Older people's access to healthcare in Myanmar

Contents

This study analyses the health seeking behaviour of older people, as well as their access to and utilisation of healthcare services, including barriers to access. This study defines access to health services as the self-reported utilisation of outpatient and inpatient healthcare. Access to healthcare has four dimensions: availability, geographic accessibility, affordability, and acceptability.[1] As discussed below, barriers to accessing health services associated with these four dimensions could originate from the demand side and/or the supply side.[2]

This brief is based on field research led by S. Irudaya Rajan and Sreerupa that resulted in the report, *Study in Accessing Healthcare by the Older Population in Myanmar*. The study, from the perspective of older persons as recipients or targets of healthcare services, included a quantitative component employing a survey of 1000 households and a qualitative component using post-survey focus group discussions among older persons in target communities. The sample of communities/households was taken from one township in each of five geographic areas of the country: hilly, delta, dry zone, plain/coastal and metropolitan. The full study is available online at http://ageingasia.org/study-on-accessing-healthcare-by-the-older-population-in-myanmar/.

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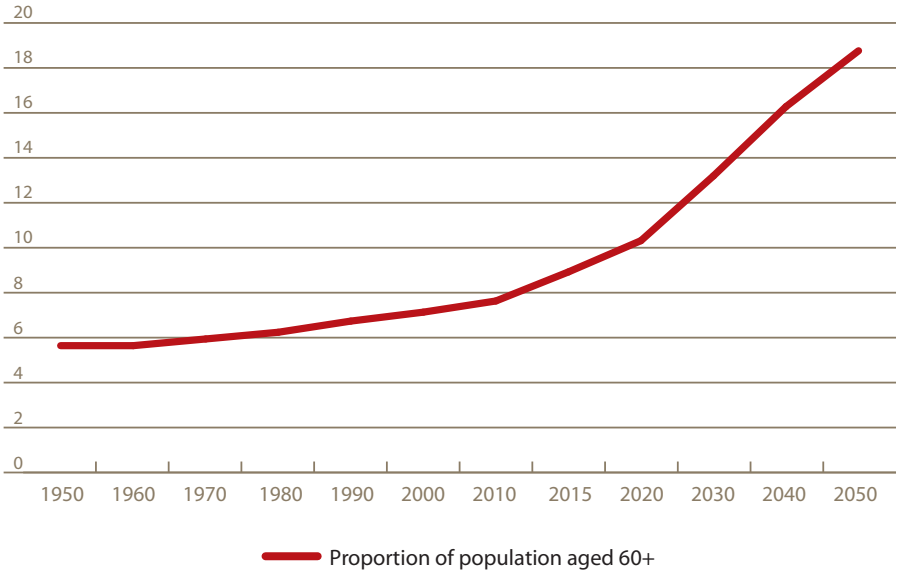
Health and healthcare in Myanmar

Myanmar's health system has suffered from gaps in supply-side investments as well as demand-side challenges and health inequities. The Ministry of Health and Sports acknowledges that the "the health status of the Myanmar population is still poor and does not compare favourably with other countries in the region."[3] To address serious challenges within the health system, public spending on health has risen sharply – from 0.2 per cent of GDP in 2009 to slightly over 1 per cent in 2014.[4] Yet the burden of healthcare expenses is still borne mainly by households and is a common source of impoverishment. Thus, one of the major challenges is providing healthcare in an equitable way, catering to the poorest of the population without increasing their burden of expenditure.

In this context, an increasingly important question is how Myanmar will address the healthcare needs of its older people. Myanmar's population of older people (aged 60 and older) is growing not only in size but as a proportion of the total population. The proportion of elderly to the total population increased from 5.6 per cent in 1950 to 8.9 per cent in the 2014 census. By 2050 the proportion is expected to more than double and will reach 18.8 per cent of the total population.[5]

The percentage of Myanmar's population that is age 60 or older will accelerate[6]



As societies age, so do their patterns of health and disease. A transition from communicable to non-communicable diseases (NCDs) will further burden an already overstretched healthcare system. According to the World Health Organization, NCDs are already estimated to account for 59 per cent of total deaths in Myanmar.[7] One of the most common NCDs and risk factors for other NCDs is hypertension or high blood pressure. Other common NCDs are cardiovascular diseases (heart disease and stroke), cancer, diabetes, chronic lung diseases, cataract and arthritis. A fragile health system that has historically focused more on treating communicable diseases would be challenged by the prolonged nature of NCDs, which may lead to increasing healthcare costs.

In this study, every third older person reported either poor or very poor health while slightly more reported their health to be excellent or good. As might be expected, negative self-assessment of health increases with age and positive self-assessment decreases. As has been found in other studies,[8] overall men reported better health outcomes than women.

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A framework for analysing access barriers

Access to outpatient and inpatient care among older persons in Myanmar has been analysed here using the comprehensive analytical framework suggested by Jacobs et al. (2012) to identify the different dimensions and aspects of barriers to access to healthcare both from the demand side and the supply side (see figure below).[9] Barriers to outpatient care are analysed in the next section, followed by barriers to inpatient care.

Barriers to healthcare access: An analytical framework

	Supply-side barriers	Demand-side barriers
	Geographic accessibility	
	• Service location	• Means and cost of transport
	Affordability	
	• Costs and prices of services, including informal payments • Dual private-public practices	• Household resources and willingness to pay • Opportunity costs • Cash flow challenges
	Availability	
	• Unqualified health staff • Absenteeism, staff motivation • Opening hours, waiting time • Drugs and other consumables • Exclusion from services • Late or no referral	• Information on services • Level of education
	Acceptability	
	• Complexity of billing system • Lack of pricing information • Staff interpersonal skills	• Household's expectations • Patient self-esteem, assertiveness • Community/cultural preferences • Stigma • Lack of health awareness

Outpatient care

Utilisation of outpatient healthcare

Outpatient healthcare refers to medical care or treatment that does not require an overnight stay in a hospital or medical facility (including traditional medicine). Outpatient care is the predominant kind of healthcare in Myanmar.

Among respondents in this study, more women (60 per cent) than men (53 per cent), and more urban residents (64 per cent) than rural residents (53 per cent), utilised outpatient care services. Survey respondents from the wealthier households consistently reported higher utilisation of outpatient care compared to respondents from less-affluent households. Chronic conditions dominate the top ailments for which older persons reported seeking outpatient care, with hypertension being the most common reason for treatment.

For outpatient care, the poorest older persons in Myanmar are reached mainly through the rural healthcare system rather than through the network of government hospitals. In rural areas, outpatient healthcare is provided mainly through the sub-rural and rural health centres (RHCs),[10] followed by private doctors and private clinics or hospitals. For villages located farther away from the heath centre, traditional medicine providers and unlicensed providers are relied on to a far greater extent compared to the main village of a village tract. The usage of rural health centres falls sharply with higher wealth. In contrast, the usage of private clinics or hospitals and private doctors is highest among the highest income group and decreases by wealth.

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Rural healthcare system

Rural health centres and sub-rural health centres play a significant role in primary healthcare delivery in rural areas. Sub-rural health centres are usually located at village tract level and provide primary healthcare services to about eight surrounding villages in perhaps a three-mile radius. A sub-RHC is usually staffed with at least one midwife, who lives in the main village of the village tract and visits the other villages about three or four times a month. (There may also be auxiliary midwives at the sub-RHC.) The midwives' primary mandate is to conduct maternal health checkups, deliver babies and provide immunisation, but they may attend to others with mild illnesses in the community, including older persons. In the context of a general shortage of doctors and nurses, these sub-RHC midwives provide basic primary healthcare services at the village level, in addition to caring for pregnant women and delivering babies. That is, they provide healthcare beyond their target group.

Barriers to accessing outpatient healthcare

Geographic accessibility of outpatient healthcare

Considering demand-side and supply-side geographical barriers, it seems the outpatient access barriers are highest for government hospitals, followed by private facilities. Drug stores and rural health centres and sub-RHCs are the most geographically accessible facilities.

The time taken to reach the healthcare facility can be regarded as a proxy for service location barriers. Some 88 per cent of older persons required less than 30 minutes to reach drug stores, and 76 per cent to reach rural health centres. However, only 45 per cent of respondents seeking outpatient care could reach a township or district hospital in under 30 minutes, and 30 per cent of them required more than an hour.

A respondent's means of transport to reach a healthcare facility suggests both the relative ease of access to that facility and the transport costs incurred. On average, 21 per cent of the respondents utilised private vehicles to reach outpatient care. As drug stores and rural health centres tend to be fairly close to home, older persons generally either walked or used bicycles or trishaws to reach them, rather than taxis. In contrast, among the older persons using outpatient care at township or district hospitals, 41 per cent took taxis, suggesting that government hospitals are less accessible.

The cost of transport can be a significant barrier to accessing healthcare in a low-income country. The results show that the median cost of transport is lowest for accessing the drug stores and rural health centres, as older people often walk or use bicycles. The median cost of transport to private facilities was between 500 to 1000 kyat, while the median cost of travel to government hospitals was 1000 kyat.

Affordability of outpatient healthcare

Accessing outpatient healthcare entails healthcare providers' fees and costs for medicines and tests, as well as indirect costs such as transport and opportunity costs, that is, loss of income while patient is seeking healthcare. The analysis examined total cost, combining the supply and demand side.

The lowest average cost of outpatient care was found with drug stores (2000 kyat), followed by rural health centres (3000 kyat), then government hospitals (5000 kyat). Private clinics and hospitals were the least affordable with the total cost of outpatient care averaging around 6000 kyat. Nearly three-quarters of the older persons visiting drug stores and half of the older persons visiting rural health centres accessed these services for less than 3000 kyat, compared to about one-quarter of older persons visiting other facilities. Another potential supply-side barrier to outpatient healthcare is the presence of a public-private dual practice, which exposes the older patients to (public) health workers' private practices, increasing the chances of spiralling treatment costs.

Demand for health services may be constrained by a household's poverty or unwillingness to pay. The study calculated the total cost of the respondents' most recently received outpatient care as a percentage of the household's total monthly expenditure. On the whole, the median total cost of most recent outpatient care was around 3 per cent of household median monthly expenditure. Other important demand-side barriers are a general lack of economic resources, and more specifically, low availability of liquid cash when the patient is seeking care. Limited cash flow correlates with seasonality, especially in agrarian societies.[12]

Availability of outpatient healthcare

A host of factors can affect the availability of adequate healthcare. In poor countries the lack of adequate funding for the healthcare system manifests at the ground level in unqualified health workers, an insufficient number of health workers, staff absenteeism, late opening hours, long waiting times, lack of motivation among staff, lack of availability of drugs and other consumables and so on.

To assess supply-side barriers, the study asked older persons about their perceptions regarding care and attention, medical treatment, availability of medicines, waiting time and cleanliness at their healthcare facilities. Overall, an extremely small number of older persons said they were "dissatisfied" or "very dissatisfied" with the healthcare they received. This may reflect reluctance to express dissatisfaction, or low expectations, or both. The highest percentage of respondents were "very satisfied" with the healthcare services provided by private clinics and hospitals, and lowest for rural health centres and government hospitals. Nevertheless, for the measure of waiting time, the highest proportion of older persons rated the waiting time at rural health centres as either "very good" or "good".

"If we go to the private clinic, on-duty medical staff are always present. The staff treat us attentively. There is neither a waiting list nor any need to come back later." [13]

"There are frequent shortages of medicines at the rural health centres."

"All the best doctors are in the government hospitals, but they do not have time and are busy. These doctors spend some time at the government hospital and then work as consultants in private hospitals or work in their private clinics."

Acceptability of outpatient healthcare

One of the critical supply-side barriers related to the "acceptability" dimension is an unwelcoming attitude or poor interpersonal skills on the part of the healthcare providers and staff. A related issue is the users' lack of trust in the healthcare providers or their intermediates.

Acceptability was assessed by asking about respondents' experiences of being treated respectfully, provided clear explanations, involved in the decision making, talked to privately and provided access to a preferred provider. Regarding how clearly healthcare providers explained things, only a small proportion of older persons had a "very good" experience at any facility, ranging from 13 per cent at a private clinic or hospital, to 8 per cent at rural health centres, to only 1 per cent at government hospitals.

Regarding older persons' experiences of being involved in making decisions about their treatment, a much higher proportion of older persons felt that their experience was "very good" at either a private clinic or hospital (28 per cent) or at a private doctor's office (22 per cent), as compared to their experiences at government

facilities (e.g. 7 per cent at rural health centres). However, with regard to having an opportunity to speak privately with their care providers, the highest rating was for rural health centres, where 91 per cent had either a "very good" or "good" experience.

Drug stores

Drug stores in Myanmar not only sell medicines, but also provide medical advice based on rudimentary medical checkups like measuring blood pressure. Many drug stores sell both traditional and Western medicines side by side. A common practice among older persons, particularly in urban areas, was to rely on a nearby drug store for treating mild symptoms and to visit a doctor only when very ill. Many older persons continue taking prescription medicines from drug stores for long durations without going back to the doctor for a follow-up consultation.

Traditional medicine

Traditional medicine is still a commonly accessed form of healthcare in Myanmar, particularly in rural and remote areas. Traditional medicines are used for mild symptoms and to keep more persistent symptoms in check, so as to avoid other, more expensive forms of healthcare. Traditional healthcare is often cheaper and more easily accessible than Western medicine. In focus group discussions, many older persons expressed that their traditional healer was like a family member, someone who was very approachable. They said that these traditional healers were patient with them, and willing to answer questions about the illness, unlike the other doctors, who would not entertain more than three or four questions.

Inpatient care

Utilisation of inpatient healthcare

Inpatient healthcare refers to medical care or treatment that requires an overnight stay in a hospital or medical facility. It is a small subset within the general category of healthcare services. To study the utilisation of inpatient care among older persons in Myanmar, survey respondents were asked whether they had stayed overnight in a hospital or other healthcare facility at any time in the preceding three years. Nearly 15 per cent reported that they had.

Surprisingly, there was a slight decrease, rather than an increase, in the utilisation of inpatient healthcare with increasingly older age groups. A higher proportion of men (16 per cent) compared to women (13 per cent) utilised inpatient care services, in contrast to the higher utilisation of outpatient care among women mentioned above. Although men report better health across indicators compared to women, it seems they are more likely than women to access the more expensive form of healthcare. A higher percentage of urban residents compared to rural utilised inpatient healthcare services, as was the case with outpatient care services as well.

Patients were most likely to have sought hospitalisation for surgery, followed by acute conditions (such as diarrhoea, fever, flu, cough and so on), respiratory ailments, and then heart diseases. The facility most often visited for hospitalisation

was township or station hospitals (44 per cent), followed by district or general hospitals (33 per cent), then private hospitals (16 per cent) and charity-run hospitals (6 per cent). This pattern is similar for rural and urban areas. Across wealth groups, the usage of township and station hospitals was highest among the poorest group but decreases with higher wealth. In contrast, the usage of private hospitals rises with wealth.

Barriers to accessing inpatient healthcare

Geographic accessibility of inpatient healthcare

The closest hospitals are generally the township or station hospitals: about 60 per cent of the older persons could reach these facilities within one hour. The district or general hospitals and the private hospitals were among the farthest: only 35 per cent of the older persons could reach these facilities within one hour.

As noted above, means and costs of transport to reach a healthcare facility suggest relative ease or difficulty of access. The median cost of transport to a township or station hospital was lower (4000 kyat) compared to transport to a private hospital (10,000 kyat) or to a district or general hospital (11,500 kyat). Forty-five per cent of the older persons accessing the district or general hospitals incurred more than 14,000 kyat for transportation, suggesting a substantial geographic barrier that could keep a number of rural poor people from accessing the specialised care at these facilities.

Affordability of inpatient healthcare

The average total cost of hospitalisation was lowest for township or station hospitals (70,000 kyat) followed by the district and general hospitals (110,000 kyat). Private hospitals were the least affordable with an average total cost of hospitalisation of around 300,000 kyat – three times more than the cost at government hospitals. One-third of the older persons hospitalised in township or station hospitals could access the services for less than 50,000 kyat. On the other hand, more than half the persons hospitalised in private hospitals incurred more than 250,000 kyat.

> *"For services, private hospitals are better, but the cost is forbidding. We can hardly afford room charges, let alone treatment and service charges."*

> *"You can't go to the [government] hospital without money. You have to pay from your own pocket to the trolley pusher, the cleaners and so on."*

As noted above, the total cost of hospitalisation as percentage of a household's total monthly expenditure can highlight demand-side barriers. The study found that the median total cost of an episode of hospitalisation constituted more than 70 per cent of the household's median monthly expenditure. Disturbingly, the median total cost of the most recent hospitalisation accounted for more than 95 per cent of the rural households' and 90 per cent of the poorest (lower wealth category) households' median monthly expenditures, respectively.

Availability of inpatient healthcare

Regarding perceptions of medical treatment, care and attention, and availability of medicines across various healthcare facilities, the highest percentage of older persons were "very satisfied" with the healthcare services provided by district or general hospitals or by private hospitals. Upon combining "satisfied" and "very satisfied" responses, it seems that more respondents favoured private facilities. In terms of the availability of medicines, respondents were most satisfied with private facilities. Regarding the cleanliness of the various facilities, older persons who had been hospitalised in private facilities reported "very good" or "good", and lower ratings for both kinds of government facilities.

"Government hospitals have a waiting list system. That means you can't see the doctor the same day you get a symptom. You have to book first so that you may see him or her the next day."

"To be fair, nowadays, the general hospital is getting better gradually. A lot of essential medical drugs and supplies are available there. We have to find and buy outside only the uncommon medications or supplies."

Acceptability of inpatient healthcare

To understand the barriers that make people reluctant to use health services, older persons were asked to rate their most recent visit to a healthcare provider or facility. The highest percentage of older persons reported "very good" or "good" experiences at private facilities. Conversely, the highest proportion of older persons reported "moderate", "poor" or "very poor" experiences at both types of government facilities.

Compared to older persons hospitalised in private hospitals, a much higher proportion of those hospitalised in government hospitals reported a lack of involvement in decision making about treatment and a lack of opportunity to talk privately with the healthcare provider. Higher percentages of older persons who were hospitalised in various types of government hospitals also reported that their access to a preferred healthcare provider was less than "good", compared to those who were admitted to private hospitals.

The way forward

- There is clearly a need to strengthen the rural healthcare system in Myanmar, since it is one of the more accessible and affordable sources of outpatient care in rural areas, where most older people live. Further investment could remedy many of the issues of poor availability and acceptability resulting from rural healthcare facilities and workers being under-resourced and over-stretched.
- This includes training and skill development for midwives. Heavy reliance on midwives is less than ideal, but with the increased scope of rural health centre staff responsibilities, they need extra support.
- Investment could also improve the geographic accessibility of the rural healthcare system to reach remote villages and villages located at a distance from the sub-rural health centres, so that elderly people in rural areas need not resort to seeking treatment from unqualified health practitioners.

As noted by older persons in the focus group discussions, the government healthcare facilities have improved over the past few years. With increased investment in healthcare in recent years, there seems to be slow yet sure improvement. The case for accelerated investment in public healthcare over the coming years is strong.

Endnotes

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4. Ibid., p. viii.

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8. Knodel J, *The Situation of Older Persons in Myanmar*, HelpAge International, 2014.

9. Jacobs B, Ir P, Bigdeli M, Annear PL & Van Damme W, "Addressing access barriers to health services for the poor: an analytical framework for selecting appropriate interventions in low income countries", *Health Policy and Planning cc27(4)*, 2012, pp. 288–300.

10. Unless otherwise distinguished, the term "rural health centres" in this brief refers to both RHCs and sub-RHCs, as data from this study generally follows a similar pattern for both. The full report has a separate discussion of both types of health centre.

11. Khun S & Manderson L, Health seeking and access to care for children with suspected dengue in Cambodia: an ethnographic study, *BMC Public Health 7*, 2007, p. 262.

12. Jacobs et al., op. cit.

13. Quotes in this brief are based on focus group discussions from the study's field work.

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is a global network of organisations promoting the right of all older people to lead dignified, healthy and secure lives.

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