3i: Health

Preamble

The MOH assumes the largest responsibility for the performance and delivery functions of public health. It fulfils these responsibilities by carrying out a variety of intervention strategies and services centred on preventive care (i.e. immunisation programmes) and disease control, from primary up to tertiary care. Short-, medium- and long-term planning and coordination are required to produce better health outcomes for the population.

The COVID -19 pandemic has exposed and tested the resilience of the health system, especially of the public healthcare sector. Insufficient funding and investment in infrastructure development over the past two decades, combined with lack of planning for human resources in the public sector, manifested in high bed occupancy rates in major public hospitals–a problem that had already existed before the pandemic, and was further exacerbated by it–and Hartal Doktor Kontrak, a nationwide workers' strike organised by young medical officers in protest against the government's contract system appointment.

The Malaysian population's health is also at risk due to rising trends and burdens of non-communicable diseases. If the government and society were to continue a 'business-as-usual' approach, the situation would deteriorate and, worse, with little or inadequate support still. The status quo is clearly not sustainable, and plans for improving and strengthening the health system must be put in place now. There are large gaps to be closed, especially in the running of primary healthcare.

I: Investment in Public Health & Public Healthcare

From 2009 to 2019, public health financing for the MOH stagnated at around 2% of GDP. Health made up only 8.5% of total government expenditure in 2018, just slightly over half the rates of similar upper-middle-income countries such as Thailand and South Africa, which ranged from 13% to 15%. This low rate does not mean Malaysians were much healthier, therefore requiring fewer health resources; on the contrary, low health allocations directly contributed to the overstretching of the public health system. As the Director General of

Health, Dr. Noor Hisham Abdullah, admitted in a 2019 news report: "We are currently underfunded, understaffed, underpaid, overworked, overstretched and with overcrowded patients." In its election manifesto for the 2018 general election, the Pakatan Harapan coalition had pledged an allocation of 4% of GDP for the MOH; this is a good starting point to address the chronic funding situation in the public health sector.

1. Prioritise health by giving it a budget exceeding 4% of the gross domestic product.

i. Significantly increase the budget for MOH with immediate effect. The funding from this budget should be separate from the COVID-19 fund.

ii. Target a 4% GDP public health expenditure within five years, and increase it after that.

(Dr. Lim Chee Han, Agora Society Malaysia/People's Health Forum, Proposal 3I-1)

2. Ensure equity in healthcare financing by implementing cross-subsidy mechanisms based on principles of progressive taxation.

The "social wage" in the form of subsidised healthcare must be increased because the wages of an average worker in Malaysia are low--only about one-sixth of wages in western countries. Any scheme requiring them to pay more for health would be unjust.

(Dr. Jeyakumar Devaraj, People's Health Forum, Proposal 3I-2)

i. Reject health financing schemes that rely on funds from the general public through mandatory contributions similar to the Employees Provident Fund, or mandatory health insurance schemes.

ii. Raise tax income from the richest sections of society and corporations to increase the funds available for healthcare financing.

(Dr. Jeyakumar Devaraj, People's Health Forum, Proposal 3I-2)

II: Healthcare Capacity & Development in the Public Sector

Overwhelmingly crowded conditions and long waiting periods for healthcare service in the government hospitals and health clinics are still a common scene, as reflected in soaring bed occupancy rates of over 70% in all state hospitals in 2019, even before the pandemic. Besides the healthcare workforce, healthcare facilities and physical capacities must be expanded to accommodate and meet local demands, especially in urban areas where over three quarters of the population reside. In recent years, the number of hospitals in the private sector have mushroomed in response to this surging healthcare demand. As of 2019, there were more private hospitals (208) than public ones (154). Nonetheless, private healthcare is not a sustainable solution as many lower middle class and low-income groups cannot afford private hospital fees. Thus, it is the responsibility of the government to take on this burden of providing a social safety net for urban communities. Moreover, setting up more private hospitals serves to encourage more specialists to migrate from the public sector to work in these hospitals, to the detriment of training and healthcare in the public hospitals.

3. Impose a moratorium on new private hospitals.

This includes a ban on expansion of beds in existing private hospitals.

(Dr. Jeyakumar Devaraj, People's Health Forum, Proposal 3I-3)

4. Build more hospitals in urban areas.

Construct more hospitals or expand existing ones in urban areas, where there is greater demand for healthcare.

(Dr. Lim Chee Han, Agora Society Malaysia/People's Health Forum, Proposal 3I-4)

III: Health Workforce Sustainability

One of the most important goals in rebuilding post-pandemic is to safeguard the collective health and well-being of the Rakyat. This cannot be achieved without strengthening the bedrock of the public healthcare system, namely its workforce, which is currently under tremendous pressure owing to the health crisis. Simply put, we need to focus on two things: increasing the supply of public health staff

to fill in available vacancies, and improving their retention within the public system, with the ultimate aim of creating a high-morale workforce that can contribute towards consistent healthcare services.

5. Exempt healthcare staff recruitment from the Human Resources Optimisation Policy.

All public healthcare personnel appointments are currently managed by the Public Service Department, and are consequently tied to the Department's Human Resources Optimisation Policy, which contains a directive to trim civil servant numbers by 1%. Under this policy, new appointments may only be carried out on a rotating basis. An appeal was made by the MOH to the Public Service Department in 2019 for healthcare staff to be exempted from these recruitment policies. This should be implemented immediately to enable more recruitment of healthcare staff, to overcome the shortage of healthcare workers and stop the deterioration of quality in public health service delivery.

(Dr. Chee Heng Leng, Citizens' Health Initiative/People's Health Forum, Proposal 3I-5)

6. Establish a Public Health Services Commission to set up a transparent promotional system.

Poor staff retention and high attrition rate from the public to the private sector continues to drive the workforce crisis even further, causing delays in services that impact most Malaysians.

(Dr. Chee Heng Leng, Citizens' Health Initiative/People's Health Forum, Proposal 3I-6)

IV: Primary Healthcare

In 2019, the National Health and Morbidity Survey reported worsening trends of non-communicable diseases (NCD), reflecting higher rates of obesity, diabetes, hypertension and hypercholesterolemia. NCD-related hospital admissions have historically been a significant burden on tertiary care services, and this trend is projected to worsen with the growth of an ageing population. As a result, the government will have to deal with competing demands on public services, even as the cost of care rises exponentially. Currently, about half of the MOH budget is used for tertiary care, which is essentially the largest budgetary category, estimated to cost RM14.4 billion in 2019. This crisis provides an opportunity to

enhance the role of primary care as the cornerstone of community healthcare, by providing timely health advice and screening through established trusting relationships between patients and their general practitioners (GPs). As the population grows older and the burden of chronic disease increases, implementing good family health practices, such as encouraging a practice of visiting the same doctor, is extremely important in capturing the benefits of continuity of care in the community.

7. Implement a Family Doctor System.

The MOH should implement a family doctor system with policy frameworks that support better coordination of health promotion, patient advocacy, illness prevention and end-of-life care. Currently, 70% of GPs are in the private sector, but a significant portion have also signed up for the ProtectHealth PeKaB40 programme, a healthcare initiative focused on early detection and prevention of non-communicable diseases among the low-income communities, which complements the often overwhelmed outpatient government clinics. The budget for such public primary care programmes should be increased accordingly.

(Dr. Lim Chee Han, Agora Society Malaysia/People's Health Forum, Proposal 3I-7)

8. Integrate private and public primary care services.

Introduce a capitation funding system for primary care services, whereby private GPs are contracted and funded by the MOH to cover and treat a certain number of patients over a period of time and within a determined geographic location, according to their place of practice. This way, GPs have "guaranteed patients", allowing them to spend ample time on health prevention strategies as well as driving excellence in chronic disease management of the population.

(Dr. Chee Heng Leng, Citizens' Health Initiative/People's Health Forum, Proposal 3I-8)

V: Social & Inclusive Care

The country has seen an increase in suicide cases especially during the pandemic, with women comprising 83.5% of 1,708 suicide cases reported between 2019 and May 2021. More than half of the suicide deaths were individuals aged between 15 and 18 years. This is part of a long-term trend as communities continue to face the double whammy of psychosocial and economic impacts.

9. Draft a comprehensive action plan for mental health and psychosocial support for women.

The COVID-19 pandemic has profoundly affected women, many of whom have been overburdened and hard hit, both at the workplace (especially in health and social sectors) as well as at home. The increase in workload due to lockdown and quarantine measures, on top of having to juggle multiple roles, has exacerbated the toll on women's mental health. In mapping out crisis responses to the pandemic, the Government must ensure that adequate access to psychosocial support resources targeted at women are put in place and strengthened, on top of demonstrating adaptability and rapid responses, and that current and future health policies include women's concerns as a prime consideration.

i. Increase the number of psychiatrists, qualified counsellors and clinical psychologists.
ii. Improve access to mental health services and treatments targeting vulnerable women.

(Dr. Roohaida Othman, IKRAM, Proposal 3I-9)

10. Apply universal approaches in migrant-focused health.

Inclusivity of care also means emphasising migrant health.

i. Replace the over-securitisation approach with universal engagement in managing migrant-focused healthcare. This should stem from an intention of balancing between disease control, economic concerns and social well-being in often fluid circumstances.
ii. Collaborate with civil society and community-based organisations in health screening and contact tracing processes to ensure cultural safety in healthcare services.
iii. Make available migrant health data, especially to relevant groups working on this issue.

(Dr. Sharuna Verghis, Health Equity Initiatives/People's Health Forum, Proposal 3I-10)

11. Give stateless persons universal access to basic healthcare services and remove cost barriers for non-citizen children.

To better promote inclusive care, the government must provide stateless persons universal access to basic healthcare services for stateless persons, such as childhood immunisation programs and subsequent maternal and child health follow-ups, with minimal administrative and financial barriers.

(Maalini Ramalo, Development of Human Resources for Rural Areas Malaysia, Proposal 3I-11)

Allow all non-citizen children (up to the age of 18) with at least one Malaysian parent to access public healthcare at the same rate as Malaysian citizens, upon provision of the Malaysian parent's identity card. Non-citizen children should also be enrolled in the National Immunisation Programme free of charge, and allowed to take part in public-school-related health programmes such as dental check-ups and other initiatives.

(Bina Ramanand, Family Frontiers, Proposal 3I-12)

12. Formulate a pandemic preparedness plan.

This includes enhanced collaborative efforts between local and regional manufacturing capacities of vaccines, as well as inclusive social protection systems at home.

(Dr. Chan Chee Khoon, People's Health Forum, Proposal 3I-13)

Concluding Remarks

Despite the existence of heavily subsidised universal healthcare for citizens, there are severe cracks in the system, as revealed and exacerbated by the COVID-19 pandemic. These key recommendations are part of a system-building effort to better serve the Rakyat during the present crisis and for decades to come.