Myanmar Health Sciences Research Journal, Vol. 31, No. 2, 2019

Current Practices and Challenges of Medical Services on Health Care System of Mandalay General Hospital

Yadanar Aung[1], Kyaw Ko Ko Htet[1], Kyaw Thu Soe[1], Kyaw Thu[1], Kyaw Thu Hein[1] , Tin Tin Moe[2] & Myitzu Tin Oung[1]*

[1]Department of Medical Research (Pyin Oo Lwin Branch)
[2]Mandalay General Hospital

In Myanmar, the main challenge to provide quality healthcare by Universal Health Care approach is documented as low health services coverage with substantial wealth-based inequality. To achieve the effective health care system, strong medical care system is essential. Understanding on challenges and needs in provision of medical services among patients and health care providers is critical to provide quality care with desirable outcomes. The aim of the study was to explore the patients' and health care providers' perceptions on the challenges in provision of medical services at the Mandalay General Hospital. This was a qualitative study conducted at the tertiary level hospital (Mandalay General Hospital). The data was collected by using focus group discussions and in-depth interviews with hospitalized patients or attendants, healthcare providers such as medical doctors, nurses, laboratory scientists and hospital administrators in March 2017. The qualitative data was analyzed using themes by themes matrix analysis. Most patients were satisfied with the care provided by the doctors because they believed that they received quality care. However, some patients complained about long waiting time for elective operation, congested conditions in the ward, burden for investigations outside the hospital for urgent needs and impolite manners of general workers. Healthcare providers reported that they had heavy workload due to limited human and financial resources in the hospital, poor compliances with hospital rules and regulation among patients and attendants, and inefficient referral practices from other health facilities. Other challenges experienced by healthcare providers were lack of ongoing training to improve knowledge and skills, limited health infrastructure and inadequate medicinal supplies. The findings highlighted the areas needed to be improved to provide quality health care at the tertiary level hospital. The challenges and problems encountered in this hospital can be improved by allocating adequate financial and human resources. The systematic referral system and hospital management guidelines are needed to reduce workload of health staff.

Keywords: Quality healthcare, Patients' perceptions and expectations, Healthcare providers' perceptions and expectations

INTRODUCTION

Health care system in Myanmar has a pluralistic mix of public and private both in financing and provisions of medical services. The country has embarked on the primary health care approach since 1978 with the aim to promote accessibility to health care and reduce health gap between the rich and poor family. As the country began to reform its underfunded health care system, public hospitals received a budget from the Ministry of Health and Sports specifically reserved for medicines and equipment. Although the Sustainable Development Goals (SDGs) have raised the new hopes for a world free of poverty and other deprivations including ill health, the gap between the rich and the poor in many societies has unfortunately either remained.[1] In line with the National Health Plan, Myanmar Universal Health Coverage (UHC)

*To whom correspondence should be addressed.
Tel: + 95-92216777
E-mail: dryadanaraung@gmail.com
DOI: https://doi.org/10.34299/mhsrj.00936

aimed to provide the optimal quality of health care to everyone in the country that is accessible, efficient, equitably distributed, adequately funded, fairly financed, and appropriately used by an informed and empowered public. To strengthen the health systems towards the provision of equitable universal coverage it is vital to focus on ways to improving health outcomes, enhancing the financial protection and ensuring the consumer satisfaction.[2] Low health knowledge and inadequate affordability to pay for medical services are major obstacles to provide quality health care in community.

Insight into quality health care services, the experiences of admitted patients in situation is fundamental to capture the challenges of accessing health cares. The challenges of health care services utilization were addressed by inadequate and unreliable supplies of essential medicine and equipment, high utilization of tertiary hospitals leading to unnecessary overload, and further compounded by inadequate numbers and maldistribution of staff.[3]

Mandalay General Hospital is the only one 1000-bedded teaching hospital that linked with the University of Medicine, Mandalay. It is one of the tertiary hospitals in Upper Myanmar which is provided with the modern diagnostic and therapeutic facilities with varieties of specialists healthcare professsionals.[4] The improved understanding of challenges facing in this tertiary hospital could enhance the proper allocation of human resources and equipment.

MATERIALS AND METHODS

Study population

The hospitalized patients who had experiences of seeking health cares at medical wards, surgical wards and emergency units in Mandalay General Hospital. Those patients were randomly selected based on the duration of hospital stays from each and every unit of medical and surgical wards. A total of five in-depth interviews were conducted with patients who were already hospitalized before a week and more than a week at the time of data collection on March 2017. Then, a total of 4 focus group discussions (FGD) were held with total 24 patients who were from medical and surgical wards; in each group six patients were involved in interviews based on their duration of hospital stays and each and every surgical and medical ward.

Healthcare is the linkage between patients and providers (doctor, nurses and healthcare administrators). So, acknowledging difference in perspectives towards medical services in Mandalay General Hospital at different wards (units), a total of ten in-depth interviews with health care providers were done with key population, ie., (a) medical superintendent who was responsible for administration, (b) a first assistant who had a leading role in the whole ward (Unit I,II,III) from medical and surgical wards, (c) logistic officers who was in charge of medicinal supplies of the study hospital, (d) pathologist - Senior Consultant, and (e) radiologist - Senior Consultant. And then four FGDs were done; a total of 12 doctors and 12 nurses were participated with 6 doctors and 6 nurses from medical wards and surgical wards proportionately in each group. Each FGD lasted one and a half hour and conducted with semi-structured interview guidelines.

Study design

A qualitative method using case study was conducted in this study by phenomenological approach. As a narrative study reporting the healthcare services experiences and challenges of healthcare utilization, a phenomenological approach was used. It was important to understand the challenges to seek the health cares a deeper considerate about the health care practices and experiences.

Data analysis

The audio-recordings from the interviews were transcribed precisely into text in Burmese language. The transcripts were manually analyzed by principal investigator. Firstly, the transcripts were read and re-read to obtain the thematic coding framework. After that, the transcript was translated into English and entered into the computer in Microsoft Word Version 2010, then analyzed using Themes by Themes matrix analysis.

Ethical consideration

This study was approved by the Ethics Review Committee of Department of Medical Research (Letter No.101/Ethics 2015). All interviews were done after taking the written and informed consent forms from each and every participant.

RESULTS

Current practices

Almost all of the medical services are available at Mandalay General Hospital (MGH). Some patients criticized long waiting time for elective operation and they were referred from other townships. The standard, systematic referral system and hospital management guidelines are needed. There was not enough hospital bed in wards as the total number of patients admitted to medical ward was 100 to 160 per day. There were also three surgical wards and 80 bedded per ward but the number of patients admitted per day was round about 100-120. Firstly, when the patients arrived at the emergency-reception center (ERC), registration was done at out-patient department. Then the patient was diagnosed by ERC medical officer and admitted to the hospital if needed according to the type of disease. All the drugs and investigations are free at ERC. After transferring out to the ward (medical, surgical), some injections and medicine were needed to be bought by patients at drug shops.

Challenges of medical services

The major obstacles were capacity building training, health infrastructure and medicinal supplies. Free drugs were insufficient because of imbalance between demands and supplies. Nearly 80% of the patients admitted to hospital could afford to pay. If not, the providers aided to find donors for their patients' treatment costs at hospital. Even though the patients expended some drugs and investigation fees, the health care costs in public hospital were cheaper than those in the private clinics. Some patients faced transportation difficulties although ambulatory services were provided. All the investigations were not free of change and most of the results of laboratory investigations were not known out of office hours but available only if they were needed urgently. Sometimes they went to private laboratory to get the urgent results. Although duties and responsibilities were already assigned, health care providers (doctors, nurses, technicians) for medical services were not enough. Therefore, the needs of medical equipment and the imbalanced workforce of human resources were critical inputs in the health system to ensure the quality healthcare provisions. Over workload might turn down the effective health care to patients.

On accessibility of services

Geographical - Health care providers in MGH reported that MGH is situated in downtown, heart of the Mandalay City. Financial - As the governmental budget alone was inadequate the hospital relied on external aids and linked with local donors, CBOs, social welfares. Logistic - Laboratory investigations were not easily accessible. Waiting time to get laboratory results was too long. Administrative - All health care providers struggle every day with enormous workloads (administrative, curative, logistic, ward round, injections, ECG, blood samplings, monitoring the hospitalized patients, discharge status D/C notes writing) in which scarce resources and systemic constraints made it difficult to provide quality healthcare for patients' satisfactions and less accessible to medical services.

Since 2007, Myanmar has produced 1500 medical graduates per year from four medical universities. Nowadays, Taunggyi Medical University is newly opened but MOHS cannot appoint all medical graduates and many of them have to do non-government officers, general practitioners in or outside the country.

Patients' and providers' perceptions on medical services

Almost all of the patients reported that all healthcare professionals were good at communi-cations, good relationship and well respect the patients' privacy. They explained in detail about diseases, treatment procedures and counselled with the relatives of the patients how they precede the diagnosis. Most patients were satisfied with the technical and professional skills of all doctors and nurses. They sensed cheerful conversations to doctors and nurses in the hospital. However, the nurses sometimes scolded the patients and attendants. Moreover, some workers were drunk even in their duty hours. The most common problem for the patients was related to investigations. Some investigations were paid half fees. Sometimes the results were lost and received by wrong patients. At that time, there was a need to do the investigations again. For improving the quality of hospitals and getting access to the quality of health care services, they suggested to provide more assigned laboratory technicians, diagnostic tools, hospital equipment and medical supplies. Moreover, there was a lack of space for patients' attendants even though only one attendant was

allowed for one patient and two for seriously ill patients. For the non-residence patients who were admitted to the hospital, the attendants faced the difficult situations in accommodations. Hospital sanitation was great and toiletry services were good.

The facilities and health infrastructures were not fully functioning and not enough for all admitted patients. There were only 30 oxygen cylinders and it was a shortage of supplies for emergency patients who needed to use oxygen cylinder. So, the health care providers linked to others CBOs, donors and religious-based organizations for financial and medicinal supplies. Trolleys were not enough and not well functioning. After launching free medical care since 2010, hospital utilization was obviously high. There were some kinds of limitations to get casual leave and earned leave because of human resources shortage. Moreover, the number of absconded staffs was significantly increased.

Patients' and providers' expectations towards medical services

Every patient decided to use services from public hospital rather than private clinics because they did not have enough money to seek the health care from private services. So they expected to cover the costs of treatment by providing free medical care at the government expenses of health. From providers' side, they thought that patients should well understand the constraints of medical services and the limitations of human resources (all level of health care providers) and health infrastructure (CT, MRI, infusion pump, oxygen). Overcrowding patients with prolonged waiting time happened at the tertiary care hospitals because of low utilization of primary and secondary level health care centers, to meet patients' satisfaction, it was essential to seek more effective referral system.

Current practices and challenges of laboratory unit

There were two types of services i.e., regular and emergency as well as out-patients and in-patients. Results were delivered within 24 hours for in-patients, but out-patients had to wait for one day. The emergency laboratory was in ERC and opened daily from 3pm to 7am. The patients' attendants had to come to the laboratory to pick up the results. There was an exception for screening test of HIV, hepatitis B and C The results of these tests were given out within one and half hours. At the same time, the regular laboratory accepted 150 out-patients per day for diagnostic tests. The laboratory closed at 2 pm for in-patients and distributed the results at 7 pm. If the investigations were requested with an urgent form after 2 pm, they were performed at ERC. For ICU, the laboratory provided 24-hour services. The investigation could be done free of charge for monks, important persons and poor patients.

Some patients complained that the result papers were lost and sometimes they requested repeatedly to do the same tests. The huge problem was human resource constraints and financial constraints of maintenance fees. As they did not have enough staffs, they had to hire the sample collector at the expense of respective wards. The trainings and aids were limited in laboratory units. Although there was a local network linked with wards, the computerized data record system is not used due to lack of human resources.

Current practices and challenges of radiology unit

All medical professionals including master students were assigned in office hours. Technicians were assigned 24-hour duties. If necessary, two consultant radiologists took responsibility between 8 pm to 8 am alternatively. All radiological investigations were free of charge at ERC. Emergency medical officers could read the results routinely. Sometimes if the expert opinions were needed, EMO had to send work request form to radiology unit. Emergency cases could undergo all radio imaging at any time but these was long queue for non-urgent cases. If the patients were unaffordable, they could get a waiver up to 50% and also cost sharing benefits. The machines were frequently breaking down and budget allowance for repairing those machines was reimbursed after taking too much time.

Current practices and challenges of administrative office

The total daily hospital admission rate in MGH was over 200, emergency patients were round about 300 and out-patients were one thousand per day. Routinely, total 1500 patients took health care seeking at MGH. So, there were so many patients and then waiting time was too long. However, the numbers of health care

providers in MGH was very few. As a result, the proportion of doctors and patients was 1 into 30 patients.

Some admitted patients lost their belongings during hospital stays and it was very difficult to handle. Moreover, the attendants did not obey the disciplines of the hospital. The misunderstandings between doctors and patients were frequently reported. Most patients never followed the rules at the hospital.

DISCUSSION

Human resources are critical inputs on health care system to ensure access to quality care. There is a need for a balanced distribution of infrastructure such as buildings and equipment. Currently, there is no clear nationwide infrastructure investment plan. Service delivery in Myanmar relies on a mix of public, private for-profit, private not-for-profit and Ethnic Health Organizations (EHOs) providers. Achieving the goals of UHC will not be possible with public health sectors alone delivering health care services. Sufficient financial resources should be mobilized to achieve those goals.

The Myanmar health system currently faces many challenges[5] to provide quality healthcare and documented as low health services coverage with substantial wealth-based inequality.[6] These are related to the availability of inputs and the weaknesses in key functions such as supportive supervision, referral, health management information system, and public financial management. The lack of oversight, leadership and accountability further exacerbates these challenges. Evidence informed policies should be developed following a clear policy cycle, and policy makers should be kept accountable throughout all levels of healthcare. Myanmar is the lowest total health expenditure among all countries in the South-East Asia and Western Pacific Regions and is well below internationally agreed minimum standards.[7] Other countries using the approach of financial risk protection mechanisms have been successful in achieving improved health outcomes, lowered inequality and reduced catastrophic health expenditures.[8]

One vital aspect of universal health coverage is the services, which are available within communities. UHC ensures that quality health services are available to all those in need without undue financial hardship. Myanmar is now going to the way of transforming and strengthening of health care system.

Conclusion

The report provides beneficial information on recent situation and challenges faced by a tertiary level public hospital (Mandalay General Hospital). The current situations of health care services on availability, affordability and accessibility of services provided impact on hospital utilization. The challenges and problem encountered in public hospital can be improved by providing budget and by allocating efficient and effective healthcare providers. The major issue raised is human resources limitations in each and every sector of quality health service. Quality health care is to be achieved by fulfilling equipment, drugs and some facilities, assigning more manpower adequately.

Systematic referral system and hospital management guidelines are very important to be published. The report also highlights areas such as medical wards, surgical wards, laboratory unit, radiology unit and administrative office intensely to emphasize the outcomes of health care services on health care system targeting universal health care.

The results of this study reveal evidences for promoting health care quality services in public sector. This report briefs the need for health system strengthening, human resources empowerment, enhanced logistic and supplies change management system to realize the results, including achieving UHC by reducing financial hardships for health care costs towards healthy nations.

Recommendations

- To strengthen health manpower by increasing the number of staffs in every unit especially in laboratory and radiology departments.
- To renovate the building and infrastructure for patients' attendants and to rehabilitate the accommodations for all health staffs.
- To strengthen effective referral system to reduce workload of tertiary hospital for unnecessary medical emergencies
- To sustain the quality of medical services in health care system

Competing interests

The authors declare that they have no competing interests.

ACKNOWLEDGEMENT

The authors would like to express our greatest thanks to World Health Organization (WHO) which provided the financial support to conduct this study. We would like to thank all healthcare providers from Mandalay General Hospital for their collaboration and kind supports. We particularly thank our research assistants from DMR (Pyin Oo Lwin Branch) for contributing a great deal of effort in note taking.

REFERENCE

1. Tin N, Lwin S, Kyaing NN, Htay TT, Grundy J, Skold M, *et al.* An approach to health system strengthening in the Union of Myanmar. *Health Policy* 2010; 95(2): 95-102.
2. Risso-Gill I, McKee M, Coker R, Piot P & Legido-Quigley H. Health system strengthening in Myanmar during political reforms: Perspectives from international agencies. *Health Policy and Planning* 2013; 29(4): 466-474.
3. Latt NN, Cho SM, Htun NMM, Saw YM, Myint MNHA, Aoki F, *et al.* Healthcare in Myanmar. *Nagoya Journal of Medical Scienc* 2016; 78(2): 123.
4. *Global Status Report on Alcohol and Health.* World Health Orgainzation, 2018.
5. Tangcharoensathien V, Patcharanarumol W, Ir P, Aljunid SM, Mukti AG, Akkhavong K, *et al.* Health-financing reforms in Southeast Asia: Challenges in achieving universal coverage. *The Lancet* 2011; 377(9768): 863-873.
6. Han SM, Rahman MM, Rahman MS, Swe KT, Palmer M, Sakamoto H, *et al.* Progress towards universal health coverage in Myanmar: A national and subnational assessment. *The Lancet Global Health* 2018; 6(9): e989-e997.
7. Zhang P, Zhang X, Brown J, Vistisen D, Sicree R, Shaw J, *et al.* Global healthcare expenditure on diabetes for 2010 and 2030. *Diabetes Research and Clinical Practice* 2010; 87(3): 293-301.
8. Chongsuvivatwong V, Phua KH, Yap MT, Pocock NS, Hashim JH, Chhem R, *et al.* Health and health-care systems in Southeast Asia: Diversity and transitions. *The Lancet* 2011; 377(9763): 429-37.