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Cut the Queue: A Basket of Solutions for Malaysian Hospitals

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Executive Summary

- Long queues in Malaysian public hospitals are caused by increased demand for subsidised healthcare, reduced or inequitable supply of healthcare, and system inefficiencies
- As the causes of long queues are complex and multi-factorial, a basket of solutions is necessary. Alongside real-world challenges of resource allocation and prioritisation of solutions, there may also be unintended consequences
- Encouraging self-reliance, education on the role of a public hospital, and negotiating a new healthcare social contract are challenging, but necessary to the success of that basket of solutions
- Malaysians must therefore realise that there is no magic solution, and must accept their civic duty to also be part of the solution

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Introduction

The long queues to obtain treatment in Malaysian public hospitals, clinics and hospital Emergency Departments probably cause the most public complaints, even without accounting for the medical, physical, emotional and financial toll of delayed treatment. This paper reviews the complex causes behind these long queues, including analysing non-obvious reasons. There is a basket of solutions that are all equally important, but contain trade-offs and compromises that will take time to be effective. The public should understand these trade-offs, as well as recognise and accept their civic duty to be part of the solution.

Multi-factorial Causes for A Complex Issue

Long queues in public hospitals are caused by increased demand for subsidised healthcare, reduced or inequitable supply of it, and system inefficiencies. A clear sign of increased demand is our larger and increasingly aging population that brings more complicated and longer-lasting diseases, giving rise to new terms like multi-morbidity and poly-pharmacy.

Secondly, the prevalence of non-communicable lifestyle diseases (e.g. diabetes, hypertension, heart disease, arthritis) is rising, driven by society's new habits of (over-)consumption and sedentary lives. Thirdly, society has higher expectations for a healthy, pain-free and inconvenience-free existence, especially in today's one-tap-on-a-smartphone world that values instant gratification.

Indeed, there could even be a lack of faith in junior doctors, thus many patients prefer to wait for specialists. More controversially, it is possible that cheap access fees of RM1 and RM5 for outpatient services in the public sector lead to unnecessary consumption of healthcare, as citizens lower their threshold to seek care. These factors visibly increase demand for healthcare, leading to longer queues.

The supply of healthcare in Malaysia may look stronger than we expect, but it still contains hidden challenges. The metrics of physician density and number of hospital beds may be helpful but they are imperfect indicators that should be examined. Although Malaysia doubled

its physician density from 0.7/1,000 population (in 2000) to 1.5/1,000 (in 2015)[1], a comparison point is with the OECD35 average of 3.4/1,000[2]. For specialists, the gap between Malaysia and OECD8 is even more significant: 3.4 specialists/1,000 population in Malaysia, compared to 14.1/1,000[3]. There are approximately 194 specialists and 3,500 house officers entering[3] the public sector annually, with 150 specialists leaving[4].

The number of hospital beds in Malaysia fell from 3.7 per 1,000 population (in 1960) to 1.9 per 1,000 population (in 2012). However, this should not cause alarm as it reflects a global trend attributable to fewer hospitalisations and serious illnesses, better technology and confidence enabling day-care procedures and reduced average lengths of stay. Consistently, bed numbers in OECD35 fell from 5.6/1,000 (in 2000) to 4.7/1,000 (in 2015)[5], and the world average fell from 4.1/1,000 (in 1985) to 2.9/1,000 (in 2005)[6]. In 2015 our public sector handled 60% of all outpatient consultations and 75% of all inpatient admissions,[7] utilising 76% of all doctors, 56% of all specialists and 75% of all hospital beds[3,4].

Although these numbers look good, supply challenges remain hidden through inefficient resource allocation that cause long queues. Firstly, more doctors, specialists and beds are allocated in Peninsular Malaysia, reducing supply in East Malaysia[3]. Secondly, the public sector disproportionately manages more complex cases requiring more specialist attention and resources (e.g. 56% of all specialists manage 75% of all inpatients, and the most common disease in public sector clinics is hypertension [33% of all visits] versus fever in private clinics [28%][8]).

Thirdly, while the public sector has more specialists compared to the private sector, the ones who remain in public service are increasingly more junior, which weakens the brain trust in the sector that needs it most. More controversially but less quantifiably, long queues could be just an unfair misperception. Penang and KL residents are the most dissatisfied with waiting times to see physicians (49.8% and 32.8% respectively, versus the national average of 25.8%[7]); this is despite Malaysia's two biggest cities probably having the highest absolute and relative number of specialists and doctors in public hospitals. Could this just be higher – or even unreasonable – expectations in a more demanding urban population that is better educated and richer?

System inefficiencies are the final piece of the long-queue puzzle. A patient's journey through the system encounters many unnecessary steps, paperwork, bottlenecks and waiting

[1] http://apps.who.int/gho/data/node.main.A1444, accessed 5 Apr 2019.
[2] https://www.oecd.org/els/health-systems/Health-at-a-Glance-2017-Chartset.pdf, accessed 5 Apr 2019.
[3] Human Resources For Health, Country Profiles 2015 Malaysia. Planning Division, MOH Malaysia.
[4] https://today.mims.com/moh--150-specialists-leave-public-sector-in-malaysia-every-year, accessed 5 Apr 2019.
[5] OECD (2017), Health at a Glance 2017: OECD Indicators, OECD Publishing, Paris.
[6] https://data.worldbank.org/indicator/SH.MED.BEDS.ZS?view=chart, accessed 5 Apr 2019.
[7] National Health and Morbidity Survey 2015. Institute of Public Health, MOH Malaysia.
[8] National Medical Care Statistics (NMCS) 2014. National Clinical Research Centre, MOH Malaysia.

periods[9]. Some of these are due to volume, but large parts of it are also due to the system, building layouts, or processes refined in the 1980s and 1990s that are no longer fit for purpose today.

Other unseen inefficiencies are the inordinate number of meetings, trainings and courses that are mandatory for physicians (the more senior, the more meetings), a lack of integration between hospitals and primary care clinics (worsened by a defensive tendency for primary care clinics to refer to specialist centres "just in case" and a tendency for specialists to "see a patient in six months' time" instead of discharging a stable patient to the periphery), and the impact of over-specialisation where one patient has six appointments (one specialist respectively for the heart, diabetes, kidney, skin, and eyes, and a poor general physician juggling five specialist prescriptions).

A Basket of Obvious Solutions

We can easily create a basket of solutions to address each individual cause described above. Firstly, demand for healthcare can be optimised through disease prevention, public awareness campaigns and appropriate patient education. Simultaneously, we train more doctors and specialists, improve the terms of service to retain specialists, reduce meetings and incentivise them to work in Sabah and Sarawak with better allowances and training opportunities.

In parallel, the Ministry of Health (MOH) should allocate a greater amount of capital expenditure for more hospitals and clinics. Additionally, efficiencies can be gained by introducing e-health records that reduce paperwork and increase effective communication between the hospital and clinics; pharmacy fast-tracks for senior citizens, clinic shift systems and weekend clinics that reduce waiting time; integrating specialties into a "Combined Clinic" approach; and more specialist-generalists (e.g. the training for General Internal Medicine) to reduce the number of appointments for each patient. Furthermore, we can consult Six Sigma Black Belts, Japan Inc.'s kaizen and just-in-time philosophy, or even McLaren's F1 team[10].

These comprehensive approaches will not only solve long queues, but aid in solving other challenges like a demoralised healthcare workforce, overcrowding in hospitals, the specialist brain drain, and a fiscal deficit – killing many birds with one stone. Unfortunately, reality requires trade-offs. Our ideal scenario requires limitless funding, political capital and organisational energy. Scarce resources will always have to be replenished, and priorities established. Increasing MOH's funds is thus necessary, realising that every Ringgit diverted to health is one Ringgit less for education, rural electrification, improving national food security, or just managing our sovereign debt; all of which also improve health outcomes.

[9] Pillay MS et al. "Hospital waiting time: the forgotten premise of healthcare service delivery?". International Journal of Health Care Quality Assurance. 24, 7 (2011) 506-522

[10] https://www.mclaren.org/main/pediatrics-program.aspx, accessed 5 Apr 2019.

Ideally, our basket of solutions should be implemented together, but it is unclear which should be implemented first or funded most. Even if it is, each of them has their own limitations, and in some cases, a high likelihood of unintended consequences. For example, while we need more doctors, there is an ongoing debate about the quality of graduating doctors, robustness of medical schools, and the stress on public sector specialists to train more junior doctors on top of seeing more patients.

Secondly, it is also uncertain that we will need more hospital beds in a future that should feature higher number of outpatients, ambulatory and day-care services, as well as community care; the reality is that opening a hospital is a politically-glamourous act, but may not be the most technically-appropriate decision. Thirdly, it assumes that money alone will incentivise any doctor, when the workload and unreasonable expectations, stifling bureaucracy, desire for due recognition via research, publications and lectures, and the ability to influence national policy are equally powerful motivations. Money alone for senior clinicians may even be perceived as insulting to their decades of service.

Bitter Remedies Remain Necessary

Our basket of solutions must also consider three politically unpopular, but necessary solutions. The first is to encourage self-reliance by examining the possibility of a modest increase in the RM1 and RM5 user fees which remain unchanged since 1982. Since then, government healthcare spending has increased by 607%[11], average consumer prices by 248%[12] and GDP/capita by 537%[13]. With fees like these, it is unsurprising that Malaysians take public healthcare for granted and demand healthcare arbitrarily. Such low access fees encourage citizens to believe that the government shoulders the responsibility of their health and welfare, thereby discouraging even moderate amounts of self-reliance.

While it is true that a government must protect its citizens, mathematical realities mean that we face a choice as a Malaysian society at a time when our national healthcare bill is unsustainable: either increase the tax base, allocate more spending to healthcare, or modestly increase the user fees. Any modest increase will reduce moral hazards in the system, with additional revenues visibly shifted to patients who need large sums for catastrophic illnesses such as a knee implant or a heart stent. Any increase in user fees must also involve a strengthened social safety net, more effective means-testing and strong surveillance to detect patients who are deterred from seeking treatment. The B40 will not be affected by this increase as they are already exempted from paying the existing RM1 and RM5 fees anyway[14]. The possibility of a modest increase will be analysed more fully in a separate policy brief.

[11] National Health Accounts Unit Planning Division (2016). Health Expenditure Report 1997-2014. Kuala Lumpur: Ministry of Health Malaysia.
[12] World Bank, Consumer Price Index data.
[13] World Bank data, GDP/capita in current USD.
[14] Interviews with Unit Hasil at two public health facilities. No published data is found for percentage of citizens who do not pay access fees due to financial constraints.

A second necessary solution is to educate the public about the fundamental role of public hospitals as a curative, and not a nursing home. Unfortunately, anecdotal evidence and the author's personal experience is that the hospital is becoming a long-term care facility for those unable or unwilling to care for their parents or loved ones. This is a symptom of our increasingly long lives, fraying familial bonds and a possible lack of emotional and financial resilience in Malaysian families. It also portrays Malaysia's inadequacy in allocating public-private provision of long-term care for patients with long-term disabilities or diseases. Public hospitals are currently fulfilling a moral duty by housing citizens who are fit for discharge back to society, but the medical risk of hospital-acquired infections and moral risk of denying someone else a needed bed loom as large as long queues. The need for long-term and aged care will also be analysed more fully in a separate policy brief.

Finally, our basket of solutions for long queues will benefit from an open conversation with Malaysians, and possibly a new healthcare social contract with clearly-defined responsibilities for everyone. However, the conversation will require actual data, rather than being based on the perceptions, whims and feelings of agitated individuals. The data should inspire a sense of civic duty because long queues are equally caused by those seeking an instant cure for a minor flu in the Emergency Department, those loudly demanding a specialist and an urgent MRI to definitively rule out a cancer for their two-day headache, and those who unreasonably insist on the most expensive medication for the most trivial of complaints. This conversation, although uncomfortable, will be necessary as it forces citizens to accept that they may actually be clogging up the system, and are therefore a part of the problem they are concerned about.

In a single-payer system with universal coverage and low user fees, queues will naturally form (the British NHS is plagued by complaints about queues). There are many easy wins and low-hanging fruits that the MOH alone can accomplish. However, without magic solutions, everyone must play a role and fulfil their civic duty in a patient and realistic manner. All citizens have a stake and a duty in ensuring that queues do not become a form of unfair rationing, the most unjust outcome imaginable.

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