflect that priorities and resource reallocation principles remain clearly focused on reducing households OOP level.

[14] WHO World Health Report 2010. HEALTH SYSTEMS FINANCING. The path to universal coverage. Geneva, WHO, 2010
[15] Myint, C., Pavlovam, M., et al.,"Catastrophic health care expenditure in Myanmar: policy implications in leading progress towards universal health coverage.," Int J Equity Health, no. 18, 2019.

4. RECOMMENDATIONS FOR FUTURE HEALTH ACCOUNTS PRODUCTION

Institutionalization

With the rich experience gained of conducting NHA exercise in Myanmar, the imperative of strengthening entire process of producing institutionalized NHA is critical at this hour. Institutionalization is key to updating and releasing NHA on a routine basis and promote utilization of key results by decision-makers through continuous monitoring of all health policies. One of the critical first set of tasks is to establish a link between different ministries and departments while at the same time working relationship among government (especially Central Statistical Organisation), non-governmental organisations and development partners must be established. Myanmar National Health Account Team under the Ministry of Health has been instrumental in steering the production and dissemination of health accounts in Myanmar in the past. Capacity building and regular interaction between Myanmar National Health Account Team with other stakeholders within and outside the government institutions is the need of the hour. The proposed Health Financing units' expertise and experience can be directed to facilitate this task. As such an exercise is often a win-win situation for all the relevant institutions/departments/ministries. Universities and research institutions must be organically linked to the Myanmar National Health Account Team at MoH so that regular interaction is ensured while gradually moving towards getting a lot of evidence-based data-driven piece of work, such as, costing of health care services at different levels of care, costing of individual diseases for unit cost, size and distribution of private for-profit and not-for-profit health care providers, size and distribution of private pharmacies, monitoring of retail prices of key essential medicines, etc.

Engaging with stakeholders

Donors and NPIs

There is a need to have a routine data reporting system of health expenditure to MOH with a common template. The template should be clear and user-friendly but needs to cover the information required to filter double counting, specify whether the support is in-kind or in-cash, whether the recipient is the government sector or not, and which services and diseases are covered by which providers. Notably, the improvement appears to be needed in priority for grants directly offered to NGOs and facilities.

Private sector

It is imperative that Myanmar National Health Account Team will need access to detailed business registries and surveys from private facilities [e.g. last set of studies in 2017]. These are to be obtained through CSO and through reports of activities to MOH. Formats and practice preferably in a health information system needs to be adjusted to capture the relevant information required. It is also important to promote the use of the updated version of the UN classification of individual consumption by purpose (COICOP 2018), in all documents related to household and NGO spending.

Government entities

All government agencies should be encouraged to report detailed UN Classification of Functions of Government (COFOG) to MOPF. This includes states, regions and districts as well as CDCs. A sub-national level analysis (using SHA2011 SNL classification), is also recommended as some of the changes are expected to take place at subnational level. A more comprehensive measurement of governance and administration may be needed.

Opportunities for reporting Health Accounts

The improvement of the health information system is critical to increase the granularity of health accounts and the quality and comprehensiveness of their results. An electronic information system, covering the private sector as well, should be the ultimate goal. Private information can be obtained in a relatively easy manner establishing collaboration with CSO entities.

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