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Health Reform: Why We Need Caution & More Meaningful Dialogue

"The Government's response to its consultation on the White Paper, 'Liberating the NHS', was a missed opportunity to demonstrate to the profession, and others, that it genuinely was listening to the concerns that many had put forward. We are not opposed to reasoned and evidence-based change, and accept that there needs to be some improvement to the way services in England are planned and run, but it is our duty to speak out when we can see the NHS we care about and work in being put at risk."

"Whilst we support proposals to increase clinical involvement in the design and delivery of healthcare, enable greater public and patient involvement and put the focus on quality and outcomes, rather than crude targets, we have real concerns about other aspects of the planned reforms. In particular, the lack of detail in many areas, the increasing emphasis on competition and the market, and the significant risks created by the process of rushed and unnecessarily risky transition…"

~ Dr Hamish Meldrum, BMA Council Chairman on the NHS Reform[1]

'Health For All' 11 years on...

In 1999, the MMA published a monograph on 'Health For All', a document, which was intended to promote and urge for a more systematic approach to our healthcare.[2] The MMA leadership then and even now, felt that Malaysia could do better by enhancing our healthcare system so that health equity can be assured for everyone residing in Malaysia—a single payer model was proposed as a possible approach towards ensuring this objective.

In that document, we discussed the dichotomous public-private divide, which was seen as wasteful and occasionally leading to lack of access or affordability for some of the less endowed, the marginalised and those encountering catastrophic ailments.

We lament the fact that up until now, Malaysia still does not have a declared policy of equitable healthcare for all (although in reality the huge healthcare subsidies are considered by many to approach such a system). Ideally, healthcare should be freely accessible for all, regardless of ability to pay, and should be based entirely on the basis of need.

Although the social aspects and ideals were widely discussed in this monograph, there was a distinct slant towards social equity taken in the context of the prevailing socioeconomic circumstances then. There was and still is that great need for courageous and prudent leadership in addressing structural as well as financial reform when it comes to healthcare.

Health Systems Malfunction—a Global phenomenon

Simply put, the past two decades have seen the unraveling of many health systems even among the richer first world economies globally. Healthcare costs have simply outstripped all economic projections and segued onto exponential trajectories, causing severe strains on national budgets.

Healthcare issues continue to arouse deep-seated partisan passions and disagreements that have become so central as to even destabilise and/or derail governments and leaders! This global phenomenon is now a core sociopolitical issue debated in every nation, rich or poor.

1 Hamish Meldrum. New Year message from the BMA's Chairman of Council. 31 Dec 2010. http://www.bma.org.uk/representation/newyearmessagehamish.jsp (Accessed 26 Jan 2011)

2 MMA. Health for All. 1999, Kuala Lumpur

The USA has been struggling with the more inclusive but mandated aspects of Obamacare vs. the Republican Tea-Party push for autonomous patient choice (with zero or as little government intervention as possible) with no regard for the huge 49.6 million uninsured.[3] And the new conservative UK government is trying to dismantle the 62-year old NHS by offering a radical GP commissioning restructuring programme in the vain hope of reducing healthcare costs by some £15 to 20 billion over the next five years; this is pitting primary care GPs against tertiary and hospital care.[4]

Surprised? The USA health system is about the most market-driven ever, consuming some US$2.57 trillion (17.3% of GDP!), with arguably the most superlative state-of-the-art care, but with huge problems of inequity: neglected uninsured poor and staggeringly high costs; whereas, the UK system has been a socialised state-organised single-payer system for decades, but with increasingly unmanageable delays and queues angering even the most patient of stiff upper lip Brits!

So what is happening? Such fraying of these entrenched systems is not entirely new. The troubles within the various if disparate health systems have been brewing for some time. The costs and structural tensions have been straining about its seams for decades, and are now finally close to bursting…

So it is questionable who has got its health system right, and it now begs the urgent question that "if it ain't broke, why change or mend it?" Because, there is no system the world over, which is of one size or one standard that fits all!

Knowledge Economy empowers greater personal choice and demand

Stupendous technological advances, diagnostics and therapeutics, have been so well-publicised that these are creating extraordinary demands for these scarce if initially exclusive and expensive technologies, surgeries and medicines. The result: more and more ordinary people are coveting these life prolonging or health enhancing treatments, all of which are simply overshooting most conceivable health budgets!

Compounding the problem is knowledge explosion and enablement for ordinary people. The Internet and WWW has empowered huge swathes of people with information, and created even more personal demands and wants!

More often than not such 'k' empowerment enhances more individualistic tendencies and self-focused behaviour.

That is a given. Knowledge begets personal power. Everyone has become more self-centred and more consumerist. Many are exposed to being more concerned as to individual rights, health and medical possibilities and 'cures' for themselves and their loved ones. Many would seek Medicine's best and especially last gasp therapeutic measures, regardless of costs or actual longer-term benefits.

So, how do we tell different groups of people that not everyone can have everything that he or she desires, especially in the current pervasive free market consumer-driven economy? Open society means non-filtering of data, which in turn means unfettered diffusion of knowledge to all who wish to access such information.

How do we explain self-restraint and eschew selfish demands to instantaneous gratification for quick diagnosis, testing and treatment? Who is to say which patient deserves to be seen first or cared for sooner? Who would have to wait and possibly suffer more pain and/or delayed complications, etc.?

How do we balance such growing demands for better, more select, more costly healthcare for a few, against the greater need for wider lower level primary care for more? How do we damp down these rising costs without appearing to curtail the free-spirited advances of medicine, of science, or the freedom to choose by patients?

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3 By Andrea M. Sisko, Christopher J. Truffer, Sean P. Keehan, John A. Poisal, M. Kent Clemens, Andrew J. Madison. National Health Spending Projections: The Estimated Impact Of Reform Through 2019. HEALTH AFFAIRS 29, NO. 10 (2010). doi: 10.1377/hlthaff.2010.0788

4 Department of Health. Equity and excellence: Liberating the NHS. The Stationery Office Limited, London, July 2010.

Rationalising the need for Reform is not universally an accepted given[5]

How do we persuade medical professionals and patients alike, that perhaps primary care gate-keeping is the way of the future? Would top-down edicts or dictates work? Would our society tacitly allow such a prescription of radical change without adequate consultative debate or choice?

In this day and age, it would be foolhardy to expect that such changes can be brought about without adequate buy-in by most if not the majority of the people. This is especially so, when more uncertainties rather than benefits appear in the preliminary pronouncements of the government, regarding the healthcare reform plans. Slogans such as 1Care remain nebulous and unclear, and are not convincing enough to encourage acceptance by our citizens, and certainly in the current form, not by the medical profession.

Many have asked why reform now? These reforms have been proposed due to concerns that healthcare costs have been escalating, particularly private spending, that there have been too much out-of-pocket (OOP) payments, that there has been possible duplication and wastage of utility of resources, and that the divide between public and private healthcare services has widened to worrying levels.

The Ministry of Health (MOH) believes that the private sector is not sufficiently disciplined or robust in addressing the growth of chronic ailments, and is not promoting primary care and health maintenance enough. The private sector is thought to be too disjointed and to have not been providing holistic or family care for patients. The MOH appears unduly concerned that there has been too much doctor-hopping/shopping resulting in poor continuity of care in the private sector. We have asked for specific data to prove this arguable presumption.

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Indeed, we have argued that the converse is true in practice. In the private sector, although the cost is higher, more patients and their families follow up with a specific doctor or group of linked doctors, than is the case in the public sector. Most private patients have family doctors who know them and their families intimately. We agree that for the more itinerant patients who doctor-hop around, or those who do not subscribe to seeking healthcare on a regular basis, this might occasionally be a problem.

But for these groups of sporadic and difficult patients, this would almost certainly also be the case within the public sector! We know for a fact, that patients following up with outpatient clinics or *klinik kesihatan*'s encounter a different doctor (MO) almost every time, or a medical assistant, and a different one at best! Most clinical notes and prescriptions are often hurriedly transcribed as harried doctors 'rush' to see through the long lines of patients! Otherwise, why should patients pay more to see private physicians, if not for greater personal and more attentive care? Also if patients were really poorly taken care of, surely market forces would dictate a discontinuation of such a failed relationship!

Notwithstanding such a preconception, the MOH understandably believes that its public sector functions more efficiently at offering this modicum of services, touting their capacity at addressing these healthcare concerns from 'womb to tomb'. We argue that because of debatable accounting methods (which do not take into consideration, infrastructure cost or manpower support staff and wages), the public sector healthcare is more costly per patient seen than that in the private GP sector.

Proposed Gate-keeping role of Primary Care Physicians feared...

One way to reduce healthcare cost is to restrict free access to doctors by any one citizen, especially to reduce self-referral behaviour to specialists and hospital. These have been shown to have an economic conflict of interest, which leads to possible over-use of already available resources and amenities.

So if every citizen can be registered, then this would perforce discipline everyone better to follow a prescribed path of healthcare access, through a primary care physician: whether a GP or a family medicine specialist. More importantly these primary care physicians would be the de facto entry point or access

5 David KL Quek. Health Reform in Malaysia: What should MMA's Response be? MMA News, August 2010.

person, from which to approach further secondary or tertiary care, i.e. they function as gate-keepers.

With such a system, it is hoped that healthcare costs can be better streamlined and kept under control. Direct referral to specialists or unnecessary testing or investigations would hopefully be discouraged and reduced, especially if reimbursement disincentives are inbuilt into the system.

Bypass the gate-keeping function of the primary care doctor and such medical bills will not be covered, i.e. this will have to be reimbursed personally, via costly OOP means. Government-assisted payment is only assured when the prescribed pathway is followed. Thus, the plan is to integrate the public-private sector at least at the level of primary care for a start, to create a seamless approach for all citizens.

But can such a system work, especially with our people being so used to the current 'free access' mechanism when seeking medical help? Do people want such a change when there would be a drastic restriction of access and care to one doctor? Do our citizens wish to be confined to one GP or FMS for all time? If not, how can anyone change doctors, and how easily can this be done? Would such GPs or designated doctors be forced down on the patients, as is already happening with the issue of foreign worker medical examinations? What about free choice, second opinions, etc?

Also how much would this cost the citizen? How much would this restructuring exercise cost? How much would everyone have to contribute to the planned social health insurance (SHI)? Or would such changes only lead to additional costs and additional taxes, without enough tangible benefits or coverage, or possibly with even less access?!

These are the pressing questions and concerns, which have arisen during our dialogue with doctors and citizen groups. Many are extremely worried that leakages (already legend with many government and government-linked entities) and inefficiencies would waste even more money and shrink their already meagre benefits with the current system.

No one is willing to pay more (through the SHI), when they are not reassured that the system would truly benefit them more and reduce OOP and costs! Why change if it benefits only a few concessionaires etc.? We have to address these perceptions, these questions, before we can get support from our increasingly skeptical and knowledgeable citizens.

Practical Concerns remain unanswered

Other more practical questions also come to fore. Can we exert control efficiently enough so that duplication and overutilisation of tests and services be truly truncated; that hospitals and tertiary care be services of last and evidence-based needed resort, without aggravating patient safety, endangering lives, even causing delayed therapies, precipitating or provoking complications or deaths?

> Most clinical notes and prescriptions are often hurriedly transcribed as harried doctors 'rush' to see through the long lines of patients!

Who would pay or be responsible for higher chances of medical misdiagnoses, delayed diagnoses, errors and mishaps possibly associated with such rational 'rationing' of healthcare?

How do we change physician behaviour that perhaps fee-for-service mechanisms may not be the best approach to rational healthcare cost reform? How do we convince professionals that they would have to accept a new reality and a possible modifying cut in fair wages for fair work based on a new paradigm? Would we be ready for case-mix DRG forms of reimbursements for health professionals as well as for corporate owners of for-profit private medical establishments?

What about the planned commissioning of healthcare services to selected consortia or regional trusts? Would these be carried out without the much-feared corruption or leakages crippling the process? Would private care survive such a change? Or would this go the way of secretive and preferential government-linked concessionaires so much a curse and exemplar of profligate waste and hiked-up costs in recent Malaysian sociopolitical discourses?

How indeed do we revolutionise an entrenched system such as ours, which can lead to probable disruption in healthcare, in reduction of choice for patients, in possible lowered and constrained professional autonomy and remuneration, as well as possible redistribution of resources and re-delineation of authority?

Clearly there is currently neither any simple solution, nor can there ever be.

Let us take the example of the current malaise in the UK's NHS reform. Health secretary Andrew Lansley has bulldozed his way towards extremely aggressive reform plans, which are now threatening to disrupt the much vaunted if flawed NHS.

Lessons from the current NHS stalemate[1]

In the wake of the financial meltdown of September 2008, the Cameron-Clegg administration seems bent on restructuring the NHS to reduce costs. This was unveiled in July 2010. Despite its purported public consultations, its rushed implementation has left much to be desired. But like most authorities, health secretary Andrew Lansley had not waited for much feedback before he unleashed the timelines or the details for the restructuring.

Sadly, this has cast a strong confrontation with the British Medical Association, which represents some 144,000 doctors in the UK. BMA, a doctors' union, argues that the NHS reform plans are potentially damaging. The rushed approach risks pitting groups of clinicians against each other, appearing to encourage competition in saving costs, which might actually be detrimental to patients' safety. Furthermore, it is not at all assured that this will bring about more prudent use of public money to enable the NHS to save a predicted £15bn-£20bn by 2015.

The BMA warns that there are many aspects of the reform proposals which could undermine the stability and long-term future of the NHS,"[6] Other critics of Lansley's strategy, such as the Royal Colleges of Physicians and Surgeons, have also warned that these measures would spell the end of the NHS in its present form.

BMA warns that changing the status of existing NHS providers to foundation trust status has threatened the character and ethos of NHS provision… Deploying more corporate entities could also destabilise the NHS, the security of its employees and their terms and conditions of service, it says.

BMA had also cast serious doubts on many of the policies, which are thought to be vital to improve NHS performance, reduce bureaucracy and improve the outcomes of treatment for patients.

In a robust message to Lansley, the BMA adds: "We urge the government and NHS organisations to focus on those areas where they can truly eliminate waste and achieve genuine efficiency savings rather than adopt a slash-and-burn approach to healthcare, with arbitrary cuts and poorly considered policies."

The BMA's stance questions the rationale of empowering family doctors fully with unprecedented autonomy, almost total influence over their patients' treatment, and control of the £80bn NHS budget through a switch to GP-led commissioning of healthcare, while leaving out hospitalists and specialist groups, thus leading to possible conflict and disagreements. Such a 'divide and rule' approach cannot hope to offer a better, more seamless health service for Britons.

Dr Hamish Meldrum, the BMA chairman, argues that doctors approve of some measures, such as patients having more say and a greater focus on outcomes. "But there is also much that would be potentially damaging. The BMA has consistently argued that clinicians should have more autonomy to shape services for their patients, but pitting them against each other in a market-based system creates waste, bureaucracy and inefficiency."

It appears that governments around the world are not dissimilar… Their pronouncements often have grave and momentous bearings on their citizens and for healthcare and medical professionals as well as for the patients and citizens!

We wait with bated breaths as disruptions and stalemate shake the very foundations in the touted NHS, which model, our very own MOH is trying to emulate!

Let's hope common sense and a greater consultative approach emerge, with most of the grievances and misgivings given a chance to be resolved for the ultimate good of the public! M

6 British Medical Association. NHS reform consultations, responses and briefings. 19 January 2011

Congratulations

The MMA congratulates the following members:

On being conferred the recent award by the

Seri Paduka Baginda Yang di-Pertuan Agong Tuanku Mizan Zainal Abidin

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DATUK DR KULJIT SINGH MAHINDAR SINGH
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DATUK DR AZIAH AHMAD MAHAYIDDIN
Darjah Datuk 'Panglima Mahkota Wilayah (P.M.W.)'

DR JELINAR MOHAMED NOOR
'Johan Mahkota Wilayah (J.M.W.)'