

Primary Health Care Reform in 1CARE for 1 Malaysia

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ABSTRACT

Primary health care is an approach to health and a spectrum of services beyond the traditional health care system while primary care is just one element within PHC that focuses on health care services. The present status of PHC in Malaysia and the strides it has made in uplifting the health status of the nation is described. The challenges that the Malaysia health system are facing have necessitated a review of the structure of the whole health system and reforms in PHC will ensue in due course. The concept of *ICare*, the proposed re-structuring of the health system, is discussed with emphasis on the reform in the PHC delivery system. The reforms are aimed at addressing three main concerns on seamless integration of care especially for the management of chronic diseases, ensuring universal coverage and responsiveness of the health system in the face of increasing client expectations and patient safety. The opportunity for macro reform to improve the health of Malaysians by developing a sustainable and high performing health care system is being seized by the Ministry of Health in *ICare*. The micro reforms are discussed as regards to increasing access to services, development of primary health care teams to deliver comprehensive PHC, the application of ICT, the renewed emphasis on health promotion & prevention activities and a renewed focus on community empowerment and participation. Support in terms of human resource, governance & funding models, capacity building in monitoring & evaluation as well as change management to affect the reforms are identified. The paper concludes with lessons learnt from other countries and the importance of systemic reform for a well functioning health delivery system.

INTRODUCTION

Primary Health Care refers to an approach to health and a spectrum of services beyond the traditional health care system while primary care is the

element within primary health care that focuses on health care services including health promotion, management of illness, injury prevention and personal care.

Healthcare services in PHC has a dual function of directly providing services at point of first contact and a coordinating function to ensure continuity of care and ease of movement across the system for individuals in developing their health.

Primary health care providers consist of a team of physicians, assistant medical officers (AMOs), nurses and community nurses, pharmacists, medical laboratory technologists, pharmacist assistants, physiotherapist and the listing grows longer as the scope of services at PHC becomes more comprehensive.

PRESENT HEALTH STATUS

The Malaysian PHC delivery system provides population-based services using a life-course approach in delivering services from womb to tomb. The health of Malaysia's population has benefited from a well-developed primary health care system, together with improved access to clean water and sanitation, and reinforced by programs to reduce poverty, increase literacy, and build a modern infrastructure.

Malaysia has made great gains in life expectancy for its people. Life expectancy at birth rose between 1970 and 2008 for men from 61.6 to 71.6 years, and for women from 65.6 to 76.4 years (Table 1); similar to the average life expectancy of 72 and 76 years for men and women respectively in 2006 in the Western Pacific Region of the World Health Organization. Infant mortality dropped substantially between 1970 and 2008 from 39.4 to 6.4 deaths per 1000 live births: just above Australia with 5 per 1000 and Singapore with 3.2 per 1000. Maternal mortality in that period dropped from 1.4 to 0.3 deaths per 1000 live births.

Table 1 Mortality and health indicators

	1970	1980	1990	2000	2008
Life expectancy at birth, female (years)	65.6	70.5	73.5	74.7	76.4
Life expectancy at birth, male (years)	61.6	66.4	68.9	70.0	71.6

Mortality rate, infant under one year (per 1000 live births)	39.4	23.8	13.1	6.5	6.4
Mortality rate, toddler (per 1000 children 1-4 years old)	4.2	2.1	0.9	0.6	0.4
Maternal mortality (per 1000 live births)	1.4	0.6	0.2	0.3	0.3

Source: Department of Statistics Malaysia, Time Series Data, Population Statistics, accessed at <http://www.statistics.gov.my>
WHO World Health Statistics 2010

Although non-communicable diseases now account for most mortality and morbidity, communicable disease continues to be a threat but great progress has been made in the past decade in prevention and control as shown in the downward trends in Hepatitis B, measles, diphtheria, neonatal tetanus, pertussis and HIV, although dengue, tuberculosis, and malaria remain concerns. Rates of vaccine preventable diseases have dropped in recent years in response to active vaccination programs with high rates of immunization coverage.

The incidence of Hepatitis B has dropped steadily since 1999 to 3.2 per 100,000 (886 reported cases) in 2008. Peaks of measles were

reported in 2000 and 2004 but the rate declined thereafter to 1.2 per 100,000 (334 measles cases) in 2008. Incidences of polio, diphtheria, and whooping cough (pertussis) have been low for the past 20 years, and neonatal tetanus has been less than 1 per 100,000 live births (Figure 1). Malaysia began its national polio vaccination program in 1972, the last polio outbreak occurred in 1977, the last indigenous wild poliovirus was reported in 1984, and no polio cases were detected until 1992 when three imported cases were reported. Malaysia was certified as polio-free country by the World Health Organization on 29 October 2000.

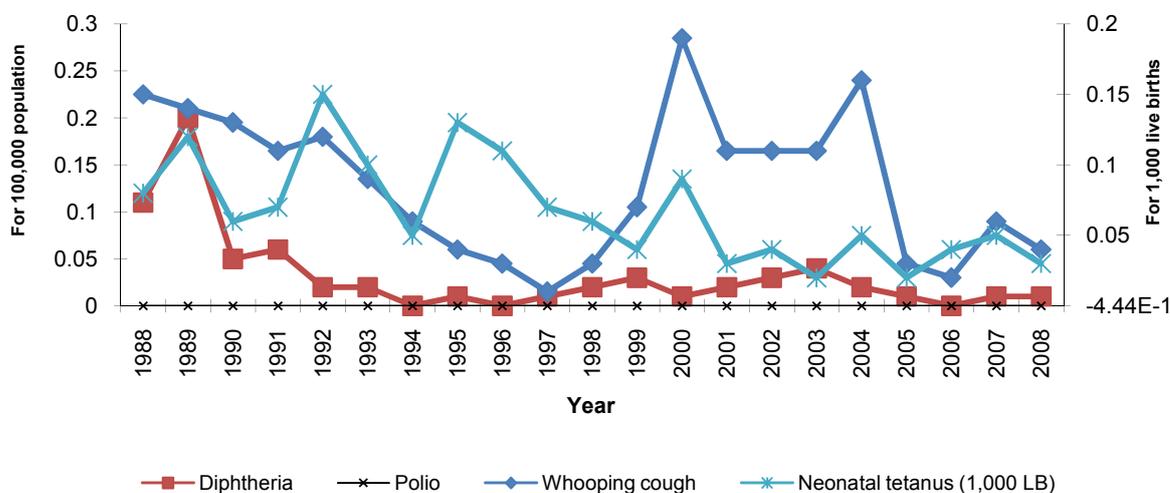


Figure 1 Diphtheria, pertussis, neonatal tetanus and poliomyelitis, 1988-2008

From the Rural Health Service Scheme (1953-1956) and the three-tier model in the late 1950s, the PHC system in Malaysia has developed in the 1970s into the two-tier system with a health clinic serving a population of 15,000 to 20,000 people and a rural clinic covering 2000 to 4000 population. The number of health facilities increased rapidly especially from seven health

clinics in 1957 to 897 health clinics (primary care and maternal and child health) in 1970, and to midwife and community clinics by 2010 (Table 2). Between 2000 and 2008, approximately 50 health centres were amalgamated with hospitals.

Table 2 Primary health care facilities, 1957 – 2010

Facility	1957	1970	1980	1990	2000	2010
Community clinic	0	943	1509	1880	1924	1919
Health clinic	7	224	725	708	947	812
Total	7	1167	2234	2588	2871	2731

Private sector doctors also offer a considerable amount of primary health care. A register of medical practitioners in 1967 listed 1759 doctors of whom 713 were in government service (41%) while the other 1046 (59%) were believed to be in private practice.

THE NEED FOR REFORM

The challenges to health systems around the world are just as applicable here in Malaysia, namely to focus on interventions that will have the greatest impact on the poor; countering major threats to health (such as tobacco); universal access to healthcare services and investing in research & development.

Health Challenges

The challenges facing the Malaysian health system include the lack of integration; the changing trends in disease pattern & socio – demography; rising public expectations; issues of economic inefficiency in the targeting of limited health fund with dependency on government subsidised services; retaining highly skilled healthcare personnel in the public sector with the limited appraisal & reward systems for performance; conflicts of interest as the MOH is the funder, provider and regulator of health services; accessibility & affordability with discrepancy of health outcomes; limited coverage of catastrophic illness (haemodialysis, cancer therapy, transplants etc.) and the pattern of private spending for health overtaking public spending. It has been shown that when a majority of health care is privately funded, there is less control on health care inflation. Consequently, cost of health care in such situations will rise even faster. Medical inflation is usually higher than overall inflation.

Ensuring Equity in Health

Strong economic growth has allowed Malaysia to significantly reduce overall poverty levels but inequality, however, remains a challenge. The gap between rich and poor has widened and income growth has been strong only for the top 20% of Malaysian income earners. The bottom 40% of households have experienced the slowest growth, earning less than RM1500 monthly, barely one-

seventh that of the richest 20%. This inequity involved disadvantaged groups (indigenous groups, legal and illegal immigrants), age groups (the young and elderly), geographic location (rural areas), and states (East Malaysia).

Lack of Integration of Dichotomous Healthcare System

The currently dichotomous healthcare system has our healthcare resources spread between the private and public sectors working in parallel to each other. The public sector is government funded with the patient receiving almost free primary healthcare services and a largely subsidised secondary care services, while the private sector is fee for service with out of pocket payment or through private health insurance and employer payment. With the mismatch between the distribution of healthcare resources and burden of work in the two sectors, the healthcare resources within the country are not optimally utilised. This is especially so in primary health care where the public sector has only about 10% of primary care clinics but handle almost 40% of outpatient visits.

Epidemiological Transition - Chronic Diseases

Chronic diseases are the major cause of death and disability in Malaysia, accounting for 71% of the mortality and 69% of the total burden of disease. The prevalence is increasing and the relative lack of emphasis on health promotion and disease prevention in the outpatient setting calls into question the adequacy of the acute care paradigm. The concept of caring for long term health problems needs to replace it. Innovative and cost-effective community-based interventions need to be translated into high quality population-wide chronic disease care to counter the challenge posed by the epidemic of chronic diseases. With these challenges confronting the health system, there is a concern on access to continuity of care with the various providers apparently working in silos, not only between the public and private sectors of our dichotomous health system but also within the public sector, between facilities and across the various disciplines. This is exemplified in the case mix in the public and private primary care clinics. The public clinics manage larger proportions of chronic diseases as compared to the private sector.

Ensuring Universal Access

Whilst we are grappling with the challenges brought about by epidemiologic and demographic transition, there are still areas in the country with problems in accessing primary care services, particularly in rural and remote areas, but also in urban centres where the lack of after-hours services often results in the use of emergency rooms for non-urgent care. To meet the increasing demands of the public, efforts have been made to extend the operational hours of the public clinics, but with no supporting increase in human resource, this has raised the providers' concerns regarding their work life balance.

Policies and implementation strategies have evolved with the changing needs of the population and the growing capacity of the health system. In 2010, health clinics delivering only curative care for minor ailments and minor procedures were set up in urban areas, strategically located in residential areas for the urban middle class and poorer groups. These *Klinik 1Malaysia (KIM)* are manned by assistant medical officers and nurses and offer services from 10 am to 10 pm daily. The response has been so good that from that initial 50 that were operationalised in 2010, another 28 have been operationalised till January 2011. In an effort to expand the present mobile clinic services for the rural areas, buses and boats equipped as mobile clinics have been introduced at the end of 2010. These differ from the traditional mobile clinics in that there are now doctors manning these services and the clinics can be run in the vehicle itself.

Rising Expectations

Person-Centred Services

The findings of the World Health Survey 2000 instigated improvements in selected facets of the Malaysian health care system to upgrade the delivery of services so as to be more responsive to patients' expectations. However, increasing client expectations has posed concerns on the health system's responsiveness. The monitoring of complaints through well-established channels (complaints boxes, media (email, telephone, verbal) to the Minister of Health and Director General Health, the Chief Secretary of the Government and to the Bureau of Public Complaints in the Prime Minister's Department) has shown that the community's concerns with the responsiveness of the healthcare system remain. The majority are due to lack of communication skills of the providers.

Patient Safety

Patient safety is addressed by ensuring competency of healthcare workers through practice standards, legislation, credentialing and privileging. Competency of health care workers starts with

basic training. Universities and training colleges offering training in medicine and health sciences have to achieve standards set by the Ministry of Higher Learning. The Malaysian Medical Council (MMC) maintains standards of medical education in the country as for their medical degrees to be recognized, the training institutions have to be inspected by the MMC. All those who deliver clinical services are mandated by Law to be registered with their professional bodies, doctors with the Malaysian Medical Council (MMC), and physician assistants and nurses with their respective professional Boards. The professional bodies self regulate the proficiency of their members through the setting of standards and enforcement of ethics and codes of conduct. Legislation, both the Medical and Nursing Acts, amongst others are also in place to prevent unqualified personnel from practising as health care workers in substandard facilities.

Quality Services

The Ministry of Health has developed a culture of quality care with recognition of initiatives at the ground level, through competitions for models of good practice, quality control circles, innovation for solving local problems, as well as setting quality standards nationwide, supported by the development of practice guidelines. In the mid-1980s, the Ministry of Health began to work on the quality of care, as part of the Quality Assurance Programme and Quality Management System by tracking indicators of quality of care at the national level. The implementation of the nationwide quality assurance programme of the Ministry of Health since 1994 has set quality standards to ensure attainment of service goals. More recently (2000), clinic-specific quality standards have been set for PHC services in Malaysia, including for diabetes management, asthma management, appropriate hospitalisation, client-friendly clinic, pathology services, radiology services, and pharmacy services.

An initiative to ensure the provision of quality healthcare in health clinics is the improvement of the work process by developing practice standards and guides for credentialing and privileging of clinical staff, standard operating procedures, and comprehensive guidebooks to guide the clinic staff on managing and coordinating the activities of the clinic, ranging from clinic administration, environmental sanitation to patient care.

WAY FORWARD - ICARE FOR 1MALAYSIA

As the country approaches developed status, as demographic and epidemiological transitions continue, and as new technology expands the possibilities for intervention, the demand for health care by the population will continue to rise, putting

pressure for health reform. In strengthening the health care system to meet the challenges posed by demographic & epidemiologic transition, higher expectations of the population and escalating health care cost, the Ministry of Health has proposed *ICare for 1Malaysia* in 2009 - a restructuring of the country's health care system to align it with Malaysia's aspiration to become a high income nation.

Target of Reform

The aim of health reform is to have one integrated national system where both the public and private sectors have managed growth and the resources are optimally utilised. Presently, the only means to manage the private sector is through the Private Healthcare Services & Facilities Act whose enforcement leaves much to be desired. With reform we want healthcare of better quality to be provided by both sectors with common standards and equal monitoring. Universal access can be improved with anybody who needs care being able to receive it at their convenience. This is facilitated by reform in healthcare financing and the attributes of social health insurance in promoting social justice and solidarity as well as financial sustainability, makes it the logical choice in alignment with Malaysia's social policies. Everybody will contribute (mandatory inclusion) with a community-rated premium; the rich, young and healthy subsidising the poor, elderly and disabled, respectively. The government will continue its function of providing a social safety net for the vulnerable groups by subsidising for their premium but the subsidy will be more targeted to those in need, unlike the present system where all, rich and poor alike, benefit from universal government subsidy. Individuals still have a choice of accessing services not in the benefit package and hotel services by paying out of pocket or taking private insurance for top up. Healthcare providers have a choice to enter the system or not as they can still cater to this group of patients who pay out of pocket or who have private health insurance.

PHC – Thrust of *ICare*

The thrust of this reformed health system is primary healthcare, where the primary health care physician (PHCP) acts as the hub of person-centred care, coordinating the care needed to deliver comprehensive and continuous care, no matter what the setting, whether in the primary health care clinic, in the hospitals for secondary care for acute conditions or in the community for self care, home nursing etc. The PHCP manages the patient in the context of his family and the community he comes from with the support available for his well being, in short being cognisant of the broader determinants of health, with links to public health. The PHCP looks at the full spectrum of disease, intervening

early to maintain wellness and to delay onset of sickness, not merely providing curative care to the sick. Leading the primary health care team including allied health professionals and paramedics as well as with NGOs and civil societies in the communities, the PHCP provides team-based care, especially for people with chronic health conditions, leading to improvements in the management of chronic diseases, which accounts for 40 to 70% of health care system costs. As experience in other countries has shown, the coordinator-of-care and gate-keeping role of the PHCP is facilitated by the financing mechanism with payment by capitation with case-mix adjustments and incentives for promotive, preventive and team-based care; and additional incentives for achieving performance targets and as inducement for working in less desirable areas.

The PHC Health Delivery System

The patient will find it more convenient in the reformed system as he can choose the PHCP he wants to register with within the community either in public or private sector. The first point of contact for the patient is the PHCP where they receive treatment and then return home. If the patients need referral for specialist care or hospitalisation, arrangement will be made by the PHCP to seek treatment either in public or private hospitals. Upon completion of treatment, the patient will be returned to the PHCP. Even though patients are registered with their PHCP, they still have a choice to seek treatment from other providers by paying OOP or through PHI. Primary health care reform will increase opportunities to improve access to primary health care physicians with innovative appointment scheduling, shifts in physician work hours, after-hours clinics and widespread availability of primary care physicians with public-private integration.

The Reformed MOH

The MOH will be a leaner organization with very highly specialized functions. It becomes more technocratic and less bureaucratic. The primary focus is governance and stewardship which includes policy and strategy formulation, evaluation and planning for implementation; standards setting and regulation, monitoring and evaluation, legislation and enforcement activities. Policies and development will encompass aspects as standard setting, quality and clinical guidelines, cost-effectiveness, HTA, training, ICT and physical infrastructure. For the regulation functions, legislations will be streamlined for all disciplines. Enforcement can be located either within the MOH or an independent body depending on the authority and responsibility. A very important function now in MOH will be the monitoring and evaluation (M&E) to ensure that the autonomous arms of

MOH function according to their specified tasks and objectives, and that standards, guidelines and regulations are adhered to.

The MOH retains some public health services mainly through the centre for disease control, research and other services. These services will be delivered through the existing state & district set-up and through partnership with local authorities and MHDS. There will still be some delivery of community health services, namely communicable disease control.

Various functions of MOH will now be under several autonomous bodies such as Drug Regulatory Agency, Health Technology Assessment and professional bodies such as MMC and MDC.

The Autonomous Healthcare Delivery System

The delivery of health care will be devolved to the autonomous Malaysian Health Care Delivery System (MHDS) comprising public and private health care providers and this increased autonomy allows it to be more responsive to the population health needs and expectations. The scope of autonomy of the independent MOH-owned bodies is as not-for-profit organisations, accountable to the MOH and with independent management boards. They manage their own budgets i.e. self accounting, with the ability to hire and fire and with the flexibility to engage and remunerate staff based on capability and performance.

Health services will be purchased from registered providers including independent Primary Health Care Providers (PHCP) which include primary care clinics, dentists and pharmacies. Public hospitals will be coordinated on regional networks and funded through a global budget based on case adjustments using DRG. Private hospitals services will be paid through case-based payments. Other payment mechanisms apply for dental and pharmaceutical prescriptions where patients will make some co-payments when receiving service. But identified population groups will be exempted from these co-payments. Payment for services in the autonomous arms will be based on their performance and fulfilment of the MOH specifications.

Healthcare Financing

Funds will be managed by the new National Health Financing Authority that is publicly owned and operates as a not-for-profit institution. The National Health Financing Authority (NHFA) will be established to undertake the task of collection of SHI contributions, pooling of funds and disbursement to healthcare providers. NHFA will also work out the formularies for premiums, pay for performance, unit costs/fees and benefits packages in collaboration with MOH and MHDS. This reform allows for integration of the presently

dichotomous healthcare delivery system with a single purchaser who is separate from the provider.

THE JOURNEY TOWARDS PHC REFORM

Strengthening of the primary health care system is needed for primary care to play its care-coordination and gate-keeping role effectively with obstacles to continuity and coordination of care are clearly identified and removed. A culture of accountability, performance measurement, and quality improvement will support targeted funding tied to expected outcome with governance and funding models which support team-based care needs to be strengthened. The important role played by the broader determinants of health is given due recognition with links to public health services at the district level.

Infrastructure support for PHC system

The support needed include an adequate health infrastructure and an adequate supply of health human resource with the right skill mix to support a team approach focused on patient needs. The existing primary health care team consists of the physician, dentist, pharmacist, assistant medical officer, nurse, community nurse, medical laboratory technologist, assistant pharmacist, assistant environmental health officer, public health overseer, health attendant and clerical staff. Human resource development in *ICare* encompasses all categories of healthcare personnel whether in primary or secondary/tertiary care. Appropriate training for health care personnel such as training in management of public providers and managers in preparation for greater autonomy has to be conducted. The current general practitioners in private practice will undergo a conversion to family medicine specialists and in the future, only family medicine specialists will be allowed to open a primary health care practice. The facilities will be accredited and credentialing & privileging of primary health care physicians will be implemented.

ICT

Information & communication technology is a prerequisite of the re-structured health system and the use of electronic medical records will increase opportunities to improve continuity of care as well as develop the capacity for performance management based on targets, coverage and key performance indicators.

Tele-primary care is one such system which has been developed for primary care in Malaysia and its implementation will need to be hastened to facilitate health reform efforts. To support continuous access to health information and advice, tele-health and myportal initiatives will be used, especially during travel. There are areas in the

country lacking IT infrastructure and in these areas special projects like the universal service provider (USP) have been developed to reach the last mile in information technology. Telephone advice/health lines need to be created or enhanced in providing 24-hours first-contact services to ensure continuity of care information to be communicated to the patient's regular care provider in addition to after-hours visits.

Change management

Given the scale of the restructuring, it is imperative that change is managed effectively at all levels of stakeholders and explicit change management activities are needed to support all activities. While developing the blueprint, many more deliberations with interested parties and stakeholders including the community will be undertaken. This is to ensure the development of a solid and widely accepted proposal, taking into consideration their concerns. Effective change management will entail initial injection of investments particularly for the restructured public system in order to compete with the private sector on similar footing.

A realistic time frame for phased implementation is required to ensure that the requisite manpower, infrastructure and ICT needs and challenges are addressed. At the same time, there will be better rationalisation of services as the system improves equity and efficiency of service delivery according to population needs. Some facilities may relocate to capitalise on the incentives provided in the restructured system and responding to the bigger market of health care buyers throughout Malaysia.

CONCLUSION

The Malaysian health system has performed well over the years, compared to countries of similar economic status, in building a system that produces well-being at a low cost to society (Merican & bin Yon 2002). The public system has not kept pace with population growth, however, and the growth of the private health sector means that people in higher income groups enjoy quicker access to private health care, while poorer people have no choice but to rely on government services⁷. Disparities in health outcomes between population groups and geographic areas have been reduced although 3% of the population reported difficulty in 1996 in accessing health care mostly due to distance and transport costs (NHMS II1996). Additional expenditure thus is required to cover needy population groups, especially in remote areas where services are the hardest logistically and most expensive per capita to provide. This is especially pertinent for Sarawak where it has been a great challenge to provide universal health care to the "unreachable", those staying in the remotest areas of the state.

The values espoused by the landmark Alma Ata Declaration, namely equity, universality and solidarity, are just as relevant today as it was more than 30 years ago. This systemic reform, *ICare*, subscribes to the PHC approach and the primary health care model as the foundation of health services, with its strong focus on preventing illness or injury and promoting health. It recognises that various components of health care system are interdependent and that the health care system's quality and access problems cannot be dealt with effectively unless we pay more attention to primary health care. Lessons from other parts of the globe has argued that the primary health care approach best "facilitate the integrated management of multiple conditions, a continuum of care, the engagement of communities, the provision of care close to home and prevention and health promotion in addition to treatment and cure."

ICare is an opportunity with a high potential to contribute to a sustainable and high performing healthcare system which subsequently will have the potential to impact on the health of Malaysians.