1Care for 1Malaysia: RESTRUCTURING THE MALAYSIAN HEALTH SYSTEM

Presented at the 10th Malaysia Health Plan Conference

by

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Presentation Outline

• Current Health System & Challenges
• Proposed Model for Malaysia
  – Delivery system & Governance
    • Primary Health Care
    • Secondary Care
    • Human Resource Development
  – Financing
• Implications
CURRENT HEALTH SYSTEM & CHALLENGES
Overview of Current Malaysian Health System

**Public Health**
- Local Authority
  - Environmental Health
  - Licensing of Premises
  - Building Inspection
  - Sanitation
  - Vector Control
  - Food Quality Control
  - Legislation and Regulations
  - Enforcement
  - Health Care Planning

**Ministry of Health (MOH)**
- Environmental Health
- Licensing of Premises
- Building Inspection
- Sanitation
- Vector Control
- Food Quality Control
- Water Quality Control
- Communicable Disease Control
- Occupational Health
- International Health
- Hospital
- Clinics
- Doctors
- Dentists
- Medical assistants
- Nurse practitioners
  (Predominantly western allopathic medicine)

**Private Providers**
- Private Insurers or Group managed care schemes
  - General Practitioner
  - Family Medicine specialists
  - Specialist clinics
  - Hospitals
  - Dentists
  - Traditional and complementary care
  - Pharmacies
  - Pathology labs

**Coverage**
- Urban Population
- General Population
- Universal Coverage
- Specific Population Groups

**Funding Sources**
- Local taxes
- Government General Revenue
- SOCSO* and EPF**
- Employers
- Individuals

**Estimated Market Share (from NHMS2)**
- Hospital Admissions: 82%
- Outpatient contacts: 35%
- 62%
- 18%
- 3% (Others includes TCM, pharmacy and lab visits)

* SOCSO - Social Security Organisation
** EPF - Employee Provident Fund

Source: Rozita Halima Hussein, Asia Pacific Region Country Health Financing Profiles: Malaysia, Institute for Health Systems Research
Access to Health Providers in Malaysia

MOH

- Rural/Community Clinics: 1: 4,000 population
- Health Clinics/Centres: 1: 20,000 population
- Hospitals without Specialists
- Hospitals with Specialists
- Hospitals with Subspeciality

Other agencies & Private sector

- By-passing
- Private Hospitals
- University Hospitals
- Medical Corps
- Orang Asli Facilities
- Estate

ACCESS / REFERRAL

PRIMARY HEALTH CARE

SECONDARY/TERTIARY CARE
Public & Private Sector Resources and Workload (2008)

Health clinics (with doctors)
- Public: 802
- Private: 6371

Outpatient visits (m)
- Public: 38.4
- Private: 62.65

No. of Hospitals
- Public: 143
- Private: 209

Hospital Beds
- Public: 41249
- Private: 11689

Admissions
- Public: 2199310
- Private: 754378

Doctors (excl. Houseman)
- Public: 12081
- Private: 10006

Health Expenditure (RM billion) (2007)
- Public: 13.54
- Private: 16.68

Source: Health Informatics Center (HIC), MOH
Current Functions of MOH

Within the dual health care system, MOH is Funder, Provider and Regulator

- Health Policies & Planning
- Regulation & Enforcement
  - Personal care
  - Public Health
  - Pharmacy
  - Technology
  - Medical Devices
- Monitoring & Evaluation
  - Quality Assurance
  - Health Technology Assessment
  - Patient Safety
  - Guidelines and Standards
- Training
- Research & Development
- Health Information Management
- Primary Care Services
  - Out-patient services
  - Maternal & Child Health
  - Health Education
  - Home Visits & School Health
- Secondary & Tertiary Services
  - In-patient services
  - Specialist care
- Pharmaceutical Services
- Oral Health Services
- Imaging and Diagnostics
- Laboratory Services
- Telehealth & Teleprimary care
- Public Health Activities
  - Communicable Disease
  - Non-communicable Disease
1. Lack of integration
2. Changing trends in disease pattern & socio-demography
3. Greater expectations from public
4. Dependency on govt. subsidised services – Issues of economic inefficiency
5. Limited appraisal & reward systems for performance
6. Conflicts of interest
7. Accessibility & affordability
   - Discrepancy of health outcomes
8. Limited coverage of catastrophic illness
e.g. haemodialysis, cancer therapy, transplants etc.
9. Private spending for health overtaken public since 2004

Source: MNHA (2007)
Ratio of Out-of-Pocket (OOP), Public & Private Expenditures

<table>
<thead>
<tr>
<th>Country/Region</th>
<th>Low Income</th>
<th>Lower middle Income</th>
<th>Upper middle Income</th>
<th>High Income</th>
<th>GLOBAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Income</td>
<td>18.6%</td>
<td>1.3%</td>
<td>14.5%</td>
<td>0.7%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Lower middle Income</td>
<td>23.0%</td>
<td>17.1%</td>
<td>4.5%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Upper middle Income</td>
<td>44.2%</td>
<td>7.2%</td>
<td>0.4%</td>
<td>0.1%</td>
<td>4.1%</td>
</tr>
<tr>
<td>High Income</td>
<td>32.0%</td>
<td>20.8%</td>
<td>2.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Global</td>
<td>34.5%</td>
<td>25.6%</td>
<td>3.7%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Source: World Bank, 2005
Total Expenditure on Health (TEH) as Percentage of GDP (2005)

TEH as % of GDP, 2005

- Low Income: 4.2%
- Lower middle Income: 4.8%
- Malaysia: 4.2%
- Malaysia (2007): 4.7%
- Upper middle Income: 6.6%
- High Income: 11.2%
- GLOBAL: 8.6%

Source: World Bank, 2005
Government Spending on Health as % of Total Government Expenditure (2006)

Source: WHOSIS data 2006
In absence of health financing reform, health system likely to become increasingly privatized… both in funding and service delivery……

In the future with no restructuring of the health system…..

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2009</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>GGHE</td>
<td>50%</td>
<td>45%</td>
<td>35%</td>
</tr>
<tr>
<td>PvtHE</td>
<td>50%</td>
<td>55%</td>
<td>65%</td>
</tr>
<tr>
<td>-PvtOOP</td>
<td>40%</td>
<td>47%</td>
<td></td>
</tr>
<tr>
<td>-PvtOther</td>
<td>15%</td>
<td>17%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Dr Christopher James, WHO WPRO – Projections from MNHA data
The Combination of Organisational and Financial Reforms A Nation Chooses Depends on What Goals A Nation Wants to Achieve
Aligning Our Health System To Our Country’s Aspirations

New Economic Model?

*Malaysia Economic Monitor: Repositioning for Growth - 4 Key Elements* (World Bank, November 2009)

1. **Specialising the economy** - high value-added, innovation-based, strong growth potential, enabling environment internally-competitive appropriate soft and hard infrastructure knowledge economy

2. **Improving the skills of the workforce** – specialised and skilled labour moving up the value-chain, social and private returns to education and skills upgrading, increase productivity

3. **Making growth more inclusive** – Strong inclusiveness policies, equity, helping household cope with poverty through health care

4. **Bolstering public finances** – broaden the country’s narrow revenue base, lessen subsidies, reduce the crowding-out of private initiatives, shift expenditure to areas of specialisation, skills and inclusiveness
PROPOSED MODEL for MALAYSIA
1Care is restructured national health system that is responsive and provides choice of quality health care, ensuring universal coverage for health care needs of population based on solidarity and equity.
Targets of 1Care

- Universal coverage
- Integrated health care delivery system
- Affordable & sustainable health care
- Equitable (access & financing), efficient, higher quality care & better health outcomes
- Effective safety net
- Responsive health care system
- Client satisfaction
- Personalised care
- Reduce brain-drain
Features of Proposed Model: **BETTER** than current system

- Strengths of current system will be preserved
- Stronger stewardship role for MOH & government
- Separation of purchaser-provider functions
- **1Care** - Integration of health care providers & services
- More responsive to population health needs & expectation through increased autonomy
- Payments linked closely to performance of provider
DELIVERY SYSTEM & GOVERNANCE
FUNCTIONS WITHIN THE RESTRUCTURED HEALTH SYSTEM

MOH

- Governance & Stewardship
- Policy & Strategy Formulation
- Standard Setting
- Regulation & Enforcement
- Monitoring & Evaluation
- Public Health
- Research
- Training

NHFA

- Professional Bodies
  - MMC
  - MDC
  - Pharmacy Board
  - Others

Independent bodies
- Drug Regulatory Authority (DRA)
- Health Technology Assessment (HTA)
- Medical Research Council (MRC)
- Patience Safety Council
- Medical Device Bureau
- National Service Framework (NSF) (Quality)
- National Health Promotion Board
- Food Safety Authority
- Others

MHDS

- Service Delivery
  - Primary Care
  - Hospital Care
  - Other Services
CHANGES TO CURRENT FUNCTIONS OF MOH WITH PROPOSED RESTRUCTURING

**NHFA**
- POLICIES
- MAKING
- SERVICES
- RESEARCH
- TCM
- HUMAN
- RESOURCES
- EDUCATION
- DRUGS
- QUALITY
- HTA

**MOH**
- REGULATION & ENFORCEMENT
- TRAINING
- RESEARCH
- MHDS
- PRIMARY
- HOSPITAL
- REGIONAL
- AUTHORITY

**INDEPENDENT BODIES**
- Drug Regulatory Authority (DRA)
- Health Technology Assessment (HTA)
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**PUBLIC HEALTH**
- Disease Control
- Food Safety & Quality
- Health Education

**MONITORING & EVALUATION**
- HIC
- MNHA
- Surveillance
- H20 Quality
- TCM

**PROFESSIONAL BODIES**
- MMC
- MDC
- Pharmacy Board
- Others
Scope of Autonomy for Independent MOH-owned bodies

- Not-for-profit
- Accountable to MOH
- Independent management board
- Self accounting – manages own budget
- Able to hire and fire
- Flexibility to engage and remunerate staff based on capability and performance
SERVICE DELIVERY & PATIENT FLOW

Patient

PHCP
Public Private
Receive treatment

Refer
Admit
Hospital

Public Private

Return to referring PHCP

Additional services (Out of pocket or private health insurance)
Outpatient and Hospital care free at point of service
Minimal co-payments e.g. for dental & pharmacy
Primary Health Care

Primary Health Care

• **Thrust of health care** services - strong focus on promotive-preventive care & early intervention

• Primary Health Care Providers (PHCP):
  – PHCP are independent contractors
  – Family doctor & gatekeeper → referral system

• Register entire population to specific PHCP according to location of home/work/schooling

• Dispensing of drugs by independent pharmacies

• Payment - capitation with additional incentives
  – casemix adjustments
• PHCPs are led by Family Medicine Specialists (FMS)
• The FMS is registered with the MMC and the National Specialist Register
• Secondary care specialist are not registered as PHCPs
• Conversion of GPs to FMS – thru x months training from accredited training centres/providers
• Over time only Primary Health Care Specialists are allowed to open a PHCP practice
• Accreditation of facilities, credentialing and privileging of PHCP will be done
Hospital Services

• Regional arrangement for hospital services & set-up to better serve the needs of local community in each region

• Patients referred by PHCP

• Autonomous hospital management

• Financing through casemix adjustments
  – ? Global budget for public hospitals
  – ? Case-based payment for private hospitals
Human Resource

- Integration of public & private health care providers → increase access for population
- Gaining of number & skills through integration
- Facilitate providers working in both sectors – suitable arrangements have to be developed
- Harmonise/equalise remuneration for public & private
- Pay for performance
  - Incentives are being considered to promote performance
  - Incentives for performance over benchmark, people who work in remote areas
Role of Allied Health

- Utilisation of allied health personnel will reduce cost & support the role of health professionals
- This will contribute towards overcoming the shortage of human resource
- In line with 1Malaysia Clinic launched by PM, it is possible for allied health personnel to carry out certain functions, such as:
  - Preventive care by nurses
  - Triaging, basic treatment e.g. T&S, STO, etc by nurses & AMOs.
Human Resource: Training

- MOH still determines the human capital needs of the country
- Within integrated system in-service training has to be planned between public & private facilities
- ? outsource training to institution or teaching facilities
- ? Open system for formal post-graduate training of doctors
  - Universities need to review current programme
- Credentialing & Privileging
  - Independent Body – e.g. National Credentialing Committee (NCC), Academy of Medicine etc.
- Continuing Professional Development (CPD)
  - Current system
    - fund - health facilities / self funded
  - Compulsory – minimum CPD points/per year for APC
  - Use for recertification.
FINANCING
Financing Arrangements

- **Combination** of financing mechanisms
  - Social health insurance (SHI) + General taxation + minimal Co-payments for a defined **Benefits Package**
  - Pooled as *single fund* to promote social solidarity and unity as per **1Malaysia** concept
A Summary of Ranking of Different Health Financing Methods

<table>
<thead>
<tr>
<th>Equity</th>
<th>Risk Pooling</th>
<th>Reduce Risk Selection</th>
<th>Efficiency*</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Rev</td>
<td>General Rev</td>
<td>General Rev</td>
<td>User Fee, OOP, MSA <em>(Low administrative cost but sometimes hard to collect – so higher cost)</em></td>
</tr>
<tr>
<td>Social Ins</td>
<td>Social Ins</td>
<td>Social Ins</td>
<td>Social Ins</td>
</tr>
<tr>
<td>Private Ins</td>
<td>Private Ins</td>
<td>Private Ins</td>
<td>Private Ins <em>(High Administrative Cost)</em></td>
</tr>
<tr>
<td>User Fee, OOP, MSA</td>
<td>User Fee, OOP, MSA</td>
<td>--------------</td>
<td>General Rev/ Direct Provision <em>(Inefficient ) – Generally – may not be the case in Malaysia</em></td>
</tr>
</tbody>
</table>

*Efficiency factors include technical efficiency and administrative costs.
Social Health Insurance

• SHI is another financing approach for mobilising funds & pooling risks, earmarked tax

• Community-rated, not risk-rated as in private health insurance (PHI) – all are eligible

• High levels of cross-subsidization
  – Rich to poor
  – Economically productive to dependants
  – Healthy to ill

• 3 distinct characteristics
  – Compulsory enrollment, payment of premium.
  – Benefits eligible for those who contribute only
  – Benefit Package is predetermined
Social Health Insurance

Advantages

• Pools Risk & Resources
• Mobilise funds designated for health system - ↑ public acceptance
• Planned prepayment - ↓ OOP
• Equity
  – payment according to ability to pay
  – improve equity in access
• Promote health system development
  – health information system
  – rational planning of health services & resources

Disadvantages

• Challenges in coverage of informal sector & determining the poor
• Need to have a good administrative capacity
• SHI requires legislation to provide a legal framework for authorising mandatory, earmarked contributions
• Need accurate estimates of the benefits package & costs
• PPM that shifts financial risk of provision to the provider, e.g. capitation need to be continuously monitored & evaluated
• Abuse of SHI fund may be a threat
Financing Arrangements

- **Combination** of financing mechanisms
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- **Social Health Insurance contribution** – mandatory
  - SHI premium – community rated & calculated on sliding scale as percentage of income
  - From employer, employee & government

- **Government’s contribution (from general taxation)** covers
  - Public health & other MOH activities
  - PHC portion of SHI for whole population
  - **SHI premiums** for registered poor, disabled, elderly (60 years & above), government pensioners & civil servants + 5 dependants
  - Higher spending by govt – 2.85% (In 2007 govt spending 2.11%)
Total Health Expenditures with and without 1Care restructuring

Constant 2009 prices (millions)

- No major changes
- 1Care
IMPLICATIONS
Implications of Proposed System

- Public-private integration
- Stronger governance role in a slimmer MOH
- Defined practice standards
- Benefits package
- Payment by performance
- Registries for providers and patients
- Gate-keeping role by primary care providers
- Autonomous management public healthcare providers
- Services free at point of care – minimal co-pay
- Mandatory regular contribution (prepaid) under SHI
- More funding of health with increased coverage
Benefits to Individuals

- Access to both public & private providers
- Reduced payment at the point of seeking care
- Care nearer to home
- Increased quality of care & client satisfaction
- Personalised care with specific PHCP
- Access for vulnerable group
- Better health outcome
- Higher work productivity
- All (except govt covered groups) will have to pay to be within the system
Benefits to Employers

• Relieve burden to reimburse worker or give loan for medical spending
• Relieve burden to cover work and non-work related illnesses (beyond SOCSO)
• Pay low contributions to cover employee and family
• Reduce administration to process medical benefits
• Avoid systems in which unnecessary care leads to higher expenditure e.g. PHI, MCO & Panel doctors
• Healthier workforce and higher productivity
• All companies have to contribute – ? tax rebate
Benefits to Health Care Providers

• Bridge the gap between remuneration and workload among health workers in the public and private sectors.
• Creates more effective demand for healthcare
• Re-address distribution of health staffs through the provision of specific incentives.
• Defined standards of care
• Ensure appropriate competency through training credentialing and privileging
• Reduce brain-drain, increase available pool of providers
Benefits to the Nation

• Strengthen National Unity
  - 1Care for 1Malaysia

• Ensure social safety nets for lower & middle income
  - Reduce OOP at point of seeking care
  - Address equity & access of care
  - Ties-in with current policies of govt

• Contain rapid growth in health care cost

• Stimulate health care market – create more effective demand for health care, multiplier effect

• Capitalise on liberalisation and global health care market

• Reduce dependence on government
Cautions & Concerns

• Manage change effectively
• Need for strategic communication of issues and plan
• Longer term planning.
• Adequate time for phased implementation including preparation of manpower, ICT & infrastructure
• Increase investments to effect change
• Acts and Regulations to enable change
• Current economic & global situation may not be an ideal time for change but is an ideal time for planning & preparing the groundwork
THANK YOU