Can the gov't continue to subsidise healthcare?
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What is the Malaysian Medical Association's (MMA) stand on the issue of the full-paying patients? The MMA has always supported better remuneration for doctors and specialists in the public health sector, although in this particular issue of full-paying patients, the MMA has some reservations.

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

temerloh hospital 110505 hospitalSo in this context, should the MOH allow specialists in the public hospitals to be given a choice to have private practice? Earlier, this was in the form of limited private practice at private medical centres and the universities to help make their service conditions more attractive, and perhaps to help retain their much-needed services in the public sector.

Whilst this has possibly helped to stem the outflow of experienced staff to the private sector, this approach has been criticised for some abuses, especially when found within the same hospital's private wing. It has been pointed out repeatedly that some specialists appeared to spend more time in private practice than in the public health facilities, thus undermining the services provided for the less privileged.

Some poor patients have also been asked to go to the private wing or centres for quicker access for some surgeries or procedures, which has caused complaints of unfair rationing, pressure and preferential treatment. Therefore the MMA supports that better regulatory limits be put in place to clearly define how many hours doctors can work in the private sector versus public institutions, where the patient load is far more onerous.

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

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

Nevertheless, the MMA has always been worried about our very heavily subsidised healthcare, so much so that our rakyat do not seem to understand that healthcare is not free - someone has to pay for it. Having a system where the poor pay only RM1 for clinic visits and medications is not sustainable in the long term, no matter that this seems to be politically correct, and popular. So the government has painted itself into a corner.

Is the rakyat ready?

We recognise that the government would love to continue to provide nearly free medical and healthcare for everyone, but the mechanism for financing this is far from adequate or structured sufficiently well. We do not have enough allocation for such a heavily subsidised system of healthcare. There has to be a form of tax or insurance buying that is big enough and purely allocated for healthcare for this to work.

But is the rakyat ready for this new form of tax or social insurance scheme? Perhaps the time has come to bite the bullet and expose the reality behind the healthcare costs - there are no short-term measures just for political grandstanding moves, which cannot be sustained. Will such a co-payment scheme help pay for costs of healthcare? A report from the Selayang Hospital full-paying patients experience showed that in 2008 and 2009 respectively, some RM1.794 to RM1.717 million per year were generated from this scheme.

This catered to a total of some 1,830 to 1,649 patients respectively, with the bulk paid for from in-hospital services (RM1.35 to RM1.47 million) but actually catering to only 497 and 499 in-hospital patients, respectively. Specialist doctors receive 30% to 90% of the services provided, but the actual quantum was not specified.

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

Given the above scenario, will 'subsidised' patients be given fair treatment in the public hospitals? There is always the fear and perception that poor subsidised patients would be shortchanged and asked to wait longer, or even be pressured to move toward the full paying side for 'quicker' queue-jumping accelerated care. This cannot be denied.

And unfortunately some poor patients have every right to feel this to be so. Because every ill patient would surely like or even demand diagnostic testing and treatment at the quickest possible time. However, for urgent treatment including surgeries for emergencies, the rakyat need not be too worried.

All doctors and health services will always give preference and priority for emergencies, no matter whether one can afford to pay or not. This fear of being ignored or wait-listed is unlikely to happen because there is always the medical 'need' consideration, which will always give such patients the leapfrog priority for all urgent or emergency cases to the front of queues for treatment. However, perception and possibly experience may be different in reality.

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

Subsidy remains unaddressed

hospital heart surgery patientsThere is a suggestion that the government reverts all healthcare personnel to be paid like the (National Heart Institute) model, where premium salaries are paid to help retain personnel and encourage greater dedication to work. This

has helped to reduce staff turnover (to less than 3%) and greater stability of available experts and other personnel and also more consistent service availability.

In other words, there is a suggestion that we develop an entirely different salary scale for the health and medical services, perhaps even a dedicated Medical Services Commission, parallel but outside the Public Services Commission. This has been suggested, but may not be feasible, as someone still has to find the funding for such a service commission.

Also, other professionals from other services may then also demand their own commission, so where do we stop? But this identification that doctor salaries are the main costs of this exercise is also misleading. Salary or remuneration costs while important and high, form perhaps just 20 to 30 percent of the costs of healthcare in most countries' healthcare expenditure.

The concept of full-paying patients is also to collect for the other services and other components other than doctor fees. So the larger subsidised component still remains unaddressed.

The health minister has said that "government and private sectors should work together. Because the doctors that we train are for the nation, irrespective of (whether they work for the) government or private.

"Doctors are serving the people. In Malaysia, 41 percent of our population go to private hospitals and clinics and 59 percent go to public health institutions. Therefore, the private sector is playing an important role to ease the burden and also the workload in government hospitals."

It is heartening that the current health minister is enlightened and positive about this private sector contribution. It is with this in mind that the MOH has recently invited GPs (general practitioners) to register and help participate in MOH health clinics throughout the country. However, whether this goes on into a viable full partnership is left to be seen.

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

No foolproof system anywhere

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

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

In his book on 'Good and Bad Power', Geoff Mulgan (a British political scientist) discusses that while most governments provide the structure, it is the more comprehensive, well thought-of infrastructure provisions that lead to transformative services - that "much of the

recent thinking about service ... has adopted models from the private sector ... largely drawn on industrial ... models favouring speed, standardisation, flow and efficiency".

He went on to describe: "(t)hese services are human, immediate, personalised and rich in communication, anticipating need rather than just meeting it and 'going the extra step'. In the case of therapeutic services the servant's job is to change the master, to make him healthier, fitter, and happier."

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

It is clear that there is no foolproof system anywhere on the globe. Some of the more successful models involve a mix of safety nets with monitored privatisation/corporatisation of services and allowing 'coopetition' (competition and cooperation) to thrive.

Lim further argues that "even in Europe, the sustainability of healthcare systems founded on egalitarian welfarism is increasingly being challenged as growth in demand outstrips supply. The debate is no longer about 'who should pay?' or 'who should provide?' but 'who can do the job more efficiently?'"

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

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

More cost-effective system

Full integration of private-public healthcare sectors appears unlikely (although this is one of the strategies of the MOH), but better partnership and collaboration of services can be aspired to, where the best of each system can be harnessed for the healthcare betterment of our citizens.

We should aim for a more cost-effective system, although not necessarily a lower-cost one. A single or easily portable system of reimbursement should also be considered.

While corporatisation/privatisation is still much feared and deeply unpopular as a model of divesting central control of unavoidable rising costs and developmental constraints, this might be the way to go if the model for market-driven healthcare is adopted.

This is the model practiced by Singapore, with its well-tried and tested schemes that can be tweaked to respond to the many diverse facets of healthcare peculiarities. Or conversely, a single-payer (and/or single insurance) National Health Service mechanism could be introduced, learning from the examples of say, Taiwan, Canada or the UK.

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

livable, affordable and acceptable for all Malaysians.

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