A CALL FOR PUBLIC-PRIVATE PARTNERSHIP IN MALAYSIAN HEALTHCARE

Noor Hazilah Abd Manaf* , Puteri Nemie Jahn Kassim**, Nurita Juhdi *

*Faculty of Economics and Management Sciences
**Faculty of Laws
International Islamic University Malaysia

Introduction- Healthcare at a glance

- Malaysian healthcare often regarded as a model for other developing countries
- Total expenditure on health as a percentage of GDP was 4.30% in 2011
- Life expectancy is 74.7 years; ie 72.6 years male and 77.2 years female; infant mortality rate is 6 per thousand life births
- Public healthcare highly accessible - nominal fee RM1 (USD 0.30) for outpatient inclusive medication; geographical access - healthcare facilities within five kilometre radius (Chua and Cheah, 2012).

- Private hospitals in urban areas mainly in Kuala Lumpur, Penang and Malacca – more affluent middle class
- 144 public hospitals and 187 private hospitals serving a population of 30 million
- Ministry of Health (MOH) still main provider of healthcare with 41,995 beds while private sector 13,957 beds
- Increased privatisation of healthcare services since 80s encouraged by government privatisation policy
- Distinct dichotomy between public and private hospitals and related issues

Human resource in healthcare

- Private sector development has not grown in tandem with national aspirations
- Distribution of medical specialists is currently lopsided
- About 30 percent of country's medical specialists are serving in public sector which has 70 percent of country's hospital beds; reverse for private sector
- Privatisation policy and medical tourism led to further outflow of health professionals from public to private sector

Table 1: Attrition among Doctors and Dentists in MOH

Category	2005	2006	2007	2008
Doctors	401	248	300	478
Dentists	56	78	107	77
Total	457	326	407	555

Source: Country Health Plan (2011-2015), MOH.

Better pay and working condition and less workload in private sector

- Human resource in healthcare mainly financed by government from undergraduate medical education to specialist training
- Public universities main provider for medical education and government scholarships for specialist training
- Doctors in public hospitals continuously upgrade knowledge and skills supported by government
- Private hospitals do not invest in training of medical specialists
- Rather, they get supply from public hospitals and contracted as independent suppliers of service to the hospitals
- Provide curative treatment and do not engage in research

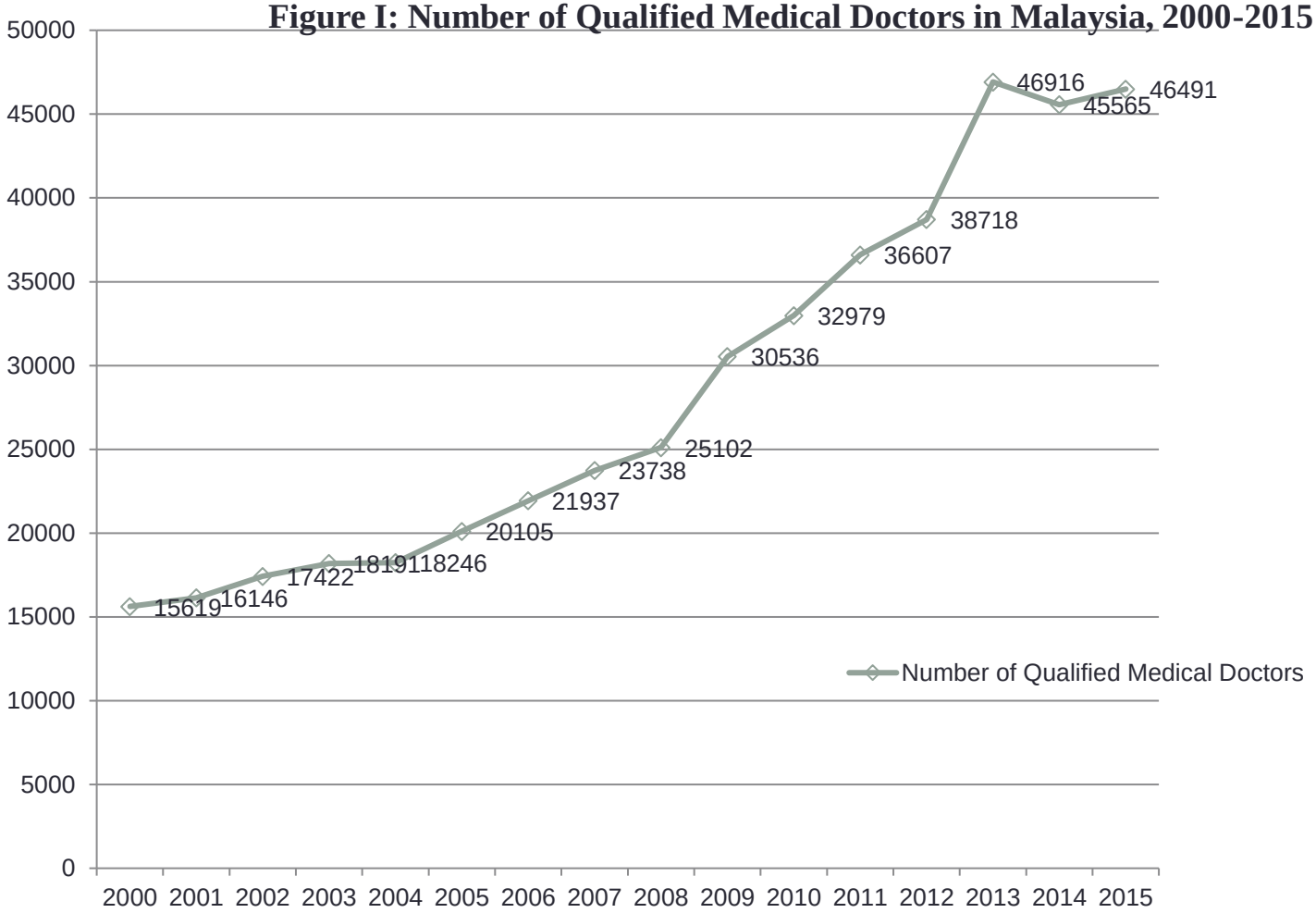
- Medical consultants who left for private sector are highly skilled; a waste when they do not continue with research and advance the field of medicine
- Loss to country because training required to produce medical specialists are mainly financed by government
- Need for medical specialists to continue their work in medical innovation and research although in private sector – academic health centre
- AHC has tripartite mission of research, education and medical care

- If private hospitals are to function as academic health centres, skills and expertise of medical consultants there can be directed towards leading medical research and innovation.
- public-private network extended to include medical research between the two dichotomous entities.

Medical education and training

- Medical education is a strategic issue - healthcare identified as key economic area through medical tourism.
- Rapid increase in medical schools for the past few years- freeze on new medical schools from 2016 to 2021
- 32 medical schools and selected recognised medical qualifications from abroad
- Produce about 5000 medical graduates a year
- More private medical schools at 2 to 1 ratio
- Has quality of medical graduates been compromised with rapid increase in number of medical schools?

Figure I: Number of Qualified Medical Doctors in Malaysia, 2000-2015



Source: Health Indicators, Ministry of Health Malaysia, cited from Han (2017).

- Rapid increase in medical schools tied to country's drive to be hub for education in the region
- But internationalisation of medical training did not take place as planned as almost all places taken up by local students, both sponsored and self-funded
- In 2008, housemanship period was extended from one year to two years – six department rotation
- Influx of housemen into training system as number of training hospitals did not increase proportionately
- In 2009, 38 public hospitals designated for housemanship training, but government only able to increase to 44 in 2015

- Affects waiting time for a medical graduate to get placement for housemanship, which in recent years increased from six months to a year.
- Pressure also faced by training hospitals which have to deal with a large number of housemen at same time.
- Less medical cases
- In 1980s, ratio of housemen to patient beds was 1:20; but by 2013 the ratio has gone down to 1: 3
- Call for need to assure quality by various stakeholders

- Housemanship provides foundation for skills and competence as new doctors, under supervision, put into daily practice knowledge, skills, behaviours and attitudes learnt as medical students (Goldacre et al, 2010)
- Inadequate supervision one of predictors of medical errors among housemen, apart from inadequate knowledge and distraction (Manaf, 2018)
- Problem too many medical graduates and not enough medical specialists in public training hospitals to supervise
- It takes a long time to produce a medical specialist
- For the long run there is a need for the country to reassess strategic direction with regard to medical education and training

- Stop-gap measure to address dire need to ease the congestion in the housemen system
- Ministry of Health is limited in its capacity to increase number of training hospitals within a short space of time
- highlights opportunity for a public-private partnership by allowing private hospitals to conduct housemanship training
- Australia-Commonwealth Medical Internship (CMI) initiative
- Pharmacy – one year Provisionally Registered Pharmacist (PRP) training in private facilities recognised by Pharmacy Board Malaysia.

- 70% country’s medical specialists are serving private hospitals which has 30% percent of the country’s hospital beds
- The private hospitals may also consider recruiting housemen upon completion of their training rather than pinching from the public hospitals
- Enable private hospitals to take a more proactive role in capacity building, paving the way towards the academic health centre model.

Conclusion

- Malaysian healthcare - distinct public-private dichotomy and shifting from public sector dominance to an increasing significance of private sector
- effect of internal brain drain where medical specialists and other health professionals leave public sector for private hospitals
- curative nature of service of private hospitals does not require their physicians to engage in research and development – waste of resources
- public-private partnership in research through AHCs
- AHC- tripartite mission of research, education and medical care

- Engagement of private hospitals in education can be achieved by providing housemanship training for medical graduates
- This will ease congestion in housemen system and contribute towards assuring quality in our healthcare system.

Thank you