1Care for 1Malaysia: RESTRUCTURING THE MALAYSIAN HEALTH SYSTEM

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by

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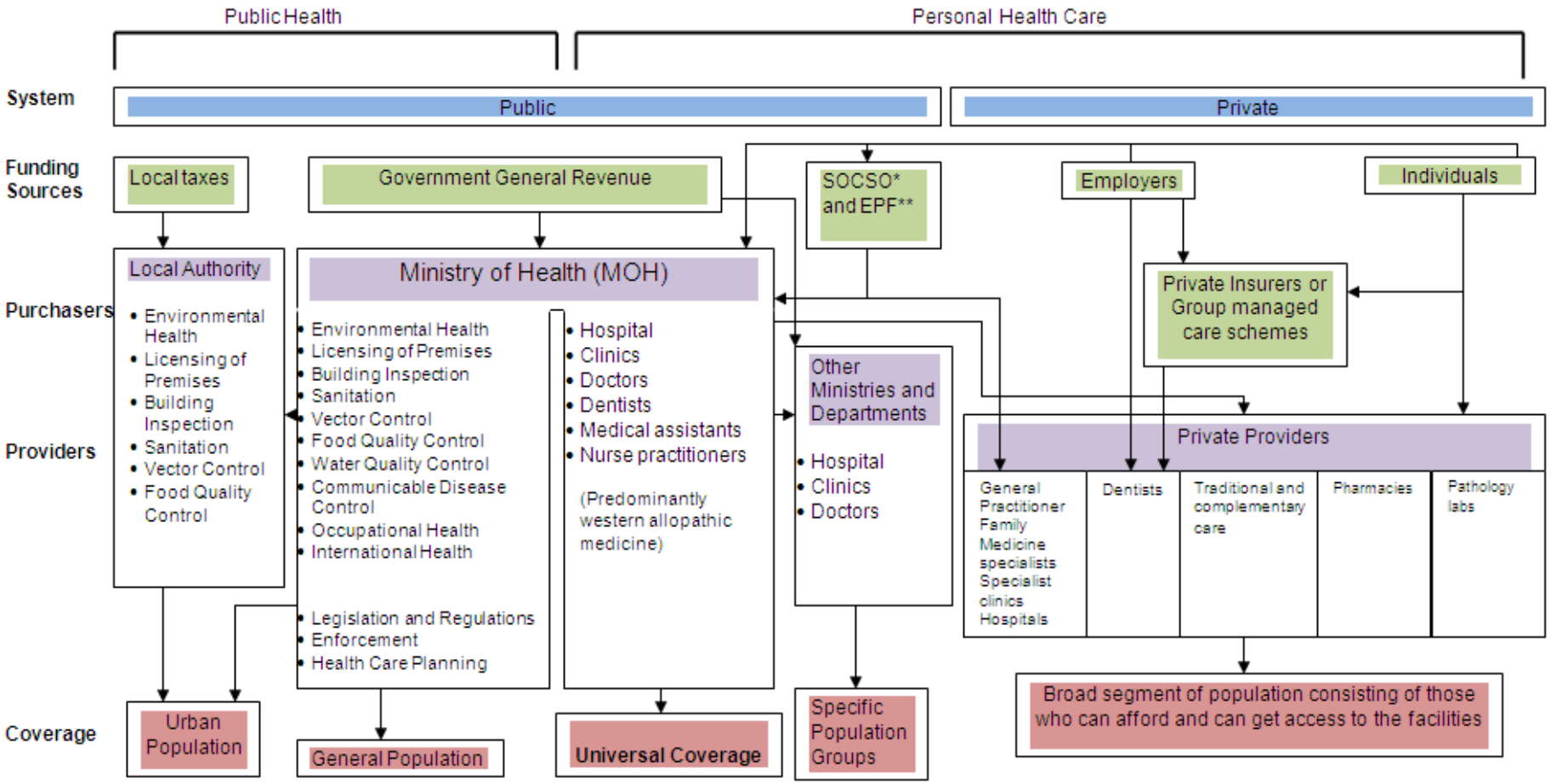
Presentation Outline

- 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



Estimated Market Share (from NHMS2)

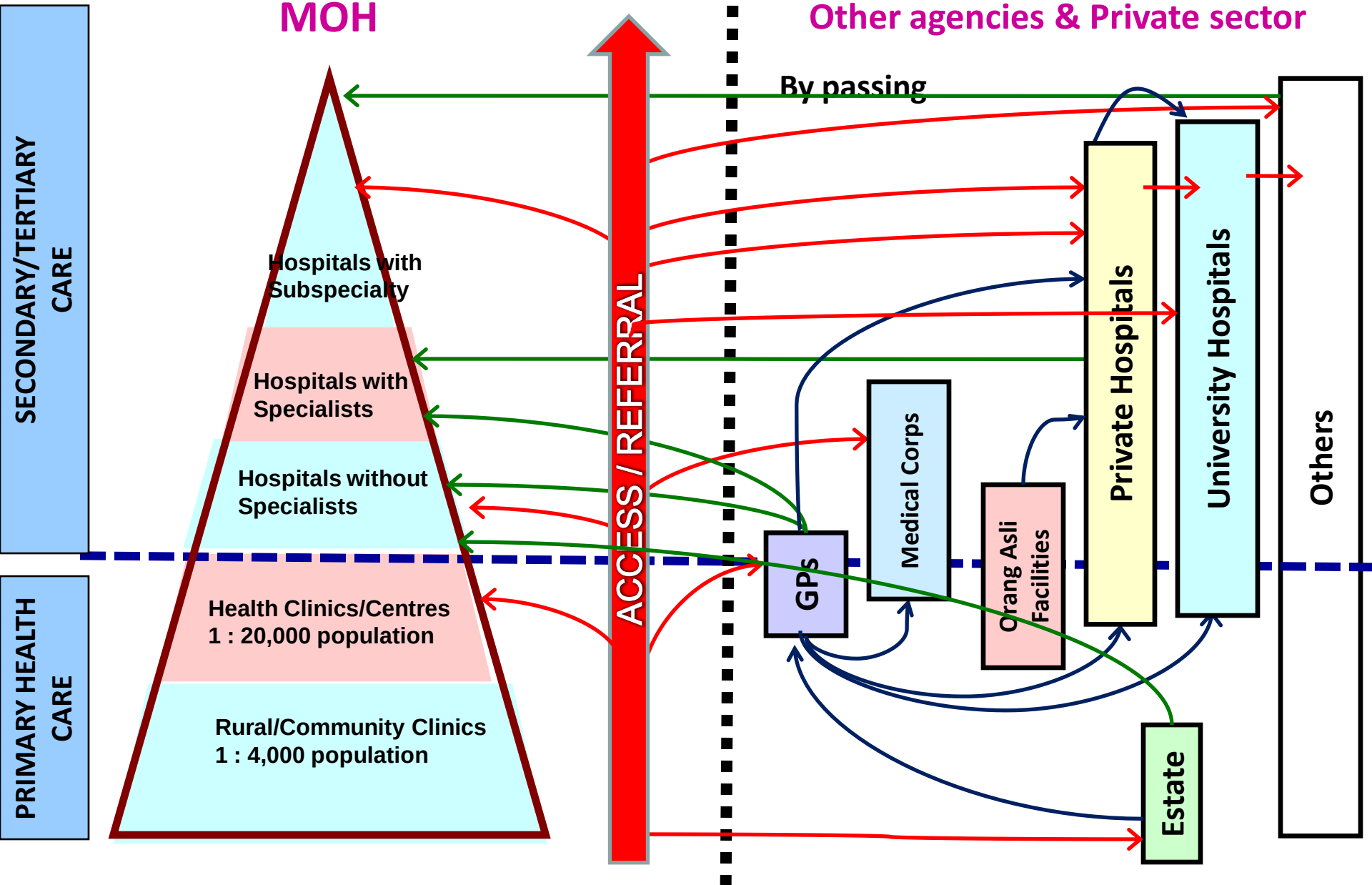
Hospital Admissions - 82% : 18%

Outpatient contacts - 35% : 62% : 3% (Others includes TCM, pharmacy and lab visits)

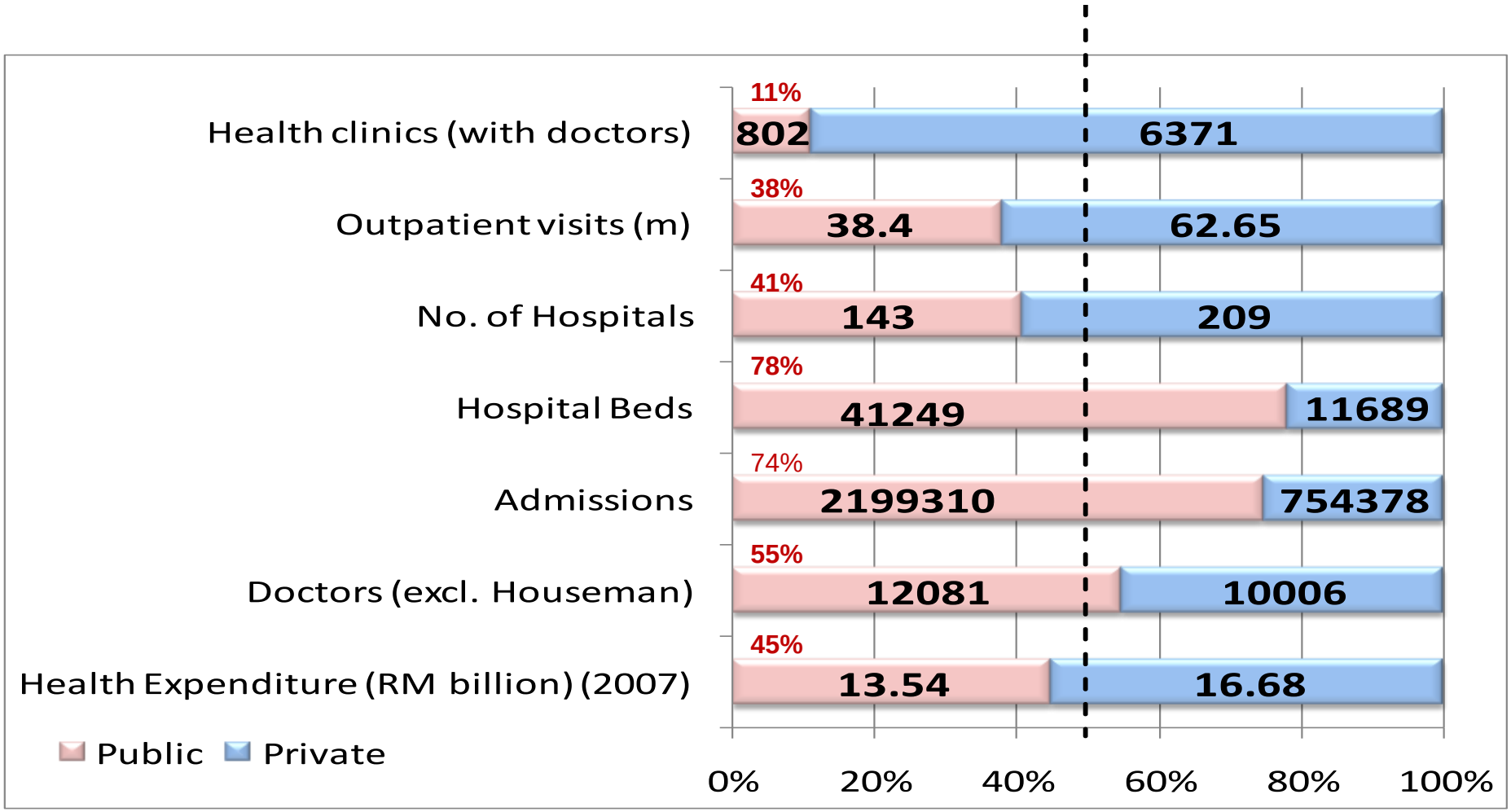
Source: *Rozita Halina Hussein,* **Asia Pacific Region Country Health Financing Profiles: Malaysia,** *Institute for Health Systems Research*

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

Access to Health Providers in Malaysia



Public & Private Sector Resources and Workload (2008)



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Source: Health Informatics Center (HIC),MOH

Current Functions of MOH

Within the dual health care system,

MOH is Funder, Provider and Regulator

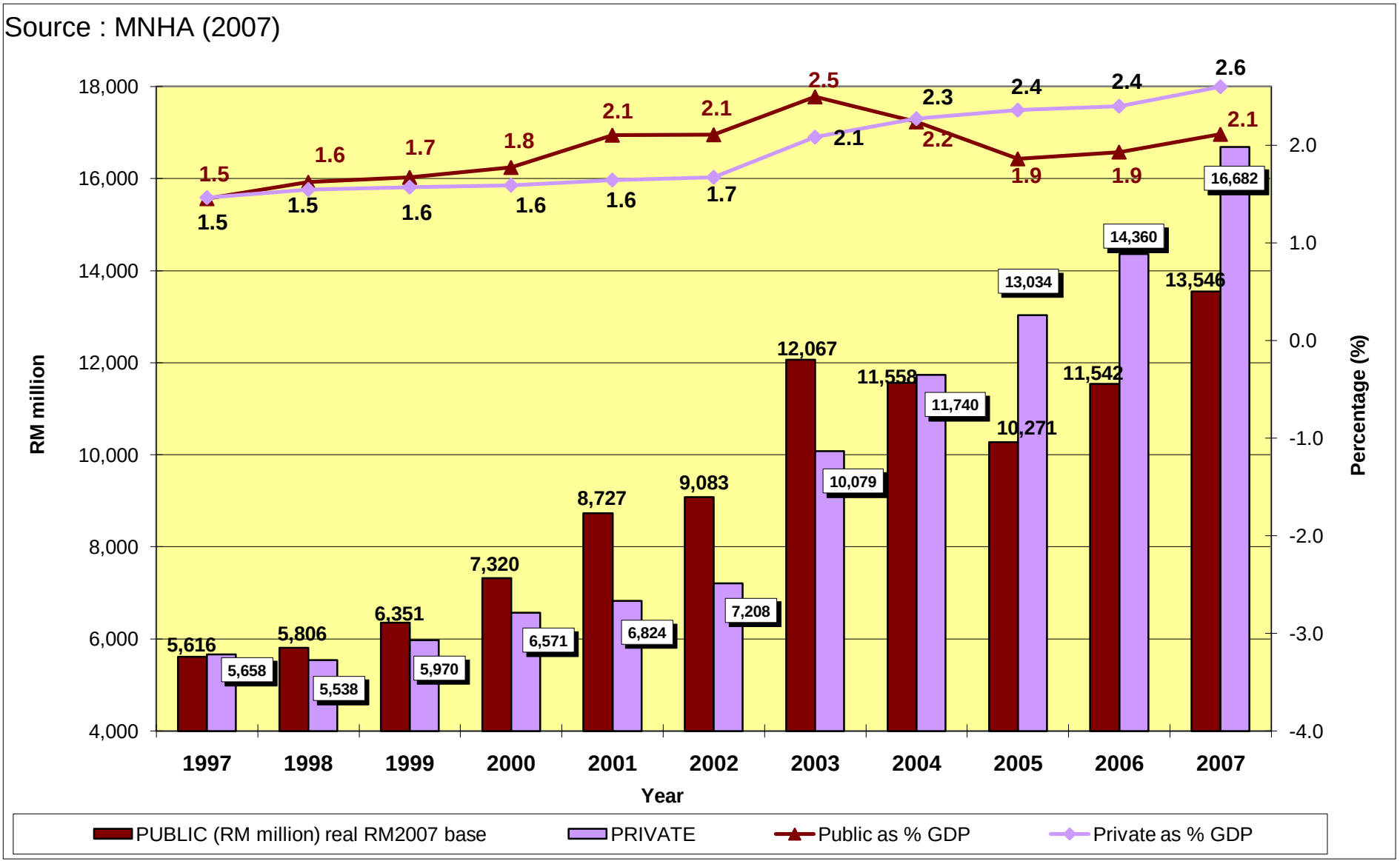
- **Health Policies & Planning**
- **Regulation & Enforcement**
  - Personal care
  - Public Health
  - Pharmacy
  - Technology
  - Medical Devices
- **Monitoring & Evaluation**
  - Quality Assurance
  - Health Technology Assessment
  - Patient Safety
  - Guidelines and Standards
- **Training**
- **Research & 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

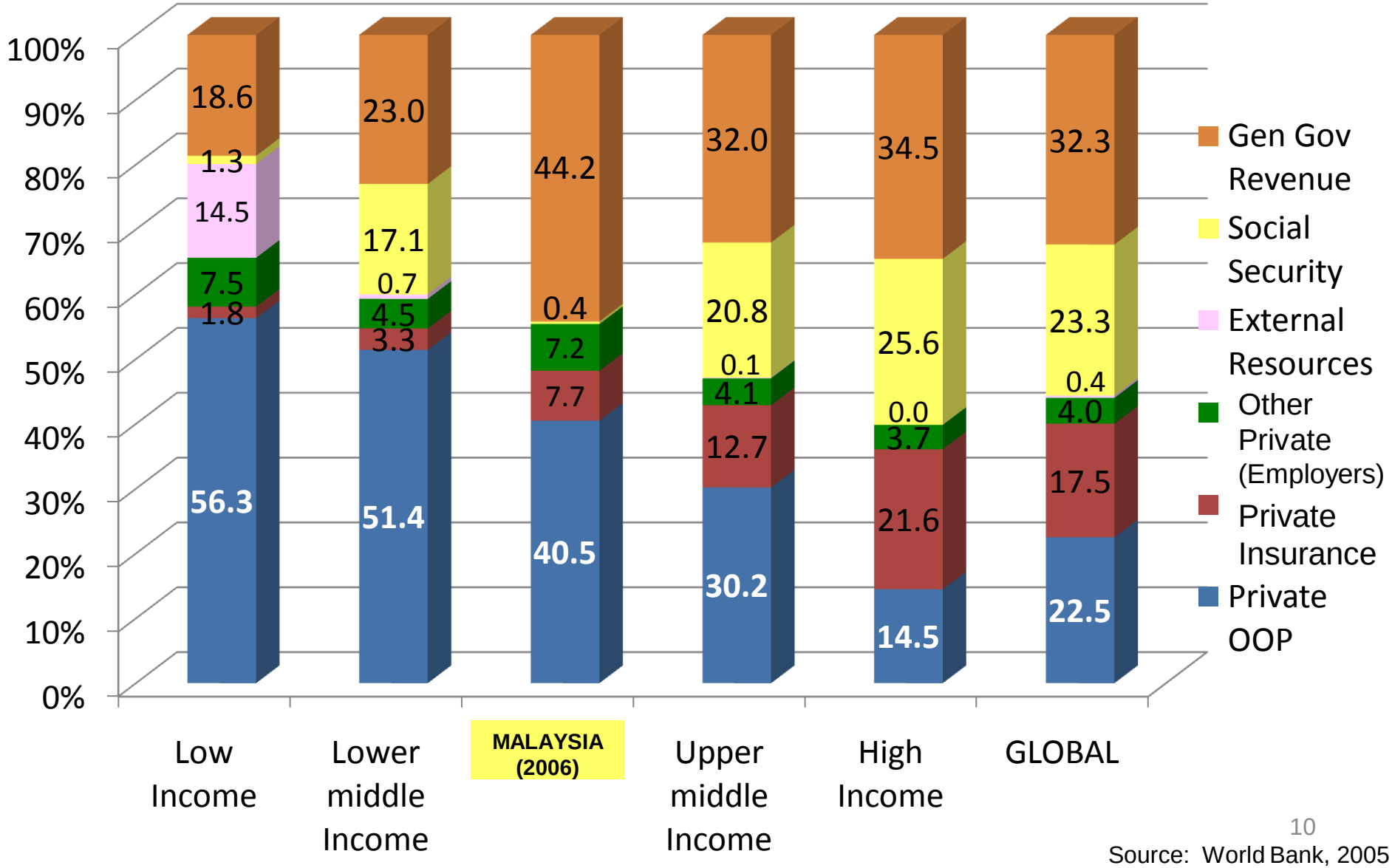
Current Challenges in Malaysian Health System

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

Public Private Expenditure on Health, 1997-2007 (2007 RM Value)

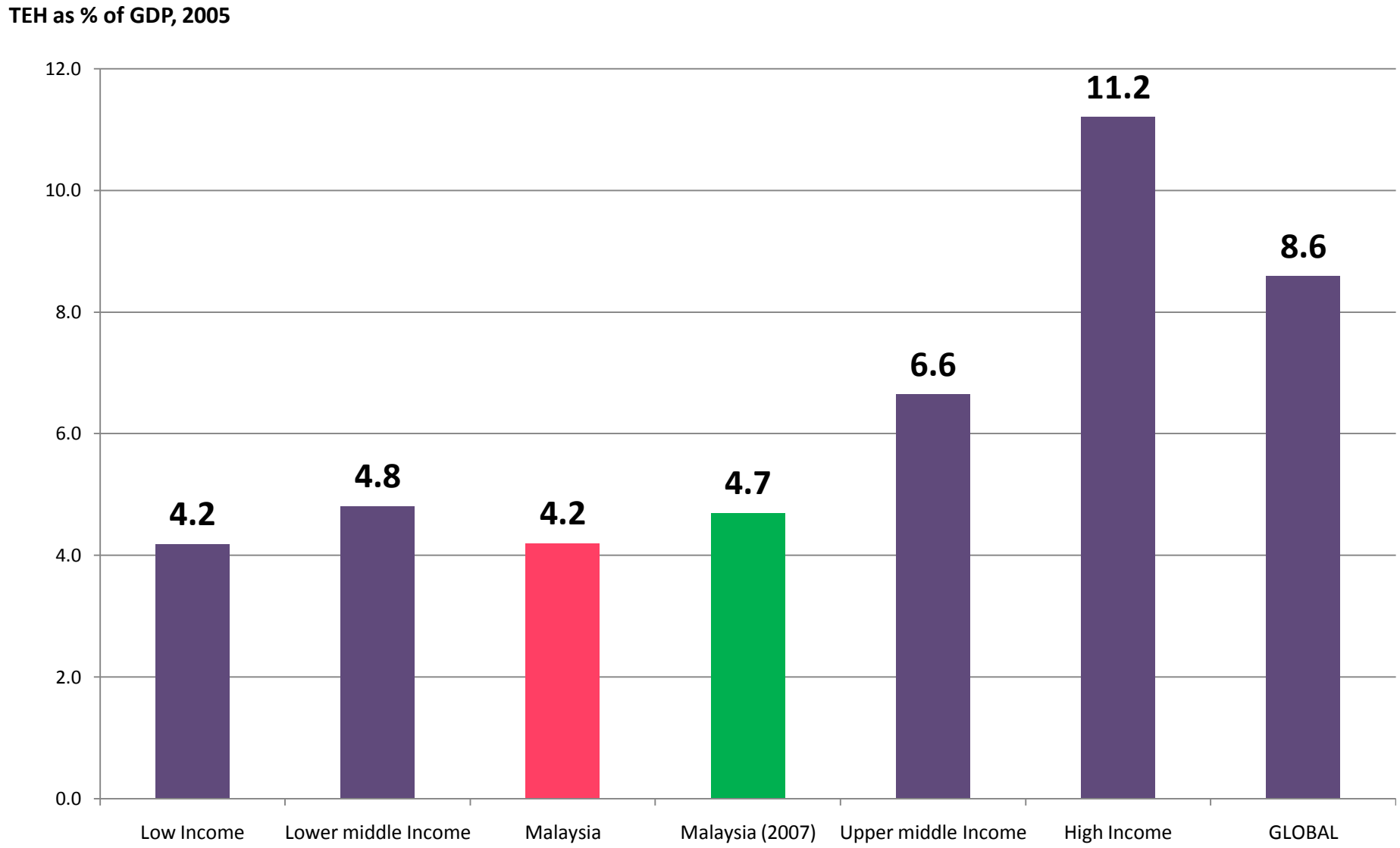


Ratio of Out-of-Pocket (OOP), Public & Private Expenditures



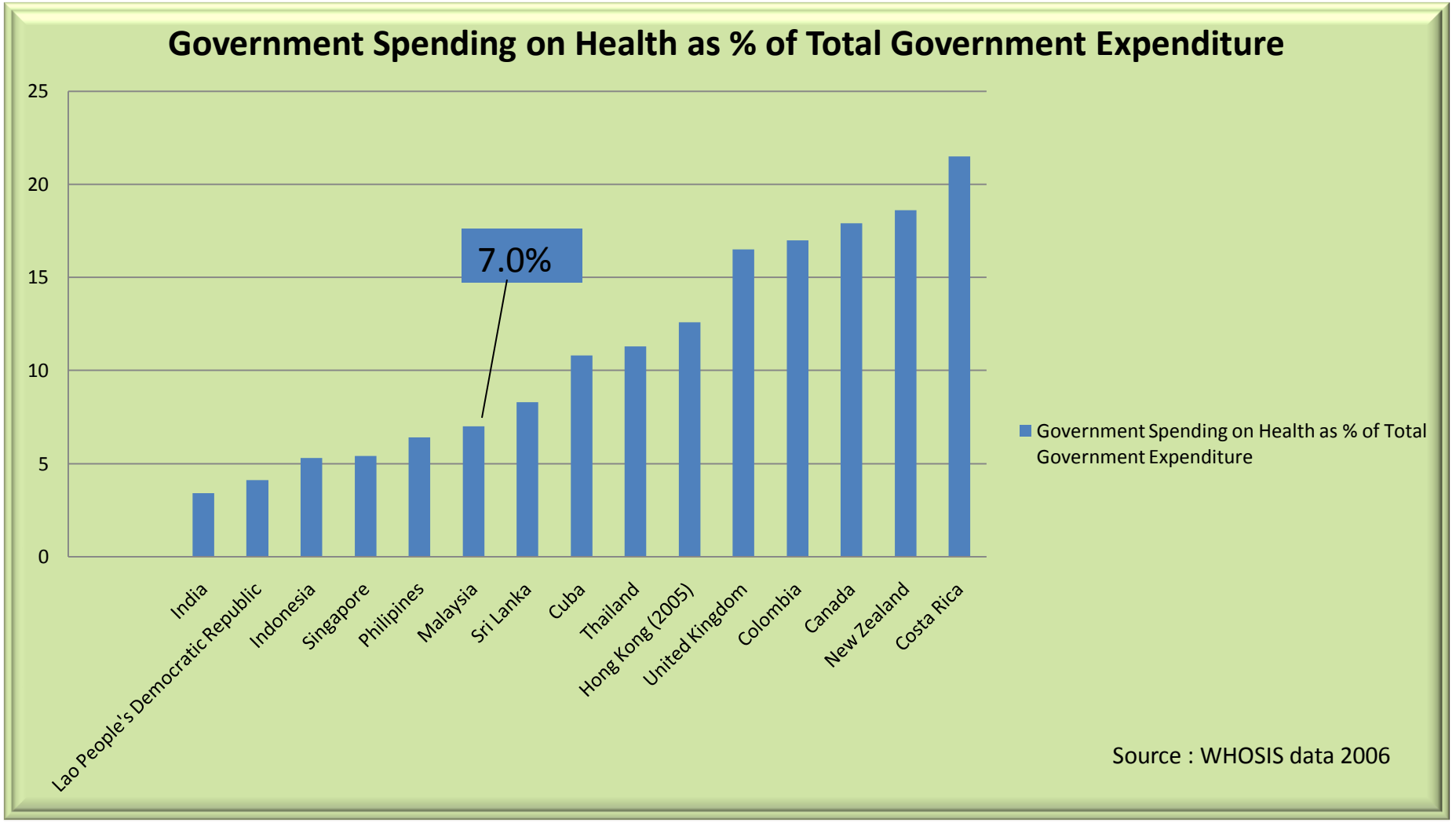
Source: World Bank, 2005

Total Expenditure on Health (TEH) as Percentage of GDP (2005)

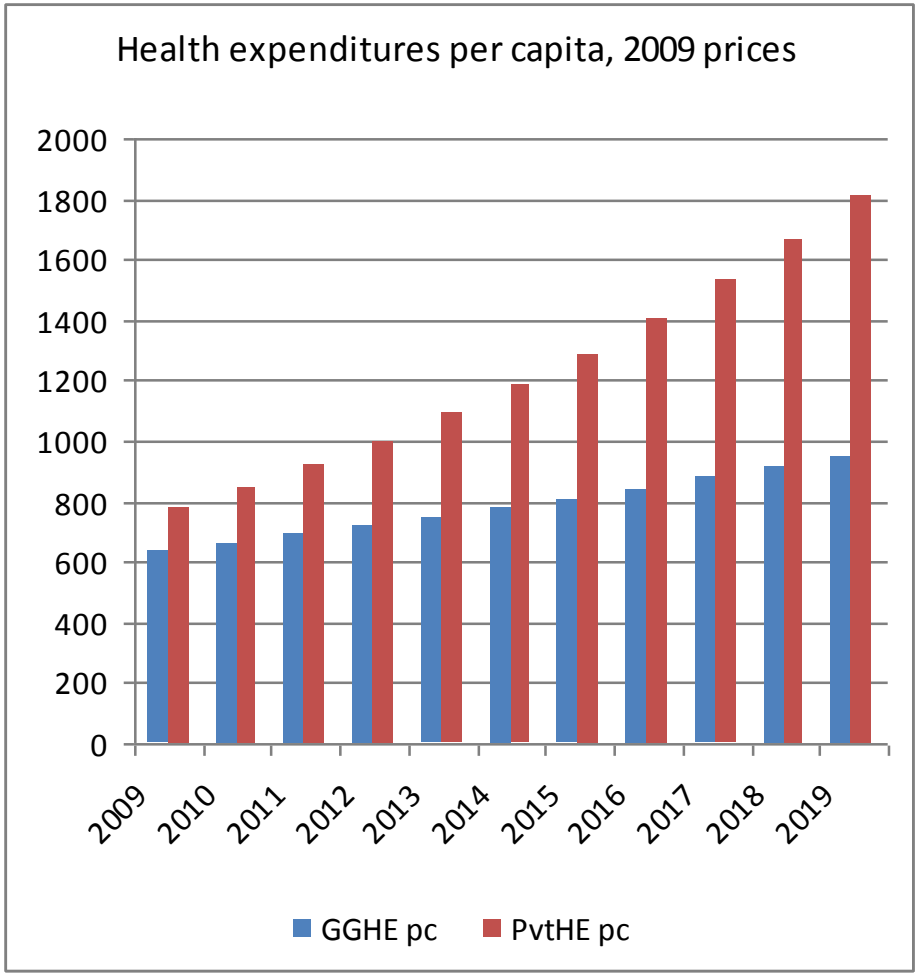


Source : World Bank, 2005

Government Spending on Health as % of Total Government Expenditure (2006)



Source : WHOSIS data 2006



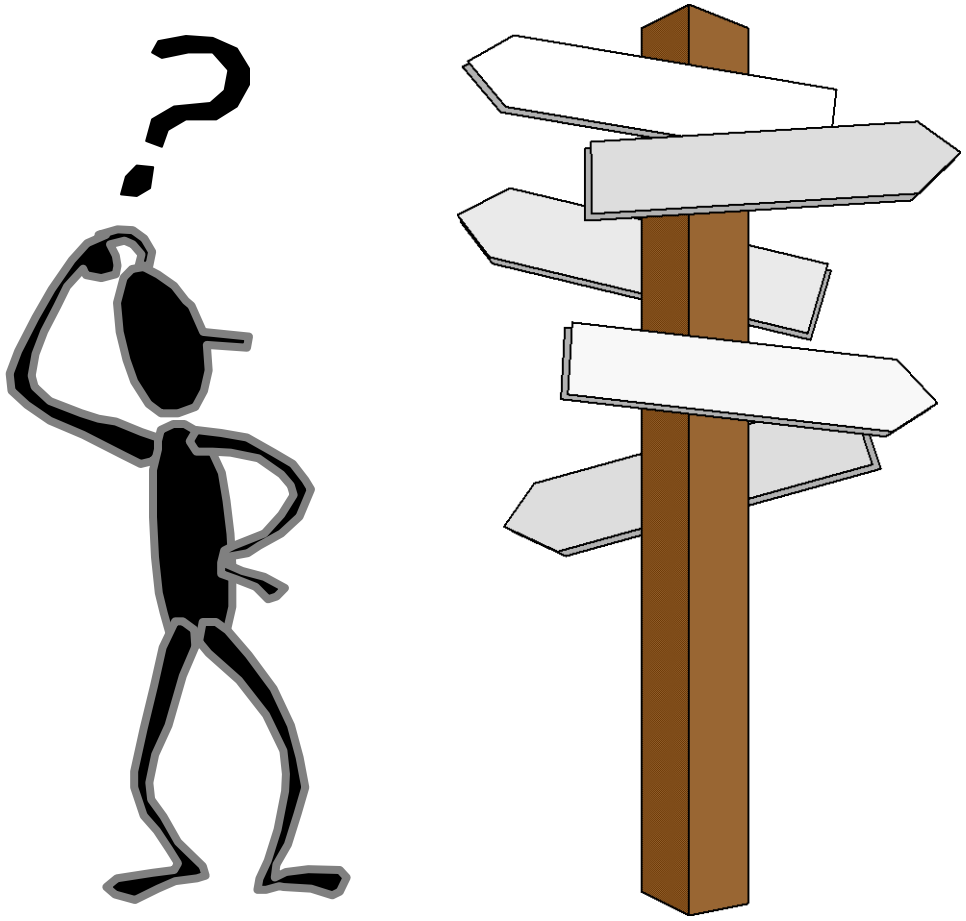
In the future with no restructuring of the health system…..

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

	2004	2009	2018
GGHE	50%	45%	35%
PvtHE	50%	55%	65%
-PvtOOP		40%	47%
-PvtOther		15%	17%

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 Concept

- **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

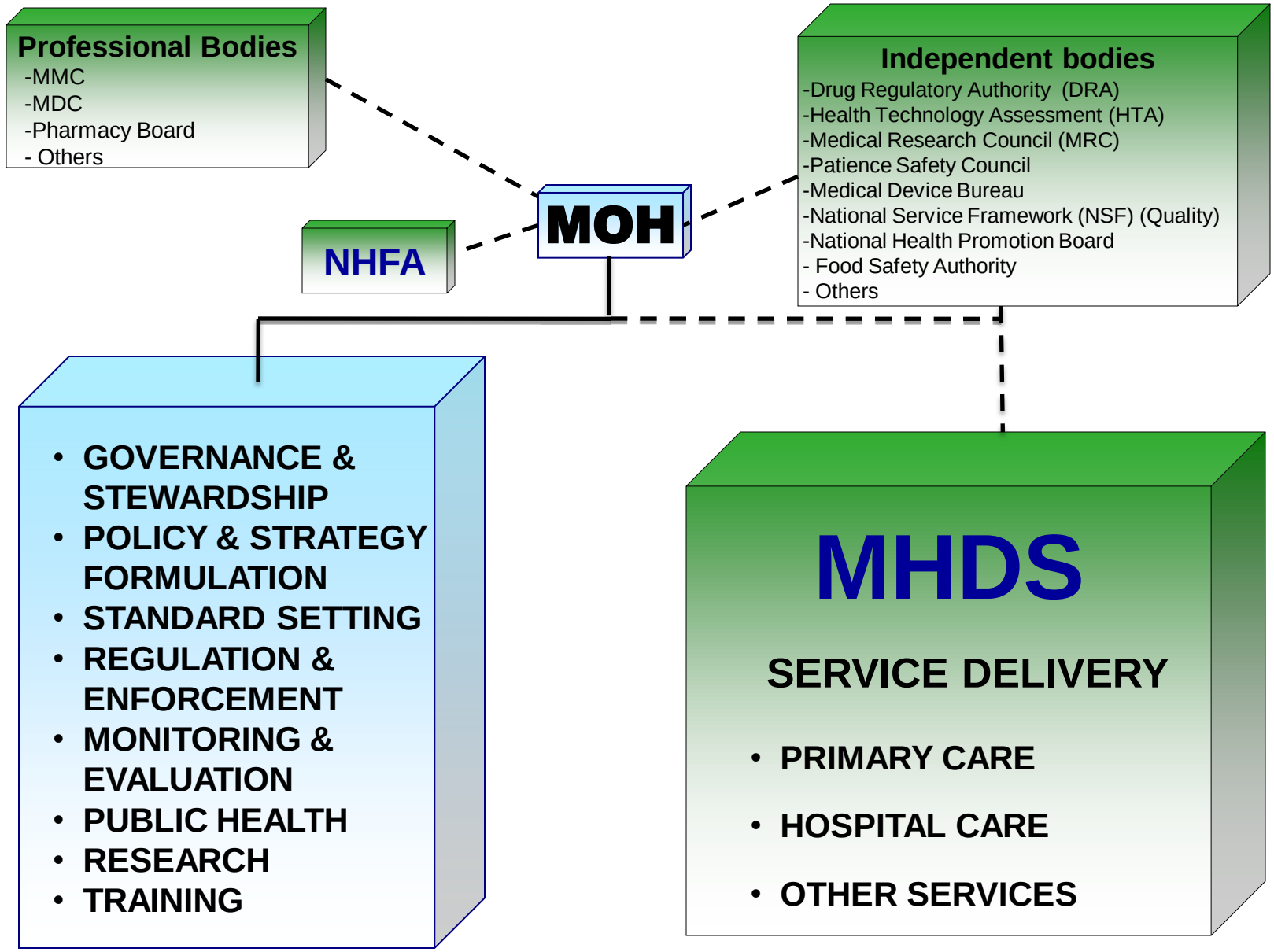
- Universal coverage
- Integrated health care delivery system
- Affordable & sustainable health care
- Equitable (access & financing), efficient, higher quality care & better health outcomes
- Effective safety net
- Responsive health care system
- Client satisfaction
- Personalised care
- Reduce brain-drain

Features of Proposed Model: BETTER than current system

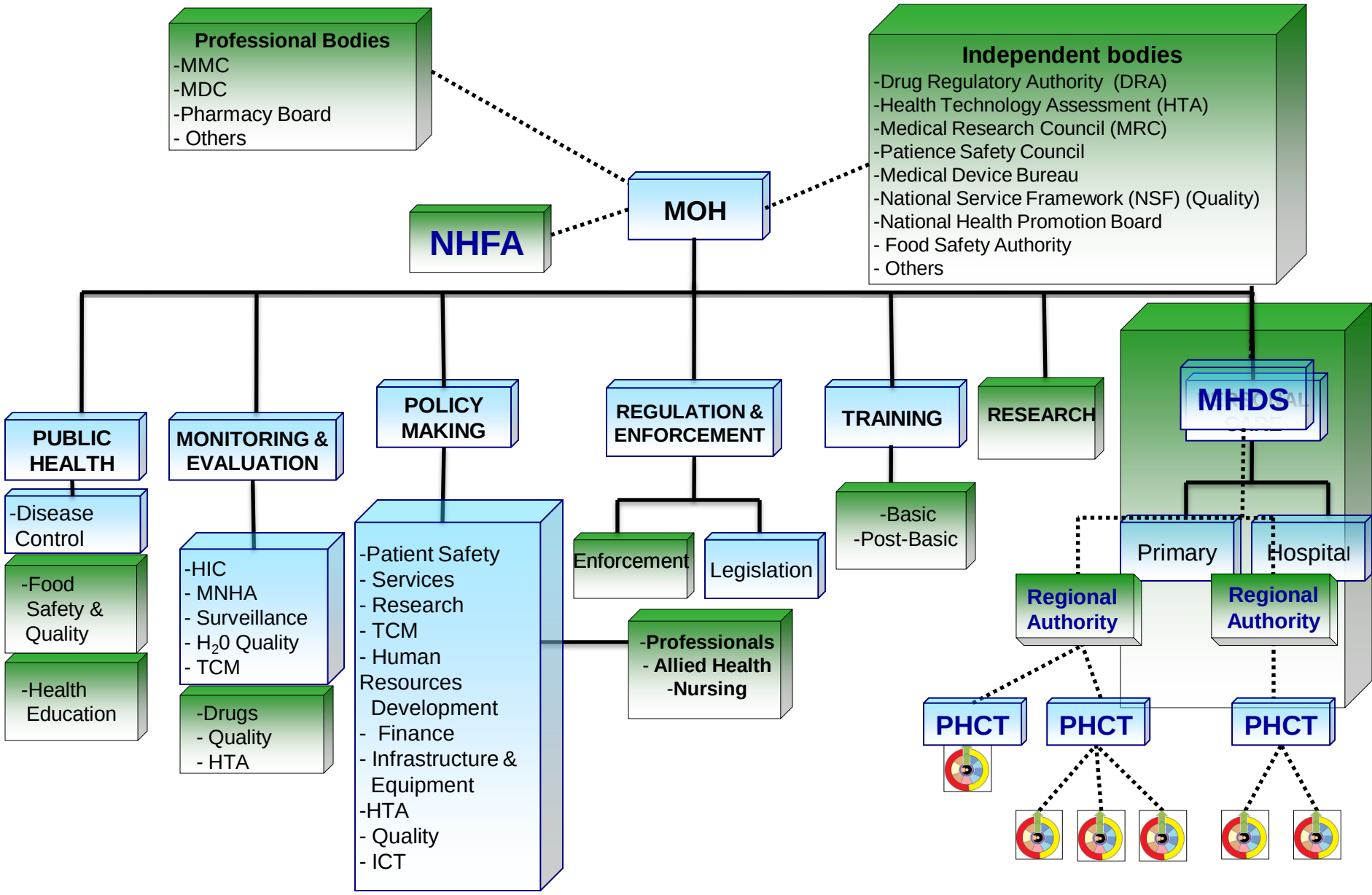
- Strengths of current system will be preserved
- Stronger stewardship role for MOH & government
- Separation of purchaser-provider functions
- **1Care** - Integration of health care providers & services
- More responsive to population health needs & expectation through increased autonomy
- Payments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

DELIVERY SYSTEM
&
GOVERNANCE

FUNCTIONS WITHIN THE RESTRUCTURED HEALTH SYSTEM



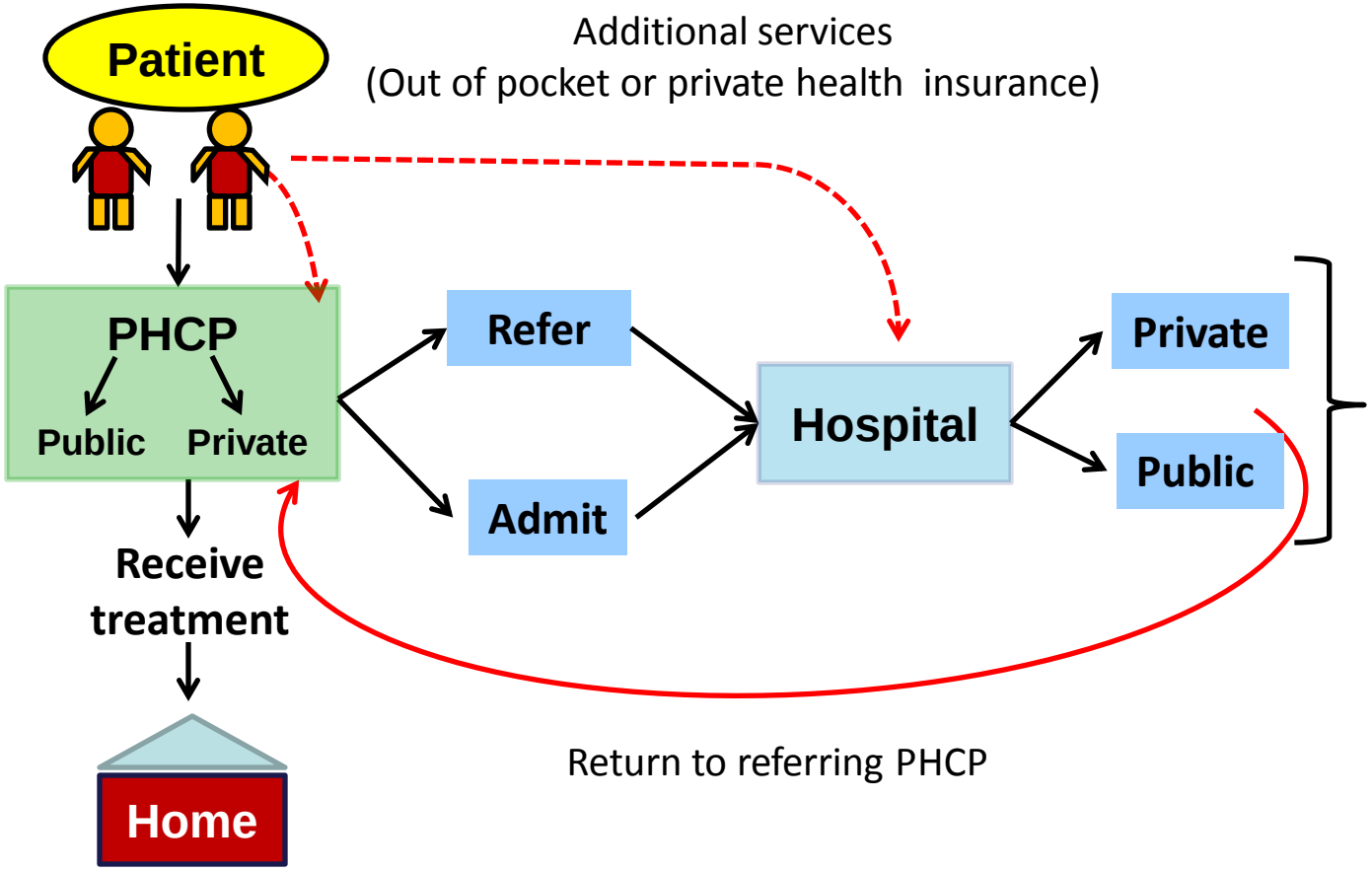
CHANGES TO CURRENT FUNCTIONS OF MOH WITH PROPOSED RESTRUCTURING



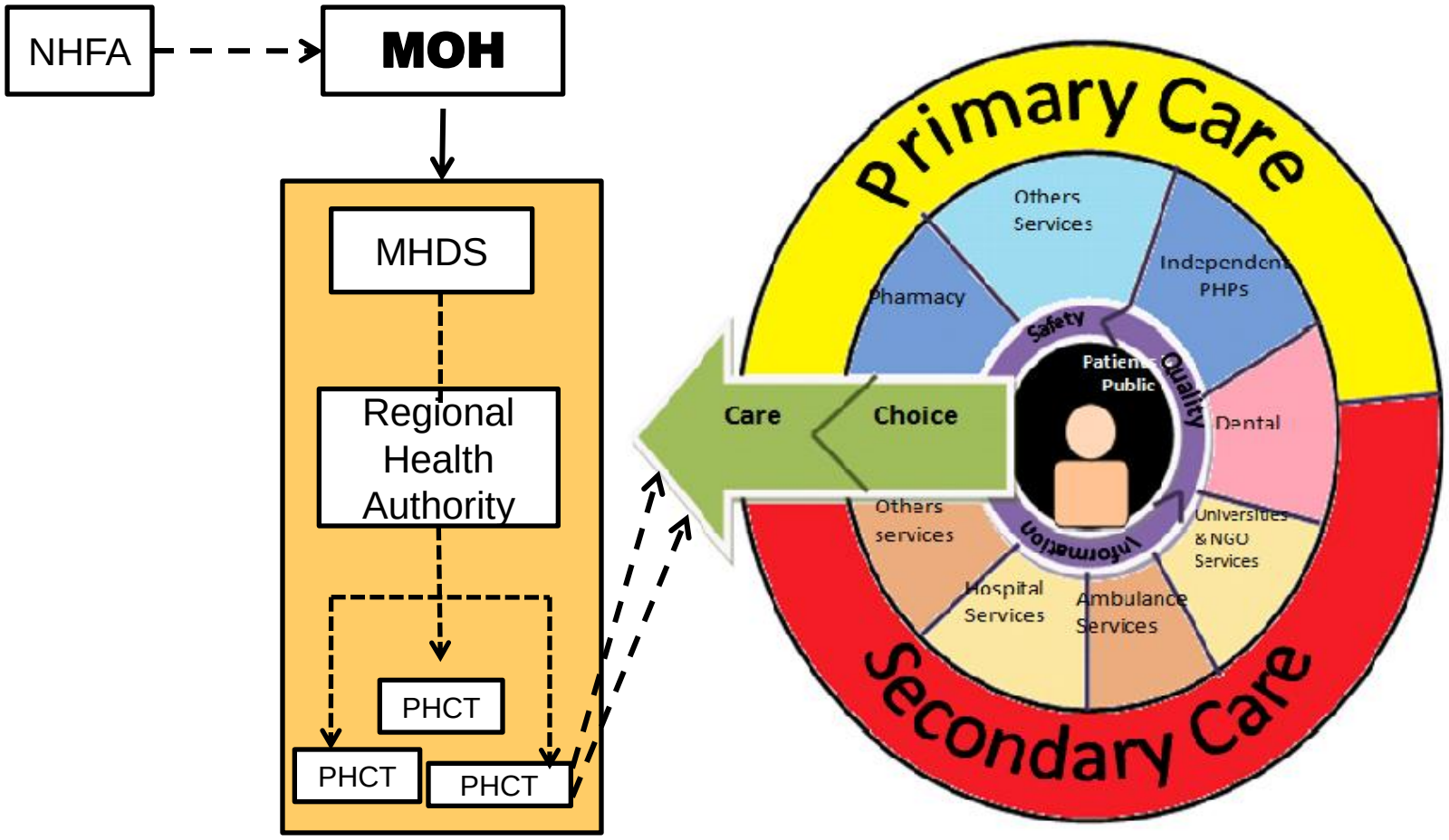
Scope of Autonomy for Independent MOH-owned bodies

- 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



FUNDING & GOVERNANCE



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

Primary Health Care Provider

- 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.

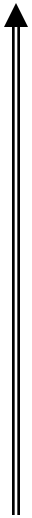
FINANCING

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

BEST



WORST

Equity	Risk Pooling	Reduce Risk Selection	Efficiency*
General Rev	General Rev	General Rev	User Fee, OOP, MSA *(Low administrative cost but sometimes hard to collect – so higher cost)*
Social Ins	Social Ins	Social Ins	Social Ins
Comm Fin.	Comm Fin	Comm.Fin	Comm. Fin.
Private Ins	Private Ins	Private Ins	Private Ins *(High Administrative Cost)*
User Fee, OOP, MSA	User Fee, OOP, MSA	----------	General Rev/ Direct Provision (*Inefficient*) – *Generally – may not be the case in Malaysia*

*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

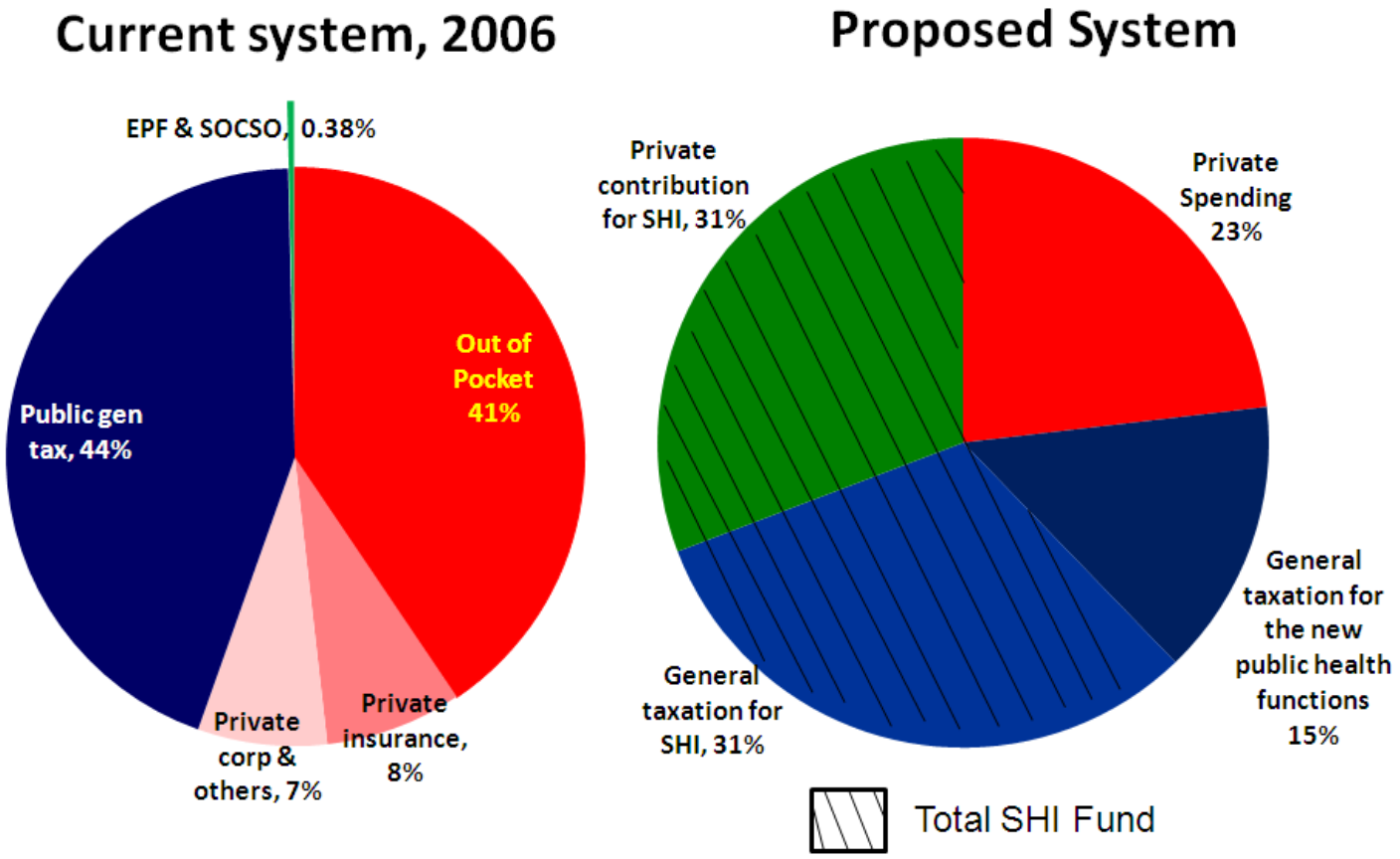
Disadvantages

- 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

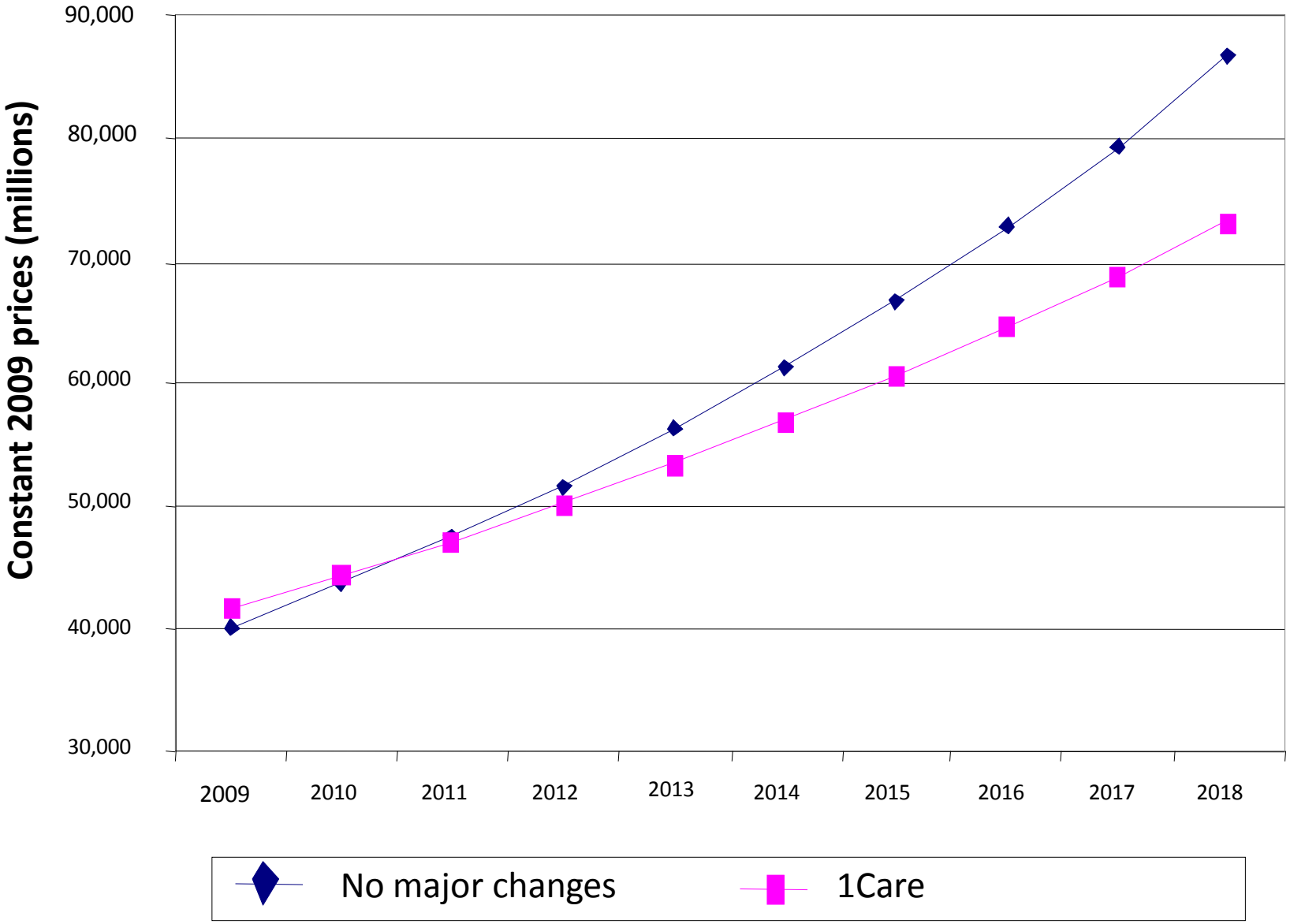
Financing Arrangements

- Combination of financing mechanisms
  - 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
- 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%)

Main Sources of Health Financing



Total Health Expenditures with and without 1Care restructuring



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 work load 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