

Health Care Costs & Challenges for Malaysia (BERITA MARCH ISSUE)

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The past few months have brought a rash of health care issues into the spotlight—1Malaysia clinics, the recent extension of Full-Paying Patient scheme in public hospitals, announcement of better promotional exercises for government health care workers especially for doctors, pharmacists and dentists, extending public sector clinical services to GPs, ensuring healthcare quality issues, etc.

While the government is determined to improve access to health care for more and more Malaysians, underlying logistical problems and manpower constraints appear to hamper its smoother implementation of a more comprehensive cohesive system.

Perhaps one issue, which has not been adequately addressed or debated, is that of health care costs. Improving and modernizing health care systems and enhancing remuneration benefits as above, incur huge costs. How to find the funding needed, will pose a serious problem if not now, then surely in the near future.

Health Care Budget: Spending Cuts

The Budget 2010 for the very first time in years, allowed for greater cuts in public spending on health care than previously anticipated. A reduction of 4.8% from RM13.8 to 13.1 billion, might seem small when compared with other economic sectors, but may be more than what the public expects as we adopt newer and more costly technologies, medicines and even therapies to keep in touch with medical advances, year on year.

Developmental budget was also slashed, and most public sector hospitals have been informed that budgets have to be drastically cut, some upwards of 50%.

The private sector has been extolled to rise to the occasion by expanding its contribution, to help stanch the shortfall from public spending. But, this is most unlikely to happen due to the just recovering economy. Further, most Malaysians are becoming overly cautious to invest in enterprises or services that may be too 'risky', under the current climate of lingering economic and political uncertainty.

Reports of outflows of human and fiscal capital disturb the confidence of those who might otherwise have contributed. Most Malaysians however have adopted a "watch-and-see" approach, which essentially stalls the forward movement of real growth.

The emphasis on Medical Tourism as another engine of growth for the economy is also overstated, given the small potential addition to the country's coffers—the forecast growth to RM 2 billion target by 2015 (from RM 399 million in 2008), will only be a very small percentage of the country's overall GDP of more than RM 700 billion.

From our many meetings with the Ministry of Health officials on a myriad of issues, the MMA is keenly aware that there are several planned programs that are rearing to be implemented. The 10th Malaysia Plan (including the 1Care Health System) should be the new platform for spearheading even greater health care reform for the better. But because of cost constraints, limited financing options, and perhaps political correctness and lack of political will, many of these would need greater tweaking and feedback before these are acceptable to the rakyat.

Importantly, the MMA believes that more stakeholders need to be consulted so that adequate input can help bring about the best consensual reform that is needed to elevate our health care system to the highest level yet. Whether one likes it or not, populist sentiments continue to dominate any debates on healthcare issues.

Globally, health care costs have been escalating. There appears to be no exception for any country. This is because of two main reasons: 1) costly, technology-driven and relentless medical advances, and 2) rising expectations of better-informed patients, who demand for these created supply side tests and therapies.

The USA is the singular example of where runaway health care costs have stymied national growth, and caused great inequities of healthcare access. This humongous health care spending has now exceeded 16% of its GDP—a staggering USD 2.3 trillion! Despite this, some 45 million Americans are uninsured. Worse, this enormous cost does not appear to justify the benefits in terms of well-documented health measures, meaning that there is a lot of wastage. Not enough bang for the buck, so to speak.

President Obama wants to mandate that more Americans be insured, so as to be entitled to easier, more affordable access to its huge health care resources, while at the same time curbing overutilization and wastages of its finite means. But, such a drastic health care reform seems to be meeting great resistance from all quarters.

Healthcare Spending & Access Issues

What about Malaysia? Is our health care spending adequate or at par with the developed world?

In 2008, healthcare spending was still suboptimum in Malaysia, the government spending just 6.9% of its total expenditure on health care services (i.e. 2.2% of the GDP). The private sector came up with 2.6% of the GDP spending on health care. In 2003, Malaysians spent just USD 374 in total per person per year on healthcare expenditure, with the government contributing USD 218. This figure approached USD 400 per person per year in 2008 (RM35 billion for 27 million population; RM1296 per person).

This compares with USD 1156 for Singapore, USD 260 for Thailand, USD 2244 for Japan, USD 1074 for South Korea, USD 2874 for Australia, USD 2389 for the United Kingdom and USD 5711 for the United States of America (for the year 2003).

As can be seen, although we pride ourselves as becoming more developed than many other nations around us, we have yet to emulate those with better and arguably more advanced healthcare services. Can we expect 6-star services and comfort levels from limited 3-star spending?

Surprisingly, Malaysians remain disbelieving that we cannot expect the same level of healthcare services, when we have a subsidy mentality, we remain steadfast and unwilling to spend more, or to be taxed more. This is not to imply that our less endowed and poor should be left to the winds of survival for the fittest and the rich. We do have in place a great social safety net, perhaps much too abused by too many.

It is true that many detractors complain about the wastages and the leakages from corrupt political and rent-seeking practices so inherent in our Malaysian society, and urge that these be eradicated. They are adamant that money thus saved can then be rechanneled to such much-needed social and health services. But surely, this radical mindset change cannot be expected anytime soon!

However, our most recent Malaysian National Health Accounts show that we have steadily increased our healthcare spending to around RM 35 billion per year. In 2008, private sector outpaced public sector healthcare spending: RM 18.8 billion vs. RM 16.2 billion, or 53.8% vs. 46.2%, respectively.

Malaysian private household out-of-pocket (OOP) spending, forms the largest component of the private health care expenditure. OOP spending takes up 57.09% (RM 10.8 billion) of the total; with some form of private prepaid plans (e.g. insurance) contributing 11.9 to 15.7% over the years from 1999 to 2008.

This is clearly disproportionately high, and that is why many people in Malaysia complain about 'high' health care costs, although this is relatively true only in the private sector when compared with that in the hugely subsidized public sector. [Social security expenditure as a percentage of spending on health hovers only around 0.8%, mostly from withdrawals from the Employee Provident Fund savings (EPF).]

Public Aversion to Paying for Health Care

Because of the ingrained norm of having to pay so little or not at all in public hospitals and clinics (i.e. almost totally subsidized!), the Malaysian public does not feel that it has to budget for health or medical care, and this is reflected in many of our pensioners complaining of costly unplanned-for medical care. This is also reflected in our government's tentative allocation toward healthcare spending in our national budget.

There has been flip-flopping ambiguity from the MOH, as whether to allow market forces to dictate healthcare costs, but overall, there has been no public will to enact what could be unpopular. Suggestions to end free treatment at public hospitals and highlighting that rising healthcare cost is too heavy a burden for the government, had not been too well-received by the citizens. These plans have always been

scuppered after public protests. Instead to cater to the urban and rural poor, more health clinics with very basic amenities and sparing personnel have been set up to cater for easier if perhaps less sophisticated access for those who are poor or less endowed—hence, the 1Malaysia clinics.

Our health minister Dato' Sri Liow has admitted that the public hospital services are heavily subsidised by the government: RM12.9 billion or 98% of the entire budget, while patients pay only 2%! But, Dato' Sri Liow reiterated his views that government subsidies for patients utilising public healthcare facilities would continue (RM1 for outpatients clinic visits, RM5 for specialist clinic visits, and maximum RM50 for third-class ward hospitalisation costs), and pledged the populist view that such a quantum would continue, despite this being unchanged since the 1970s!

There is great expectation that the government of the day should not jeopardise this status quo, by instituting any mechanism that can bring about the 'unknown'—hence there is relatively little public or open debate on these issues.

Access Failure & Medical Assistance Fund

But concerns as to failures in access continue to pop up sporadically in the mass media. Poorer patients have resorted to the mass media appealing for financial assistance to help defray medical costs, especially for some costly or tertiary specialist care—almost weekly and sometimes daily, we get newspaper appeals for financial help.

Thus, this has prompted some stopgap measures such as setting up a Medical Assistance Fund (MAF) of RM 25 million, by the Ministry of Health. However, this fund can only be utilised at public or quasi-governmental healthcare facilities, and appeals have to be vetted stringently to ensure need and priority, which had drawn sharp criticisms of this being too bureaucratic and slow, even unfair. Yet another Emergency Fund (D'tik, an acronym for Dana Talian Insan Kritikal Yayasan Kebajikan Negara) has been set up. This fund of RM5 million, provides critically ill patients access to treatment within 24 to 72 hours, but is currently only available at Kuala Lumpur Hospital as its pilot medical facility to kick-start the programme. These two programmes seem to have become dormant of late with little news as to whether this are still functioning.

Clearly, such setbacks and failure of access imply that our healthcare system needs a revamp to enhance its capacities. Providing such public sector services at huge or near-total subsidy appears untenable and unsustainable, and still left gaps, which had to be filled by creation of some extra mechanism to expedite access (predominantly by offering extraneous funds and/or donations).

Thus, this explains in some way the government's tacit encouragement for the private sector to flourish and develop, in order to cater to the more willing, more discerning, paying citizens, and leaving the public sector to look after the less endowed. But attempts to regain some copayments from more affluent patients attending public healthcare facilities have been made.

Full Paying Patients (FPP)

What is MMA's stand on the issue? The MMA has always supported better remuneration for doctors and specialists in the public health sector, although in this particular issue of Full Paying Patients, the MMA has some reservations.

We have always been working closely with the MOH and the government including the JPA (PSD) for better conditions and wages and other perks for our doctors. We recognize that doctors who opt to remain in service often place a lot of their potential earnings on hold and sacrifice a lot for their civic duty and responsibilities. In the recent announcement by the Prime Minister, the enhanced and accelerated promotional exercises and benefits for doctors are therefore greatly welcomed.

So in this context, should the MOH allow specialists in the public hospitals to be given a choice to have private practice? Earlier this was in the form of limited private practice at private medical centres and the universities to help make their service conditions more attractive, and perhaps to help retain their much-needed services in the public sector.

Whilst this has possibly helped to stem the outflow of experienced staff to the private sector, this approach has been criticized for some abuses, especially when found within the same hospital's private wing.

It has been pointed out repeatedly that some specialists appeared to spend more time in private practice than in the public health facilities, thus undermining the services provided for the less privileged.

Some poor patients have also been asked to go to the private wing or centres for quicker access for some surgeries or procedures, which has caused complaints of unfair rationing, pressure and preferential treatment.

Therefore the MMA supports that better regulatory limits be put in place to clearly define how many hours doctors can work in the private sector vs. the public institutions, where the patient load is far more onerous.

The approach of using public hospitals for full paying patients may put the pressure on doctors to subconsciously prefer these patients and may encourage queue jumping and even undermine natural justice of fair waiting times and queues for limited resources. This may be a natural human response to immediate 'reward' for services, but is unfair in the context of a public sector expectation, where equitable care should be the standard.

So we hope the MOH and government would seriously reconsider this move. Particularly at this time when the economy is far from being healthy, and many people are still reeling from the financial crisis. Perhaps a better system of health care financing or insurance can be put in place before embarking on this sort of "luxury" or "Cadillac" buying move for healthcare services.

Nevertheless, the MMA has always been worried about our very heavily subsidized health care, so much so that our rakyat do not seem to understand that health care is not free, someone has to pay for it! Having a system where the poor pay only RM1 for clinic visits and medications is not sustainable in the long term, no matter that this seems to be politically correct, and popular!

So the government has painted itself into a corner. We recognize that the government would love to continue to provide nearly free medical and health care for everyone, but the mechanism for financing this is far from adequate or structured sufficiently well. We do not have enough allocation for such a heavily subsidized system of health care.

There has to be a form of tax or insurance buying that is big enough and purely allocated for health care for this to work. But is the rakyat ready for this new form of tax or social insurance scheme? Perhaps the time has come to bite the bullet and expose the reality behind the health care costs—there are no short-term measures just for political grandstanding moves, which cannot be sustained.

Will such a copayment scheme help pay for costs of health care? A report from the Selayang Hospital FPP experience showed that in 2008 and 2009 respectively, some RM 1.794 to RM 1.717 million per year were generated from this Full Payment Patient scheme. This catered to a total of some 1,830 to 1,649 patients respectively, with the bulk paid for from in-hospital services (RM 1.35 to RM 1.47 million) but actually catering to only 497 and 499 in-hospital patients, respectively. Specialist doctors receive 30% to 90% of the services provided, but the actual quantum was not specified.

Considering the amount of money retrieved by one such hospital experience, the MMA is not at all convinced that a sufficiently large financial return can be collected to overcome the subsidies that the government has to dish out so far. We are talking about RM13 billion of health care expenditure per year, so even if all the main tertiary hospitals embark on this mode of financial reimbursement scheme, it will be a small fraction of the total...

Unequal Treatment Fears

Given the above scenario, will 'subsidized' patients be given fair treatment in the public hospitals? There is always the fear and perception that poor subsidized patients would be shortchanged and asked to wait longer, or even be pressured to move toward the full paying side for "quicker" queue-jumping accelerated care. This cannot be denied. And unfortunately some poor patients have every right to feel this to be so. Because every ill patient would surely like or even demand diagnostic testing and treatment at the quickest possible time!

However, for urgent treatment including surgeries for emergencies, the rakyat need not be too worried. All doctors and health services will always give preference and priority for emergencies, no matter whether one can afford to pay or not. This fear of being ignored or waitlisted is unlikely to happen because there is always the medical "need" consideration, which will always give such patients the leapfrog priority for all

urgent or emergency cases to the front of queues for treatment. However, perception and possibly experience may be different in reality.

For less serious conditions however, when this is not life threatening, there could be some inconvenience and possibly longer painful periods of waiting for their turn, e.g. hip/knee arthritis or stable angina patients.

There is a suggestion that the government reverts all health care personnel to be paid like the IJN model, where premium salaries are paid to help retain personnel and encourage greater dedication to work. This has helped to reduce staff turnover (to less than 3%) and greater stability of available experts and other personnel and also more consistent service availability.

In other words, there is a suggestion that we develop an entirely different salary scale for the health and medical services, perhaps even a dedicated Medical Services Commission, parallel but outside the Public Services Commission. This has been suggested, but may not be feasible, as someone still has to find the funding for such a Service Commission. Also other professionals from other services may then also demand their own commission, so where do we stop?

But this identification that doctor salaries are the main costs of this exercise is also misleading. Salary or remuneration costs while important and high, form perhaps just 20 to 30% of the costs of health care in most countries' health care expenditure. The concept of full paying patients is also to collect for the other services and other components other than doctor fees. So the larger subsidized component still remains unaddressed.

Partnership: Collaboration Vs. Integration Of Services

The health minister Dato' Liow has said that "Government and private sectors should work together. Because the doctors that we train are for the nation, irrespective of (whether they work for the) government or private. Doctors are serving the people. In Malaysia, 41 percent of our population go to private hospitals and clinics and 59 percent go to public health institutions. Therefore, the private sector is playing an important role to ease the burden and also the workload in government hospitals."

It is heartening that the current health minister is enlightened and positive about this private sector contribution. It is with this in mind that the MOH has recently invited GPs to register and help participate in MOH health clinics throughout the country.

However, whether this goes on into a viable full partnership, is left to be seen. But we certainly encourage all our members to participate and help make this collaboration succeed. Therefore, this is an opportune time to ensure that these mechanisms for better partnership between public and private healthcare sectors be further forged to facilitate closer and more meaningful collaboration.

Toward a More Efficient System

We do need some reform of the health care system, but this has to be done carefully with the rakyat fully understanding that no government can continue to heavily subsidize health care to the tune of 98% in the public health sector! There is no free lunch in health care services, and the sooner the people understand this, the better.

The rakyat has to learn to accept some form of copayment, either from specified taxes, social health insurances (similar to EPF or SOCSO), and the government cannot sidestep this issue much longer—a dedicated allocation from such a mandated community collected financing scheme is the best way forward. Finding the exact numbers and correct formula is the tremendous challenge, but it is not impossible. It can and should be done, soon.

In his book on '**Good and Bad Power**', Geoff Mulgan (a British political scientist) discusses that while most governments provide the structure, it is the more comprehensive, well thought-of infrastructure provisions that lead to transformative services—that "much of the recent thinking about service... has adopted models from the private sector... largely drawn on industrial... models favouring speed, standardization, flow and efficiency." He went on to describe: "(t)hese services are human, immediate, personalized and rich in communication, anticipating need rather than just meeting it and 'going the extra step.' In the case of therapeutic services the servant's job is to change the master, to make him healthier, fitter, and happier."

In a paper on the Singapore model of public-private partnership, Dr MK Lim identifies 3 key questions which should be answered: (a) how to raise revenues to pay for health care; (b) how to pool risks and resources; and (c) how to organise and deliver health care in the most efficient and cost-effective manner.

It is clear that there is no foolproof system anywhere on the globe. Some of the more successful models involve a mix of safety nets with monitored privatization/corporatization of services and allowing 'coopetition' (competition and cooperation) to thrive. Dr Lim further argues that "even in Europe, the sustainability of health care systems founded on egalitarian welfarism is increasingly being challenged as growth in demand outstrips supply. The debate is no longer about 'who should pay?' or 'who should provide?' but 'who can do the job more efficiently?'"

Thus, as our two-tiered system is now so well entrenched, we should find ways and means to ensure that it works better and more efficiently, where we can synergise our efforts to provide good quality, safe, and cost-effective healthcare for our patients.

However, this must not only be affordable but also be self-funding and self-sufficient. Where too much bureaucracy bogs down the better productivity and efficiency, these should be dismantled and restructured in ways that encourage best practices, and which empowers and benefits the patient ultimately.

Full integration of private-public healthcare sectors appears unlikely (although this is one of the strategies of the MOH), but better partnership and collaboration of services can be aspired to, where the best of each system can be harnessed for the healthcare betterment of our citizens. We should aim for a more cost-effective system, although not necessarily a lower cost one. A single or easily portable system of reimbursement should also be considered.

While corporatisation/privatisation is still much feared and deeply unpopular, as a model of divesting central control of unavoidable rising costs and developmental constraints, this might be the way to go, if the model for market-driven healthcare is adopted. This is the model practiced by Singapore, with its well-trying and tested schemes that can be tweaked to respond to the many diverse facets of healthcare peculiarities. Or conversely, a single-payer (and/or single insurance) National Health Service mechanism could be introduced, learning from the examples of say, Taiwan, Canada or the UK.

Whatever the decision, the government must make greater efforts to engage and explain to the public the policy directions that it wants the country to advance with regards healthcare services. The MMA stands ready to assist in any way to bring about the best system that is livable, affordable and acceptable for all Malaysians.