President's Message

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Every country in the world has been grappling and trying to come up with the best healthcare system. However, there is no perfect system and each nation has had to adapt and change accordingly to their varying finances and circumstances. Some have stated or claimed that we already have a good system that does not need much improvement. Our dichotomous system is seen as complementary to each other but the disparity is very stark. The unequal distribution of medical personnel, the income disparities, the work load and the urban rural divide realities all contribute to a highly unstable situation. Cherry pickings by the profit-driven private sector and the bottomless safety net provided by the government sector cannot continue forever. There is a limit on how much each person can afford to spend on his healthcare over a life time. Sustainable healthcare is the reason why we need more dialogue between the stakeholders in this country.

I will attempt to add to the discussion by providing a quick survey of the issues in USA, Australia (where I am holidaying currently) and at home in Malaysia.

In USA

Immediately after President Trump's inauguration on 20 January 2017 he issued an Executive Order to repeal Obamacare. What was so wrong with Obamacare that the new President would want to repeal it?

American healthcare is big and diverse. In 2010 at the start of Obamacare, there were 46 million uninsured citizens and this was seen to be a big problem. Obamacare enabled 20 million to buy subsidised Medicare over the last 6 years. Medicare is a Washington DC controlled, single-payer system, with over 42 million enrolees. Obamacare has many benefits: it has allowed the uninsured to buy health insurance with no pre-existing exclusion clauses, it has enabled children up till the age of 26 to be on their parents' plan and it removes the qualifying age of 65. This problem requires the support of more government subsidies, which President Trump is unwilling to offer.

Now the cost of medical care has continued to escalate. This has resulted in increased premiums and many insurance companies are dropping out providing Medicare.

Additionally, Obamacare has greatly expanded the eligibility of the low-income group to join Medicaid (a health program run by the State Governments for 47 million low income people). Provision of Medicaid is mainly provided by contracted HMOs. The HMOs are known to tightly control costs by limiting medical services.

Medical healthcare for veterans is also fully paid for by the government under the Veterans Health Administration which has 150 VA Hospitals, 820 VA Community–based outpatient clinics and serves 22 million veterans.

The central goal of the Republicans in overhauling Medicaid is to reduce its funding. They also want to remove the requirement of having to pay a penalty if one does not wish to buy insurance. They want Americans to be able to buy skimpier health care plans in the hope of bringing down costs.

The majority of Americans (approximately 170 million) subscribe to private healthcare insurance. The plans are partially paid for as part of their employment.

The Americans are well known to have the highest spending per capita in the world (18% of GDP). They are also well known for having the latest innovations as well the highest in administrative cost.

It is thus evident that USA is a complex and a huge country with both private insurance and government-funded healthcare.

In Australia

In Australia, the Medicare, brought in by Gough Whitlam in 1972, is also facing much debate. Personally, I benefitted from free tertiary medical education and free health care when I entered medical school in 1972 following the victory of the Labour party. Australians pay a Medicare levy of 2% of their taxable income if they earn above AUD 22, 000 per year. The Medicare Levy Surcharge of between 1% to 1.5% extra is levied on tax incomes above AUD 90, 000 for singles or 180,000 for families if they do not have private hospital insurance. The surcharge aims to encourage individuals to take out private hospital cover and where possible, to use the private system to reduce the demand on the public Medicare system. The

private health insurance generally costs about AUD 2,000 per person or AUD 4,000 for a family. It is becoming more unsustainable as more and younger people fail to take up private insurance.

Under public discussion now is the National Disabilities Insurance Scheme (NDIS). This was first proposed by Gough Whitlam in 1974 and only became law in 2013. So any proposal does take a long time before it is accepted. This is projected to cost 1.4 billion to be made up from 0.5% of the Medicare levy. The Medicare levy was increased from 1.5% to 2% to pay for NDIS.

General practitioners get paid AUD 37.05 by the government's Medicare for a 20 minute consultation and this rebate has been frozen for four years under an agreement with the government. This has been negotiated with the freeze being extended three more years. GPs can charge more but patients have to pay the gap. However, 85% of GPs bulk bill, that is, they bill the government directly and the patient pays nothing to see a General Practitioner. General Practitioners only consume 7 % of the total health budget, but they play a very important role as the gatekeepers for social welfare and subsequent specialist care. Healthcare runs into social care with the GPs playing a central role in coordinating, making sure the patients are well looked after.

Social care in Australia is run by each local council and State Government with grant from the Federal Government. Similarly, hospitals are run by each State Government.

In Malaysia

1. The Chief Secretary Tan Sri Dr Ali Hamsa has expressed his disappointment with the report from the Disciplinary Committee of the MoH which said that many doctors failed to turn up for work, especially during their housemanship. He also said the highest termination from the civil service is from the medical sector and this has tarnished the reputation of the profession and our country. This has resulted in a big loss to our country, especially with many going overseas as government scholars. He also alluded to possible pressure at the work place, and many medical opinion leaders have pointed to the "toxic culture" of bullying in medicine.

While this might be true, the elephant in the room is the "too fast, too many" expansion of the medical trainees over the last decade. We are now seeing the consequences of such decisions made ten years ago to increase the number of training doctors both in government and private universities. The unknown number of doctors returning from overseas each year has exacerbated the problem to crisis proportion. This is the reason behind long waits for the Houseman training places. Employing the Housemen on contract might postpone the crisis for a little while, but with 5,000 new graduates every year, we are just kicking the can further down the road. The sensible thing to do is to turn off the tap now. It is the responsibility of our universities to select and train the right people for a medical career, which is both demanding and stressful. Some rational action is needed urgently now.

2. The arrest of seven medical doctors and one clinic assistant in Penang by the MACC for falsifying medical examination certificates of heavy goods drivers has no doubt damaged our reputation. MACC raided seven clinics and two private kiosks and premises. The doctors were paraded in bright orange scrubs for running a "express check-up" for taxi and bus drivers when the law required a mandatory health screening. The high carnage on our roads made this medical examination for public vehicle drivers essential in our fight against the unnecessary loss of lives. The Road Traffic Accidents deaths were recorded at 6,813 in 2014; 25 per 100,000 population, amounting to 18 being killed on our roads every day. Charging a lowly sum of RM 5 to RM 30 for the "health screening" for Public Service Vehicle (PSV) without examining the drivers led to the sting operation and arrests.

A review on our Health Policy is needed. The above two reports suggested things may not be going the way they should. Everything we do must centre on how it impacts our patients. The National Health Morbidity Survey 2015 will give us a good start to where we can do better; smoking, obesity, diabetes, an aging population and road deaths. Deaths due to communicable diseases are unnecessary. We fear the spectre of Multi Antibiotic Resistant bugs and the next influenza pandemic. We have to re-examine our medical training, primary and preventive care services, hospitals and how to pay for it all. We must re-evaluate our values and goals as affordability of healthcare service is increasingly a deciding factor determining whether many get treatment or not. We have to decide how much we want private enterprise to play a role. Whether "efficiency" and "rationing" are the same thing or just different side of the equation? Whether medical bankruptcies are morally acceptable. Is free treatment at the point of delivery still attainable at this age? How do we pay for the services? Is the lucrative private specialist practice attracting more to become specialists? How sustainable is the current system?

We need to discuss these and a host of other issues.

However, the conversation will not be complete without bringing in a discussion on the human dimension; how has the business and privatisation dehumanised the practice of medicine? Has the profit motive, the need to make an extra dollar or the competition to get ahead of the pack produced a toxic work culture? Are these doctors suffering in silence, unable to cope and finding no solution to resolve their problems? Proper selection and counselling of new entrants to the medical careers might prevent such losses. We, in our Association should do more by offering a helping hand to the isolated practitioners who had seemingly been doing what they thought was right for decades. A gentle nudge, a kind word, offering a listening ear, or extending our collegiality, will break down the walls we have built to protect ourselves. After all we are a caring profession.

Perhaps we can suggest making it compulsory, as part of the Continuing Professional Development requirement of maintaining our Annual Practicing Certificate, to belong to, and actively participate in the Malaysian Medical Association.