2022

PEOPLE'S HEALTH FORUM

Blueprint on

HEALTH REFORM IN MALAYSIA

Health For People, Not For Profits

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HEALTH REFORM IN MALAYSIA

2022

PEOPLE'S
HEALTH
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The People's Health Forum (PHF) is a platform created in April 2019 by several not-for-profit organizations and individuals who are committed to the principle of healthcare as a human right, i.e., universal healthcare as an entitlement based not on the ability to pay, but on the basis of need.

Reforms in the organization and financing of healthcare (to cope with key health challenges in Malaysia), affordable access to medicines, and health equity along multiple dimensions are among the issues that have brought members of the PHF together.

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EXECUTIVE SUMMARY

1. Malaysia has developed an impressive healthcare system. The public sector provides a major portion of healthcare through its network of hospitals and clinics and handles about 75% of all admissions to hospitals. The private sector has developed over the past 40 years from providing almost entirely outpatient care to the current situation where private hospitals cater to about 25% of total admissions.

2. Coverage is good, with 92.6% of the population living less than 5 kilometres from the nearest health facility. Childhood vaccination rates are impressive, consistently hitting 97% of the target population or even higher.

3. However, the Malaysian public healthcare system faces several serious problems, including:

    3.1. Congestion of its clinics and larger hospitals
    3.2. Long waiting times for certain investigations (such as CT scan, MRI)
    3.3. Ongoing attrition of specialists who leave the public service to go into the private sector. This results in longer waiting times for patients who need a specialist opinion.
    3.4. Rising costs of co-payments for equipment and appliances such as cataract lenses, orthopaedic plates and screws, surgical staples, stents for angioplasty, etc. This sometimes leads to postponement of surgery and other therapeutic procedures.
    3.5. Poor healthcare access for foreigners especially migrant workers and refugees who are charged much higher rates for investigation and treatment compared with the Malaysian population. The requirement that medical personnel should inform the immigration department should they suspect that the migrant worker has overstayed also keeps patients away from seeking healthcare services, and this can have dire consequences for the Malaysian public when an infectious epidemic breaks out in the country.
    3.6. Inability to provide adequate supervision and training for the large numbers of housemen joining the service. This number has swelled from about 1,200 per year to more than 5,000.
    3.7. Insufficient medical officer posts in the service to absorb the large volume of doctors who have completed housemanship. They are now given only four-year contracts, which is too short a time for them to specialize in any field.

4. The People's Health Forum (PHF) proposes the following approaches to improve the healthcare system and service delivery, which would require a significant increase in the health budget:

    4.1. More physical facilities – clinics and hospitals – have to be built and equipped with the necessary laboratory and radiological equipment.
    4.2. A moratorium on the building of new private hospitals as the expansion of the private sector is the main driver of the brain drain from the public sector.

4.3. A separate Public Service Commission should be set up for the staff of the Ministry of Health (MOH). This would enable the adoption of a pay scale that mirrors that of the Institut Jantung Negara as well as programmes such as three-month sabbaticals for medical specialists every five years of service.

4.4. More permanent posts for medical officers should be created. The young doctors who do not succeed in getting these permanent posts should nevertheless be offered contract positions for a duration of at least 10 years if they wish to specialize in any field.

4.5. Posts should be increased for "community nurses" whose role would be to visit stroke patients, children with special needs, patients with chronic wounds etc in their homes and provide basic nursing care, physiotherapy as well as health and nutritional education.

4.6. The 8,000 general practitioners in the country should be invited to participate in the management of patients with non-communicable diseases (NCDs) such as diabetes mellitus, hypertension, gout, ischaemic heart disease and bronchial asthma. The GPs who are willing to partake in this scheme should be reimbursed on a capitation basis and they would see their allocated patients free of charge. Investigations would be free of charge for these patients and medications would be supplied by the government. Having a dedicated personal doctor would help improve the quality of care for patients with NCDs and reduce the incidence of complications arising from the NCDs.

4.7. Migrant workers and refugees should be charged the same rates as Malaysian citizens at the point of treatment. A portion of the close to RM2 billion collected yearly from foreign workers as levy payments should be channelled to the MOH for the provision of health services to this population.

4.8. The quotas for medical colleges in the country should be set based primarily on the capacity of the MOH to provide adequate training opportunities to medical graduates. If there is a need to reduce the quotas, the percentage reduction in quotas for the existing public universities should be half that for the private medical colleges.

5. Adequate funding for the Ministry of Health is the key to many of the above reforms. Regarding funds for healthcare, the PHF makes the following points:

5.1. The MOH budget should be raised to 4% of gross domestic product (GDP) over the next five years. It is currently at about 2.5% of GDP. A phased increase is suggested as this will give time for the MOH to utilize the increased budget optimally.

5.2. The government shouldn't implement mandatory insurance or a health tax on ordinary Malaysians because

5.2.1. Wages are already low and many in the B40 group are struggling to make ends meet. About 20% of our children are stunted, reflecting the inadequacy of disposable incomes.

5.2.2. There is wage suppression in Malaysia, with Malaysian workers only getting about one-sixth of the wages in Germany or in the US. As Malaysian workers are being under-paid, it is only fair that they be offered subsidized basic services.

5.2.3. Mandatory health insurance will necessitate the corporatization of government hospitals and the implementation of a fee-for-service mechanism for the claiming of funds from a National Health Fund. Both of these would be drastic departures from

current practice and it is very likely that they will spawn a whole new set of problems. If the current system is not broken, do not rush to dismantle it!

5.2.4. The fee-for-service mechanism for claiming funds may lead to over-diagnosis of more severe conditions and the provision of more surgical interventions (e.g., appendectomies and caesarian sections) as these belong to "diagnosis-related groups" (DRGs) that entitle the hospital for higher remuneration. It will also lead to a huge increase in bureaucracy, with staff in hospitals submitting claims for each patient, and staff at the National Health Fund assessing and evaluating these requests for remuneration.

5.3. The creation of a National Health Fund to handle the more than RM60 billion annual health budget would be worrisome given the deficiencies in financial governance in the country. The scope for mismanagement is large.

5.4. Malaysia should increase tax revenue in a progressive fashion (with the richer individuals and larger corporations paying more taxes) and use this to provide subsidized basic services including healthcare.

6. Additional points

6.1. Sharing of information on health issues is important as it empowers the people, communities, and researchers to find out about the particular needs in the system and allows the public to monitor and help provide solutions to problems faced.

6.2. The intellectual property rights regime should be tightened by increasing the stringency of patent approval, rejecting second-use or non-inventive chemical modification claims (to prevent evergreening of patents), and allowing pre- and post-grant patent opposition to strike out unsubstantiated claims.

6.3. There needs to be price regulation of medicines to control excessive mark-ups by private healthcare providers.

6.4. Malaysia should work towards self-sufficiency in medicine supply and reduce our reliance on imports. Increased local production can create multiplier effects in the local economy, as well as attract and retain talents/professionals in the industry.

6.5. The government needs to be mindful that the health sector is one where the private lobby is strongly present in many parts of the world. Hence the government has to stand firm in protecting the public interest, including scrutinizing whether professional bodies, industry actors and the Bretton Woods institutions (viz., the International Monetary Fund and the World Bank) could have a vested interest in the proposals they put forward to the government.

6.6. The government should always listen to the voices of the most affected end-users – patients and consumers, as well as social workers and activists who work and care for the health of local communities.

6.7. The current Health Minister's proposals to prepare a White Paper on healthcare and to set up a permanent Health Commission to oversee the development of the healthcare sector are steps in the right direction.

7. A well-funded public healthcare system does not only provide better healthcare for Malaysians. It also brings many other benefits to the nation such as an increase in productivity, enhanced social solidarity and a sense of belonging, and a reduction in delinquent behaviour, anti-social tendencies and “street anger”. We all need to rally to protect and enhance our public healthcare system as it is an important modality of “sharing the prosperity of the nation” with all its residents.

0.0. INTRODUCTION

FROM 2019 to 2020, the People's Health Forum (PHF) conducted a series of six roundtable discussions with various stakeholders including medical and allied health professionals, academics, civil society organizations, representatives from the Ministry of Health (MOH), patient groups, and trade unions to discuss challenges confronting the healthcare system in Malaysia and the way forward. The last session was held in March 2020. Based on these discussions and further research, the PHF has identified the main issues confronting the Malaysian healthcare system and the reforms that are needed. These are summarized in this document, the Blueprint on Health Reform in Malaysia.

The PHF believes that the people's interest is best served by a public healthcare system that provides e*quitable access* to *high-quality* healthcare for all. The ability (or non-ability) to pay, geographical location (whether rural or urban), and citizenship status should not be barriers to accessing quality healthcare. To achieve this, the system of healthcare financing should be based on *social solidarity*, *cross-subsidization,* and s*ustainability* over the long term.

In the first two sections that follow, we provide a general overview of how health and healthcare have developed in the last few decades and note the strengths of the public healthcare system in the country. This is followed by the third section, where each of the numerous problems and challenges that confront the healthcare system is discussed. Finally, having set out the context, we present our proposals for healthcare reform, as well as the rationale for each measure that we propose.

1.0. OVERVIEW: HEALTH AND HEALTHCARE IN MALAYSIA

IN the 60-odd years since its formation, Malaysia has moved rapidly towards urbanization and industrialization, with its population structure fast changing from being young and rural to being predominantly urban and ageing. Where before, infant and maternal mortality and infectious diseases (malaria, tuberculosis, parasitical infestations) were the primary concern of health authorities, the current predominant health problems are non-communicable diseases (NCDs) such as diabetes, hypertension, hypercholesterolemia, mental health issues and cancers.[1]

Nevertheless, the persistence of communicable diseases such as tuberculosis, dengue, and HIV,[2] as well as the increasing prevalence of nutritional stunting among children at the same time with high prevalence of overweight and obesity among adults and children,[3] indicate a more complex picture of new as well as intractable problems.

The healthcare system in Malaysia is constituted by a mix of private and public provisioning and financing. At the primary care level, the population of 32 million is served by over 3,000 health clinics in the public sector and about 8,000 medical (largely general practitioner, or GP) clinics in the private sector.[4] Hospital care is dominated by the public sector, as indicated by hospital beds (79% public, 21% private) as well as hospital admissions (75% public, 25% private).[5] In 2019, just before the COVID-19 pandemic, total health expenditure was 4.26% of gross domestic product (GDP), with 2.23% public (primarily central treasury funds) and 2.03% private (out-of-pocket, health insurance, employers).[6]

The privatization policy led to the privatization of the PJ Medical Store (the entity that handled the purchase, supply and manufacture of medical supplies on behalf of the Ministry of Health) in the 1980s, outsourcing of clinical waste disposal services in public facilities in the 1990s, and rapid growth of the private hospital sector over the past 40 years. The public health sector faces numerous challenges, chief among which are the insufficient allocation of funds and the leaching of health expertise from the public sector into the more lucrative private sector.

This polarizing trend has resulted in a de facto two-tier system of healthcare in Malaysia. While the majority who cannot afford the charges in the private sector continue to rely on the public hospitals, where inadequate resources and overcrowding lead to delays in investigation, diagnosis, and treatment, those who can afford it utilize the private sector, where specialist treatment may be directly and promptly accessed without going through a referral system.

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1 MOH. 2020. National Health and Morbidity Survey 2019.

2 *Malaysia Health Systems Research, Vol 1: Contextual Analysis of the Malaysian Health System, March 2016*.

3 Wan Manan Wan Muda, Jomo Kwame Sundaram and Tan Zhai Gen. 2019. Addressing Malnutrition in Malaysia. Kuala Lumpur: Khazanah Research Institute.

4 In 2019, there were approximately 3,171 government-run health clinics, of which 1,114 were health clinics (including maternal and child health clinics) with doctors posted, while 2,057 were community clinics (i.e., rural clinics and community clinics formerly known as 1Malaysia clinics) manned by paramedics. Besides this, there were 7,988 registered private medical clinics in small and big towns providing primary care. From MOH, *Health Facts 2020*, October.

5 MOH, *Health Facts 2020*, October.

6 MOH. 2021. *Malaysia National Health Accounts: Health Expenditure Report 1997-2019.*

2.0. STRENGTHS OF THE MALAYSIAN PUBLIC HEALTHCARE SYSTEM

AT Independence, the country had the rudiments of a healthcare system in place, but it was only during the 1960s and 1970s that its public healthcare infrastructure expanded throughout the country and into the rural areas. Today, over 90% of its population live within 5 kilometres of a public health centre.[7] While urban populations have the choice of using private GP clinics and private hospitals, rural populations rely heavily on public facilities. The entire public healthcare service imposes only nominal user charges, and is therefore generally available and affordable to the poor.

The Ministry of Health offers a comprehensive range of services, including health promotion, disease prevention, and curative and rehabilitative care delivered through clinics and hospitals, while special institutions provide long-term care. An indicator of achievement in preventive health is the nearly universal coverage of childhood immunization. BCG, DPT-HIB and polio immunization were administered to between 98.4-98.5% of infants born in 2018. In the same year, MMR was administered to 97.67% of children aged from 1 to <2 years, while 97.3% of infants received Hep B immunization up to the third completed dose and 99.45% of girls aged 13 received complete double doses of HPV immunity.[8]

The MOH maintains 146 hospitals (including 11 special medical institutions) that provide inpatient treatment. The smaller district hospitals only have visiting specialists and do not have high-tech facilities for investigation or treatment – for example, there are no CT scanners, and most do not have the capacity to conduct operations under general anaesthesia. The larger district hospitals have resident specialists and a limited number of specialties, while the state- and national-level hospitals are well-equipped with diagnostic modalities and specialist departments.

Importantly, the utilization of the different levels of healthcare is rationalized through a referral system, where access to specialist care is based on medical need. In contrast, the lack of a referral system in the private sector essentially means that access to private specialist care is rationed by the ability to pay.

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7 In 2019, 92.6% of the population lived within 5 km of a public health centre (EPU Malaysia. 2021.*Twelfth Malaysia Plan, 2021-2025*).

8 Ibid.

3.0. PROBLEMS AND CHALLENGES FOR HEALTHCARE ACCESS AND EQUITY

AS shown in the previous section, the Malaysian public healthcare system has achieved much in its mandate to provide accessible and equitable healthcare to the Malaysian population. Nevertheless, it also has shortcomings and faces many problems which present challenges to healthcare access and equity. In this section, we highlight some of the main problems, grouped under three types of issues – facilities, utilization, and financing issues.

Facilities

3.1. Infrastructure development has not kept up with patient load

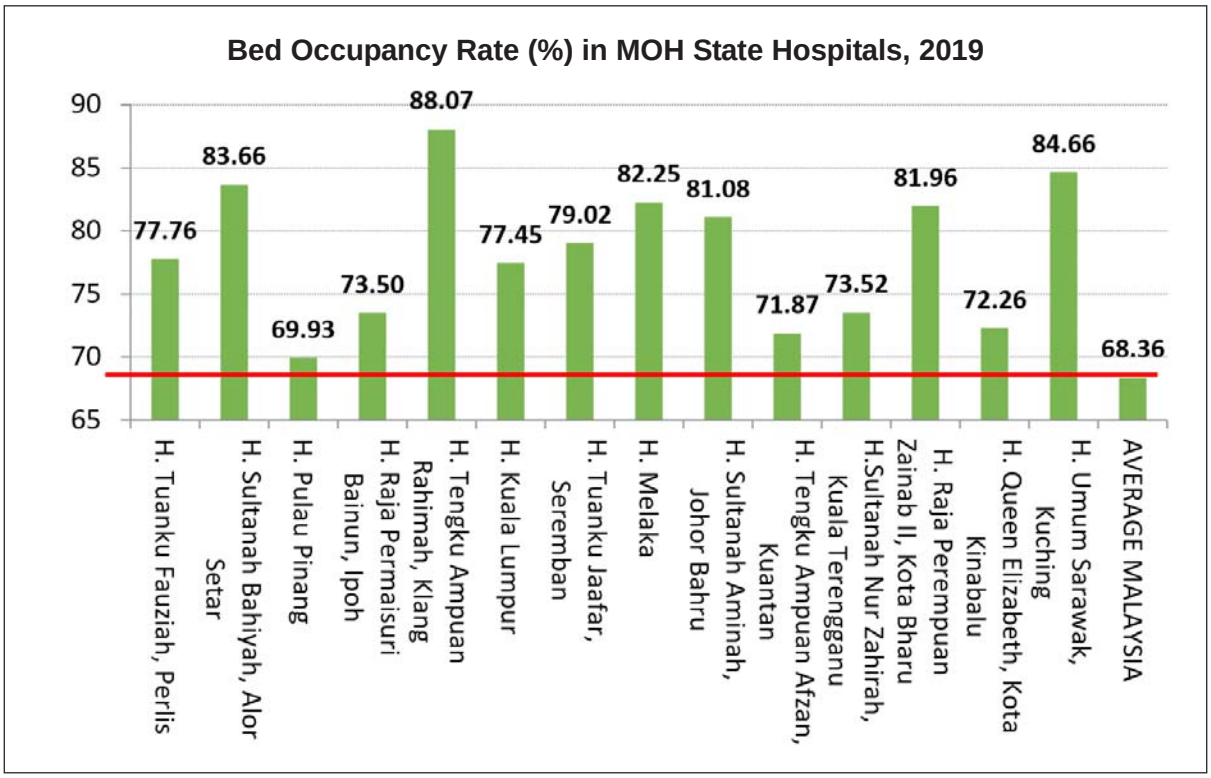
Over the years, infrastructure development within the public sector has struggled to keep up with the increasing patient load. This is reflected in overcrowded public health facilities and the long waiting time for investigative procedures.[9] The waiting time to get certain investigations done, for example, MRIs, CT scans, stress tests, and echo and cardiac angiograms, can take up to months. This sometimes puts patients at risk of suffering a deterioration of their condition before they are fully investigated.

Overcrowding in public clinics and hospitals is a symptom of infrastructure capacity insufficiency. One good indicator for hospitalization is the bed occupancy rate (BOR). In 2019, all state hospitals had a BOR that was above the national average, and a few, such as Hospital Tengku Ampuan Rahimah in Klang, even reached 88% (Figure 1). It was not uncommon to see some patients made to sleep in makeshift beds in the corridor due to congestion in the wards.

The COVID-19 pandemic exposed and tested the limits of the public healthcare sector, where the government had to decant many of the non-COVID patients to the private sector. Overcrowding in the outpatient department in hospitals and health clinics is a common sight, especially in urban areas where people do not even have adequate seats while waiting for long hours just to see a doctor!

[9] *Malay Mail*. 2017. Hours-long hospital waits driving some to abandon treatment. 22 August. Available at https://www.malaymail.com/news/malaysia/2017/08/22/hours-long-hospital-waits-driving-some-to-abandon-treatment/1447711

Figure 1: Bed occupancy rate (%) in MOH state hospitals, 2019



Source: Health Indicators, MOH

3.2. Shortage of specialists in the government sector

The distribution of specialists is uneven – geographically as well as between private and public sectors – partly due to the concentration of hospitals in urban areas. In the highly urbanized areas on the west coast of Peninsular Malaysia, the proportion of specialists between the public and private sectors is 53.5% and 46.5%, respectively, even though the public hospitals account for 75% of total hospital admissions, indicating a higher workload for public sector specialists.[10] In some specialties, such as oncology, private sector specialists outnumber those in the public sector.[11]

This imbalance is further exacerbated by the "specialist brain drain", a continual attrition of specialists from the public to the private sector. Since many specialists usually serve for a period of time in the public sector before leaving to join private hospitals, this attrition leads to a shortage of senior and more experienced specialists in the public sector. Between 2016 and

[10] Human Resources for Health Country Profile 2015-2018.

[11] Out of 128 oncologists in the country, 78 are in the private sector, 36 are in Ministry of Health hospitals, and 14 in university hospitals. See: *Free Malaysia Today*. 2020. Khairy acknowledges inequality problem in cancer treatment. 17 February. Available at https://www.freemalaysiatoday.com/category/nation/2022/02/17/khairy-acknowledges-in-equality-problem-in-cancer-treatment/

2019, more than 50% of MOH specialists in the 30-39 age group resigned from government service after serving an average of less than three years post-specialization.[12,13,14]

The shortage of specialists in the public sector overall, and of the more experienced and senior specialists in particular, has negative consequences for health equity as well as the future development of public healthcare. One major concern is related to the loss of quality and experience in training, as senior specialists working in private settings do not transmit their knowledge and experience to junior doctors in the public system.[15] Furthermore, the development of sub-specialty services in the government sector is continually undermined by this leaching of sub-specialty doctors within a few years of sub-specialty training.

3.3. Challenges in primary care delivery

3.3.1. Organization of primary healthcare

One of the main challenges in primary care delivery is the lack of continuity of care, which is particularly important for the effective treatment of patients with NCDs. This is partly an organizational problem, but it is also associated with a larger set of problems, including lack of bi-directional coordination in the referral between primary and secondary/tertiary care, inadequate training of house officers, patients' tendency to bypass primary care levels to access care at hospitals, and patients' eclectic health-seeking behaviour.

On the supply side, in public hospitals, the referral system where patients are first screened in outpatient departments before being referred to specialist clinics is not well coordinated for the purpose of continuity of care.[16] Primary care doctors are seldom informed after a patient has been treated or diagnosed by a specialist, and over half (58%) of primary care doctors rarely or have never received discharge reports from the hospital frequented by their patients.[17] On the demand side, many Malaysians do not have a primary care physician but "shop" around, going to government outpatient departments or health clinics, private GPs, as well as private specialists. For example, 85% of patients in a survey indicated that they did not have a regular doctor whom they would usually consult for health problems.[18]

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12 Human Resources for Health Country Profile 2015-2018.

13 From observation, most specialists tend to peak in their professional skills just before resigning from public service to cross over to the private sector. We estimate that more than 70% of the specialists with over 10 years' experience post-specialization are in the private sector.

14 To determine the extent of the specialist shortage on a national scale, the percentage of specialists below 60 with over five years of post-specialization practice, and who are still in active government service, should be tracked and monitored regularly by the MOH or the Malaysian Medical Council. These health workforce figures should be calculated and updated regularly so that concrete data can be generated to assist with workforce planning.

15 "Improving Terms of Service", People's Health Forum Roundtable 3: Human capital for Health in Malaysia (2019).

16 S. Sivasampu, K. Mohd Noh and C. Chin May. 2016. *MHSR Report on QUALICOPC Survey in Malaysia*. Ministry of Health of Malaysia and Harvard T.H. Chan School of Public Health, Harvard University.

17 Ibid.

18 Ibid.

The NCD problem, however, is not only about effective treatment; more importantly, it requires effective prevention – primary prevention as well as secondary prevention.[19] Broadly speaking, our healthcare system is too treatment-oriented and does not place sufficient emphasis on primary and secondary prevention. This is reflected in the increasing proportions that Malaysia spends on secondary and tertiary healthcare, the decreasing proportion on primary care, and very little on long-term care.[20]

One of the consequences of this skewed spending is the high rate of undiagnosed NCDs, as well as diagnosed NCD cases that are not effectively managed at the community level.[21] As a result, there are large proportions of patients admitted to hospitals for ambulatory care-sensitive chronic conditions, i.e., conditions that could have been treated and arrested at the primary care level but were not, resulting in their need for hospital care.[22]

3.4. Oversupply of medical graduates and lack of housemanship posts

3.4.1. Proliferation of medical schools and overproduction of medical graduates

There has been a proliferation of private medical colleges and universities offering medical courses over the past two decades. Before 2000, there were 11 medical schools, six public and five private. Today, there are 34 medical schools for a population of 31.53 million across the whole of Malaysia.[23] This equates to 1 medical school for every 0.93 million people, a significantly higher per capita ratio compared with the United Kingdom, which has 35 medical schools and a population size of 67.91 million (1:1.94 million), and the USA, with 193 medical schools and a 331.08 million population (1:1.72 million).[24] Between 2000 and 2015, the number of Malaysian medical graduates each year increased 500%,[25] and the figure is now estimated to be between 5,000-6,000 every year, of which about 50-60% are locally trained, while the rest are graduates from overseas.[26]

3.4.2. Inadequate training infrastructure and implications for quality

Medical graduates need to complete two years of housemanship training followed by two years of compulsory service in government health facilities before being given registration certificates. The overproduction of medical graduates has serious consequences when the government does not have sufficient healthcare facilities for housemanship training, a shortfall in medical specialists to conduct the training and not enough posts for the graduates in the public healthcare service.

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19 Secondary prevention is screening to identify diseases in the earliest stages, before the onset of signs and symptoms, through measures such as mammography and regular blood pressure testing.

20 Refer to the analysis on allocative efficiency on pages 87-91 of *Malaysia Health Systems Research, Vol 1: Contextual Analysis of the Malaysian Health System, March 2016.*

21 National Health and Morbidity Survey 2019.

22 According to *Malaysia Health Systems Research, Vol 1: Contextual Analysis of the Malaysian Health System, March 2016*, 15-20% of hospital (both public and private) admissions are for ambulatory care-sensitive conditions.

23 World Directory of Medical Schools search. Available from: https://www.wdoms.org/

24 Ibid.

25 Lim Chee Han. 2017. Housemanship programme in Malaysia: Availability of positions and quality of training. Available from: https://penanginstitute.org/wpcontent/uploads/jml/files/research_papers/HousemanshipIssue_LCH20July2017-Final.pdf

26 https://www.pressreader.com/malaysia/the-star-malaysia/20210728/281655373106956

In 2015, 44 public hospitals were designated for housemanship training, and the government was only able to increase this to 48 in 2019, excluding the Ministry of Education (MOE) teaching hospitals and the three military hospitals which have accepted house officers since 2017.[27] In its Medical Programme Strategic Framework 2021-2025, the Health Ministry has outlined plans to add a minimum of one hospital per year to its list of accredited training hospitals.[28] However, this increase has not been sufficient, and each year, medical graduates have to wait for months to gain entry into the training system.

Furthermore, various medical associations and senior practitioners have voiced concerns over the pressures faced by these public training hospitals and senior staff in having to manage large batches of housemen at any one point in time. The high ratio of house officers (HOs) to patient beds means that many HOs only clerk an average of 2-3 patients daily. This lack of clinical exposure and inadequate supervision because of the lack of specialists can lead to medical errors.

The COVID-19 pandemic has worsened the situation by causing the recruitment of new housemen to be suspended. In 2020, the waiting period for housemanship postings had stretched up to nine months, from the previous six.[29] The overloaded situation in training and prolonged delay for entry into healthcare practice have a negative impact on the quality and standard of medical practice in our country.

Utilization of care

3.5. Overcrowding of government clinics and hospitals

The general hospitals are overcrowded. Wards routinely have more than double the number of patients that they were built for, patients sometimes wait in the emergency department for over a day for a bed in the wards, and sometimes patients have to be discharged before they are fully recovered. The overcrowding not only stresses the medical personnel and adds to the discomfort of patients but also predisposes them to nosocomial (hospital-acquired) infections.

Figures 2 and 3 below indicate that despite the rising demand for outpatient attendance and inpatient admissions over the years, the number of hospitals and beds as well as the healthcare workforce are not keeping up well to meet the demand.

The overcrowding of facilities is a reflection of how the development of health services (including both infrastructure and adequately trained personnel) has not kept up with the increasing demand and patient load. Overcrowding and long waiting lists are related to understaffing and underfunding. The shortage of medical personnel was exacerbated in the last several years due to a policy to freeze hiring in the civil service, which includes medical and allied health personnel in government health facilities.

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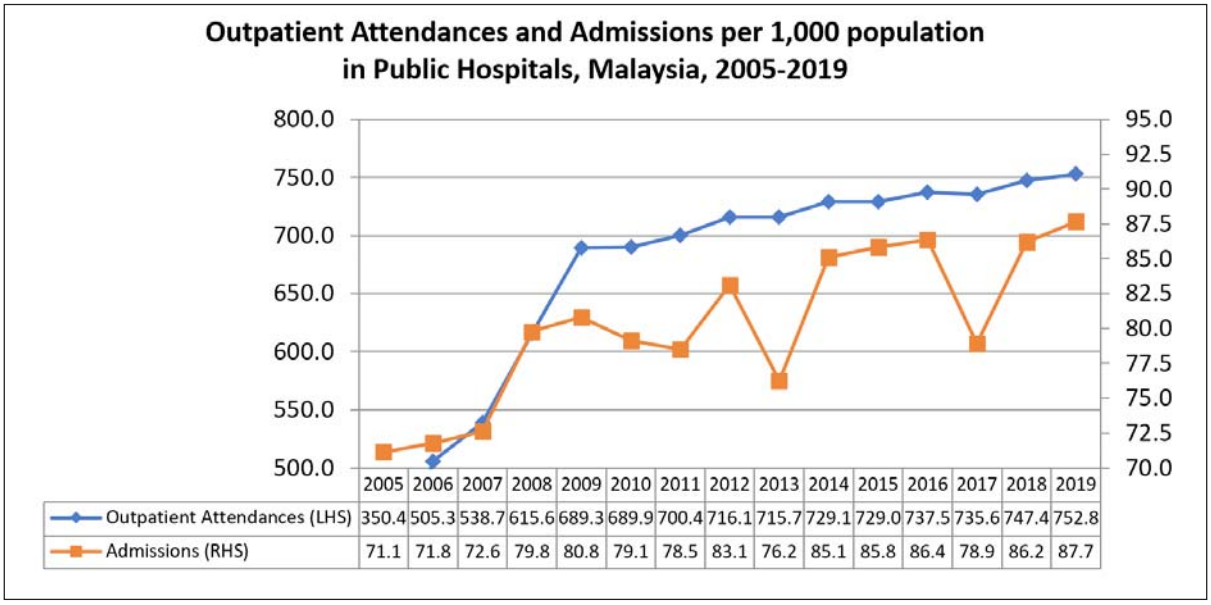
27 https://themalaysianreserve.com/2021/07/28/the-contract-doctor-conundrum-is-there-a-long-term-solution/

28 Strategic Framework of the Medical Programme, Ministry of Health Malaysia (2021-2025), p. 59.

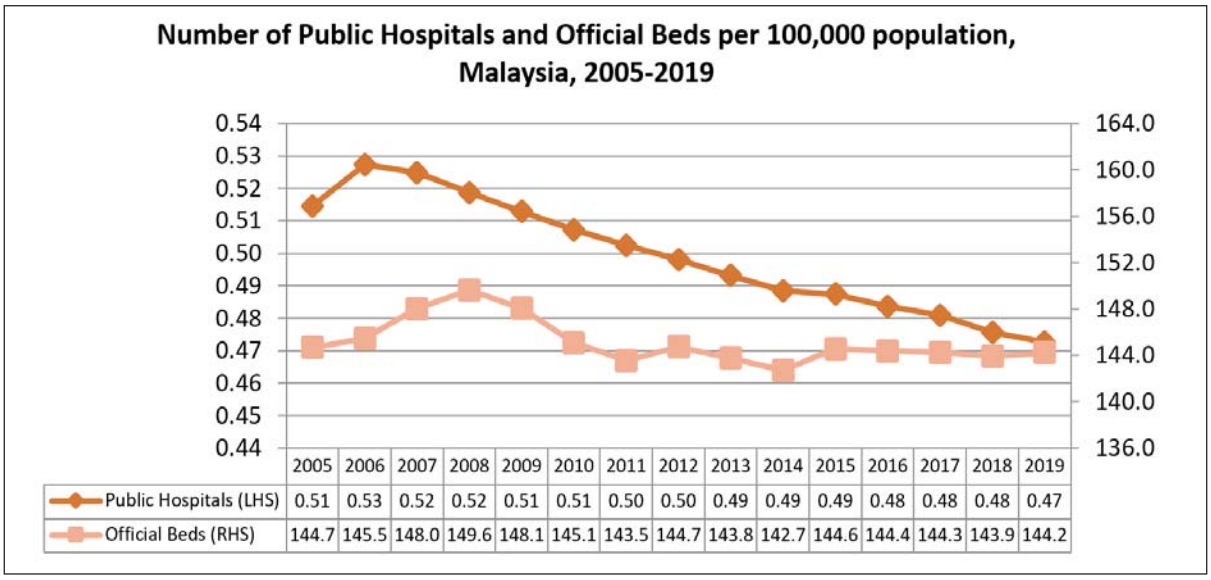
29 https://www.thestar.com.my/news/education/2020/10/04/housemanship-delay-solution-in-sight-experts-say

Figure 2: Outpatient attendances and admissions per 1,000 population



Source: Health Facts, MOH, Population Estimates, Department of Statistics Malaysia and author's calculations

Figure 3: Number of public hospitals and official beds per 100,000 population, Malaysia, 2005-2019



Source: Health Facts, MOH, Population Estimates, Department of Statistics Malaysia and author's calculations

3.6. Rising costs of "co-payments"

Although public health services are provided at nominal or no charge at the point of utilization, users have had to pay for certain treatments. The newer devices and treatment modalities are not provided free of charge by the government hospitals; they must be bought by the patient – for example, cataract lenses, plates and screws for fractures, coronary artery stents, oesophageal stents, surgical staplers for colon anastomoses, etc. Some of these devices are expensive, for example, RM7,000 for a drug-eluting stent. The number of implants and devices that now must be paid for by the patient is large and expanding.

3.7. Catastrophic expenditure

Families of patients with critical illnesses such as heart attack, stroke, and cancer are often under severe financial stress as they struggle to obtain the best treatment for their loved ones. In many cases, a diagnosis of cancer and/or other critical illnesses creates significant financial strain and may even lead to financial ruin for a significant number of families.

The 2015 ASEAN CosTs in Oncology (ACTION) study, which sampled almost 10,000 cancer patients across eight low- and middle-income countries in Southeast Asia, found that close to half of respondents in the region experienced catastrophic health payments (defined as out-of-pocket payments exceeding 30% of annual household income) within a year of diagnosis,[30] resulting in economic hardship and impoverishment.[31]

In fact, these problems are not confined to low-income groups. A more recent study on the financial needs of Malaysian women breast cancer survivors found that even those from high-income groups, and those with health insurance, had faced a variety of challenges, ranging from financial assistance to cover out-of-pocket payments for medical and non-medical costs following a cancer diagnosis, to navigation through the complex system to claim medical insurance or social security benefits and return to work assistance.[32]

3.8. Barriers to the accessibility of healthcare

3.8.1. Underserved populations

There are several sectors of the Malaysian population which still face difficulties in accessing healthcare. The distance from healthcare facilities and the cost of travel is a major factor for some Orang Asli communities and indigenous communities of Sarawak and Sabah. The LGBT community and those dependent on drugs may live near healthcare facilities but social and cultural factors impede their access.

3.8.2. Inadequate care for migrant workers, refugees, and stateless persons

Malaysia is highly dependent on migrant labour. In 2016, it was estimated that there were up to 5 million migrant workers, both documented and undocumented.[33] Besides migrant workers, there is a wider non-citizen population that includes refugees, asylum seekers, victims of trafficking, stateless persons, as well as students, businessmen, expatriate employees, and Malaysia My Second Home (MM2H) visa holders.

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30 M. Kimman, S. Jan, C.H. Yip et al. 2015. Catastrophic health expenditure and 12-month mortality associated with cancer in Southeast Asia: results from a longitudinal study in eight countries. *BMC Med* 13 190.

31 ACTION Study Group. 2017. Policy and priorities for national cancer control planning in low- and middle-income countries: lessons from the Association of Southeast Asian Nations (ASEAN) costs in oncology prospective cohort study. *Eur J Cancer* 74 26-37.

32 Y.C. Kong, L.P. Wong, C.W. Ng et al. 2020. Understanding the financial needs following diagnosis of breast cancer in a setting with universal health coverage. *Oncologist* 25(6) 497-504.

33 Counting Migrant Workers in Malaysia: A Needlessly Persisting Conundrum. ISEAS–Yusof Ishak Institute. 2018. Paper available at: https://www.iseas.edu.sg/images/pdf/ISEAS_Perspective_2018_25@50.pdf

In 2021, the official number of non-citizens in Malaysia was estimated to be 2.65 million.[34] Those who do not have valid residency or employment permits will have compromised access to healthcare unless they are able to pay for private health services.

While fees at public healthcare facilities are highly subsidized for citizens, non-citizens are charged at unsubsidized foreigner rates, which are very much higher. Documented workers have limited medical coverage through governmental social protection schemes such as SOCSO and SPIKPA (the government's mandatory healthcare insurance for documented migrant workers).

Under the SPIKPA scheme, migrant workers pay a yearly premium of RM120 for an insurance policy that entitles them to claim up to RM20,000[35] annually (as of the end of 2016) in health protection benefits from Malaysian government hospitals. Medical charges in excess of this annual limit would have to be paid out-of-pocket by either the worker or his/her employer.[36]

Undocumented migrant workers, however, do not have any health coverage, and they face barriers to accessing healthcare even if they are able to pay the charges. Government policy reinforced by a 2001 Health Ministry circular[37] requires all health workers to report undocumented migrants to the police, thereby creating a climate of fear for them to attend public health facilities as they could be arrested and detained. This creates problems for the effective control of communicable diseases, such as tuberculosis, hepatitis B and, lately, COVID-19. Furthermore, many employers fail to ensure proper medical screening and timely medical check-ups, health education, and preventive health interventions, including vaccinations, for their workers.

Majlis Keselamatan Negara (MKN, National Security Council), which is in overall charge of the government's actions in the COVID-19 pandemic, has been coercive towards migrants, rounding up undocumented migrants for detention. Such measures render preventive healthcare interventions ineffective. Individuals who may be infected, instead of coming out for testing and treatment, will avoid the health authorities and will not be quarantined nor self-isolated.

Financing issues

From 2010 to 2019, the Federal Government increased its annual budget allocation for public healthcare from RM14.8 billion to RM28.7 billion. As a percentage of the total Federal budget, the allocation to the Health Ministry increased from 7.7% (2010) to 9.1% (2019) (although it was higher at 9.5% in 2018). During the COVID-19 pandemic years of 2020-2022, the relative proportion of the health budget increased to 10.2%-10.4%.

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34 Demographic Statistics Third Quarter 2021, Malaysia (PMD, DOSM).

35 As at end 2016, the original stipulated coverage limit of RM10,000 was doubled to RM20,000.

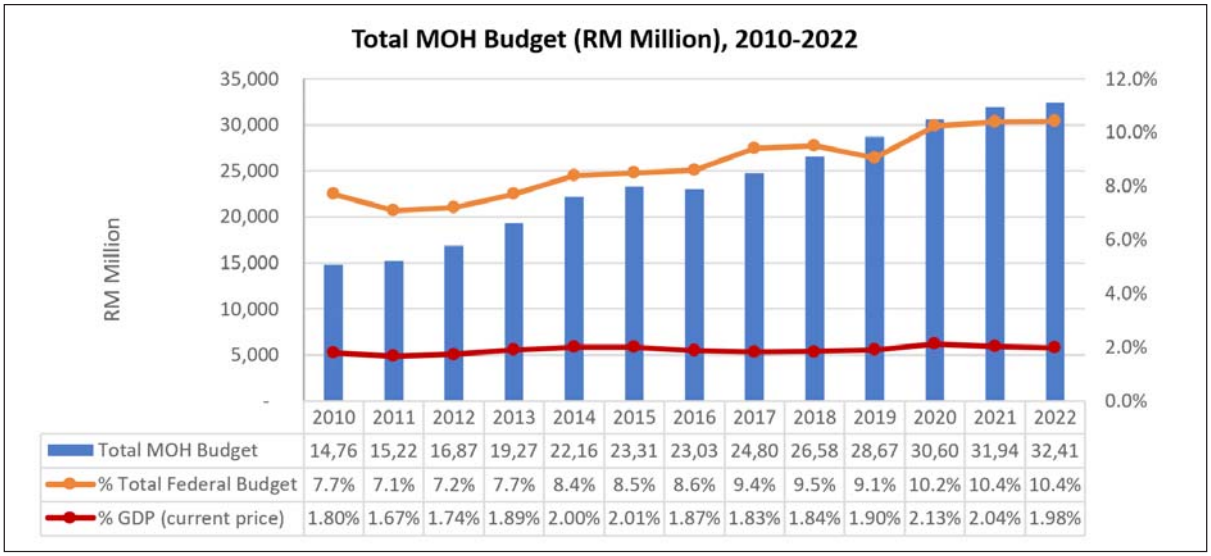
36 There is no legal provision for SPIKPA. SPIKPA provision is set out in policy documents, i.e., Surat Pekeliling Bahagian Kewangan Bil. 1/2011: Prosedur Kerja Bagi Kemasukan Wad dan Tuntutan Caj Hospital Pekerja Asing Yang Dilindungi di Bawah Skim Perlindungan Insurans Kesihatan Pekerja Asing (SPIKPA) di Hospital Kementerian Kesihatan Malaysia.

37 Pekeliling Ketua Pengarah Kesihatan Bil. 10/2001: Garispanduan Melaporkan Pendatang Tanpa Izin Yang Mendapatkan Perkhidmatan Kesihatan di Hospital dan Klinik Kesihatan.

3.9. Governmental allocations to health

Government health spending as a share of total government spending reflects the priority a government accords to health. Though there is wide variation in spending among upper-middle-income countries[38] (between 3% and 28% of government expenditure), Malaysia spends relatively less on healthcare compared with most countries in this group (Figures 4 and 5). For example, in 2018, Malaysia spent 8.5% of its total government expenditure on healthcare, whereas the comparable figures for Thailand and South Africa were 15.0% and 13.3%, respectively.

Figure 4: Total MOH budget (RM million), 2010-2022



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Total MOH Budget	14,76	15,22	16,87	19,27	22,16	23,31	23,03	24,80	26,58	28,67	30,60	31,94	32,41
% Total Federal Budget	7.7%	7.1%	7.2%	7.7%	8.4%	8.5%	8.6%	9.4%	9.5%	9.1%	10.2%	10.4%	10.4%
% GDP (current price)	1.80%	1.67%	1.74%	1.89%	2.00%	2.01%	1.87%	1.83%	1.84%	1.90%	2.13%	2.04%	1.98%

Source: Federal Budget Estimates (B/P. 42), author's own calculations

3.9.1. Public spending on health is inadequate

Over 1997-2020, Malaysia's total expenditure on health (TEH)[39] as a share of GDP increased from 3.04% to 4.73%. Both public and private sector spending showed increasing trends, with the share of public spending (52.5%) being slightly higher than private spending (47.5%).[40] Public expenditure on health as a share of GDP was on an upward trend from 1997 (1.55%) to 2001 (2.08%), but from 2006 onwards, it hovered at about 2.2% until 2019. In 2020, when the COVID-19 pandemic caused overall GDP to shrink and necessitated higher expenditures for health, the share increased to 2.58% (Figure 6).

This relatively flat trend suggests that the government has not really been committed to progressively spending on healthcare. Furthermore, the share is much lower than the World Health Organization (WHO)-recommended level of at least 5% of GDP.

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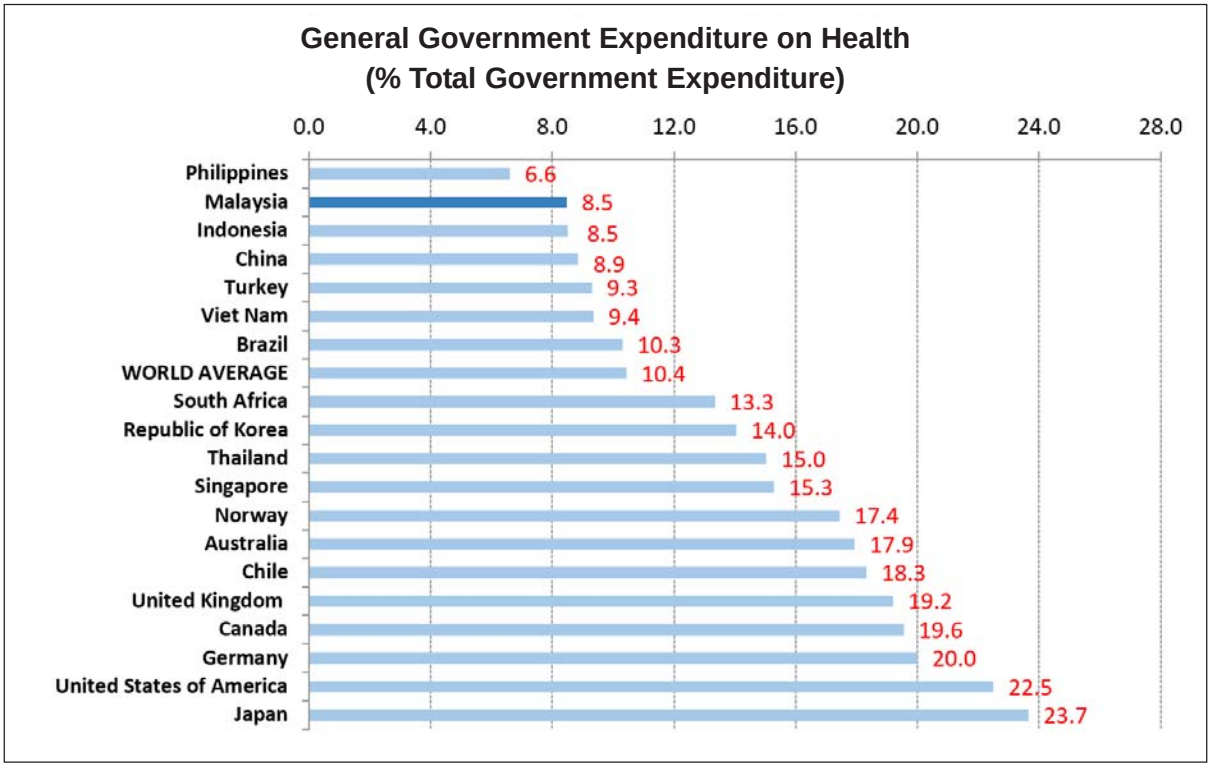
[38] On the whole, there is an observable wide variation among upper-middle-income countries (and indeed all income groups) with regard to health spending as a share of GDP. Generally, there is no clear correlation between income and share of health spending within any income group. Rather, the policy choices that each country makes in the organization of its health financing system, as well as differences in epidemiological patterns, have greater implications for health spending levels overall.

[39] TEH refers to the sum of aggregate public and private health expenditure in a given year. The figures for TEH mentioned in this report are based on data contained in the *Malaysia National Health Accounts* (MNHA) report.

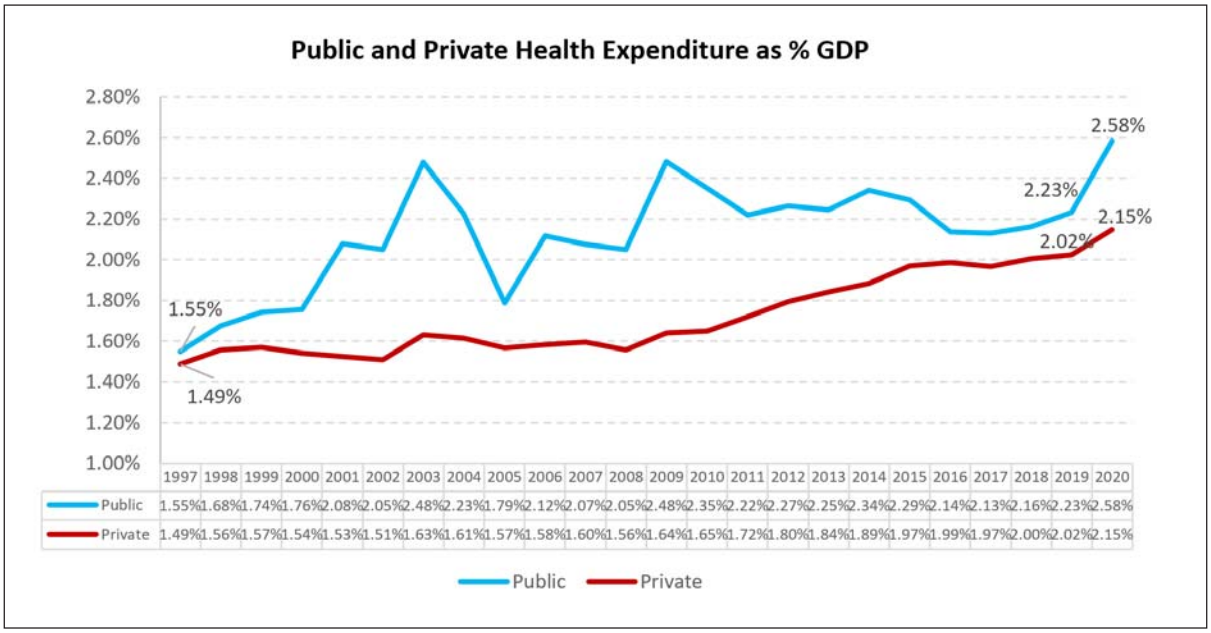
[40] MOH. 2021. *Malaysia National Health Accounts: Health Expenditure Report 1997-2019*, pp. 26-27.

Figure 5: International comparison of healthcare spending



Source: Global Health Expenditure Database 2018, WHO

Figure 6: Public and private health expenditure as percentage of GDP



Source: Malaysia National Health Accounts (MNHA) Health Expenditure report

3.10. Equitable financing

In 2020, out-of-pocket (OOP) expenditure on healthcare was 35% of total expenditure on health and 76% of private sources of financing.[41] Although smaller than the share of OOP expenditure, nevertheless the private insurance share of total health expenditure has increased rapidly in the last 30 years, constituting 16% in 2020.

Having to come up with OOP payments at the point of healthcare utilization is often a barrier or a disincentive to seek healthcare. When the OOP share is high, it reflects a high level of inequity because it means that the risks are not shared across society.

Private health insurance is also not highly equitable as health risks are pooled only across those who buy the insurance, excluding others from it. At the community level, 22% were found to be covered by private health insurance, while 43% said that they cannot afford private insurance.[42]

Malaysia's current system of financing public healthcare through the central treasury provides health services on an equitable basis insofar as the taxation system is progressive and the health services are accessible and affordable (free of charge or with nominal charges) at the point of utilization.

Implications of COVID-19

The COVID-19 pandemic has had a tremendous impact in almost all countries, disproportionately affecting the poor and vulnerable populations almost everywhere. Malaysia is not an exception. The numerous lockdowns and other measures put in place to control the pandemic have resulted in increased unemployment, decreased income, and rising poverty levels. Those without economic reserves had to depend on governmental relief measures, which, though helpful, were insufficient and have since come to an end.

The public healthcare service was on the frontline of the COVID-19 pandemic. Underfunded, understaffed, and overstretched, its staff and contract workers – doctors, nurses, allied health workers, cleaners, etc. – nevertheless rose to meet the challenges of a new and highly contagious disease from the time when its parameters were largely unknown and before there were vaccines and treatments.[43]

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41 MOH. 2021. *Malaysia National Health Accounts: Health Expenditure Report 2006-2020*.

42 National Health and Morbidity Survey 2019.

43 Even before the pandemic, Datuk Dr Noor Hisham Abdullah, the Director-General of Health, had posted on social media on 17 July 2019 that "We are currently underfunded, understaffed, underpaid, overworked, overstretched and with facilities overcrowded with patients." Available at: https://www.facebook.com/publichealthmalaysia/photos/we-are-currently-underfunded-understaffed-underpaid-overworked-overstretched-and/2386585661631292/ (accessed 1 April 2022).

During the pandemic, as the bulk of resources were shifted to treat COVID-19 cases, other types of health problems suffered from neglect and inattention. Among the public, many avoided attending public healthcare facilities and postponed elective procedures for fear of contracting COVID-19.

The increase in the workload of the public health sector due to the COVID-19 pandemic will not end in the foreseeable future, and demand on the public healthcare sector will increase rather than decrease. When faced with economic pressures, many Malaysians who have been utilizing private hospitals will revert to public healthcare. This shift was seen, for example, during the 1997 Asian financial crisis, when some private companies cut back on staff health benefits and overall purchasing power was lowered, causing many households to lapse in their private medical insurance premium payments. A 1998 United Nations Population Fund (UNFPA) study[44] reported a 10-30% decrease in utilization rates among private hospitals during this time, contrasting with a 10-18% increase in public hospitals. These statistics underscore how the public healthcare system functioned as a social safety net during that economic crisis.

3.11. Impact on the treatment of NCDs[45]

The management of NCDs has deteriorated throughout the course of the pandemic. In March 2020, when the first wave of the pandemic struck, human personnel and financial resources were diverted away from NCD patients to concentrate on managing COVID in acute settings. As a consequence, between March and June, diabetes, hypertension and cancer patients faced up to two-month appointment delays.

In the second wave of the pandemic, the government had to divert even more health resources for COVID-19 cases to the detriment of other cases, including NCDs. For example, with the creation of special COVID hospitals, all non-urgent NCD surgeries and treatments were postponed. Appointments for stable patients were moved from six months to a year. The stop-gap measure was to shift appointments online, but this was not ideal for patients who are not tech-savvy.

The public healthcare sector will have to prepare for the potential impact in the care continuum for NCDs, owing to cutbacks in spending for NCD prevention and control. All aspects, from screening and diagnosis to treatment and long-term care, will be affected. Early diagnosis and screening programmes are usually the first to be deprioritized when financial resources are scarce. These pandemic-induced delays and disruption of timely access to NCD care could lead to patients presenting with worsened conditions and at more advanced stages when treatment options are costlier.

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44 UNFPA (in collaboration with the Australian National University). 1998. *Southeast Asian Populations in Crisis: Challenges to the Implementation of the ICPD Programme of Action*. New York: UNFPA.

45 The points raised in this section are taken from a panel discussion on public health hosted during the PHF's Roundtable 6: COVID-19 pandemic impact on vulnerable and marginalized communities.

3.12. The burden of "long COVID"

Studies carried out on post-COVID populations have shown that many survivors tend to experience long-lasting medical residual effects, including fatigue, dyspnea, chest pain, persistent loss of taste and/or smell, cognitive changes, and decreased quality of life. Researchers have classified these symptoms as post-acute sequelae SARS-CoV-2 infection, or "long COVID", and have stressed that it must be factored into existing healthcare systems "especially in low- and middle-income countries."[46] For example, the National COVID-19 Infection Survey in the UK estimated that approximately 1 in 10 COVID patients will have health issues that persist for 12 weeks or longer after the COVID episode. This will mean that out of every 1 million patients, 100,000 patients may require long-term follow-up care and rehabilitation.

In Malaysia, a study conducted by the University of Malaya Department of Social & Preventive Medicine showed that approximately one-fifth (20.7%) of all 480 sampled COVID survivors had self-reported lingering symptoms beyond the twelfth week of being diagnosed with original infection, and this percentage decreased to 11.2% after six months. Those who had suffered severe COVID infections had a slightly higher long-COVID incidence rate after 12 weeks (26.4%) and six months (17.2%),[47] suggesting that survivors of severe COVID infections are more likely to experience long-term debility, versus those with mild and moderate cases. As of 1 April 2022, close to 4 million people have recovered from COVID-19.[48] If we estimate that 10% of them would have experienced long COVID, this would be about 400,000 people; but without more studies and monitoring, we do not know how many of them still suffer from long COVID symptoms.

3.13. Strategies and costs associated with shifting of COVID-19 to an endemic phase

COVID-19 will probably become endemic and there will continue to be cases, some of which will require intensive care. It is also possible that new variants might emerge. There is a need for vigilance and the capacity to screen for such variants – genotyping of a small percentage of all new cases should be carried out continually – so that cases of imported new variants can be identified early and appropriate action taken. This requires planning and commitment of funds.

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46 D. Groff, A. Sun, A.E. Ssentongo et al. 2021. Short-term and Long-term Rates of Postacute Sequelae of SARS-CoV-2 Infection: A Systematic Review. *JAMA Netw Open.* 4(10):e2128568. doi:10.1001/jamanetworkopen.2021.28568

47 These statistics are taken from the preliminary findings of the "Self-reported post-COVID 19 conditions among COVID-19 survivors in the community" (CLEAR) study conducted by the Department of Social & Preventive Medicine, University of Malaya.

48 COVIDNOW, Malaysia, available at https://covidnow.moh.gov.my/ (accessed 2 April 2022).

4.0. PHF BLUEPRINT FOR HEALTH REFORM

THE People's Health Forum proposes key reforms covering the six building blocks of the health system: health services delivery, health workforce, health financing, health information, access to essential medicines, and leadership/governance. The objectives of our call for reform are to increase access to healthcare services, improve health outcomes, and increase social and financial risk protection for the population. We propose policy measures that could address the current structural gaps and bottlenecks, suggesting ways to tackle long-term challenges and chronic issues that plague the public health sector.

4.1. Health services delivery

4.1.1. Expand public healthcare infrastructure

4.1.1.1. Build a second general hospital or major specialist hospital in larger towns and cities according to need

This will be costly – about RM400 million per 300-bed hospital, going by estimates that the average cost of building a 100-bedded hospital is between RM120-130 million.[49] The determining factor for the decision is the specialist, equipment, and inpatient capacity demands and waiting time in the current hospital facilities in a particular state/locality.

The government should develop its own in-house capacity to manage hospital building projects and project oversight. This will lead to building institutional capacity as civil servants learn from experience. Even for building projects that need to be outsourced to the private sector, institutional capacity and in-house expertise is required to handle and make judgements in the tender process (whether by direct negotiation, selective tender, or open tender), in order to avoid awarding contracts to construction firms that do not have the experience.[50]

4.1.2. Expand availability of primary care

4.1.2.1. Expand PeKaB40 to include M40, paving the way to a family doctor system

The currently underutilized public health screening programme PeKaB40 was unfortunately introduced during the COVID-19 pandemic which has slowed down the original targets. However, it holds the potential to expand health screening as the contracting arrangements between the

[49] https://www.thestar.com.my/news/nation/2019/10/12/dr-dzulkefly-rm416mil-allocation-to-be-used-for-building-clinics-new-hospital

[50] The former deputy health minister Lee Boon Chye has publicly raised the issue of millions being wasted on cost overruns in hospital construction delays. In a June 2021 webinar, he cited the following examples:

i. Hospital Petrajaya Sarawak, a 300-bed hospital, was budgeted to cost RM495 million. Work began in 2013 and was due to be completed in 2016 but this target was not achieved, resulting in the termination of the contractor's services in 2018 and a re-tender, with a projected cost of RM600 million.

ii. Hospital Lawas Sarawak, an 80-bed hospital that initially was estimated as costing RM175 million when construction started in 2012, is now expected to cost RM240 million by 2023, owing to project delays.

iii. Hospital Bera Pahang, a 40-bed hospital that was initially budgeted at RM88 million in 2015, is now expected to cost RM120 million due to a 5-year delay. (Webinar may be accessed at https://www.youtube.com/watch?v=MJlZTLmmA4M)

government (via a government-linked company called ProtectHealth) and the private GPs are growing. As such, it will provide a good foundation for the future expansion of services to widen the coverage of the population.

The government should aim for a gradual expansion to first cover the M40 population, then schedule to cover family members of all ages, preparing for the eventual system of having GP-led family doctors. The GP-led family doctors can work on a capitation basis catering to a particular size of the local population on set criteria for periodic health screening and health consultation.

Ultimately, this will enable the establishment of a solid family doctor policy and system at the primary care level that will promote regular screening, timely health advice to patients, and better building of trust between patients and their healthcare providers.

4.1.2.2. Outsource patients to private hospitals for the usage of particular equipment or service

To reduce the waiting time for diagnosis or treatment in the public sector owing to limited capacity and to decongest public hospitals, equipment or services in private hospitals can be used subject to decisions which consider the long-term financial and human resource implications of cost-sharing with the private sector. The terms of such an arrangement should also be mutually beneficial to all parties.

4.1.3. Expand community-based services

4.1.3.1. Increase outreach of community nursing programmes

The success of decades-old community nurse home visit programmes to care for postnatal mothers and newborns shows that community nursing programmes can serve certain unmet needs in the community. Community programmes that can provide nursing care and physiotherapy at home, such as for post-stroke cases, brain injury cases, disabled children, people with chronic lower limb ulcers, and patients on catheters and tube feeding, should be increased and extended.

Community health workers should be trained in basic nursing, physiotherapy, and giving nutritional advice and health advice regarding NCDs, obesity, etc., so that they can also deliver health promotion information for maintaining health and preventing disease. In the long run, effective community programmes will be able to reduce healthcare costs due to the reduced need for hospitalization.

4.1.3.2. Better coordination with grassroots groups that work with special needs groups, and address barriers to access for underserved populations

The community programmes proposed above should be coordinated with non-governmental organizations (NGOs) that currently support special needs groups. More financial support is needed for such NGOs working at the grassroots level with dementia patients, cancer survivors, rare diseases patients, and those under hospice/palliative care.

A system of matching grants should be implemented whereby the government supplements the fund-raising efforts of these health NGOs. Government financial support should be conditional on the NGOs accepting financial and governance audits by an independent group which they are to form with government involvement.

4.1.4. Address barriers to access of migrant populations

4.1.4.1. Provide universal access to healthcare for migrant workers and non-citizens

The economic contributions of migrant workers in Malaysia are significant. They alleviate labour shortages, increase productivity, and, as consumers, pay a consumption tax. Migrant workers and their employers also contribute in terms of annual levy payments, which may be considered a form of labour tax, but to date, these have not been earmarked towards the workers' benefit.

In Malaysia, these levies generate revenue of close to RM2 billion annually. The government also collects various fees from employers for migrant worker employment, such as security bonds, which vary by nationality and range from RM250 to RM1,500.[51]

Migrant workers pay taxes in various forms and contribute significantly to the country's overall GDP.[52] As such, they should be entitled to the same medical benefits as Malaysians in public healthcare, that is to say, to be subject to the Malaysian fee rate at the point of payment. On top of this, a portion of their levy payments should be earmarked for healthcare provision.

4.1.4.2. Repeal directive to arrest undocumented migrants in public healthcare

The policy of reporting undocumented migrants seeking care at MOH clinics and hospitals should be removed as it represents a significant barrier towards healthcare access. We propose that the government table a bill to delink immigration law enforcement actions from the healthcare system in the long term.

The Health Ministry should adopt measures to expand healthcare to migrants, and indeed all foreign residents. Support services such as setting up translation services in government hospitals and clinics, and collaboration with NGOs to perform screening, contact tracing, and health education activities for foreign residents should be initiated.

In the broader view, the framing of non-citizens as a potential national security threat, as evidenced by the raids and arrests since May 2020, is dangerous, particularly during a pandemic. It erodes confidence among them to come forward and be tested.

Blaming foreign workers for spreading the virus is erroneous. The COVID-19 virus did not discriminate. It is a highly infectious viral disease that affects all populations, with the poor being more vulnerable, largely due to living and working conditions that are crowded, unhygienic,

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51 Syarat-syarat Pengambilan Pekerja Asing (information accessed via Malaysia Immigration Department's webpage: https://www.imi.gov.my/portal2017/index.php/ms/pekerja-asing.html).

52 World Bank Group. 2015. *Malaysia Economic Monitor, December 2015: Immigrant Labour*. World Bank. URL: https://openknowledge.worldbank.org/handle/10986/23565

and unsanitary. The frequent outbreaks of infections among foreign workers in places of detention and in construction and manufacturing industry workplaces only underscore the reality of these conditions that allowed for the easy spread of COVID-19.

Stronger, more humane, and compassionate messages should be sent out coherently by the whole of government (including the Department of Immigration, National Security Council, and Ministry of Health) to reassure migrants that it is safe to seek care from public healthcare facilities. This should be accompanied by universal approaches to testing and treatment for migrant workers.

Moreover, preventive actions should be taken to address their living conditions by enforcing the Workers' Minimum Standards of Housing and Amenities Act 1990 (Act 446) and ensuring that the law's provisions are applied by all employers providing living quarters to workers. Reforms should be instituted in detention healthcare services, including setting standards to ensure proper monitoring of disease prevalence and death.

Finally, certain marginalized and vulnerable non-citizen population groups such as refugees, asylum seekers, and stateless persons also do not enjoy reasonable access to healthcare. Currently, treatment for infectious and vector-borne diseases is free of charge in the public health system, irrespective of citizenship status.[53] We propose that these groups be exempted from foreign medical rates for other health problems too given their economically precarious status; instead, they should be granted access to the same subsidized rates accorded to Malaysian citizens. Meanwhile, the state should provide immunization to all children, and maternal and child health follow-ups to all non-citizen women and children who reside in this country as a basic healthcare right, irrespective of status.

With regard to primary care, in integrating public and private sectors, it is important that NGO clinics providing primary care to refugees and asylum seekers should also be integrated into the wider system because of their significant caseload. In 2019, one NGO alone with three static clinics and one mobile clinic provided 39,749 consultations to refugees.[54] If the rest of the 12 NGO clinics in Kuala Lumpur, Selangor, Penang, Johor, and Kedah were considered, the number of consultations would be much higher.

4.1.5. Strengthen pandemic control capacity[55]

Malaysia's response to the coronavirus pandemic has exposed critical gaps and inequalities in pandemic preparedness and response, including:

i. A narrow security and policing mindset approach towards undocumented migrant workers adopted by Majlis Keselamatan Negara, the federal body empowered to coordinate the country's pandemic response. The criminal enforcement approach

[53] Surat Pekeliling Bahagian Kewangan Bil. 1/2013: Pengecualian Bayaran Caj Perkhidmatan Perubatan dan Kesihatan di Luar Hospital/Fasiliti Kementerian Kesihatan Malaysia.

[54] Data provided by UNHCR, 2022.

[55] The points in this section are taken from Dr Chan Chee Khoon's presentation on "Lessons learnt for pandemic preparedness in Malaysia", delivered during the People's Manifesto Policy Town Hall on 3 October 2021.

not only creates costly challenges in managing COVID testing, contact tracing, isolation and treatment, and vaccination for undocumented migrants (many were already fearful of detection, arrest, and deportation in pre-pandemic times), but also poses risks to the overall safety of the general population in the long term, since in any infectious outbreak, no one is safe until everyone is safe.

ii. Malaysia's dependency on foreign vaccine suppliers (largely due to lack of local manufacturing capacity) which in turn slowed down the rollout of the vaccine.

iii. Poor integration between the public and private healthcare sectors in coping with novel infectious outbreaks, with the distribution of the COVID patient care burden unequally skewed towards the public health sector.

In its response to present and future novel infectious outbreaks, the state has a duty to create an enabling environment for "the highest attainable standard of health as a fundamental right of every human being", citizens and non-citizens alike. Based on lessons learnt from the country's prior responses, we propose the following to be integrated into future pandemic preparedness and response plans:

i. MKN's security and policing mindset should be replaced by a public-health-led approach that seeks a balance between disease control and economic and social wellbeing in often fluid circumstances. Coordinated responses on multiple fronts – health, economic, financial, essential goods and services, public order and security, social support – are key elements.

ii. Take concrete steps to address the pervasive and deep-rooted issue of corrupt mismanagement of the country's foreign labour "supply chain". Over the course of decades, this has resulted in a persistently large pool of undocumented migrant workers with strong incentives to avoid contact with government agencies. Inaction on this front will repeat our costly experience in future pandemics.

iii. Map out the respective roles of public and private healthcare sectors in responding to various contingent scenarios of pandemic outbreaks, with the aim of creating a more equitable distribution of the burden of care.

iv. Formulate and implement measures to support local manufacturing of vaccines, so as to increase self-sufficiency and reduce vulnerabilities in access that may arise from overdependence on foreign suppliers. For example, Pharmaniaga's RM3 million collaborative investment with China in the fill-and-finish process of Sinovac's CoronaVac vaccine may be seen as a first move towards a needed mature capacity, while also developing greater local vaccine technology and expertise. Besides China, Putrajaya has also received offers from Cuba and Russia for collaborative research and product development. Besides bolstering pandemic preparedness, these joint venture offers can position Malaysia as a manufacturing and distribution platform for vaccines and essential medicines for the ASEAN region.

4.2. Health workforce

4.2.1. Set up Public Health Services Commission[56]

The government must seriously address the push factors underpinning the migration of experienced healthcare personnel in public service to the private sector. Many specialists leave because they are attracted by higher remuneration. But there are also non-financial reasons such as heavy workload, non-transparent promotional practices, and lack of upskilling opportunities.

One way to address these issues is to set up a separate Public Health Services Commission to specifically handle public health service staff. Currently, the Public Service Department (JPA) controls salary scales and working terms and conditions for the entire civil service. However, it is difficult for JPA to delink issues affecting any one particular group of civil servants from the overall civil service, let alone a specific subset such as the senior experienced medical personnel, and respond to the causes of dissatisfaction.

An independent Public Health Services Commission would be better able to tackle the following issues:

i. Set up more transparent processes for promotional exercises, with fixed terms and clear criteria for promotion.

ii. Incentivize specialists to remain in public service by awarding them three-month sabbaticals after every five years of service to dedicate to upskilling. During this time, they may choose to subspecialize and learn new skills or engage in activities that are not strictly tied to medical service but still support career progression such as research, publishing, and teaching.

4.2.2. Increase the number of specialists in government service

4.2.2.1. Place a temporary moratorium on new private hospitals to minimize specialist brain drain

Further to the "push" factors encouraging brain drain, equally important is the "pull" factor created through setting up new private hospitals. A new private hospital will very likely "poach" government specialists, incentivizing them to move out of public service to the private sector to work as independent consultants.

Market forces in Malaysia's de facto mixed public and private healthcare system are the main reason why the private sector can attract specialists with the promise of higher incomes and better work conditions. To address this, the government should place a temporary moratorium on the building of new private hospitals, while it takes other measures to slow down the brain

[56] The points in this section are taken from Dr Chee Heng Leng's presentation on "Establishing a public health services commission", delivered during the People's Manifesto Policy Town Hall on 3 October 2021.

drain (such as setting up the commission to offer better service terms) and replenish its stock of MOH specialists.

In our view, the temporary moratorium is not an extreme measure since it does not call for the nationalization of the entire private sector. It allows existing private hospitals to continue running and maintaining their services. The moratorium could be lifted once a better balance in the deployment of our specialist doctors is achieved.

4.2.2.2. Create more training posts for doctors in active service while continuing to recognize external specialist qualifications

Currently, all local medical specialization training offered by higher learning institutions, including partnerships or internationally certified training programmes, must be registered with the Ministry of Higher Education and be accredited with the Malaysian Qualifications Agency. However, foreign qualifications such as the MRCPE, FRCS and MRCOG that are acknowledged by the Malaysian Medical Council or the MOH-managed Parallel Pathways do not need to undergo this. These external specialist qualifications should continue to be recognized so that those who cannot get into the local Master's programmes still have an avenue to specialize.

Opportunities to specialize should be created for the 23,000 contract doctors currently working in the MOH. Their contracts should be extended to 10 or 12 years if they are keen to specialize and they should be allowed study leave and the other incentives that are available for trainee doctors who are part of the civil service.

To implement an effective family doctor system in the long run, more primary care physicians need to be trained in family medicine. However, in the current scenario, many doctors are disincentivized from training further to become family medicine specialists (FMS) due to the nature of short-term work contracts that make it difficult for them to qualify for Master's programmes in universities.[57] The government must seriously look into this issue as well as related weaknesses in the housemanship training programme that have been outlined above, to create a more streamlined and clear training pathway for junior doctors.

4.2.3. Review medical student intake

The MOH needs to determine the number of housemen it can train properly each year. The quotas for admission to medical schools in the country have to be set based on the capacity of the MOH to continue the process of training the medical graduates. The PHF would like to suggest that the percentage reduction in admission to private medical colleges in Malaysia should be twice as high as that for the public medical universities. The private medical colleges can either merge to maintain efficiencies of scale or canvass for more overseas students. Many

[57] To qualify for basic specialization training through a university-based Master's programme, junior doctors or medical officers (MOs) are required to have first served as a permanent doctor for at least two years at a government hospital. However, permanent tenure is notoriously difficult to achieve owing to the shortcomings of the contract system. After completing housemanship training, MOs are typically given a two-year contract followed by a one-off, one-year contract extension by the Public Service Department, but both these contracts do not count as permanent positions. MOs can alternatively opt to study one of the parallel programmes offered by professional global organizations, but these are more expensive and also require MOs to be actively serving at a hospital.

of the private medical colleges have retired Health Directors-General and Deputy Directors-General as senior management. This has enabled the private colleges to lobby the regulatory bodies for higher admission quotas for that enhances their earnings. This reality has to be acknowledged and addressed if we wish to optimize our recruitment and training of doctors.

4.2.4. Task shifting to relieve the current government healthcare burden at the primary care level

4.2.4.1. Create designated NCD clinics and posts for nurse educators

Reorganize the government clinics to enable continuity of care for patients by assigning patients to dedicated NCD clinics and deploying trained nurse educators to these clinics. These nurses would be responsible for initiating surveillance and follow-up measures per protocol. This can help decongest the current *klinik kesihatan* and *klinik desa* which are heavily burdened by the healthcare demand.

4.3. Health financing

The People's Health Forum recommends the Federal government gradually increase the budget and expenditure for the Ministry of Health, aiming first at a budget equivalent to 4% of GDP, to address the chronic underfunding constraints over the decades. The PHF proposes to the government to raise revenue and reprioritize the government fund for strengthening public health. People need affordable and accessible healthcare of reasonable quality, and the resource provision has to be community-risk rated.

4.3.1. Increase total expenditure on health as a proportion of GDP and increase the proportion of federal government expenditure for MOH

Malaysia's current total health expenditure of 3.82% of GDP[58] is below the upper-middle-income countries' average of 6.9% of their respective GDPs. This is not because Malaysians are healthier or the cost of healthcare in Malaysia is lower. Compared with the governments in other upper-middle-income countries like Thailand and South Africa which spent 13.9% and 15.3% of the total government expenditure on health respectively in 2019, the Malaysian government spent only 8.48%. The COVID-19 pandemic exposed the challenges related to this underspending on health. It is high time that the repeated avowals by Director-General of Health Dr. Noor Hisham Abdullah that the public health system will be strengthened are supported by political will and action.

To get close to the world's average of 6.6% of GDP for total health expenditure, the government must close the current gap by investing an additional 2% of the GDP in health. Thus, the PHF calls on the government to allocate a budget equivalent to 4% of GDP to the Ministry of Health within five years, with a minimum RM8 billion increment per year for the next five consecutive years.

[58] WHO. Global Health Expenditure Database, 2019.

The PHF proposes that 40% of the increment should be invested in developmental expenditure to increase the capacity and sustainability of the healthcare system. This should include building new hospitals and clinics, expanding and upgrading the facilities, better maintenance and repair works, investing in digital infrastructure and logistics, as well as allied health training facilities. These development plans will take time to complete and are better planned ahead according to needs.

If 60% of the additional allocation would still largely be used to improve healthcare delivery, the resource attention must be placed more significantly on strengthening primary healthcare and preventive care, as well as on training more specialists and retaining expertise in the public healthcare system. In this regard, the PeKaB40 programme could be better funded and expanded, and the Public Health Services Commission can have more resources to hire medical officers (a break from the current contract system) and retain highly experienced specialists.

In order to not reduce or reallocate the funding from other ministries to provide more funds to the MOH, the Federal Government needs to increase its overall budget from the current level of approximately 20% of GDP to a higher percentage share. A 5% increment would translate to RM80 billion more to spend on social programmes. The government must raise its revenue rather than increase its debt level to fund all these.

4.3.2. Introduce a GP capitation system

In 2020, there were nearly 8,000[59] private medical general practitioners in the whole of Malaysia versus some 3,000 government clinics, of which roughly only a third are clinics staffed by doctors. By numbers alone, private GPs outnumber government primary care providers nationwide. The government should incorporate GPs into public healthcare to address the gap in the management of NCD patients. This can be done by contracting GPs under a capitation payment system, where each participating GP will be allocated a set of NCD patients (or a certain number of the local population that qualifies for the scheme) for a particular time period. Payment can be on a per-patient basis and adjusted accordingly for demographic and health factors.[60] The GP should also be given bonus payments if certain outcome criteria are met, such as when diabetic patients attain acceptable HbA1c levels.[61] Patients are thereby given access to medical care free of charge at the point of utilization in exchange for committing to a particular GP as their regular primary care physician. Other benefits include shorter waiting time for lab tests and consultations, better and more timely access to medicines, and receiving more personalized

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59 https://www.thestar.com.my/news/nation/2020/03/29/mobilise-gps-in-battle-against-covid-19-urges-private-doctors039-group

60 In the UK's National Health Service, doctors are paid the equivalent of RM24 per patient per month to treat all cases. We suggest that the MOH could fix the capitation fee at RM15 per patient per month for unlimited access, after adjusting for per capita differentials, with potential for increment if patients are put on follow-up with their assigned GPs.

61 The PHF estimates that the overall project costs of implementing a pilot capitation scheme for 1 million NCD patients will amount to approximately RM350 million, with 51.4% (RM180 million) going towards annual capitation fees for doctors, 28.6% (RM100 million) as "inducement bonus" cash benefits to patients who choose to opt into the scheme, 17.1% (RM60 million) for the transport of lab blood tests and medicines, and the remaining 2.9% (RM10 million) dedicated to covering infrastructural costs (setting up a dedicated online data bank) and various administrative costs incurred for overseeing GP payouts, results tracing, patient enrolment, patient satisfaction system performance monitoring etc.

care. In short, there will be continuity of care for each patient who is registered with a GP and ample scientific evidence has proven that this creates beneficial outcomes for NCD treatment.

As stated earlier, as a first step, this can be integrated in the government's PeKaB40 scheme (which already enlists GPs to perform NCD screening for the B40 group) to include treatment and screening and to eventually cover wider population groups, including the M40, and all ages.

4.3.3. Reduce co-payments for implants and equipment

The current practice of requiring patients to pay for certain implants and equipment for medical treatment should be reviewed with the aim of reducing or removing these payments or co-payments. This could be made possible if the health budget is enlarged in the coming years to include these benefits. In the meantime, the PeKaB40 scheme could be the temporary solution to help fund coverage of such co-payments.

4.3.4. Proposals to revamp healthcare financing

Ever since the 1980s, the government has been toying with proposals to revamp the financing of healthcare. Numerous studies have been done. There are three common components in most of the proposals to revamp healthcare financing. These are:

1. **An additional source of revenue** to fund healthcare expenditure. These proposals argue that the country cannot continue to rely on general taxation alone to meet all of its healthcare budget. Some form of revenue in the form of a health tax or mandatory insurance should be raised to provide additional funds for healthcare spending. The current "frontrunner" is social health insurance, which would be mandatory, community-rated and borne by the government for B40 individuals working in the informal sector.

2. **A National Health Fund (NHF)**, which would be a non-profit agency independent of the Ministry of Health, and would receive revenue from social health insurance as well as from general taxation. The NHF will pay for healthcare in both the public as well as private sectors.

3. **Payment to "providers" based on services rendered.** Public hospitals are to be "corporatized" so that they function like companies. Both public and private hospitals will be paid by the National Health Fund based on services provided to the public. Payment to providers (the hospitals) will be calculated using the case mix and diagnosis-related groups (DRGs) classification system. Under the DRG system of billing, hospitals will be reimbursed a specified sum for each particular disease, regardless of whether that particular patient's illness is simple or complicated and/or requires more advanced treatment. This method of reimbursement would require the MOH to switch from its current practice of allocating each public hospital a sum based on the expenditure in previous years (the so-called "global" budget) to a "fee-for-service" model.

4.3.5. PHF's reservations

The PHF has serious reservations about all three components of the health financing reform outlined above. These are:

a. There is a significant risk that the fee-for-treatment system will induce perverse practices whereby hospitals try to increase their revenues by ordering additional tests and procedures on patients so that they can cross-subsidize other patients and/or finance other operational expenses. There is marked information asymmetry between doctors and patients. Generally speaking, most patients are not on par with their healthcare providers in terms of health literacy. This means that patients cannot know whether they are being over-investigated/ over-treated or not.

b. The introduction of a social health insurance system and reimbursement of healthcare providers based on treatment given will require new bureaucracies and will incur a significant increase in administrative costs and workforce resources. These additional costs will drive up the cost of healthcare in Malaysia.

c. The fee-for-service payment model will make hospitals and clinics focus more on treatment, as payment is according to the amount and types of procedures used to treat patients. In the long run, this will disincentivize physicians from providing health promotion, education, and preventive care since these services are not rewarded in the payment mechanism.

d. The National Health Fund will be entrusted with an annual budget of more than RM60 billion which it will then disburse to or use to buy services from various "providers". Is our present system of governance sturdy enough to handle such a huge fund properly or will there be tendencies for certain "well-connected" companies to be given sweetheart deals that shortchange the rest of society?

e. There is significant wage suppression in Malaysia. This has persisted for many decades. Malaysian workers are paid a fraction (a sixth) of what workers in Germany receive for similar jobs. We are constrained to accept these low wages as we are competing with our neighbours for foreign investment. This is a sacrifice that our working people are making for the good of the national economy. Since we are unable to pay fair monetary wages to our workers given our disadvantaged position in the international economic system, the least we can do is to provide them a "social wage" in the form of universal access to essential services to improve their quality of life overall – services such as healthcare, education, and public transport – at subsidized rates.

f. Such a radical change to healthcare financing is a non-starter. Despite multiple proposals over the past 30 years to transfer a portion of healthcare costs to the general public, governments have balked at implementing the idea as it will entail a high political price. So, it is really pointless to keep resurrecting the proposal to transfer a significant portion of the healthcare financing burden to the general population.

g. Lastly, with regard to the practice of "strategic purchasing" of services, if done properly, this may potentially help stretch the value of the ringgit for the health budget and improve overall cost efficiency for the Health Ministry. However, there is a real danger of misuse of this system to benefit certain parties. There must be a robust peer-reviewed system in place to make sure that the services being purchased are necessary and correctly priced.

It is true that with the increasing sophistication of medical treatment modalities, healthcare costs will keep going up. It is also true that government tax revenue has not kept up with the growth in GDP. Individual and corporate tax rates have plummeted, not only in Malaysia, but in most other countries. The PHF believes that the second trend can be arrested and reversed by international action. The recent 15% global minimum tax for multinational companies is an example of what can be done. It is a good start. Responsible governments and civil society organizations need to begin strategizing how loopholes in our tax systems can be closed and billionaires and the largest corporations be made to pay higher taxes so that a larger portion of the wealth of society is available to expand the "commons".

To sum up, our stance is to:

i. favour incremental changes and improvements to the current system over massive restructuring

ii. keep to the global budget/capitation approach to allocating the health budget

iii. rely on progressive taxation, not extra contributions from ordinary (lower-income) citizens, to fund healthcare

iv. decentralize healthcare administration and get local governments and communities to play a larger role in managing it.

In short, if the system is not broken, do not dismantle it.

4.4. Health information

4.4.1. Set up data hubs for public visualization, usage and downloading health data

The COVID-19 pandemic has revealed that the government can disclose and publish data in bulk and in organized formats in the GitHub database depository. Working with the right data team in helpful partnerships could yield a productive and meaningful result such as the COVIDNOW website.

The health informatics centre under the Ministry of Health is tasked with working to collect, compile and publish Health Facts and Health Indicators every year, and the Ministry also publishes its Annual Report – all of which are rich sources of health data. But the statistics could be made more useful if the structure used for GitHub is adopted and applied to a website with data visualization, to help people see more clearly the trends for many data categories.

These efforts will empower the people, communities, and researchers to find out about the particular needs in the healthcare system, allowing the public to monitor and help provide solutions via collaboration.

4.4.2. Update and publish national registries more frequently

The common issue with various registries published in the MOH and ICR (Institute for Clinical Research) websites is that some are absent, discontinued, or outdated. For example, one of the important registries, the Malaysia National Cancer Registry Report 2012-2016, was published in 2019, and now the data is outdated by at least five years. The National Suicide Registry Malaysia was last reported in 2009, and now there are efforts to resume publication of the report.

4.4.3. Publish health information for migrant populations

Currently, disaggregated data on non-citizens is unavailable. However, statistics and information about migrant populations in Malaysia will help the communities improve their health and quality of life; for example, to ensure minimum standards of living and hygiene. Information such as healthcare utilization by disease categories, type (outpatient, daycare, or inpatient) and frequency of visits, health expenditure, as well as National Health and Morbidity Survey (NHMS) data would be helpful to understand the health status and wellbeing of the community. The information release, even in a controlled way (not direct release), would help collaboration between social welfare or civil society groups and the government in raising health standards for all and allowing accessible healthcare.

4.5. Essential medicines

4.5.1. Ensure affordable medicine and treatment by making the patent system more stringent as well as imposing medicine price regulation mechanism

The principal cause for the high cost and unaffordability of some medicines is the patent system which offers patent holders legal monopoly control in the market. Sometimes the holders abuse the system to maximize their gains including through arbitrary high price-setting and intimidating potential generic competitors. When the patent system is rigged and gamed by multinational “Big Pharma” companies to their advantage, especially by “evergreening” patents surrounding their medicines (effectively prolonging their monopoly), the high price tag stays longer and life-saving medicines become less affordable to needy patients. The unchecked mark-ups in private hospitals, clinics, and pharmacies add still more misery to the patients.

Hence, we propose to tighten the patent system by increasing the stringency of patent approval, rejecting second-use or non-inventive chemical modification claims (to prevent evergreening of patents), and allowing pre- and post-grant patent opposition to strike out unsubstantiated claims. At the same time, we support a policy to have price regulation of medicines to control excessive mark-ups by private healthcare providers. With these, in the long run, the medicine prices in Malaysia would be much more reasonable and affordable, and patient and consumer rights will be protected against unfair market practice.

4.5.2. Promote local pharmaceutical industry for production of generic medicines, vaccines and medical devices

The local generic industry in Malaysia is growing. Many local firms do have the capability and capacity to produce many medical products. The stumbling block is still the constant legal threat from the originator multinational pharmaceutical companies due to patent monopoly.

The People's Health Forum supports the self-sufficiency of medicine supply in Malaysia and stopping our reliance on imports. The COVID-19 pandemic taught us that dependency on vaccine imports, especially during the early period of the vaccination campaign in 2021, could morph into a national security issue.

Increased local production can create multiplier effects in the local economy, as well as attract and retain talents/professionals in the industry.

4.6. Leadership and governance

4.6.1. Guided by evidence-based and value-based healthcare policy, with the best public interest at heart

All policies and measures proposed by leaders in the Ministry of Health, be they the Minister and deputies or the Director-General and deputies, must be evidence-based and value-based and serve the best public interest (ordinary people) as the ultimate goal. Policy research and planning need to guide the decision-making prominently.

If the issue is big and the consequence is far-reaching, meaningful consultations would be required to explain and clarify to the public and collect feedback from them. Effective and clear lines of communication to disseminate information to the public are important for the success of any new policy.

4.6.2. Show political will to address long-term issues in the right way

The Health Minister and deputies need to use, apply and trust the in-house intelligence provided by civil servants including on long-term trends, planning, and projections about healthcare demand and utilization.

The government needs to be mindful that the health sector is one where the private lobby is strongly and actively present in an organized manner in many parts of the world. Hence the government has to be clear and stand firm in protecting the public interest, including scrutinizing whether professional bodies, industry actors and the Bretton Woods institutions (viz., the International Monetary Fund and the World Bank) could have vested interest in the proposals they put forward to the government. What is good for private healthcare providers is not always good for the people/patients and the government (see our reservations about the "market mechanism"). The converse is also true. Public-private partnership deals should be reviewed by an independent third-party audit to ensure that the deals are genuinely beneficial to the public at a reasonable cost.

Ensuring that decision-making for the health system leads to equitable, efficient and responsive care requires careful and independent judgement by the Minister especially at the current time when the Ministry is beleaguered by a host of problems such as the issue of contract doctors, unaffordable medicines, outsourced hospital services, and chronic insufficient funding for the public health sector. The Minister needs to demonstrate political will by taking action to remedy existing problems. The current Minister's proposals to prepare a White Paper on healthcare and to set up a permanent Health Commission to oversee the development of the healthcare sector are steps in the right direction.

4.6.3. Listen to stakeholders including patient groups, consumer associations, civil society organizations and community leaders

Besides the usual groups which often engage with the Ministry such as professional bodies/ associations, and pharmaceutical and private industry representatives, the government should always listen to the voices of the most affected end-users: patients and consumers, as well as social workers and activists who work and care for the health of local communities. Without hearing from end-users on their needs, experiences and observations from the ground, the risk of bias towards the point of view of service providers or product sellers is high.

5.0. FINAL POINTS

SUBSIDIZED healthcare is an important leveller.

Government planners must consider the fact that expenditure on health has many positive "externalities". This means that apart from the immediate benefit of treating our sick more efficiently, a well-funded public healthcare system also brings other benefits to the nation such as an increase in productivity, enhanced social solidarity and a sense of belonging, and a reduction in delinquent behaviour, anti-social tendencies and "street anger". In fact, a good public healthcare system will mean that employers do not have to worry about buying health insurance for employees. It contributes to a conducive investment (for production) environment.

On the other hand, making people pay for their own healthcare by taking up health insurance and further increasing the disparity in access to healthcare will have negative externalities. It will generate insecurity and resentment and result in an erosion of social solidarity.

Malaysians need to come together to support and improve the public healthcare system.

PEOPLE'S HEALTH FORUM

Health For People, Not For Profits

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