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MALAYSIA HEALTHCARE REFORM - THE WAY FORWARD

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I truly sympathize with the current Minister of Health, who seems to be in a constant firefighting mode. The challenges he faces range from high-profile issues, like healthcare inflation, rising medical insurance premiums, and doctors leaving public hospitals, to internal administrative struggles such as the failed implementation of the Waktu Bekerja Berlainan (Staggered Working Hours) system.

There are also ongoing investigations and concerns about an unhealthy work environment, which tragically led to the suicide of a biochemical pathology specialist in Lahad Datu. Meanwhile, long-standing problems like overcrowding in public health facilities, a lack of parking, and lengthy waiting lists for specialist appointments and certain diagnostic tests remain unresolved, with no solutions in sight.

To be fair to the Ministry of Health, the quality of care and the range of services offered by public hospitals and Klinik Kesihatan have improved significantly over the years. In fact, the standard of care in some centers can rival, and in certain cases even exceed, that of private hospitals and GP clinics. However, the challenges within public healthcare facilities remain, including long waiting lists for specialist consultations and surgeries, overcrowding, inadequate parking, and poor inter-disciplinary communication.

While it's unrealistic to expect public hospitals to provide the same hotel-like accommodations found in some private hospitals, this is understandable, as hospitality is not the primary function of a hospital.

The standard of nursing care and other supportive care had also improved significantly.

Healthcare inflation is a global issue. The cost of medicine has been rising steadily over the years, and the situation worsened after the Covid-19 pandemic due to supply chain disruptions and the depreciation of the Ringgit against the USD. Additionally, an aging population is consuming more healthcare resources. On top of this, the introduction of new technologies and drugs, which tend to be more expensive, is driving costs even higher. While these innovations often lead to better patient outcomes, they also contribute to escalating healthcare costs, as patients are living longer.

With the array of challenges at hand, unfortunately, the solutions put forward by the Ministry of Health so far have been piecemeal, reactionary, and short-term in nature, failing to provide a long term solution.

I was initially impressed when the Health White Paper, outlining a 15-year health reform plan, was presented to Parliament in June 2023. This document should serve as the blueprint for reforming Malaysia's healthcare system.

The first phase focuses on strengthening public healthcare facilities, followed by an in-depth study on sustainable healthcare financing and the introduction of National Health Insurance.

THE NEED FOR THE HEALTH WHITE PAPER

- The Covid-19 pandemic has tested the health system's capacity and resilience, exposing gaps and constraints that need urgent attention.
- Reform is crucial in ensuring sustainability and resilience of the health system.

Graphics: New Straits Times

WHAT IS THE HEALTH WHITE PAPER?

A national health reform plan that outlines main challenges faced by the country and presents solutions in achieving a more sustainable, resilient and quality health system.

- Developed by taking into account input from stakeholders, including the people, to ensure that it is holistic and inclusive in nature.
- Tabled in Parliament to gather bipartisan support from members of parliament for further implementation.

THE HEALTH WHITE PAPER OUTLINES 4 PILLARS AND 15 HEALTH REFORM STRATEGIES:

1 Transforming healthcare service delivery

a. Prioritising primary healthcare
b. Optimising hospital care services
c. Increasing effective public-private partnerships
d. Harnessing digital technologies
e. Ensuring equity in healthcare delivery

2 Advancing health promotion and disease prevention

a. Strengthening public health functions
b. Improving intersectoral coordination and collaboration for health
c. Incentivising pro-health practices and behaviours

3 Ensuring sustainable and equitable health financing

a. Increasing investments in health
b. Ensuring comprehensive and fair coverage for all
c. Ensuring effective and efficient healthcare expenditures

4 Strengthening the health system's foundation and governance

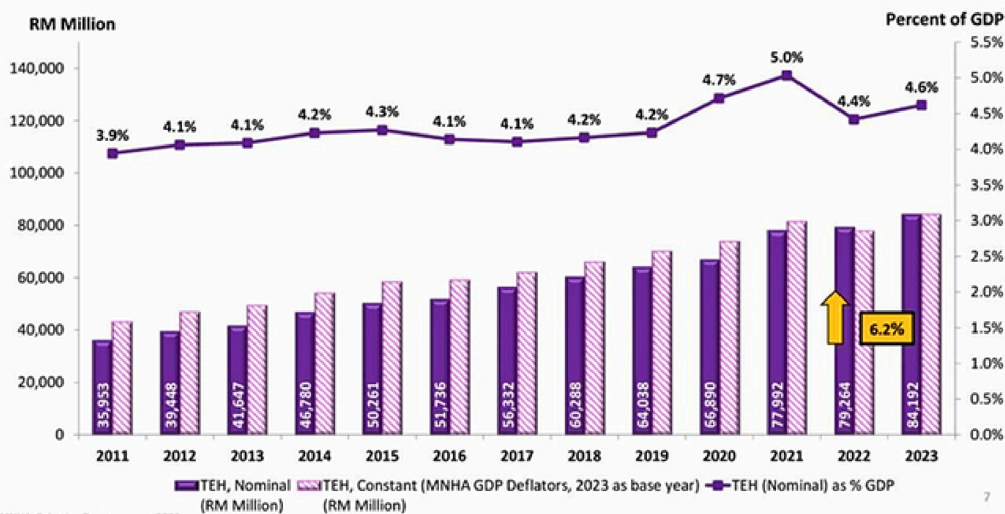
a. Restructuring of Health Ministry's role
b. Strengthening policies, legislation and regulations
c. Fortifying the health workforce
d. Stimulating research, innovation and evidence-based approach

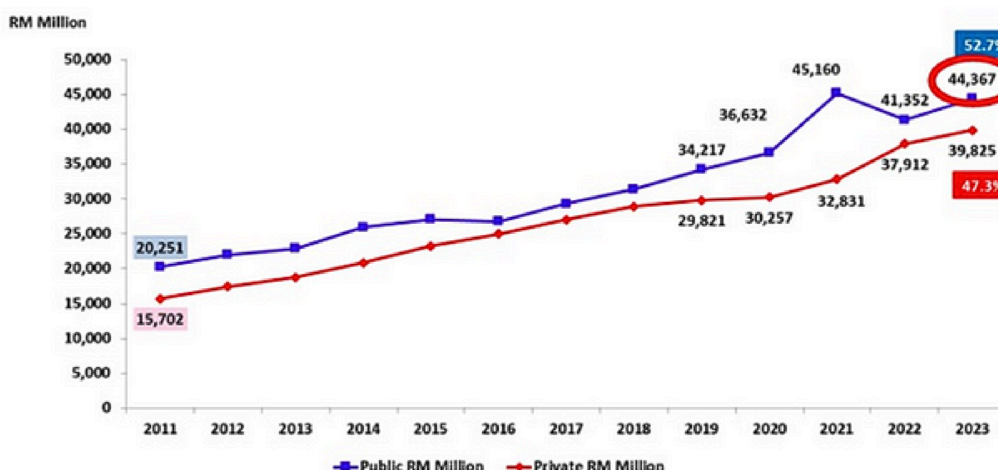
SUGGESTIONS:

Phase 1 (near term)

Strengthen The Public Healthcare Facilities

According to the data available from the Malaysia National Health Accounts (MNHA) on National Health Expenditure 2021-2023, released on December 24, 2024, Malaysia's Total Expenditure on Health (TEH) in 2023 amounted to RM 84 billion, which represents 4.6% of the country's GDP, with a per capita expenditure of RM 2,500. The public sector contributed RM 44 billion, or 53%, while the private sector accounted for RM 40 billion, or 47%, of the total TEH. Notably, 36% of the TEH came from out-of-pocket payments by households. In comparison, Thailand, despite having a lower per capita income, spent 5.2% of its GDP on health, with the public sector contributing 70% of the total expenditure.

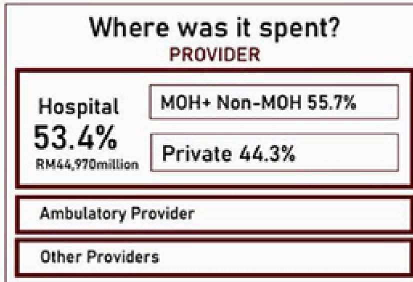


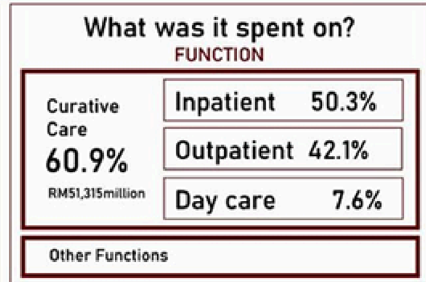


Seksyen MNHA, Bahagian Perancangan – 2024

SUMMARY OF 2023

TEH
Total Expenditure on Health
RM 84,192 m





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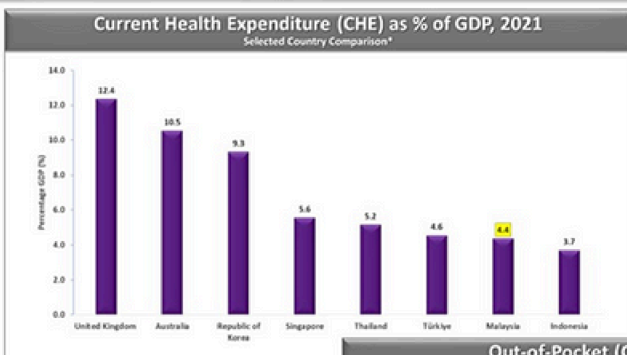
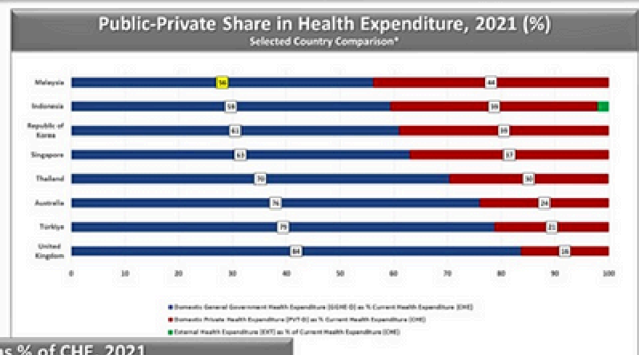
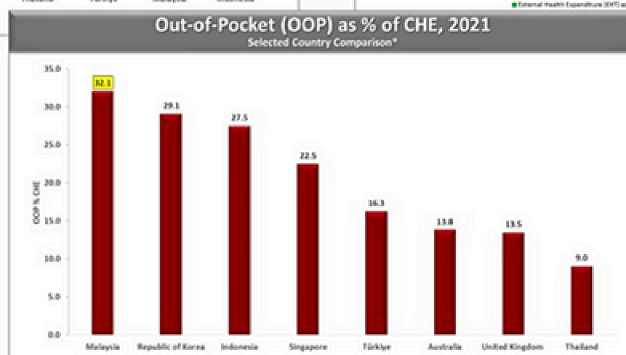
Seksyen MNHA, Bahagian Perancangan – 2024

Referring to the Health Fact 2024 data published by the Ministry of Health (MOH) for 2023, the total number of public hospital admissions was 2,795,800, compared to 1,362,564 admissions in private hospitals. Clearly, the RM 44 billion allocation is still insufficient. To address the underinvestment in public healthcare facilities, a total allocation of around RM 80 billion (in stages) would be necessary. With this level of investment, the Total Expenditure on Health (TEH) would reach approximately 6% of GDP, a figure more aligned with our current level of economic development.

International Comparison 2021







Source: International data from Global Health Expenditure Database, WHO NHA Oct 2024

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Seksyen MNHA, Bahagian Perancangan – 2024

To improve the services provided to the public, there are several measures that the MOH should consider.

1.	**Set KPIs for Waiting Times**	Establish key performance indicators (KPIs) for waiting times, covering specialist consultations, elective surgeries, and specialized tests or investigations. This would ensure a more efficient and transparent system, helping to manage patient expectations and improve overall service delivery.
2.	**Establish Minimal Care Standards**	Define a minimum standard of care for public healthcare facilities, ensuring that limited resources are utilized efficiently to benefit as many people as possible. This will help in setting clear expectations and ensuring a baseline level of care across all public facilities.
3.	**Assess Healthcare Resource Needs**	Accurately determine the healthcare resource needs, particularly the number of specialist doctors required, to meet the KPIs and maintain the established minimum care standards. The persistent issue of doctors leaving public service needs to be addressed, with a notable 6,417 medical officers having resigned between 2019 and 2023. Although there are 2,000-3,000 new medical graduates joining public hospitals each year (down from 5,000 in 2020), the problem isn't with replacement at the general level, but with specialist doctors. Alarmingly, 1,046 medical specialists resigned during this period. This issue must be tackled with urgency, especially considering that out of the 47,000 doctors in MOH, only about 5,000 are specialists. The specialist shortage is becoming critical. Currently, with only about 1,000 specialist training slots available each year and ongoing resignations, the target of having 30% of all doctors in MOH as specialists by 2030 is increasingly difficult to achieve.

		In advanced countries, specialists typically make up 40-60% of the medical workforce. Therefore, addressing the resignation issue and providing more training opportunities for Medical Officers (MOs) to specialize must be a top priority to ensure the future sustainability of the healthcare system.
4.	**Public-Private Partnerships** for Capital-Intensive Equipment	Strengthen public- private partnerships, particularly for sharing capital-intensive medical equipment. This initiative has already begun and should be expanded to help ease the financial burden on public healthcare while improving the availability of advanced medical technology.
5.	**Digitization and Electronic Medical Records (EMR)**	Prioritize the digitization of healthcare services, particularly the implementation of Electronic Medical Records (EMR). This will significantly improve efficiency, streamline processes, and enhance the sharing of patient information across healthcare providers. It is crucial that this be incorporated into the upcoming 13th Malaysia Plan with a dedicated lump-sum allocation over the next five years. The current yearly budget allocated for IT in the Ministry of Health (MOH) is insufficient even to maintain the existing IT systems, let alone support the transition to a fully digitalized healthcare infrastructure.
6.	**Reform the Work Culture Within MOH**	**a. Reorganize MOH to Reduce Bureaucracy**: The Ministry of Health should consider reorganizing to minimize bureaucratic inefficiencies. Moving away from the traditional pyramid system of organizational structure, more authority and responsibility should be delegated to local levels, such as district or hospital levels. Currently, with the multi- layered bureaucratic system, recommendations often pass through hospital directors, district health offices, and state offices before reaching Putrajaya, creating a significant disconnect between grassroots recommendations and final approvals.

		Streamlining this process would foster quicker decision-making and improve responsiveness to local needs.
		b) Reorient the Working Cultureto Be Patient-Centric: The work culture in MOH must always prioritize the patient experience. For example, many patients in MOH hospitals who require follow-up blood tests are asked to complete the tests at the hospital a week before their appointment, leading to unnecessary congestion at the hospital. An excellent example of innovation is the approach taken by Hospital Sultanah Bahiyah in Alor Setar, which set up mobile blood collection units at shopping malls, allowing patients to conveniently get their tests done at a time that suits them. MOH could expand on this idea by establishing multiple testing labs, with results shared on the cloud. This would save patients from unnecessary trips to the hospital and enhance the overall efficiency of the system. I am sure there will be more innovative ideas from the local leaders when they are given more responsibility and authority.

These suggestions aim to make public healthcare facilities remain the foundation of our healthcare system, regardless of whether a national health insurance scheme is eventually implemented. Without substantial improvements in public hospitals and Klinik Kesihatan, an increasing number of patients, particularly from the M40 group, will have no choice but to turn to private healthcare, putting a strain on their financial resources. It's important to note that public healthcare facilities also act as a price stabilizer, preventing excessive profiteering in the private sector.

In the absence of quality public healthcare, patients will inevitably flock to private facilities once national health insurance is introduced. This shift will significantly increase the Total Expenditure on Health (TEH), placing even more pressure on the system. Ensuring that public healthcare remains strong and accessible is therefore essential to managing costs and maintaining a balanced, sustainable healthcare system.

Phase 2

Exploring Sustainable Healthcare Financing

When formulating healthcare policy, there are severalfundamental principles that must guide us: **Universal, Accessible, Quality,** and **Choice**.

Universal and Accessible are fairly straight forward. These principles mean that no one should be excluded from healthcare, and services must be available even in the most remote areas of the country. This stands in contrast to private healthcare insurance, where high-risk patients—such as the elderly or those with pre-existing conditions—are often excluded from coverage. Additionally, private healthcare facilities are primarily concentrated in urban areas, leaving the public sector to fill the gap, unless further incentives are provided to encourage private healthcare providers to serve rural communities.

Quality care is dynamic and must evolve with the population's needs. As mentioned earlier, the Ministry of Health (MOH) should establish a minimal standard of care for public healthcare facilities. This minimum standard would serve as the foundation for coverage when national health insurance is implemented. However, these standards must be dynamic, adjusting as the income levels of the population rise. As the country's overall wealth improves, so too should the standards of care.

Regarding whether services should be based on needs rather than just the minimum standard, the answer is no, simply because we are working within the limits of available resources. While the ideal is to provide care based on needs, the reality of resource constraints means that a minimum standard must be maintained to ensure that healthcare remains equitable and accessible for all.

For instance, ventilating a terminally ill cancer patient might deprive a young, critically injured patient from a motor vehicle accident of a life-saving ventilator. Even someone as high-profile as Michael Schumacher, the former German Formula 1 driver, who suffered a severe brain injury in a skiing accident in December 2013, was placed in a medically induced coma and later received extensive medical treatment and rehabilitation privately at home for the past ten years. The resources dedicated to such cases could easily surpass the cost of dialysis treatment for 20-50 patients annually.

This highlights that **rationing healthcare resources is unavoidable**. There is a delicate balancing act between rationing resources and ensuring that quality service is still provided. Healthcare systems must prioritize care based on the needs of the population while acknowledging the limitations in resources, striving to strike a balance that ensures fairness and the best possible outcomes for all patients.

Can we do away with the **public-private healthcare dichotomy** when a National Health Insurance (NHI) system is implemented? The answer is no, if we respect individual choice. The dichotomy will likely persist because patients with financial resources should still have the option to seek care above the minimum standard using their own funds. This is where private healthcare facilities come into play. Without these private options, wealthier individuals would simply seek treatment overseas, creating a strain on national resources and potentially harming the local healthcare sector.

What if the government took a "hands-off" approach, allowing **market forces** to dictate the supply and demand for healthcare? In such a scenario, the supply of healthcare services would be tailored to those who can afford to pay, and not necessarily to those who need it most. This would leave the poor unable to afford even basic medical care, making the public sector essential for ensuring equitable access to healthcare.

Some may argue for completely **free healthcare services** for all, funded by general taxation. While this model could provide access to all, rationing would still be necessary. Additionally, even in this system, the wealthier individuals would seek treatment abroad if the services here do not meet their expectations. Moreover, people tend to be less judicious when consuming services that are free, leading to overconsumption. This could strain the system, especially as the poor, who are generally less health-conscious compared to the wealthier population, might overuse services, despite their overall poorer health status. In such cases, the higher-income group would likely consume more healthcare resources, despite generally having better health. Thus, while free healthcare sounds appealing, it could inadvertently result in inefficiencies and inequities.

Ultimately, a balance must be struck between providing universal, accessible, and quality care while also respecting individual choices and ensuring that resources are distributed equitably and sustainably. The public sector remains crucial to ensuring that healthcare is accessible to all, particularly the most vulnerable.

Phase 3
(Long-term)

Financing Healthcare Services

Option A: Maintain the Status Quo

Under this option, healthcare services would continue to be financed through a combination of general taxation, private third-party payers (e.g., private insurance companies), and out-of-pocket payments by patients.This model preserves the existing mix of public and private sector funding, with the public healthcare system funded primarily through taxation, while private healthcare continues to be driven by individual payments or insurance. The challenge with this model is the growing strain on public resources as demand for healthcare increases, leading to longer waiting times and disparities in care access. Additionally, reliance on private insurance and out-of-pocket payments could widen the gap between different socio economic groups, limiting accessibility for lower-income populations.

Option B: National Health Insurance (NHI)

A National Health Insurance (NHI) system would shift the focus to a single, unified public insurance scheme that covers the majority of healthcare costsfor all citizens.

Who Pays for NHI:

- **Option A: From General Taxation:**

One option for funding the NHI systemis through generaltaxation, where the government would allocate a portion of national tax revenues to fund healthcare for all citizens. This approach is straightforward but requires a significant tax base to ensure sustainability.

- **Option B: From Premiums Paid by Everyone with an Income:**

Alternatively, the funding could come from premiums paid by those with an income, with a progressive system where the B40 group (bottom 40%) is fully subsidized, and the M40 group (middle 40%) receives partial subsidies funded by general taxation.

This model encourages personal responsibility for health financing, while ensuring that the most vulnerable groups are protected. The Ministry of Health's (MOH) budget would be reduced by at least 80%, as it would no longer be the direct service provider, which would free up resources. These savings could then be used to subsidize the premiums for the B40 and M40 groups.

Proposed Framework for National Health Insurance (NHI) Implementation:

1. Universal, Basic Quality Care (Minimum Standard of Care):

National Health Insurance (NHI) can guarantee a universal, basic standard of healthcare for all citizens, ensuring that everyone has access to essential services. For those in the higher-income groups (T20), they can top-up by purchasing additional private insurance to access services beyond the minimum standard. This would allow for a tiered approach where the basic care is universal, while those with greater financial resources can seek higher levels of care without overburdening the public system.

2. Lifetime Coverage Caps and Resource Management:

The lifetime coverage under NHI should have a cap, preventing overconsumption of healthcare resources. Individuals would have the responsibility to manage their own coverage within this limit, encouraging a focus on preventive care and healthier lifestyles.

This cap helps to promote efficiency and sustainable use of resources. In cases where low-income individuals exhaust their lifetime coverage, an alternative safety net should be in place, such as means-tested support, but it should be subject to independent scrutiny to prevent abuse and ensure fairness.

3. Ministry of Health (MOH) Role:

Under this framework, the role of the Ministry of Health would shift to a more strategic and regulatory one. The MOH would focus on planning, human resource training, public health, enforcement, and regulatory functions. This would allow the Ministry to focus on maintaining overall system quality, ensuring that public health standards are upheld, and making sure that healthcare delivery remains equitable and efficient.

4. Corporatization of MOH Hospitals and Klinik Kesihatan (KK):

MOH hospitals and Klinik Kesihatan would be corporatized as not-for-profit entities. This means that the management of these facilities would become more independent, with greater control over finances, human resources, and service planning. However, their mission would still be to serve the public good rather than generate profits. The financing of these entities would primarily come from the services provided to patients funded by the NHI, ensuring that public healthcare remains well-funded and operationally efficient.

5. Existing Private Healthcare Facilities:

There would be no change to the existing private healthcare facilities. Private healthcare would continue to function as a parallel system, providing services above the NHI minimum standard. However, individuals would still be able to choose private healthcare for services that fall outside of the basic coverage provided by NHI. This ensures that the private sector remains a viable option for those who can afford it, without undermining the public healthcare system.

6. Establish an NHI Board to Manage Collection and Disbursement:

A dedicated NHI board should be established to oversee the collection of premiums and the disbursement of funds to healthcare providers. This board would be responsible for ensuring financial sustainability, efficiency, and transparency in the NHI system. It would also help ensure that funds are allocated appropriately to maintain high standards of care while keeping premiums affordable.

7. Co-Payment for Services:

A mandatory co-payment system should be put in place for healthcare services under the NHI. This would help prevent overuseor abuse of services by ensuring that individuals share in the cost of their care. Co-payments can be structured to be affordable based on income levels, thereby encouraging individuals to seek care when necessary, while discouraging unnecessary visits and overconsumption of resources.

8. Review Payment System to Service Providers:

The current fee-for-service payment model in both public and private healthcare facilities should be reviewed. In the private sector, this system often leads to supply-driven demand, where healthcare providers may be incentivized to offer more services than necessary.

The NHI model should consider alternatives, such as bundled payments or capitation, to reduce over-provision of services. For public non-for-profit healthcare facilities, income for doctors and healthcare staff should be significantly increased, and performance-based incentives should be introduced to encourage high-quality care and efficiency. This would help attract and retain qualified professionals, ensuring that public healthcare facilities remain effective and sustainable.

This proposed framework ensures that the NHI provides a strong foundation for universal care while maintaining flexibility for higher-income individuals to access additional services. It also balances government regulation with the operational independence of healthcare facilities, which would improve efficiency and quality. By capping lifetime coverage, the system encourages responsible use of healthcare services, promoting a healthier society overall.

It also aims to create a sustainable, equitable, and efficient National Health Insurance system. By ensuring appropriate funding, proper management, and strategic incentives for both providers and patients, the NHI system can provide high-quality, accessible healthcare for all citizens while maintaining fiscal responsibility.

As we work to reform our healthcare services to meet the evolving needs of the future, it's essential to acknowledge the dynamic nature of the situation. The healthcare landscape is constantly changing—whether due to technological advancements, shifting demographics, new health challenges, or economic fluctuations. We must be prepared to adapt our strategies, policies, and systems in real-time, responding to emerging needs and unforeseen challenges as they arise.

Flexibility and continuous evaluation will be key to ensuring that the reforms remain relevant and effective over time. By staying open to adjustments, incorporating feedback, and learning from both successes and setbacks, we can builda healthcare system that not only meets the current demands but is also resilient and capable of handling the challenges of the future.This forward-thinking approach will ensure that we continue to deliver high-quality, accessible care for all.

26th January 2025