

Country Summary Report: Myanmar

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Acronyms

CDM	Civil Disobedience Movement
CSO	Civil Society Organization
DHIS2	District Health Information Software 2
EPHS	Essential Package of Health Services
FDA	Food and Drug Administration
HMIS	Health Management Information System
HPRD	Health Professional Resource Development
HRH	Human Resources for Health
HW	Healthcare Workers
ILO	International Labour Organization
MOH	Ministry of Health
MoHS	Ministry of Health and Sports
M-HSCC	Myanmar Health Sector Coordinating Committee (M-HSCC)
NGO	Non-governmental Organization
NHP	National Health Plan
OOP	Out-of -pocket health spending
SDG	Sustainable development goals
SEA	South-East Asia
SSS	Social Security Scheme
THE	Total Health Expenditure
UHC	Universal Health Coverage

Country Summary Report for Myanmar

Overview

Myanmar serves as a textbook example of a modern fragile state. It has a lower-middle-income economy and is the second largest country in Southeast Asia. Additionally, Myanmar is one of the most disaster-prone countries, exposed to extreme weather (cyclones, earthquakes, etc.), civil unrest, and the COVID-19 pandemic, creating a high demand for the healthcare system that is often unmet (World Bank). Healthcare system performance significantly declined following ongoing ethnic conflicts and government instability in 2005. Most recently, the military coup in February 2021 led to complete government overthrow and the establishment of rebel disobedience groups, thereby dismantling the public healthcare system.

Between 2011 and 2019, Myanmar had a high economic growth rate at ~6 percent annually and a significant reduction in poverty (World Bank). However, this development was halted by compounding effects of the Rohingya conflict in the Rakhine state (2016), COVID-19 pandemic, and Tatmadaw military coup (2021), effectively reverting 10 years worth of progress in all aspects of development, most notably in healthcare. Despite ongoing domestic conflicts, Myanmar has transitioned into stage 4 of the demographic transition model, characterized by low birth rates, death rates and a “youth bulge” preparing to enter the workforce with 42.4% of the population under 25 as of 2025 (UN World Population Prospects)¹. Most recent reported data in 2023 indicated the maternal mortality ratio as 184.6 per 100,000 population, significantly greater than the Southeast Asia region average (120 per 100,000 population) and neonatal mortality as 21.06 per 1000 live births (WHO). Additionally, the GDP growth remained negative or stagnant, with the latest reported -0.97 percent in 2024 (PIP World Bank). Myanmar is ranked 150 out of 187 countries on the Human Development Index (UNDP 2025). Overall, Myanmar’s health indicators remain poor compared to regional standards.

¹ Mass migration and ethnic conflicts may lead to inaccurate population estimates. Official estimates do not account for any international out-migration during the military regime or the fluid populations at the borders with Bangladesh, India, Laos, China, and Thailand. (Population Reference Bureau)

Challenge stems from a lack of institutional stability and regional disparities, resulting in high out-of-pocket (OOP) costs, poor healthcare outcomes, and limited access to care. The goal is now to establish a strong public sector healthcare system with a sustainable national social health insurance to increase financial protection and progress towards achieving UHC by 2030. Thus, healthcare reform must be prioritized in the post-coup restructuring of Myanmar.

Table 1. Data Overview

Population	~54.8 Million (2025)
GDP	74.08 Billion (2024)
Health Expenditure (THE) as % of GDP	4.46% (2023)
THE per capita	\$51.97 (2023)
Life expectancy at birth	68 years for total population (2025)
Under 5 mortality rate	39 deaths per 1,000 live births (2023)
Density of physicians	7.57 physicians per 10,000 population (2022)
Hospital beds per capita	10.1 beds per 10,000 population (2019)

Source: World Health Organization and World Bank Indicators

I. Leadership and governance

The Ministry of Health (MOH) serves as the central governing body formally responsible for healthcare governance, priority setting, and service delivery in Myanmar. The MOH contains 6 specialized departments (public health, medical services, HPRD and management, medical research, FDA, and traditional medicine) to oversee public health provision and research regulations. Healthcare governance follows a decentralized structure, delegating authority to state/region, district, township, and community health departments (Nagoya Journal of Medical Science). While this model strengthens community level care and accountability, the ability for each community center to self determine budget distribution creates health financing and human resource distribution fragmentation leading to uneven service quality across regions and widening gaps in essential service delivery.

Due to Myanmar's fragmented healthcare system, the Myanmar Health Sector Coordinating Committee (M-HSCC) acts as a multi-stakeholder to align the many actors (government, private, NGOs, international donors) around a uniform governance manual and strengthen the overall health sector. Despite the M-HSCC public-private provider relations remain a recurring challenge.

After 2021, the legitimacy and operations of formal governing bodies such as the MOH have been contested by opposition groups. Civil society organizations (CSOs) that arose during the coup outlined their own health policy framework under the National Unity Government (NUG) emphasizing community-led systems in promoting equity, and collaborating with ethnic health groups. Federal health principles proposed by the NUG-MOH reflect a demand for re-structured healthcare governance towards a bottom-up approach. Currently the long term impacts of alternative governance structures remain unclear.

II. Service Delivery

Prior to the coup, the MOH and departments of public health and medical services delivered ~50-60% of all formal healthcare throughout the country from rural health centers supervised by the township health system to large specialist hospitals in Yangon and Nay Pyi Taw². There is a high density of private sector providers within the same urban regions, amplifying the rural urban divide within Myanmar.

While the public sector is responsible for a majority of healthcare service provision across the country, owning 77% of healthcare facilities (WHO), private hospitals and NGO backed grassroots community health centers have expanded in the last decade to meet increasing demand of rural and conflict impacted regions (table 2). Ethnic Health Organizations (EHOs) serve displaced populations the government cannot reach notably operating in the Rakhine region during the Rohingya crisis. Facility assessments in 2019 with 5 EHOs revealed that collectively, they provided care to over 500,000 individuals through more than 100 health facilities, indicating the scale of EHOs (World Bank). CSOs play a similar role, delivering care in the absence of government presence to central Myanmar and ethnic controlled areas.

² Top 3 largest urban regions within Myanmar. With Yangon as the economic center and Nay Pyi Taw as the capital.

Table 2. Total Number of Health Facilities of Level (2020)

Facility Level	Public	Private	Total	Remark
Hospitals (incl. Specialty, Referral, General)	1,144	253	1,387	Secondary+Tertiary
Specialty Centers/Clinics	N/a	144	144	Tertiary
Health Stations/Sub-stations	10,477	0	10,477	Primary
Maternal and Child unit/ Primary Clinics	441	7,390	7,831	Primary
Total	12,062	7,787	19,839	

Source: Ministry of Health & Sports Three Year Achievement and MoHS Private Healthcare

High costs and limited access have driven patients towards opting for self-treatments or informal providers. A post-coup survey (n=1500) found that 59% of individuals sought private healthcare compared to 23% public healthcare and 18% who sought no form of care at all (World Bank 2024). A failure to seek care is also reflected in a lack of routine screenings for NCD prevention as demonstrated by a 2014 survey which reported that 86% of respondents had never had their blood sugar measured (WHO, MoH 2014). These results reflect early detection, treatment, and preventative measures for NCDs as a key gap in Myanmar's health service delivery.

There exists a need for regulated price regulation of private sector providers and equitable distribution of specialized care to rural areas which make up 70% of Myanmar's population (Britannica). Service coverage varies greatly by geographical location and social strata within Myanmar. In Yangon, Myanmar's largest and most prosperous city, 65.4% of births were conducted in a health facility, compared to 14.7% in Chin State, one of the least developed regions and containing the highest poverty rate in Myanmar. Similar discrepancies can be observed in immunization, and home births. These inequities in access are contrary to Myanmar's efforts towards UHC. As a large portion of the population continues to be left out of fundamental services such as NCD prevention, Myanmar still has significant room for growth in terms of ensuring equitable coverage across the rich vs poor and rural vs urban populations.

III. Human Resources for Health

Human resources of health (HRH) serve as the backbone of health systems and care delivery, thus it is critical to have HRH of high availability, quality, and accessibility. In achieving the sustainable development goals (SDGs) and universal health coverage, low-and- middle income countries rely on healthcare workers to respond to current contexts under limited resources. Since 2006, Myanmar has been 1 of 57 crisis countries facing health workforce shortages. Thereafter, the distribution of medical doctors continues to decrease with 13 out of 15 States and Regions in Myanmar below the WHO recommended minimum of 2.5 medical doctors per 1,000 population (Saw 2019).

The health workforce shortage can be attributed to a high demand and low supply for health professionals, especially within the public sector. Beginning with medical education, there are 5 universities for doctors, 2 for nursing, and 2 for pharmacists (Ministry of Health and Sports 2016). There is also a significantly higher attrition rate for doctors in training (6.7%) compared to nurses (1.1%) mainly through voluntary attrition (resignation and absenteeism), making retention of medical doctors a challenge (Htun 2013). Long working hours, poor working environments, and heavy workloads create barriers to both HRH retention and recruitment into the public health industry (WHO Asia Pacific Observatory). Thus, many young professionals seek employment from private sectors and international organizations such as the United Nations, WHO, and non-governmental agencies.

During the 2021 coup, healthcare workers played a key role in the opposition forces, leading the pro-democracy civil disobedience movement (CDM), resulting in violent military attacks on health care workers and hospitals diminishing entire healthcare systems (Haar 2024). Through a “no recognition, no participation” approach, healthcare workers (HWs) refused to work for the military regime resulting in targeting of HWs through surveillance, revoking of licenses and even assassinations. Post-coup, there are significant threats to the healthcare workforce presented by mass migration to neighboring countries such as Thailand and Bangladesh following threatening economic and security conditions. A mass flight of Myanmar’s youth, with 3.7 million having migrated to Thailand by 2023 presents a looming brain drain not just within the healthcare industry but nationwide (UN News).

IV. Information and technology

Digital health solutions hold immense potential for transforming healthcare in developing countries facing HRH shortages and inequitable distribution of care. Currently, digital health is still in early stages of development in Myanmar and continues to face barriers in achieving nationwide rollout. Stakeholder investment in digital health is a growing trend that should be encouraged for improved healthcare outcomes (Toth 2015). Federal policies that permit 100 percent foreign ownership and a drop in SIM card prices in 2013 have encouraged international investments, mainly from China, Singapore, Japan, and the EU to provide funding for digital health innovations.

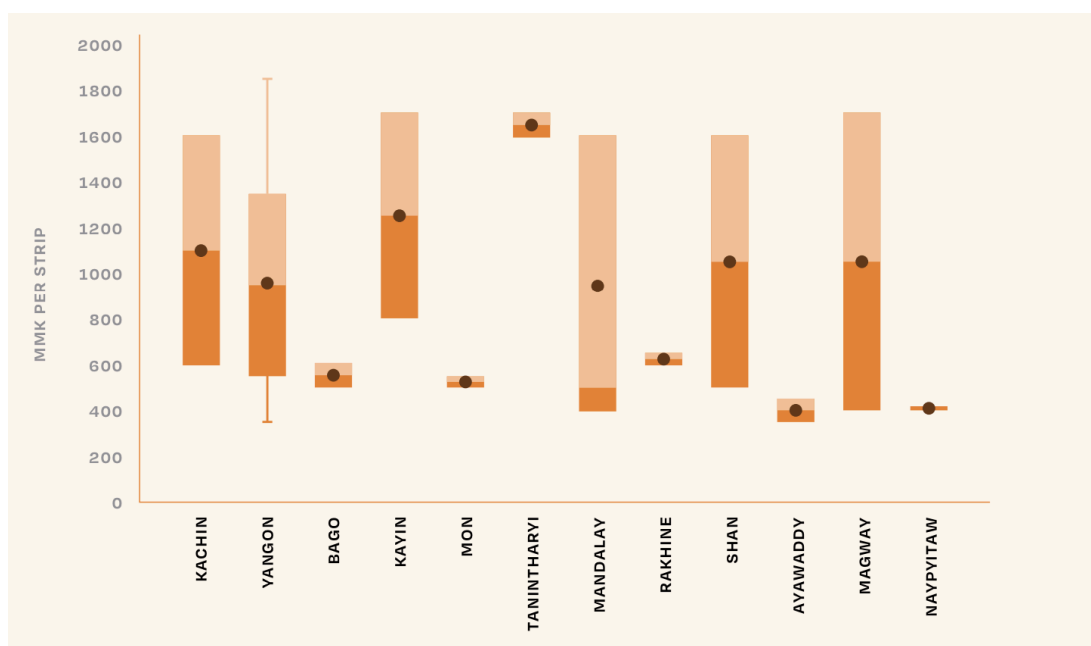
Myanmar has scaled district health information software (DHIS2), an internationally utilized open-source health data system, as the HMIS platform across all districts and townships. Further, MoHS has distributed 26,000 mobile tablets with guidelines and procedures to frontline HWs to support access to DHIS2 and other management systems (GSMA 2020). Along with information systems, there has also been a focus on telemedicine as a key player in reducing the rural urban divide. As of 2020, there were 13 digital health startups in Myanmar, with a majority in the telehealth and lifestyle industries (GSMA 2020). While there is a high demand for digital health, there still remain significant barriers to integration such as internet stability, private sector involvement, and risks foreign dependency.

V. Access to Essential Medicines

Access to essential medicines in Myanmar has historically been limited by systemic constraints and spending capacities. With the rise of domestic conflict and the COVID-19 pandemic, increased border closures, reduced transportation, and limited supply have led to spikes in drug prices and limited access. The national list of essential medicines by the World Bank determines a list of medicines that should be available, compared to what is currently available. According to the 2015 Service Availability and Readiness Assessment (SARA) conducted by the MoHS with support from the WHO, only 43% of surveyed facilities had the required amount of essential medicines in supply, with only 41% having basic amenities (World Bank 2024). During the COVID-19 pandemic, essential medicines experienced a two fold increase in price, particularly antibiotics, cough medicine, vitamins, and respiratory infection treatments.

Availability has also varied over time and setting, with major public hospitals showing higher availability (80%) compared to primary care health centers (59%), further demonstrating significant impacts of the rural-urban disparities (World Bank 2024). Price variation is also evident among pharmacies within the same region, with Yangon, the country’s urban center offering the widest range of brands, thus resulting in the largest inter-regional price variation (figure 3). Extreme price fluctuations and lack of financial risk protection contribute to gaps in treatment accessibility forcing many patients to face debt or opt not to seek care altogether.

Figure 3. Price variation of amlodipine³ across states and regions (N=47)



Source: World Bank and WHO Essential Medicine Retail Price Tracking data, 2023

VI. Current insurance model

Health insurance and social protection in Myanmar is negligible. Health care is only named as a constitutional obligation of the Union through Article 28; “earnestly strive to improve education and health of the people” rather than declaring a constitutional right to health. Beginning in 2012, Myanmar provided free access to all emergency, maternal, and childhood illness at all public MoHS hospitals. While in theory this program provides free access to health services for the entire population, substantial challenges to coverage and access led to a lack of translation from theory to practice.

³ Calcium channel blocker used to treat hypertension

Myanmar's lack of explicit benefits package creates uncertainties regarding which services are free for patients. Additionally, insufficient resources in funding, human resources, equipment, etc. limit individual providers' ability to deliver services. A 2015 survey found that <50% of facilities met the prerequisites of essential medicines (42%) and basic amenities (37%) showcasing the impact of insufficient resources in achieving UHC. Prior to 2015, health insurance was only available to government and international organization employees, with health care spending only comprising 3.4% of general government expenditure (Latt et al 2016). In 2015, expansion to a nation-wide insurance plan operated by a state owned Myanmar insurance and 11 private companies was launched under a one-year trial. Subsequently, the National Health Plan (NHP) was developed by the democratic government in 2017 as a strategy to achieve UHC by 2030. It aimed to roll out a basic essential package to health services (EPHS) by 2021, prioritizing coverage of primary care and services at township level and below. However, this plan was insufficient in increased equitable coverage, due to stagnant high OOP spending and low government budget allocations to health.

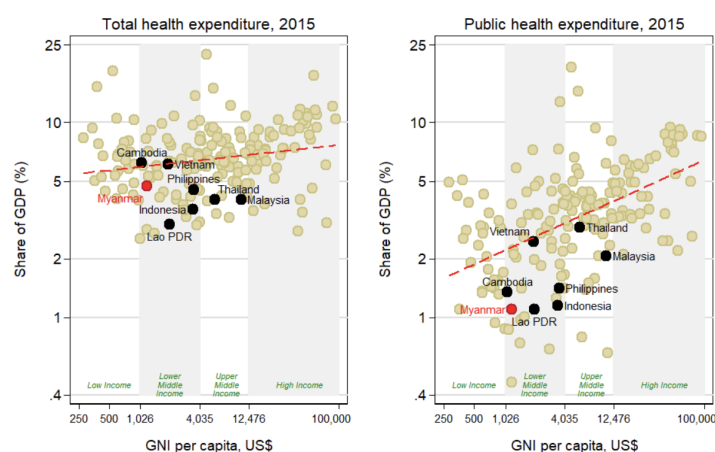
Lastly, the Social Security Scheme (SSS) covers private sector workers and public employees through employer (3%) and employee (2%) contributions—serving as the only resemblance of a formal social health-insurance program in Myanmar. The SSS only covers a small segment of the population, with a majority of the population being left uninsured due to a high informal employment rate of 81% (International Labour Organization 2020). The military coup and mass labour rights violations deprived workers of social welfare services such as the SSS and any healthcare coverage (Myanmar Labor news).

VII. Health Financing and Financial Protection

Myanmar's health financing system has historically involved low government spending with government investment ranked amongst the lowest in the world and highest OOP spending in the world between 1988-2011 (World Bank). Challenges persist today with ~80% OOP spending in 2019, creating large financial burdens on households (WHO). In the absence of any formalized payment system, both public and private providers rely on fee-for-service financing models, further reinforcing high OOP expenditures and unpredictable costs.

This pattern is reflected in Myanmar's total health expenditure, which is significantly less delegated towards public health than other countries in the SEA region (figure 4). Since the 2012 coup, political and economic disruptions have further deteriorated healthcare financing. In fiscal year 2023/2024, government spending dropped significantly to ~2.5% of total budget, compared to the previous ~4.6% in 2018/2019 (World Bank). During COVID-19 Myanmar re-allocated 10% of each ministry's initial budget towards disease response, totalling 306 billion Myanmar Kyat (WHO SEA 2021). This reallocation system should serve as the groundwork for future federal budget restructuring for a sustainable solution to increased government spending on the public healthcare system.

Figure 4. Total and Public Health Expenditure vs. Income, Myanmar and Comparator Countries



Source: Myanmar, MoHS 2017; World Bank WDI; WHO 2017b

In Myanmar, budgeting for health services is highly decentralized, leaving financing responsibilities to the discretion of subnational authorities. While the MoH allocates funds through the central budget, township health departments determine how resources are distributed across facilities, often adjusting priorities based on immediate constraints rather than long-term planning. This system results in significant variation in financing across regions and a lack of oversight regarding budgeting. Thus, along with increased government expenditure, there is also a need for increased centralization of financing, which balances local and federal power to ensure accountability in healthcare financing.

VIII. Conclusion

Rebuilding Myanmar's health system in the post-coup era requires long-term commitments carried out through strong governance and increased investments in healthcare. Achieving equitable UHC will require a clear framework for service availability and accountability, supported by financing mechanisms that protect individuals from debilitating burdens. The country has historically underinvested in healthcare; thus, as the country moves towards recovery, prioritizing healthcare needs within government spending will be essential as a foundational component of reconstruction. As a remedy for high OOP expenditures, Myanmar urgently needs the establishment of the National Health Plan (NHP) as proposed by the government in 2017. An emphasis on basic essential health packages through primary and preventative care coverage is crucial to minimizing regional disparities and addressing individual needs.

Beyond increasing financial investment, significant efforts must also be directed towards strengthening service delivery. Through investing in healthcare infrastructure and increasing access to essential medicines in accordance with the WHO national list of essential medicines, facilities will be well equipped to provide adequate care. While multiple non-governmental health providers such as EHOs, CSOs, and private clinics have met the needs of critical populations that lacked access to healthcare otherwise, there now exists a further fragmented healthcare system posing challenges to successful implementation of nationwide reforms such as the NHP and regulation of financing. There is a need to consolidate healthcare provider avenues under the MoHS to improve coordination, oversight, and equitable service provision.

With progress towards political stability and economic growth, the demand for a stable healthcare system continues to rise. Managing healthcare needs for providers and patients while reducing financial burdens will be essential for the rebuilding of Myanmar.

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