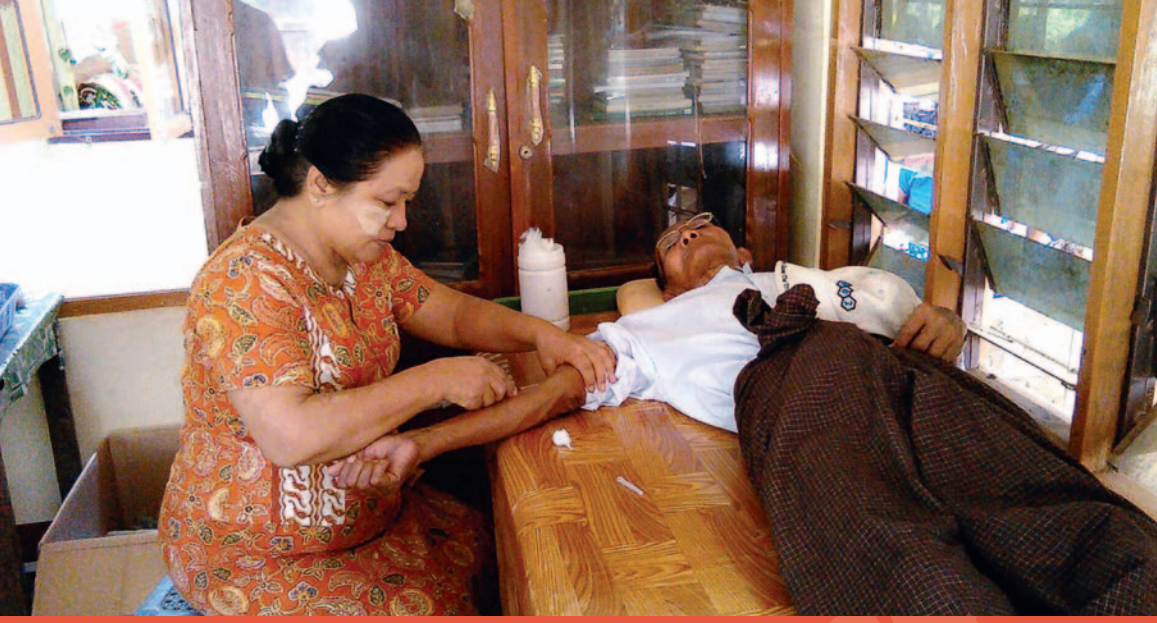

THE ROLE OF GENERAL PRACTITIONERS IN THE MYANMAR HEALTH CARE SYSTEM:

A Study of Private Clinics in Yangon Region, Myanmar

Pyone Mjinzu Lwin

Understanding Myanmar's Development
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Foreword

The Understanding Myanmar's Development (UMD) Fellowship program, sponsored by the International Development and Research Centre (IDRC) of Canada, aims to enhance the knowledge of Myanmar's development, strengthen the research capacity of Burmese researchers, and encourage them to become actively engaged in the study of development policy and practice. The fellowship seeks to promote sustainable academic exchange and dialogue among researchers from Myanmar, Thailand, and other GMS countries. Under this program, 30 fellowships have been awarded to mid-career researchers in their respective areas of social and economic transformation, agricultural, environment and climate change, health and health care systems, and social media and innovations.

In this volume, "The Role of General Practitioners in the Myanmar Healthcare System: A Study of Private Clinics in Yangon Region, Myanmar," Pyone Mjinze Lwin explores the experience of both patients and general practitioners under the current healthcare system of Myanmar. It studies the experience of how patients deal with the health care system and develop health care preferences for different services, in relation to how general practitioners manifest their practice within the constraints of the healthcare system.

The Myanmar government once provided free healthcare in the late 1960s, but the program slowly declined due to lack of funding, as more money flowed into military spending. There is no well-established insurance system. Therefore, people must always pay out-of-pocket fees to receive medical care, in any situation. Public

hospitals are overcrowded and underfunded, which leads to lower patient satisfaction in regards to quality of care. Private hospitals seem to provide better care, but they charge and raise their prices for medicine or care by three-fold the regular rate. As a result, many people of Myanmar see general practitioners who work from their own clinics. Whether these patients use general practitioners regularly or for specific purposes is to their discretion.

With this work, the author hopes to expand and bring awareness to the importance of GP in Myanmar's health care system. She hopes, through her study, to encourage GPs to further their education, participate in public health service, and follow the clinical guidelines in their practice in order to improve the overall effectiveness and quality of healthcare services throughout Myanmar.

Chayan Vaddhanaphuti, PhD
Director, RCSD

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Abstract

This study was conducted to examine the role of general practitioners (GPs) in the urban setting of Yangon Region, Myanmar. The nature of their interactions with patients, their perceptions of primary healthcare and professional development, and the patients' expectations regarding the services of GPs were studied. The study was conducted with the participation of 15 clinics and their patients by using qualitative methods. Most clinics offered a wide range of curative and preventive services, operated for longer, had more flexible hours, and reached further to the communities compared to public facilities. For broader expansion of comprehensive primary healthcare services, GPs should be encouraged and supported in their professional development and in their participation in public health activities. Interactions between the public and private sector are potentially beneficial in reducing the workload of the public sector, improving the quality of care in both sectors, and expanding healthcare delivery.

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INTRODUCTION: GENERAL PRACTITIONERS AND PRIVATE CLINICS IN MYANMAR

Healthcare services for the population of Myanmar are supported by a pluralistic mix of public and private sectors. Formal health insurance has not yet been developed, while social security schemes with limited coverage exist only for employees of some government ministries and enterprises. In general, Myanmar people must pay out-of-pocket when medical attention is needed. Although there are some public healthcare services available through a cost-sharing system, families still need to spend their own money when one of their family members requires medical attention. In the private sector, clients must pay their healthcare expenses completely out-of-pocket.

Recently, the availability and accessibility of public healthcare facilities in Myanmar have become more favorable. In 2013, the country had 1,010 public hospitals, which is double the number of such hospitals that existed in 1988 (Myanmar Ministry of Health, 2013). However, despite the increase in availability of public healthcare facilities, public demand for equal access to such facilities is still not able to be fulfilled, resulting in high workloads for practitioners in many public health facilities. These facilities are overwhelmed by the demands of patients, and clinicians are unable to provide enough time for each patient. Insufficient time sometimes results in patient dissatisfaction and an inability to develop good doctor-patient relationships.

While public health facilities remain overcrowded, private healthcare facilities have become more favored among the people

as they provide better services for their patients. As in other developing countries, the private sector has complemented or taken on health service delivery functions with positive outcomes in some contexts (Saksena et al., 2010). Many urban people today do not bother to visit and queue up at a crowded public healthcare facility if they can receive special attention at a private health facility. Moreover, for ambulatory healthcare services, general practitioners (GPs) at these private healthcare facilities have an increased capacity to reach the population.

Thus, GPs have become the main healthcare providers in Myanmar, providing services for a wide population. Of course, it is important that they are competent and capable in their own profession. As accreditation is not a mandatory process in Myanmar, there is no evaluative measure for assessing the healthcare services provided by GPs. Thus, this study attempts to describe the competency and, more generally, the role of GPs in Myanmar's healthcare system. It is hoped that findings from this study will help to identify the needs for capacity-building to improve the competency of GPs in practicing primary healthcare in Myanmar.

Aims of this Project

The aim of this research was to learn how general practitioners operate in the healthcare system in Myanmar and to identify constraints to the efficient and effective provision of services.

Specific Objectives

1. Describe GPs' perceptions of the key primary healthcare services provided in the community, and their experiences in offering these primary healthcare services.

2. Identify various supports, such as training, collaboration with health staff, education materials, health talks, etc., to help increase GPs' capacity to provide key primary healthcare services to the community.

3. Elicit patients' as well as communities' expectations of GPs, as well as their experiences receiving healthcare services from GPs.

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BACKGROUND: THE HEALTHCARE SYSTEM IN MYANMAR

In 1964, under General Ne Win's military-socialist administration, the "Township Health System" was established as the backbone of the national system for providing healthcare to the population. Under this system, a health department in each township was expected to provide primary and secondary healthcare services down to the grassroots level with each department covering 100,000 to 200,000 people. The Township Health System was meant to cover everything, including urban health centers, school health teams, maternal and child health teams, station health units, and rural health centers. In 1978, the country embarked on a new primary healthcare approach with the aim to augment the first contact between patients and health workers, to promote accessibility to healthcare, and reduce health disparities between inhabitants of urban and rural areas. In this way, Myanmar attempted to tackle the problems of healthcare delivery at the primary level.

The role of the government in healthcare provision began to change beginning in the 1980s, although, in principle, the government continued to provide free healthcare to all citizens until 1993 (Soe Moe and Khin Saw Naing, 2011). Although the model of government-provided health services was established, in fact, the state failed to provide the human and material resources that were needed. Under military-socialist and direct military rule, Myanmar substantially neglected investment in healthcare. According to World Bank data, government expenditure for health

was about 0.3% of GDP throughout the 1990s. It increased to 0.4% in the 2010s. Under the elected government that has been in place since 2011, reforms have slightly raised expenditures—to 0.8% of GDP in 2011. However, this is still lower than in neighboring countries. Presently, the government accounts for slightly more than 12% of all healthcare spending, which is still small compared to government healthcare spending in countries such as Thailand (75%) and Vietnam (37.8%) (Rubicon Strategy Group, 2014).

Healthcare services and financing are currently provided via a pluralistic mix of public and private sectors. The public sector includes government hospitals, diagnostic services, outpatient clinics, and primary health care programs, all of which are managed by the Ministry of Health. There are also public healthcare centers affiliated with the Ministry of Defense, Ministry of Labor, and Ministry of Railways that provide services for their employees. The government has envisaged a policy to encourage alternative healthcare financing by promoting the role of co-operatives, joint ventures, the private sector, and non-governmental organizations (NGOs) in the delivery of healthcare.

In 1993, a community cost-sharing system was introduced in all government hospitals and health clinics (Soe Moe and Khin Saw Naing, 2011). Since the late 1990s, because of the general economic transition from socialism to a private market-based economy, many private clinics have been established throughout the country. In this way, the private sector has been engaged to support the healthcare needs of the general population. In addition, beginning in the mid-2000s, internationally funded NGOs and local community organizations have been providing medical services and other aid to some of the poorest and most vulnerable communities in Myanmar.

In Myanmar, over 70% of the population resides in rural areas. Under the government's healthcare system, rural health centers are supposed to provide the main healthcare services for these rural communities. However, in fact, most health services continue to

be concentrated in larger towns and cities. According to a 2013 annual report published by the Myanmar Ministry of Health, rural health centers have only increased in number from 1,337 to 1,635 since 1988. Another problem is that many of these centers lack basic supplies, medications, and equipment. Thus, patients in rural areas with complex medical conditions must often travel great distances from villages to towns, or to large cities such as Yangon or Mandalay, in the hope of accessing appropriate treatment. Outside of Yangon and Mandalay, there are few government hospitals that are able to provide treatment for complex cases.

It should be noted that, even at public facilities that do offer care, treatment must be paid for with "out of pocket" (OOP) funds. Even though there is a cost-sharing system in public healthcare services, the family still needs to spend its own money when one of their family members requires treatment or hospitalization.

In urban areas, new trends in healthcare-seeking behavior have emerged since the late 1990s. As mentioned, the number of private pay clinics and private hospitals has increased significantly, and in urban areas, healthcare services have become easier to access as compared to earlier times. When someone in an urban area requires medical attention for a general illness, they will most likely go to a specialist clinic if they can afford it.[1] Alternatively, the person may go to a private pay polyclinic, or a free mobile clinic or charity clinic in his or her ward to receive basic primary care services.

When it is at all financially feasible, patients may choose to incur the great cost of consulting a private practitioner in order to avoid the long waits and impersonal treatment usually associated with public facilities. Many urban dwellers do not bother to visit and queue up at the public clinics or public healthcare facilities. The lack of basic supplies and medications, plus the unhealthy

[1] With the growth of private pay facilities, doctors have more opportunity to practice in their specialties. There are specialist doctors who work in public hospitals and then sit clinic in private hospitals later in the day. There are also specialist doctors who practice independently in private hospitals.

environment at government hospitals and clinics, drives those with moderate or higher incomes to private pay clinics and hospitals.

Of course, not every patient can go to private hospitals when they need medical attention. Private hospitals charge double- or triple-fold for services compared to public hospitals. As Myanmar has not yet developed a medical insurance system, very poor people still depend on the government-supported health system, even for complex problems. They do not have many choices. Even when they require superior services, they still must depend on the government hospitals and the cost-sharing healthcare system as part of the complications of the poverty they endure.

For less complex problems, however, poorer urban dwellers may turn to the clinics of GPs. Patients can receive medical attention for minor illnesses with very low costs, and sometimes free-of-charge (if the GP shares their costs). Thus, for these various reasons, GP clinics and the GPs who work in them play an important role in providing healthcare in Myanmar, reaching a wide population.

Another factor that has affected the development of the healthcare system in Myanmar is education, specifically the superfluity of doctors trained as GPs relative to their possibilities for employment. Starting in 1998, Myanmar has produced nearly 1,500 medical graduates from four medical universities each year. In Myanmar, a great number of students pursue a medical degree as the medical profession carries the highest status. Many parents want their children to become doctors, and if the children pass their exams with sufficiently high marks, their parents will push them into this profession whether the children are interested in the field or not. After completing their medical degrees, these new professionals must often wait to take up their compulsory civil service with the government. The country cannot afford to appoint all these medical graduates at once.

In Myanmar, some fresh graduates choose to go abroad, either for further studies at foreign universities or to seek opportunities in

better careers.[2] They also have other options: they can practice in private hospitals, work for pharmaceutical companies, or they can work with NGOs. For those who want to practice independently, they can start as GPs to gain experience treating community health problems while waiting for the call of civil service.

In Myanmar, the GP profession is not considered part of the public health service category. Therefore, GPs can operate clinics independently and make their own money. They can choose to open their own clinics in favorable places and with favorable hours. Many GPs have opened their clinics in the peri-urban areas of major cities and small towns where they can get many kinds of experience in community settings.

According to official statistics, in 2014, 18,443 doctors were working in the private sector, while 13,099 doctors were in the public as well as governmental services (Ministry of Health, 2014). As a civil servant's salary is quite low, about $180 USD per month, some doctors also have dual practices, practicing in private GP clinics after their regular working hours.

Through decades of military rule, Myanmar's healthcare system was neglected and massively underfunded. But along with political and economic reforms following the installation of a quasi-civilian government in 2011, the health sector has received a facelift of sorts. Because health programs are key to improving quality of life, they draw much attention from the government and people. Under the post-2011 government, Myanmar is now putting much more emphasis on primary healthcare, especially for people and areas experiencing numerous disadvantages and difficulties. However, even though reports in the media suggest that large amounts of the country's resources are being allocated for primary healthcare, in fact Myanmar's total (both public and private) spending on healthcare as a percentage of GDP is still quite low in relation to other neighboring countries. According to World Health Organization data, Myanmar spends roughly 2% of its GDP on healthcare, while Laos spends 4.5%, Cambodia 5.6%, and Indonesia 2.6% (WHO database).

2 In a global context, many developing countries are facing 'brain drain': the emigration of trained health professionals to developed countries (Pang et al., 2002).

3

THE GENERAL PRACTITIONERS' SOCIETY

In Myanmar's healthcare system, general practitioners (GPs) play a very important role. In Myanmar, the term "GP" refers to medical doctors who have completed their basic six-year general medical training, and also those who took an additional one-year post-graduate diploma in family medicine. GPs may be employed in government service, or they may run their own private clinics. Actually, many GPs who work in government service also see private-pay patients outside of office hours. Unlike the specialist's clinics associated with private hospitals, GP clinics receive patients with all disease categories and patients from all socio-economic statuses.

In many areas, patients are able to choose a particular GP from among many. A variety of factors, such as the physician's manner, age, and gender, or their willingness to spend time with individual patients or to prescribe certain drugs, are important (Boonzaaier, 1985).

In Myanmar, GPs are the most important category of health worker because they are gatekeepers between patients and the healthcare system. They have the knowledge and skills necessary to relieve a number of medical problems at the peripheral level. They also can relieve illnesses for minimal costs and prevent the consequences of patients' late arrival to hospitals or specialists. GPs' skills at detection, diagnosis, management of diseases, and early referral are of paramount importance to their patients as well

as the health system.

Recognizing the key role played by GPs in the country, a General Practitioners' Society was established as part of the Myanmar Medical Association in 1987. This society has the largest number of private practitioners and its branches provide a link between GPs and their counterparts in the governmental sector so that they can better participate in primary healthcare activities. The society supports collaboration between private and public sectors.

In part because of the activity of the General Practitioners' Society, GPs are increasingly involved in public health and disease control activities, including prevention and control of tuberculosis, HIV, malaria, and respiratory diseases, working in cooperation with different departments under the Ministry of Health. The idea is to incorporate the private sector into the public sector to deliver healthcare in different ways to meet community needs, to shorten delays in diagnosis, and to prevent complications arising from the respective diseases. The goal is to take pressure off public hospitals and improve the financial sustainability of Myanmar's health and hospital system.

A key concern of the General Practitioners' Society is to improve the training of GPs who were unable to acquire sufficient experience within their formal six-year education. Young graduates who enter general practicing are usually ill-equipped to provide quality primary care in a community setting, since they have been trained only in hospital settings. The Society is also concerned with continuing education. According to its statements, medicine is a profession that requires continuing learning from formal and informal training and experiences. Therefore, doctors who have spent years in general practice should try to update their knowledge at trainings provided by the General Practitioners' Society.

The General Practitioners' Society provides GPs with the opportunity to update and exchange their knowledge and experience at seminars, talks, and symposia on currently emerging issues and updated diagnostic and therapeutic measures to improve their competency. The Department of Medical Science of the Ministry of Health also offers a Diploma in Family Medicine

course for GPs. This formal education for general practitioners is intended to upgrade the level of private sector provision and to help doctors keep abreast of international medical education. However, these programs do not reach every GP working at the primary care level.

Research Methods

As noted above, the aim of this research was to explore how GPs currently operate in Myanmar's healthcare system and to identify constraints to efficient and effective provision of services. I have also attempted to identify possible strategies to improve the role of GPs in the country's healthcare system.

Qualitative research was carried out at 15 selected general practitioner clinics. Qualitative and descriptive methods were used for data collection, including participant observation and in-depth, face-to-face interviews. In-depth interviews were conducted with the GPs themselves, as well as with the patients and their relatives who presented at their clinics. Key informant interviews were conducted with local authorities and medical officers and staff from Township Health Departments. Because qualitative methods were utilized, complex topics and relationships were able to be explored in detail.

Field Site Description and Informants

My general study site was Yangon Region in Myanmar. There are 45 townships in this region with a total population of seven million (Myanmar Ministry of Health, 2014). Since Yangon is the former capital and the main commercial center in Myanmar, private sector involvement in providing health services is quite high. Private GP clinics are particularly abundant, with about 50 to 100 GP clinics in each urban and peri-urban township.

I conducted my research at 15 GP clinics in the greater Yangon area. I chose clinics in the following seven townships: Lanmadaw, Tharkayta, South Okkalapa, Kyi-myin-daing, Hlaing, Yankin, and

North Dagon. As there are clinics in almost every ward of the urban and peri-urban townships of Yangon, I selected my study sites mostly on the basis of convenience, accessibility, and availability of subjects. I tried to find clinics that varied along several criteria: size, urban vs. peri-urban, wealthier patients vs. poorer patients, etc. At these clinics I spent time with and interviewed the GPs at the clinic (a total of 15 GPs), patients coming to these clinics, and local health staff. I also interviewed local elders, representatives of NGOs, and authorities in these townships.

The study began by identifying clinics where research could be conducted. The 15 GPs I chose as my main informants included seven younger and eight older practitioners. Nine were male and six were female. I went to three larger clinics, four medium-sized, and eight smaller ones. The eight small, home-based clinics were the practitioners' own clinics. The other seven practitioners were practicing on a part-time basis. I met with busy doctors as well as doctors who were not so very busy. I was interested to observe the patient-doctor relationships in both busy and not-so-busy conditions. I conducted my study in urban as well as peri-urban areas. Therefore, I was able to observe both wealthy and poor patients. In these various settings, I was able to learn how the doctors dealt with patients of different socioeconomic status, and also what different patients expected and the contrasts in their behaviors.

To start, at each clinic, I introduced myself as a researcher conducting a study about GPs in those townships. I felt that I should introduce myself as a doctor because the participating doctors would feel more comfortable having conversations with someone who could share their experiences. For the patients as well, I introduced myself as a doctor conducting a study related to their experiences interacting with their practitioners.

Initially, the practitioners were confused about what I was going to do in their clinics and asked about the details of the research. I had to explain the course of the research, the methods I planned to use while observing them and their patients, and the information I hoped to receive from them and what I would be doing to fulfill

the objectives of the study. After I explained, some gave consent to participate in the study while others did not. Actually, I found it was easier to get consent from the patients to participate in the study than from the doctors.

The methods I used in the study included participant observation and informal, face-to-face interviews. I found that participant observation was not problematic. It was not difficult to be involved in the practitioners' process of seeing the patients (depending on how friendly the GP was). However, to sit with individual GPs and conduct formal interviews would be more difficult. Therefore, I chose to rely on informal interviews using unstructured questions at the same time that I was participating in and observing activities in the clinic.

As I said, the clinics for my study were chosen based on whether the practitioner was accessible and whether he or she felt it was convenient to help with the study. It was important to me that the practitioners would not consider that their time was being wasted and would welcome me.

After I had visited each clinic several times, I produced sample questions and a checklist of topics and questions for further study. Participant observation and informal interviews were started on the third or fourth visit to each clinic. After paying five or more visits to a particular clinic, I would then conduct an in-depth interview with the GP, which would take about an hour. My questions were mostly concerned with the experiences of the practitioners in dealing with their patients during their daily working hours. As the interviews were approached informally, the questions started with the daily activities and experiences of the practitioners in seeing the patients. These questions included:

- What were the most common diseases and problems with which the patients were presented?
- How did the practitioner diagnose possible illnesses and determine the course of the patients' treatment plans?
- On average, how many patients per day was the practitioner seeing?

- How did the practitioner manage the patients to ensure that patients returned for follow-up visits?
- How did the practitioner work to maintain positive patient-doctor relationships?
- What was his or her intention for the community, and how had he or she participated in building healthcare awareness for locals?
- What are the differences between his or her previous experience and the experience after attending a refresher program?
- What was his or her idea about refresher courses and continuing medical education?
- What are his or her expectations from attending the continuing medical education programs?

A research assistant was hired to help me conduct observations and interviews with patients. The assistant's task was to make the interviews easier and to make the patients more comfortable while being interviewed. The assistant helped me to locate participants. For example, while I was engaged in conversation with the practitioners, the assistant helped identify patients who were willing to be interviewed. During each visit I asked permission from the practitioner to interview his or her patients. Some patients were eager to participate, while others did not want to bother. Sometimes the practitioner helped me in identifying appropriate participants from among his patients.

By doing informal, in-depth interviews, and also by observing activities at the clinic, I was able to study patients' perceptions, expectations ,and experiences regarding healthcare services they received. I interviewed patients as well as their relatives. Some questions included:

- What is the patient's complaint?
- How long has the patient had this problem? Is it recurrent?
- How long had he or she been seeing this practitioner?
- Did the patient come to this particular practitioner each time he or she was troubled by this illness? Why or why not?

- Why didn't he or she choose another clinic?
- Did the patient ever recommend this practitioner to relatives or friends? Why or why not?
- What was the patient's opinion about his or her illness? Is it getting better?
- What is the patient's description of his or her experiences with private clinics and hospitals?
- Where was the patient from? How long had he or she been living in the neighborhood?
- Were there any other practitioners that the patient was seeing?
- Did the patient feel he or she was receiving the right medical advice? Why or why not?
- What is the difference between this practitioner and others?

Fieldwork Findings

In general, I found that some practitioners were enjoying what they were doing while others were simply working to earn incomes. Some practitioners were practicing according to modern, updated guidelines of clinical medicine, but some practitioners were practicing as they wished, relying on their personal experience. Some practitioners were actively seeking to update their knowledge, while some practitioners did not feel it was necessary to pursue further medical education. I found that, in general, patients appreciated the GPs for their caring attitudes and their willingness to spend time with them. Patients had various strategies for managing their healthcare needs and selecting among possible healthcare providers.

In the next section I will discuss more specific findings from each clinic visited. In early November 2012, I conducted research in one clinic in downtown Yangon (an urban area), one clinic in Yankin Township (an urban area), and another clinic in Tharkayta Township (a peri-urban area). I will first discuss my findings from these three clinics.

4

YANGON CLINICS

The downtown quarter where I visited the clinic is a very complex area, also known as the Chinatown of Yangon. Almost all the people residing in this area come from middle socio-economic status families of Chinese origin. The area is also well-known for having famous private clinics of specialist doctors. However, the GP clinic I chose to study was not famous. It was a small home-based practice: the clinician lived in the same building as the clinic. He ran his clinic for the whole day and most of the patients who came to him were neighbors with general illness complaints and debility. I studied this clinic mostly in the evenings, and even though it was an urban area, the clinic was never crowded. The doctor had enough time to examine each of his patients, and his patients did not need to wait for a long time before being seen.

Dr. MYA *(Ed. Note: abbreviations have been used to protect the identities of informants)* is an older doctor, in his late 50s, and has practiced in this downtown area for more than two decades. He started practicing in a clinic soon after he quit from civil service. During his time spent in civil service, his duty was in Mon State in southern Myanmar. The monthly salary was not enough to live on, so while he was working as a civil servant, he also opened his own clinic. He served there for nearly ten years, but then he needed to come back to Yangon for a family matter.

When I asked him why he became a GP, he answered, "I didn't know if I would become rich or stay normal, but I needed to do

something to survive. I didn't have any other business plan, so I decided to open a clinic here." He said that being a doctor was his only profession. He decided to become a GP in his hometown, Yangon, because he believed that it was the best way to survive. He added that back in the 1990s, he could make a lot of money from his clinic, but these days he had to operate an attached pharmacy for his clinic to survive. Since the late 2000, private clinics have been established widely, especially in the downtown area. This is one of the reasons why the number of patients coming to see him has been reduced.

Interviews with his patients revealed that they were also seeing other specialists as well, even though they considered Dr. MYA to be a skillful and well-experienced clinician. When I asked what the reasons were for going to see other specialists, one patient simply answered, "Yes, Dr. MYA is a really good clinician and we've known him for a long time. But I also like to try other specialist clinics. There's no offense. I never think of him as incompetent. And still I'm seeing him and discussing with him the medicines that the specialist gives me."

U Ko is a 40-year-old patient with chronic diabetes who typically visits Dr. MYA twice a month. He was also seeing a well-known diabetician in a private specialist clinic and coming to Dr. MYA for his medication. He also mentioned that it cost him about 20,000 kyats (approximately $20 USD) when he visited the diabetician, and that Dr. MYA only charged him 2,000 kyats (approximately $2 USD) per visit. As there is a ten-fold difference in the consultation fee, it is understandable why patients would see a general practitioner first rather going straight to a private specialist clinic.

U Kyein is a 60-year-old patient who came to Dr. MYA for general debility. He said, "I'm also seeing my heart doctor, but it seems she does not have enough time to answer all my questions. So I visit Dr. MYA as he's very generous with his time in explaining everything I'd like to know."

When I asked him about this patient, U Kyein, Dr. MYA said, "I'm giving the primary care for U Kyein. The medicine can control his disease situation. We both know that. What I emphasize here is

the healthy, quality lifestyle. I'm taking care of the general well-being of his body and his mind. It's called the holistic approach."

Dr. MYA believes that a doctor is responsible for both the patient's physical and mental wellbeing, and also a good mental attitude can support the treatment for a disease. Moreover, the caring attitude of the doctor can easily influence a good patient-doctor relationship.

Dr. MYA is a member of the GP Society and he has been attending the continuing medical education (CME) program hosted by the Myanmar Medical Association. When I asked about the training he received and his perception of it, he answered that because of the programs, he is able to maintain his profession. As the medical world is changing rapidly, he fears he will be left behind if he fails to regularly update his knowledge. If he fails one of his patients due to a lack of knowledge, he will be guilty.

He is also working together with the local health staff concerned with public health problems like tuberculosis and AIDS. He said that he did not have enough understanding about how to handle patients with these diseases. He typically will refer them to specialists, but he seeks to collaborate with local healthcare personnel and to attend trainings focusing on public healthcare problems. After he began attending CME programs, he became a member of Population Services International (PSI), one of the largest NGOs in the country, which conducts numerous health interventions focused on HIV, tuberculosis, malaria, pneumonia, diarrhea, and reproductive and maternal health in nearly all 331 townships. After this, he felt differently about his ability to adequately help those patients.

It seems that the CME program has played an important part in improving Dr. MYA's ability to offer key primary healthcare services to his community.

Yankin Township Clinic

Yankin Township is another urban area in Yangon Region. It is famous for Yankin Housing and Yankin Children's Hospital. Most

inhabitants in this township are government employees with middle socio-economic status. The clinic I studied is situated on the Yankin Main Road. It is run by a 27-year-old female doctor I will call "Dr. E". She rented a small place for her clinic that is quite close to the Yankin Children's Hospital. She works as a civil servant, and she opened her private GP clinic in her free time from work. The clinic is quite small and usually not very busy. The majority of the patients that come to see her are pediatric patients, as people know she works in the Children's Hospital.

When I asked one mother at this clinic why she chose this particular female practitioner, she said, "I have come to Dr. E three or four times. The first time was for myself. After I found out she is working in Children's Hospital, I also bring my children to see her." This mother was a Yankin resident. I asked her why she did not go to Children's Hospital for her children. She replied, "I can go to the hospital if Dr. E tells me to. But if it is okay here, I don't want to go there. They have no space or time for us."

It seems that, even when public health services are available and easily at hand, patients like this mother do not rely on them, instead preferring to go to GPs. For this mother, the issue is the overcrowding and poor service at public centers compared to the facilities of private GPs.

Tharkayta Township Clinic

For another peri-urban township setting, I chose Tharkayta Township. Although I expected all the clinics in this area to be busy, this was not universally the case. I was able to spend the whole evening at the selected clinic during my visits. I observed the practitioner during his consultations with patients, and I conducted informal interviews with them. As the clinic was not crowded, there was enough time to conduct interviews with the practitioner. The population residing around the study clinic had low socio-economic status. They could not pay priority attention to their health problems because they had to strive for their daily living.

The clinic I studied was small-sized. The doctor was 25-years-old and freshly graduated from medical school. When I met him in November 2012, his clinic had been open for a little more than four months. He had rented a small space that was attached to a stationary store to open his clinic. The stationary shop owner later sold medicine in the shop, starting with over-the-counter medicine, and later also filling prescriptions. I asked the practitioner why he did not sell medicines at his own clinic. He answered, "I did not open my clinic to sell medicine. If the shop owner wants to sell medicine, he should sell while the clinic is open. I came here to gain experience. So, as long as I can treat the patients and my patients are fine with my treatment, that's all the result I need."

When I asked him why he needed more experience, he answered that he was practicing to become a specialist physician. All he learnt as a medical student was based on hospital settings. Therefore, he felt he should gain experience and build his career by opening a clinic in a community setting.

North Dagon Township clinics

In late November 2012, I began conducting research at three clinics in the peri-urban township of North Dagon. This township in the northern part of Yangon Region is quite densely populated. Although there are housing estates filled with people of higher socio-economic status, many wards are still crowded with the houses of middle and lower socio-economic status people. On my way to these clinics, I observed fully loaded buses with people going back to their homes after work. The people living in the area are mostly either government employees, or manual workers who work in the industrial zones and construction sites. Some earn their livings as vendors in local markets.

The clinics that I will refer to as "ND-1" and "ND-2" were in the same neighborhood in North Dagon Township. It is an area where middle and low socio-economic status people reside. ND-1 is situated on a main road while ND-2 is ten minutes' walk away in another lane. The third clinic I visited in North Dagon ("ND-3") is in another part of the township that is close to the housing estates. Higher socio-economic status people reside there.

Clinic "ND-1" (in North Dagon Township)

Dr. SD is a 55-year-old female doctor who has been operating her clinic for more than twenty years. It was the first clinic to open in the area. As she lives in the center of the town, she must spend 45 minutes to drive to her clinic each day. Her clinic is open in the evening from 4 until 8 pm, but sometimes on very crowded days, she doesn't close the clinic until after 9 pm. She has tight bonds with many of her patients. Because of her commitment to the community, she bought the clinic space.

I found that the patients coming to her clinic were mostly poor. Some could not even afford their own medicines. In such cases, the doctor gives away medicines and treats the patients free-of-charge. The doctor told me she feels quite satisfied with her job. Her clinic was not a very large or grand one, but it was more crowded with patients than the big, new clinic situated just across the street from hers.

When I conducted my interview with her, she explained about her patients. "They have known me for more than twenty years, and I've known each of them individually. I think it gives them a sense of security to keep coming to someone who already knows them."

When I asked her about her twenty years of experience with her patients, she described her relations with her patients as follows: "I did not expect anything back from them. But they showed their gratitude by bringing eggs or bananas or some other things. I'm just pleased that I can help them with their health problems. I think that is also one of the reasons why they come to me, as most of them are poor and here they don't need to worry about the medication fees."

When I asked her how she felt about her role in the community, she answered, "I think I've got some kind of status here, because elders come to my clinic and sometimes they talk about their children. For instance, Grandpa Mya requested me to tell his son about the consequences of drinking alcohol. I couldn't say no, because I've known his child for years. He's thinking that I'll make some progress with the son. Some people ask me not only about their healthcare problems, but also their social problems as well."

When a GP has been in a neighborhood for a long time, they get to know nearly everyone in that neighborhood. They are involved in most activities of that neighborhood and become a part of the community.

This doctor was always busy with her patients, asking them about their daily business and also giving treatments. When I asked her whether she had time to take the continuing medical education (CME) programs and attend seminars or symposiums, she answered, "As long as my patients are okay with me, I don't think I need to attend CME programs." I asked her how she managed to update her knowledge and she said, "I read medical journals and magazines. Of course, I'm not keeping myself up-to-date, but I don't consider CME as essential for me."

I interviewed several of her patients and learnt their perspective on Dr. SD. Daw Sein is a 62-year-old female with a known case of hypertension. As she lived in another ward, it took her half an hour to visit this particular practitioner. I asked her why she kept coming to Dr. SD's clinic and she answered, "I'm coming to my doctor although it takes a half an hour of time. Of course, there is another doctor in our ward, but I still want to see Dr. SD and hear what she would say. We have known each other for years, and I have a sense that she knows me best."

Ma Moe is a 23-year-old female patient who came to Dr. SD's clinic with a urinary tract infection. It was her first visit to this practitioner. I asked her why she chose to come to a GP rather than a government healthcare service provider, and she explained, "My friend recommended Dr. SD to me. She said Dr. SD is well experienced. Also, how can I go to the government healthcare service? I'm working in an industry and I can only get a one-hour leave for medical reasons. I cannot line up and wait for two to three hours. My supervisor would be mad at me."

What we see in this case is a patient who might like to go to for treatment at the public healthcare services, but cannot afford to wait and spend a lot of time at the crowded hospitals. Even if Ma Moe needed special medical attention for her health problem, she would have to rely on a GP, as it is the only available medical provider located near her environment.

Clinic "ND-2" (in North Dagon Township)

The second clinic in North Dagon where I conducted my study was not very far from Dr. SD's clinic: they used to be in adjacent wards. Dr. KK is a male practitioner in his mid-forties. His clinic is home-based and large compared to Dr. SD's clinic. As it is a home-based clinic, he keeps it open for most of the day. It is a nice and tidy clinic with a pharmacy attached. The layout of his clinic is quite convenient. He has a helper at his clinic to assist him while he gives injections and prescribes medicines. Sometimes, the helper assists him by providing health education to the patients.

Like Dr. SD, this GP also offers personalized care to his patients. He tries to maintain good relationships with patients. He admitted that his clinic was not crowded, probably because of his higher fees. He said his clinic charges higher fees compared to other surrounding clinics because he uses high profile and quality medications that he keeps in his pharmacy. He did not want to lose face by using cheap medicines. He thought this might be the reason that many patients did not choose to come to him. However, he wanted to keep on only using quality medicines.

A 45-year-old male post-surgical hernia patient shared his experiences with Dr. KK as follows: "I have known Dr. KK for more than four years. He is smart and kind. He has great knowledge and practices, so most of his patients do not need to come back for follow-ups more than two times. And he does not care about the money. If someone does not take his advice and bothers him, he does not hesitate to scold that patient. Some might think he's a frustrating doctor, but we know he's doing it for the patient's sake."

Clinic "ND-3" (in North Dagon Township)

Clinic "ND-3" is run by a 30-year-old female practitioner, Dr. PP. She is currently working as an assistant surgeon in a government hospital close to her clinic. She comes to the clinic in the evenings as she has duty shifts in her hospital during the day. This clinic is funded by a local NGO, Better Burmese Health Care (BBHC), which has a mission to support quality healthcare for poor people in slum and peri-urban areas in Myanmar.

BBHC appointed Dr. PP and another practitioner to be on duty at this clinic in the evenings. These two GPs share duties depending on their duty shifts at the government hospital and their convenience. Most of the patients who come to this clinic are poor people, as the clinic is situated in a very poor neighborhood. The consultation fees charge sare, at most, 500–1,000 kyats per visit, so the poor dwellers in this neighborhood mostly depend on this clinic.

I encountered a patient who was not satisfied with the treatment that he was given, and I asked him the reason. He replied, "I come here because I know what I need. All I need is an injection because I'm too weak. But that doctor, all she is doing is talking… I'm done here." This patient, Ko Nyo, was a 35-year-old who worked as a manual laborer at various construction sites. He told me he was an alcoholic, and because of the nature of his work and nutritional status, he easily gets fatigued. I had heard the doctor explaining to him about the importance of having a balanced diet and reducing his consumption of alcohol. She did not advise him to take an injection of glucose because it would not make him better. I witnessed the reasonable advice that she offered.

Dr. PP said to me: "Some patients are just too difficult. They don't recognize that I'm giving this advice for their own good. I'm sure he'll go to the next clinic, which will give him injection. I'm sick of some doctors who give up easily on the patients."

Many doctors I spoke with expressed similar frustrations. They said to me that patients will not know about the adverse effects of taking inappropriate injections if their doctors do not explain to them. But when doctors do explain, the patients have no confidence in that doctor and think that the doctor is incapable of giving injections. Another similar problem concerns patients who increase or reduce the dosage of their prescribed drugs without their doctor's recommendation.

The NGO, BBHC, recruits GPs for their Sunday mobile clinic, and fresh, recently graduated young doctors have been joining them. At the Sunday clinics, which are usually held at monasteries in North Dagon Township's poorer neighborhoods, these practitioners see hundreds of new and follow-up patients. As the clinics are

open only once a week, and the consultation fees are low (about 1,000 kyats or $1 USD per visit), there are huge crowds of patients waiting to be taken care of. Some come for more medicines, some come with new complaints, and some just come for the health advice and preventative medicine that these practitioners provide.

I interviewed a 55-year-old female patient at one of these Sunday mobile clinics. She was a diabetes patient who had come for the health education. "I would have to spend more than 10,000 kyats to see a physician at my other clinic. I know that my blood sugar level doesn't go down because I'm not controlling my diet. But I'm not going to get scolded by a physician when I'm paying my own money!" said Daw Phyu.

Kyi-myin-daing Township Clinics

In December 2012, I continued my research at three clinics located in Kyi-myin-daing Township. Kyi-myin-daing Township is located on the western side of Yangon Region. The socio-economic status of the inhabitants in the study area is mixed, including middle and low socio-economic statuses. The clinics referred to as "KM-1" and "KM-2" are in a poorer neighborhood, while the "KM-3" clinic is in a middle socio-economic status area.

Clinics "KM-1" and "KM-2"

The KM-1 clinic is a small clinic. Three young, recently graduated doctors sit in the clinic alternately. Two of them participated in my study: a 26-year-old female, Dr. SU, and a 25-year-old male GP, Dr. KK. These two young GPs, together with a mutual doctor friend, rent the small space. When I met them in December, their clinic had been opened for about five months. They sit the clinic in the evenings from Tuesday to Sunday.

The KM-2 clinic is a small, home-based clinic situated in another lane. A 25-year-old male GP named Dr. BB sits in that clinic most days of the week. The patients who come to these two clinics are mostly from the surrounding neighborhood.

When I asked these young doctors why they decided to become

GPs, they answered that they wanted to gain community health experience and they wanted to keep practicing while they were waiting to enter into civil service. I asked them what they did to treat the health problems of their patients. Dr. KK responded, "Sometimes, the patients need to be referred to a hospital. I tell them this, but they don't listen to me. Instead, they ask me to give them two or three medicines, and then they try to come back again. I think we need to raise the health-awareness of the patients."

Dr. SU added, "I saw a patient once who never came back to me. Instead he went to Dr. KK. It's because I asked that patient to stop smoking and drinking alcohol. Even though I told him this for his own good, he did not want to stop."

Dr. BB also answered, "I would want to provide my patients information about illness prevention and health promotion. But whenever they to to a GP clinic, they think only about a short-term cure. I am tired of giving health education sometimes, as I cannot see that they [patients] will follow my advice."

These doctors suggested that the health awareness of the population needs to be raised. People should focus not only on the cures, but also on preventive and promotive measures for healthy lives.

Clinic "KM-3"

Clinic KM-3 is situated on the main street of the township, Lower Kyi-myin-daing Road. This part of Kyi-myin-daing Township is quite busy with vendors and shops in a big market place. Dr. MZ opened his own clinic in this area more than ten years ago, when he moved to this part of the town. Unlike other GPs, he is a specialist with a master's degree in medicine. He is still working in government hospitals. Although he is only able to open his clinic in the evenings, he manges to see a lot of patients.

When I asked the patients their opinions of Dr. MZ, a 42-year-old patient replied, "Dr. MZ is a caring and patient doctor. Although I have to wait twenty minutes to see him, it is worth it because he gives answers to my questions patiently. He never makes his patients dissatisfied."

Another visitor to the clinic, a relative of a patient, said, "I met *Saya* [Dr. MZ] when my mom was hospitalized. In the hospital, he was so busy running from here and there among the patients and he could not pay attention very well to every patient."

It seems that patient-doctor relationship is quite important for patients when they choose their healthcare providers. Even though patients have to wait for a GP, they do not complain if they are not fully satisfied with the way the doctor listens and explains. In addition, it seems patients do not mind waiting because they know every patient will have enough time to discuss their health problems with the doctor.

South Okkalapa Townships Clinics

In January 2013, I continued my study in South Okkalapa Township. In People from various socio-economic classes, including both middle income and low-income families, populate South Okkalapa Township. They work as government employees, company employees, shopkeepers, and also as manual laborers.

Clinic "SO-1" (in South Okkalapa Township)

Dr. MM in South Okkalapa is a pleasant man who was eager to share his experience seeing patients. He invited me to his clinic to observe while he was doing consultations. Sometimes he explained to me how he identified the signs and symptoms of various illnesses. Although he is also a very busy doctor, he was willing to spare his time for my research. He said that he believed it was his duty to help and he was happy to take part in the study.

I found that the patients who came to his clinic were mostly those who could well afford the services. Usually higher income status people in Myanmar choose to go to a specialist clinic, but Dr. MM's older patients were still seeing him instead of a specialist. When I asked the patients why they chose Dr. MM's clinic, seven out of ten patients answered that they had been seeing Dr. MM for their whole lives, in some cases, over two decades. Respondents said that Dr. MM was a part of their family. They considered him

a family doctor whom they could trust with their general well-being.

When I asked about the differences in Dr. MM's clinic compared to ten years ago, the patients answered that the clinic was more crowded, so the waiting times were prolonged; however, Dr. MM's caring demeanor was still the same. They were not sure if the treatment had changed.

Dr. MM's clinic has been in this part of South Okkalapa for more than 20 years. He started his clinic when South Okkalapa Township was first established. At that time, the area was not heavily populated. He had to keep his clinic open for the whole day in those early years as there was no other clinic in the area. Sometimes he had to make house calls if a patient was too sick to come to the clinic.

Because of his strong commitment, Dr. MM is well known in the area. He has become one of the elders of the community and is often asked to participate in the community's religious ceremonies, social events, school health programs, and health education in the community, such as anti-obesity campaigns.

Clinic "SO-2" (in South Okkalapa Township)

Dr. TM's clinic is also situated in South Okkalapa Township in an urban neighborhood. Although it is on the main road, it is not very large compared to Dr. MM's clinic. As it is small-sized, patients are crowded during the consultation time.

Dr. TM is a male practitioner in his late 50s. He opened the clinic 20 years ago. As he didn't live in the area, he had to rent the space to open his clinic. He has remained in that very same spot ever since. The helpers in his clinic have changed, one after another, and the clinic's decor has changed from time to time, but what has not changed is his 20 years of medical records. He still keeps the records for his patients on bookshelves in his clinic.

During my observation, I saw his specific style of interaction with patients. More than the other GPs I interviewed, he is quite relaxed. He seldom chats with the patients; mostly, he listens. He listens carefully to what the patients say.

U Thantzin, a 57-year-old male patient who came to Dr. TM's clinic, related his experience. He had seen a specialist four or five times for his hypertensive problems. Although his problems were relieved with the medication that the specialist prescribed, he was frustrated after the last visit as the consultation time given to him was very short. The specialist just continued the same treatment. U Thantzin went to Dr. TM's clinic following his friend's suggestion.

He said: "I went to the specialist, but he didn't even ask me about the course of my disease. It was like he thought he already knew what I was suffering just by seeing my face. I am not going to him again. I'm okay with my new doctor now [Dr. TM]. He always listens to my problems until the end," he said. "*Saya* [Dr. TM] says less, but unlike Dr. Gyi [the specialist], I feel that he listens with his heart."

Another patient explained that she kept coming to Dr. TM because he listened well and responded promptly when she asked about her complaints. What she liked most about him was that he was patient. Sometimes she got frustrated because her symptoms were never relieved. Dr. TM would explain to her about the nature of her disease in a kind and patient manner. That is why, even though she moved to another part of the city, she continued coming back to Dr. TM's clinic whenever she got ill.

Dr. TM told me that being an active listener really helped him in his profession. He could find out the details for his diagnosis through conversation with his patients. That is how he gained experience: learning from the patients. When I asked him how he could improve and keep up-to-date with medical knowledge, he answered that, while he gained experience from his patients, he also had to improve his professional skills by attending refresher courses and symposiums and subscribing to medical journals. These were the main sources where he gains knowledge about new findings and trends in the medical world.

Figure 1 SO Clinic-2 – Front View

Figure 2 SO Clinic-2 – Patients' Records

Clinic "SO-3" (in South Okkalapa Township)

The last clinic I studied in South Okkalapa Township is situated on the main road, a five minutes' walk from the market. It is a medium-sized, home-based clinic owned by Dr. SS. There is also a pharmacy attached to the clinic. Sometimes when I visited, the clinic was crowded with the consignments and sales materials from pharmaceutical companies.

Dr. SS was a close friend of Dr. MM at SO-1. The two doctors opened their clinics at about the same time. As he had been in the area for 20 years, Dr. SS knew very well about the background context of the ward and its residents. From my interviews with patients, I learned that Dr. SS is like a family physician to them. They rely on him so much that they do not want him to move from this ward.

Ma Phyu is a 45-year-old woman and the mother of two children, ages 14 and 12. She usually comes to Dr. SS with concerns about her children's health. She said, "Pho Lone [14-years-old] and Mee Nge [12-years-old] were brought up with the help of *Saya* [Dr. SS]." Both of her children have asthma, and every time their symptoms are bad, she is frightened and feels she must go to Dr. SS. "Even if it was in the middle of the night, he was never reluctant to treat the kids. They only had the lives that *Saya* granted to them."

Hlaing Township Clinics

In January 2013, I went to two clinics in Hlaing Township to continue my study.

"H-1" Clinic (Hlaing)

The first Hlaing clinic where I conducted research was on Baho Street, the main street in that township. The clinic referred to as "H-1" is in a crowded peri-urban area. In this area are people of middle to high socio-economic status, but most of the patients who come to Dr. YD's clinic are middle socio-economic status people.

Dr. YD is a 27-year-old female practitioner. She graduated two years earlier, and has had her clinic open for a year. As it is a home-based clinic, she is able to see her patients full-time, but she chooses to keep the clinic open from 9 am to 12 in the morning and 5 to 9 pm in the evening.

The "H-1" clinic is large, occupying the whole ground floor of a three-story building, with a wide and clean appearance and excellent layout, including a patients' waiting area, reception, and a consultation/ treatment room. Although the clinic serves mostly middle socio-economic status people, the equipment and facilities in the clinic are quite modern and of high standards. Dr. YD has not only the standard medical equipment, but also more advanced tools to help in diagnosis, such as a pulse-oxymeter, an oxygen cylinder, a nebulizer, and a well-equipped emergency box. This equipment is so expensive that most clinics in peri-urban areas in Myanmar are unable to afford them.

During my first visit, the clinic was so crowded with patients that I did not have a chance to interview the doctor. I observed her consultations and then I interviewed the patients and their relatives about their experiences with GPs and private and government hospitals. Later, when I conducted an in-depth interview with Dr. YD, she told me why her patients kept coming back to her. She said, "It's my relationships with the patients. Everyone has the same treatment guidelines, but I know I'm good at talking with people."

I witnessed that she was good at dealing with patient complaints. She was taking medical history, assessing the patient's condition, and giving treatment, all simultaneously, in about ten minute intervals. Moreover, she provided health education to the patients.

As she was a recent graduate, I asked her why she chose to become a GP. She said, "Instead of being a specialist, I prefer to be a generalist, because I can treat every kind of patient, young and old, rich and poor. They all can come to me freely. I can get various experiences from them."

I asked how she maintained and updated her professional knowledge. She said she attended the CME programs provided by

the Myanmar Medical Association. She said, "For fresh doctors like us, they offer the only opportunities for us to improve ourselves. I gain not only knowledge, but also skills to diagnose medical problems and to relate with the patients."

"H-2" Clinic (Hlaing)

The second clinic I visited in Hlaing Township is on Kan Road in a wealthy neighborhood. Dr. EI, a 44-year-old female practitioner, had opened her home-based clinic over a year ago in this area. She also owns a pharmaceutical shop in the Mingalar Market, so she is not able to open her clinic regularly.

Her clinic is not a busy one, but whenever I went to interview her, I found her with one or two patients or she was busy doing accounts for her shop. After three or four visits, I could not find any new information and I thought I might be disturbing her, so I stopped visiting her clinic.

Interviews with Personnel from Local NGOs

In addition to visiting clinics, I also interviewed key personnel at Better Burmese Health Care (BBHC), which, as previously mentioned, is an NGO that is working to improve healthcare for the poor and to improve education for local medical professionals in Myanmar. They provide health services, capacity-building programs, and resource enhancement. In addition to BBHC, there are some other NGOs offering healthcare to the poor population through mobile and evening clinics. The mobile clinics are offered at monasteries in remote areas of Yangon Region. They provide free or low-cost consultations, as well as medications. For many of the poorest populations in the region, they are the sole provider of healthcare.

Figure 3 Studied Clinics in Yangon Region

When I conducted an interview with the founder of BBHC, she explained that she was not only focused on providing health services, but also on building the capacity of doctors. She said she had seen how recent medical graduates who enter general practice are ill-equipped to provide quality primary care because their formal training does not include dealing with people in community settings. She is concerned that these young doctors' practices would deviate from the standard guidelines. She decided to recruit and start building doctors' capacity by providing continuing training and education to the healthcare professionals who run these clinics.

Interviews with Personnel from the General Practitioners' Society

I visited the secretary of the General Practitioners' Society to conduct a key informant interview. He said he was willing to help with the study. He explained what the Society had done historically, what they are doing presently, and their future plans to benefit GPs.

He repeatedly noted the lack of support from the government for GPs, which is why the GP Society had to work independently to reach their goals. He emphasized that GPs are the gatekeepers of the health system, as only GPs provide primary care to the community. He said it was important to continue professional development to maintain practitioners' competency. Although there may be some GPs who just sit in their private clinics and are not interested in their communities, there are also practitioners who love to be involved in public healthcare delivery.

He gave me information about the Society's efforts to strengthen continuing medical education (CME) programs. CME programs include information about how to set-up clinics, how to keep records, and how to make a complete referral. The secretary mentioned that there are also practical sessions for procedures such as suturing skills. These programs are clearly very advantageous for the practitioners.

I mentioned to the secretary that one of the GPs I had met said that it was not necessary for her to attend CME programs so long as her patients were happy with her medicine. The secretary responded that she would be left behind and would not learn about updated treatment guidelines and the new generation of medicines. He said: "If this doctor thinks CME is not necessary, how will he or she know about the changing trends of the medical world? A doctor like that could even be judged as unethical if they fail to maintain their competency."

With CME, a GP can improve his or knowledge and skills. However, it can be difficult for doctors to access these programs. The secretary pointed out that the GP Society has been providing online CME programs for GPs residing in remote areas.

5

DISCUSSION

From my interviews with GPs, patients, their relatives, and key informants from NGOs and the General Practitioner Society, it is clear that Myanmar GPs play an important role in delivery of Myanmar's healthcare services.

Even though government policies have changed and we have seen increased funding to health infrastructure, there are still gaps in the coverage. Myanmar does not yet offer full healthcare services for the whole population. Because of inadequate patient-to-doctor ratios, the government's primary healthcare services are insufficient and people have to go to GPs when they experience health problems.

Although the government has been raising standards in public hospitals and healthcare centers, there are patients who continue seeing their own GPs in private clinics because they believe they can get quality and comprehensive healthcare services only from their GPs. From my observations and interviews with patients, it is clear that patients highly value the good patient-doctor relationships and individual care that they can get at their GP clinics.

Some of the older doctors included in this study told me that because they had been working in their neighborhood for a long time, people regarded them as an integral part of the community. As caring doctors who have lived or worked in the community for years, they have an important status. Sometimes, they are involved

in local community programs because they are asked to do so by the authorities, but in many cases, their commitment to the community is a natural extension of their work as primary care doctors.

From the point of view of the GPs I interviewed, they understand that they provide key primary healthcare services and also relieve pressure from the public hospital system. However, they are not appointed by the government. They are running their own businesses and working independently. Sometimes, in their practices, they cannot meet all the needs of the patients in the community. Some of the GPs I interviewed expressed a desire to receive more information, tools, and support. As primary healthcare providers, they need to treat everything from pregnant women to babies and from mental illness to sports medicine. Several GPs I interviewed expressed hope that more education programs will be provided so they can provide better services for people with these diverse issues.

Most GPs I interviewed acknowledged that in order to continue in their profession, they must commit to lifelong learning. They agreed that resources such as trainings and continuing medical education from the Myanmar Medical Association, as well as health talks and scientific seminars, provide them with opportunities to improve themselves and to provide better healthcare services.

Some of the GPs who participated in my study argued that they did not really need the trainings to improve. But most agreed with the idea of continuing medical education and gave ideas and suggestions on how to improve the coverage for the whole country. They suggested the government sector should be involved to encourage such support.

My research was also concerned with patients' and communities' expectations of GPs and their experiences regarding the healthcare they received. I found that the following factors were important in patients' assessments of the services offered by GPs.

Size and Space of the Clinics

The clinics I visited can be differentiated into three categories: small, medium, and large. This categorization is not related to the patient population but to the actual size of the clinic. Most of the larger clinics in my study were home-based clinics, where the GPs lived in the same building or in same compound as the clinic. Larger clinics were about 20x30 square feet in area, while the smaller clinics were about 10x10 square feet in area. The medium-sized clinics were about 10x20 square feet.

In the smaller clinics, the practitioner had to see and treat the patient in the same room. For privacy, they put a curtain beside the consultation bed. Other patients would wait on two or three benches in the waiting area. Compared to a specialist clinic, patients have little privacy.

In medium-sized clinic settings, there is more space and the practitioner can see the patient in a separate room. The patient is assured of more privacy. These clinics also have a drug stall and prescribing area attached to the waiting area. The large ones have extra space in the waiting area. Sometimes, there are one or two helpers to assist the practitioner in seeing patients, arranging medicines, and processing consultation fees.

Some patients complained about the narrow waiting area in small clinics, so it seems the size of a clinic is a factor in patients' satisfaction. However, when a GP can handle patients' clinical complaints adequately, space problems are not much of an issue.

Consultation Fees

The consultation fee that is charged is also is an important factor in patients' choices of practitioners. A low fee is a key reason why many patients will choose to go to a specific GP instead of seeking other healthcare services. Considering all the GPs that I studied, the consultation fees they charged varied from 2,000 to 3,000 kyats per visit (approximately $2-3 USD). Sometimes these fees included three or more day's worth of medications. If an injection was needed, they added another 1,000 kyats to the total cost. So, for an

average consultation session, a patient at a GP clinic might pay around 5,000 kyats (approximately $5 USD). In comparison, consulting with a physician in a specialist clinic costs about 10,000 kyats per visit, not including the cost of medications and diagnostic investigation fees.

Some patients go once to see a specialist physician, take the medicine that is prescribed, and later visit their GP to assess their progress. They do this because they cannot afford repeat visits to a specialist clinic. In fact, sometimes, if a patient cannot afford the medication, the GP will provide it free of charge or on credit. This is an important motivation for poorer patients to visit GP clinics.

Consultation Time

For a doctor to consult with one patient in a GP clinic, it takes 15 to 30 minutes. Even in a very busy GP clinic, the patients will each get at least 15 minutes of the doctor's time. Very short consultation times at specialist clinics is one of the main complaints I heard from patients about the services they receive in other settings.

From my experience, specialist physicians who offer consultations usually work at a public hospital from 9 am to 5 pm and then open their private clinics in the evening. Some of these physicians do not get back to their homes until midnight. This is the trend or fashion for a specialist's life: to be always rushing and competitive. It is very uncomfortable for patients when they have to wait to see the doctor for a very long period of time, but then the utmost time the doctor can allot to each is about five minutes, as there are still hundreds of patients waiting to see him or her.

Unlike specialists, the GPs who do not work in governmental service can open their clinics when it is most convenient. They may open the clinic in the morning as well as in the evening. The evening is when most workers are free to see the doctor. Sometimes, GPs can even go to see very sick persons in their homes. They can provide sufficient consultation time for the patients.

Patients I interviewed also pointed out that, sometimes, after they have waited for an extended time at the specialist clinics or in a

queue at a public healthcare facility, they still do not get the services they expect. With the same amount of waiting time, the GPs give them what they need. For many patients, this is why the GP is still their first choice for healthcare services.

6

MEDICAL HEALTH EDUCATION

A major problem in Myanmar is the lack of general health knowledge. In fact, it seems this problem is actually worsening. People have to strive for the daily living, so they have little opportunity to raise their general knowledge. Meanwhile, the very busy doctors often do not have enough time to provide health education or offer suggestions for disease prevention.

As mentioned above, it is very frustrating for doctors who try to provide education and appropriate care, instead of just giving the glucose injections that patients ask for. This is one of the complaints I heard from GPs. Patients do not understand about the adverse effects of taking inappropriate injections. When they meet doctors who try to explain to them, they may lose confidence in that doctor and think that the doctor is incapable of giving an injection.

As I observed in this study, when a GP takes more time for the consultation, from 15 to 30 minutes, then it is possible to effectively provide health education to the patients. I have seen GPs giving healthcare education and self-care suggestions at the same time as they are examining the patients.

7

CONCLUSION AND RECOMMENDATIONS

In Myanmar today, healthcare services need to keep expanding. There is a growing need for primary care and especially for high-quality primary care. Unfortunately, the population's need for healthcare cannot be fulfilled by the public sector alone. In fact, GPs reach the population better than the hospital system. Thus, improving primary healthcare services through this channel should be encouraged.

As my study demonstrates, no matter whether the practitioners are young or old, or the clinic is big or small, patients go to see the practitioners whom they trust and who are accessible and convenient to visit. Moreover, patients prefer practitioners who have good social skills and the ability to provide health education.

Due to overcrowding and the lack of a health insurance system, the public healthcare system is not well regarded. At present, Myanmar is undergoing a sort of "face-lift" of its healthcare sector. But while standards at government hospitals are rising, people continue going to their GPs because of the individualized care the GPs provide.

Interactions between the public and private sector are potentially beneficial in reducing the workload of the public services, improving the quality of care in both sectors, and increasing patients' choices. To ensure this, policies supporting public and private interactions should be strengthened. GPs should be encouraged and supported in their professional development and

participation in public health activities. This is not only the duty and responsibility of the government, but also of the individual GPs. Their commitment to the community and their specific involvement in career development would enhance the work force and improve the delivery of healthcare services.

For these reasons, I believe interventions aimed at improving the services of GPs, such as incentives to encourage participation in continuing medical education, to participate in public health activities, and to follow clinical guidelines for case management should be reinforced. In this way, the effectiveness and efficiency of GPs could be improved for better and more effective delivery of healthcare services to the people of Myanmar.

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THE ROLE OF GENERAL PRACTITIONERS IN THE MYANMAR HEALTH CARE SYSTEM:

A Study of Private Clinics in Yangon Region, Myanmar

The Understanding Myanmar's Development (UMD) series is an exploration and analysis of the economic, political, and social changes of Myanmar. This volume aims to address how the current healthcare system of Myanmar affects patient-doctor relationships and satisfaction. It focuses on general practitioners' roles in the medical industry and what can be issued to improve the overall quality and accessibility of health care in Myanmar.

In this third volume, Pyone Mjinze Lwin conducted qualitative research among 15 independent general practitioner clinics, which consisted of voluntary patient observation and in-depth interviews with general practitioners, patients, and relatives of patients. This research explored how general practitioners manifest their practice within the constraints of Myanmar's healthcare system, both in relation to patients' experiences dealing with the health care system, and in how patients develop health care preferences for different services.

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