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Challenges for Living: Health for All*

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***Abstract*:** Health is a basic human right and the modern state has a social responsibility to safeguard the health of its citizens and to ensure equitable access to health care and quality in utilisation of health services. The health care system in Malaysia is conceptually sound and has a strong foundation that will benefit from positive structural and administrative reforms to correct deficiencies rooted in inadequate provision of funds. Reforms should be shaped by WHO principles based on human values, centred on the needs of the community and quality of care, oriented towards primary health care, and sound financing. The corporatisation and privatisation of health services, proposed in the Seventh Malaysia Plan, are not appropriate responses to increasing health care costs and other problems. Universal coverage and equitable access to health care are best achieved through a public health care system mandated by the government, through direct taxation and/or compulsory social insurance, and a single-payer, non-profit health financing authority.

1. Introduction

It was Hippocrates who said, *A wise man ought to realise that health is his most valuable possession*. Today, we would add that health is also a basic human right and that all governments have an unequivocal social responsibility to provide health services that would ensure universal access to comprehensive health care for all its citizens.

We also need to reassess assumptions about medicine and health, particularly the assumption that the determinants of health and illness are predominantly biological, as evidence mounts that the patterns of morbidity and mortality are often related to economic, social and environmental factors. Numerous studies have shown that health is largely determined by economic and social inequalities such as low income levels and poverty, poor housing and sanitation, the lack of safe water and electricity, and inadequate education and illiteracy. Medicine and health care, therefore, need to be woven into the fabric of social policies of governments, many of which now appear to be preoccupied with the triumphalism of capitalism and a belief in economic growth as the beacon of development.

The nature of the links between economic growth and human development and human security needs to be better understood. Human development and human security are the ends – economic growth is the means to those ends. In other words, the purpose of economic growth should be to enrich human lives. But ever so often, economic growth is unsustainable, damages the environment, and widens the gap between rich and poor, all of which have health consequences.

In 1978, the World Health Organisation (WHO) ended its conference with the *Alma ata Declaration, Health for All,* which emphasised the importance of equity, economic and social development, and community participation in the process of improving health care, particularly the central role of primary health care. It follows that improvements in health can only be

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effected through partnerships between national and local governments, health professionals, employers and employees, educational institutions, communities and voluntary organisations, individuals and families.

In recent years, health services in many countries have come under critical review, partly because of increasing health expenditure, much of it coming from public funds. This has put pressure on governments to control public spending on health and increase the efficiency and cost effectiveness of health care. Further concerns have been the need to ensure equitable access to health care, enhance patient choice, and to make health providers appropriately responsive to health care needs.

Underlying these concerns, two fundamental developments have had an impact on the performance and cost of health services. First, demographic changes in population where the growth of an ageing population increases the demand for health care and, at the same time, a decreasing proportion of younger working people reduces the ability to pay for the increasing demand. Second, advances in medical science and technology, together with information technology, are creating expectations and new demands for higher standards of care and new treatments, with significant implications for funding the provision of services.

Against this background of continuing pressure to contain costs, increase efficiency and raise service standards, health policy makers in many countries have been introducing a range of health reforms to improve health care systems. In 1996, the World Health Organisation adopted the Ljubljiana Charter on the principles of health reforms, which stressed that health reforms should first and foremost lead to better health and quality of life for people, and be driven by human values, targeted on health, centred on the needs of people, focused on quality, based on sound financing, and oriented towards primary health care. Studies of these different reforms confirm that almost everywhere there is dissatisfaction with existing methods of financing and the organisation and delivery of health care, and that no ideal system has emerged. Some governments have realised that such reforms carry great responsibilities and have serious political repercussions, as health care affects every individual and family, regardless of age, gender or social class. Other governments ignore the political importance of equity on health care at their own peril.

The two main goals of every health system are to optimise the health of the population, by using the most advanced knowledge on medical science, and to minimise the disparities across population sub-groups by ensuring universal and equal access to health services. One of the central features of *health for all* is its emphasis on equity and equality. Although the words 'equity' and 'equality' are often used interchangeably, there are important differences between them. Equity is about fairness and justice, implying that everyone should have an opportunity to attain his or her full potential for health. Equality is about comparisons of the level of health between individuals and communities, or ability to obtain access to health care.

Equity and equality in health care are age-old issues and are related to priority setting, rationing, and the allocation of resources derived from decisions based on social values which determine what is fair or just. There is general agreement that most health issues related to equity come under the category of 'distributive justice' or how benefits, resources and burdens of society are distributed to each individual, based on societal values.

2. Health Care in Malaysia

The general health standards of Malaysia are reasonably good and are continuing to improve, as measured by health status indices. For instance, the infant mortality rate (the number of children below one year who die per one thousand live births each year) was 10.4 in 1995 compared with 23.8 in 1980. Similarly, life expectancy for males and females improved from 66.7 and 71.6 respectively in 1980 to 69.4 and 74.2 in 1995. This can be attributed as much to its social and economic development and improvements in living standards as to its public health services. These health standards are in many ways remarkable, in view of Malaysia's low expenditure on health, which amounts to about 3 per cent of its gross domestic product.

This is partly due to the cost effectiveness of developing rural health services and to the transformation of the health system from a mainly urban-based curative system to a comprehensive system, encompassing promotive, preventive, curative and rehabilitative health care for both urban and rural populations. A network of general hospitals, district hospitals, polyclinics, health centres, midwife and mobile clinics has placed 90 per cent of the population within one hour or five kilometers of a health facility.

Complementing the public sector is the private health sector, mainly consisting of urban-based general practitioners, focused largely on curative care. However, in the past fifteen years, private hospitals have mushroomed in most large towns, particularly in the Klang Valley. Most private hospitals represent large investments by business corporations, all in the business of making profits from health care. They have lured away large numbers of highly trained, dissatisfied specialists from government and university hospitals, causing a serious brain drain and a severe strain on public health services.

3. Health Care Financing

Health care financing is perhaps the most important aspect of any health system, which basically has three major objectives: equitable distribution of health care to all citizens, clinical autonomy for providers, and budgetary and cost control for the government. All these are competing objectives. Consumers will want equity; providers will want to be free to provide patient care and determine fees as they see fit; and the government will want an affordable health budget. The end result must inevitably be a compromise. Health care financing is therefore a politically sensitive and value driven issue that will determine the nature of a country's health system and reflect the state's commitment to providing universal, accessible and comprehensive health care for its citizens.

The spiraling cost of health care has stimulated efforts to control costs and achieve efficient use of health budgets. The effort to balance equitable funding of health services with finite resources is a major challenge for all governments. In fashioning appropriate systems of health financing, policy-makers need to ask important questions. What is the best way of mobilising funds to finance health care? How should finite resources be allocated to obtain the best value for money and provide universal and equal access to good quality care? Who determines where and how health care resources will be deployed and used?

Those countries which have traditionally relied on a market in health care are turning to greater use of regulation and planning. Equally, those which have relied on regulation and planning are moving towards a more competitive approach. Everywhere there is a search for new policy instruments, and Malaysia is no exception.

3.1 Sources of Funds for Health Care

There are four main sources of funds for health care: direct taxation, social insurance, private

health insurance and out-of-pocket payments. Taxation and social insurance may be classified as compulsory or statutory systems, and private health insurance and out-of-pocket payments as voluntary.

Studies of health care systems in industrial countries show that most subscribe to one of two models:

1. The Beveridge plan, which is financed by taxation and is state controlled, providing free access and universal coverage of the population, including all residents, although there may be an element of co-payment in some countries. Through state budgets, it operates hospitals and other health care facilities, and employs salaried health professionals. Tax-based financing comes from revenues derived from national taxation (as in the United Kingdom), regional taxation (as in Canada), and local taxation (as in Sweden and China).
2. The Bismarckian model, which is based on compulsory social/health insurance and financed by compulsory contributions from employers and employees. In most European countries, compulsory social/health insurance is part of a comprehensive social security system. The funds go to non-government statutory finance management bodies or 'health insurance plans', which are essentially non-profit, independent, government-regulated entities. By making social insurance compulsory, the rise is broadly spread and there is a mechanism for redistributing income from the higher income group to the lower income group.

Basically, there are two types of social insurance programmes that provide universal health coverage:

1. Government plans, which have a standardised benefits structure and contribution rates, which are derived from a combination of general taxes and payroll taxes from both employers and employees. Decision-making is centralised and rests with government administrators. Health care services may be provided directly or indirectly. In many countries, the plans own and operate hospitals and other health facilities, where financing, ownership, payment and health care delivery are well integrated.
2. Mandated private and public plans, where it is compulsory for every citizen to purchase health insurance but with freedom to choose from several private or public plans, which have a standardised benefits structure and actuarial standards, specified by the government. Governments subsidise the premiums of the elderly and low income group from general taxes. A global budget is often set and all insurance plans make payments through a single payer entity which sets a standard method and rate for medical services. There is evidence that a single payer system linked to a global budget has the benefit of control of health care costs.

3.2 Pluralistic Health Care Systems

All health care systems are pluralistic and rely on a mix of all four sources of funding – direct taxation, social insurance, private health insurance and out-of-pocket payments – with one source being predominant. In almost all Commonwealth countries, including Malaysia, there is universal provision of health care by public hospitals and an independent and parallel private sector. Those who avail themselves of private health care, do so with private health insurance or out-of-pocket payments.

A pluralistic system has the advantage of a wide choice of services, but the reality is that choice is narrowed and limited to the affluent few. The vast majority have to rely on medical services provided by the public sector. The theoretical underlying principle of free choice and

market competition is that market forces are expected to produce efficient health care and control costs. In practice, this does not work. The United States is the only country that has used this approach, and it has clearly demonstrated that it has the most expensive, the least efficient and the least equitable system of health care in the world.

3.3 Solidarity

The concept of solidarity, with its roots in the libertarian idea of social contract, has come to play a central role in the construction of twentieth century welfare states. In health care, solidarity has become synonymous with risk pooling or arrangements in which health care costs are not financed individually but by healthy people financially supporting the sick through compulsory taxation or compulsory social insurance. In other words, solidarity is aimed at reducing health-related inequalities by ensuring that a person is not penalised by his or her health status and that health services are delivered not according to ability to pay but according to need.

In terms of solidarity, private health insurance and out-of-pocket payments represent the most regressive form of health financing. Private health insurance operates on risk-adjusted premiums which corrode social solidarity by forcing the old and chronically ill to pay higher premiums than the young and healthy. On the other hand, solidarity is enhanced when health care is funded through general taxation or social insurance.

3.4 Health Financing in Malaysia

The financing of health care in Malaysia has traditionally come from general taxation, although the role of the private sector has become more significant with the recent growth of private hospitals. The operating budget of the Ministry of Health in 1997 was RM 3,447 million, compared with RM 759 million in 1980. Corresponding allocations for health in relation to the national budget were 5.8 per cent and 5.3 per cent in 1997 and 1980 respectively. The corresponding allocations for defence and education were 15.2 per cent and 24.7 per cent respectively

Health care costs in government hospitals are low because they are heavily subsidised. Even if all chargeable fees were collected, they would amount to only 30 per cent of the government's health expenditure. In reality, fee collection is inefficient and amounts to 5 per cent of the total health budget.

When the Malaysian government launched its privatisation plan in 1983, which included the privatisation of health services, it was interpreted as the transfer of dominant responsibility for the financing of health care or the supply of services from government to agencies or companies in the private sector. Government health policy on health reforms became clearer in 1996, when the Seventh Malaysia Plan announced the corporatisation and privatisation of hospitals and medical services, and the implementation of a health financing scheme. The Malaysian Medical Association (MMA) has unreservedly opposed privatisation. Accepting that the corporatisation of public hospitals had some merit but predicting that corporatisation would increase costs for the low income group, the MMA reluctantly agreed to corporatisation but on very specific conditions. These conditions are:

1. Corporatised hospitals must be non-profit, 'communitised' entities, wholly owned by government.
2. Corporatisation must be preceded by transparent consultation with the medical profession

and the public.
3. Corporatisation must be part of a fundamental, comprehensive structural reform of health, not an incremental piece-meal change.
4. Corporatisation must include functional integration of the public and private sectors, and the health system must be primary care-led.
5. A single-payer health financing scheme must be in place before corporatisation.

In August 1999, after the formation of a Citizens' Health Initiative (CHI) and just before the general elections, the Minister of Health announced that the government had decided not to go ahead with corporatisation. This reversal of policy has been widely welcomed by the MMA, the CHI and the public, who had been expressing their objections, concerns and reservations for three years to the government.

However, the fact remains that corporatisation and privatisation have already been carried out selectively, without a health financing scheme in place. Between 1992 and 1998, the corporatisation of the Department of Cardiothoracic Surgery in the Kuala Lumpur General Hospital, the Government Medical Store, and the University Hospital were carried out. Since then, fees for consultation, treatment, laboratory tests, radiological investigations, operations and drugs at these corporatised entities have increased significantly. Without a national health financing scheme, the burden of increased costs has fallen hardest on the low income group.

4. Managed Care

In 1995, several for-profit managed care organisations (MCOs) started operations in Malaysia as third party administrative organisations, modeled on American MCOs. When they were vigorously criticised by the MMA, the response of the Ministry of Health was, "Let market forces decide." Knowing that MCOs represented the discredited business model of health care in the United States for the containment of health care costs, this was an unfortunate response and a lost opportunity for the government to stop the intrusion of profit-driven, third-party management into the Malaysian health care system.

All managed care models restrict access to health care, patient choice and professional autonomy of the provider. For the past five years, MCOs have had free rein to proliferate and infiltrate the Malaysian health system, unfettered and unregulated. It is estimated that at present about fifty MCOs are operating and servicing about 300,000 Malaysians, all employees of corporations interested in containing health care costs.

Unfortunately, at present, there is no enforceable law for the registration and regulation of MCOs. Regulations for MCOs in The Private Health Care Facilities and Services Act 1998 have yet to be gazetted and, until they are in force, MCOs cannot be held liable by patients or health professionals. If they are implemented, these regulations should ensure patient confidentiality, the right of a patient to a medical report and a second opinion, patient access to medical records, full information on treatment and procedures, and a channel for the investigation of complaints. The register of MCOs will be open to public scrutiny and there will be transparency and full disclosure of contractual agreements with hospitals and clinics, and billing procedures before treatment is started. An independent panel of medical practitioners will be set up to monitor and ensure that the medical code of ethics is adhered to and advertising prohibited.

The American experience with managed care abounds with examples of unethical practices,

commercialisation of medicine, reduced quality and equity of health care, and erosion of the physician's professional independence, the code of medical ethics and the sacred covenant of trust between doctor and patient. Although managed care has now become an integral part of health care in the United States, it has failed to contain costs or to provide the Americans with universal, accessible and good quality health care. In the United States, private profits from managed care organisations have soared. In 1994, nine publicly traded Health Maintenance Organisations (HMOs) had accumulated reserves of more than USD 9.5 billion. The main beneficiaries were the chief executive officers of HMOs who had annual incomes of more than USD one million.

5. Private Health Insurance

In most European countries, private health insurance provides voluntary, supplementary cover for the few, who are affluent enough to forgo the benefits of national health insurance or social insurance and opt for private health care benefits, such as shorter waiting times, choice of physician or hospital, and greater comfort. Generally, there is little scope for private health insurance in health systems that are based on taxation or social insurance, where comprehensive and quality care is accessible free at the point of entry.

Consumers realise that private health insurance is for profit and risk-rated, and that there are many exclusion clauses that will defeat the purpose of health insurance. In risk-rated health insurance, premiums vary according to the age and health status of the policy holder. Those over the age of 65 are often excluded or have to pay exorbitant premiums. Risk-rated health insurance is inimical to universal access and equity in health care, and therefore needs to be better regulated, especially when it is being promoted among large segments of the population, such as our recent experience with members of the Employees Provident Fund (EPF) and Confederation of Unions of Employees of the Public and Civil Service (Cuepacs).

As individual policy purchasers of health insurance face different risks, it is in the interests of insurance companies to either exclude high risk clients or charge them higher premiums. Many health conditions, such as AIDS, are also excluded. Very few countries have been able to exclude 'selection bias'. It is easier to eliminate selection bias with social insurance, because contributions are compulsory and fixed as a percentage of the wages of employees, regardless of their age and health status.

Empirical data from both developed and developing countries indicate that private health insurance is not a viable option for health financing. In 1993, the World Health Organization concluded, "There are no private health insurance markets at all. When they do exist, they are guilty of cream-skimming." In other words, the very people most in need – the poor and the unhealthy – are excluded.

Another problem with health insurance is that it reduces or eliminates the marginal cost of health care to the consumer. This often leads to the tendency of the consumer to over-use a service. So, providing health insurance does not only shift the way health care is paid for, but also increases the amount of health care demanded by the consumer. Passing on costs to others, such as insurers, because one does not bear full consequences of one's actions, is called 'moral hazard'. This also happens when providers create demand for health services that neither they nor consumers will pay for. Once widespread insurance coverage is achieved, costs can easily spin out of control, unless provider compensation is tightly regulated or determined in ways that encourage cost containment.

In principle, insurance should cover a person's entire lifetime, with sharing of risks that may arise in the distant future, as well as current ones. In Australia and other countries, not-for-profit, community-rated health insurance ensures that the total cost of health care is averaged out over the entire population and that all enjoy universal coverage from "womb to tomb", making for solidarity and social justice.

There is no perfect insurance system. But there are two important generalisations:

1. Third party insurance leads to escalation of health care costs.
2. Social insurance and community-rated and regulated private insurance avoid selection bias far better than voluntary private insurance.

5.1 Private Health Insurance in Malaysia

Uneven health care in public hospitals has persuaded the growing number of affluent Malaysians to seek the services of private hospitals. Caught in the tide of rising health care costs, many have been driven to purchase private health insurance. Until recently, private health insurance played a very small role in Malaysia. In 1983, it was estimated that only about 1.5 per cent of the population were covered by private health insurance. In 1995, the estimated insured population had risen to 15 per cent. Recognising this trend, insurance companies are actively promoting private health insurance. As health insurance is not regulated under the Insurance Act, the stage is set for unethical and irregular practices.

In November 1999, the National Insurance Association of Malaysia (NIAM) launched its Sihat Malaysia Plan, with the participation of 28 local insurance companies. The Plan, which covers a wide range of medical, surgical and hospitalisation benefits, is reported to have attracted 50,000 policy holders within five months. Two months later, Cuepacs launched CuepacsCARE, a voluntary, community-rated private health insurance scheme with two insurance companies. It gives government employees the option of seeking health care at private hospitals up to a maximum of RM60,000 per annum, with individual annual premiums of RM 87 and family premiums of RM 225. As civil servants and their immediate families are entitled to treatment free or for a minimal charge, this is a damning vote of no confidence in the public health sector that will further lower morale and invite an exodus of government doctors from government hospitals.

Almost simultaneously, EPF, with five million working and contributing members and three million retired and non-working members, also launched a private health insurance scheme with the Life Insurance Association of Malaysia (LIAM). This scheme allows EPF members to withdraw funds from Account III (health) to meet annual private health insurance premiums. Members can opt for a low-premium scheme covering 13 critical illnesses or for one covering 36 critical illnesses for a higher premium. The annual premium will range from as low as RM 30 to a high of RM 20,000, depending on the age of the policy holder and the category of benefits. Accrued profits would be shared by EPF (70%) and LIAM (30%). The scheme has yet to be approved by the Treasury.

In the absence of any concrete proposals by the government to launch a national health financing scheme, the recent moves by EPF and Cuepacs, which the Ministry of Health has publicly encouraged, may be perceived as the turning of a blind eye on the deplorable state of health care financing in the country. By allowing a vacuum to persist in health care financing, there is a real threat that private insurance will make greater inroads and start the slide towards a market-dominated health care system, similar to the one in the United States, the only

developed country in the world that does not provide universal coverage for its citizens. Only the establishment of a national health financing scheme will stop the continuing slide towards an inequitable two-tier system – public hospitals for the poor, the aged and the chronically ill, and private hospitals for the rich and healthy.

Although the Ministry of Health is always declaring that it is 'pro-poor', there is little evidence of this. Much of the inertia and lack of a political will on the part of the government perhaps stems from the absence of effective public pressure, which in turn comes from the lack of public understanding and awareness of health issues. Education of civil society is a matter of urgency for the medical profession and other NGOs.

6. Conclusion

Health for All must not remain a mere slogan. Health is everyone's responsibility, but the state has an overriding responsibility to safeguard the health of the nation and to ensure universal, equitable access to health care, by eliminating inequalities in health care. The health care system in Malaysia, which is a mix of public and private health services, is conceptually sound. Many of its weaknesses and efficiencies are rooted in the inadequate provision of funds. The present model should therefore be retained, reformed and restructured by establishing a National Health Financing Authority, functionally integrating public and private health sectors at all levels to reduce wastage, duplication, and inappropriate distribution and utilisation of resources. Above all, it must be strengthened by a massive infusion of resources. Health expenditure amounting to 3 per cent of the GDP is woefully low and less than the 4–8 per cent recommended by WHO.

Radical measures must be taken to improve the low morale of doctors in the public sector and stem the exodus of government doctors to the private sector. As primary care is the essential core of a rational and effective health care system, there is a need to reform primary care and develop a community-based system through changes in the professional education and training of primary care physicians.

Health financing should be a joint responsibility of the state, employers and employees. A single-payer National Health Financing Authority should be funded by a combination of allocations from general taxation and compulsory contributions from employers, the self-employed and employees, based on payroll and income. Where the individual is unable to bear the cost, the State has the responsibility to provide subsidised care.

The Financing Authority could be incorporated into a restructured Social Security Organisation (SOCSO) or some such body, secured by statutory legislation and publicly administered. If it is to be the core of a successful health care system, the Financing Authority must be government-run and never be privatised.

There is overwhelming evidence that market-oriented health care financing and cost-containment through market mechanisms undermine the accessibility, affordability and quality of health care. Private health insurance is the most regressive method of health financing. We are still at a stage where the right leadership can steer the country towards an equitable health system that will make quality health care accessible to every Malaysian, a system of health for all.