A Federal, Devolved Health System for Burma/Myanmar

A policy paper (draft)

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Summary

Soon after it assumed power in March 2011, the nominally civilian government led by President Thein Sein has openly declared that his government is reform-minded and announced a number of reform agendas. Most of the areas in which reform initiatives have been introduced, though, are mainly concentrated in commercial and foreign investment sectors. While it has made internationally heralded progress in securing ceasefire agreements with many ethnic armed organizations, the government simultaneously has attempted to expand its administrative reach into the once ethnic-controlled areas by providing some health and education services to the local populations.

However, without any meaningful structural changes to the governance, the government's approach is seemingly premature as provision of primary healthcare services has both political and public policy implications. Despite having a bicameral parliament (or *Hluttaw*), Burma/Myanmar is still a centralized country with a defacto unitary form of government. The ethnic nationalities, on the other hand, are calling for constitutional reform to build a federal union of Burma/Myanmar, wherein political control, fiscal authority and administrative responsibilities are decentralized, and the states/region governments will have more autonomy in all three areas. As such, development of a national health policy and system should be according to the framework of a Federal Union.[1]

This paper outlines key policy considerations for a decentralized, federal healthcare system with emphasis and analysis based on governance, financing and administrative dimensions. In doing so, three critical challenges are presented and policy options to address them are discussed: (1) the challenge of a highly centralized management of health system and the opportunity to decentralize it so that concerns at the state/region level are addressed with efficiency; (2) the challenge of inadequate budget and finance for healthcare and the need to grant state/region governments budgetary authority – their ability to seek funding, propose revenue options and decide on how and where the funds will be spent; and (3) the challenge of lack of incentives from the central government to address local needs and concerns, and the opportunity to develop local community commitments especially in terms of empowerment of state/region and local authority in dealing with issues unique to their localities.

While a special emphasis is placed on ethnic nationalities' community priority, high importance is given to the complex nature of relationships between various aspects of the health system administration, budget and financing, and facility and personnel management. And it is emphasized that these interactions too, in addition to the state of the individual aspects, are ultimately connected to the goal of providing quality, affordable and effective primary healthcare, particularly for the country's poorest and most vulnerable population.

The paper asserts that it is insufficient for the government to claim that it wants to help improve healthcare in the ethnic areas and impose upon them its current centralized health system without taking into consideration the nature and characteristics of existing health systems developed by ethnic organizations in their respective areas. In fact, the overall decentralization of health system – decision-making authority, developing resources and public financing of health, and management of health programs and facilities – is required in order to address both the issue of accountability and the need for efficiency, and broader political reform is a necessity that must precede the efforts to decentralize the health system.

Simply put, decentralization transfers decision-making power and resources closer to the local population. It also encourages and creates mechanisms for more citizen participation in local government, a fundamental building block of democratic societies.[2] Decentralization of health sector, therefore, is expected to not only improve performance of healthcare overall but also promote a stronger and better democracy for everyone in the country.

[1] "Building Trust and Peace by Working through Ethnic Health Networks towards a Federal Union," Statement by the Health Convergence Core Group, March 11th, 2013

[2] See "Going Local: Decentralization, Democratization and the Promise of Good Governance," Princeton University Press, 2007

Background

Until 2011, Burma/Myanmar was ruled by successive military regimes. All key decisions over the country's affairs were made by a group of military generals with no accountability at all to the needs of the people. Key socioeconomic sectors including health and education were given a very low priority. Schools and hospitals, as a result, were centrally controlled but minimally funded. Sanctioned by the United States and Europe, it was a pariah state with little or no direct contact with the outside world.

Today, the political atmosphere in the country is considerably different. To the international community's surprise, the new quasi-civilian government has taken some significant steps to open up the country. Ministries that were given little or no attention in the past are now getting a more serious attention both from the government and the international community. Reform is now a familiar word often used by top government officials to signal to the international community that they are indeed breaking from the past military rule, though they are the same generals who were once part of the previous regime. Domestic travel restrictions have been lifted, so ordinary people can now travel freely within the country. Hundreds of political prisoners have been released, though they were, in some cases, strategically timed to coincide with visits by international dignitaries. Most significantly, ceasefire deals have been cut with more than a dozen ethnic armed groups. New special economic zones were announced to turn former battlefields into commercial centers for mineral extraction and border trade routes. At the moment, the government is trying to further seal the deal with armed ethnic groups for a nationwide ceasefire agreement.

For a country that had been under successive military rule for decades, the past two years have been somewhat encouraging. With the help of international partners, the Ministry of Education began conducting its own comprehensive sectoral review – a precursory step to reform the country's deteriorating education system. High-ranking officials from the Ministry of Health met twice with officials from the Karen Department of Health and Welfare, an administrative branch of the Karen National Union (KNU) and discussed possible ways in which they could collaborate, and perhaps to even converge someday.

To move forward with the peace process and the reform agendas, however, there are a number of challenges the government has to overcome. The reform efforts that have been made so far are primarily one-sided initiatives from the part of the government. Ethnic nationalities that have been fighting for autonomy and a federal union had no role in the formulation of reform initiatives. They were not a part of any discussion about the shape, scope, design and direction of government's reform agendas. It is in this context that both the government and ethnic nationalities have to think carefully about how to move forward. The ongoing peace talks and government's one-sided reform agendas are not mutually exclusive. There must come a point where the two processes are synchronous so that the reforms are all inclusive, participatory and sustainable.

Scope and Purpose

The semi-structured interviews were conducted, where respondents – leaders of HCCG member organizations, independent health professionals and public health experts – were asked about their general reactions to converging community-based, decentralized ethnic healthcare services in ethnic areas and the highly centralized government health system, what they felt would be the feasibility of responding to the demand to implement specific convergence options in their facilities, what would be the policy implications, the benefits and barriers of convergence, and who would be influential in creating a federal, decentralized health system for Burma/Myanmar.

Taken into consideration the responses received from the interviews, there are three sets of relationship that touched upon in this policy option paper. They are: first, the nature and characteristics of current health system, non-governmental organizations' activities and partnerships developed within ethnic states and their healthcare systems; secondly, the levels of government and the nature of their involvement in public policy concerning the healthcare systems (particularly, central and state/region relationship); the third area focuses on factors influencing state/region governments' political dispositions to act (related to political leadership and healthcare provision issues).

This paper is not written to serve as a complete policy prescription; it is meant rather to frame policy discussion over health system reform in Burma/Myanmar with an emphasis on key convergence issues facing ethnic health organizations based in Karen, Karenni, Shan and Mon states. The hope also is that policy options discussed

herein will complement the ongoing political reform towards a federal union of Burma/Myanmar wherein all the ethnic nationalities can live in harmony and enjoy peace as well as equality.

Characteristics of Current Health Systems

Ranked one of the lowest in performances by the World Health Organization,[3] health sector in Burma/Myanmar remains a highly centralized one. The 2008 Constitution provides the central government an exclusive legislative power over health policymaking.[4] The state/region governments have no jurisdiction, but only coordination role, over state/region health departments. Healthcare facilities including hospitals are administered directly by and therefore accountable to the Ministry of Health in Naypyidaw.[5] As a result, there is a lack of incentive and a poor line of accountability; there is no mechanism existed to make hospitals responsive to the local communities' needs. Communities are not part of decision-making about strengthening or improving health facilities and services.[6]

Burma/Myanmar at a Glance

Total Population (million)	52.79
Life expectancy at birth m/f (years)	63/67
Gross national income per capita (PPP international $)	1950
Total expenditure on health per capita (International $2011)	28
Total expenditure on health as % of GDP	2.0 (2011)

Government spending on health is 12.2% of all health spending - and private is 87.8% of all health spending

How does private health break down?
92.4% of health spending is 'out of pocket' expenses
0% is in private health plans

How big is the medical system?
There are 23,709 doctors, which is 4.57 per 10,000 people. For comparison, in Vietnam there are 12.24 doctors per 10,000 people (2009)

Source: WHO and Global Health Observatory, 2009-2011

Despite significant increase in health budget in the recent years,[7] the country health system is still grossly underfunded. The system is centrally funded and fiscal authority rests with *Hluttaw* and the ministerial level officials. Overall, only 3.6% of the union budget is transferred to the state/region budgets.[8] As a result, decisions on resource allocation and prioritization of health programs do not represent local interests or realities. Given the sheer size and scope of the problems within the country's health infrastructure, it is extremely difficult for anyone in the Ministry of Health to have a clear hierarchy of priorities on where financial resources should get directed towards first.

With the new government in power, there seems to be some interest at a certain level of decentralization, albeit within the context of a de facto one-party-dominant state with 25% military presence in all the legislative bodies. The Ministry of Health (MOH) began reviewing its existing policies, institutions, structures and systems deal with issues of efficiency and equity.[9] State/Region health departments and hospitals are now allowed to procure medicines and medical equipments for health facilities. And yet, the health system overall remains centralized, both in terms of structure and administration.

Quite in contrast, health systems in the liberated ethnic areas are completely decentralized. The Karen, the Karenni, the Mon and the Shan each has their own health system with complete autonomy over programming as well as administration of programs in their respective areas. As part of their primary healthcare approach, which is adapted to local contexts and involves community participation, "ethnic health service providers"[10] manage an extensive network of workforce members who live and work in their own communities across all conflict-affected areas, and areas where ceasefire negotiations are underway.

3 The World Health Organization (WHO) ranked Myanmar's health system against its global counterparts, the country was the last out of 190 countries with respect to what the WHO calls "overall health system performance."
4 The Constitution of the Union of Myanmar, 2008.
5 See appendix 1: Organization of Current State/Region Governments, Burma/Myanmar.
6 Interviews, independent health professionals from Yangon.
7 Government Health Expenditure as percentage of General Government Expenditure has increased from 1.03 in 2010-11 to 3.1 in 2012- 13, Myanmar Healthcare System, Ministry of Health website.
8 "State and Region Governments in Myanmar," the Center for Economic and Social Development (CESD) of Myanmar Development Resource Institute and the Asia Foundation, September 2013. pp 16.
9 Myanmar Healthcare System, Ministry of Health website - http://www.moh.gov.mm.
10 Ethnic health organizations (EHOs) or departments, and community-based organizations (CBOs).

It is estimated that all the EHOs and community-based health organizations combined service a target population of approximately 500,000 people in the southeastern part of Burma/Myanmar. Their total workforce – approximately 4,000 – includes a variety of positions, based on local need and availability: medics; maternal and child/reproductive health care workers; community health workers; laboratory technicians; village health/community health volunteers; and traditional birth attendants.[11] Through their partnerships with various International Non-governmental Organizations, all of them have received training and were selected in a participatory manner by their communities, based on trust as well as perceived capacity and potential.[12] These EHOs and community-based health organizations, no doubt, play an indispensable role in providing primary healthcare for people in the rural areas of the country, especially remote villages that are under the control of ethnic armed resistance groups. They are aspired to expand their programs and continue servicing some of the neediest communities in Burma/Myanmar.

Envisioning a Federal Health System

In the envisioned federal health system, the law making power over health sector will be shared between the central and autonomous state/region governments. And, most of the functions, fiscal authority and administrative responsibilities in health sector will fall under the management of state/region governments. To what extent these powers are shared with the subnational governments determines how *federal* or decentralized the system is.

Obviously, the current state/region governments, under which there is no portfolio for health, will unlikely be able to handle any of these responsibilities.[13] Even before a federal health system is imagined, there are some key elements that must be present in the structure of government. First, there must be a clear structure of independent state/region ministries in terms of executive and legislative authorities over health sector. State/region legislature (or *Hluttaw*) should have the right to enact law related to healthcare within its boundaries.[14] Secondly, there should be a set of jurisdictional boundaries for each order of government and the state/region governments should have the right to enforce laws passed by the state/region legislature in the area of health. Third, the composition of state/region governments must be expanded to include a State/Region Ministry or Department of Health. Preferably, the minister or head of department who will occupy the position is appointed from an elected pull of members of state/region *Hluttaws* by an elected, not appointed, Chief Minister of the state/region. Only then, will there be a clear structure of independent ministry of health as part of state/region governments.

Constitutionally, the state/region governments must have explicit grants of authority to shape discussions of health policy, finance and administration. It means that the health system would be decentralized within a framework that clarifies and details the responsibilities and functions of each government level and agency. And, the design of such policy framework would encompass delineation on which functions and responsibilities should be decentralized to state/region level, and which would remain centralized.

Decentralization Defined

Decentralization, commonly understood, is a process by which political, administrative and fiscal authority, responsibilities and functions are transferred from the central government to the state/region governments. In other words, governance over a certain sector, be it health or otherwise, is shared or divided specifically between the central and state/region governments. In essence, decentralization arrangement allows local governments certain decision making powers over their own affairs. This is one of the reasons the concept of decentralization may be attractive to policymakers in countries where different ethnic nationalities coexist.

It is important to note that there are at least three aspects of decentralization – devolution, deconcentration and delegation. For the sake of consistency, this paper will adhere to the following definitions throughout.[15]

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[11] The Health Information System Working Group (HISWG) collects and compiles figures for all of its members, including Karen, Karenni, Mon, and Shan ethnic areas. It is currently in the process of updating overall figures for these areas 2012. HISWG has recorded that in 2012 in Karen State alone, 2,369 people worked for ethnic health service providers.

[12] Interviews with officials from EHOs; compiled from various EHO websites - *http://www.bmahealth.org, www.backpackteam.org, www.kdhw.org, www.maetaoclinic.org.*

[13] "State and Region Governments in Myanmar," report by CESD-MDRI and the Asia Foundation, September 2013.

[14] Health is not currently in the Region/State Legislative List (schedule 2 in the 2008 Constitution).

[15] Dennis A. Rondinelli. et al. 1990.

Devolution: transfer of authority and responsibility from central government ministries to lower-level, autonomous units of government through statutory or constitutional provisions that allocate formal powers and functions.

Deconcentration: transfer of authority and responsibility from central government ministries in the country's capital city to field offices of those ministries at a variety of levels (region/state or local).

Delegation: transfer of authority and responsibility from central government ministries to organizations not directly under the control of those ministries, for example, non-governmental organizations, and/or autonomous region/state and township governments.

Therefore, what this paper proposes as a policy option for future federal Burma, in essence, is devolution rather than deconcentration or delegation.

Rationales and Objectives for Devolution

Health system governance, generally defined, is a set of rules that govern the distribution of roles, responsibilities and the interactions – among political and government decision-makers, health service providers (public, private, nonprofit) and beneficiaries or service users – that determine health policies pursued, services provided, resources allocated and outcomes to be achieved.[16] It is recommended that the responsibility of health governance is shared between the central and state/region governments. Such responsibility sharing arrangement is very much in line ethnic nationalities' political desire to establish a federal Union of Burma/Myanmar, wherein diverse ethnic communities are allowed to have their respective autonomous governments. The rationale for devolution, thus, is two-fold: it promotes efficiency and accountability on the one hand, and accommodates the aspiration of political autonomy for, and thus peace and harmony among ethnic nationalities, on the other. It essentially boils down to encouraging a "regional autonomy" in designing healthcare programs.

Obviously, devolution is a highly sensitive policy issue, especially in countries that are ethnically heterogeneous with seemingly competing political interests. It has to be considered and implemented as part of the overall political reform. Along with the peace process and other reform initiatives, devolution of health system in Burma/Myanmar should be pursued with the objectives to:

1. *augment* health services delivery effectiveness though adaptation to unique local conditions and targeted local needs;
2. *enable* state/region governments to exercise decision making powers in and administer their own affairs;
3. *enhance* efficiency of resource utilization by involving local citizens in resource mobilization and allocation;
4. *improve* accountability and legitimacy by integrating health services delivery in local administrative system; and,
5. *increase* citizen participation in health services delivery by allowing locally elected government to be responsible for planning, oversight and evaluation.

These are general, but critical, objectives that have to be seriously considered for the devolution process given the sensitive nature of political transition in the country. As the peace and national reconciliation process continues, it may be necessary that more specific objectives are developed and mapped with each facet and types of decentralization.

A Multi-faceted Approach

In an effort to integrate all the existing health systems and achieve improved health status of Burma's poorest and most vulnerable population, important steps in the decentralization of the overall health system have to be taken. In particular, decision making processes in the development and implementation of the health system should be shared between the Ministry of Health and the State/Region governments. The central Ministry of Health is to function more on policy matters and providing technical support, while the state/region health

[16] "Health Governance: Concepts, Experience, and Programming Options," Health Systems 20/20, 2012.

departments have to play the pivotal roles of managing and coordinating the operation of the primary healthcare services. This process of decentralization, which should take the form of a multi-faceted process and has to be synchronous with steps to be taken in the overall political reform, is not an either/or proposition but indeed a priority.

Political Decentralization – The first facet of decentralization has to start with the devolution of political authority to the more autonomous state/region governments.[17] This, in practice, will require changes in the constitution in order to allow state/region parliaments to have certain legislative authority over health sector, and chief ministers of the state/region governments should be directly elected by the people, not appointed by the president. In this case, the state/region governments become autonomous and shall administer health governance according to their own priorities and within clear geographical boundaries. While the central government maintains authority over standard setting, regulating and accrediting health institutions, the state/region governments must be able to maintain authority over how the design and implementation of health sector plan is organized, managed and communicated to the public in their respective states/regions. Because the state/region governments in the present form are not autonomous, the small step in decentralization currently taken by the Ministry of Health is more in the form of deconcentration within the central government to grant state/region health departments some authority to procure medicines and medical equipments, etc. The problem with this sort of deconcentration is that it gives state/region health department more responsibilities but it does not make them more accountable to the local communities for the quality or efficiency of their services.

Fiscal Decentralization – The second facet of decentralization is in the area of developing resources and financing of health care. Currently, the primary sources of finance for healthcare services are the government; private household; bilateral and multilateral international aid (both grants and loans); non-governmental organizations. Of the total spending for health, the government spending accounts only 12.2% and much of the rest are from private spending.[18] This is an alarming indication that health sector in Burma/Myanmar is grossly underfunded, and the burden of financing healthcare is largely shouldered by private households. Two policy options should be considered to alleviate the issue:

> (1) When implementing decentralization, allocation of financial resources must follow the shift of mandates. State/region governments should have enhanced control over prioritizing allocation of health budget according to their own assessments and needs. This will allow states/regions to avoid one-size-fits-all policy in health budgeting and, in the meantime, increase allocative efficiency. It is worth noting that the current fiscal arrangement allows only 3.6% of the union budget is transferred to the states/regions.[19] This, in fact, leaves the state/region governments with almost no budgetary authority, and there is no constitutional assignment of state/region budget for health.[20] Overall, the current, extremely unbalanced fiscal arrangement should change to increase the share of budget for state/region institutions, and also constitutionally assign budget for health at the subnational level of governments.
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> (2) The policy to decentralize cannot only emphasize vertical transfers of resources and authority from central to state/region governments at a time when the central government may be experiencing severe resource shortages. Instead, the state/region governments should have authority and responsibility to develop local revenue sources, by means of either collecting fees or levying relevant taxes. Currently, tax base allowed under the schedule 5 of the 2008 Constitution for subnational governments is very limited. Along with the shifting of health system responsibilities, expansion of tax base for the state/region governments must be considered. For example, the subnational governments should have authority to collect tax on natural resource extractions, business income and sale of goods and services.

Administrative Decentralization – The third facet deals with the management authority at the facility level, including hospitals and health centers. Past experience with decentralization in other countries suggest that if health facilities have little or no autonomy to carry out their responsibilities, decentralization will stop half way

[17] The state/region governments, within the current structure of governance, are not autonomous as the Chief Ministers, who is the head of the governments, are directly appointed the President. In some cases, the President can appoint a non-elected military officer, instead of choosing from a pull of elected parliamentarians.

[18] Global Health Observatory, 2009-2011. In OECD countries, up to 75% of total healthcare expenditures are publicly financed (OECD, 2009).

[19] See "State and Region Governments in Myanmar," Report by CESD-MDRI and the Asia Foundation, September 2013. The graph showing % of union budget transferred to state/region institutions is reproduced here in the appendix 3.

[20] See appendix 2: State and Region Budget Units and Constitutional Assignments.

and will not achieve its intended consequences – bringing accountability closer to the community it serves.[21] Thus, delegation of authority in health administration needs to reach down to the local level. That is, the state/region government should delegate specific administrative decision-making powers to township level or to local facilities and/or entities of the civil society operating health facilities. Health administration authority includes, but not limited to, the management of hospital and health facilities, staffing (planning, hiring and firing) and training of health professionals. Such delegation of authority in healthcare management is crucial if the ethnic health programs such as Back Pack Health Worker Team and Mae Tao Clinic are to converge with the overall health system. In addition, local health facilities must have authority to enter into contract with international agencies and non-governmental organizations to seek financial as well as technical assistance. Only then, community-based health systems in the ethnic areas – that are currently able to establish collaborations with international organizations and agencies – will be able to continue their partnership programs in the new federal health system. Otherwise, they will just be absorbed into the current centralized health system and be managed directly by the Ministry of Health. It is very likely that many ethnic health workers with skills will lose their employment as a result of premature convergence.

Lastly, there is an important part of the current governance structure that needs to be paid critical attention – the General Administration Department or GAD, which serves as the administrative "backbone" of the government. It has pre-existed during the era of previous military regimes and has been hitherto retained to provide administrative and coordination functions for the different levels and departments of union as well as state/region governments.[22] As the bureaucratic core of government, the GAD is also given the authority to handle all the funding at the state/region level. Its functions often interfere with the state/region executive and legislative authorities. Furthermore, the Executive Secretary of GAD is directly accountable to the Ministry of Home Affairs and, by extension, to the Commander-in-Chief, who appoints the minister for this portfolio. In practice, the Commander-in-Chief is given both the ability and means to control the affairs of states/regions or even townships and villages through the elaborate and extensive structure of GAD.[23] Moving towards a federal structure of governance, it is recommended that the GAD's ubiquitous authority be curbed and its accountability stopped at the respective state/region governments, so that the central government cannot interfere with health and other policies at the state/region level through the GAD.

The chart below indicates the level of governments and the health system responsibilities and functions that each level shall maintain in a federal, decentralized health system.

Health System Responsibilities and Functions	Level of Government		
	Central	State/Region	Township
Policy formulation	X	X	
Program and project design		X	
Revenue generation and resources allocation	X	X	
Budgeting and expenditure authority		X	X
Monitoring and oversight of hospital and health facility		X	
Setting norms, standards and regulations	X		
Drug and supplies (*ordering, payment, inventory*)		X	X
Contracting hospitals		X	
Data collection, processing and analysis	X	X	X
Facilities and infrastructure		X	
Training and Staffing (*planning, hiring, firing*)		X	X
Salaries and benefits		X	
Hospitals and health facility management		X	X

"We should have the freedom to plan and prioritize health programs in our state in accordance with policies drawn up by the central and subnational governments. We must be able to maintain and expand our partnerships with international agencies and organizations to augment our health resources and fulfill the needs of the communities in our area."

P'doh Eh Kalu Shwe Oo,
Head, Karen Department of Health and Welfare

[21] The study conducted by Bernard F. Cuttolenc for the World Bank, "Decentralization and Governance in Ghana Health Sector," finds that devolution of managerial autonomy to health facilities is key to creating incentives and brining accountability as close as possible to the communities served.
[22] See "State and Region Governments in Myanmar." pp. 32.
[23] See appendix 5: Structure of General Administration Department.

Critical Challenges

Proponents of decentralization policy are not without concern for uneven and unequal development of infrastructural and institutional capacities between regions and states that could make decentralization asymmetric, which may further such inequalities. Some policymakers in the African countries that have gone through their own decentralization expressed concerns that they have responded to the demand of efficiency at the cost of equity considerations.[24] Again, it is very important that the concept of decentralization is not taken as either/or proposition, but as a practical option for mixed arrangement that some level of centralization is also maintained to ensuring fair and equitable development of the sector.

Inadequate capacity at the state/region level, for instance, is a major concern when shortages of skilled health professionals can be felt throughout the country. It may be difficult for some states or regions to even recruit trained professionals working for them.[25] Language and cultural constraints are also realities that need to be factored in. Underdeveloped infrastructures in sectors such as education, transportation and communication in certain parts of the country will definitely have some impact on the state/region governments' ability to attract people with managerial capacity. This very issue could easily lead to unequal institutional strength and development between states/regions.

It may be that the central government has to play the role of equalizer by providing more financial support to the weaker states/regions for capacity development. In the meantime, fiscal policy coordination and funding mechanisms should be developed to help alleviate, if not completely prevent, this potential inequality. The central government can play a coordinating role and help balance financial and capacity gaps in some states/regions through special grant programs and/or even the Poverty Reduction Fund that has been set up.

Finale

Having the Ministry of Health regulates both the management and allocation of resources for health through the fourteen states/regions, the current health system in Burma/Myanmar is still comparable to the old health systems of the former Soviet Union and Poland, who have since decentralized their systems during their semi-democratic reforms in the early 1990s. Health sector decentralization has been an important part of political reforms in almost all countries – in Eastern Europe and elsewhere – that have gone through difficult but successful transitions. Their experiences powerfully suggest that "effective democratic states needed strongly participatory local democracy," and "as citizens have opportunities to participate, they become more effective at rewarding and punishing the behavior of local official."[26] That is, transferring decision-making power and health resources closer to those in the localities will not only enhance health performance but augment incentive for citizen participation in the democratization process that the country is embarking on.

At the same time, efforts to converge community-based primary healthcare setups in the ethnic areas with the current health system in Burma/Myanmar calls for the serious discussion of overall health sector reform with decentralization at the core. Such an endeavor will also require strong and committed leadership from the part of the union government. It is also critical that all stakeholders are mobilized – and included in consultation – to build consensus and support around such effort. A Coordinating Committee jointly established by officials from the Ministry of Health, representatives from the state/region governments and leaders of ethnic health organizations may lead the efforts to coordinate and formulate a comprehensive decentralization framework that must be complementary to the ongoing peace negotiation process leading towards a federal union of Burma/Myanmar.

[24] C Collin and A Green, who have long studied effects of decentralization in countries in Africa and Latin America, suggest that decentralization can strengthen political domination of certain regions or localities within a country and consequently lead to further social inequalities.

[25] Of the two Burmese health professionals interviewed, one observes that some states in the country may experience hardship in recruiting medical professional due to poor living condition and underdeveloped transportation in the state. However, the second one interviewed indicates that medical doctors are now required by the government to transfer every three years. The policy often results in many health professionals not feeling committed to their work in one place as they are expected to move onto another place in three years.

[26] See "Going Local: Decentralization, Democratization and the Promise of Good Governance," Princeton University Press, 2007.

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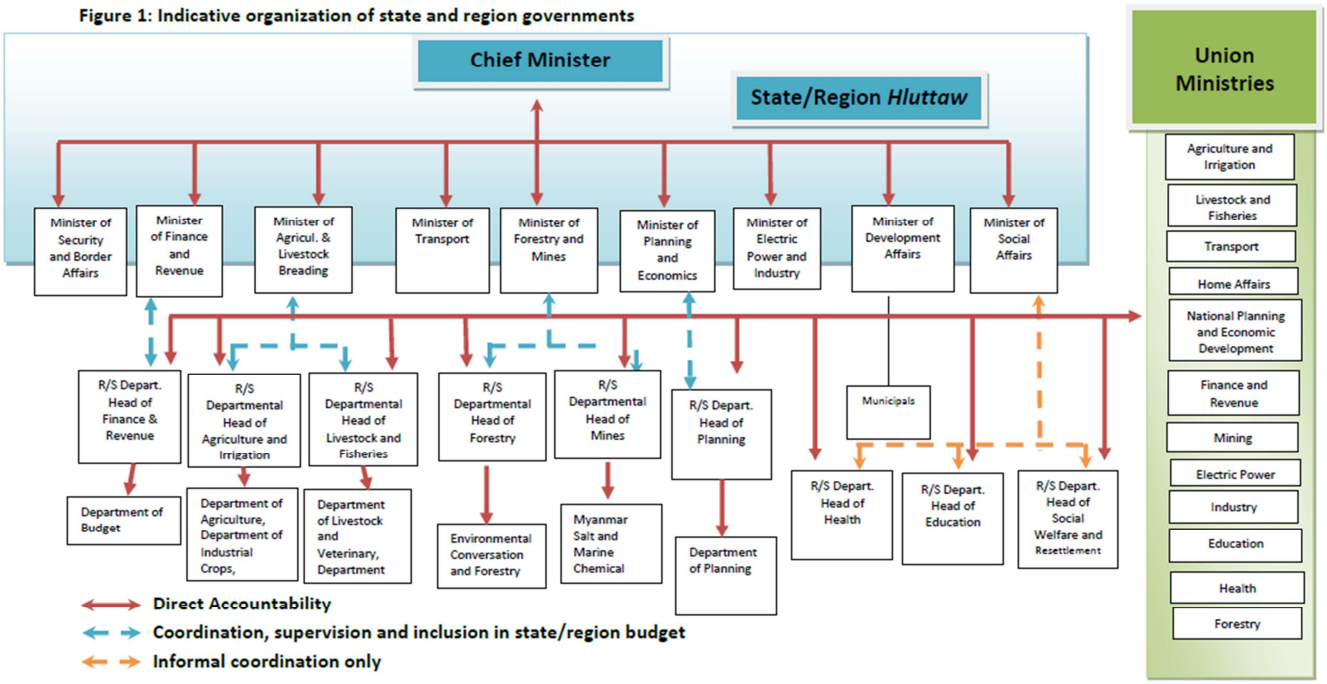
Appendix 1: Organization of Current State/Region Governments, Burma/Myanmar



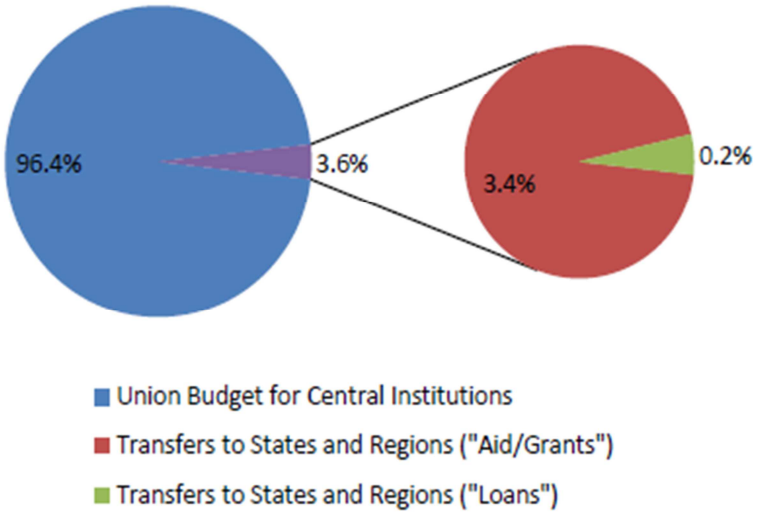
Source: State and Region Governments in Myanmar, CESD-MDRI and the Asia Foundation, September 2013

Appendix 2: State and Region Budget Units and Constitutional Assignments

Departments appearing in state/region budget	Schedule One (Union)	Schedule Two (State/Region)	Residual/ Uncertain
General Administration Department	✓		
Special Investigation Department	✓		
Prison Department	✓		
Settlements and Land Records Department	✓		
Department of Agriculture	✓	✓	
Department of Industrial Crops Development	✓		
Cooperative Office	✓		
Department of Small Scale Industries			✓
Fisheries Department			✓
Department of Livestock & Veterinary			✓
Department of Beekeeping			✓
Dept. of Human Settlement & Housing Dev.		✓	
Maintenance of Building, Roads & Bridges			✓
Public Construction	✓		✓
Budget Department	✓	✓	
Department of Planning	✓	✓	
Central Stevedoring Committee			✓
Forestry Department	✓		
Dry zone Green Project Department	✓		✓
Department of Sports and Physical Education	✓		
Water Transport Department	✓		
Municipals		✓	
Myanmar Film Making	✓	✓	
Myanmar Salt and Marine Chemical Enterprise	✓	✓	
Myanmar Pharmaceutical & Foodstuff Industry	✓		
Home Utilities Industry			✓

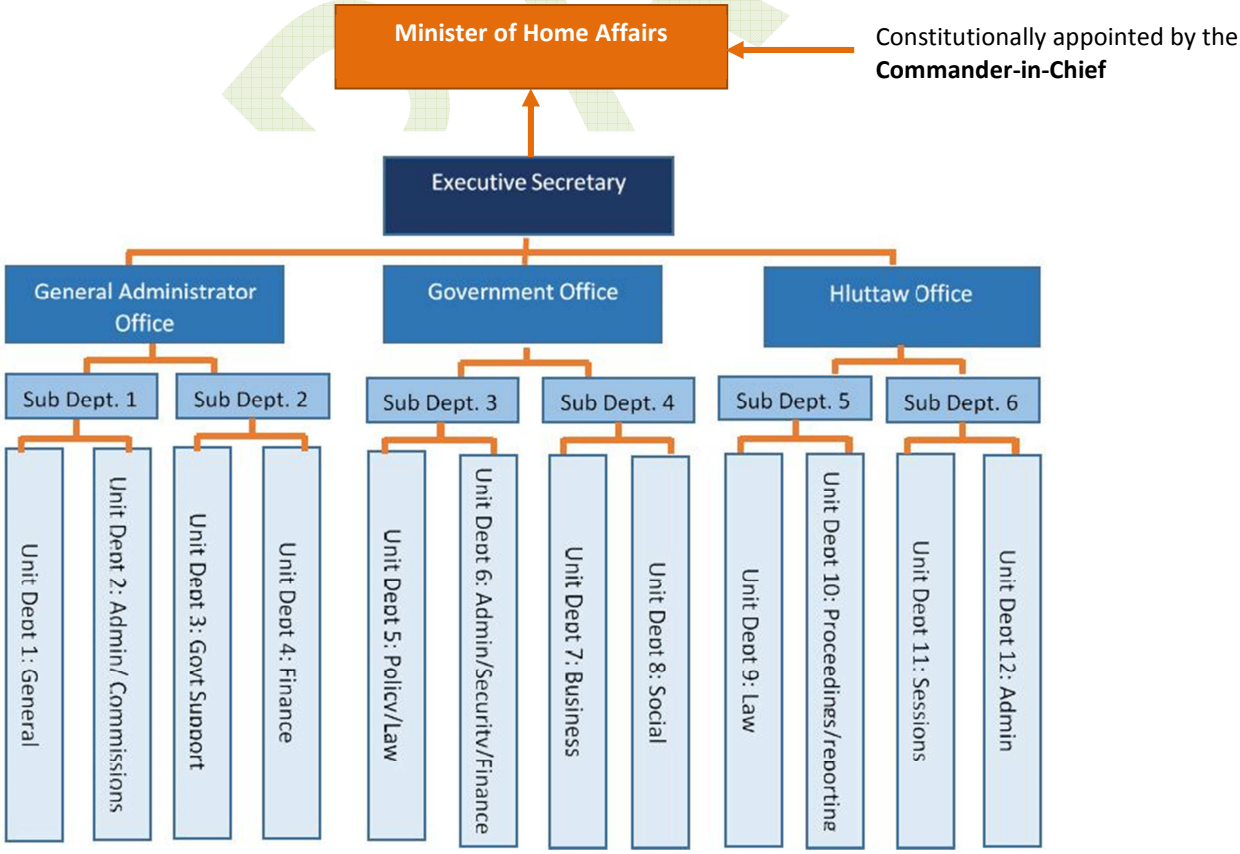
Source: State and Region Governments in Myanmar, CESD-MDRI and the Asia Foundation, September 2013

Appendix 3: Share of the Union Budget Transferred to State/Region Budgets, FY 2013-14



Source: State and Region Governments in Myanmar, CESD-MDRI and the Asia Foundation, September 2013

Appendix 4: Structure of General Administration Department



Source: Adapted from the "State and Region Governments in Myanmar," CESD-MDRI and the Asia Foundation, September 2013