KINGSLEY STRATEGIC INSTITUTE FOR ASIA PACIFIC

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NAPIER Healthcare

PROCEEDINGS REPORT

Malaysian Healthcare Conference 2019

"Optimising Outcomes and Creating Value in a Changing Healthcare Landscape"

Proceeding from discussions on 7th March 2019

at Hotel Istana Kuala Lumpur

Key Points and Recommendations

- Healthcare cost will continue to increase, making current financing models unsustainable.
- More public-private collaborations should be encouraged with greater utilisation of resources in terms of facilities, equipment, and human resources to create a more efficient and sustainable health system.
- Exercise caution towards value-pricing as doing away with tender agents may have an adverse impact on overall healthcare cost for the government as prices may have to be increased when private sector companies are forced to incur the same cost required for compliance.
- Lift the embargo on the Harvard report presented to the Ministry of Health in March 2016 to enable stakeholders to offer suggestions of how the situation can be improved.
- Decisions should be made based on evidence using Health Technology Assessment (HTA), Horizon Scanning, and Clinical Practice Guidelines provided by the Malaysian Health Technology Assessment Section.
- Data from electronic medical records can to be shared securely among researchers to develop more effective treatments and procedures. Despite progress with the Malaysian Health Data Warehouse, continued government funding is still necessary to build a virtual environment to enable researchers and the public to conduct analysis.
- More insurance companies should partner with the government on funds like mySalam and PeKa B40 to offer social protection insurance premiums.
- A Citizen-Funded National Health Insurance Scheme supplemented by private health insurance is key to sustainable healthcare funding.
- The funding of the health insurance system should come from contributions from both the employer and employee. A compulsory rather than a voluntary national health insurance scheme needs to be in place to provide coverage for all. The ideal means would be to have a single-payer multiple-provider system where public and private institutions would have equal access to patients.
- Co-payments or an ear-marked tax can be introduced to create a more efficient tax system. There is also a need to convert out-of-pocket payment insurance and private insurance schemes to cover pre-existing illness conditions and include family plans.
- Introduce a patient card that is capable of storing lifetime health records and all transactions of patients.
- Utilise the Internet of Things (IoT), teleconsultations, real-time alerts, analytics and other advances in healthcare technology to improve mobility and access to healthcare.
- Introduce a back-end system via a voice interface using artificial intelligence to manage task of nurses to save time and reduce cost.
- Policies developed by the MoH need to be tailored appropriately to create a vibrant pharmaceutical industry and prevent predatory pricing. Generic-friendly policies have to be in place to bring down prices. The government must be firm with their policies and be patient in expecting ROI from this sector.
- Clear long-term policies for aging care must be developed as it will become an issue in the future.
- Adopt a common coding for medical procedures which has been developed by the MMA.
- There is a need to revise the 1992 fee schedule that is still being used in 2019. The government should review MMA's proposal for a revised fee schedule for its feasibility.
- The MoH needs to be given the ability to take give direction to other ministries to enable joint action through smart partnerships.

PROCEEDINGS REPORT

Kingsley Strategic Institute for Asia Pacific

MALAYSIAN HEALTHCARE CONFERENCE

Optimising Outcome and Creating Value in a Changing Healthcare Landscape

7th March 2019 | Hotel Istana Kuala Lumpur

WELCOME ADDRESS

Tan Sri Dr Michael Yeoh, President, Kingsley Strategic Institute

There are many challenges in the healthcare industry with the provision and availability of healthcare becoming a growing demand of all Malaysians in making it more affordable, accessible, and of better quality. The healthcare sector is also moving into Healthcare 4.0 in the same way industries are moving into Industry 4.0 with the impact of health and medical technologies. There is also growing demand for medical tourism in Malaysia, which is one of the leading centres for visitors from overseas. Another challenge is the notion of training of professionals and upgrading of healthcare workers at all levels in both the public and private sectors.

KEYNOTE ADDRESS

YB Datuk Seri Dr. Dzulkefly Bin Ahmad, Minister of Health Malaysia

<u>Optimising Outcomes and Creating Values in a Changing Healthcare Landscape</u>

As Malaysia continues to develop rapidly, escalating health care costs, diseases related to lifestyles, increasing numbers of elderly who require more and expensive healthcare services, the introduction of new technologies, and ever-increasing consumer expectations have become familiar issues. Concerns with issues of social justice will increase.

Malaysia's existing healthcare system comprises a two-tier system public and private system. The private system mainly caters for the urban population and those who can afford it, while the public system provides access to everyone, including civil servants, with token payments being imposed. Although the two-tier system is inherently inequitable and inefficient, it has nonetheless served Malaysia well thus far. However, overtime, this will no longer be sustainable. The existing healthcare system, like most around the world, has been

organised around acute, often catastrophic illnesses. As such, the healthcare system treats the patients during this episode until they are well again.

In many countries, a "casualty" approach to health insurance has been developed to fund healthcare, based on the fundamental unpredictability of disease and injuries. Expensive health systems have been developed based on this "acute care" model. However major advances in diagnostic and therapeutic technologies have enabled earlier interventions in chronic disease such as heart disease and cancer, and increasingly more patients can be treated on an ambulatory basis without hospitalisation. In the coming decades, this "acute care" model and existing health insurance concepts, as well as society will have to deal with the increased predictability of risks of disease. Major advances in immunology, predictive genetics and the human genome project will make it possible to predict disease in many people long before symptoms emerge. The present paradigm of diagnosis and treatment will be replaced by prediction and early management of risk factors and illness. With this development, the "casualty" model of health insurance becomes fundamentally flawed.

The manner in which resources are mobilised to support the healthcare system, and how it is organised for services delivery and its influence on health status is also important for its influence on the other aspects of the country's social, economic and political well-being. Under Budget 2019, around MYR29 billion has been allocated to the Ministry of Health (MoH), which included a MYR10.8 billion allocation to provide medicine and upgrade the quality of health services at clinics and hospitals. This allocation will help to cover the overall objectives of the healthcare system which include:

a) improving health status and promoting social well-being
b) ensuring equity and access to healthcare
c) ensuring efficiency in the use of resources
d) enhancing clinical effectiveness
e) improving quality of services and patient satisfaction, and
f) ensuring sustainability of the system.

The rate of growth of healthcare spending has exceeded that of GDP since records began. Moreover, spending and economic recession are closely linked. Malaysia's healthcare industry spending is expected to reach about MYR 80 billion by 2020. The industry spending, which recorded MYR 52 billion at the end of 2017, has increased, fuelled by demand for healthcare services and the emergence of new care models beyond traditional hospital settings. Macroeconomic factors like the aging population or insufficient public funding also pose as a challenge to both receivers and providers of healthcare. Adoption and penetration rates of clinical information systems vary greatly. Additionally, purchasing behaviour is shifting towards a more coordinated, joint purchasing to bring about economies of scale.

People are living longer, tribute to the advances in the of understanding of causes of diseases and consequent improvements in diagnostic techniques and treatments. The average life expectancy in Malaysia has reached 75.3 years and continues to lengthen. However, not only are people living longer, but are also increasingly living longer with chronic disease.

There is growing consensus among stakeholders in the multi-trillion dollars global healthcare sector that the industry faces a serious value problem. Despite decades of efforts to control spending, costs continue to rise at roughly double the rate of GDP growth in most developed countries. In addition, there are wide variations in health outcomes across hospitals, regions and countries, with no clear causal relationship between money invested and health delivered. The national health systems that spends the most money do not necessarily provide the best care. There is considerable evidence that a substantial portion of healthcare spending is wasted on avoidable medical complications, medically unnecessary treatments or administrative inefficiencies.

This new focus on value of healthcare seeks to address these interlocking problems holistically. It does so by taking a principle that has guided healthcare professionals throughout history, namely, by doing their best for patients given the resources available and making it the centrepiece of health system design and organisation. Value-based healthcare makes the delivery of improved health outcomes for the same or lower cost the primary objective of global health systems. The approach is founded on the systematic measurement of health outcomes and of the costs required to deliver them for clearly defined subpopulations, such as patients who suffer from a given disease or condition, such as type 2 diabetes, or who share a similar risk profile, such as the multimorbid elderly. Teams of clinical specialists use this outcomes and cost data to develop customised interventions to improve the ratio of outcomes to costs for each patient group over time.

By aligning industry stakeholders around the shared objective of improving health care value, value-based health care has the potential to deliver substantially improved health outcomes at lower costs than most health systems around the world are currently able to achieve. This approach also improves access to appropriate care, defines relevant innovations in treatment and care delivery, and provides major new business opportunities for healthcare organisations in both the public and private sectors. The value-based approach to care rests on three foundational principles; measuring systematically the health outcomes that matter to patients and the costs required to deliver those outcomes across the full cycle of care, tracking those outcomes and costs for defined population segments on an ongoing basis, and developing customised interventions to improve value for each population segment. Four enablers are key to accelerating the adoption of value-based healthcare; *health informatics*, to facilitate the easy collection, analysis and sharing of outcomes and cost data; *benchmarking***,** research and tools, to leverage data on outcomes and the costs for clinical practice improvement and innovation; *value-based payments*, to create incentives for all stakeholders to focus on value; and *innovations* in organising care delivery, to improve coordination across the health system.

Because healthcare is a highly regulated industry, public policy has a critical role to play in enabling the value-based transformation. The MoH may mandate the tracking of health outcomes and set standards for data collection, analysis and transparency. There is a need to balance the trade-off between patient privacy and data sharing; enable cooperation, coordination and partnerships along care pathways while protecting against conflict of interest; establish new payment models that support improvement in patient value; and make it easier for pharmaceutical and medical technology companies to be more accountable and contribute more actively to healthcare value.

In India, the Aravind Eye Care System, a network of hospitals dedicated to providing low-cost, high-quality cataract surgery, combines systematic tracking of health outcomes with an integrated approach to care delivery. The resulting health outcomes are equivalent to those of the world's best providers, and at approximately 10 percent of the cost per surgery in the United States. In Germany, Martini-Klinik, a prostate cancer centre at the University Hospital Hamburg-Eppendorf, collects comprehensive data on its patients' health outcomes, including documentation of all post-surgical complications down to the level of individual surgeons and uses the data to continuously improve its performance in prostate

cancer care. As a result, the clinic's rates of severe erectile dysfunction one year after surgery were less than half the national average and instances of urinary incontinence were about one-seventh of the national average. In Sweden, more than 100 quality registries covering the majority of national health expenditure systematically track health outcomes for patients suffering from a specific condition or disease. The accumulating body of data has allowed Swedish clinicians to identify which providers deliver the best outcomes, codify their clinical best practices and share them with other providers, thus improving average health outcomes over time. A recent study demonstrated that 30-day mortality after acute myocardial infarction is 37 percent higher in the UK than in Sweden. Researchers are leveraging the provider networks affiliated with Sweden's quality registries to conduct clinical trials evaluating the effectiveness of treatments and procedures at roughly 10 percent of the cost of traditional clinical trials

The above examples suggest the potential of a relentless focus on value to transform the healthcare sector. National health systems have an extraordinary opportunity to deliver substantially improved health outcomes to patients and at significantly lower cost than today's health systems. Given the size of healthcare budgets in most countries, such improvements promise to significantly raise national productivity through more rational use of resources and by allowing more people to stay at work longer and contribute to society, necessary in creating a high-income economy. The value-based approach to care will also improve access to appropriate care, spur innovations in treatment and care delivery, and provide major new business opportunities for the public and private sectors.

MoH has launched a different B40 scheme called National Health Protection Scheme (PeKa B40) focusing on health screening for early Non-Communicable Diseases (NCDs) for those aged 50 and above. This scheme is expected to benefit 800,000 people and starts with an allocation of MYR100 million. This is not limited to the Peduli Sihat programme operating in Selangor but runs on an evidence-based conviction based on its needs. There is a mismatch as the system has always been on curative, secondary, and tertiary care. There needs to be commitment to the primary care, where each patient needs to be seen and managed by a family medicine physician. Electronic medical records will allow information to move with patients, enable vertical and horizontal integration of all clinics and hospitals, not just in public facilities, making it possible to enhance cooperation between public and private facilities.

MySalam provides coverage to recipients admitted to government hospitals or diagnosed with one of the 36 critical illnesses including cancer, heart attack, and Alzheimer's. Recipients whom are diagnosed with one of the illnesses will receive MYR8,000 as a one-off payment. Patients are entitled to an income-replacement or MYR50 a day up to a maximum of 14 days, which is substantial for the B40. The Khazanah Research Institute found that a majority of B40 families have savings which can only last for two weeks, should there be a medical-related shock. The government will use the MYR2 billion contribution from an insurance company for the mySalam scheme to pay the social protection insurance premium for eligible individuals at MYR112 per person per year. MoH welcomes more insurance companies to come aboard and collaborate with the government. The fund is expected to offer medical protection to 3.69 million individuals from the B40 group for at least 5 years. The mySalam Scheme and PeKa B40, which share the same social principle of expanding health access, reducing cost of living and increasing the welfare of the people, will complement each other in providing access to healthcare for the B40, leaving no one behind, in an effort to achieve universal health coverage and the SDGs.

Malaysia has the best healthcare in the world, scoring 95 points out of a possible 100. Malaysia also took the top spot in the healthcare category in the International Living Annual Global Retirement Index of 2018. Neighbours, Thailand took third place while France was placed second. Malaysia has maintained the top spot for 2015 and 2016. As of 2015, the revenue generated via medical tourism stood at MYR 1 billion, contributed by more than 850,000 medical travellers to Malaysia. In 2016, the industry's contribution to the GDP exceeded MYR 1 billion. Total exports for medical devices are expected to reach MYR18.4 billion in 2020 from the RM11.3 billion registered 2017. Similarly, the pharmaceutical segment also saw its exports growing from MYR577.8 million in 2011 to MYR938.5 million 2017 at an average annual rate of eight percent per year. Registration of generic products also reduced to 90 days compared 210 working days for prescription drugs, improving ease of doing business. Lastly, Malaysia has stood firmly behind the multi-sectorial approach and vision of the Alma-Ata Declaration 1978 to achieve Health for All.

SESSION 1

Value-based Healthcare: Putting the Patient at the Heart of Care

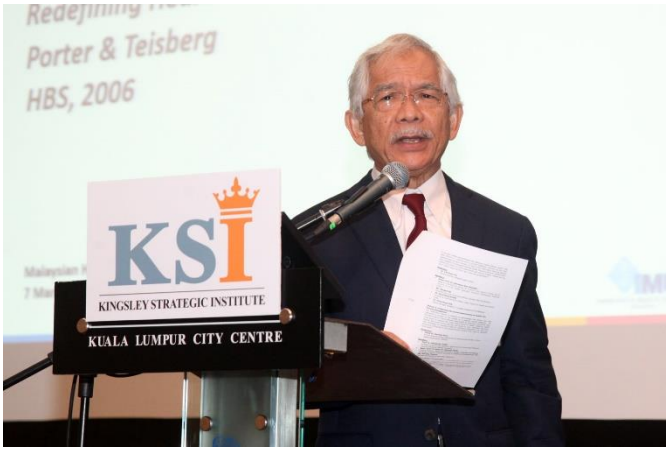
Moderator:

Tan Sri Dato' Dr Abu Bakar Suleiman, Chairman, IMU Group

Value and patient-centred care are two very complexed matters as the concept of value needs to be seen from the perspective of the patient, who are the ones paying for the care, as well as that of providers of care, and also the perspective of the community.

The state of Vermont, US, a relatively small state with a population of approximately 3-4 million, introduced a new system where no budget was set as long as value was obtained. This led to the introduction of the n-fault insurance, which was then adopted in New Zealand. Such developments from Vermont need to be given attention as more policy literature from this case is expected to emerge in the near future. There is also an initiative in France which introduced a patient's lifetime health record and all transactions on a card. Co-payments can be made without needing to apply for reimbursements from the patient or the healthcare provider. Patients can be reimbursed within two weeks (minus co-payment) without even needing to apply for it. Similarly, doctors receive their payment within a month without needing to apply for it. 20 years ago, Malaysia once had this among one of its blueprints, but it is uncertain what has happened to the plan since. Such a system will bring down administrative cost and bring value, as well brings convenience of the patient and provider.

Michael Porter and Elizabeth Teisberg in a book entitled *Redefining Healthcar*e, which was published by the Harvard Business School in 2006, examines the value of healthcare in terms of its concept, framework of outcomes, as well as the concept of value and how it is measured. Patients seldom receive value as much time is wasted in the process of receiving care, presenting an opportunity cost for additional financial cost. Instead, value is ascertained by the experience and clinical outcome one received for treatment for the price paid. Patients expect certain guarantees when the pay for treatment. Thus, value is based on the outcome as well as the care that has been provided. Using this approach, patients spend less, health outcomes are more consistent, and have greater satisfaction. Providers will gain more trust and become more efficient, leading to better quality. Cost will become more predictable for funders. Health status will be improved for the community. Therefore, incentives need to be put in the right place, which is focused on patients getting better and the reduction of unnecessary care.



There is much over-servicing and over-utilisation in all health systems, including Malaysia's. New Zealand has taken the approach in consideration of cost, health, and care. Models for care to ensure that care is continuous, connected, integrated, and seamless irrespective of time and geography can empower people to make good decisions about their healthcare and lifestyle. Patient Centred Medical Homes (PCMH) were introduced in the US 15-20 years ago. It does not have to be a physical facility as it can be virtual if electronic health records are shared. In PCMHs, healthcare providers and welfare supporters from the community can work together with the patient and families in the delivery of care.

The future is about taking a value-based approach and with resistance expected from hospitals and doctors who will resist change. There is a need to move towards digital health and digital medicine. Doctors and hospitals need to embrace the future. This way, Malaysia can move from a fee-for-service to fee-for-value system.

Speakers:

Dr. Izzuna Mudla Mohamed Ghazali, Public Health, Physician / Head of Horizon Scanning Unit, Malaysian Health Technology Assessment Section (MaHTAS), Ministry of Health Malaysia (On behalf of Dato' Dr Hj. Azman bin Hj. Abu Bakar, Deputy Director General of Health (Medical), Ministry of Health Malaysia)

Decision making in healthcare has always been complex, overwhelming, and challenging with demanding needs and expectations. It has finite resources, but yet, the ultimate goal of healthcare is to improve value for patients. Value-based care evolved from evidence-based medicine (EBM) which has since become the prevailing medical paradigm of the 1990s. Sackett, Rosenberg, Gray, Haynes, and Richardson defined evidence-based medicine as "*..the conscientious, explicit, judicious and reasonable use of modern, best* evidence *in making decisions about the care of individual patients*". This definition has been expanded to include groups of patients and healthcare policy. Before EBM, there was no requirement to adhere to scientific evidence. However, during the evidence-base era, emphasis was given to the adherence of scientific evidence. During this time, health technology assessment was established in many countries, especially in developed nations. At the same time, evidence-based clinical practice guidelines were developed to reduce variations in healthcare and to improve the quality of care.

Value-based medicine was introduced by Dr. Brown and his team from the Centre for Value-based Care at the University of Pennsylvania. They defined value-based medicine as "*..the practice of medicine incorporating the highest level of evidence-based data with the patient-perceived value conferred by healthcare interventions for the resources expended*". Value-based medicine is similar to evidence-based medicine where a patient's perceived-value is converted in terms of utility value, which is measurable. Value-based healthcare is the most holistic approach in managing patients as patients are at the centre of care. It uses the best available evidence to ensure better patient outcome and includes patient value in the utility. Utilising value-based healthcare will not only reduce cost to the healthcare system, but also increases satisfaction, quality, and outcome, through information sharing. Such cost utility enables comparison between different treatment options to make objective decisions.

Government agencies, academics, and private agencies have conducted systematic approaches to apply these values-based concepts. For example, Health Technology Assessment (HTA) is used to evaluate health technology. Horizon Scanning is the systematic process of identifying new and emerging technologies with innovations in healthcare has the highest potential in terms of clinical outcomes, including organisational and societal cost. This will provide information for future planning of the healthcare system to ensure that decisions made are based on evidence and value. Lastly, clinical Practice Guidelines provide the current and evidence-based recommendations for practice in managing patients. This reduces variations in care and reduce cost in managing patients. Together, HTA, Horizon Scanning, and Clinical Practice Guidelines provided by the Malaysian Health Technology Assessment Section will help provide input to the MoH to make better decision making on healthcare.

HTA goes beyond evidence-based medicine as it looks into other values that are sometimes not available in clinical research. It takes account of patient satisfaction, patient value, organisational, societal, and the ethical impact of certain technologies which have been introduced to the healthcare system. It is also used for procurement decisions, price negotiations, and clinical practice where it provides input for clinical guidelines. However, it is interesting to note that in some countries, Coverage with Evidence Development programmes involve new technologies, though not as much evidence is available. If the technology is safe, it will be allowed in the market. At the same time, it remains

necessary to collect data on the use of the technology to ascertain if there are any safety issues or other usage of technologies. Should issues emerge, the technology can be removed from the system.

The meaning and composition of 'value' is dependent on how one attributes meaning to it. Traditionally, this comprised of life years gained, improvement in quality of life, cost-savings within the health system, productivity, and cost-savings outside the health system, all of which are measurable. Hence, the determination of value depends on the perspective one has, be it the healthcare provider as payers or the government or a societal perspective. Other elements that can be included in value include scientific spill overs, insurance value, real option value, value of hope, and reductions in uncertainty. However, these elements are not easy to measure and thus have not yet been included.

There are four steps in the application of value-base healthcare. The first step is to ask answerable questions which uses the PICO concept (population, intervention, comparators, and outcome parameters). The search is for the best available evidence and whether it is economically viable and whether such data is available to conduct such evaluation in the first place. The third step is to conduct a cost utility analysis. The final step is to handle uncertainty through a sensitivity analysis.

The World Health Organisation (WHO) has recommended strategies in managing non-communicable diseases by investing in prevention and control. Evidence has shown that prevention and control not only increase longevity and life, but it also improves productivity and thus improves the countries' economic performance. For the first time, the WHO has introduces the Best Buys in six areas, three in disease areas and three to tackle the risk factors. For example, for every investment of USD1 in NCDs, the return of investment is USD7.43 for the prevention of tobacco use. The investment for every USD1 to campaign against unhealthy diet, the return of investment is USD12.82. Therefore, this is an evaluation of the intervention in public health.

Value-based healthcare incorporates the highest level of evidence data for quality care. Patient-perceived outcomes of value is what matters the most. By prioritising the options by maximum utility per cost facilitates an efficient allocation of resources and an objective decision-making process.

Dr. Milton S W Lum, Consultant Obstetrician & Gynaecologist, Alpha Specialist Centre

People have moved away from the concept of volume to value. Instead, what they want are cost reductions and value for money. There have been attempts at diagnostic assessments of various healthcare systems to reduce waste, harm, variation, and the prioritisation of most impactful interventions. People have been less interested about patient satisfaction and have turned their attention towards patient experience. They have begun to move from hospital settings to the community. When the patient is at the heart of healthcare, it will in turn put the family in the centre of every decision, empowering them to be genuine partners in their care. The mental model has to shift from a "what is the matter with you" to a "what matters to you" mindset, with the former focusing on the diseases condition and the latter on the person. A prominent physician once said that it is more important to know what sort of person has a disease, rather than to know what disease a person has.

WHO's Western Pacific region (of which Malaysia is a member) published its People-Centred Health Care document in 2007 which discussed the weaknesses of the health care system. They had three objectives in their vision for people-centred health care; the (i) culture of care and communication; (ii) responsible, responsive, accountable services and institutions; and (iii) supportive health care

environments. It also recommended several proposals for reform with regard to individuals, families, communities, healthcare practitioners, healthcare organisations, and healthcare system. Leadership is essentially involved in all these matters. An article from the Institute of Health Care Improvement (based in Boston, Massachusetts) talked about high impact leadership, improved care, improved health of the population, and reduced cost.

A people-centred healthcare has community participation, vision, defined outcomes, the right culture, and a need to work across boundaries. It is driven by the community with the patient included right from the outset, not when there has been an adverse event. There are recommendations with regards to creating vision and building will, recommendations on developing capability, delivering results, shaping culture, and engagement across boundaries.

To determine how Malaysia is faring, one needs to look at the quality of primary care. A Harvard report presented to the MoH in March 2016 found that primary care doctors were not identified as a first point of contact and that doctors in public clinics were not involved in comprehensive follow up over a wide-range of primary care sensitive conditions. The continuity of care between specialist and primary care providers is weak. Medical officers do not regularly carry out many medical and surgical procedures which a primary care practice should be carrying out. The report also examined the quality of secondary and tertiary care but was limited by a lack of data from public hospitals while there was almost a complete lack of data from private hospitals. The report found that the 30-day mortality for acute myocardial infarction and stroke was high in 2008 compared to OECD countries. However, this was a tremendous improvement from a decade ago. Cataract day surgery has increased from 29 percent to 52 percent in MoH hospitals between 2012 and 2013 compared to 83 percent in OECD countries.

In terms of allocative efficiency, it was disturbing that 49 percent of total healthcare expenditure is spent on secondary care and only 17 percent on primary care when these figures should be reversed. There was also little expenditure on long-term care. The shift of expenditure towards secondary and tertiary care was marked in 1997 and 2013. The real expenditure per capita on secondary and tertiary care increased by 130 percent in this period, whereas expenditure per capita on primary increased by only 74 percent. This implies that funding is not allocated to the right areas. There is a high share of hospital admissions for ambulatory care-sensitive conditions and a very high rate of admissions to hospitals for long-term complications of diabetes.

The Harvard report also looked at technical efficiency and were meant to come up with a health facility costing study, but the results of the study have not yet been made public. The Official Secrets Act should be lifted on this report to enable stakeholders to discuss this matter and offer suggestions of how the situation can be improved. It was also disturbing that the public sector's procurement of medicine was 3-4 times the corresponding international reference pricing (IRP). Therefore, the public sector has been purchasing medicines at much higher prices than some private healthcare facilities. The report's concluding remarks pointed out that the Malaysian healthcare system is at a crossroad as it is demonstrating a classic case of asymmetric transition, whereby rapid transitions have not been matched with a corresponding transition in the health system to better address the current and future needs of the population.

Despite the existence of the Private Healthcare Facilities & Services Act with provisions for patient grievance, incident reporting, and mortality assessment, there have been a lack of reports. There are also legal provisions for the Director General to issue directives on quality. Yet, there has been an absence of such directives from the MoH. There are also provisions that healthcare management should be at the hands of practitioners. However, practitioners have complained about interference from third parties to the MoH for the past decade, but there has been no response.

The Patient Safety Council was established in 2003 and came up with its Patient Safety Goals in 2013. It commenced electronic incident reports in 2015 and patient safety awareness courses for House Officer in January 2017. However, there has been no data to show that patient safety has improved since 2003. In 2018, the MoH announced that a probe will be carried out on a hospital fire in Johor Bahru, but such a report has still not been made available in the public domain as at March 2019.

A study conducted by the Galen Centre involving 242 respondents of which 46 percent were patients and 12 percent were caregivers, examined what mattered most to Malaysians in healthcare. They found that the main complaint towards private hospitals was that they were too expensive while public hospitals have long waiting times. The Mid Staffordshire NHS Foundation Trust made several recommendations; to foster a common culture, develop a set of fundamental standards, provide professionally endorsed and evidence-based means of compliance with the said fundamental standards, ensure openness, transparency and candour, policing compliance, and ensure proper accountability to ensure the public is protected from those of whom are not fit to provide such service.

In the report, Robert Francis said that "*..the NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires leadership at all levels, from ward to the top of the Department of Health, committed to and capable of involving all staff with those values and standards".* David Evans, a consultant with Northumbria in 2015 wrote that "*..the training of people to lead and manage only works if you have got a system that allows them to do that, and supports them in the decisions they make. People see the value in this because we've put in place a very clear structure. It's not only doctors who lead services; we've had psychologist, therapist and midwives running out services and doing it very well*". The US-based Planetree organisation has made a list of myths of patient-centred care, among which were providing patient-centred care is too costly and too time consuming, that patient-centred care is "nice" but not important, and so on.

High-impact leadership is required at all levels of care delivery organisations in order to deliver results. The question is if there is enough political will and leadership in the Malaysian healthcare organisations to put patients at the heart of care.

Datuk Dr. Kuljit Singh, President, Association of Private Hospitals of Malaysia

In terms of the mindset of the Malaysian populace, Baby Boomers expect healthcare to be free as that is how this generation was brought up. Millennials on the other hand would not know what the cost and value is. Malaysians expect high value in healthcare, but are not willing to pay. They want faster services, accessible and care. However, this comes at a cost. As patient-centred care is provided in private hospitals, it is only natural when someone pays for care, they expect to receive value immediately. Once a patient completes treatment, they will assess if they have received an appropriate amount of value. However, when something is given for free, such a mindset is absent.

In the private setting, patients are already at the centre point as they have become clients more than patients. They can select their specialist, have avenues of discussion, and can decide which healthcare provider they want. Electronic medical records allow the patient to be the centre point and be treated holistically. Doctors rendering treatment will have access to the entire record of patients in every area of health. In this manner, a patient-centred healthcare helps as the patient feels that they have been treated at a faster rate and with more accuracy. Electronic medical records have entered a new paradigm with artificial intelligence (AI). Healthcare has been moving towards AI and may even move fully into it in the near future, becoming the core component of patient-centred care.

Patients have access to information available on the public domain and the web. However, it is questionable if healthcare providers are ready to deal with such patients. Although, the cost of running a private hospital in Malaysia is very expensive it is still more affordable compared to its neighbouring countries. However, in terms of pay outs patients can give or the potential amount of money they can

pay in Malaysian society, there is a low level of affordability when compared to other regions. It is difficult to render medical care at higher value as cost escalates. Private hospitals will attempt to reduce cost and at the same time attempt to get margins from patients in terms of medication, treatment, and care. At times, this becomes very unacceptable to patients.

To move forward, there needs to be stronger public-private partnerships (PPP). Although this has been widely discussed in the past, it has never been crystallised as there are no commitments from both parties. Should there have been greater commitment, one would find that the private sector has much to offer to those who are unable to afford private healthcare. The government can help these groups of patients by using the resources in the private sector. A robust and sustainable healthcare financing system is required. This would be the way forward when planning for value-based healthcare with patients at centre through the use of technology, AI, PPPs, and a good healthcare financing system that is sustainable.

Q & A

Tan Sri Dato' Dr Abu Bakar Suleiman asked for the panel opinion as to which is more affordable to patients in terms of the cost of care; public or private sector hospitals.

Dr. Milton S W Lum noted that there is a distinction between cost and price. Cost is the expenditure needed to produce a product or service, while price is what one pays for it. In the public sector, everyone who goes there pays a token sum. However, this is not the actual cost, which is much more. This cost is borne by the taxpayers. In the private sector, the patient has to pay an amount that is needed for the hospital or clinic to produce the service, plus professional fees and profit margins hospital require. Private hospitals have a return of 7-9 percent per annum.

Datuk Dr. Kuljit Singh pointed out that public hospitals, university hospitals, and private hospitals are all different in terms of cost. More thought should be given to the public sector on whether or not they are spending the correct amounts on services they are actually providing to members of the public. If they adjust their expenditure, they will be able to save and provide much more. Public sector hospital should engage their private sector counterparts to rework their cost which can lead to potentially savings of up to 7-8 percent. Restructurings may also be necessary for more sustainable savings.

Tan Sri Dato' Dr Abu Bakar Suleiman clarified that cost is more easily known in the private sector due to greater transparency. This is more challenging in the public sector due the large amounts of hidden cost which may be 2-3 times more than the calculated cost from the public sector. However, there are formulas to calculate the hidden cost. In 1992, the MoH conducted a study with the World Bank on the cost of services of general practitioners (GP) outpatient department in Penang. It found that GP costs were more affordable. People seldom want to invest in hospital due to high cost, unless it is able to pay for itself. In fact, the first few private hospitals in Malaysia were funded by doctors, such as Pantai Hospital and the first KPJ hospital. Once it was shown that the model is workable, then investors will come in. Therefore, cost is relative. There needs to be returns, otherwise there will be no investments. In 1985, the Malaysian government conducted the first health financing study. It found that the country spent 1.8 percent of GDP on health. A more recent study by Harvard found that this has increased to over 4 percent of GDP. Therefore, in the span of more than 30 years, spending on healthcare has increased significantly, during a time when GDP has been growing 6-7 percent annually. This is a huge investment in healthcare, which is why must question of the value being received. Based on data in the last century, Malaysia has done well and has good value in its healthcare. But there is still a need to do better.

Dr. Tan Ai Mei posed a question concerning public insurance for the M40 group, seeking clarification on how value is justified for the patient whilst taking care of their wellbeing avoiding unnecessary leakages. The public is primarily concerned with how the government justifies how resources are being used effectively between the public sector and private sector in terms of how these insurance schemes

are being used. There is also the issue of lobbying which is rampant among public insurance. How can Malaysia avoid making the same mistakes seen in many other countries?

Dr. Milton S W Lum explained that insurance must be seen from the perspective of a social insurance or commercial insurance as there is a difference between the two. The basis between the two is risk sharing. Social insurance involves the young supporting the old and the healthy supporting the unhealthy. Commercial insurance has an element of returns to shareholders which is not present in social insurance. It is difficult to explain insurance schemes like mySalam and PEKA, which should best be explained by the agencies involved. Regardless, there has to be clarity on the operationalisation of both the mySalam and PEKA simply because the people on the ground, like the B40, should know the process and exceptions. In social insurance, they should not be any exceptions, unlike commercial insurance.

Dr. Izzuna Mudla Mohamed Ghazali argued that for the B40, the PEKA and mySalam schemes compliments each other, explaining that PEKA is the assistance given to the B40 group who are more than 50 years old for screening and assistive medical devices such as implants. They also give MYR1,000 to those who have completed their cancer treatments. It was also explained that PEKA is under the MoH while mySalam in under the Ministry of Finance. This is an insurance risk sharing scheme to help those in the B40, especially with chronic diseases, who struggle with financial capacity. The cost of treatment, even for the M40, for cancer can be quite high.

Datuk Dr. Kuljit Singh expressed concern that these schemes could be discontinued after a period of time. He hopes that they will be sustainable and continuous over time.

Tan Sri Dato' Dr. Abu Bakar Suleiman explained that in social insurance there is a pulling of risk and pulling of funds and no one is left out. However, private insurance is risk-rated. The moment a policy holder has a certain illness, disability, or becomes older, they will become excluded. In Malaysia, the number of people with health insurance is quite limited. Most are group insurance from employers. Another form consists of life policies with health benefit features. The positive note about PEKA and mySalam is that an initiative has begun, which is a bold step forward. Yet, this is not the solution and more work need to be done as more components need to be put in place. However, there is still a gap between the availability of resources and encouraging people to make use of it. Services like health screen by PEKA B40 and SOCSO have not be utilised by members of the public.

Dr. Tan Ai Mei was concerned with the wellbeing of the patient, including the family, where the insurance concept is involved. With private insurance, there are many unnecessary investigations, including high cost imposed which does not constitute to any benefits to the patient or family members nor the country. She argued that the government cannot impose a law to justify the concept of insurance to ensure wellbeing and value in Malaysia.

Dr. Izzuna Mudla Mohamed Ghaza clarified that even private insurances have certain regulations that they need to follow. A fee schedule exists under the Private Healthcare Facilities Act. Usually only procedures listed under the fee schedule will be reimbursed by insurance companies. They can refer back to the MoH and its Health Technology Assessment Section to determine whether certain technologies are recognised and if patients can be reimbursed for the treatment. Hence, there are regulations and methods to control treatments received by patients to avoid unnecessary treatments.

Dr Mohamed Namazie Ibrahim, Malaysian Medical Association shared that the Komuniti Sihat Perkasa Negara (KOSPEN) programme was started in 2013 as a community-based screening programme. These community centres were internal centres in the community where volunteers were trained to conduct screenings, including taking weigh to calculate BMI and taking blood to conduct blood-sugar screens. During a pilot project in Selangor, 26 centres were identified. In a period of 6-months over 4,000 people were screened of which 2,000 over were referred for some problems. This revealed that 50 percent of the population screened have NCDs or some issues ranging from obesity, hypercholesterolemia, and diabetes. This is the reasons why PEKA B40 was created. While KOSPEN is community-based, general practitioners have been asking the government to bring about a public-private initiative where over 9,000 private clinics can be involved. Regarding insurance, there is a very urgent need for a health financing reform as 39 percent of out-of-pocket payment is unsustainable.

Tan Sri Dato' Dr Abu Bakar Suleiman stressed that the wellbeing of the community is important which is why they require a platform. In the US, patient-centred medical homes involve everyone coming together to manage health matters. In Cuba, a doctor is assigned to 70-80 families and has records of each family. They manage not only care, but also health in terms of health promotion, disease prevention, and early detection. To move forward, there is a need to move away from hospitals, which should focus on intensive care, as so much can be done outside the hospital.

SESSION 2

Perspectives on The Patient at the Heart of Care

Moderator:

Mr. H K Yong, Trustee & Audit Chair, World Fish/Asian Council, International Project Finance Association

Perspective 1: Advancing Connected Health to Improve Patient Engagement

Speakers:

Dr. Md Khadzir B. Sheikh Ahmad, Deputy Director, Head of Health Informatics Centre, Planning Division, Ministry of Health Malaysia

Having a "healthcare data warehouse" does not imply that medical records are directly connected to every patient in healthcare facilities. Rather, it is about the collection of secondary-used data for statistical purposed, which is then used for evidence-based decision making. When the system was first launched, there was much confusion regarding security and privacy of data which is considered of upmost importance. Great care was undertaken to select appropriate providers of this technology which resulted in the selection of MIMOS. Although Malaysia is the seventh country to develop a data warehouse, it is the first to use its own local technology. This is an assurance that Malaysia is using its own local provider. It subscribes to all requirements regarding privacy and security following Raksa, which are guidelines provided by the Malaysian Administrative Modernisation and Management Planning Unit (MAMPU).

The Malaysian Health Data Warehouse is about the collection of patient's visits to any healthcare facility, from clinics to hospitals, as well as day care centres. It allows users of the system to minimise the work they do, requiring only to collect patient data once. It also enables the visualisation of data based on

user's query with data synchronised with the geographic information system and the analysis of discharge summary data which can generate KPIs for users. The system also has statistics and predictive analytics. Users who want to use the data, rather than taking the data out, can use the system and utilities the pre-prepared statistics it provides. This ensures that the data is more secure. The project also enables a virtual environment. There are many researchers who have requested the use of data and also has their own data to offer. The system ensures that the data used does not leave the system to protect the privacy and security of the data.

With this basic information going into the data warehouse, medical practitioners can link from outpatient to inpatient and to day care. This enables them to analyse information as required. All forms of healthcare facilities have been encouraged to participate in this initiative from MoH facilities, private hospitals, the military, and university hospitals. 80 percent of data comes from unstructured information in the form of discharged summaries, pathology reports, and so on. With technology from MIMOS, an artificial intelligence component was developed with knowledge-based learning, allowing the analysis of discharge summary. KPIs can then be generated from discharge summaries which is then returned to the healthcare providers. The process of generating KPIs which would normally take 3 years to formulate can now be done in 24 hours.

The patient registry information system is being managed by private investigators acting on behalf of the government on specific registries. The first roll out was conducted for the cancer group of patients, where this registry was used to monitor the patient's development. This registry allows the generation of population-based registries and allows users to generate queries based on incidents and prevalence. Users can then generate information required for the nature of the treatment.

Once a patient is registered, information of each visit will be updated into the database. This will reduce the frequency of data entry processes. The data, once keyed in, is applied throughout the various visualisations in the system. Each time data from a patient goes into the Health Data Warehouse, the data will split demographic data from clinical data, to which demographic data is anonymised. Data from the data warehouse can be linked to another database if the same anonymised demographic data is given. Therefore, data stored in the data warehouse is secure.

Due to interest to use this data, one has to go through the Data and Information Governance Committee which follows strict guidelines on who can be the users of the system. The Data and Information Quality Framework will also be established to ensure that quality data will be provided. The MoH will also work with MIMOS' security committee who oversees the development of the MyHealth Data Warehouse to ensure security. They will also attempt to work with international agencies to test if the system is hackable.

Despite much development with the system, government funding is still needed to build the virtual environment to enable researchers and the public to analyse the data with permission.

Mr. Tirupathi Karthik, Chief Executive Officer, Napier Healthcare Solutions Pte Ltd

In the last few years there have been changes to the healthcare industry which has become more ubiquitous and pervasive, impacting the way how healthcare is conducted. Acute care is under much pressure as the paradigm has changed. It is no longer an expectation for patients to go to a specific healthcare provider, but rather it has become an expectation of how healthcare providers can deliver care to their patients. At the same time, the need for home care for the elderly is on the rise. Globally, the homecare segment is growing at a rate of 13-15 percent, implying fast growth in elder care and long-term care. This is occurring for a variety of reason, especially in Asia due to the stigma associated when one sends their parents to a long-term care facility like a nursing home, which is looked down upon.

Residential care is also on the rise as many countries globally and in the region are undergoing demographic changes. For example, in Singapore, 25 percent of the population will be over the age of

65 in the near future. This will have consequences on a country's healthcare budget. Countries like Australia and Hong Kong will soon face the same dilemma. Even China is expected to have 440 million citizens over the age of 65 by the year 2050. Hence, eldercare is a massive burden on the healthcare system, putting strains in taxation, the construction of nursing homes for home care and day care.

There is also the issue of mobility. The way millennials consume and manage information is changing as they expect mobile devices to be the first point of contact. They have the same expectations when it comes to healthcare services. Therefore, information must be made available to them that is customised to their preferences, instead of the preferences of the healthcare provider. To respond to these changes, there is a need to develop an ability to deliver healthcare anywhere, even in the remote areas. This can be done with the Internet of Things (IoT) with the utilisation of bio-sensors, custom apps, assessments, and activities which can be done on site, at home, or the clinic of a physician. Teleconsultations, real-time alerts, and analytics related to outcomes can be conducted without incurring the physical cost of travel or the setting up of healthcare infrastructure in remote places.

The weakness of the conventional system, being unlinked, is that it forces patients to explain their health scenario repetitively as they consult various physicians, needing to carry stacks of reports required for each stage. This can be frustrating for patients. Instead, technology can be used to bring value to the system by enabling a referral network for practical use, such as EMR diagnostics, which can be used universally by the healthcare system to allow the appropriate delivery of care. Therefore, it is about managing patient's data and the experience in a seamless manage through the use of technology.

In any country, the biggest concern for healthcare is the availability of nurses and nursing care expertise. Many nurses come from other countries, implying a lack of nursing expertise locally. However, when one considers the daily task of nurses which normally involves the recording of patient data. This can be resolved by having nurses interact with back-end system via a voice interface using artificial intelligence to manage task. For example, vitals readings can be transmitted via Bluetooth connected to IoT which can go directly to a patient's EMR. This saves approximately 2-3 minutes per patient in terms of data reading and entry, avoiding human error. Such technology has the potential to deliver superior patient engagement and improved outcomes.

Perspective 2: Unlocking the Pharma Value Chain

Mr. Amrahi Bin Buang, President, Malaysian Pharmaceutical Society

Medicine management involves four processes; prescribe, dispense, administer, and monitor. The process repeats in a continuous cycle. This process gives value to patients which are at the heart of healthcare.

The role of pharmacist has changed. They are no longer drug sellers playing a major role in the healthcare value-chain. Instead, they are medicine experts and are managers of medicine using the latest means such as electronic prescription.

Policies involving healthcare are isolated and disjointed. For example, a prescription from MoH is not valid in non-MOH facilities. These issues do not benefit patients.

The Malaysian National Medicines Policy provides clarity for the Malaysian pharmaceutical sector and the management of medicine which has greatly evolved since 2006. This policy covers (i) governance in medicine, (ii) quality, safety and efficacy of medicine, (iii) access to medicine, and (iv) affordability. This, alongside other issues such as national healthcare financing and the use of generics area also addressed in this policy.

There needs to be greater quality use of medicine. It is found that 50 percent of patients are not taking their medicines. Failure in doing so causes uncertainties in knowing whether the medicine was effective. Hence, pharmacist need to play a bigger role.

In the area of patient education, the government has been doing effective campaigns, such as the Kenali Ubat Anda (Know Your Medicine) programme. However, this should also involve community pharmacist to enable sustainability.

Partnership and collaboration are ways towards integrating the entire system. Without this, the system will not function effectively. Patients should be empowered to have a list of medicines they can take at their fingertips which they can show to doctors anywhere they go. When it is owned by the patient, the issue of personal data ceases to become an issue.

Pharmaceutical care involves the management of medicine which involves doctors, pharmacist, and nurses. Just like doctors, pharmacists are highly regulated to ensure certain levels of quality. They need to follow a certain benchmark to remain in practice, whereby good dispensing practices and other requirements are mandatory.

There are more than 17 thousand registered pharmacists, but only around 14 thousand are practicing and available to serve the nation. These pharmacists are involved in promotive care, preventive care, curative care, rehabilitative care, and palliative care. Therefore, the role of pharmacist must be carefully taken into account.

Mr. Leonard Ariff Abdul Shatar, Group Managing Director, Duopharma Biotech Bhd

Pharmaceuticals are the starting point of the healthcare supply chain. However, there is a disparity of pricing which exist in the government side which has not been sufficiently user funded. On the other extreme, the private sector looks at profit driven means to fund the hospital. The question is whether price distortions are occurring at the manufacturing or supply chain side.

Almost all multinationals operating in Malaysia use third-party logistics with very little between them and the end users. There are around 2,500 pharmacies and 5,000 practicing GPs in Malaysia. In the public sector, there are numerous hospitals throughout Malaysia and more than 2,500 Klinik Kesihatans (public health clinics). The supply chain needed to service this is quite costly.

Duopharma directly handles customers located within an 80-kilometre radius and third-party distributors for anything beyond. One of the biggest issues faced is having good distribution practices among third party logistic providers. There is a lack of specialised medical supply logistic companies as there is no requirement for it. This causes medicine to be shipped by third-party distributors alongside general household items. To remedy this, regulators have stipulated certain standards which need to be met. However, the consequence of enforcing these standards is that it causes pricing pressures. The cost

of delivery to the end user is around 12-17 percent uplift on drug prices. Meanwhile, the government's supply chain is slightly different with around 40-50 percent going through a concession agreement and another 50 percent of direct deliveries. Whether or not this is the most efficient means boils down on policy decisions.

Direct deliveries to Klinik Kesihatans and hospitals are the preferred option for major pharmaceutical companies. However, smaller producers of medical devices do not have the same level of reach. Last mile delivery is a policy decision. The situation may end up with anti-competitive types of practices if manufacturers are allowed to deliver directly to end users as it may kill off the smaller competitors. This is why the last mile delivery, especially within the government sector, should be managed by an independent party. This last mile delivery ensures that there is the right level of stock and supply. The question is less on the hospitals, but more for the Klinik Kesihatans. This is where supply chains come in and why policy decisions have much impact.

To ensure that drug prices are cost effective, there a need to realise at the beginning that the pharmaceutical sector is one of the most heavily regulated sectors in the world. Malaysia, with a population of only 33 million people, is not big enough to manufacture lots of products nor does it have scale. The patient's money required to develop an export market and reach a level of scale will take 7-10 years. However, this does not mean that Malaysia cannot be self-sufficient as there are other options.

There is a need to learn from past mistakes. Malaysia once built a vaccine facility - but there is no such thing as a facility that will only produce a single vaccine. There needs to be a more robust risk mitigation exercise where for each vaccine produced, there needs to be at least three global suppliers which will guarantee cost benefits from a scaled-plant and ensuring self-sufficiency with a range of companies.

Predatory pricing is a major issue for local generic manufacturers. For example, when a multinational Indian company opened a facility in Johor, prices of a particular product fell by half. In response, the multinationals dropped their prices even lower. Prices also fall in the advent of generics or biosimilars due to predatory pricing from multinational producers trying to ensure that the developments that are being done by their competitors gets stopped. To remedy this, the policies developed by the Ministry of Health need to be tailored appropriately to create a vibrant pharmaceutical industry. Bearing in mind the desire for generic to bring down prices, generic-friendly policies have to be in place.

The government must not change their minds on its policies which can harm this industry as good ideas in the developing a pharmaceutical plant require years to manifest. Policies need more determination if the government wants to have more generics and biosimilars in the country. The NPRA looks at the patient's interest angle. There is also a National Medicine's Policy looks at the interest of patients. Better policies are needed to look into the development of pharmaceuticals in Malaysia. This may require a National Healthcare Policy.

Q & A

Dr. Tan Ai Mei sought clarification on how data collection can be optimised to empower patients to own it. Currently, patients in most public and private healthcare facilities are not allowed to draw out their own MRI reports. Policies in place need to be effective in optimising data, avoiding the constraints of bureaucracy and unnecessary KPIs to improve value for patients. Data management in general hospitals is not synchronised between its own departments, leading to delays and misdiagnosis which crucially affect patient health. The delivery of information needs to be more reliable in other for patients to be at the centre of care.

Dr. Milton Lum asked what value tender agents in medicine procurement bring to patient care.

Dr. Ganabaskaran Nadason, Malaysian Medical Association (MMA), explained that healthcare providers have no issue with recommendations for separate specialised dispensing of pharmaceutical companies, but they will not give up dispensing as long as the fee schedules are not provided. The government must come up with clear policies for aging care as this will be an issue in the future. Rules and regulations need to be in place to mandate that children have to care for their parents, similar to what Singapore is practicing.

Dr. Lim Kuan Joo asked the panel for their thoughts on value pricing for drugs, such as the one being practiced in the United Kingdom.

Mr. Sheikh A'bdullah Salman Jalani pointed out that there is a big drive from MNCs in other countries to decriminalise CBD-THC based medication due to the huge potential for revenue. He then asked what was Malaysia's position on this in light of developing the pharmaceutical industry.

Dr. Md Khadzir B. Sheikh Ahmad explained that the utilisation of reliable data is very much needed in the MoH. One of the challenges faced in the research component of the data is that interest parties want to take the data out of the Malaysian Health Data Warehouse. This presents a tricky situation as once the data is extracted, it will then be shared around. Therefore, this is not allowed to protect the interest of patients. Instead, researchers need to come to the warehouse centre in order to gain access to the system. There will be more developments in the virtual environment to improve user access and process data. These are efforts undertaken to ensure that data remains in the data warehouse whilst enabling data analysis.

Mr. Tirupathi Karthik shared that there are several notable countries recognised for their elder care policies and the delivery of elder care; the NHS in the United Kingdom, Australia, New Zealand, and Singapore. Built-in standards can be implemented to ensure that elder care operators maintain consistency of service quality across various elder care facilities.

Mr. Amrahi Bin Buang explained Malaysian Pharmaceutical Society's stand regarding dispensing separation. There are clear separations of roles between doctors and pharmacists. To move forward, there needs to be an emphasis on the benefits these measures brings towards patients. The structure of healthcare consists of primary care, secondary care, and tertiary care. Its dichotomous nature requires that this be further divided into two, leading to six sectors. Dispensing separation already exist in five out of the six. It is important to realise that there is in fact no issue and there is already an understanding of the roles of separation, which ultimately benefits the patient. If doctors feel that this is a prerequisite, it will be supported by the pharmaceutical industry. Hence, this is now up to the government. The government should form a taskforce or committee to look into this this.

Mr. Leonard Ariff Abdul Shatar revealed that tendering agents do not earn much. They were once able to earn a 7 percent margin, but it is not down to just 3 percent which is then taxable – around 1.4 percent, leaving a balance of 1.6 percent which they earn. In a way, this is beneficial for the industry as manufacturers will take on a lesser number of sales persons whilst maintaining the same level of coverage. Although Duopharma supplies new products directly to the government, tendering agents are still used for old products with the lowest rate at 2.2 percent, giving them a 0.8 percent profit. Therefore, there are savings manufacturers can pass on to the government.

MNCs tend to be more vocal against tendering agents, disagreeing to the 3 percent payments for supplying to the government. However, if Malaysian pharmaceuticals want to supply their products to Europe or the United States, they will first audit the Malaysian facility, then audit the supply chain, and followed by requirements for the Malaysian pharmaceutical to register in their country. When all this is

done and when local pharmaceutical wants to ship their products, they will ask for pre-arrival inspections which has to be carried out by a European-licenced company. Therefore, what is reflected in the press is not presented in a factual manner. In short, tendering agents can be done away with, but there may be an adverse impact on overall healthcare cost for the government as prices may have to be increased when all private sector companies, which were using agents, are forced to incur the same cost when required to conduct a monitoring of orders and other matters of compliance.

More caution needs to be exercised towards value-pricing which is being tested in the United Kingdom and certain places in the United States. There is a new development taking place where pharmaceutical companies are offering products to the government for free, with payment dependent on success. There are many ethical issues surrounding it.

The healthcare system Malaysia, in light of budgetary constraints, is considered excellent. The problem is not that the rate of illness incidents has gone up, but it is more due to improved diagnosis detecting these illnesses. The issue is that the cost of new medications being introduced is very high, which will take up significant portions of Malaysia's healthcare budget. This is the reason why there needs to be more user-pay system to assist the MoH rather than rely on taxes.

On the question on legalisation of marijuana, a policy decision needs to be made from the point of view of the patient. The USFDA has approved the first ketamine treatment for depression. There is a change happening. However, Malaysia should be act too hastily, but continue to observe developments elsewhere before making a value-judgement.

SESSION 3

Whither the Malaysian Healthcare Financing Scheme?

Moderator:
Dr. Lim Kuan Joo, Former Director, Hospital Kuala Lumpur

Since the 1980s the government has recognised that the cost of healthcare is rising and there is a need to find alternative sources of financing. In Malaysia, the term "insurance" is still a taboo. According to the WHO healthcare system framework, healthcare financing is only part of the bigger Health System Framework.

Speakers:
Assoc. Prof. Dr. Azimatun Noor Aizuddin, Head of International Center for Casemix and Clinical Coding/ Senior Lecturer & Public Health Specialist, Universiti Kebangsaan Malaysia

There are many challenges in Malaysian healthcare financing which has caused the cost of healthcare to rise. These challenges include advances in medical technologies that has increased longevity, changes in disease patterns from communicable disease to non-communicable disease, new effective mix of diseases, efficiency in the use of resources, and also the sustainability of health financing.

There are several issues in Malaysian healthcare financing, namely; equity, efficiency, quality, acceptable and adaptability, affordability, comprehensive, and integrations. There are some questions for the people to ponder about in terms of health financing system; who is paying for it? Is it by government or community? If is it by community, what are some of the criteria? Is there any equity? How much is the government or community is paying? What is the criteria? Is it affordable? Is the health financing scheme beneficial and acceptable? What are the services covered, is it comprehensive enough? Who provides services? Is there any integration? How adaptable and efficient is the financial

system used? Is the provider payment mechanism used efficiently? How frequent do financial issues occur? Is the authority efficient in holding fund or have a quality monitoring system? What is the level of efficiency, acceptability, adaptability, comprehensiveness and integration of the reformed health financing system?

There are several types of available healthcare financing schemes, such as forms of taxation like the General Tax Revenue, Social Health Insurance or National Health Insurance, Personal Health Insurance, "Out-of-Pocket" fees, Medical Saving Accounts (MSA), and so on. In developed counties, the main health financing system is the Social health Insurance, which is complemented by taxation, medical saving, personal insurance and the employee benefits. However, in developing countries, the health financing system is primarily based on the taxation system, personal insurance, out-of-pocket payments, employee benefits, and community financing. In Malaysia, health financing still relies heavily on the taxation, but it is slowly moving towards a National Healthcare Financing Scheme.

Mr. Rangam Bir, President and Chief Executive Officer, Gibraltar BSN Life Berhad

Malaysia is ranked top in healthcare for its high-quality services and infrastructure by the International Living Annual Global Retirement Index 2019. Out of 200 hospitals, 12 are accredited by Joint Commission International (JCI). This could be due to higher investments in hospital infrastructure and capacities in recent years that has enhanced the quality of delivery. In terms of health expenditure, 43.1 percent of the total expenditure is borne by MoH and 37.6 percent of the expenditure is from "out-of-pocket" expenditure.

While allocations to the MoH has increased, healthcare inflation is taking place at a rapid rate of around 12 percent in the past three years. This implies that the sustainability of funding to ensure Malaysians continue to enjoy high quality and affordable healthcare is not assured in the medium-term. There needs to be alternative models for sustainably funding healthcare system, including an active public and private insurance market place. The funding from government is also constrained by a debt ceiling of 55 percent of GDP which it has committed to.

Healthcare inflation has accelerated in recent years could be attributed to the several factors. Firstly, the increasing number of lifestyle or non-communicable disease. Obesity has increased from 4.4 percent in 1996 to 17.7 percent in 2015. Malaysia also has the highest diabetes rates among ASEAN countries at 17.5 percent in 2015. Secondly, there is an increased use of private hospitals. Healthcare inflation could also be due to the expensive technologies and treatments as more sophisticated tools offering advanced treatment and the weakening Ringgit has led to higher cost of imports. Lastly, there has been an increase in the size of the ageing population.

A solid and robust Citizen-Funded National Health Insurance Scheme supplemented by private health insurance is the key to sustainable healthcare funding. The advantage of a National Health Insurance Scheme is that the premium is more affordable due to larger pool. Premiums will also be charged according to the percentage of wages, with earning capacity being considered. Private health insurance provides additional protection on top of the basic coverage and offers access to personalised packages

and a variety of services. Top healthcare systems globally are funded by citizens whom contributed to national health schemes along with private health insurances. This is practiced in Germany, France and Singapore where the funding of the health insurance system comes from contributions from both the employer and employee.

The sustainability of healthcare funding can be enhanced with comprehensive cost containment strategies such as co-payments, transparent and itemised billing, increasing or promoting use of generic drugs, shortening of hospital stays, regulating price of drugs and other medical supplies, and encouraging market competition. There is a need to leverage technology to contain healthcare costs by optimising utilisation and staffing to avoid inefficiencies, implementing a national healthcare database, identifying potential risks or monitoring health conditions to improve outcomes as well as to leverage data and modern technologies for targeted treatments.

Mr. Azrul Mohd Khalib, Founder & Chief Executive Officer, Galen Centre for Health and Social Policy

According to a survey conducted by the Galen Centre, the five most important things to people in healthcare are (i) shorter times at the hospital, (ii) more affordable treatments besides medicine, (iii) more affordable diagnostic tests, (iv) more affordable premiums for private health insurance, and (v) more caring doctors. Most respondents indicated that the positive thing about public hospitals were the low cost of treatments and experienced and caring doctors. As for private hospitals, respondents favoured the fast treatments, comfortable facilities, access to the latest drugs, and more attentive and caring doctors and nurses.

A direct consequence of people living longer has resulted in a growing ageing population and more non-communicable diseases, becoming a health burden which gets progressively larger and heavier each year. Subsidisation is so high to a point that every patient entering the public system has more than 98 percent of their actual costs borne by the government utilising the public purse. The tax-based financing system Malaysia currently has is not bottomless and its demands are becoming larger. Hence, the current model has become unsustainable, leaving people behind.

Moving forward requires investment in better approaches to healthcare financing. 2019's allocation of MYR29 billion is the largest allocation ever, but concern have emerged that existing pools of funds will not be able to keep up with the increasing cost and burden of chronic and non-communicable diseases such as cancer, diabetes, and cardiovascular diseases. The quality and coverage of healthcare will suffer due to the shrinking ability to provide a level and standard of care and treatment equivalent to an upper middle-income country.

A national health insurance scheme or social health insurance is very much needed. The current system is increasingly untenable and unsustainable. Thus, a compulsory rather than a voluntary national health insurance scheme needs to be in place, providing coverage for all. The ideal means would be for a single-payer multiple-provider system where public and private institutions would have equal access to patients.

In order to maintain Malaysia's current two-tier system, a multi-payer approach is required, such as a monthly contribution to a national pool of funds similar to SOCSO and EPF. This would be applicable to all workers and be based on a sliding scale linked to monthly income and age. This way, there would be collective pooling of both funding and risk. Those unable to pay, such as those earning the minimum

wage or less should be fully subsidised, while those of whom already have their own insurance policies should be able to keep them. These suggestions widen the funding base for public healthcare and has the potential to change the status quo by improving access as well as the quality of access. New treatments, drugs and therapies would be made possible and be introduced without solely being dependent on the annual national budget. It would address the issue by co-sharing the burden and responsibility of financing the healthcare system. It also has the potential to stabilise public subsidisation and allow room for cost-containment while maintain access and quality to essential services.

In a value-based approach, it is important to remember to whom the value is for. Patients and people should no longer be passively waiting for the industry, government, and other key stakeholders to make decisions affecting and impacting them. The government, especially the MoH and Ministry of Finance (MoF), must make deliberate efforts to consult the necessary and pertinent stakeholders to ensure buy-in and ownership of any proposed national health insurance. The intent is not to make everyone happy per se, but to ensure that something as important healthcare has the best possibility of success and has necessary support.

Dr. Chua Hong Teck, Senior Advisor, Research Triangle Institute (RTI) Malaysia

Malaysia spent between 3.03 to 4.4 percent of its GDP on health over the past 20 years. In 2017, Malaysia spent MYR57.4 billion on health. In fact, the source of financing for public and private mix for total expenditure has almost reached a 50:50 ratio, whereby the expenditure by private health providers is 49 percent, whereas the public expenditure is 51 percent. Out of this figure, 43.1 percent is funded by the MoH while 37.6 percent are from private household out-of-pocket payments.

Expenditure at hospitals and ambulatory healthcare providers account for 76 percent total healthcare expenditure. In 2017, total out-of-pocket payment (OPP) expenditure amounted to MYR21.6 billion. Out of this expenditure, 46 percent was spent on out-patient services, while more worryingly, 24 percent is spent on in-patient services.

There have been numerous healthcare financing and related studies carried out since 1985. In 2007, a study by Karol Consulting, which was sponsored by the United Nations Development Program (UNDP), proposed an ear-marked tax for Malaysian healthcare financing scheme. However, MoH opted for social health insurance instead. After May 2018, the new government has developed new health schemes such as mySalam and PeKa B40.

The way forward should involve the strengthening of the tax-funded system. Co-payments or an ear-marked tax can be introduced to create a more efficient tax system. There is also a need to convert out-of-pocket payment insurance and private insurance schemes to cover pre-existing illness conditions and include family plans. People should be encouraged to build savings for themselves and their families through medical savings accounts. There should also be public-private collaborations to allow for more improved utilisation of resources, such as facilities, equipment, and human resources to create a more efficient and sustainable health system.

Q&A

Dr. Ganabaskaran Nadason, MMA, pointed out that the subsidies and public health services have also been utilities by patients whom were wealthy and could easily afford them. Much resources are wasted, becoming a cost to taxpayers. Yet, the current financing model and fee schedule payments have remained the same for decades. The needs of front liners must be met for sustainability. More concrete solutions need to be developed to resolve this issue.

Dr. Jason Tee, Cerner, highlighted that several articles have mentioned that DRG Casemix would reduce the cost of healthcare due to price transparency and would lead to improvements in care. However, insurance providers prices are based on schedule 13. Dr. Tee asked if the DRG Casemix has been implemented with the insurance companies. If it is not, when is the timeline for its implementation and will it help to reduce the cost of healthcare?

Assoc. Prof. Dr. Azimatun Noor Aizuddin explained that DRG Casemix is already used in Hospital Universiti Kebangsaan Malaysia (HUKM). From this system, they have developed a hospital tariff which allows them have an overview of their expenditure and also forecast projected expenditure which can also be used as the benchmark for subsequent expenditures. It has also allowed them to measure the cost of treating patients according to disease, diagnosis, severity, and procedures. In MoH, a different type of Casemix is being used called myDRG Casemix, though it is yet to be adopted by all of its hospitals. The Casemix used in HUKM has been adapted by Indonesian hospitals and primary care.

Mr. Rangam Bir gave an insurance industry prospective, advocating for high transparency and standardised coding across the country to enable billing to be transparent and itemised. The challenge is that different organisations are using different types of coding, which is problematic for insurers.

Dr. Lim Kuan Joo stressed that DRG was developed in the US, initially for acute care instead of chronic care. However, the landscape for payments have changed. It is now for a series of care services which can be bundled for greater cost saving instead of a fragmented means of payment for single episodes of care.

Assoc. Prof. Dr. Azimatun Noor Aizuddin explained that calculations may be per episode, but it also includes follow ups and other services. Hence, chargers are not purely per episode, but bundled.

Dr. Mohamed Namazie Ibrahim, MMA, shared that 1985 watershed for the medical professions when the Director General of Health called the then president of MMA, Tan Sri Abu Bakar, to develop a fees schedule for the doctors to coincide with the introduction of a national health insurance. This led to the introduction of the first edition of the fee schedule in 1987. A second edition was introduced in 1992. The reason outpatient services are very affordable for patients is because it is heavily subsided by the GPs themselves. The 1992 schedule is still being used in 2019 with chargers between MYR10-35. MMA's efforts to introduce the sixth edition of the fee schedule has not been taken up by the government. MMA has also spent hundreds of man hours to develop common coding for six thousand medical procedures, including vaccinations, but nobody has taken it up seriously. There must be initiative and political will to move forward.

SESSION 4

Integrating the Social Determinants of Health in Patient Management

Moderator:

Datuk Dr. Narimah Awin, Former Regional Adviser (Maternal and Reproductive Health), World Health Organisation (SEARO)

Speakers:

Prof. Dr. Hematram Yadav, Professor of Community Medicine, Department of Community Medicine, Faculty of Medicine, MAHSA University

According to the World Health Organization's (WHO) definition in 1948, *health* is a state of complete physical, mental and social well-being and is not merely due to the absence of disease or infirmity. The social determinants of health (SDH) revolve around 4 pillars, namely to live, learn, work, and play. Factors of SDH include socio-economic status, poverty, housing, education, and so on. In short, the WHO has defined SDH as factors that have an impact upon health and wellbeing. The circumstances to which people are born, grow, live, work and age, including the health system, are interrelated with each other. These SDH affect health outcomes, such as mortality, morbidity, life expectancy, healthcare expenditure, health status, and functional limitations.

Inequality in health refers to the differences in health status between different groups due to social determinants. Research has shown that the genetic predisposition only comprises 30 percent of premature deaths, whereas other SDH such as behavioural, healthcare, environmental exposure, social circumstances contribute up to 70 percent of premature death. Even adult deaths are attributable to social factors such as low education, racial segregation, low social support, individual-level poverty, and income inequality. Research also found that children who experience multiple forms of abuse, witness domestic violence, and grew up in households where family members are mentally ill, suffer from substance abusers, or sent to prison are more likely to have attempted suicide, be alcoholic or drug abusers by the time they reach adulthood.

Low-income earners are disproportionately affected by major medical events. For example, in the US, it is found where income inequality is higher, the instance of people suffering from mental illness is also higher. On the other hand, in Japan where income inequality is low, the percentage of people with mental illness is also low. Failure to identify social challenges can lead to misdiagnosis and a path of inappropriate investigations. A study in Canada which involved a survey of patient care and social determinants found that 40 percent of patients have indicated that their family doctors were unaware of their struggles. Despite women having bruises and broken bones, only 14 percent of them have been asked about the occurrence of violence.

In 2008, the WHO Commission on SDH in a report entitled 'Closing the Gap in a Generation' identified two broad areas of SDH. The first area involved daily living conditions which include healthy physical environments, fair employment and decent work, social protection across the lifespan, and access to healthcare. The second major area identified by WHO was the distribution of power, money and resources, equity in health programs, and public financing of action on the social determinants. In 2011, delegates from 125 member states made the Rio Political Declaration on Social Determinants of Health affirmed that health inequities are unacceptable. In 2017, the Rio Declaration on SDH once again cited the need for accountability and called for pledges to be made by all the member countries.

Training of physicians, nurses and others involved is important in addressing SDH. Physician can better support patients with social challenges by inquiring of their social history, provide them with suitable advice, and refer them to local support services. Social diagnosis and social prescription involve connecting patients to support services beyond the health sector. Clinical practice guidelines in these areas are lacking and can lead to misdiagnosis and a path of an inappropriate investigations.

Assoc. Prof. To' Puan Dr. Safurah Jaafar, Head of Division, Family and Population Health, International Medical University, Program Director Business in Healthcare Management, IMU

SDH is the way to which social, economic, and physical environments elements interact with individual biological factors, behaviours and shape health status. The key issues related to SDH in the elderly include loneliness, coping with physical changes, medical problems, boredom, financial stress, social isolation, and feeling inadequate.

There are mainly three types loneliness, in elderly context; situational loneliness, developmental loneliness, and internal loneliness. In order for the elderly to avoid social isolation, they need to have a sense of belonging, engagement, fulfilling relationships, quality relationship and social contacts. While some of the elderly are perceived as wise, experienced and kind, most of the time they are being labelled negatively as grouchy, demented and incompetent.

There is an inequality of healthcare for the elderly compared to the health resources offered to the younger population as old age is perceived as at the end of the life stage. Moreover, certain groups of elderly would receive disproportionate levels of care, causing an inequity in the distribution of healthcare resources.

The elderly population is increasing, but policies for an ageing society is still lacking in Malaysia. Recently, the Deputy Prime Minister revealed that the Ministry of Women, Family and Community Development is collaborating with the UNDP to develop an age-friendly city. In addition, the government will also establish 29 new activity centres nationwide to encourage community participation from senior citizens.

Ms. Natasha Francis, Business Development Executive, Doctor2U

The healthcare industry is shifting its focus on greater quality care and prevention of health issues before they arise by increasing its attention on an area outside of healthcare that needs to be addressed – the SDH. Among SDH's relating to patient management include accessibility to healthcare, transportation options, a fragmented ecosystem, surrounding physical factors, healthy behaviours as well as economic status.

In 2017, the expenditure in healthcare is MYR50.3 billion or 4.4 percent of Malaysia's total GDP. 90 percent of costs in public healthcare is absorbed by the government while patients need to fork out more than 39 percent of expenditure from their own pockets.

In order to overcome rising healthcare expenditure, there is a need to consolidate data from all user touchpoints and existing systems through data mining and machine learning. This will provide greater

insights on patient's behaviour and demands to help improve operational effectiveness and outcomes as well as increase patient satisfaction.

Digital health is a powerful tool in revolutionising NCD care. Companies in the likes of Apple, Grab, Babylon, and Amazon are also working on health technology to improve the healthcare provider system. In order to bridge the health inequality gap, a patient-centred service needs to be established with integrated data platforms, holistic care, constant engagement with patients, and to improve the accessibility and communication.

Q&A

Ms Jade Chan, Galen Centre asked panellist for their thoughts about introducing universal social protection schemes and how it would affect the SDH.

Dr Lim Kuan Joo pointed out that the premature mortality rate is high in Malaysia, especially in the underserved areas, many of which are caused by SDH. There must be a greater political will when it comes to addressing SDH issues. The MoH needs to be given the ability to take give direction to other ministries to enable joint action. Here, advice from the WHO rings true, where HIAP (Health in All Policies) needs to be practice to affect meaningful change.

Datuk Dr. Narimah Awin added that effective smart partnerships are needed in bring together all other agencies to make health a priority in the policy making process.

Prof. Dr. Hematram Yadav clarified that social protection in Western countries is very developed compared to Malaysia. He shared that when his teacher in the UK had a stroke, the government made adjustments in this home to accommodate his disability.

Assoc. Prof. To' Puan Dr. Safurah Jaafar added that in developed countries, policies for long-term care exist, where a major part of the population is contributing the moment they are employed. Therefore, a budget is available for use when required. Such a system is not yet available in Malaysia.

Datuk Dr. Narimah Awin shared that Australia also has a good model of taking care of elderly, which is prepaid. However, there is still no single cohesive government programme to do this in Malaysia, which is something that can be recommended to the government.

Full session recordings available on YouTube. Search:

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