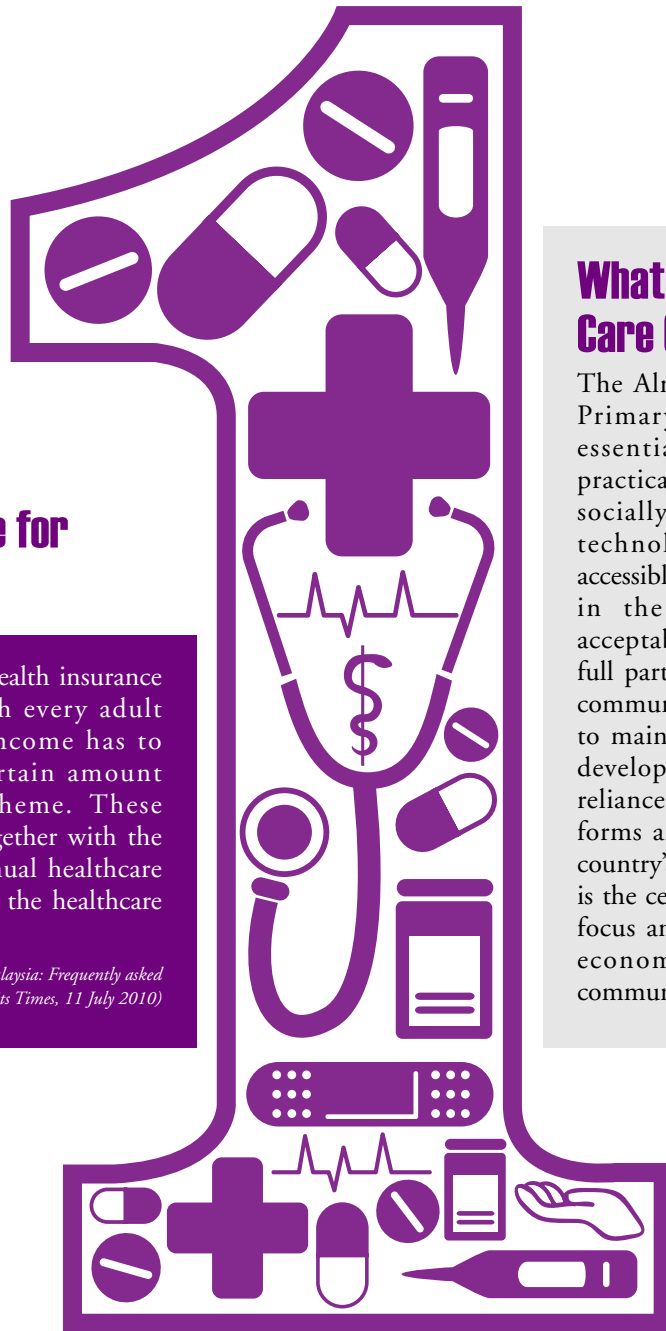




**DATO' DR MOHAN SINGH**  
PPS Chairman (2010/2011)



### What is 1Care for 1Malaysia?

“It is a national health insurance scheme in which every adult who earns an income has to contribute a certain amount towards the scheme. These contributions, together with the government’s annual healthcare budget, will fund the healthcare of all Malaysians.”

*(Source: 1Care for 1Malaysia: Frequently asked questions, News Straits Times, 11 July 2010)*

### What is Primary Health Care (PHC)?

The Alma Ata Conference defines Primary Health Care (PHC) as essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally, accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both the country’s health system, of which it is the central function and the main focus and of the overall social and economic development of the community.

# 1Care for 1Malaysia Future of Primary Health Care

The essential health services in Primary Health Care (ELEMENTS) are:

1. E — Education for health
2. L — Locally endemic disease control
3. E — Expanded program for immunisation
4. M — Maternal and child health including responsible parenthood
5. E — Essential drugs
6. N — Nutrition
7. T — Treatment of communicable and non-communicable diseases
8. S — Safe water and sanitation

There are five basic principles of Primary Health Care (PHC):

1. Equitable distribution of PHC irrespective of gender, age, caste, colour, urban, rural and social class.
2. Community participation toward achievement of PHC.
3. Manpower development
4. Use of appropriate technology
5. Multi sectoral approach

*(Source: Wikipedia, the free encyclopedia)*

## Core Principles of Primary Health Care



PHC provides an essential universal package to all registered members of the population.

PHC providers are “private businesses/corporatised bodies” which enter into a contract with Social Health Insurance “insurers” to supply services to the customers of the Social Health Insurance institute.

PHC will be paid capitation fee per patient registered with their practice. Reimbursement depends on services offered, staff employed, and the achievement of quality and efficiency indicators.

Payments will be according to ‘pay for performance’ with standards, case mix decided/set collectively by the Ministry of Health. It is monitored under the New Reform (1Care) Act. Fees are paid to the PHC providers by the Social Health Insurance Institution.

The PHC system will be served by PHC physicians who will play the role as gatekeepers.

Every member of the population will be registered with a PHC physician and they are free to choose their own PHC physician.

Each PHC physician will be responsible for the health and primary care of their registered population.

The PHC physicians are independently established and self-employed. They must be trained and accredited.

Social Health Insurance will be compulsory and the government will contribute for those who are not able to pay.

GPs will refer patients to any hospital as agreed mutually between them, the client and the hospital. Fees will be based on case mix and will be partially borne by the capitation at rates to be decided by the National Health Financing team. Out-of-hours services after 5.00 pm will be provided by groups of PHC physicians and allied health or cooperatives.

The government will be responsible for the accessibility, affordability and quality of healthcare.

## Topical Issues in Primary Health Care

- Rising demand by consumers for high quality, high technology and affordable medical care; free from errors and incompetence; and delivered by healthcare professionals who are caring, competent, compassionate and trustworthy.
- Changing demography and the rising importance of non-communicable diseases.
- Shortage of skilled healthcare workers.
- Equity and access to primary health care. Groups like the aborigines, indigenous groups, hard core poor in the rural and urban squatters.
- Increasing healthcare costs.
- Newly emerging global public health threats.

Under the 1Care for 1Malaysia plan, a draft framework for PHC delivery has to be developed with regards to its relationship to the restructured autonomous health delivery system, PHC Board and the national health financing authority. Among the items which need to be taken into account would be policy development for programme direction, implementation policies accounting for equity, universality, accessibility and affordability, incentives and disincentives, quality as well as standards.

There is a need to develop phases for implementation. Plan for awareness and motivation/buy-ins prior to reform — providers and population participation. Develop the essential universal package — scope of services to be agreed taking into account costing. To develop standards,

accreditation, credentialing and privileging in preparation for public-private integration — timelines for uplifting professional standards in private sector to meet accreditation requirements. To train GPs and primary care providers and the accreditation process. To develop new provider payment systems — capitation formula for primary care using case mix and pay for performance and reimbursement mechanism. To propose an organisational and management structure of various levels with regards to reform I Care structure. To develop clear roles and relationship of non-government related Primary Care Physicians' Association and other organisational support systems. To develop indicators to monitor risks or impact — impact of the Health Reform Programme on PHC providers, impact on population behaviour, motivation, acceptance and communication between MOH and reform PHC.

## Accreditation

The Malaysian Society for Quality in Health (MSQH) was initially set up to accredit hospitals only but now, clinics too have become their targets. A fee is imposed for the process of accreditation and it must be renewed every three years.

The Academy of Family Physicians of Malaysia (AFPM) on the other hand has its own programme. It is recognised overseas especially in New Zealand and Australia. It is an Internet based programme — clinic based.



## Managed Care Organisations (MCOs)

The National Library of Medicine, defines managed care as programmes or organisations “intended to reduce unnecessary health care costs through a variety of mechanisms, including: economic incentives for physicians and patients to select less costly forms of care; programmes for reviewing the medical necessity of specific services; increased beneficiary cost sharing; controls on inpatient admissions and lengths of stay; the establishment of cost-sharing incentives for outpatient surgery; selective contracting with health care providers; and the intensive management of high-cost health care cases”.

In a shorter version, managed care organisations are about two things: health insurance and delivery of healthcare at low cost.

In 1994, MCOs were allowed to operate in Malaysia. They act as ‘middlemen’ healthcare and lack transparency as well as accountability in negotiations. Doctors and patients are not consulted. Currently, there is no law/Act to regulate them. The MMA is initiating some form of regulation for the Ministry of Health to govern the MCOs.

## Proposed Guidelines for MCOs and Healthcare Professionals

### 1. Healthcare Professionals/Doctors

- They must place the interests of the patients first.
- They should not enter into any contractual agreement that poses a conflict of interest between their practices and patient care.
- They should not participate in schemes that are beyond their professional standards or clinical capability.
- Good clinical practice should be the basis of efficiency rather than enticement with financial incentives.
- They should avoid action/commitments which endanger the doctor-patient relationship and breach of confidentiality.
- Informed written consent must be obtained before any information is divulged to a third party.
- They should not engage in any fee splitting or kickback arrangements.
- They are not allowed to interfere with the doctor's management of the patients.
- It is the inherent right of the patient to seek a second opinion.
- They should appoint an independent panel of medical practitioners to provide the clinical leadership and input on medical practice issues.
- The panel should be allowed to contribute towards the development of the healthcare programmes of employees, review the coverage and restrictions of services, and the system of charges and payment.
- They must follow the Fee Schedule of the Private Health Care Facilities and Services Act 1998 and Regulations 2006.
- Patients have the right to legal redress if unauthorised information is divulged to a third party.
- They must be a member of the Association of Managed Care Organisations.



## 2. MCOs

- They should be transparent regarding offers and non-offers and the limitations of benefits, entitlements/exclusions.
- There should be a proper grievance mechanism to address disputes and contracts.
- They should ensure their actions do not allow or compel any doctor to breach his code of professional conduct.
- Confidentiality of doctor-patient relationship must be respected.
- They should not give marketing support to medical practitioners as this infringes on the MMC's and the Medical Advertisement Board's guidelines on advertising.
- They should not restrict medical practitioners' freedom or his patient to any other medical practitioner best suited to assist him.

## Fee Schedule

As per the 4th MMA Fee Schedule, the consultation fee is as follows:

- Minor RM30 - 35
- Intermediate RM35 - 75
- Major RM75 - 125

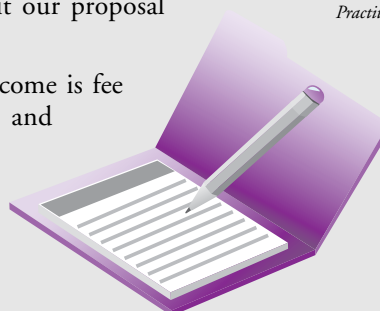
The consultation fee after the stipulated clinic hours would be 50% above the usual rates.

The Ministry of Health has set up a task force to look into the 13th Schedule and the GPs fee structure. The MMA's suggestion was to increase the fee by 30%. This task force committee was set up on 2 July 2010 to amend the 13th Fee Schedule and to reach a consensus on the agreed fees. Four meetings have been held but failed to reach any consensus.

On 20 December 2010, the task force committee was restructured with the main committee chairman being the Director General of Health and the task force committee chairman being the Deputy Director General (Medical). There was only one representative from each organisation.

The GP's consultation fee is to be between RM30-50. We need to submit our proposal by 20 January 2011.

The current mode for GP's income is fee for service, third party payers and capitation basis (package).



## GP Summit 2010

The GP Summit was held on 14 - 15 August 2010 in Kuala Lumpur. The theme was GPs At The Crossroads. The goal of this Summit was to arrive at a consensus document among the GPs which can then be presented to the government which besides conveying our frustrations and grievances, also suggests some possible alternative plans for restructuring.

More than 60% of the outpatients in this country are seen by GPs. Therefore, there should be grants for GPs to upgrade their services and provide services to the rural population.

## Future Of General Practitioners

- GPs simultaneously manage health problems in physical, psychological and social dimensions.
- GPs offer care in the patient's own community.
- GPs manage undifferentiated symptoms often at the early stages in the development of an illness.
- GPs have expertise in risk management that reduces the need for unnecessary investigation or referral.
- GPs simultaneously manage both acute and chronic health problems, and patients presenting with multiple chronic problems.
- GPs address both individual and public health issues through their consultations and the unique potential of a registered list of patients.
- GPs coordinate the patient's overall care, including managing the interface with other specialties, and offering a strong advocacy role.
- GPs offer care that is personal, focused mainly on the individual patient, and founded on mutual trust, but GPs also frequently offer family care.
- As medical doctors, GPs are trained to make diagnoses, not just in physical but also in psychological and social terms.
- GPs are the people with whom the 'buck stops'. Those patients who are turned away by specialist care, or who do not fit the criteria for care elsewhere, can and do return to their GP.

(Source: "The Future of General Practice", A Statement by the Royal College of General Practitioners, September 2004)

It has been reported: "In the future, families will be registered with the PHC physician, either from the public or private sector. The people will be able to choose their family doctor. When people fall sick or need a check

up, they will go to the regular PHC provider as their first point of contact. The PHC provider will have their registered patients' complete medical records from womb-to-tomb, as well as the medical history of their family members. Under this new structure, the PHC provider would be in a better position to play the role of an effective gatekeeper, thus reducing inappropriate access to secondary and tertiary care and managing the rampant rise in healthcare costs. Thus, there is a need for a restructured integrated health system that is responsive and provides choice of quality healthcare to ensure universal coverage for the healthcare needs of the population based on the concepts of solidarity and equity...."

(Source: "Towards total health care", *The Star Online*, 13 November 2010)

Currently, the GPs are governed by the Private Health Care Facilities and Services Act 1998 and Regulations 2006, Medical Act 1971, Medical Devices Act, 1Care Health Reforms and the Primary Health Care Board.

The current competitors of GPs include laboratories or pharmacies, wellness clinics, outpatient clinics, feeder clinics, traditional physicians, MCOs, 1Malaysia clinics, mobile clinics, etc.

## Conclusion

"Malaysia has been cited by international bodies as being a good model in healthcare, especially in terms of primary health care for the rural population..."

"The goals for restructuring are to enhance universal coverage in line with the 1Malaysia concept. An integrated public and private healthcare delivery system is proposed to ensure that healthcare remains affordable and sustainable; improve equity in terms of access and financing, to ensure efficiency, quality of care and optimal health outcomes; improve effective safety nets for catastrophic payments; enhance responsiveness of the healthcare system; increase client satisfaction; increase provision of personalised and community care and reduce the brain-drain especially to overseas market..."

"Primary health care will remain the thrust of this transformed health service delivery system in order to manage rising healthcare costs and ensure equity in health, through better utilisation of resources. This will be implemented without compromising on the universal coverage and ensuring services that are efficient, responsive and of good quality." **M**

(Source: Speech by the Prime Minister at the Sixty-First Session of the World Health Organization Regional Committee for the Western Pacific, 11 October 2010)



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