[Malaysia]

Task Shifting Concerns in Malaysia

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MMA Supports Universal Healthcare for All[1]

In general, Malaysia has nearly universal access to health for most Malaysians, but this is undeclared and not structurally defined. The government's heavily subsidized public health sector provides most health care to all patients, with minimum copayment, often a token one to five ringgit per outpatient visit. Even hospital admissions and treatment are subsidized to the tune of 98% of all total health expenditure (THE).

Our health expenditure consumes just 4.7% of the GDP, with the government providing just 2.1% (44% of the THE) from tax revenue allocations, amounting to around RM13 billion per year. (Total National Health Expenditure amounts to RM35 billion in 2008.)[2] This entire sum is spent exclusively for maintaining and providing for the public healthcare sector, which provides 38% of outpatient services and 70% of in-hospital services.

The private healthcare sector is funded predominantly by third party payers (TPP, such as employer health benefits, and health insurance ~14 to 15%), with another 35% from out of pocket payments (OPP). The private sector looks after some 62% of outpatient services, and 30% of in-hospital treatments.[3]

The MMA respects and acknowledges government measures, which help to bring better access of healthcare to the population, especially the poor, the marginalized, and the underserved, whether in the urban or rural locations.[4]

We fully support every effort to ensure that the poorest among us, as also of every resident of Malaysia, must have easy, affordable and high quality healthcare, as a human right for all.[5]

We fully appreciate that for many decades now, many world authorities, have praised Malaysia's primary healthcare structure as being among the best among developing countries, the world over. We are proud that nearly every citizen of Malaysia (~90%) has relatively easy access to a healthcare facility under a radius of less than 5 km.

However, while the MMA supports better, affordable and more accessible healthcare facilities to the public, the manner in which so-called "1Malaysia clinics" has been announced, where they are to be sited, as well as the fact that these clinics were to be manned by medical assistants and nurses, took many doctors by surprise.[6]

Paramedic-operated 1Malaysia Clinics Frustrate Doctors

At the last announced national budget 2010, 50 such clinics around the country were set up. Thus, this small number of clinics would probably have little impact on any doctor's rice-bowl. However, the MMA has reservations about opening these in urban areas, because we already have so many GP clinics (>7,500 clinics) in almost every town and suburb in the country.

Dr Mah Hang Soon, Perak State exco member, while visiting the soft opening of these clinics, alluded to the fact that there were already some 319 GPs in the four towns where these 1Malaysia clinics have been sited!

Many GPs are much angered by such arbitrary setting up of these paramedic-manned clinic services. Such was the general impression that they are once again bearing the brunt of perceived one-sided governmental action, following so closely on the heels of the unpopular Private Healthcare Facilities and Services Act and Regulations (PHCFSA).[7]

The major peeve is the manning of these clinics by non-medically registered personnel, i.e.

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medical assistants and nurses rather than doctors. This approach appears to many GPs and doctors as taking many steps backward, despite reassurances that there will be oversight and supervision by some doctors, periodically.

The Prime Minister tried to reassure us that our doctors will not be impacted, and that these clinics are simply basic ones to cater for monitoring diabetes, hypertension and some simple ailments. However, he left the question of expansion of these clinics opened, depending on the success of its popularity… Hence, our concerns remain. Many GPs continue to feel strongly that these clinics should not have been opened and manned in this manner.

Poor Distribution of Doctors, Better Deployment the Answer

MMA believes there is no real shortage of medical doctors, but a misdistribution of resources. As of 2010, we have a doctor-population ratio of 1:900, but in the interiors of Sabah and Sarawak, the distribution is quite in disproportionate, 1:2,000 or more.[8]

The public sector primary care clinics (called 'klinik kesihatan') number just over 800 around the country and are severely overcrowded, overutilized and often understaffed. Many of these are rural- or suburban-based, and most are manned by paramedics supervised by medical officers, on a rotating roster of visiting services.

The MMA feels strongly that more doctors should be deployed to man these clinics.[9] We understand the logistical problems, which have arisen time and again due to doctor reluctance to be relocated to more rural or remote locations. Yes, despite all the improved perks, retaining doctors in the public service remains a challenge.

Proper and fair deployment with guaranteed career paths for further training or preferred posting after such rostered 'hardship' postings will allow greater participation by ambitious younger doctors.

Also if these 1Malaysia clinics are now to be part of the expanded public healthcare system, then the MMA believes that even more public sector doctors would be willing to be deployed in rotation, or as part of a training initiative for an enhanced family practice/general practice vocation.

Upgrade All Health Clinics, Including the Remote and Rural

The MMA strongly believes that even rural or suburban 'klinik kesihatan's should be upgraded to doctor-manned clinics which would enhance the overall standard and quality of care for everyone, urban and rural. We believe that these services even for the poor, can be made even better with clinics, which are doctor-covered 100% of the time.

Paramedical personnel, whom we all deeply respect and are dependent on, are specifically-trained and have defined scopes of practices, which are as stated quite explicitly, to 'assist' doctors to carry out healthcare services, and never intended to replace doctors.

Thus, the specific roles of allied health personnel will not be eroded, but instead should complement those of doctors. It is a norm that doctors should remain in this day and age, as the minimum standard of care, where indeed possible.

We cannot always look backwards in time and compare the 1960s and 70s, where because of our fledgling healthcare service then, we had to utilize these medical assistants, assistant nurses and midwives to provide very critical services, especially in rural and remote areas around the country. Then, quite obviously some kind of healthcare service is better than none at all, and these have served us very well, indeed.

Our maternal and childhood mortality and morbidity data underscores the success of such a much-lauded program, which are being emulated by many other developing nations. We are rightfully proud of this. But, despite such strides, our health vital statistics still lag behind more advanced countries, which suggest that more improvement can still be achieved.

It is acknowledged that some nurses now have degrees, Masters and even PhDs, but the reality on the ground remains that these are few and far between. Furthermore it is well-known that these better-trained personnel are usually administrative and not deployed to service health clinics. However, it remains incontestable that their training does not equal that of a doctor's.

Nevertheless, we fully support the Malaysian Nurses' Association's call to further upgrade the calibre, responsibilities and training of nurses in the country. This will undoubtedly enhance the

standard of care for all Malaysians.

However, there are also rising concerns that the mushrooming nursing colleges (>120) around the country has also cast a growing cloud of ambiguity as to the average quality and standards of our nurses trained recently. This is also true of our many (30) medical schools!

This is the hard truth, which our health system must learn to address before they become unmanageable. But do we dare ask these difficult questions? Is any one authority seriously looking into this, or are we just too comfortably complacent at simply getting out the numbers?

Thus, the MMA maintains that all of these clinic services are best fully supervised directly by a doctor in proximity, in every healthcare establishment. This practice of having surrogate allied health personnel should always be a stopgap measure, which should be discontinued once sufficient efforts were made to enhance our services.

Using such alternate substitute personnel to replace doctors would never be allowed in any of the private hospitals or private medical facilities. So, clearly because of real life shortages and economic factors, we resort to such practices. But in an ideal world, these would not be the preferred choice.

We should not be stuck in the past; we have to move forwards. The MMA believes that we have sufficient doctors to be deployed to service clinics around the country, notwithstanding logistical problems such as doctor reluctance to be deployed to more remote locations, and the continued attrition of public doctors to private sector ventures.

We are convinced that we are now producing sufficient number of doctors and they can now hopefully function in their true capacity and training to oversee and run these clinics. That is the premise of the MMA and most doctors—we should not compromise on this, simply for economic or other purposes.

Surely if all else are equal, if payment for service is not the concern, who would any one sick person prefer to see, a doctor or another healthcare professional?

This is not to say that there cannot be a complementary assistive role for allied health professionals. Nurses, nurse practitioners, medical assistants, special technicians, physiotherapists, all or some of these, are indispensable and would enhance the overall healthcare experience.

Our premise is that to each professional, its own tasks and duties based on its specific capacity and training. However, this does not mean we are disparaging or looking down on these very important personnel, whom we work with on a daily basis!

Double Standards & Legal Implications of Clinics

Most doctors believe that this approach of using clinics run by MAs and nurses alone, is wrong in law. Our Medical Act dictates that only registered doctors should operate any health/medical clinic. Yet, while this is the law for the private medical practitioners, there appears to be another law for government-backed facilities where this requirement can be ignored! (It is true that under the Medical Act, the Health Minister can waive or exempt certain regulations.)

That there appears to be one law for private doctors and another for the government or MOH has provoked a sense of injustice and deep anger, especially because quite a number of doctors who had fallen foul of this law had been severely punished recently. Some doctors have openly asked why they too cannot also employ MAs in their clinics, to look after simple basic health issues too, while each doctor can oversee a few clinics without being physically present!

Of course, the MMA does not and will not condone or encourage any doctor to break the law. Therein lies our dilemma of such a perceived differential application of the rule of law. Blatant double standards are badly frowned upon by well-reasoning people, including doctors!

If all these 1Malaysia clinics can be manned by doctors, even house or medical officers (registered medical practitioners) then this degree of unhappiness would be much dissipated. The MMA urges an overall upgrading of these clinics to that manned by at least registered doctors. We believe this will help defuse the situation, and more importantly will enhance the quality of care for patients.

It should not be that if one is poor, then one has no option but would be serviced by whatever is offered at the cheapest mode. Such inequity exacerbates social injustice and is an affront to modern human rights concerns.

Safety & Quality of Care Concerns, Likely to be Better with Doctors

With such a move, there will not only be improving access to the poor but also ensuring safety, higher quality of care, possibly fewer errors, lessen medico-legal mishaps, despite the payment of only RM1! Of course, we can harness the special capabilities of the MAs and nurses to offer quicker access, but one that is supervised by a doctor. With such a move, the question of legality, more appropriate therapies, timely referral and even medical chits can be resolved.

A recent report by a group of doctors in Penang[10] (Dr Jayabalan T and others,) stated that "A study in 2009 revealed that medical assistants at government health clinics and government hospitals were found to be responsible for many medication errors. Of the 1,612 prescriptions generated by medical assistants in a single week, 1,169 errors were noted and some were critical errors, involving the use of at least one medication categorised as Group B medicine, which only medical officers are authorised to prescribe."

They concluded that "It must be noted that medical assistants are trained to assist medical officers and not to provide treatment in the same manner as medical officers."

Another study published in 2008 by the (comprising researchers from both University Malaya and MOH doctors), on **"Medical Error in MOH Primary Care Clinics,"** had also found many more errors hitherto unexposed to the public.[11] Of 1,753 clinical records reviewed by a team of family medicine specialists, a very high percentage of medical errors were discovered: 57.2% occur in primary healthcare sites, and 93% of medical errors were deemed preventable. The majority of medical errors are related to medication. Medical assistants saw 81% of the total of records assessed, and thus were responsible for the majority of these medical errors.

A lack of knowledge and skills of MOH staff has been shown to contribute to medical errors. They concluded that there is a need to improve the quality of healthcare services provided by MOH health clinics.

Therefore, safety issues must always be considered. This is not to say that doctors cannot make such similar mistakes, but with far more comprehensive training and education, doctors are expected to make fewer of these errors. Medical protection insurance, when taken up by doctors, also helps to ensure greater patient protection.

MMA shares World Medical Association Concerns about Uncontrolled Task-Shifting[12]

For many of us in the MMA, the delegation of duties in the 1Malaysia clinics to non-doctors despite its noble intentions of trying to reach out to more of the urban poor, is a form of task-shifting from the medical doctor, which is much feared and roundly cautioned by medical professionals around the world.

While some poorer nations with very short supply of doctors have resorted to task-shifting some of health care to nurse practitioners or health assistants (even encouraged by WHO), this is not the usual exercise for countries aspiring toward a higher standard of care.

This move also contrasts starkly with our vaunted new approach to encourage greater Medical Tourism initiatives, and could lead to questions of uneven healthcare standards, and possibly safety issues. This could unfavourably impact our efforts to promote health tourism from safety conscious foreigners.

Doctors and the MMA have been lambasted as being 'elitist." But this is not true, we respect standards and clear task demarcations, which define one profession from another. Task separations have been mankind's refining benchmarks for better and more specialized work designations, and we believe this approach is particularly appropriate for the medical and health profession.

Importantly, MAs and nurses **do not** replace the need for doctors, they **assist** them to help free up more time for more consultative, diagnostic or more special therapeutic roles. This exercise should never be an exercise for economic or other purposes. Safety and Quality of healthcare must always be our prime concern.

Utilise our Extensive GP Network[13]

Our GP clinic network is extensive in the urban setting. All towns small and big have perhaps too many GP clinics. In major cities these are now highly competitive, even excessive and oversupplied. Many clinics have concerns of viability and

under-utilisation. Perhaps, some of these are not sufficiently popular because of poor preparation or other reasons, but most can be improved upon with proper distribution or dispersal of patients.

Therefore, many GPs have asked why they have not been roped in to help out in these clinics for the poor, if only the MOH or government can help reimburse these clinics to help out. We understand the differences in expectations, amenities and perhaps problems with reimbursement protocols, but these can be worked out for the benefit of all.

Our GPs stand ready to be incorporated into a partnership, even an integrated system for better primary care for all our citizens.

But MOH concerns that some or most GPs are of unsure/unsound standards are unfounded and biased. Otherwise how is it that some 62.1% of Malaysians who need medical treatment, seek private primary care consultations in the first instance? (2006 National Health and Morbidity Survey)

The MMA is leading a primary healthcare workgroup to further coordinate measures to raise the standards and quality of patient care among all our GPs and/or family physicians.[14] This will enhance the quality of care even higher for our citizens. We are also working with the MOH to see how we partner or integrate the primary health care system in the country. Again differing standards of expectations, logistics and reimbursement mechanisms need to be sorted out.

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