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Health Reform: Striving for Value, Technical Research, Data Sharing and Macro/Micro-Economic Planning Crucial...

"Traditionally, physicians and other healthcare professionals have regarded financial efficiency as outside the scope of their professionalism (indeed, often at odds with it). The concept of value-useful health outputs divided by the resources needed to achieve them—as advocated by Porter and Teisberg and others is relatively new and unfamiliar to many clinicians. However, the need to achieve more with less puts the need to strive for value into sharp focus. Following a decade of above-inflation increases in NHS funding, the urgent need to reduce the United Kingdom's national debt means the NHS is entering a sustained period of flat or declining funding, while demand for services continues to increase (from technological progress, an aging population, increasing expectations, and population growth). Striving for value therefore becomes an ethical imperative..."

"An era of increasing financial constraint paired with greater emphasis and transparency on quality should drive a value centered approach. To benefit patients and populations, it is imperative that the quality numerator of the value equation measures those outcomes that are most relevant to patients across whole pathways."

~ James Mountford & Charlie Davie¹

"Patients, physicians, other providers, and payers are in a better position to guide the redesign of the health care delivery system than government agencies, policy organisations, or elected officials, no matter how well intended. We strongly believe—and ACC has proclaimed—that change in health care delivery must be accomplished with patients and physicians at the table."

~ James T. Dove, W. Douglas Weaver, Jack Lewin (American College of Cardiology)²

Technical Data Sharing Critical for greater public input & better understanding

In our 1999 MMA 'Health for All' document, there was not much in-depth economic analysis or practical details as to how the socio-economic considerations of these policy changes can be arrived at—mostly because there was precious little data or number crunching which were available to us then. Sadly these data and technical details remain as elusive to us now, as then.

Clearly for civil society to truly understand and rationally discuss or debate such gargantuan social services, we need more transparent and detailed data. We need academics and other NGOs to do comprehensive research on a reality based scenario as well as pilot in-depth studies, which can be scrutinised by experts from all quarters, so that a better understanding or consensus can be built around more solid bases. Importantly, this has to be relevant localised data and not simply those extracted and imported (whether wholesale or cut-and-paste) from foreign models. This is especially critical when we are

¹ James Mountford, Charlie Davie. Toward an Outcomes-Based Health care system — A View From the United Kingdom. JAMA 2010; 304 (21): 2407-2408.

² James T. Dove, W. Douglas Weaver, Jack Lewin, Health Care Delivery System Reform — Accountable Care Organizations. J Am Coll Cardiol 2009;54:985-8

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now debating as to a radical restructuring of our health care system—we need more data, more input, more discussions and debate with as many parties as possible.

To add to the changing scenarios, the Ministries of Health and Higher Education had embarked on a concerted programme to quickly produce more doctors than we had anticipated. Beginning with the setting up of public medical colleges in nearly every state, licences were then also dished out to commercial enterprises which saw the establishing of another dozen or so private medical colleges.

Sadly in their rush to produce more to meet such arbitrary targets, there was arguably some laxity in the standards of accreditation, and lack of means testing as to the real need or speed with which to generate so many doctors. Now we are facing an annual accrual of 3,000 to 4,000 medical graduates, which include nearly 1000 from disparate foreign schools, many of varying standards and quality.

At this juncture nearly every capital city hospital has upwards of 40 to 50 House Officers per medical or surgical discipline—simply straining and overwhelming the training capacity of these institutions! The intention to reach a doctor-population ratio of 1:400 while noble, should not be hastily made, without outcome projections as to the possible capacities to absorb the ongoing factory-style production!³

MMA has bluntly and robustly informed the authorities that such a rapid and uncontrolled production rate of medical graduates would severely congest the system, as the health authorities grapple with the logistical nightmare of how to fairly and adequately provide these young doctors in training with sufficient experience, mentoring and proctorship.

Would we really have enough material and manpower to equip these young charges with the skills and acumen to become independent doctors in the two years of rotation, and another two years of compulsory service-filling in the innumerable posts which have long been vacant in many district hospitals and rural clinics?

Yes, we do recognise the maldistribution of our doctors in the rural and more remote health facilities around the country, especially in East Malaysia and the interiors of Peninsular Malaysia, but would such an unprecedented quick production be the correct move? Or would we be just be placing more doctors nationwide without the necessary quality to ensure patient safety?

Healthcare Microeconomics needs to be addressed before any meaningful Reform

The laudable efforts to fill vacant unpopular posts with registered medical personnel are of course very much welcome, but more importantly, we need to address the issue of ensuring that once deployed there, we are able to retain these doctors, so that their services can be continuous and uninterrupted.

Could we ensure that these doctors be adequately compensated and interested enough to stay the course and serve the *rakyat* the best they can? Or would we be just constraining these reluctant officers temporarily, where they might simply be marking time before

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³ Medical Development Division. Doctors: Country's requirement by the year 2020. Ministry of Health, July 2010.

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quitting the service altogether once the compulsory service is over?

These issues and more suggest that there are still many imponderables as well as already known problems that need to be seriously addressed by the planners within the MOH. Not just the macroeconomics of our projected future, but more importantly the truly important 'micro' aspects of systematically ensuring that every doctor going through the system be offered a structured career plan as well as to provide the necessary work service.

The time has come to ensure that every doctor in service be offered more than just filling in the vacancies, most of which are in unpopular or unattractive disciplines and remoter sites.

It is just neither fair nor tenable to simply use these as 'worker bees', and then when these doctors decide to leave the public system, they are deemed incapable or not sufficiently equipped to function as good enough general practitioners or family physicians! It is the responsibility indeed the duty of the MOH to ensure that these medical officers (MOs) are good enough to practice medicine independently, and not cast aspersions as to their capability based on some biased perception that once these doctors leave, they become lesser doctors, incapable of providing high quality medical care! Yet conversely, if these MOs remain within the system, they are acceptable! Such would be the contrived duplicity at play by the MOH!

Hurried Reform could lead to Health service Disruptions, Increased Patient Risks

MMA's recent dialogues with some of our branch members and leadership have brought to light some

worried views that the proposed 1Care for 1Malaysia health restructuring plans could pose serious systemic problems and wreak schisms within our ranks, and severely test our professionalism.

And this is notwithstanding the 1Care objectives, which are obviously ideal and good for all Malaysians- no one can seriously disagree with the goal to offer equity, quality and safety for all, at rational costs.

But, we fear that this 'hurried' reform could cause harsh dislocations within the system due to inadequate (meaning "not comprehensive" enough) planning and nitty-gritty detailing. In this regard, we believe that meticulous attention to 'micro' aspects is highly necessary and critical to whatever success we hope to achieve from such radical restructuring, although the government has now announced that this reform would still have some years to go to materialise. Still, the very thought of these unfamiliar proposed changes should serve as a brutal shock therapy to the health system and medical practitioners!

With the expected possible glitches, we worry that patients could be at the receiving end of a severely disrupted delivery of services and get short shrifted safety... We too fear implementation irregularities, overwhelming regulatory and credentialing mechanisms, which would put doctors and patients at great disadvantages and socioeconomic professional risk.

There is a huge chance that instead of increased equity and access for all patients, there might instead be restricted and reduced choice. Some of us feel that instead of improving access, we might inadvertently be tamping down service for more people than we anticipate-i.e. impoverishing the healthcare experience rather than elevating it.

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Professional Concerns

Someone expressed the metaphor that we might be attempting to do what the communists did, i.e. distributing and ensuring poverty rather than wealth! Yes, everyone would be assured of greater access to one form or other of healthcare service, but at diminished levels of care, quality or safety... Already there have been loud rumblings as to the quality and adequacy of our overflowing medical graduates, and our acutely burdened and struggling training infrastructure-an inverse if distorted goal of quantity over quality, many detractors have expressed.

Patients might face delayed or denied access to tests or therapies, as overzealous gate-keeping money-counting consortia of managers and/or primary care physicians knuckle down to prevent the much-maligned overutilisation or duplication of resources and services (so much blamed by health economists!)

Questions on medico-legal responsibility remain unanswered. Who would be responsible should some of these denied or delayed tests or therapies come into play, especially when untoward or bad outcomes occur?

Particularly, despite reassurances from the authorities, we fear that our sizable private sector professionals would become severely marginalised. Our current 10,000-plus strong private sector doctors might be put at conflicting odds vis-à-vis the public sector professionals. The latter has been earmarked for wide administrative powers to control and implement these innumerable but yet undisclosed changes.

No private doctor would like to revert back to being under the yoke of a renamed public sector controlled authority. Would the private sector survive being 'employed' or reimbursed by some authority in the public sector, in this entrenched age of free economic practice? Would the public-private integration be 'that' comprehensive and complete as to stifle out private enterprise entirely?

We fear that our professional livelihoods might be disrupted due to unfair, discriminatory or corrupt application of new rules, new dictates, as well as infrastructure, manpower and reimbursement failure, as we rush to integrate and empower a single payment authority or regional commissioning trusts. Worse, the proposed integrated system would almost certainly unravel our current pragmatic if imperfect private-public dual system, which has served us arguably well these many decades.

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MMA-MIDA workshops⁴ (so far conducted in Sabah, Sarawak, Selangor, Malacca, Kedah) also highlighted the accelerated liberalisation of health services within ASEAN and also via other country-to-country mutual recognition arrangements. The doctor would soon have to contend with having to compete on equal grounds with our neighbouring countries in terms of specialist care and services, private specialist hospitals, mutual recognition of medical degrees, as we move towards a plan to form a single ASEAN Community (AC) by 2015. Of course, this would imply that Malaysian doctors could also cross over borders to practice in the mutually recognised nations too.

To be fair there is no perfect health system the world over. In fact, most healthcare systems around the globe appear to be staggering under the oppressive weight of spiralling costs and greater public expectations.

In Massachusetts recently, it has been shown that financial sustainability of near-universal coverage can be attained if waste resulting from unnecessary and unsafe care was eliminated. Expensive technology and fee-for-service payment of physicians were found to be the primary cause of costly and unnecessary care. Most physicians want to do the right thing for their patients, but their decisions on what services to provide are best guided, by science and patients' needs rather than by personal financial considerations. Thus, switching to prospective payment to physician groups rather than via fee-for-service can help achieve this goal, but physicians must be paid appropriate salaries⁵

4 Dr Federa Aini Bibit. LIBERALISATION OF HEALTHCARE SERVICES IN ASEAN. Medical Practice Division, Ministry of Health. Presented at MMA-MIDA Workshop, Alor Star, on 28 Jan 2011.

5 Francis J. Crosson. 21st-Century Health Care — The Case for Integrated Delivery Systems. N Engl J Med 2009; 361(14):1324-1325. Oct 1, 2009

Obamacare (The Affordable Care Act)⁶

What about the case in the United States of America? Contrary to what many believe, the American government (public sector) does spend a lot of money on healthcare, close to 50% of total healthcare expenditure.⁷

Healthcare reform proposed by Obama is now undergoing intense debate and legal constitutional challenges.⁸ Detractors such as Republicans and Tea Party supporters say such a mandating of forcing people to help finance their own healthcare is indefensible on constitutional grounds. But others argue that this is in line with the government's power to tax, i.e. this same authority that undergirds Social Security and its health insurance analogue, Medicare, can now mandate the new health reform law.

The Affordable Care Act does not actually force everybody to get insurance. It merely requires that everybody who is both financially capable and likely to use medical care make a financial contribution toward the cost, while leaving them to choose which contribution they prefer.

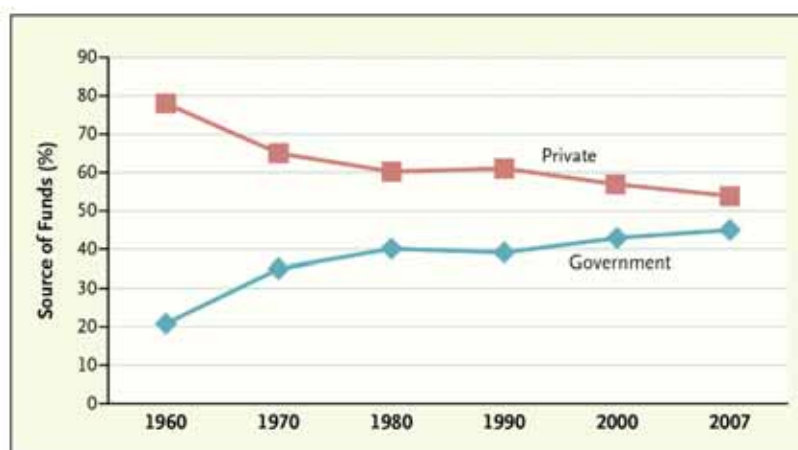
With Medicare⁹ already, the government demands that people help finance the cost of society's medical treatment through payroll

taxes. With the Affordable Care Act, the government demands that people help finance the cost of society's medical treatment either by paying for a reasonably comprehensive insurance policy, or writing a check to the government, if they did not.

Otherwise, without insurance, a person falling ill would incur huge costs, which might have to be unfairly borne by others! Many US Hospitals are already unable to collect on uninsured bills. Overall, care for the uninsured costs an estimated \$60 billion a year in uncompensated care. Sadly, these costs of care end up being passed on to the insured and to taxpayers.¹⁰

What makes the mandate "necessary and proper," the government and its allies say, is the way that individual decisions about whether to buy insurance ultimately affect prices throughout the nation's health care system.

"When doctors and hospitals give uncompensated care to people without insurance, these providers of care pass along higher prices to everybody else who pays, and those higher prices show up as either larger taxes, larger insurance premiums, or larger out-of-pocket expenses. In addition, if people know they can get insurance even if they have pre-existing conditions, some will wait until getting sick before buying



Source of Funds for Personal Health Care Expenditures in the United States, 1960–2007.

6 Peter R. Orszag, Ezekiel J. Emanuel. Health Care Reform and Cost Control. *N Engl J Med* 2010; 363:601-603 August 12, 2010

7 Victor R. Fuchs. Government Payment for Health Care — Causes and Consequences. *N Engl J Med* December 2, 2010;363(23):2181-2183.

8 Cutler DM, Davis I. K, Stremikis K. The impact of health reform on health system spending, May 2010. (Accessed June 14, 2010, at <http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2010/May/Impact-of-Health-Reform-on-Health-System-Spending.aspx>.)

9 Medicare does not cover all health care costs. Medicare beneficiaries can purchase supplemental insurance from private insurance companies to help pay for coinsurance, copayments, deductibles, and noncovered services. Low-income beneficiaries may receive assistance from Medicaid and other public insurance programs to help pay for costs not covered by Medicare. Beneficiaries with Medicare typically pay out of pocket for costs related to premiums, deductibles, coinsurance, copayments, and noncovered services.

10 Matthew Buettgens, Bowen Garrett, and John Holahan. *Why the Individual Mandate Matters. Timely Analysis of Immediate Health Policy Issues*. December 2010. Urban Institute. Robert Wood Johnson Foundation. <http://www.rwjf.org/files/research/71601.pdf> (Accessed 3 Feb 2011)

There have been rising bankruptcies due to inability to reimburse medical costs, mostly from credit card debts or loans.

insurance. That upsets the delicate actuarial balance of insurance plans, which depend on premiums from healthy people to offset the costs of the sick. Premiums end up rising even more."¹¹

If this Affordable Care Act is not mandated, an additional 18 million people would end up without insurance. Jonathan Gruber, a respected MIT economist has calculated and determined that without a mandate, premiums for people buying coverage on their own would be 27 percent higher. Gruber has advised healthcare reformers, including the architects of the Affordable Care Act. But the non-partisan Congressional Budget Office got similar results from its calculations.¹⁰

In a recent healthcare economics discussion round table, Harvard public health expert Dr. Meredith Rosenthal admitted that "We have lots of evidence that when people pay out of pocket, they don't make terrific decisions about what to seek and what not to seek. And because of the nature of insurance, we need to protect people against catastrophic risks, against high costs. This cost sharing would be limited to the end of the distribution of healthcare spending that matters least. What is driving high and growing healthcare spending in the U.S. is in the tail of the distribution, very high cost interventions and very sick people. And cost sharing is totally inappropriate there."¹²

Transforming the Malaysian perspective on Affordable healthcare

The American scenario outlined above shows that as a model of healthcare, it is imploding with skyrocketing costs. We therefore need to re-assess how we Malaysians look at healthcare. Sure, all of us would prefer our health system to be endowed with as many choices and be able to access any medical attention as quickly as possible. We all want access on demand and at whatever cost, without really thinking or calculating exactly how much this would mean to the health system as a whole.

Unfortunately, we are deceived by the government's half-century-old entrenched system of near-total subsidy. This has artificially kept the price of public healthcare cost so low; until recently, when this is found to be unsustainable. More disturbing is that out-of-pocket payments for healthcare for Malaysians now exceed 40.7%, which place an unnecessary financial risk for the paying patient. There have been rising bankruptcies due to inability to reimburse medical costs, mostly from credit card debts or loans.

The government tax allocations for healthcare have remained low at 2% of the GDP, which represent some 40% or so of the nation's total health expenditure. We have now to reevaluate how we can renegotiate this untenable model. But this exercise must employ greater stakeholder buy-in and acceptance—we need greater public discourse and debate on this.

How do we educate our patients and our Malaysian public that we have to exercise greater prudence when it comes to accessing healthcare or medical attention? Does every feeling of being unwell require urgent medical attention? Does having a cold and/or fever require immediate attention with the implied need to be treated with antibiotics or medical leave?

How do we discourage our public from doctor-hopping or shopping? Can we educate our patients that we all need to have greater patience and submit to some degree of rationing, queuing, so that only the most ill gets to be prioritised for earliest treatment or surgery? This way, there is less chance of queue jumping and less harried need for quick access to some of the more selective specialised therapies?

11 Jonathan Cohn. The Worst Case: How health care reform really could get repealed — and why the repercussions would go well beyond health care. The New Republic. 19 Jan 2011. <http://www.nnr.com/article/politics/81708/repeal-health-care-reform-repercussions> (Accessed 3 Feb 2011)

12 Atul A. Gawande, Elliott S. Fisher, Jonathan Gruber and Meredith B. Rosenthal. The Cost of Health Care — Highlights from a Discussion about Economics and Reform. N Engl J Med October 8, 2009;361(15):1421-1423.

How do we get our public to understand that healthcare is an infinite need, which must be funded from shrinking finite resources? Can we persuade our public to change their paradigm of doctor access, from 'any doctor on demand' to another that is limited to 'one registered GP' model? Would he or she be agreeable to a highly regulated gate keeping by the designated GP or family doctor to constrain unnecessary or too early referral to secondary or tertiary specialist care?

Would our patients be prepared to pay more for another form of health insurance mandated by law? Would our doctors agree to a socialised, capitated form of reimbursement mechanisms in a free market system that Malaysia espouses to practice? Would there be discriminatory or bureaucratic hitches or practices, which would unhinge the system, and create unwanted disruptions to our reasonably well-ordered system available now?

Clearly we need much more in depth consultation and dialogue with more experts and all stakeholders to find a common ground of acceptance. Too drastic a change could possibly paralyse and cause huge distortions to the system and endanger lives and patient safety. We need to create complex models of

possible changes, which can answer the many minutiae and details, but which are sadly lacking under the current proposed model of 1Care health reform! 'Work in progress' answers or planning styles are simply too risky and too chancy. A fuller more comprehensive policy model must be made available for society to scrutinise and debate even to critique, to find the best way forward, and smoothen out or remove all the potential glitches! **M**

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