JOURNAL OF CLINICAL AND HEALTH SCIENCES

EDITORIAL

Issues in Healthcare Reforms

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INTRODUCTION

The recent 14th General Election signalled a fundamental change in the way this country had been governed since independent. For more than 6 decades, a single coalition government was in power, the victory of hope coalition parties or known as PH ushered a new era of change and enthusiasm with a genuine desire for good governance and transparency [1]. This is a calling that had permeated all government ministries [2] including the Ministry of Health (MOH). The appointment of an energetic yet ideological new health minister, an Imperial College London trained toxicologist to head the ministry and reign in all issues regarding health heightened the clamour to reform and improve our healthcare system, to face challenges of a changed nation and people, and the future.

HOW ARE WE PERFORMING?

As a nation, we attest to the importance of the principle universal health coverage or known as UHC; whereby the country will always seek to ensure that all her citizens have access to the required health services (promotive, preventive, curative and rehabilitative) of quality to be effective, and to ensure that the people do not suffer financial hardship to acquire these services[2]. To answer the question of performance, here are some recent external reviews of the performance and trajectory of our healthcare system.

HARVARD SCHOOL OF PUBLIC HEALTH STUDY

The Harvard TH Chan School of Public Health completed a comprehensive study of our healthcare system for the MOH in March 2016 [3]. In the report they concluded that our healthcare system is at a crossroad. Over the years, programs and plans have been very successful at meeting predetermined health challenges such as high levels of maternal mortality, infant mortality and under-five mortality, but the health system is ill-prepared to face new and rapidly evolving challenges the nation poses.

These challenges arise from significant demographic and epidemiological transitions, a shifting socio-cultural environment, technological changes and rising income levels, which have contributed to a nutritional transition, increasing health risks and new user expectations. I quote the report "in effect, Malaysia demonstrates a classic case of asymmetric transition, where the rapid transitions in context have not been matched with a corresponding transition in the health system to better address the current and future needs of the population." While we rejoice at the excellent health achievements of the recent past, but we seem slow or even oblivious to the changing and evolving health needs of our people, somewhat emanating from the successes and highs of our own system and national policies. There is a need for a fundamental shift in approaches to healthcare delivery as a result.

TRACKING UNIVERSAL HEALTH COVERAGE: 2017 GLOBAL MONITORING REPORT

In December 2017, a joint report [4], entitled above, was issued by the World Bank and World Health Organization on universal healthcare coverage and financing. As the title alludes, it scrutinises the worldwide performance of health systems in two major areas; UHC and catastrophic healthcare spending. The latter is defined as out-of-pocket expenditures (OOP) exceeding thresholds of more than 10% to 25% of household total income or consumption.

In the summary, on the first count, Malaysia scored a UHC index of 70 out of 100 points, ranking a respectable fifth out of 48 Asian countries and just behind Singapore, Brunei, Japan, Korea (>80), China (76) and Vietnam (71). Similarly, on the financial risk aspect, we have emerged as one of the best in the world, scoring 0.74 and 0.04 at the 10% and 25% threshold respectively, which was even better than the UK (1.64; 0.48) and US (4.77; 0.78). What makes these numbers even more significant, we have managed to attain these rankings through a very low healthcare expenditure, average of 4.5% of GDP or 9.4% of the total government budget for 2018. As a comparison, the total healthcare expenditure in Malaysia in 2016 was RM52.6bil, of which government contribution was 51.47%, private OOP expenditure of 38.9% and private insurance 8%.

Worryingly however, the data shows a rapid rise of OOP from RM2.93bil in 1997 to RM17.44bil in 2013, an average rise of nearly 29% per year with similar recorded trend of increase of nearly 52% in the private insurance sector over the same period. These trends exhibit the preference for the citizens to seek healthcare in the private sector which at the outset promises better access (avoiding significant delay and wait) and choice (first visit seeing consultant level practitioner and at preferred facility) and the overall service convenience (less congestion and hospital comfort) of the private sector. When OOP is used as option into private care, it increases the health gap and inequality in the healthcare costs, evident by 50% of the total health payment covering a meagre of only 20% of the population.

There is also the inherent risk of economic uncertainties or even downturns or other life challenges, which impact on income and therefore directly burden people's health and cause serious repercussions in an OOP-dominant environment as we are seeing today. The reliance on OOP and private insurance for care delivery are highly inefficient and they are expensive, and akin to allowing the growth of an unregulated commercialisation of healthcare which in the end is detrimental to the overall healthcare delivery [5].

CATASTROPHIC ILLNESS HEALTH SPENDING

This relates to the presence of a severe illness requiring prolonged hospitalisation for recovery, and inevitably results in expensive health spending. Our current healthcare coverage that includes a spectrum of catastrophic illnesses, which invariably incurs catastrophic health spending is highly variable. For example, coverage varies from universal cover for cataract surgery, dialysis, medicines for organ transplant and CML (chronic myeloid leukaemia) and dialysis, to practically non-existent for HCV (hepatitis C virus), stroke, epilepsy surgery or psoriasis. In another category, the coverage for some targeted therapies for knee replacement surgery, solid cancers, coagulation factors for haemophilia and anti-TNF for arthritis were poor, while coronary revascularisation, epoetin and anti-retrovirals and iron chelation for thalassaemia were insufficient.

The coverage for catastrophically costly treatments is uneven and inequitable in Malaysia. Despite many of these treatments are in fact affordable, on many occasions the coverage decisions are driven by inexplicable political-economic consideration. In one study that was conducted in many countries in ASEAN, it found that Malaysians (45%) are most likely to suffer economic hardship following a cancer diagnosis compared to the people in Indonesia (42%), and Thailand (16%) [6].

GLOBAL BURDEN OF DISEASE ON HEALTHCARE ACCESS AND QUALITY

A comparative study, the 2015 Global Burden of Disease, estimated the measure of healthcare access and quality (HAQ) index to enable comparisons to be made among 195 countries in the world from 1990 to 2016 [7]. The index is based on amenable mortality, defined as risk-standardised mortality rates or mortality-to-incidence ratios from causes that, in the presence of quality healthcare, should not result in death. The HAQ Index encompasses 32 causes of death considered to be avoidable, and they include infectious diseases; maternal and child health; vaccine-preventable diseases; non-communicable diseases, including cancers, diabetes and cardiovascular diseases; and conditions in gastrointestinal system (e.g. appendicitis) from which death can easily be avoided by surgery. All the causes are measured on a scale of 0 to 100, with 0 as the first percentile (the worst), and 100 as the 99th percentile (the best) [8].

On these scales, Malaysia obtained an HAQ index of 68 and thus ranked 84th, but surpassed by all our near neighbours; Singapore, Brunei, and Thailand, the best in the region being Singapore, ranked 22nd with a HAQ index of 91. There is a great consternation in this fact, HAQ index for Malaysia, Sri Lanka and Thailand Malaysia were somewhat pegged in 2000, but a decade and a half later, both Sri Lanka and Thailand leapfrogged us resulting in their significantly better ranking.

DIFFERENTIAL MORTALITY

It is well known that our healthcare is geographically uneven and in some areas numerically incoherent to health needs and demands, and the results from a local study [9] from an anonymised mortality data from 1998 to 2006 from the Statistics Department is important to elucidate this aftermath. The authors found that socially disadvantaged districts in Malaysia had worse mortality outcomes compared to more advantaged districts. The mortality outcomes within ethnic groups were less favourable among the poor and premature mortality was concentrated among the poor of every ethnic group. They concluded that the findings suggest that national policies should emphasise the degree of need rather than ethnic-based policies to ensure that support is provided and distributed in an equitable manner. This is vital to prevent the gradient in health from becoming any steeper.

HEALTHCARE REFORM

The healthcare challenges our country faces are complex, multifaceted and interconnected and therefore the reforms will take time because some aspects are fundamental in nature, and will be slow because of system inertia and old mindset, but the changes are necessary as the present system is unsustainable and unstable, "while transformative change cannot be achieved overnight, Malaysian policymakers would be wise to implement stepwise innovations which will strengthen the Malaysian health system in order to more effectively address population needs and changes in the national context" [10].

The reform strategies and solutions require the participation of all stakeholders in the public and private sectors including the feedback from patients' groups and relevant welfare advocacy organisations. This is imperative as patient engagement is at the heart of accessible and safe care that is vital to achieving UHC goals and support the United Nations Sustainable Development Goals which prioritises healthy living and promotes well-being for all.

Healthcare reforms can be viewed as short term and long term. In the short term, the current administrative practices and cultures should be improved or revamped to avoid wastage, overlap, redundancies and uneconomical practices. Examples include overlapping committees or units, poor procurement or purchasing practices and processes, overlapping responsibilities, and overlapping new portfolios with already in existent in other ministries such as medical education and training. As the pertinent issues are numerous and interrelated and sometimes institutionalised; an internal self-induced reform will be superficial and cursory, thus an independent committee of previous health experts headed by a senior lawmaker should be useful to guide the process through.

Long term reforms are designed to stop and reverse the negative trends we see in the international reports that have been alluded to above. First, the primary health services (public and private) need a major and thorough reform to ensure that they become the gatekeep of secondary and tertiary healthcare in this country. This will maximise use of available resources for optimum healthcare, avoid health system abuse especially secondary care, ensure tight monitor and care of exploding non-communicable diseases among the population, and provide a good value for expenditure on healthcare. Data are awash on the benefits of a comprehensive primary healthcare provision that ensures a nationwide coverage. We have a disjointed provision of private and public primary care services, the former with the tendency for overlaps and unused capacity at the same time stretching resources in the public sector to the limit.

Second, there must be a meaningful and mutually beneficial partnership between the private and public healthcare providers, the latter is bursting with increasing demands for its services and the opposite for the former with extra capacity. The combination of clinics and family medicine specialists from both private and public sectors will be adequate to set the scene for a comprehensive primary care service where

an individual is accorded a family doctor for primary healthcare. For secondary and tertiary care, private hospitals could provide the extra beds and facilities required to reduce the pressure on government hospitals and ensure better healthcare delivery to the people.

Thirdly, there must be a new healthcare financing scheme to fund the healthcare delivery in the country. The present setup in both public and private is unstable and unsustainable. This is a major shift in healthcare policy and requires a bipartisan approval at the parliament because the implication is far and wide for the country.

Lastly, there must be a major revamp on the roles of MOH to allow a more focused, and decentralised MOH to monitor and regulate the healthcare delivery in the country. MOH should be lean, in doing so minimise or even forsake overlapping roles with other ministries such as medical education and training, research and development, and health financing. In the long term, MOH should ideally be devolved into independent regional health authorities where they can operate hospitals and clinics with autonomy but with greater accountability and scrutiny with their own funding

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