Reflections on Health Reform: The Health White Paper

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It is good that we are undertaking a reform of health, the 'Health White Paper' that is expected to be tabled in parliament sometime this year. I hope that there will be extensive public engagement and ownership of this critical and long overdue initiative.

Having served in our national health service for many decades and been involved intimately with health services delivery, allow me to add some reflections on the direction of these reforms.

The Key Challenges to Achieving Health in Malaysia

At one point in time, Malaysia's health system was highly praised by the World Health Organisation (WHO), especially for our excellent primary care services. However, those days have long passed and today some of our neighbours offer better health services than we do. We need to ask what have been the challenges or factors that have relatively regressed our health care and health services? What has made our population unhealthier with a non-communicable disease pandemic? Some possible reasons are outlined below.

1. Ministry of Disease (MOD) not Ministry of Health (MOH)

In healthcare, often the loudest voices dictate resource allocation and development. Specialisation and sub-specialisation have engulfed health care and clouded the issues. Medical schools enamour students to curative fields and most healthcare professionals, especially doctors who hold much of the 'power', have lost a prevention focus. The 'brightest and best' of our medical personnel tend to opt for a hospital-based profession and career.

We no longer run a Ministry of Health (MOH) but a Ministry of Disease (MOD); an institutionalisation of medicine. Sadly, Public Health has not been able to advocate for a substantive growth in preventative services. Our initial primary care success, in the 1970s and 1980s, of antenatal and child health clinics with immunisation, growth and development focus has not been sustained. It has also not been duplicated in urban settings where 70% of our population live. Hence hospitals take up a large proportion (60-70%) of health resources in terms of funding, manpower and development. In recent decades there has been an 'explosion' of tertiary level specialised services as means to 'meet' the health needs of the community; these are meeting disease needs and not health needs.

Our current model is doctor and illness focused, expensive, fragmented and institutional based. Hence, we tend to focus on disease and not health. This 'curative' model is inappropriate for the majority of the population, is not financially viable and a never-ending thirsty black hole.

2. A Public Addicted to Curative Services

We have nurtured our public to depend on doctors and the curative health services. The cry of the public is for more hospitals nearer their homes, more specialists at their door-step and more quick-fixes for their medical problems. Our public has been weaned on a diet of curative services offered by doctors and focused on specialists. They are now addicted to this model - specialist care and curative care. They have little concept of prevention. They desire to live as they choose and ask us to fix their health problems with drugs or procedures.

This is very much akin to our public transport problems, where the public has been weaned on a diet of cars and become addicted to them. Hence it is extremely difficult to institute a meaningful public transport system and the resultant urban chaos. Similarly, in healthcare, we have an enormous uphill task of changing the mind-set of the public to a sustainable health outlook rather than a fix-the-disease outlook.

3. The Damage of Private Health Services

The Private-Public divide also worsens our health services. I have many friends and colleagues in the private sector, some doing excellent work, and many trying to help patients. But the private sector is almost totally dedicated to treating disease; they thrive on the non-communicable disease (NCD) epidemic. The growth of big business in the health industry has meant that it is now predominantly profit driven; hence there is no major incentive to promote preventative health.

The commercialisation of healthcare, the use of healthcare as a means of obtaining financial wealth, has undermined the trust of individuals and communities in healthcare professionals and even governments.

Our government has also begun investing in private healthcare, a serious conflict of interest. There may also be a subtle opposition from the private sector and big business (private hospital groups) to a preventative approach as they thrive on a curative model and on sick people.

4. Inadequate Financial Resources, Health Spending by Governments

It would be tempting to infer that improvements in health of our society have been brought about by improvements in the health services. However, we are aware that while advances in health services have some impact, particularly immunisation and access to primary health services (maternal-child clinics), the major decrease in mortality is related to improvements in socio-economic status, education, infrastructure, utilities (safe water supply) and transport. For example, every doubling of the gross domestic product (GDP) per capita more than halves the under-five mortality rate in children.

Having said that, how much governments invest in health will determine outcomes for children and adults with severe illness; those that require intensive care. Here we have failed. Our limited national expenditure on health infrastructure has meant that many cannot receive intensive care in our public hospitals, unless they can afford the exorbitant private hospital fees.

5. Failure to deal with Social Determinants of Health (Inverse Care Law)

It is important to recognise that a major failure in health delivery is the ‘Social Determinants of Health’. Families that are poor, disadvantaged, marginalised or have poor access to health care are the ones where the children have the highest mortality and morbidity. This is often called the ‘Inverse Care Law’. Most of our services, resources and manpower are concentrated in selected urban locations and better reach the middle and upper income segments of our population.

Because we do not show disaggregated data, i.e. data broken down by detailed sub-categories (indigenous, inner city children in slums, poor rural communities, marginalised groups, level of income), we suggest our national mortality rates are reasonable. We can get some glimpse using under-5 mortality data on indigenous children as a proxy. The age-specific mortality rate by ethnic group for Peninsular Malaysia indigenous children (Orang Asli) is 11 times that of major ethnic groups; while the mortality rate for indigenous ethnic groups in Sabah and Sarawak is 1.7 times that of the major ethnic groups (Malay, Chinese,

Indian). I often describe Malaysia as a developing nation with pockets of Sudan (severe unresolved poverty).

Resources and health services are disproportionately allocated to urban communities at the expense of rural and indigenous communities. Healthcare for documented and undocumented migrants, stateless, refugees and those in detention is often very poor.

6. The Failure to Provide Personalised Care
One major, persistent weakness in the MOH healthcare delivery system is the near-absence of personalised care. Every time a person with a chronic illness goes to the hospital, they see a different doctor; one who does not know their problem well, despite some case records. This is extremely frustrating to our community and undermines the fundamental element of health care which is a therapeutic relation between the patient and the healthcare professional. This is one major reason many choose to see a private specialist. VIPs and people with wealth, of course, often circumvent this in MOH.

7. The Elephants in the Room
Often in discussing reform we do not address fundamental problems in our society, the 'elephants in the room'.

One concern is the tsunami of poorly trained medical undergraduate and poor experience that house officers obtain due to huge numbers. This has resulted in a crisis at the health centre and district hospital level. Medical errors and incompetency have risen. This needs to be addressed with concerted action.

Secondly, any reform needs to address the large impact of institutionalized corruption and corrupt practices on the healthcare system in terms of spending and development. Any new system may also be open to becoming corrupt.

Thirdly, we have neglected the ethnic problem in our civil service. We are moving towards a near-mono-ethnic civil service, including in the MOH; both in staffing and leadership. People who are not from the Malay ethnic group see little hope in the civil service in terms of growth, promotion, leadership, etc. Meritocracy is lacking and this damages the use of the best person for the job and a haemorrhage of many health professionals into the private sector and overseas.

A Transformative Approach to Healthcare Reform
While we have made some progress in healthcare, this has not been achieved in all communities equally – we have left behind many marginalised communities. In addition, we have had a relative regression in healthcare when compared with some progressive neighbouring nations. If we are serious about health in our country, then we require a radical change in approach and not 'more of the same'. We must achieve health for ALL, not as an average or for a portion of the community. We can no longer rely on traditional and incremental approaches to improve health. We require a transformative approach that focuses on inclusive growth to achieve equality.

What does a transformative and inclusive health service look like?
Some key aspects include:

1. A Healthcare System which Focuses on Community Care
We need to move away from a mind-set of delivery of healthcare to the community and work towards the development of capability within the community for self-care. The cornerstone for developing community care will be enabling and empowering the community to care for themselves. We need a healthcare system that is developed for children and families, and not one that is developed for managers and the healthcare professional. This requires health

professionals to understand community-social-health-behaviour and to be present in the community, listening to and working with them, rather than 'waiting' in their clinics or hospitals for the community to reach out to them.

2. A Healthcare System which Focuses on Preventative Services
We need to revolutionise the training of our healthcare professionals and move away from a disease approach. We need to move to develop a 'wellness' service as opposed to 'illnesses' service. This includes a lifetime health plan that aims at keeping the child and family well. It focuses on prevention issues and includes interactions with health professionals on a regular basis from conception right through childhood and adolescence to adulthood to maintain wellness.

We need to provide incentives for our brightest medical minds to work in the community and in prevention activities. We need to encourage clinicians to spend at least 40% of their working time in the community. We need to dramatically increase funding and manpower resources for public health. We need to develop and enlarge mobile health services to meet urban and rural health needs.

3. A Healthcare System which Focuses on Marginalised Communities
For true change to occur we require disaggregated data, broken down by detailed sub-categories (indigenous, marginalised groups, ethnicity, level of income, gender, geographical regions). For this to happen we also need compulsory death registration and mandated medical certification of deaths by law. We then need to map communities with high mortality / morbidity rates and focus sufficient resources on those with the high rates. A redistribution of health care resources, especially staffing, from the black holes of the Klang valley and other cities to poorly served regions is required.

4. A Government Committed to Adequately Funding the Healthcare System
Recognising the problem and what needs to be done for health is half the battle. We need for the government to allocate sufficient health resources to meet the need in the community. Funding for our national health service needs to be doubled (for a start). This must be the agenda of any good government and advocating for it to become the mandate of all political parties is a way forward. We must resist further attempts to privatise our health services and recognise that health and access to adequate healthcare is a basic human right.

5. Environmental and Societal Change
And a Government Committed to Ending Child Poverty and Malnutrition
The 'battle' for health and a transformative approach cannot be undertaken by just the MOH; there will be a need to involve many agencies to get this done. Working on health alone will not result in the dramatic change in mortality and morbidity that we hope for. For this to happen there is a need to end child poverty and hunger.

Urban transformation to promote safe green spaces and recreational areas is vital; a re-wilding of our cities. We need to remove cars as the primary mode of transportation and use electrical bus rapid transit (eBRT) systems complemented with walking and cycling. All available evidence shows that an investment in mobility for the community improves health status, increases physical activity, reduces obesity, reduces air pollution-related effects, reduces road injuries, reduces NCDs (hypertension, cardiac disease, Diabetes, Chronic respiratory illness), with a resultant higher life expectancy.

We must address the growing impact of the climate emergency that threatens to engulf us, and will reverse any health gains. This may prove to be the major health challenge of our time and children will be the most affected.

Some Closing Remarks

While we may look to governments to provide strong leadership, direction and funding to develop such a health system described above, the real transforming movement might be from the community itself – a grassroots, grounds-up advocacy and development. It is vital that all of us take responsibility to support the change that is needed and not leave it to any one organisation. What is required is a willingness in our hearts to choose to do so.

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