President's Message

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September has been an eventful month when Malaysian Medical Association hosted the 33rd General Assembly of the Confederation of the Medical Associations of Asia and Oceania (CMAAO) and as a host the President of CMAAO came to MMA with Immediate Past President Dr Ravi Naidu, who then took the helm of CMAAO.

As it is the tradition of the CMAAO General Assembly, the first day consisted of the constituent members of each National Medical Associations (NMA) presenting the various countries reports on the activities of each respective NMA.

The second day is reserved for the scientific symposium and the theme for this year was "The Path to Universal Health Coverage (UHC)". Each Association was requested to present the progress in achieving UHC in their respective countries. A common string that was palpable in the presentations was the lack of investment or underfunded health care systems. Several countries have introduced social health insurance in some form or the other, while certain countries failed but readjusted their systems based on the experiences they obtained.

Our Director General of Health, Dr Noor Hisham Abdullah, was given the honour of being the Orator for the 16th Taro Takemi Memorial Oration which is held every year during the General Assembly. Dr Taro Takemi was a Japanese physician who was instrumental in the founding of the CMAAO and contributed significantly to both CMAAO and the Japanese Medical Association. His family together with the Japanese Medical Association fund the annual memorial oration and usually the host country is given the opportunity to nominate the orator.

Overall it was good learning experience for all the Council members as well as the SCHOMOS National Working Committee members who attended the scientific symposium.

I presented the Malaysian experience in universal health coverage and the lessons learnt and the paper is shared here for the members.

Universal Health Coverage in Malaysia

A COUNTRY is said to have achieved UHC "when the whole population of a country has access to good quality services according to the needs and preferences, regardless of income levels, social status, or residency" and when the country adopts policies "which incorporate objectives of equity in payments (where the rich pays more than the poor), financial protection (where people should not become poor as result of using health care) and equity in access or utilisation (where care received is according to need rather than ability to pay)."

The 2010 WHO report emphasises the equitable access to health care and the financial protection the system should provide as a pre requisite for UHC. These services should be of sufficient quality to be effective

How has Malaysia fared in the three components of UHC:
1. Access
2. Equity
3. Financial protection

Access to Health Care and Equity

According to a WHO report Malaysia has one of the best health care systems in the world in terms of access to health care and the public health indices. The health indices will be discussed later.

The health system in Malaysia is dichotomous with two well-established health care sectors, i.e. the public and the private sectors which are based on the health financing functions.

Public System

The public system has a wide network of around 1061 health clinics extending from the urban to the remote rural areas to provide primary and preventive health care. While it can be said that a public health care facility is within easy reach of any one living in the peninsula Malaysia, this cannot be said for those living in the very remote areas of the East Malaysian states of Sabah and Sarawak where it may take hours of trekking through dense tropical forests or perilous river journey to reach a health clinic. Nevertheless, there are

helicopter flying clinic services to reach some of these places. In general rural development has benefitted most of the rural population and has improved the health care since independence in 1957.

The public sector also provides secondary and tertiary health care services throughout the country and some of them are centres of excellence dedicated to provision of services in different specialities e.g. the National Heart Centre and the National Cancer Centre and a few University Teaching Hospitals. As of 2016 there were a total of 153 government hospitals with a total of number of 45,680 beds.

Services provided by government owned facilities are heavily subsidised and maintained through the structured progressive general taxation and therefore the taxation is concentrated among the rich. The cost recovery is extremely low at a rate between 3% and 5%. The heavy subsidy and low cost recovery has given a false impression to the public that health care is cheap.

The public health care system has been the backbone of health care delivery system though in the recent two decades private sector has been increasingly contributing to access especially in the secondary and tertiary care but limited to the affluent, direct out of pocket payments, through employee healthcare benefits provided by corporations, and to those with self-funded private insurance.

Private System

The private health sector has about 6,978 general practice facilities providing primary care to a significant section of the population on a fee for service model. These clinics are widely used though of recent these facilities are facing challenges due to low patient load combined with restrictive and regulated fees by the government and also by the third party administrators. Nearly 500 clinics had to close down in the last two years due to financial constraints imposed by the Government regulated consultation fees and also by the Managed Care Organisations.

The secondary and tertiary care in the private sector is provided by 216 private hospitals and medical centres which together have 14,260 beds. The private hospitals are mainly in the urban areas dictated by market forces and nearly all with the exception of a few are for-profit organisations with two corporations linked to the government having the majority of the private beds.

There are public perceptions of differentials in quality of care provided by private hospitals which have more advanced medical equipment compared to the public counterparts. The other differential is the distribution of medical specialists in the private sector and this is related to better remuneration that these specialists are able to obtain. The access to care at the primary, secondary and tertiary levels is also better for those who have the means with a minimum waiting time for consultation, investigations and surgery. In fact certain private hospitals have excess capacity available that are underutilised. This excess capacity can be better utilised by effective public-private partnership through social health insurance or by the government buying the services from the private sector. As it is, for-profit private hospitals are counter intuitive to universal coverage by not providing all the three components of UHC to all but they do reduce the burden on the public facilities.

Health Care Access by the Migrants

In Malaysia the international borders are porous. There is large number of legal and illegal migrants and workers. While legal workers may access health care through the employee benefit provided by the employers, a significantly large number of illegal migrants are unable to access health care if they are unable to pay. On humanitarian grounds lifesaving care is provided by the public facilities but in general the illegals who are generally poor do not access health care even when needed for fear of deportation and other legal actions that may be taken.

Key Health Care Expenditure Indicators

In relation to the country's economic development, Malaysia's investment in health care is relatively modest. It was increasing since 2000 but in the last few years there has been a reduction in the government allocation due to economic downturn.

Health care expenditure as percentage of total government spending has been around 5-6%.

Public health expenditure over 10 from 1994 has been 50-60%. In 2017 it was 52% due to budget cut, and RM25 billion was allotted for health care

Private health expenditure has been steadily rising over the same period of time and constituted 2.1% of the GDP amounting to RM 23 billion.

However, for 2018 the government allocation was increased to RM 27 billion consisting of about 2.3% of the GDP.

The private expenditure of another 2.1% raised the total health care expenditure to around 4.4% of GDP. This is still below the recommendation of 7% of GDP.

However, the new government that came into power through a political tsunami has pledged to double the public expenditure which will bring the total health expenditure to the recommended level. To be realistic this will not be achievable in the next few years due to the economic factors and the high debt of the country.

Sources of Funding

Federal financing of healthcare is through general tax sources and constituted about 55% of total health expenditure in 2012 reducing to 52% in 2016.

The private health care sector expanded rapidly in the last two decades. One of the consequences of this

expansion was a change in the health financing mix in the country.

The local authorities and town councils provide health care related services related to sanitation, food quality control and vector control services. The financing is mainly through rates collected, licensing fees and some allocation from the federal government.

The other sources of financing is provided by the Ministry of Defence to look after the health care of the military personnel and the Ministry of Education which manages the teaching hospitals.

Expenditure through self-funded private pre-paid health insurance plans constitute about 7-9%.

Out of Pocket (OOP) Payment

Direct purchasing of services through out-of-pocket (OOP) payments, especially in the private sector, plays a significant role in Malaysia. While in 1997, OOP payments accounted for just over 10%, in 2012 the OOP constituted 35% of total expenditure and this has risen to nearly 39% now. This form of purchasing is not very efficient especially when the fee for service system incentivises over supply of services.

The fees in the public sector is only a nominal sum of RM1 or RM5 which can purchase a consultation, investigations, medication and any other services a patient may need and have not changed since 1982 when they were first set.

Recently, the provision of expensive drugs and medical devices has been restricted and often, patients have to purchase them out of pocket.

Fees in the private sector are very much higher than in the public sector. The doctors' professional fees are regulated by legislation while the private facilities are free to charge without any restrictions.

Financial Protection

The fundamental objective of universal health coverage is also to provide financial protection for everyone in the country.

The parameters used to gauge the level of financial protection are the:

1. extent of catastrophic expenditure for health care
2. the impoverishment due to these payments

While these are good indicators but often may under estimate the actual extent of the problem as it may not capture a certain segment of the population that may not utilise the services being unable to afford OOP payments at all.

With this limitation it has been estimated that 1% of those who accessed the health services through OOP suffered catastrophic payments and mainly affected the wealthier segment of the population as they more often accessed the more expensive private services. This is relatively low compared to other countries in the Asia Pacific region.

The poorer households used the heavily subsidised public services more and therefore are less subject to catastrophic spending.

The intensity of impoverishment as a result of OOP is relatively low as there is a safety net in place for those who cannot afford to pay as they can always fall back on the free public health care system. However, there is one report released in 2013 that estimated impoverishment in some households up to 0.3%.

However, very poor patients may not be able to access health care due to other reasons like high transportation cost.

These indicators for the population that uses the public services may increase with the reduction in the budgetary allocation for health care resulting in increasing OOP.

Health Indices

In general the various health indices has improved over the years. However, of recent, certain indices are showing some disturbing changes, for instance the maternal mortality. The figures indicate that millennial development goal of reducing the maternal mortality rate to about 11% by 2015 has not been achieved.

Health Care Utilisation

UHC fundamental requirement is that the entire population receives health that they need. Has this been achieved in Malaysia. We can obtain some evidence indirectly from the health care utilisation rate.

In 2016 there were 63.5 million outpatient visits in the public health care facilities and 3.82 million (3,821,698) in the private facilities and this gives a figure of 2.13 outpatient clinic visits per person. Total hospital admissions in both private and public hospitals were 3,583,477 giving a figure of 113 admissions per 1000 population. Compared to 2011 the outpatient visits had fallen while the admission rate had increased

Health Care Utilisation

Year	Outpatient Visits per Person	Hospital Admissions per 1000
2011	2.32	110
2016	2.13	120

These services were utilised equally by all households irrespective of the socio economic but as expected the poorer households used more of the public services than the rich.

Based on these figures it can be safely said that Malaysia has achieved UHC and because of the virtually free public health care system the financial risk protection for the population is high.

Challenges Ahead

The great stride in economic development in Malaysia has brought about significant changes in the demography, changes in the lifestyle and the environment. Together with these the morbidity and mortality patterns have also changed. The demographic projections estimate those aged 65 years and above will more than double in thirty years from 5.0% in 2010 to 11.4% in 2040. Life style of the population has also changed with high consumption of tobacco and food with high content of fat and salt.

What are the effects of these changes?

The disease pattern has been gradually changing in the last three decades from one of communicable diseases to non-communicable diseases of which diabetes, hypertension and ischaemic heart diseases are becoming prominent together with the obesity epidemic. As a middle income economy the mortality rates of NCDs are nearly five times that of communicable diseases. With increasing life expectancy the disease for NCD is set to increase further.

There are also worrying trends of poor quality medicines and low availability of even drugs in the National Essential Drug List and this may have some implications for patient's access to drugs.

The study by the Harvard TH Chan School of Public Health which was commissioned by the Malaysian government has reported that the *"Malaysia's health system is at a crossroads. The system has very effectively countered the health challenges it was designed to address, namely, high levels of maternal mortality, infant mortality and under-five mortality, and has achieved excellent outcomes."*

The report further added:

"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."

In order to maintain universal access certain structural changes need to be made and this will require public engagement and debate and consensus. All the ingredients to bring about transformation of health care in Malaysia are already there.

It is also time to seriously consider a form of social health insurance to sustain the health care system as recommended by several studies.

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