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Health Reform:

Understanding the Social Dynamics of Health equity & costs, Government's role, Public response and responsibility

"Those whose perspective is limited are likely to err in judgment, taking wrong turns, making bad judgments, and inflicting harm on others... Narrow-minded thinking undermines dynamism and prosperity... The ancient saying that goes, literally, 'The thinking of a wise sage turns thrice a day,' is meant to say that the sage is always receptive to new ways of thinking—that is, ready to learn new lessons and see by fresh perspectives. It behooves us to avoid rigid ways of thinking."

~ Konosuke Matsushita (Founder of Panasonic)¹

"In every country, regardless of its economic position, the future is likely to include severe pressure to increase value for money in healthcare. Governments will need to respond intelligently, or face public/voter acrimony, a loss of solidarity underpinning healthcare, and avoidable ill health, that in turn damages economic prospects. Given the great difficulty of examining the impact of different, often diffuse policies, the necessarily limited evidence base, and the length of time needed to develop policies and implement them, decisions as to the best approaches to reform may be necessarily based more on pragmatism, experience, instinct, and ideology than evidence. Pooling international experience here will be crucial and may help to short cut years of otherwise well-intended but ineffective reform."

~ Jennifer Dixon and Vidhya Alakeson, Nuffield Trust²

Health—an indispensable social structure

Most people accept that health is a human right. Everyone expects that whenever anyone falls ill or suffers an injury, he or she is entitled to some form of treatment, especially first aid or resuscitation, even lifesaving surgery. The question of costs is usually not considered upfront, and is regarded distasteful if broached or worse, demanded!

It has become an accepted custom that society finds some mechanism to pay for such a system of entitlement. It would appear socially unacceptable even reprehensible, if a patient presents to any health facility and is turned away because of inability to pay for the service, worse if the injury or ailment appears life threatening!

However, despite this expectation, it has always been known that if one goes to a public sector health facility, some degree of waiting and queuing is in order. And unless this is grossly or unbearably prolonged, most patients would accept such a mechanism of service, given the constraints of reality—people sort of know that there is some need or basis for prioritising, for triaging, for rationing; although sometimes this sequence of events may be broken and loudly complained about.

Historically however, healthcare has had a checkered and less salubrious past. Even as recently as the last 18th-19th century, most people could not afford 'professional' medical care. Medicine though long in history, was still at its infant magical if wondrous best, with more diagnostic physician prowess than actual lifesaving therapies or cures.

¹ Konosuke Matsushita, *The Path*, McGraw-Hill, New York, 1968.

² Jennifer Dixon, Vidhya Alakeson. Reforming health care: why we need to learn from international experience. The Nuffield Trust Briefing, September 2010.

These days more than 100 countries boast a commitment to the right to health or health care in their national constitutions.

Clever prognostication or dubious amelioration of pain and suffering appeared to be the usual outcome of then medical encounters. Poor houses were aplenty where quasi-scientific medicine was practiced. The hapless ill and the poor were often tested upon for case studies or for much needed experience building for younger aspiring doctors/surgeons. Many ordinary people had even less rights than perhaps even a domestic pet or a draft horse.

More than anything else, public health measures such as sanitation and sewage reforms ultimately changed the dire consequences of the squalid ghettos, tenements and working and living conditions for the indigent. Doctors then only performed house calls or carried out highly dubious surgeries, bloodletting, leaching, cupping, blistering, etc. for a fee, or for some barter exchange of goods or services. Wandering 'surgeons' and stone-cutting, cataract-extracting barbers were the lesser peripatetic tradesmen who thrived on providing some painful 'cures'.

The poor really did not have any assured access to any doctor. At best they availed themselves only to traditional 'snake-oil' health restoratives and old wives' tales of magical panaceas and 'cure-alls'. Social conscience did not really pervade the 19th century

until enlightenment gradually resulted in wider egalitarian spread of ideas, humanising man as man and not man as indentured serfs or slaves!

However, over time most countries of the world have accepted the moral imperative that attaining the best possible standards of health is an inalienable moral and legal right.³

Health as a Human Right

It was the 'British laws' in 1802 that led the way in establishing that 'health' was a civil right and expected public goods, triggered by the dreadful health conditions and threats among the destitute of the Industrial Revolution.

In 1925, Chile became the first enlightened nation ever to incorporate the right to health into its constitution. Surprisingly, despite its capitalistic bent, 72% of Americans strongly believe that healthcare should be considered a human right, in a poll undertaken in 2007. However, this is not enshrined in its constitution or laws.⁴ Therefore, America remains ambiguous about labeling health as a human right. While the United States is a signatory to ICESCR (International Covenant on Economic, Social, and Cultural Rights), it has yet to ratify this key treaty, unlike the other 160 nations.

A recent paper exhorts for a more enlightened premise for American healthcare:

"It is an assertion of the responsibility of governments to strive for 'the highest attainable standard of physical and mental health.' It is an asseveration that governments will respect, protect, and fulfill the right to health by ensuring the availability, accessibility, acceptability, and quality of the care required. It is an averment that governments will honor the tenets of accurate information, non-discrimination and equality, and participation. It is an avouchment that governments will address the 'underlying determinants of health' such as sound housing, clean water, and adequate nutrition, especially as these determinants apply to the needs of poor and other marginalised populations."⁵

3 United Nations, Economic and Social Council. Substantive Issues Arising in the Implementation of the International Covenant on Economic, Social and Cultural Rights (ICESCR): General Comment No. 14: The Right to the Highest Attainable Standard of Health. <http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En>. Accessed November 22, 2010.

4 The Opportunity Agenda. Human rights in the US: opinion research with advocates, journalists, and the general public. August 2007 http://opportunityagenda.org/files/field_file/Human%20Rights%20Report%20-%202007%20public%20opinion.pdf. Accessed November 22, 2010.

5 Eric A. Friedman, Eli Y. Adashi. The Right to Health as the Unheralded Narrative of Health Care Reform. JAMA, December 15, 2010; 304(23): 2639-2640.

These days more than 100 countries boast a commitment to the right to health or health care in their national constitutions.⁶

Thus aligning oneself with such social scruples as 'health for all' is a fairly modern societal phenomenon. We all believe that attaining health is a rightful and timely human development goal for everyone.

Sadly however, healthcare equity appears once again to be overshadowed and challenged by a rising consumerist-capitalist mindset. Many people increasingly deem self-preservation as their overriding personal philosophies of self-interest and self-advancement. There are mounting qualms of yielding too much perceived individual sacrifices, and diminution of individual space and choice, in deference for the avouched 'greater good' for more people or others...

Simply put, every man wants only to pay for those things or services, that he can afford for himself and perhaps for his immediate family: he is less willing, even unwilling to contribute to the benefit of others, unless forced upon him to do so by certain laws or authority, i.e. an overarching hegemon, a Leviathan.

Of course, many of our more socialist-minded colleagues might take exception to such a deconstruction of our healthcare dilemma or such a cold depiction of our self-interested persona. Perhaps in reality there might be more selfless religious practitioners, altruistic persons than they have been given credit for. Many do believe that healthcare is an irrevocable human right—that governments of all nations have a duty to provide adequate allocations to ensure such a non-negotiable social prerogative!

My personal social perspective is generally altruistic, but also realistically sober. I have always enunciated such a stand, that man needs to be more humane, more human—this is ideally, politically correct. Pragmatically however, rising costs and competing demands have made such a commitment extremely difficult to follow-through, for many people eking out a living! Hence, I also understand that more and more people are drifting toward a less charitable self-serving mindset... notwithstanding the fact that we continue to constantly remind ourselves, and others, of society's inherent goodness—that we must be greater than our sum of individual identities and self-interests.

But I have been accused of being too preachy, too idealistic, too goody two shoes, which often rankles

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many who simply wish to be left alone to their own devices... Many would simply switch off, rather than to be bothered by conscience-disturbing 'noises' or moralising sound bytes!

Health vs. Competing Public Goods & Services—Reality of Rationing Care

Our complex society however, ensures that we have even more convoluted contending requirements or partisan needs. The harsh reality is that healthcare is simply just one of the many competing public goods that most governments have to juggle with, particularly with finite yet gradually diminishing fiscal resources. Everyone is always trying to appease and accommodate disparate if expedient and politically-correct rival demands. There is no right or wrong in this, certainly no one model that encapsulates the best approach.

Thus, there will always be some degree of healthcare rationing or compromise.⁷ Some have argued however, that governments which under-capitalised their health system tend to get away by under-servicing and under-provisioning, thereby justifying the very limited services available to their charges because of this low or under-allocation of funds.

Lack of supply side services would invariably lead to greater delays and queues. This in turn, directly or conveniently discourages public demand due to enforced wait times: for some, inability to wait leads to

6 Kinney ED, Clark BA. Provisions for health and health care in the constitutions of the countries of the world. *Cornell Int Law J.* 2004;37:285-355.

7 Donald W Light, The real ethics of rationing. *BMJ* 1997;315:112-115 (12 July)

Healthcare Reform: Issues & Economics of Integration and Reimbursement Mechanisms

Date: Sat, 16 April 2011

Venue: Sime Darby Convention Centre
1A, Jalan Bukit Kiara I,
60000 Kuala Lumpur, Malaysia

Time: 3.00 - 6.00pm
Forum (open to the public)

6.30 - 9.00pm

Networking Dinner (for invited guests and all NUS alumni)



SPEAKERS



Health Reform in Malaysia: 1 Care & Public-Private Integration
Uncertainties & Future of Private Health Sector

Dr David Quek

Consultant Cardiologist
President, Malaysian Medical Association



Comparative Reimbursement Mechanisms in Health care role
of Case-mix/DRG vs. fee-for-service

Prof Dato Dr Syed Mohamed Aljunid

Professor of Health Economics & Consultant Public Health Medicine
United Nations University – International Institute of Global Health



Health Economics: Singapore vs. Malaysia experience
-is change worthwhile or beneficial?

Dr Phua Kai Hong

Associate Professor of Health Policy & Management
Lee Kuan Yew School of Public Policy
National University of Singapore

ENQUIRIES

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The harsh reality is that healthcare is simply just one of the many competing public goods that most governments have to juggle with, particularly with finite yet gradually diminishing fiscal resources.

resorting to private care; or for others without means, stoically resigning to the fate of waiting in lines—the ultimate unvarnished truth of the powerless...

Fewer people are willing to pay for others who have not seen fit through their own personal efforts or capacities to help look after themselves, their families and their own socioeconomic interests. Everyone is expected to make reasonable contributions toward covering such eventualities. 'Fend for yourselves', everyone seems to imply. Certainly not everyone can.

Because, there would certainly be those who are genuinely destitute or disadvantaged—they cannot afford to contribute beyond their 'poverty' level. Disposable income is already very marginal among the poor in most countries. Health just does not figure high up in their hierarchy of immediate personal or family needs! Sadly, in many parts of the world including developed nations, this group of the poor and the marginalised is growing.

In the USA alone nearly 50 million people are uninsured.⁸ They are thus exposed to the extreme

whims and the flawed quality of erratic healthcare, mostly via emergency department visits with no long-term follow-through solutions to their more chronic ailments! Thus, health outcomes remain sub-standard and below that achievable by those who have insurance or means.

For the poor, most people expect the government to take care of this, in as unobtrusive a manner as possible, preferably without jarring our own comfort zones and our conscience. We expect the government to provide these social safety nets, at bare minimum encroachment on others, certainly not to reduce the expected benefits for ourselves. Certainly this is the overriding version of the American psyche, which threatens to miscarry the Obamacare health reform—notwithstanding the sporadic clanging discordant sound bites from the "Michael Moore"s of alternate views.

Many Americans and I dare say even Malaysians, are simply not prepared to spend any more to help others, merely because the latter cannot afford to do so for themselves. Modern society is more self-centred and less altruistic. Paradoxically however, the latter characteristic is demanded of medical professionals, and perhaps also of the governing authorities, which should somehow provide the necessary facilities and source the appropriate funds!

The difficulty in offering any modicum of healthcare service is that this is an ill-defined bottomless pit. What and how much healthcare can be provided as universal coverage for all? What constitute indisputably as necessary services? How do we determine unavoidable variations of coverage? What about less evidence-based, more questionable or very marginal benefits of some care options? How does one define what constitutes emergency care or barest basics medical care, fully accessible to everyone? Or should every conceivable healthcare service be made freely available to just everyone?

The complexity is trying to agree on the minimum basket of healthcare services that everyone is entitled to, without undue strains as to costs. We expect this would be provided as an inclusive basket of rights, through prudent payroll or government tax revenue allocations, and hopefully not through another reimbursement mechanism or another additional levy, social health insurance, whatever, etc. Remember, most Malaysians are already against any idea of a GST type

⁸ 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); pg 3.

of taxation, which penalises the poor more than the rich...

Where can we keep a lid on expectations to whatever comprehensive medical care possible? If someone has say, a cancer—how does one define how far to go with investigations, surgery, treatment and even access to experimental if marginally beneficial drugs, which cost astronomical sums? How much is a human life worth to keep sustaining or prolonging—a few years, a few weeks, or days?

What about a debilitating stroke or heart disease? Who should provide for some or all of the possible therapeutic modalities? Already many people balk at having to take a polypharmacy of medications to reduce risk factors and improve function and survival. Does age or mental capacity or terminally-ill status, factor into this equation to provide or deny some of these quasi-beneficial treatments?

Costs can run into a significant portion of anyone's wages, so who should subsidise, or should this be provided as a privilege, without co-payment, etc? This is indeed the crux of why a collective social health insurance is so useful and a fairer mode of community-distributed risk sharing, why we should urge everyone to buy-in. Major catastrophic illness can and has bankrupted many people before and would do so again in the future, unless hedged by some form of community risk sharing.

Yet the converse is also alarming; the uninsured have poorer control of their diabetes, high blood cholesterol levels or achieving blood pressure goals. Not surprisingly, many uninsured in America are also those who have badly managed risk factors and therefore more inclined to suffer more complications and suffer poorer health outcomes!⁹

Catastrophic illness and end of life care is frightfully expensive and accounts for as much as 60 to 95% of all lifetime healthcare costs!¹⁰ Would this economic consideration be different or the same for say a young person vs an elderly dying? Whose life is worth more and whose less? Can we play God? Should we? Would such huge costs be better applied for more life promoting healthcare for many more people? Would the rights of the many subsume to or override that of one special case?

More and more health authorities now recognise that some form of co-payment or premium payments toward some form of social health insurance, is needed.

Socio-economic Realities & Essential Government Role

When it comes to healthcare, economic and social realities dictate that some form of rationing always has to be put up with. There is usually some agreed upon basket of health and medical services, which would form the bare minimum basis of access for all. It is rare that every possible test, medication or care is readily or fully accessible to everyone, on demand, or even when in need.

No health system in the world can provide every possible healthcare service on demand to everyone, without some constraints or queues. But for those who are able or willing, private purchase of such services is often expedited without delays and upon demand. This approach is impossible without free market mechanisms to private care access, but this is way too expensive for just about every person!

No system can survive without government intervention and contribution of government tax revenue allocations. But even this is proving to be too much for most modern budgetary prudence. Demand

9 Schober SE, Makuc DM, Zhang C, Kennedy-Stephenson J, Burt V. Health insurance affects diagnosis and control of hypercholesterolemia and hypertension among adults aged 20-64: United States, 2005-2008. NCHS Data Brief, no 57. Hyattsville, MD: National Center for Health Statistics. 2011.

10 Mike Mitka. Hospitalizations for Extreme Conditions Mean Extreme Expenses, Study Verifies. JAMA, December 15, 2010; 304(23): 2579-2580

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nearly always outstrips supply. There is always that moral hazard of everyone who is ill to demand and to expect to be tested and treated—early, quickly and comprehensively—often over-utilising scarce or limited facilities and costly resources.

Thus, there is growing need for citizen education, input, contribution and empowerment too—there needs to be buying in by citizens. More and more health authorities now recognise that some form of co-payment or premium payments toward some form of social health insurance, is needed. This is crucial so that everyone then has a responsibility in knowing that because they are contributing to this finite fund, they have a joint duty to use this fund prudently and responsibly, and with collective social conscience.

It is important that every citizen recognise that health is an essential social service which although usually provided for or 'guaranteed' by government, is not a given.

Many lesser-endowed countries usually do not apply sufficient attention or resources to this sector, which is why poorer economies have citizens who have poorer sanitation, more communicable diseases, and shorter life expectancies. They generally lack access to even basic healthcare services, suffer high maternal and child mortalities, and most need to pay extraordinary out-of-pocket expenses to buy even a small modicum of medical services.

But enlightened governments usually allocate sufficient resources to health as a critical social service, which is provided through tax revenues or specially apportioned allocations or levies. However, there must be true accountability and transparency as to the use of such funds so that people can feel satisfied that there is as little wastage and leakage from administrative or improper practices. Otherwise, this will prove to be very unpopular and many among the citizens would resist such an extra form of GST-like taxation.

If everyone understands this social need for such a contribution, then it would be easier to discuss the harder options more sanguinely. It is critical to explain that there is no such thing as a 'free lunch' in healthcare, because demand for health services will almost always exceed any country's finite resources.

But unfortunately for many Malaysians, there have been confusing stands made by the authorities: on the one hand pledging free healthcare for the needy, while on the other, also asking the rest of the public to pay more. The government appears to be flip-flopping, making reassuring sporadic pronouncements of free or almost free healthcare services, especially during political posturing, while also warning about subsidy removals, when in more sober moments of tackling budget deficits!

Greater Government allocation for Healthcare Critical

Of course, this is not to deny the fact that our very poor citizens need to be protected—that we need a more robust structure of social safety nets. But apparently we do have a large segment of our population whose family income is less than RM2000 per month, which would place them in the "poverty" level, even if not defined as hard core poor. There is an estimated 40% of the working population under this category! This is indeed a huge burden!

Because of this, most civil society advocates have urged our government for larger allocations for healthcare, up from the current 2.1% to at least 4 to 5% of the GDP. This might help boost private enterprise contribution by a similar margin, whose current contribution amounts to only 2.7% of the GDP^{11,12} So do we have the political will to do this well and fairly? Instead of the usually paltry RM12 to 13 billion a year, an allocation of some RM25 to 30 billion would certainly help boost the coffers for much needed restructuring efforts, catering to the poorest and the needy.

11 David KL Quek. Budget 2010: What's in it for Health Care?

12 Ministry of Finance, Government of Malaysia. National Budget 2010

Major catastrophic illness can and has bankrupted many people before and would do so again in the future, unless hedged by some form of community risk sharing.

Importantly, how do we allocate these much-needed funds more openly, more prudently, so that citizen misgivings and resistance can be allayed? This will be the true test of the government's sincerity and commitment to good governance in the delivery of such dutiful intrinsic public goods and services!

We have to move away from entitling concessionaires or special interest groups or companies to handle some of these critical services. Special negotiated contracts should be done away with; they reek of too much cronyism and rent-seeking patronage, which not only have become despised buzzwords, but also increase costs without the attendant benefits of cost-effectiveness. This results in unnecessary leakages and decreased productivity.

Transparent and prudent allocation of funds would encourage our citizens to accept greater contribution towards some collective sharing of healthcare costs and community-rated insurance, when they know their money and tax contribution is well spent.

The MMA urges the government to set up a more structured healthcare social safety net system, which must include such crucial need-based Medicaid, Medicare and CHIP (for children). This social construct already available in many developed nations, would be that crown in the accepted array of government sponsored public goods, funded from tax allocations. Such subsidised care would exempt these poorer or retired (non-economic-wage earning) groups from contributing to the planned SHI. With this in place, we can then calculate more accurately how much

each paying citizen can contribute, as painlessly as possible!

The most important part of any health reform is the appropriate and frugal utilisation of this finite health fund, the actual structure of the services, which should not marginalise or sideline any stakeholder. Most importantly our public and our patients should not be the worse for it due to disruptions caused by inept, technical or corrupt glitches!

Dialogue & Consultation with Civil Society Vital

Medical doctors should be at the forefront of such changes and must be allowed the greatest feedback and consultation, as they are the ones on the ground running. They have enough clinical experiences, albeit not the technical knowledge about macroeconomic costs and personnel requirements, etc. of how to exactly do what is right or practical.

It is true that doctors would have their vested interests, but collectively doctors have always been greater than their individual selves. Most medical groups would always tend toward the greater public good, while subsuming their own self-interests.

However, most doctors just do not have the expertise, energy or time to study these restructuring plans in detail or minutiae. Sadly, we do not even have any comprehensive documents to review or study, for helping to streamline or improve some of these plans and programmes. This contrasts starkly with the nearly 100 odd publications and technical details made

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available on the new 'Liberalising the NHS' reforms, first mooted last year!^{13,14}

But as interested professionals with responsibilities, the MMA must rise to the occasion and immerse itself into this process, and our members must be more ready to participate in this ongoing dialogue. Otherwise, we would truly be marginalised and left on the wayside!

Sadly too there has been a desperate dearth of research and publications (whether for discourse or debate) on many of these absolutely necessary health policy issues. Our Universities must do more to encourage more academic as well as research-based practical, economic and policy health studies, so that we can have clearer definable information about 'real' data from the ground, which can help create better systems.

Physicians must take the lead; we cannot afford to be apathetic and adopt a 'couldn't care less' attitude! Neither would it do, to simply complain on the sidelines—we must get involved and participate by coming forwards to be engaged in the process and in helping to steer the direction of healthcare transformation. Griping and hoping that interested physicians out there and 'others' would do the job for them, is just what is wrong with the process these days. More must come forward to actively take part, and play a more critical helpful role.

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Medical professionals must take part in understanding and studying these consequences of changing healthcare across the globe, and particularly in this country. We just have to! No one else would understand the healthcare scenario better, if we allow the powers that be a free rein at structural reforms, which could impact the profession, our patients and the public, radically and irreversibly!

But recognising these physician-led social duties and responsibilities is not new. In the 1930s just after the Great Depression, the Committee on the Costs of Medical Care, chaired by Stanford University president, Dr Ray Lyman Wilbur, recommended that "Medical service should be more largely furnished by groups of physicians and related practitioners, so organised as to maintain high standards of care and to retain the personal relations between patients and physicians."¹⁵

So, it is this constantly shifting dynamic of balancing demand with need and supply at the best cost-efficiency that most nations try to achieve a modicum of equilibrium. Otherwise, these nations face runaway healthcare costs and fractured disruption or meltdown of their health services!

The leadership of the American College of Cardiology recently urged physicians and public policy makers to work together when enacting any major changes in

13 Department of Health Services, UK. Liberating the NHS: Legislative framework and next steps. 15 December 2010. <http://www.dh.gov.uk/en/Healthcare/LiberatingtheNHS/index.htm> (Accessed 20 Jan 2011)

14 British Medical Association. NHS reform consultations, responses and briefings. 19 January 2011 http://www.bma.org.uk/healthcare_policy/nhs_white_paper/consultationpaperswp.jsp (Accessed 26 Jan 2011)

15 Falk IS, Rorem CR, 1. Ring MD. The costs of medical care: a summary of investigations on the economic aspects of the prevention and care of illness. Chicago: University of Chicago Press 1933:515-93.

Statistics according to State and Category of membership as at 28 February 2011

No	State	Ordinary Members	Life Members	Total	Student Members
1	Johor	247	394	641	31
2	Kedah	319	196	515	117
3	Kelantan	85	105	190	35
4	Melaka	179	181	360	725
5	N. Sembilan	145	225	370	34
6	Penang	239	406	645	162
7	Pahang	109	153	262	12
8	Perak	726	549	1275	181
9	Perlis	95	21	116	1
10	Sabah	250	232	482	125
11	Sarawak	348	286	634	153
12	Selangor	613	830	1443	169
13	Terengganu	40	45	85	16
14	W.P	635	912	1547	135
15	W.P Labuan	3	6	9	0
GRAND TOTAL		4033	4541	8574	1896

Overseas Members = 129

Exempt Members = 322

Honorary Members = 7

Associate Members = 3

health care reform, especially when it comes to point-of-care professionalism where standards and quality of patient care must not be compromised, in the continued search to contain healthcare costs:

"The right amount of care and how best to deliver it is uncertain. Medical care is a point-of-care interaction between the patient and a clinician. It is a blend of the observations, fears, and concerns of the patient balanced by the expertise and experience of the clinician. This joint decision-making is a balance of the art and science of medicine. At its best, it is exceptional. At its worst, it can include inappropriate care because of knowledge-based deficiencies or even personal financial gain. In truth, it is easier to identify blatant overuse than errors of omission... The goal for the best healthcare, however, is not harmonisation of a utilisation map but deciding the right amount of care at the right time."¹⁶

But more than 20 years on, the dynamics have changed tremendously—we have seen the establishment of even more private hospitals and clinics, which have grown to absorb some 62% of the outpatient clinic consultations of the Malaysian public, some 65 million patient visits out of more than 100 million such

outpatient encounters. But because of higher cost considerations, hospital use in the private sector only caters to some 30% of the population, with 70% still overcrowding the heavily subsidised (less than 2% of the hospital cost is reimbursed by the patients) public hospitals.¹⁷

Hence, there is widening discrepancy in access and use of these health services, which lead to greater delay and longer queues for those who cannot afford the private sector. The public hospital sector with its constantly short staffing problems continues to look after the rest of the 75% who need hospitalisation for more difficult surgeries and therapies.

Can we now suddenly merge and integrate these two systems, private and public seamlessly, without adequate comprehensive planning and exchanges of ideas and details, about how best to bring this about without upsetting the current system and endangering this working if imperfect system?

Mustn't we be more involved in this national dialogue to truly improve the system together, and not in fits and stutters, and certainly not in possibly disruptive experimentations...? **M**

¹⁶ James T. Dove, W. Douglas Weaver, Jack Lewin, Health Care Delivery System Reform—Accountable Care Organizations. J Am Coll Cardiol 2009;54:985-8.

¹⁷ Dato' Dr Maimunah bt A Hamid, Deputy Director General of Health (Research and Technical Support). 1Care for 1Malaysia: Restructuring The Malaysian Health System. Presented at the 10th Malaysia Health Plan Conference on 2 February 2010