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Bridging Barriers:

A Report on Improving Access to

Mental Healthcare in Malaysia

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making ideas work

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Last but not least, the author gives God the glory for the completion of the research into mental health in the country. Though a drop in the ocean, it is hoped that this work will be read not just by those involved in mental health, but by the public at large, and contribute towards better understanding on mental disorders, and destigmatizing mental illness.

This report is dedicated to all persons living with mental illness, to encourage them as they journey through life in recovery, filled with trials and struggles, acceptance and hope. Above all, it is hoped that the information contained in this report may empower them to seek treatment without fear of judgement, and to keep moving forward with a sense hope and purpose.

Introduction

In 1974, the late Thomas Szasz wrote a treatise called “The Myth of Mental Illness”, a scathing rebuke of psychiatry and the ‘vague, capricious and generally unsatisfactory character of the widely used concept of mental illness and its corollaries, diagnosis, prognosis and treatment.’

Ironically, though he was an established psychiatrist, Szasz had written many books throughout his life scorning mental disorders as invalid illnesses, as compared to physical disease. His argument was that mental disorders, unlike malfunctions of the human body, relied on subjective judgements of misbehaviour and misconduct. These were relative traits that lent themselves to subjective diagnoses, instead of diagnoses grounded in physical and objective fact. In one of his searing critiques, Szasz had even called mental illness an invented concept and a ‘convenient myth’.

Following Szasz’s logic, and by extension, the reasoning of the Enlightenment forefathers, mental illness is indeed a difficult concept to pin down and measure. According to this logic, in order to pass off as a genuine disease, the entity must somehow be capable of being approached, measured or tested in scientific fashion. While science has granted humans the ability to objectively trace and define physical malfunctioning, scoping out the terrain of ‘diseases of the mind’ is admittedly much harder.

What truly counts as sickness and what is merely within the usual range of variations from normal behaviour? The American Psychiatric Association has produced up to five editions of the Diagnostic and Statistical Manual (DSM), which provides descriptions of various disorders, syndromes and character traits. (The WHO maintains its own definition system, called the International Classification of Diseases, or ICD). In each edition, some disorders are removed and others added. The categories of description assigned to symptoms too, are subject to revision and change.

In some ways, it might be understandable why Szasz, and other critics of mental illness, have taken such a sceptical approach. In the changeability of definitions and symptoms, there appears to be no proper understanding of mental illness, even by qualified doctors and professionals. Moreover, the symptoms not only change over time but by region and culture. In certain societies, special experiences like hearing voices or speaking in tongues is considered normal- even desirable- but in others, it is deemed a deviant and unacceptable trait.

In the absence of ‘objective’ definitions, however, it can be easy to lose sight of how debilitating the effects of poor mental well-being can be. The WHO uses the yardstick of “Disability-Adjusted Life Years” (DALYS) to measure the amount of healthy life lost due to ill-health, disability or early death. Previous estimates placed the global burden of mental illness at 7.1% - recent analyses suggests that the actual share of mental illness-related DALYs is 32.4%, a significant one-third of the overall health burden (Harvard School of Public Health).

Suicide rates are another form of measuring mental illness burden, and one that is apparently more ‘objective’. The WHO estimates that each year, approximately one million people die from suicide, equating to a global mortality rate of 16 people per 100,000 or one death every 40 seconds. The WHO

further states that over 90% of all suicide cases are associated with mental health disorders, particularly depression and substance abuse[1].

If the concept of mental illness is vague and elusive, one way that we might capture a better understanding is to frame it through the lens of health.

According to the WHO, mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.

Mental health exists on a continuum from healthy living to chronic illness. By and large, people with positive mental health are able to function successfully and engage in meaningful relationships with sense of purpose and a degree of self-confidence and self-reliance, while understanding and accepting their strengths and weaknesses.

Conversely, mental ill health emerges when a person's assets and skills are compromised due to alterations in thinking, mood and behaviour, leading to a struggle to cope with life's challenges and demands. When significant distress or impaired functioning happens for a prolonged period, the onset of mental illness occurs.

Through the paradigm of health, a more heuristic definition of mental illness becomes possible. Mental illness occurs when a person's positive mental health traits become outweighed by negative traits, creating an imbalance which significantly impacts his or her ability to function well in life.

Traditionally, most Asian-Pacific health systems neglected to place mental illness on par with physical health, but things have improved greatly over the last decade. In 2010, for example, Japan declared mental illness to be one of its five priority diseases and in 2012, China passed its first mental health law. Two years later, Indonesia significantly modernized its mental health legislation and India adopted its first mental health policy (The Economist Intelligence Unit).

In terms of its policy commitments to mental health, Malaysia has established a fairly good track record compared to other countries in the Asia-Pacific region. In 1998, the National Mental Health Policy was developed, aiming to promote mental health and reduce the prevalence of psychological problems "through providing treatment and rehabilitation for those with chronic disabilities and adequate and appropriate facilities for the care of clients."

Following this, the National Mental Health Service framework was established in 2001 as the official blueprint defining service models for psychiatric and mental health services, focussing on aspects such as psychiatric services for children and adolescents, adults, the elderly and people with special needs. Malaysia's current national operational policy document on mental health services (the Psychiatric and Mental Health Services Operational Policy) is a product of this framework.

[1] Notwithstanding, it should be remembered that suicide results from many complex sociocultural factors and may especially be precipitated during periods of socioeconomic, family and individual crisis.

Mental health services were further enshrined in the law through the setting up of the Mental Health Act (MHA) 2001. This Act had specific provisions for mental health care delivery in three types of facilities, namely psychiatry hospitals, psychiatry nursing homes and community mental health care centres (MENTARI). In particular, the MHA addressed patient rights through regulating various processes, and promoted the setting up of decentralized community services such as community mental health workers and teams, and psychiatry homes. Care in the private sector was also addressed, albeit to a lesser extent.

These policy choices appear to reflect a desire on the government's part to strengthen the accessibility and comprehensiveness of mental health services for the community at large.

Yet when it comes to actionable outcomes, there is much room for improvement. In spite of mental health policy advances, there are substantial barriers to treatment for the mentally ill. This report has identified three major gaps that exist in Malaysia, while acknowledging that there are many other issues and challenges which lie beyond the scope of the current research.

The first of these barriers is systemic, and pertains to the mental health workforce. The supply and distribution of mental health workers in government health care, especially psychiatrists and clinical psychologists, is problematic. Although the number of psychiatrists in Malaysia has increased over time, their distribution is uneven and heavily skewed towards urban centres. Clinical psychologists, on the other hand, are spread very thinly due to their critically low numbers. These shortages mean that certain states and rural areas are in dire lack of access to mental health services in public healthcare.

The second of these barriers is financial. Although treatment is largely affordable in government hospitals, staff shortages and other attendant issues often result in a compromised service standards, with issues ranging from long waiting periods to make an appointment to limited consultation hours with mental health specialists. By comparison, private mental health services offer a higher degree of privacy and better service standards, but treatment charges here are prohibitively expensive. With no health insurance coverage for mental health treatment, access to private healthcare is largely restricted for the lower socio-economic groups.

The third, 'invisible' barrier lies in the stigmatization of mental illness, a common phenomenon in many countries. In Malaysia, a country made up of various multi-ethnic groups, cultural and ethnic narratives tend to portray mental illness as a condition resulting from either a personal moral deficit, a lack of religious piety or both. Coupled with this, there is also a tendency to associate mental illness with weakness and failure to cope.

These negative stereotypes in turn create a loss of social standing, and discriminating attitudes towards the mentally ill. Of these, labelling and rejection are perhaps the most damaging in terms of discouraging the mentally ill from seeking treatment, as they would not want to be associated with the disease.

This report begins with a perspective of the state of mental health in Malaysia, as provided by national surveys on the prevalence and socio-demographic patterns of mental illness in the population. Next, it describes the different tiers of mental health services delivery, including in hospitals, primary care and community settings, and evaluates the demand for these services in the public healthcare sector.

The report will then outline key barriers to accessing mental health services. It will argue that barriers exist both from a health provider standpoint, in the shortage of mental health workers, as well as from the patient perspective, in terms of steep healthcare costs and social exclusion associated with having a mental illness.

Each of these barriers will be examined and discussed in greater detail. Finally, the report will suggest actionable policy recommendations to address these problems.

Though it is by no means an exhaustive analysis, it is hoped that the information presented here will serve as an introductory primer for policymakers to understand the issues linked to access to mental health services in Malaysia, and that the knowledge derived will be useful to advocate for improvement in the areas outlined.

Above all, it is hoped that these findings will help promote greater awareness and acceptance of mental health issues in Malaysia and improve the availability and accessibility of quality mental health care to all individuals in need.

Executive Summary

Workforce Shortages in Government Mental Health Services

- Shortage of psychiatrists and clinical psychologists in government hospitals.
- Different driving factors for each group:

Psychiatrists

- Psychiatry unpopular as a chosen career among medical students, due to:
  -negative perceptions on the nature of psychiatric work (working with 'crazy' people)
  -reluctance to invest long years of education and training into obtaining specialist qualifications

Clinical Psychologists

- Limited vacancies for clinical psychology officers in government hospitals.
- 'Three-in-one' hiring conundrum that combines recruitment of counsellors, psychologists and clinical psychologists into a single position

Financial Costs

- Expensive treatment charges in private healthcare creates a barrier to access for poorer groups
- Treatment is largely affordable in government hospitals but quality of service is compromised by staffing shortages and other factors.
- Patients have no choice but to pay out-of-pocket as private health insurance providers do not offer cover for mental health treatment.

Stigma and Discrimination

- Workers who have a mental illness face discrimination in the workplace, particularly in employers' hiring and retaining practices
- In wider society, embedded cultural narratives have given rise to certain negative perceptions of mental illness among the major ethnic groups.
- Generally speaking, mental illness tends to be construed as:
  -a negative character trait, usually linked to moral or religious deficit
  -a mark of personal weakness; a failure to 'cope' that is associated with social disgrace or discredit

PART ONE: THE STATE OF MENTAL HEALTH IN MALAYSIA

1.0. Examining the Prevalence of Mental Illness in Malaysia

1.1. The National Health and Morbidity Surveys (NHMS) and the 12-item General Health Questionnaire (GHQ-12)

In the context of evaluating the mental health care system, it is important to have some awareness of the extent to which mental health services are required by the population.

To the author's best knowledge, a definitive study of mental health needs in the Malaysian population has not been carried out. However, certain national studies on the epidemiology of population health in Malaysia may offer some degree of insight.

Once every four years[2], the Malaysian government routinely collects detailed information on health-related behaviours and health demands of the population (including mental health) based on a nationally representative population sample.

These national surveys, called the National Health and Morbidity Surveys (NHMS), undertake to measure several aspects of health, including the psychological well-being of the Malaysian population. Different screening tools have been used in different NHMS cycles to measure and assess psychological well-being.

In the NHMS 2015, the 12-item version of the General Health Questionnaire (GHQ-12) was used as a screening tool. This questionnaire is made up of 12 statements related to mental health, comprising a mixture of positively phrased and negatively phrased items.

The binary scoring method is used, with the two least symptomatic answers scoring 0 and the two most symptomatic answers scoring 1. In NHMS 2015, the threshold level for achieving 'caseness' was set at a score of 3 and above. A respondent who achieves this score is considered extremely likely to be diagnosed with a (non-psychotic) mental disorder if he or she were to be examined by a mental health professional.

One limitation of using the GHQ-12 as a screening tool is the ambiguous wording of response choices to question items. For example, the response choices to statements such as 'felt constantly under strain' are: 'Not at all', 'No more than usual', 'Rather more than usual' and 'Much more than usual.'

'Not at all' and 'No more than usual' are fairly non-specific responses that may have posed difficulty to respondents wishing to indicate the absence of a negative mood state. Likewise, respondents wishing to indicate the presence of a negative mood may have found it hard to distinguish between choosing 'Rather more than usual' and 'much more than usual' as a response.

[2] First initiated by the Health Ministry in 1986, the NHMS was initially conducted at an interval of once every 10 years. Since 2011, this interval was shortened from a 10 to 4 year cycle, with the most recent completed iteration being the NHMS 2015.

In some cases, researchers who use GHQ-12 include a scoring 'buffer' that eliminates this ambiguity. This method uses a two-point response scale where both 'Not at all' and 'No more than usual' responses are lumped together under the same category of an 'absent' response.

However, in the NHMS 2015, a four-point response scale, or the 'Likert method' was used. This method assigns a numerical value to each response, based on the assumption that the intensity of experience is modelled on a continuum (in this case, from 'not at all' to 'much more than usual').

The drawback of the Likert Scale attitude measurement, as discussed above, is that respondents may find it hard to match the degree of intensity of their experiences to the given scale. Secondly, the Likert Scale method also has potential to be compromised due to response bias, whereby out of a desire to remain 'socially acceptable', respondents may lie to put themselves in a positive light.

Nevertheless, in spite of these limitations, the GHQ-12 is still a useful screening tool to estimate the prevalence of mental health problems in a population. Its utility lies in detecting probabilistic cases of mental illness, where positively tested individuals face a high risk of developing a (non-psychotic) mental disorder.

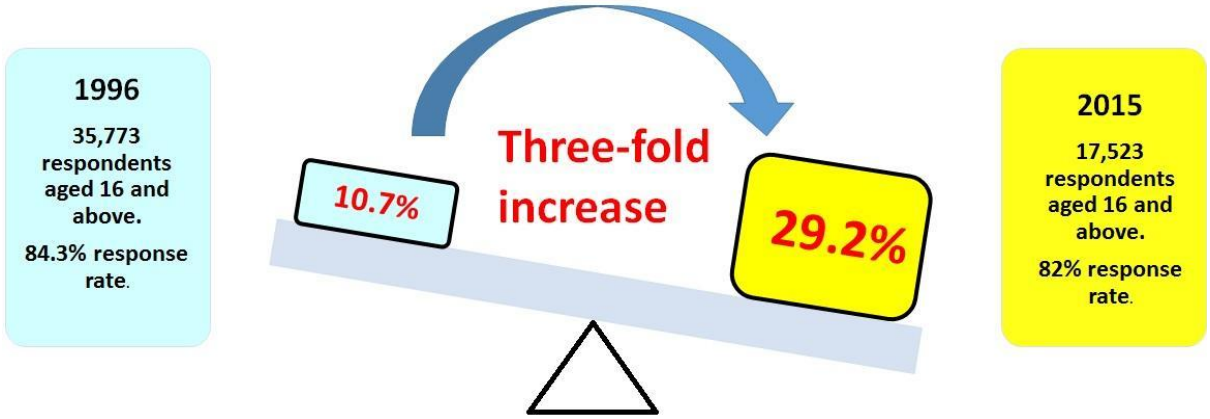
1.2. Patterns of Mental Illness in Malaysia based on the 1996 and 2015 NHMS surveys

The best sources of data that we have to study the epidemiology of mental illness are the NHMS 1996 and NHMS 2015. Both national surveys had investigated the prevalence and socio-demographic trends associated with mental illness among adult Malaysians, by distributing the GHQ-12 to respondents in community settings, using sampling designs that were nationally representative.

Besides NHMS 1996 and NHMS 2015, two more NHMS cycles were carried out between the years 1996 and 2015. However, from a methodological point of view, it is best to compare the 1996 and 2015 versions, as these had used the same type of screening tool (GHQ-12) to survey psychological trends. Studying these two reports is also useful as it gives us a longitudinal perspective of mental health patterns in the community.

1.3. Prevalence trends of Mental Health Problems

Figure 1: Comparison of Prevalence of Mental Health Problems in Respondents Aged 16 and Above Between 1996 and 2015



Source: National Health and Morbidity Survey 1996, Volume 6: Psychiatric Morbidity in Adults and National Health and Morbidity Survey 2015, Volume II Chapter 7: Mental Health Problems of Adults

In 1996, 10.7% of the Malaysian population aged 16 and above were found to be in a state of psychological ill health. In other words, approximately around one in nine adults surveyed using the GHQ-12 met the criteria for a non-specific minor psychiatric disorder.

In recent years, this ratio of one-in-nine has shrunk to worrying proportions. The NHMS 2015 found that approximately 29.2 %, or one in three, adult Malaysians were suffering from mental health problems and at risk of developing a diagnosable mental illness.

Plugging these percentages into actual population figures, the total number of adults in Malaysia who were estimated to be 'at-risk' of developing mental disorders numbered 4,206,697 cases in 2015. This is a significant increase from 1996, when the estimated number was around 2,249,493 cases[3].

The rise from 10.7% to 29.2% indicates a statistically significant increase in reporting of mental health problems among Malaysians between the two decades. As the NHMS 2015 report analysis pointed out, 'the prevalence of mental health problems among adults (has) shown an increasing trend.'

Some caution should be exercised when interpreting these results. Firstly, it should be remembered that the GHQ-12 questionnaire used in both NHMS surveys is designed to detect only very general mental

[3] The NHMS 1996 surveyed a total of 35,733 respondents aged 16 years and above, and collected 84.3% complete and valid responses for analysis. By comparison, the NHMS 2015 had a sample size of 20, 940 respondents and an 82% response rate. Though the sample size of the NHMS 2015 was slightly smaller than NHMS 1996, response rates in each sample were fairly similar, lending credence to our comparison.

health problems. It is not a diagnostic tool for specific mental disorders. Hence, 10.7% and 29.2% reflect the proportion of adults experiencing a state of psychological distress, rather than those suffering from clinically diagnosable mental disorders (although they too would be picked up as a sub-set of the'at-risk'group').

Secondly, the steep rise in prevalence rates between 1996 and 2015 could be attributed to increased awareness about mental health conditions in modern times, and a consequently higher level of disclosure of symptoms from respondents.

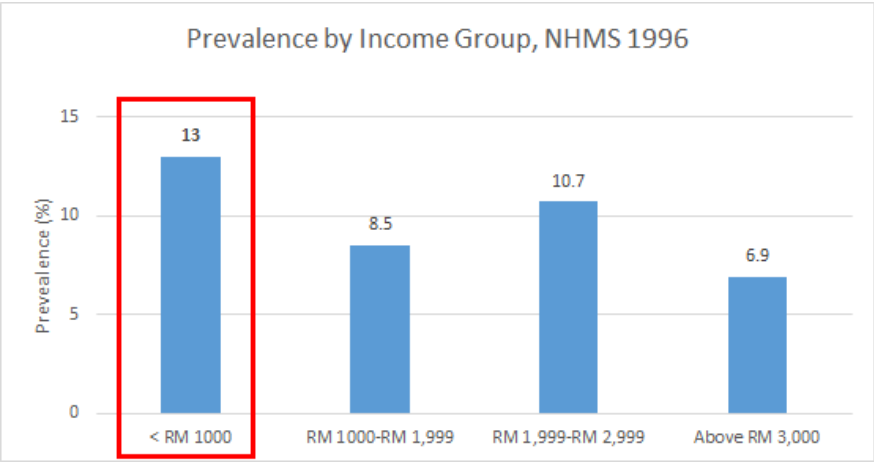
Notwithstanding these issues, a comparison of both NHMS results shows that psychological ill health among the adult population has indeed increased significantly over the span of the 19-year period.

1.4. Patterns of Mental Illness

Apart from measuring the overall prevalence of mental health problems in the general population, the NHMS 1996 and NHMS 2015 also studied prevalence among groups according to certain socio-demographic categories such income group, occupation, age, sex, and ethnicity. A comparison of results from both surveys are presented below to show how prevalence has changed over time. The possible factors driving trends in the past and present will be discussed.

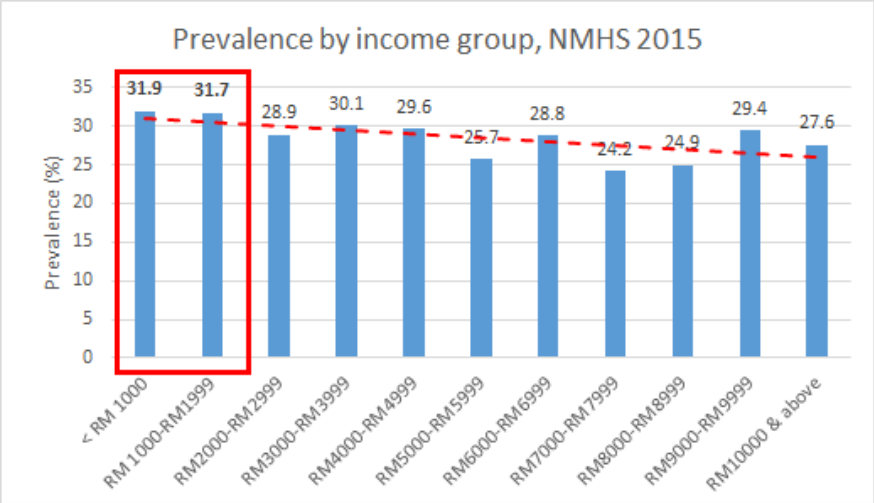
1.5. Income Group Prevalence

Figure 2: Prevalence of Mental Health Problems by Income Group in 1996



Source: Ministry of Health, Malaysia, National Health and Morbidity Survey, Psychiatric Mobility in Adults, pg. 35-38, 1996

Figure 3: Prevalence of Mental Health Problems by Income Group in 2015



Source: Ministry of Health, Malaysia, National Health and Morbidity Survey, Non-Communicable Diseases, Risk Factors and Other Health Problems, Vol. 2, pg. 188-189, 2015

Figure 2 and Figure 3 above show the prevalence rates of mental illness by income group in Malaysia for the years 1996 and 2015 respectively. It is interesting to note that for both years, the low-income group had consistently registered the highest prevalence rates. In 1996, individuals earning an average personal gross monthly income (purata pendapatan kasar) of below RM 1,000 had a significantly higher rate of mental health problems compared to the rest of the groups.

Likewise, in 2015, low income earners were also at a higher risk of developing mental health issues compared to other groups – nearly one third of individuals earning less than RM 1,000 and between RM 1,000- RM1,999 respectively were in a state of psychological ill health.

Another important point to note is the significant increase in prevalence rates of mental illness across all income groups. Between 1996 and 2015, mental illness prevalence among the groups earning less than RM 1,000 and between RM1,000-RM1,999 had increased by 2.5 times and 3.7 times respectively. Similarly, the higher income groups also experienced a high rise in prevalence rates. Compared to 1996, when merely 6.9% of the income group earning above RM 3000 were reportedly in a state of psychological distress, the 2015 prevalence rates for above RM 3000 income earners were much higher, with at least 24.2% suffering from poor mental health[4].

Comparing 1996 and 2015 prevalence among income groups, there are clear patterns of continuity and change. Firstly, the prevalence of mental health problems among low income groups has remained constantly high over the years, reflecting strong association between the risk of developing poor mental health and poverty as a social determinant. A likely reason for this is because financial insecurity creates

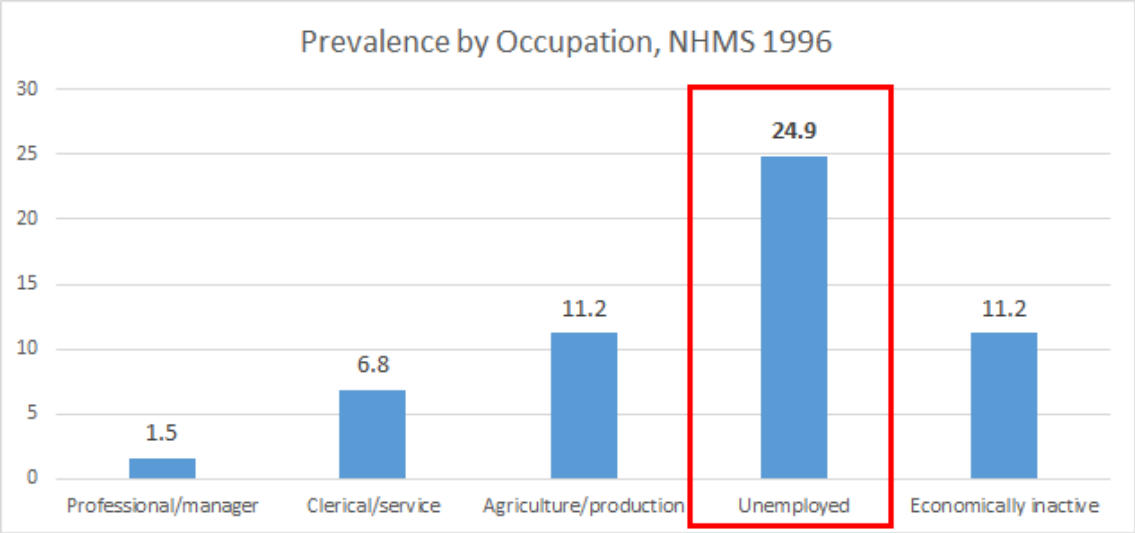
[4] Compared to NHMS 1996, the NMHS 2015 had a more detailed breakdown of income categories for the higher income levels, making it difficult to draw direct comparisons.

conditions of vulnerability, which in turn places a strain on mental health. More research is needed to uncover the factors linking poverty to poor mental health.

Secondly, compared to the past, the prevalence of mental health problems has risen significantly among high income earners. There suggests that there may be a different set of pressures which negatively impact mental well-being higher up the income scale.

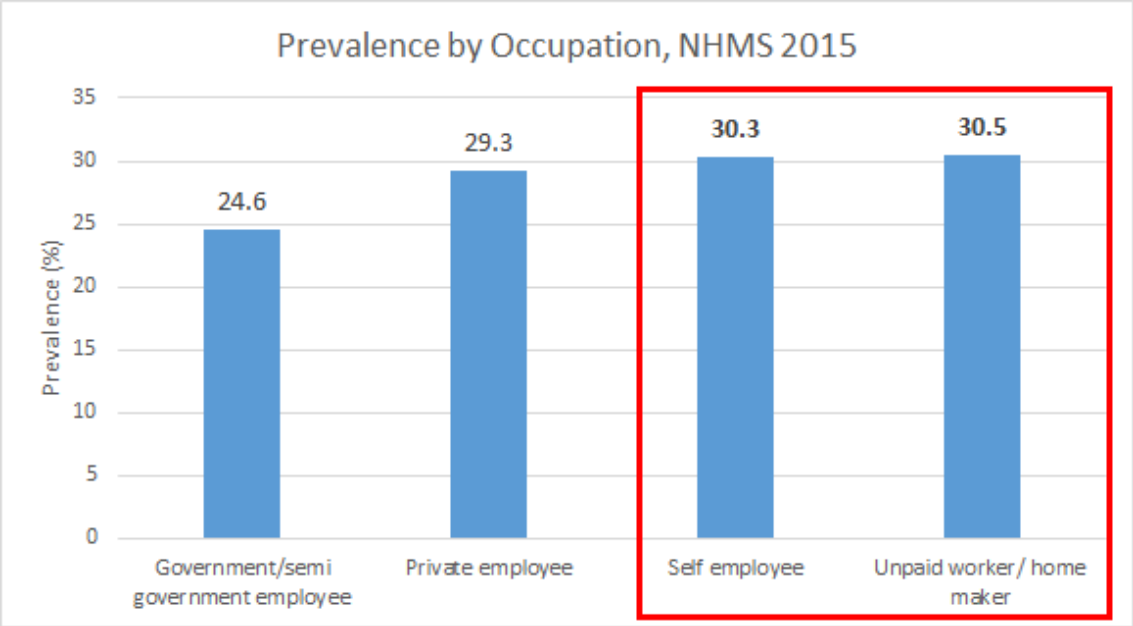
1.6. Occupational Prevalence

Figure 4: Prevalence of Mental Health Problems by Occupation in 1996



Source: Ministry of Health, Malaysia, National Health and Morbidity Survey, Psychiatric Mobility in Adults, pg. 35-38, 1996

Figure 5: Prevalence of Mental Health Problems by Occupation in 2015



Source: Ministry of Health, Malaysia, National Health and Morbidity Survey, Non-Communicable Diseases, Risk Factors and Other Health Problems, Vol. 2, pg. 188-189, 2015

In 1996, the prevalence of mental health problems fluctuated significantly across all occupational categories. Highest prevalence occurred among the unemployed group, at 24.9%. The unemployed reported disproportionate levels of mental health problems compared to other occupational groups. For example, only 11.2% of agriculture and production workers reported experiencing mental health problems, while for those working in the clerical and service line (6.8%) or as professionals/ managers (1.5%), prevalence levels were even lower.

By contrast, data for 2015 shows that prevalence rates were fairly uniform across all occupations. On a sliding scale, government and semi-government employees had the lowest prevalence rates at 24.6%, followed by private employees (29.3%) and a plateau of just above 30% among the self-employed and unpaid worker/homemaker groups.

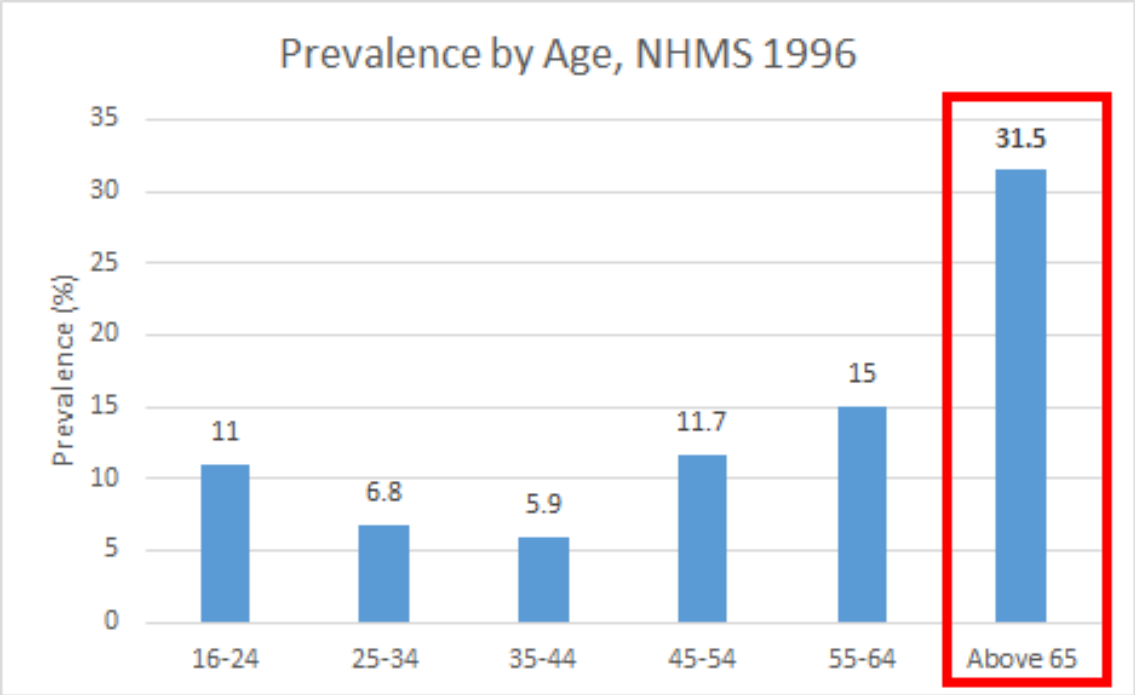
It is interesting to note that the self-employed and unpaid worker/homemaker groups had recorded the highest rates of mental illness prevalence. Unpaid workers, like the unemployed group in NHMS 1996, probably recorded high rates as they too would be in a state of financial insecurity[5]. However, more research is needed to understand the factors driving poor mental health among the self-employed and homemaker groups.

[5] NHMS 2015 did not include the unemployed group as a category of analysis.

Since the NHMS 1996 and NHMS 2015 use different grouping terms to classify occupations, it is difficult to draw comparisons for specific groups. However, in a broad sense, there has been a marked increase in mental illness prevalence rates across all occupational groups. Moreover, comparing the 1996 and 2015 results, it is immediately clear that threshold boundaries of mental illness prevalence have shifted immensely over the years. In 1996, mental illness prevalence ranged from as low as 1.9% to a maximum threshold mark of 24.9% among the different occupational groups. By comparison, in 2015, 24.6% was the lowest threshold mark recorded. This seems to suggest that the strain on mental health caused by work stress has increased, regardless of the occupational category.

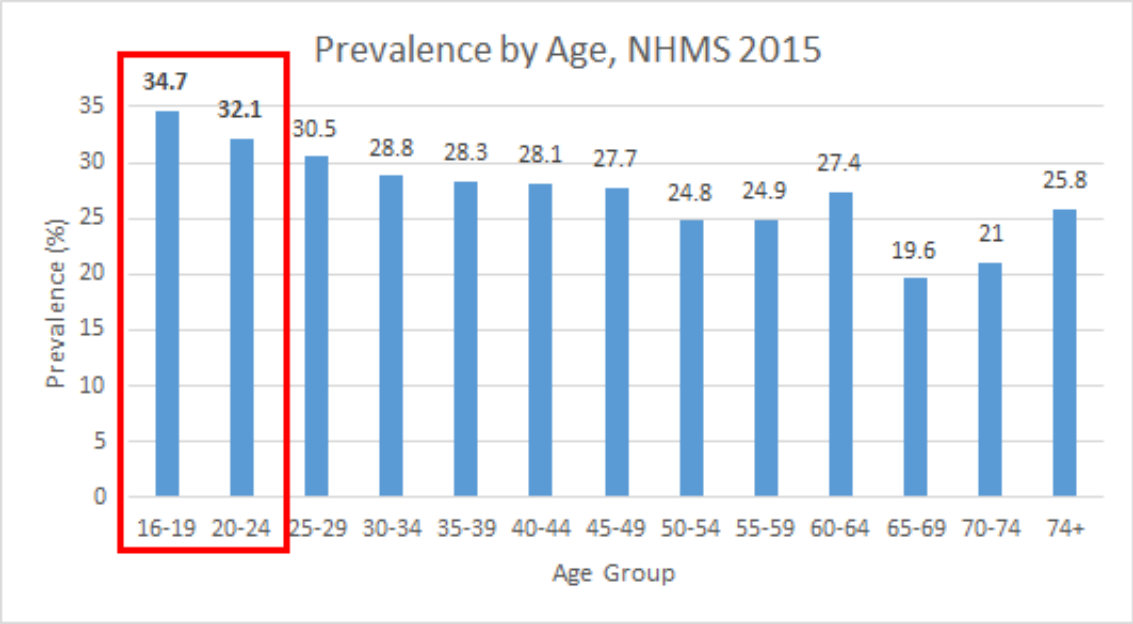
1.7. Age Group Prevalence

Figure 6: Prevalence of Mental Health Problems by Age in 1996



Source: Ministry of Health, Malaysia, National Health and Morbidity Survey, Psychiatric Mobility in Adults, pg. 35-38, 1996

Figure 7: Prevalence of Mental Health Problems by Age in 2015



Source: Ministry of Health, Malaysia, National Health and Morbidity Survey, Non-Communicable Diseases, Risk Factors and Other Health Problems, Vol. 2, pg. 188-189, 2015

Comparing the data for age-related mental illness prevalence rates, a number of interesting observations emerge.

In the past, the highest mental illness prevalence rates were recorded by the 'above 65' age group, at 31.5%. This figure was nearly six times that of the 35-44 group, which reported the lowest prevalence at 5.9%. Meanwhile the youth (16-24) and the middle-aged (45-54) groups recorded nearly identical prevalence rates of 11% and 11.7% respectively.

In the past, the older generation seemed more prone to developing mental illnesses. Over the years, however, it seems that the direction of the skew has changed. In 2015, it was the younger generation who reported the highest prevalence rates of mental illness. 34.7% of youth aged 16-19 and 32.1% of young adults aged 20-24 were found to have met the criteria for an unspecified mental illness.

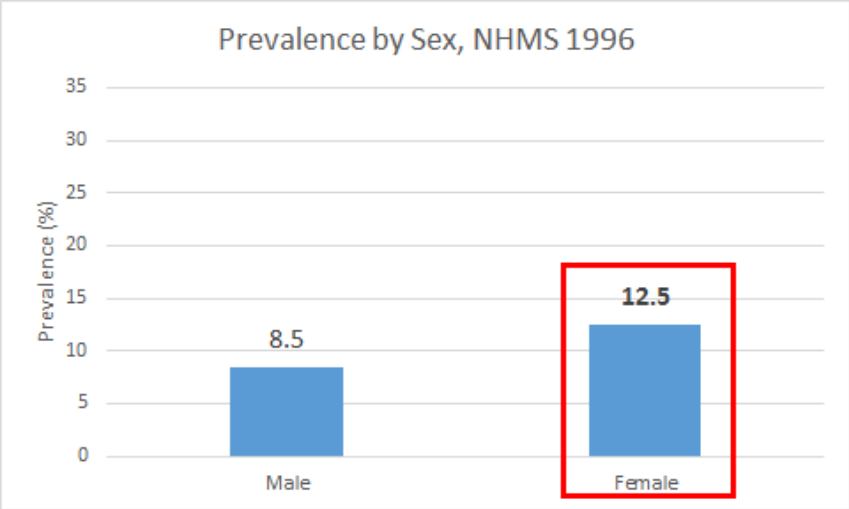
Furthermore, a comparison of both graphs shows that overall, prevalence rates have increased quite steeply across all age groups. Between 1996 and 2015, mental illness prevalence rates had tripled for the youth and young adult categories, whereas for the 35-44 age group, the increase was even larger, by fivefold.

While it was beyond the scope of this report to research further into mental illness among the youth, more research is urgently needed to understand this phenomenon and the underlying factors driving the spike in prevalence rates for this age group. For example, is greater awareness among the younger

generation on mental health issues driving part of this increase? Are academic and social pressures among the younger generation more acute compared to before, especially with the advent of social media?

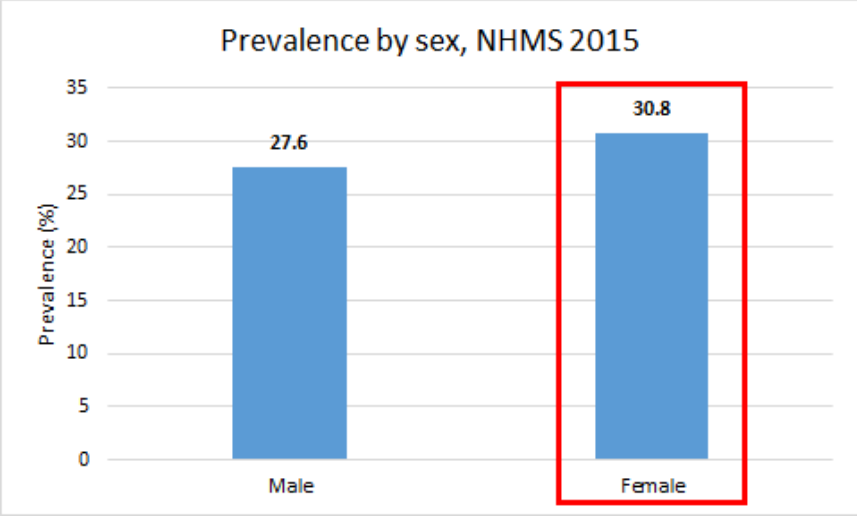
1.8. Sex-based Prevalence

Figure 8: Prevalence of Mental Health Problems by Sex in 1996



Source: Ministry of Health, Malaysia, National Health and Morbidity Survey, Psychiatric Mobility in Adults, pg. 35-38, 1996

Figure 9: Prevalence of Mental Health Problems by Sex in 2015



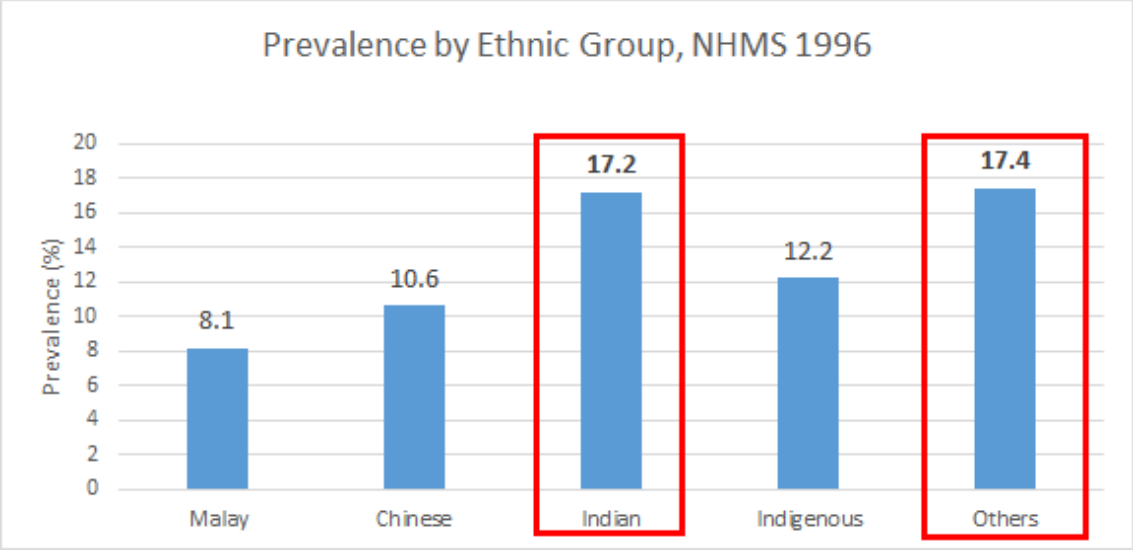
Source: Ministry of Health, Malaysia, National Health and Morbidity Survey, Non-Communicable Diseases, Risk Factors and Other Health Problems, Vol. 2, pg. 188-189, 2015

Comparing the data for sex-related prevalence in 1996 and 2015, women consistently reported higher prevalence rates for mental health issues versus men. However, the difference in prevalence rates between both sexes was fairly minor, and the range of difference did not change significantly over the years. In 1996, the male: female prevalence ratio was at 1: 1.5. This ratio decreased slightly to 1: 1.1 in 2015.

In 1996, approximately one in eight women and one in twelve men were estimated to suffer from mental ill health. In 2015, the ratio of mentally unwell men and women shrunk to one in three, reflecting the proportion of prevalence of mental health problems in the population.

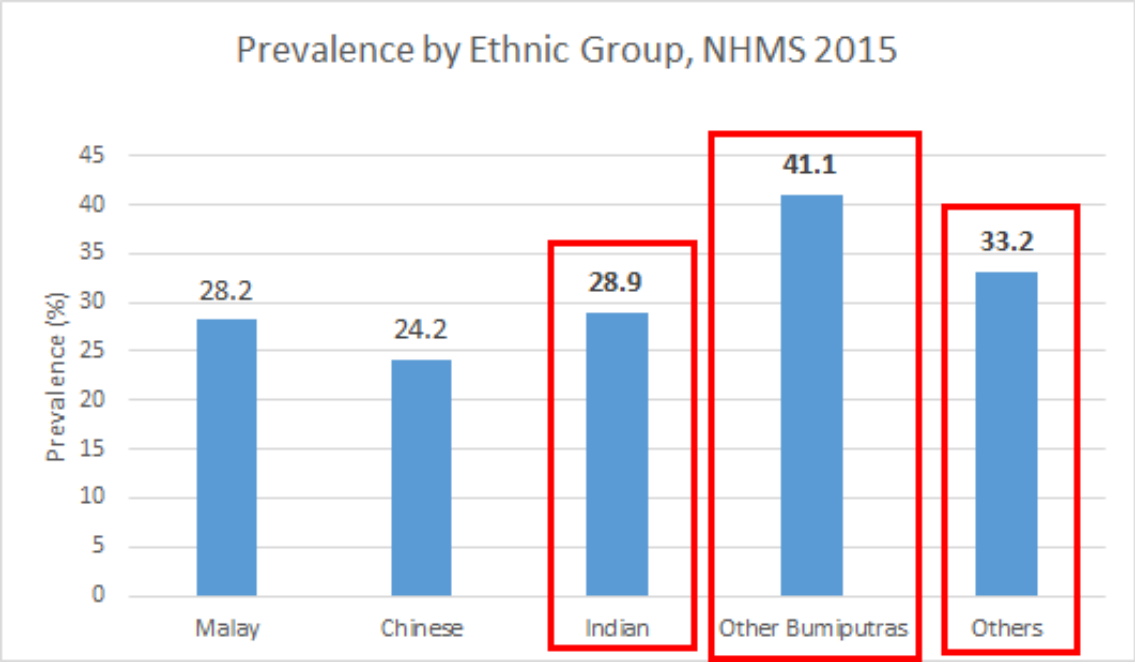
1.9. Ethnic Group Prevalence

Figure 10: Prevalence of Mental Health Problems by Ethnic Group in 1996



Source: Ministry of Health, Malaysia, National Health and Morbidity Survey, Psychiatric Mobility in Adults, pg. 35-38, 1996

Figure 11: Prevalence of Mental Health Problems by Ethnic Group in 2015



Source: Ministry of Health, Malaysia, National Health and Morbidity Survey, Non-Communicable Diseases, Risk Factors and Other Health Problems, Vol. 2, pg. 188-189, 2015

In 1996, Indians and the 'Others' (referring to non-Malaysian citizens and individuals who do not fall under other listed categories) group were found to have the highest prevalence levels of mental distress. The prevalence rate for both these groups was approximately 17%.

All ethnic groups reported a rise in prevalence rates of mental illness rates between 1996 and 2015. In 2015, out of the three major ethnic groups, Indians recorded the highest prevalence at 17.2%, followed by Chinese (10.6%) and 8.1% of Malays (8.1%) reporting experiencing symptoms of mental illness.

Between 1996 and 2015, the level of prevalence among Malays rose significantly, from 8.1% to 28.2%, an almost triple-fold increase. Compared to this, the Chinese experienced a slightly lower rate of increase, going from 10.6% to 24.2%. Out of the three major ethnic groups, Indians maintained the highest prevalence rates at 28.9%, though this figure was only marginally higher than the rates recorded by Malays.

Aside from the major ethnic groups, it is equally important to note that the Indigenous[6] group (re-categorized as 'Other Bumiputra' in the NHMS 2015) experienced a drastic rise in mental illness prevalence rates. From 12.2% in 1996 to 41.1% in 2015, this rise represented a threefold increase. In 2015,

[6] This is a collective label for the Orang Asli of Peninsular Malaysia and the natives of Sabah and Sarawak.

the ‘Other Bumiputra’ group registered the highest prevalence of mental health issues out of all ethnic groups.

While it is beyond the scope of this study to delve deeper into the factors driving these patterns and trends, it is strongly recommended that more research be done into mental illness vulnerability among the different ethnic groups in order to identify precipitating factors and tackle issues in an effective and targeted manner. In particular, focus should be given to studying the Indian and Malay communities, as well as the indigenous groups, as these groups appear to be especially prone to developing mental health problems based on a comparison of the 1996 and 2015 data.

2.0. Overview of Mental Health Services in Malaysia

2.1. History of Mental Health Care Delivery in Malaysia

In order to understand the issues facing the delivery of mental health services in Malaysia, it is useful to trace the evolution and development of psychiatric care throughout the years.

The first instance of psychiatric care in the country dates back to the era of British Settlement in the 1830s. Back then, mental health facilities and programmes were primitive, involving the incarceration of mentally ill patients in asylums. The first asylums were established in three of the Federated Malay States during the late 18th century (Hague, 2005).

The provision of mental health services in psychiatric hospital settings officially began in 1911, with the establishment of the Central Mental Hospital (CMH) in Tanjung Rambutan, Perak, with 280 inpatient beds (Hague, 2005). In the 1920s, two more psychiatric hospitals were set up in Sabah and Sarawak (Hospital Sakit Jiwa in Bukit Padang, Sabah and the Sarawak Mental Hospital in Kuching), followed by a mental hospital (Tampoi Mental Hospital) in Tampoi, Johor in 1935 (ASEAN, 2016).

The services provided in these facilities were of an institutionalized nature, whereby patients were kept confined within the four walls of the institution. The patient population in these hospitals was largely made up of individuals with untreatable and chronic mental illnesses, as well as those deemed to have committed crimes due to their unstable psychological state.

Despite the designation of 'hospital', treatment services were heavily institutionalized, and patients (or 'inmates') were commonly subjected to poor living conditions. According to research, there was a high incidence of patient mortality in these hospitals due to overcrowding and lack of quality care (Hague, 2005).

It was not until the late 1950s and early 1960s that the mental health care system experienced a transformation in terms of service delivery.

In tandem with Malaya gaining independence in 1957, the responsibility for health services, including mental health, passed from British hands to the newly established federal government. This was also around the time that the advent of 'deinstitutionalization' was beginning to take effect in transforming mental health systems around the world. Instead of incarcerated care in the asylums, newly emergent "public health" principles called for mental health care to be provided in communities.

In Malaya (and later Malaysia), efforts to mainstream mental health services into the Ministry of Health's (MOH) network of public hospitals were starting to take off as well. The first general hospital psychiatric department was set up in Penang General Hospital on 1 March 1959 (ASEAN, 2016). In 1970, a committee from the MOH was set up to review the mental health needs of the nation and plan accordingly for development of mental health services. Support was given to decentralize the provision of psychiatric care, as well as to upgrade the existing psychiatric hospitals. In the same year, the Central Mental Hospital

was renamed Hospital Bahagia and Tampoi Mental Hospital was renamed Hospital Permai, as a move towards reducing stigma (ASEAN, 2016).

In 1971, the MOH established a Special Unit within the Directorate of Hospitals Administration to oversee the preparation and implementation of a comprehensive Mental Health Program, with special emphasis on community care. From 1974 onwards, the Health Ministry actively decentralized and regionalized mental health services to general and district hospitals in both the Peninsular and East Malaysia regions.

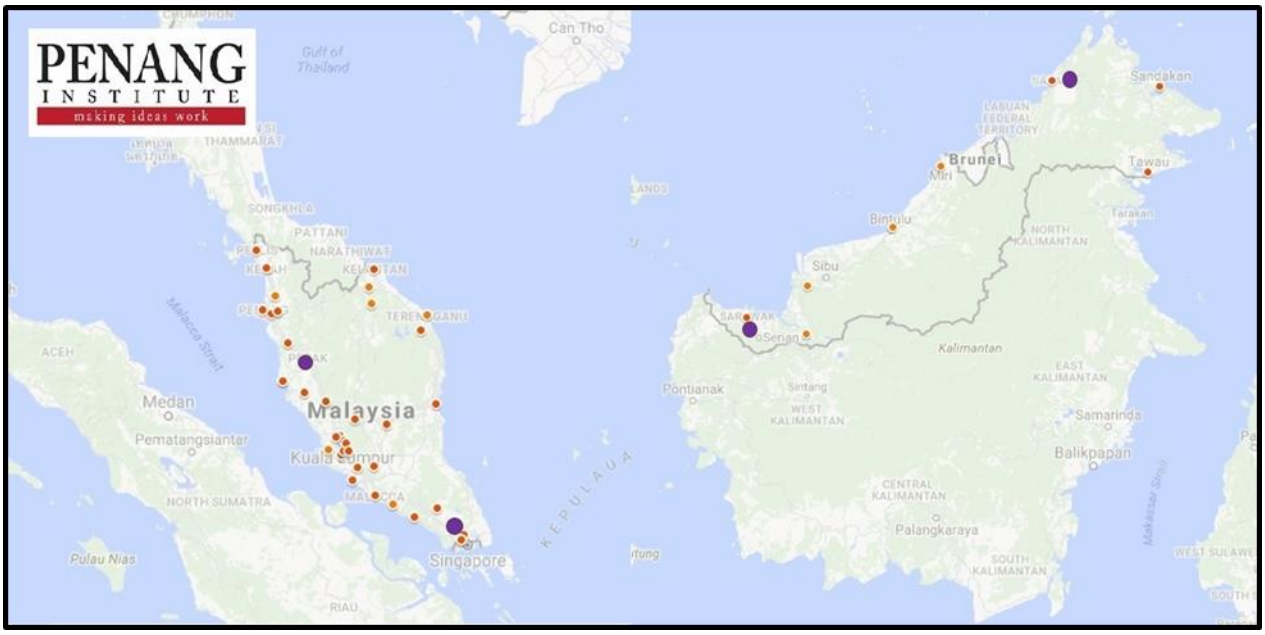
Decentralization continued to define the trend of service provision until 1996, when mental health care was further extended to the primary level healthcare clinics (Klinik Kesihatan), with the aim of improving accessibility to such services for home and communities, and to reduce the stigma of association with hospital-based care. Initially, mental health services offered at these clinics were centred on the follow-up of mentally ill patients and psychosocial rehabilitation care, but in recent years, this has expanded to include screening and stress management intervention, mental health and well-being promotion and prevention and treatment measures (ASEAN, 2016).

2.2. Current Mental Health Care Delivery System

Currently, formal mental health care services are delivered through three main branches, namely mental health services in hospitals, mental health services in primary health care and community-based mental health services.

2.2.1. Mental Health Services in Hospitals

Figure 12: Distribution of Mental Health Services in MOH Hospitals, 2016



**Smaller red dots represent specialist hospitals. Larger purple dots represent psychiatric hospitals.*
Source: Specialty & Subspecialty Framework for Ministry of Health Hospitals Under 11th Malaysia Plan 2016 report; author's own derivations.

Figure 12 shows the distribution of mental health services across MOH hospitals in 2016.[7]

As of 2016, there were four psychiatric hospitals and 48 specialist hospitals within the MOH system providing psychiatric and mental health services (Ministry of Health, Malaysia).

A majority of specialist hospitals had established psychiatric departments with resident psychiatrists and facilities such as outpatient clinics and dedicated bed wards for psychiatric patients. However, some smaller district hospitals had less comprehensive psychiatric manpower and facilities. Besides providing clinical service in their own hospitals, resident psychiatrists also paid regular visits to the smaller district hospitals to provide service.

The range of mental health services offered in hospitals consist mainly of outpatient care based in clinics, inpatient care in the wards and hospital-based community services.

For outpatient care, services include the following (Ministry of Health, Malaysia, 2011):

[7] Data on the names of MOH hospitals providing psychiatric and mental health services in 2016 was retrieved from the MOH Specialty & Subspecialty Framework for MOH Hospitals under the 11th Malaysia Plan 2016 report. The Google MyMaps tool was then used to generate a map showing the distribution patterns of these hospitals across the country. As data was taken from an MOH report, the hospital sample does not include the three teaching hospitals (MOHE) nor the two Ministry of Defence (MOD) hospitals, although these hospitals do also provide psychiatric services.

- Promotion of mental health, including measures to promote mental health literacy
- Prevention measures, including measures to prevent identify and screen 'at risk' groups
- Assessment and diagnosis of mental health conditions
- Treatment interventions, such as pharmacological treatment (medication therapy) and psychosocial treatment interventions (including counselling and behavioural therapy).[8]

Inpatient services include the following (Ministry of Health, Malaysia, 2011):

- High dependency care for acutely ill and unstable psychiatric patients who require close supervision. These wards typically have a 1:1 or 2:1 patient-to-staff ratio.
- Acute care for acutely ill psychiatric patients. All new inpatients are admitted to these wards. The patient-to-staff ratio is 4:1.
- Convalescent care is categorized as a 'step down' from acute care. Convalescent care wards provide non-disruptive settings and a safe environment for the patient as he or she recovers from the illness. Unlike high dependency and acute wards, where visiting may be restricted by the overseeing medical officer or specialist, all patients in the convalescent wards are allowed to have visitors, and a special visiting area is provided with reasonable privacy. This is to encourage and increase social integration of patients with their families and social support.
- Rehabilitation care applies broadly to all categories of inpatient care, and consists of individual care plans drawn up by psychiatrists and occupational therapists. These plans are aimed at educating patients and their caregivers on their illness, and to prepare patients to return to their home and society.

2.2.2. Mental Health Services in Primary Care

Mental health services were integrated into primary healthcare clinics (klinik kesihatan) from the late 1990s onwards. From a service decentralization perspective, this was a significant milestone in devolving mental health care outwards from hospital settings to local communities.

At primary care level, treatment services include:

- Promotion of well-being
- Prevention and screening of mental health risk
- Treatment of mental health patients, including follow-up of stable cases
- Psychosocial rehabilitation

According to the MOH's 2014 Annual report (the latest publicly accessible report at the time of writing), a number of mental health screening activities had been carried out in primary healthcare clinics in that

[8] Patients diagnosed with mental health problems at primary care level, whose conditions warrant more specialized treatment, are usually referred to see a psychiatrist in outpatient clinics. The referral letter is issued by the treating doctor based in the primary health care clinic.

year. These activities included outpatient screening for risk of mental health problems among outpatients using standardized screening measures such as the MOH Health Status Screening Form (BSSK) and Depression Anxiety Stress Scales (DASS).

In the same year, a majority of primary healthcare clinics also provided treatment for new and follow-up mental health cases. A total of 28,720 cases were treated, and services were provided in the form of pharmacological treatment and counselling for patients.

Finally, in 17 selected primary care clinics, psychosocial rehabilitation centres were established to assist the mentally ill to 'understand and control their illness, achieve optimal functional level and reintegration into the community'. A total of 229 clients had received rehabilitation services at these centres, according to the MOH 2014 Annual report. The same source also stated that these centres would be upgraded into community mental health centres (CMHCs) to provide more comprehensive screening, intervention, treatment and rehabilitation services for people with mental health problems in the community (Ministry of Health, Malaysia, 2014).

2.2.3. Community-based Mental Health Services

In recent years, the reinforcement of the Mental Health Act (MHA, 2001) and Mental Health Regulations (MHR, 2010) spurred greater efforts to improve the re-integration of the mentally ill into community settings. This was advanced through the setting up of two types of community-centred mental health facilities: community mental health centres and psychiatric nursing homes.

(A) Community Mental Health Centres

The MHA 2001 defines a CMHC as a centre providing diagnosis, treatment and rehabilitation services for any person suffering from any mental disorder (Part VI, Section 32). These centres are either located within hospital outpatient facilities, on the site grounds of psychiatric institutions or outside formal hospital settings, in health centres and other designated areas.

The main objectives of CMHC services are to provide continuous treatment for patients in an easier and more accessible manner within community settings. The services provided include counselling and psychotherapy services for patients and carers; education on the use and side effects of medication; social skills training; and assisted job search and placement activities (Ministry of Health, Malaysia, 2011).

CMHCs are typically overseen by a medical officer with relevant training and experience in psychiatry or, in the case of psychiatric hospitals, under the authority of the hospital's medical director. However, at the management level, most CMHCs adopt a clubhouse approach where patients play a large role in running the centre's day-to-day operations. This is aimed at promoting patient empowerment and assisting with transitional work, while fostering suitable conditions for a low key and drop in approach.

In a 2017 Parliamentary reply, Health Minister Datuk Seri Dr S Subramaniam stated that there were a total of 20 community centres distributed throughout the country: Perak and Sarawak each had 3 centres, while Kedah, Pahang, Selangor and Johor had 2 centres each. In the states of Penang, Putrajaya, Negeri Sembilan and Terengganu, Kelantan and Sabah, there was one centre each.

In the same statement, Health Minister explained that the centres were staffed with 138 mental health workers of various disciplines. Among the activities conducted to help patients along in the rehabilitation and recovery process included relaxation techniques, exercises on coping strategies and counselling sessions. Besides this, the centres also ran 'play therapy' sessions for child patients and classes on grooming and dining skills for adult patients. For the more stabilized category of patients, job placement and transitional employment services were also offered[9].

(B) Psychiatric Nursing Homes

Besides CMHCs which adopt a daily outpatient treatment approach, there are also residential psychiatric rehabilitation facilities which cater to families of individuals experiencing and recuperating from mental illness, who require additional support to care for their loved ones.

The MHA 2001 clearly spells out the role of psychiatric nursing homes as one of providing accommodation and nursing and rehabilitative care for persons suffering or recovering from a mental illness (Mental Health Act 2001).

In Malaysia, psychiatric nursing homes fall into two categories: those that are run by the government and those that are privately managed and operated.

In government psychiatric nursing homes, a medical officer or government staff nurse with suitable qualification, training and experience in psychiatry is appointed to be responsible for the management and control of the home by the Health Minister. In private centres, those running the centres are required to comply with the provisions of the MHA 2001 and the Private Healthcare Facilities and Services Act 1998 (Mental Health Act 2001).

Unlike hospital-based facilities where referrals are usually required, patients may voluntarily admit themselves into a psychiatric nursing home, either upon their own request, or that of a relative. However, admission must be executed under the direction of a medical officer or registered medical practitioner (preferably a psychiatrist).

The MHA 2001 states that all admitted patients are to be examined by a medical officer or registered medical practitioner at least once every two weeks. Following examination, if the patient's mental health condition is deemed to have deteriorated or that it is necessary for the patient's own health and safety and that of others that he receive further care and treatment, the patient shall be referred to a psychiatric

[9] Parliamentary reply by Datuk Seri Dr S Subramaniam, Health Minister of Malaysia in response to YB Lim Kit Siang (Question No. 272), 2017.

hospital. Applications to enter the hospital may either be made the patient's relatives or (in the absence of relatives) by the person in charge of the nursing home.

(C) Hospital-based Community Services

Finally, a third prong of community-based mental health services stems from hospitals, as a way of providing a continuum of care for existing psychiatric patients by assisting and supporting them in the community. These services (officially termed hospital-based community mental health services) are regarded as an alternative to hospitalization, and a way of reducing the burden on existing hospital inpatient services that cater for acute admissions (Ministry of Health).

Hospital based community psychiatry services provide treatment and rehabilitation to patients who, for various reasons or circumstances, would benefit from home-based treatment instead of receiving treatment in hospitals[10]. Services are provided by a multidisciplinary team of mental health providers[11] who make scheduled home visits to patients who live within a designated zone radius within the hospital site.

There are two main types of services offered to patients. The first form of service, Assertive Community Treatment (ACT), caters to recently discharged psychiatric patients whose conditions warrant a prolonged period of monitoring and supervision.

The second form of service, Acute Home Care (AHC), provides intensive support for patients with acute-degree mental health problems who fulfil the criteria for admission into the inpatient wards, yet due to having good family support systems, are able to be supported in the home environment.

In both ACT and AHC services, the frequency of home visits are determined by the specialist in charge after due assessment of conditions have been made, taking into account the reason for the visits, the type of interventions needed and patients' and families' response to intervention.

Examples of interventional activities in the home include providing psychoeducation to patients and families on aspects of the illness; ensuring adherence to medication; supported job placement activities and (where relevant) collaboration with key local figures such as village leaders to aid reintegration into the community (Ministry of Health, Malaysia).

[10] Examples of such circumstances include, but are not limited to: patients who default on treatment due to logistic reasons and require reminders for them to follow up; patients who have multiple relapses with aggressive behaviour and disruptions in lifestyle that require more assertive follow-up measures; or patients who, after a brief period of hospitalization, may be sent home early on the condition that their families continue to receive professional support from a medical team.

[11] Typically, the team consists of a psychiatrist, medical officers, staff nurses and assistant medical officers, although in some cases, where manpower is available, other members may include clinical psychologists, occupational therapists, social workers and support staff.

3.0. Evaluating Demand for Mental Health Services in the Public Healthcare Sector

To estimate the level of demand for mental health treatment[12], the study examines trends in the number of patient visits made to psychiatric outpatient and inpatient services in government hospitals. According to the World Health Organization (WHO), psychiatric outpatient visits constitute at least 90% of total mental health service utilization in most regions, making it a useful measure of demand for general psychiatric treatment.

Data was taken from the MOH estimated operating expenditure or '*anggaran perbelanjaan mengurus*' (MOH-EOE) documents.

The MOH-EOE contains information relating to the MOH's various Programmes and related activities, and the performance output of each activity for a particular year.

For psychiatry and mental health (psikiatri dan kesihatan mental), which is listed as Activity 27 under Programme 3: Medical Treatment (Rawatan Perubatan), output is measured through the number of outpatients (pesakit luar) and inpatients (pesakit dalam) that receive treatment in government healthcare facilities.

Data on inpatient and outpatient numbers was taken from the 2015, 2016 and 2017 MOH-EOE documents (see Figure 12, Figure 13 and Figure 14 below). The reason for selecting these as sources was because all three documents contained information outpatient and inpatient figures over a number of years, enabling a timeline to be drawn out[13].

[12] Treatment services here includes access to specialist mental health services and physical facilities for mental health care.

[13] As the Estimated Operating Expenditure sheets do not give a breakdown of outpatient and inpatient figures by hospitals, these figures were assumed to reflect the numbers of outpatient attendances and inpatient admissions across all government healthcare facilities.

Figure 13: Psychiatric Outpatient and Inpatient Figures recorded in Government Healthcare Facilities for years 2013-2015

Aktiviti 27 : Psikiatri dan Kesihatan Mental

Objektif – Menyediakan perkhidmatan pesakit luar di klinik-klinik pakar dan pesakit dalam (*in–patient*), perkhidmatan diagnosa, rawatan, pencegahan, penjagaan dan pemulihan yang berkesan bagi pesakit psikiatri dan kesihatan mental untuk mengembalikan keadaan pesakit-pesakit dengan masalah kompleks kepada keadaan kesihatan optima dan kembali pulih serta mengurangkan kadar kemasukan semula pesakit ke wad dan memendekkan masa tinggal di wad, seterusnya meningkatkan perkhidmatan rawatan pesakit psikiatri dan kesihatan mental di komuniti dan klinik kesihatan dengan melaksanakan perawatan di dalam komuniti yang lebih meluas dengan penglibatan ahli keluarga dalam perawatan.

PRESTASI AKTIVITI

Output	2013 (Sebenar)	2014 (Anggaran)	2015 (Anggaran)
Bil. pesakit luar (baru)	35,939	38,000	40,000
Bil. pesakit luar (ulangan)	524,970	552,000	580,000
Bil. pesakit dalam	17,738	19,000	20,000

Source: Extract from 2015 MOH Estimated Operating Expenditure sheet, p. 473

Figure 14: Psychiatric Outpatient and Inpatient Figures recorded in Government Healthcare Facilities for years 2014-2016

Aktiviti 27 : Psikiatri dan Kesihatan Mental

Objektif – (a) Menyediakan perkhidmatan pesakit luar di klinik-klinik pakar dan pesakit dalam (*in–patient*) bagi pesakit psikiatri dan kesihatan mental; (b) Menyediakan perkhidmatan diagnosa, rawatan, pencegahan, penjagaan dan pemulihan yang bersesuaian serta berkesan; (c) Untuk mengembalikan keadaan pesakit-pesakit dengan masalah kompleks yang tidak boleh dirawat di jabatan pesakit luar am atau poliklinik kepada keadaan kesihatan optimum; (d) Memberikan rawatan yang berkesan dan sempurna kepada pesakit di dalam wad dan klinik supaya kembali pulih; (e) Mengurangkan kadar kemasukan semula pesakit ke wad dan memendekkan masa tinggal di wad; dan (f) Meningkatkan perkhidmatan rawatan pesakit psikatri dan kesihatan mental di komuniti dan klinik kesihatan dengan melaksanakan perawatan di dalam komuniti yang lebih meluas dengan penglibatan ahli keluarga dalam perawatan.

PRESTASI AKTIVITI

Output	2014 (Sebenar)	2015 (Anggaran)	2016 (Anggaran)
Bil. pesakit luar (baharu)	33,927	36,500	39,200
Bil. pesakit luar (ulangan)	540,123	580,600	624,200
Bil. pesakit dalam	18,121	19,500	20,800

Source: Extract from 2016 MOH Estimated Operating Expenditure sheet, p. 473

Figure 15: Psychiatric Outpatient and Inpatient Figures recorded in Government Healthcare Facilities for years 2015-2017

Aktiviti 27 : Psikiatri dan Kesihatan Mental

Objektif – (a) Menyediakan perkhidmatan pesakit luar di klinik pakar dan pesakit dalam (*in–patient*) bagi pesakit psikiatri dan kesihatan mental; (b) Menyediakan perkhidmatan diagnosa, rawatan, pencegahan, penjagaan dan pemulihan yang bersesuaian serta berkesan; (c) Untuk mengembalikan keadaan pesakit dengan masalah kompleks yang tidak boleh dirawat di jabatan pesakit luar am atau poliklinik kepada keadaan kesihatan optima; (d) Memberi rawatan, menstabilkan dan berusaha mengurangkan penyakit serta beban yang dialami oleh pesakit dan ahli keluarga; (e) Memberi pendidikan dan latihan yang berterusan kepada para doktor dan paramedik serta pendidikan kesihatan kepada pesakit dan keluarga; (f) Memberikan rawatan yang berkesan dan sempurna kepada pesakit di dalam wad dan klinik supaya kembali pulih; (g) Mengurangkan kadar kemasukan semula pesakit ke wad dan mengurangkan masa tinggal di wad; dan (h) Meningkatkan perkhidmatan rawatan pesakit psikiatri dan kesihatan mental di komuniti dan klinik kesihatan dengan melaksanakan perawatan di dalam komuniti yang lebih meluas dengan penglibatan ahli keluarga dalam perawatan.

PRESTASI AKTIVITI

Output	2015 (Sebenar)	2016 (Anggaran)	2017 (Anggaran)
Bil. pesakit luar (baharu)	34,699	35,740	36,800
Bil. pesakit luar (ulangan)	553,257	569,850	586,900
Bil. pesakit dalam	18,286	18,830	19,400

Source: Extract from 2017 MOH Estimated Operating Expenditure sheet, p. 473

For each of the MOH-OEO sheets, data on inpatient and outpatient numbers was recorded as actual (sebenar) and estimated (anggaran) figures (see Figures i, ii and iii above). The 'actual' number of patients for a year can only be confirmed 2 years later while the figures for the current year and for the year before have not been confirmed and are thus stated as 'estimates' (anggaran).

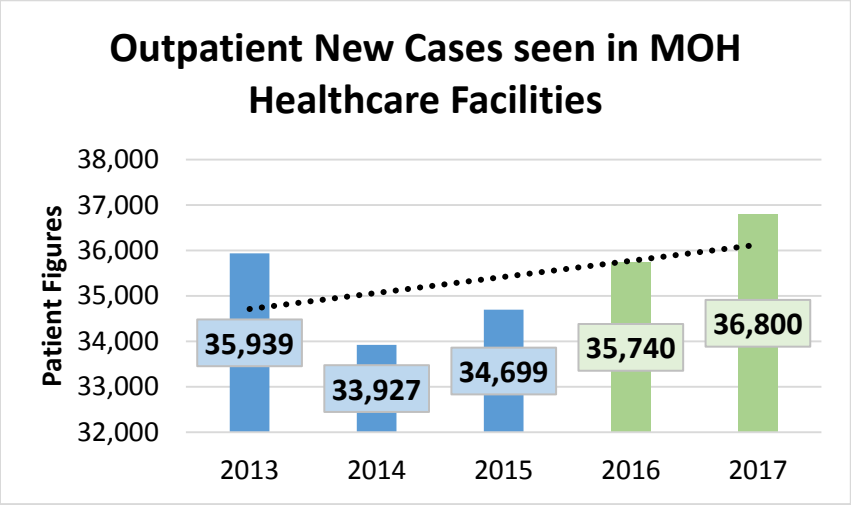
In this study, actual inpatient and outpatient figures were used for the years 2013, 2014 and 2015, while for the years 2016 and 2017, estimated figures were used in lieu of actual figures since the latter was not available.

3.1. National Outpatient and Inpatient Trends in Government Hospitals

3.1.1. Outpatient New Cases and Follow-up Visits in Government Hospitals

Figures 16 and 17 show the number of new outpatient cases and follow-up outpatient visits to all MOH healthcare facilities from 2013 to 2017.

Figure 16: Number of New Outpatient Cases seen at MOH healthcare facilities, 2013-2017*

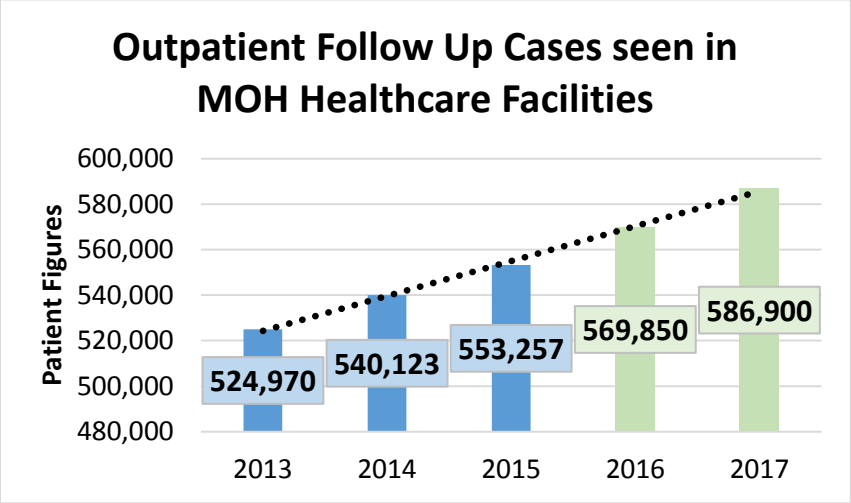


Source: MOH Estimated Operating Expenditure sheets, 2015-2017

**blue bars denote actual figures; green bars denote estimated figures*

Based on the data, there has been a trend of overall increase in the number of new psychiatric outpatient cases seen in government healthcare facilities. Between 2013 and 2014, the number of new cases fell slightly by 5.6%, but this was followed by an incremental rise in numbers of new cases. From 2014 to 2015, the number of actual cases increased by 2.3%. Based on estimated figures, the number of new cases then further increased over the years 2016 and 2017, reaching 36,800 cases in 2017.

Figure 17: Number of Follow-Up Outpatient Cases seen at MOH healthcare facilities, 2013-2017*

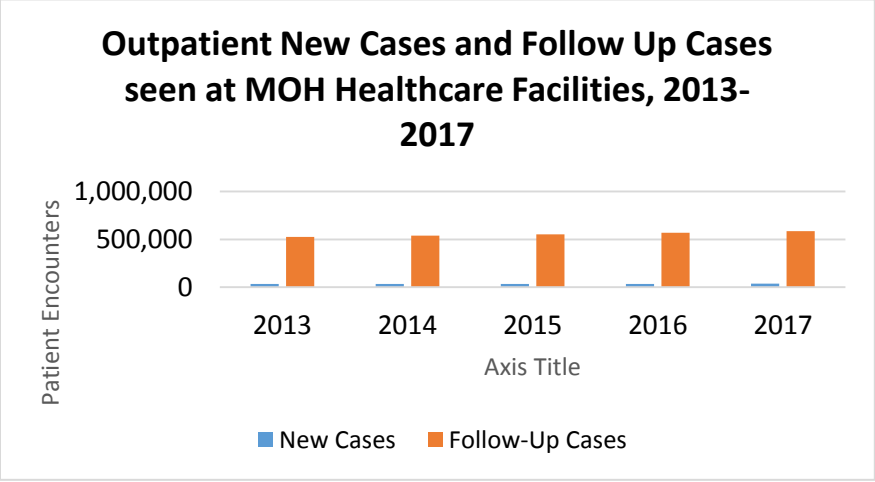


Source: MOH Estimated Operating Expenditure sheets, 2015-2017

*blue bars denote actual figures; green bars denote estimated figures

Unlike the trends for new outpatient cases, the number of follow-up outpatient cases seen in government healthcare facilities recorded a year-on-year increase, from 2013 to 2017. This increase occurred at a fairly consistent rate. From 2013 to 2014, the number of actual follow-up cases increased by 2.9%, followed by a 2.4% increase from 2014 to 2015. Based on estimated figures, follow-up cases then increased by 3.0% between 2015-2016 and 2016-2017 respectively.

Figure 18: Comparison of Outpatient New Cases and Follow Up Cases seen at MOH Healthcare Facilities, 2013-2017



Source: Source: MOH Estimated Operating Expenditure sheets, 2015-2017

Comparing the two groups of outpatients (new cases and follow-up cases), there was a strong outnumbering of the new cases group by the follow-up group.

In 2013 alone, the follow-up group outnumbered the new cases group by a ratio of 15:1. For the rest of the years, the ratio had increased to 16:1, suggesting an even greater discrepancy.

One possible explanation for the larger volume of the follow-up group is the 'spill-over' phenomenon of cases from year-to-year.

In the United States, studies have shown that approximately one-fifth of mental health patients drop out of treatment prematurely, and over 70% do so after the first or second visit. In Malaysia, social stigma against mental disorders can also lead patients to default on treatment, especially if they come from backgrounds that might predispose them to early dropout behaviour, such as low-income, unemployment and lower educational attainment.

With support from family and friends, such patients may resume treatment after a period of dropout, but inconsistent attendance may result in a prolonged treatment duration, hence the yearly spill-over effect.

A second possible reason for the larger volume of outpatients may simply be due to the fact that treating any mental illness is not a straightforward process. To take the example of pharmacotherapy (treating mental illness with medication), patients who are started off on a prescribed medication may along the course of treatment incur major side-effects or find that the medication has limited efficacy in alleviating illness symptoms. Under such circumstances, the treating psychiatrist may need to alter the treatment plan by adjusting the dosage measure, or even switching the type of drug, before arriving at an optimal dosage that meets the patient's needs.

In most cases, drugs alone are not sufficient to cure a person of their mental illness, as the function of medication is merely to alleviate symptoms. In most cases, it is recommended that a combination of medication and psychotherapy be administered to treat the patient suffering from mental illness. Examples of psychotherapies include cognitive, behavioural and interpersonal therapy, where a clinical psychologist works together with the patient to change negative and/or harmful thoughts and behaviours. Standard psychotherapy treatments are often of a prolonged duration and the efficacy of these therapies is largely dependent on how well the patient recognizes his or her illness and is willing to adhere to treatment.

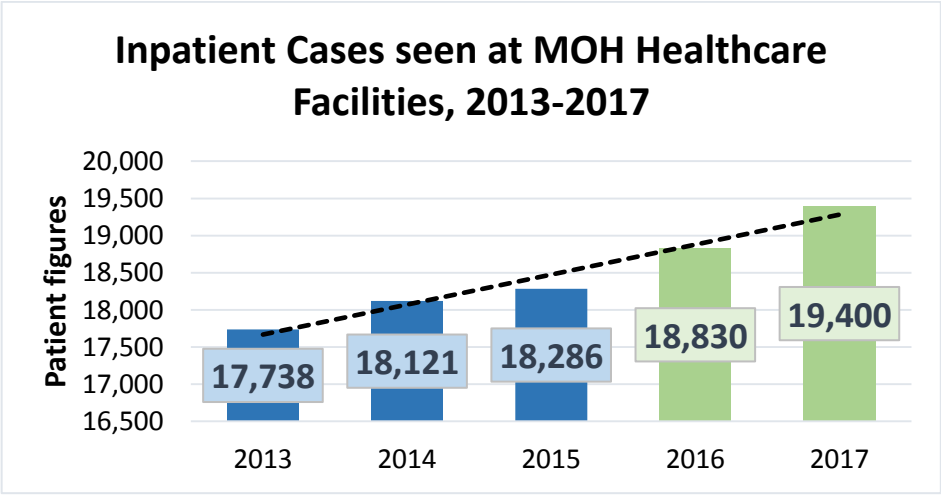
3.1.2. Inpatient Admissions to Government Hospitals

Patients who seek mental health treatment at outpatient clinics may sometimes be referred to inpatient wards for hospitalization, if outpatient treatment and therapy is not sufficient, and close professional monitoring and evaluation is recommended.

In Malaysia, a majority of inpatients tend to be admitted involuntarily from Emergency Departments. At the point of admission, these individuals are usually suffering from an acute mental health episode, and have been deemed a danger to themselves or others. Some more common reasons for hospitalization include:

- Severe Depression
- Suicidal Behavior, Ideations or Threats of Suicide
- Schizophrenia
- Seeing or hearing things that aren't there
- Not eating or sleeping for several days
- Having significant substance abuse problems
- Not being able to take care of their daily needs, such as eating or bathing
- Unsuccessful treatment with previous medication and therapy

Figure 19: Number of Inpatient Encounters at MOH Hospitals from 2013 to 2017



Source: MOH Estimated Operating Expenditure sheets, 2015-2017

*blue bars denote actual figures; green bars denote estimated figures

Data shows that there has been mounting pressure on mental health inpatient services over the years. From 2013 to 2014, the actual number of inpatients increased by 2.2%, before dropping slightly to 0.9% from 2014 to 2015. Based on estimated figures, the number of new cases recorded at a year-on-year increase of 3.0% between 2015-2016 and 2016-2017 respectively.

These figures thus may not necessarily represent new and unique admissions. Unlike data for outpatients, the MOH-EOE documents do not provide a breakdown of inpatient cases into new admissions and existing cases; instead, inpatient data is presented under a single category ('bilangan pesakit dalam').

It is hence difficult to determine if the inpatient figures represent the actual headcount of new cases, or a combination of new cases and existing cases, where patients originally admitted to hospital wards for short-term psychiatric care may have been subsequently transferred to mental institutions for prolonged treatment.

Despite data limitations, what is clear is that overall pressure on mental health inpatient services has increased over the years. The trend is one of consistent increase from 2013 to 2017.

3.2. Discussion

Comparing the service uptake of mental health outpatient and inpatient services in MOH hospitals across the time period, several key patterns emerge.

Firstly, the number of outpatient new cases (including estimated figures for 2016 and 2017) has increased overall from the years 2013 to 2017, reflecting a rise in the number of individuals seeking such treatment at government healthcare facilities.

Likewise, the number of outpatient follow-up cases also increased. However, unlike the new cases group, where numbers had decreased between 2013 and 2014, the increases in the follow up group were largely consistent year-on-year, ranging from a 2.4%-3.0% increase each year.

Between the two groups, the number of follow-up cases strongly outnumbered the number of new cases each year, by a ratio of 15:1 (follow-up: new) in 2013, and an increased ratio of 16:1 for the remaining years.

One possible explanation for the larger volume of patients in the follow-up group is the 'spill-over' phenomenon of cases year-on-year, whereby patients who register irregular attendance, or do not respond well to prescribed medication and psychotherapy, are required to prolong their treatment course. The author was not able to carry out extensive research to substantiate this argument. Further research is recommended to look into this issue.

Finally, the pressure on inpatient mental health services has also increased over the years, although it is uncertain whether this was due to influx of new and unique inpatient admissions or a stagnation of existing cases in the inpatient facilities.

Overall, the rising trends of outpatient cases and inpatient cases indicate that pressure on mental health services has indeed increased over the years from 2013 to 2017.

While it is hard to conclude definitively that these rising trends are evidence of a rise in mental illness in the population (over the years, changing attitudes and a deeper perception and understanding of mental health, might have encouraged greater levels of help-seeking behaviour among the mentally ill), the inpatient and outpatient data trends do show a clear trend of increase in case reporting over the years.

More significantly, the rate of increase in all three groups appears to be highest for the outpatient follow-up group. This indicates that there is an increasingly high demand for this particular form of mental health treatment service in the public healthcare sector.

PART TWO: THE MENTAL HEALTH WORKFORCE IN MALAYSIA

4.0. Human Resources in Mental Health Care

4.1. Introduction

Malaysia currently has a dual-tiered system of healthcare services: a government-managed and funded public sector, and a thriving private sector. Within this dichotomous model, mental health services are available in both public and private treatment settings.

Malaysian public healthcare was founded on principles of universal health care. Thanks to high governmental subsidies, treatment services are affordable for a majority of the population. Moreover, the Ministry of Health provides free health services to civil servants, pensioners and the needy.

An examination of mental healthcare services within this system is therefore particularly crucial, since it is the gateway to accessing treatment for a majority of the population.

In particular, the availability of trained and qualified mental healthcare providers in the public healthcare system has a clear bearing on the access to treatment. A workforce supply that is sufficiently staffed to meet the population demand for treatment sets a good foundation for access. Conversely, a shortage of available mental health workers results in compromised access to mental healthcare.

On 2nd April 2017, Health Ministry deputy director- general Datuk Dr Jeyaindran Sinnadurai publicly stated that the Health Ministry was aware of the lack in mental health facilities in Malaysia and was working towards getting more psychologists and psychiatrists in the service (Kanyakumari, 2017).

The Health Minister's comments, while referring primary to physical mental health facilities, appeared to signpost a troubling deficit of certain core mental health providers in government healthcare facilities.

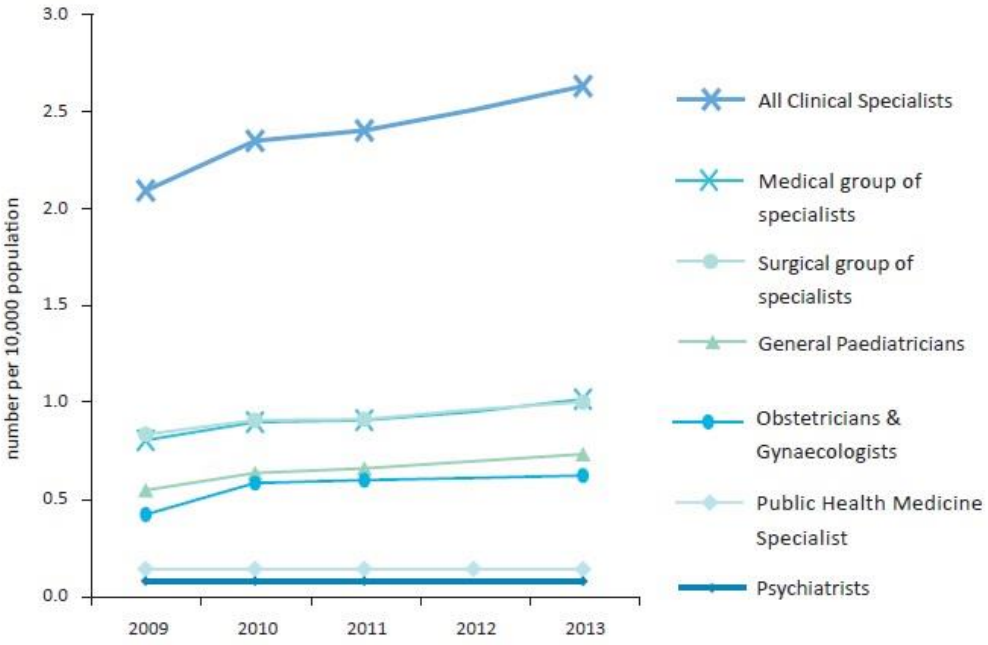
4.1.1. Undersupply & Maldistribution of Psychiatrists in Public Service

Psychiatrists are specialist doctors who have specialized training in the field of mental health care. Their skills lie in diagnosing and treating mental disorders using medication (pharmacotherapy). In other words, they are qualified to prescribe drugs to help alleviate psychological distress and reduce symptoms of the mental condition.

Access to psychiatrists is an essential cornerstone of any mental health care system. In Malaysia, as we shall see, the supply of psychiatrists in the public healthcare system has lagged behind the numbers of other clinical specialists for several years.

From 2009 to 2013, psychiatrists registered the lowest increase in numbers among all hospital-based clinical specialists, both in the public and the private sector.

Figure 20: Number of Specialist Doctors per 10,000 population from 2009 to 2013



Source: *Clinical Research Centre 2011a, 2012 and 2015a; Office of the Deputy Director General for Public Health, Ministry of Health. (Unpublished)*

Note: *the surveys included only those specialists who were practicing in hospitals.*

Source: Human Resources for Health Country Profile 2015

Table 1: Percentage Increase in Number of Specialist Doctors per 10,000 population from 2009 to 2013

Specialist categories	2009	2013	Percentage of increase
Medical group	0.810	1.016	25.4%
Surgical group	0.832	0.996	19.7%
General paediatricians	0.546	0.725	32.6%
Obstetricians & gynaecologists	0.432	0.616	42.6%
Psychiatrists	0.077	0.090	17.0%
All Clinical specialists	2.09	2.62	25.1%
Public Health Medicine Specialist	0.137	0.155	13.1%

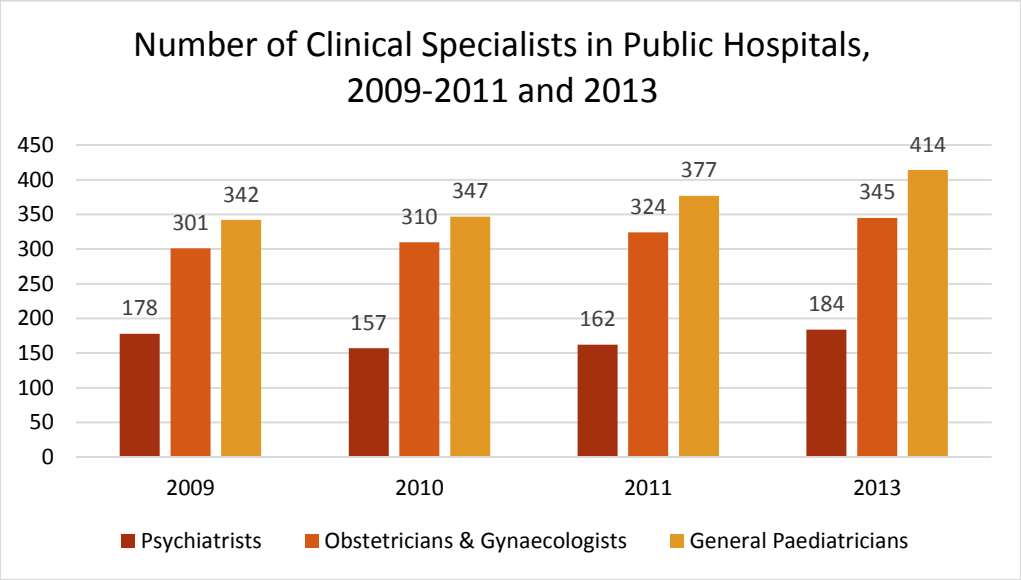
Source: *Clinical Research Centre 2011a, 2012 and 2015a; Office of the Deputy Director General for Public Health, Ministry of Health. (Unpublished)*

Source: Human Resources for Health Country Profile 2015

Based on data taken from the MOH Human Resources for Health Country Profile report, from 2009 to 2013, the number of psychiatrists per 10,000 population practising in public and private hospitals had increased by a marginal 17.0%, compared to a 42.6% increase in obstetricians and gynaecologists, and a 32.6% increase in paediatricians.

Zeroing in to the MOH health workforce, data on the number of clinical specialists working in public hospitals shows that psychiatrists consistently make up the lowest proportion of the clinical specialist population between the years 2009-2011 and 2013. Moreover, the rate of increase of psychiatrists are also the lowest out of all three groups, registering a mere 3.4% increase against the 14.6% increase in obstetricians and gynaecologists and 21.1% increase in general paediatricians.

Figure 21: Number of Clinical Specialists in Public Hospitals from 2009 to 2011, and 2013



Source: National Healthcare Establishment and Workforce Statistics NHEWS reports, 2009, 2010, 2011, and 2012-2013

Table 2: Percentage Increase of Clinical Specialists in Public Hospitals from 2009 to 2011, and 2013

Specialist category	2009	2013	Percentage increase (%)
Psychiatrists	178	184	3.4
General paediatricians	342	414	21.1
Obstetricians & Gynaecologists	301	345	14.6

Source: National Healthcare Establishment and Worforce Statistics NHEWS reports, 2009, and 2012-2013; author's own calculations

Studying the coverage and supply of psychiatrists as mental healthcare providers in the public system is important, as their services form one of the key pillars of mental health care. Ensuring a good supply and distribution of these doctors across the public health system is necessary to secure ease of access to mental health care for all individuals who need it. Conversely, an inadequate supply and maldistribution of these mental health providers will affect the delivery of treatment and care to patients in need.

The following sections will discuss issues pertaining to the supply and distribution of psychiatrists based in public hospitals across the country.

4.1.3. Studying Psychiatrist-to-Population Ratios

This section evaluates access to mental health services, using availability of two types of mental health care providers (psychiatrists and clinical psychologists) as a measure. Methodology-wise, it calculates health provider-population ratios to present the number of psychiatrists and clinical psychologists relative to the population, both at national level and by state breakdown.

Where comparable data is available, the Malaysian figures will then be compared to international averages to gauge if the supply of mental health workers is of acceptable standard. State-specific ratios can help policymakers to identify areas where communities are medically underserved, so that resources may be channelled to increase human resources in these areas.

How far are health provider-to-population ratios a reliable measure of access to services? This is difficult to say. Measuring access to service must also be sensitive to other factors besides numbers of health care providers. For example, average travel time or distance to mental health facilities and the spatial/geographic distribution of services are all factors which affect the ability of the patient to access treatment services.

Nevertheless, the health provider-to-population ratio has been, and is still being used in many reputable international studies and in Western health systems. It remains useful as a quantifiable measure, as long as we bear in mind that it is not the only indicator that can be used to measure the quality of access to mental health treatment services.

In the United States, the Department of Health and Human Services' Health Resources and Services Administration (HRSA) uses Health Professional Shortage Areas (HPSAs) to identify areas and population groups that are being medically underserved. It designates geographical areas with less than one mental health provider per 10,000 population (or 0.1 per 100,000) as a HPSA for mental health (Sundararaman, 2009).

According to the findings of the WHO 2014 Mental Health Atlas report, the absolute number of psychiatrists per 100,000 population varies enormously depending on countries' income level (The World

Health Organization, 2014)[14]. There were 6.6 psychiatrists per 100,000 population in the sampled high-income countries, compared to less than 0.5 per 100,000 population in low- and lower-middle income countries[15].

Taking the WHO figures of 0.5 and 6.6 as the upper and lower range points, this study assumes a range of 0.5-6.6 psychiatrists per population as a 'benchmark' from which to compare and evaluate the number of psychiatrists in Malaysia.

In the report, Malaysia is classified as an upper middle-income country, together with countries like China, Thailand and Brazil.[16] Theoretically speaking, our psychiatrist per population ratio should therefore fall within proximity of the median (the middle number of the data set) of the range, which is calculated to be **3.55**.

4.1.4. Number of Psychiatrists and National Psychiatrist-to-Population Ratios In Malaysia

Table 3: Psychiatrist-to-Population Ratios from 2010 to 2016

Year	Number of Psychiatrists	Population	Psychiatrist per 100,000 population
2009	233	28,081,500	0.83
2010	229	28,588,600	0.8
2011	234	29,062,000	0.81
2013	242	30,213,700	0.8
2016	360	31,660,700	1.1

Sources: CRC National Healthcare Establishment & Workforce Statistics (NHEWS) 2009, 2010, 2011, 2012-2013 reports;

[14] The WHO Mental Health Atlas Project is designed to collect and disseminate data on mental health resources such as policies, plans, financing, care delivery, human resources, medicines, and information systems in the world. The project started in 2001 and the data was updated in 2005, 2011 and 2014. The full report may be found at: http://apps.who.int/iris/bitstream/10665/178879/1/9789241565011_eng.pdf?ua=1&ua=1

[15] For the 2014 WHO report, data was analyzed and reported both by WHO region and by World Bank income group. For the section dealing with availability of human resources, reporting by income group is more informative and comprehensive, hence this paradigm was chosen as an analytic framework for this paper. As of 1 July 2014, low-income economies were defined as those with a gross national income (GNI) per capita of $1,045 or less in 2013; middle-income economies are those with a GNI per capita of more than $ 1,045 but less than $12,746; high income economies are those with a GNI per capita or $12,746 or more. Lower-middle-income and upper-middle-income economies are separated at a GNI per capita of $4,125. Rates of 100,000 population were calculated using official UN population estimates for 2013.

[16] For the full list of participating countries in the WHO Mental Health Atlas 2014, please refer to Appendix A: Participating Countries and Contributors (pp. 59-63) of the report.

Specialty & Subspecialty Framework for Ministry of Health Hospitals Under the 11th Malaysia Plan, p. 321; Department of Statistics data, author's own calculations

Data on raw numbers of psychiatrists was sourced from various government reports on the healthcare workforce, as well as a framework report for MOH hospitals under the 11th Malaysia Plan. These figures reflect the total number of psychiatrists working in both public and private sectors. Meanwhile, the psychiatrist-to-population ratios for each year were calculated by the author based on population figures taken from the Department of Statistics.

The rates for 2012, 2014 and 2015 could not be calculated as no data could be found for those years.

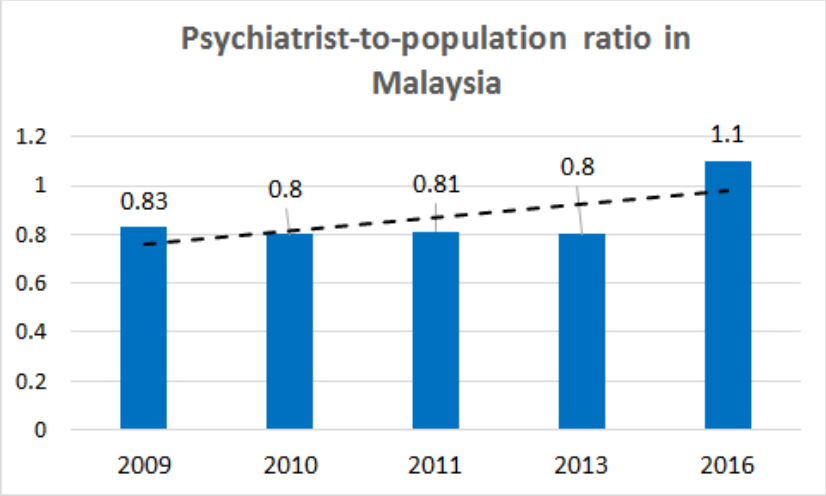
Based on the numbers, there has been an overall increase in the number of psychiatrists in Malaysia between the years 2009 and 2016. However, significant increase only occurred in the latter half of the period (2011-2016). Prior to this, the number of psychiatrists was largely stagnant, increasing by just one specialist from 233 to 234 between 2009 and 2011.

Between 2011 and 2013, the number of psychiatrists rose from 234 to 242, an increase of 8 specialists. Assuming that there was a consistent increase each year, merely 4 new psychiatrists had entered the workforce each year.

By comparison, between 2013 and 2016, the number of psychiatrists rose from 242 to 360, an increase of 118 specialists. Assuming a consistent increase, 39 new psychiatrists had entered the workforce each year between 2013 and 2016, a significantly higher rate than that of the previous years.

Based on the calculations, the psychiatrist-to-population rate has increased over the years, matching population increase.

Figure 22: National Psychiatrist-to-Population Ratios in Malaysia from 2009 to 2016



Sources: National Healthcare Establishment and Workforce Statistics, NHEWS report, 2009, 2010, 2011, 2012-2013; Department of Statistics, Specialty & Subspecialty Framework for Ministry of Health Hospitals Under the 11th Malaysia Plan

Between 2009 and 2013, the number of psychiatrists per 100,000 population remained constant at the 0.8 per 100,000 mark. This reflects the minimal increase in actual numbers of psychiatrists, where merely 9 new specialists entered the workforce in this period.

In contrast, between 2013 and 2016, the psychiatrist per population rate rose to **1.1.** This is connected to the upsurge in psychiatrist numbers during this period, where 118 new specialists entered the workforce.

Overall, there has been a trend of increase in our national psychiatrist-to-population ratios. However, compared to international figures, this increase has been very gradual and statistically speaking, not very significant. Based on the WHO benchmark range of 0.5-6.6, Malaysia's current figure of 1.1 falls at the lower end of the range and far away from the calculated median of 3.55.

Several takeaways may be derived from the discussion above.

Firstly, in terms of actual numbers, the overall trend shows that there has been a growth in psychiatrist numbers between the years 2011 to 2016, especially in the latter years of the period.

Between 2009 and 2011, the increase in the number of psychiatrists was extremely minimal and statistically insignificant. However, this was followed by an incremental rate of increase between the years 2011 and 2016. At first, the rate of increase of psychiatrists was modest, increasing by 8 specialists from 2011 to 2013. However, this was followed by a significant upsurge in numbers, where 118 new psychiatrists entered the workforce between 2013 and 2016.

While the growth trends in raw numbers over the years is indeed encouraging, turning attention to our national psychiatrist-to-population ratios, the progress made here has been gradual and very minimal compared to international standards. Currently, Malaysia is capped at 1.1 psychiatrists for the entire population of roughly 32 million people, a ratio that falls far below the expected level for an upper middle-income country, based on the WHO benchmark range.

These ratios suggest that the availability of psychiatrists to serve the population in need is still very limited. To what extent does this affect access to mental health care in the localities? For this, we turn to the state breakdown of psychiatrists.

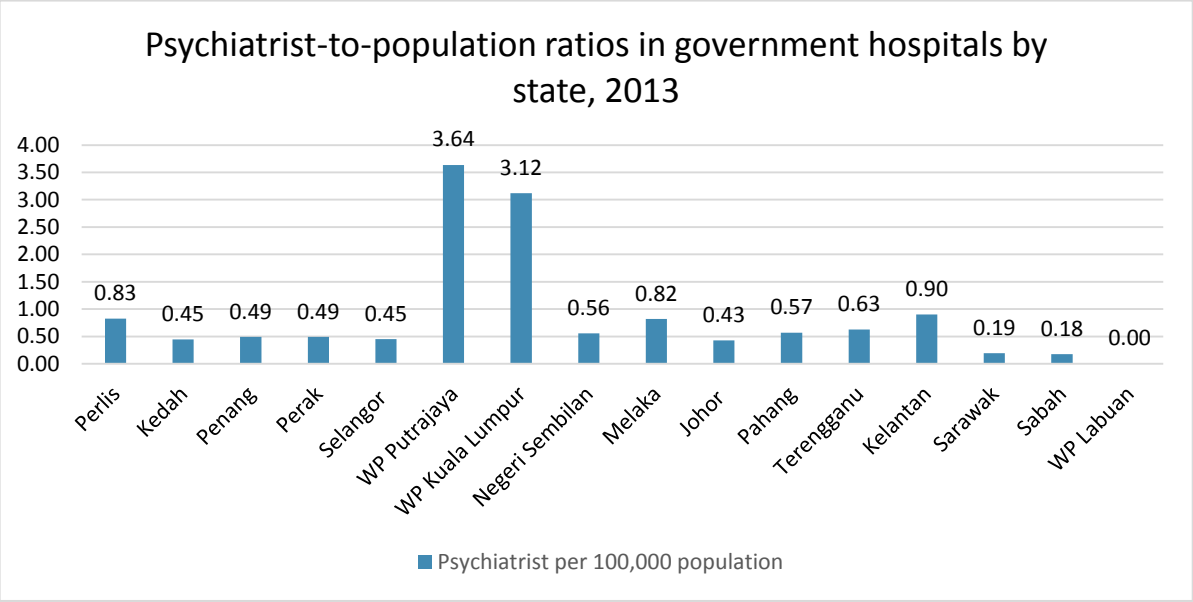
4.1.5. Studying Psychiatrist-to-Population Ratios by State

Compared to national doctor-to-population ratios, the breakdown of psychiatrist-to-population ratios at state level gives better insight into the number of psychiatrists available to serve the population, and hence, the level of access to services, at local level.

This section studies the numbers and distribution of psychiatrists based in government hospitals. From a cost perspective, their services are far more accessible to citizens compared to the private sector.

Figure 23 gives the psychiatrist-to-population ratios of psychiatrists that were based in government hospitals across the states for the year 2013.[17]

Figure 23: Pattern of Psychiatrist-to-Populations Ratios in Government Hospitals by State in 2013



Source: National Healthcare Establishment & Workforce Statistics NHEWS report, 2013

In 2013, states which had a remarkable large supply of psychiatrists were WP Putrajaya and WP Kuala Lumpur. These states recorded high psychiatrist-to-population ratios relative to other states, at least three times higher compared to the rest of the states.

[17] The numbers given in Figure 17 are slightly different from the psychiatrist-to-population ratios listed in the NHEWS 2013 report. This is because the report calculates ratios based on psychiatrists working in both the public and private sector. In order to calculate the psychiatrist-to-population ratios for only public hospitals, the author divided the number of psychiatrists working in public hospitals for each state by the state population figures used by the report (these figures are found on page 119 of the report) and multiplied the result by 100,000 to arrive at psychiatrist-to-population ratios specifically within government hospital settings.

In fact, the psychiatrist-to-population rates for Putrajaya (3.64) and WP Kuala Lumpur (3.12) are fairly approximate to the calculated median point of 3.55 in the WHO benchmark range, hence matching the proposed 'target' ratio for an upper-middle income country.

However, these were the only states that managed to reach the target ratio of 3.55. A majority of states faced an undersupply of psychiatrists, based on WHO benchmark figures.

For example, Kelantan, the state with the third largest psychiatrist-to-population ratio, still fell far below the target ratio of 3.55, at 0.90 psychiatrists per 100,000. Likewise, Perlis and Melaka averaged around 0.8 psychiatrists per 100,000 respectively. These states fall at the extreme lower end of the WHO benchmark range of 0.5-6.6, on par with low income states.

States in East Malaysia suffered from an extremely limited supply of psychiatrists based in the public hospitals. Sabah and Sarawak recorded 0.18 and 0.19 psychiatrists per 100,000 population respectively, critically low compared to the Peninsular states, where even the lowest ratio is 0.43 (Johor). Shockingly, there were no psychiatrists available to serve the population of Labuan, which at the time numbered 93,300 individuals.

4.1.6. Comparing supply of psychiatrists versus patient load in government psychiatric outpatient clinics in 2013

In 2013, a majority of states in Malaysia experienced very low psychiatrist-to-population ratios in the government hospitals.

The low supply of psychiatrists in government hospitals suggests that there may have been an inability to meet the mental healthcare needs of the population utilizing the public healthcare system, thus creating a barrier to access.

To ascertain whether this was indeed the case, the study compares the numbers of government hospital-based psychiatrists against the number of recorded patient visits made to government outpatient clinics in 2013, based on data taken from the NHEWS report.

A concrete example of how access to services is limited is 'case overload'. If a particular psychiatry department in a government hospital is overburdened with a large number of mental health patients, yet has a low supply of psychiatrists, this would limit the number of patients who are able to access treatment services.

Table 4: State Breakdown of the Number of Psychiatrists based in Public Hospitals, and Corresponding Numbers of Psychiatric Outpatient Clinic Visits for the year 2013

State	Number of psychiatrists in public hospitals	Total Outpatient Visits	Number of Patient Cases per Psychiatrist
Perlis	2	8,026	4,013
Kedah	9	39,509	4,390
Pulau Pinang	8	28,404	3,551
Perak	12	87,489	7,291
Selangor	26	45,381	1,745
WP Putrajaya	3	3,026	1,009
WP Kuala Lumpur	54	68,297	1,265
Negeri Sembilan	6	21,688	3,615
Melaka	7	20,169	2,881
Johor	15	47,084	3,139
Pahang	9	44,563	4,951
Terengganu	7	61,484	8,783
Kelantan	15	28,579	1,905
Sarawak	5	28,643	5,729
Sabah	6	16,071	2,679
WP Labuan	0	614	N/A
Total	184	501,492	N/A

Source: National Healthcare Establishment and Workforce Statistics (NHEWS) report, 2013; author's own calculations

Table 4 above gives the state breakdown of the number of psychiatrists based in public hospitals, and the corresponding numbers of psychiatric outpatient clinic visits for the year 2013. The final column on the right lists the doctor-to-patient caseload for psychiatrists working in public hospitals in each state for that year, which calculated by dividing the total outpatient visits by the number of psychiatrists.

Based on the calculated doctor-to-patient caseload, there was a tremendous gap between the availability of psychiatrists and the demand for their services.

Taking Terengganu as an example, based on data recorded in the NHEWS report 2013, only 7 psychiatrists were available to treat 61,484 cases in the year 2013, equivalent to a doctor-to-patient ratio of 1:8,783, a staggeringly heavy caseload.

Other states which faced a critical mismatch in the demand and supply of psychiatric services were Perak, where 12 psychiatrists handled a total caseload of 87,489 patients (doctor-per-patient ratio of 1:7,291), Sarawak, where 5 psychiatrists handled 28,643 cases (doctor-per-patient ratio of 1:5,729) and Pahang, where 9 psychiatrists handled 44,563 cases (doctor-per-patient ratio of 1:4,951).

Although the state of Labuan did not have any doctors serving in public hospitals, the NHEWS 2013 report still states that 614 outpatient clinic visits were made by patients hailing from this state. Making an educated guess, one might surmise that these patients had travelled to the public hospitals in the neighbouring states of Sabah or Sarawak to seek treatment.

4.1.7. Discussion of 2013 findings

The evidence for 2013 flags up several troubling symptoms in mental healthcare services in the public sector.

Based on the psychiatrist-to-population ratios in public hospitals, it appears that many states had faced an undersupply of psychiatrists. Compared to the WHO income-level benchmark range of 0.5-6.6 psychiatrists per 100,000 population and the 'target ratio' of 3.55, states (with the exception of Kuala Lumpur and Putrajaya) had psychiatrist rates that fell far below the range of upper middle income countries; many were instead on par with low income countries.

Moreover, based on the doctor-per-patient ratios, it was clear that many states faced a critical mismatch in the demand and supply of psychiatric services within the public hospitals. States that were particularly affected by this were Terengganu (where psychiatrists in public hospitals faced a staggering doctor-per-patient ratio of 1:8,783), Perak, Sarawak and Pahang.

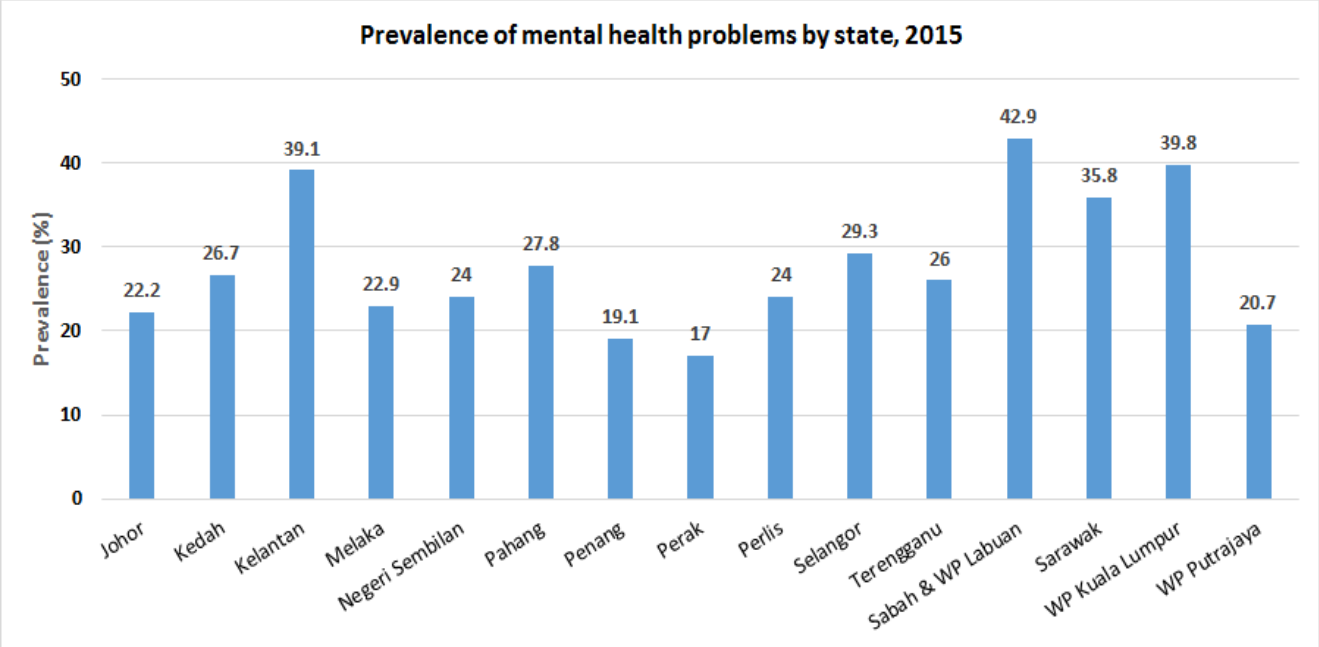
The evident shortage of psychiatrists in public health care suggests that, in 2013, a majority of mental health patients seeking treatment from public hospitals had chances of encountering compromised services. Being put on long waiting lists for appointments, and enduring long wait times for consultations

are just some examples of poor service which may have deterred them from adhering to treatment. In the long run, this would bear poorly on health and treatment outcomes.

4.1.8. Increased Pressure on Mental Health Services in Public Hospitals

If one were to compare mental illness prevalence rates in 2015 against 2013 psychiatrist-to-population ratios, one would find that the supply of psychiatrists in 2013 was hardly sufficient to meet mental health needs in 2015.

Figure 24: Prevalence of Mental Health Problems by State in Malaysia in 2015



Source: Ministry of Health, National Health and Morbidity Survey 2015

Based on the breakdown of mental illness prevalence rates by state, the top four states that recorded highest prevalence of mental health problems were Sabah (42.9%), WP Kuala Lumpur (39.8%), Kelantan (39.1%) and Sarawak (35.8%).

Table 5: Comparison of 2015 Mental Illness Prevalence Rates against 2013 Psychiatrist-to-Population Ratios

State	2013 psychiatrist-to-population ratio	2015 mental illness prevalence (%)
WP Kuala Lumpur	3.93	39.8
Kelantan	0.9	39.1
Sarawak	0.27	35.8
Sabah	0.2	42.9

Sources: National Healthcare Establishment and Workforce Statistics NHEWS report, 2013; National Healthcare Establishment and Workforce Statistics NHEWS report, 2015; author's own calculations

With the possible exception of WP Kuala Lumpur, all other states had doctor-to-population ratios which did not match the high prevalence rates of mental illness versus doctor-to-population ratios. Sabah and Sarawak each had 0.27 and 0.2 psychiatrists per 100,000 population in 2013, yet in 2015, these states recorded extremely high mental illness prevalence rates (42.9% and 35.8% respectively).

Likewise, for Kelantan, a state with mental illness prevalence rate of 39.1%, yet only 0.9 psychiatrists per 100,000 population in 2013.

It is even more worrying to note that the state of Labuan had no psychiatrists available in public hospitals at all in 2013. While there was no way to definitively assess the prevalence rates of mental illness in Labuan (the NHMS aggregates data on Sabah and Labuan into a single category), given its relatively sizeable population, it is likely that there were those facing psychological issues and in need of mental health services, yet had no access to professional help and treatment.

If the 2013 supply of psychiatrists in government hospitals was insufficient to meet population mental health needs in 2015, the question we must ask is this: has there been any improvement in numbers since 2013? Does the current public healthcare sector have an adequate supply of psychiatrists to meet the potentially increased demand for their services?

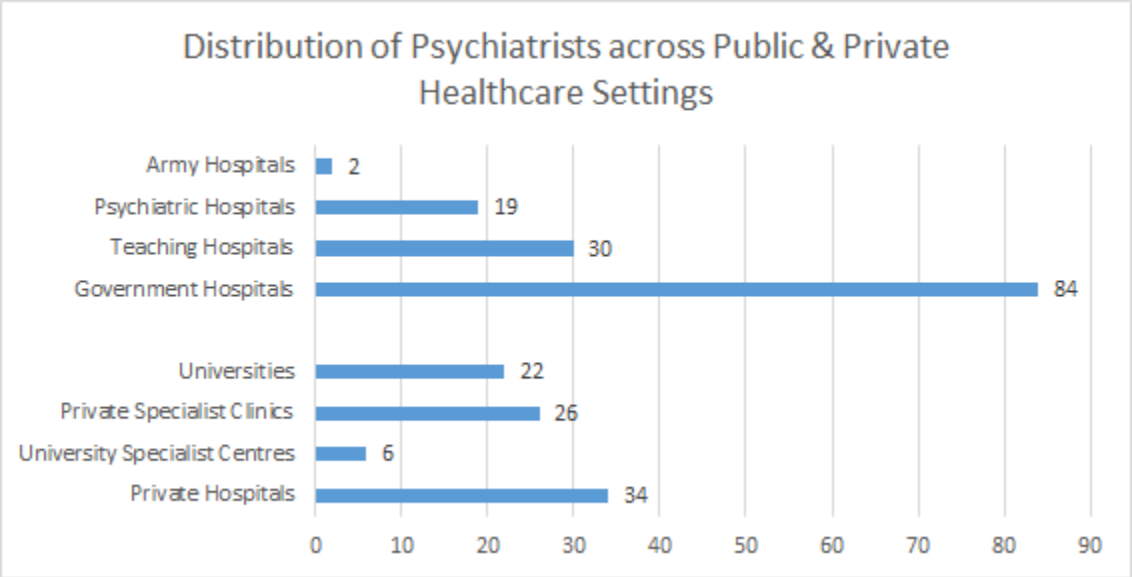
4.1.9. Collecting Data on Psychiatrists in Government Hospitals in 2017

At the time of writing, secondary data on psychiatrists based in government hospitals for the year 2017 was difficult to locate. After 2013, no further publications of the National Healthcare and Establishments Workforce Statistics (NHEWS) reports, which were the author's source of data for 2013 psychiatrist figures, were published on the website of the Clinical Research Centre, a clinical research arm of the MOH (Clinical Research Centre, Ministry of Health Malaysia).

In order to find out the numbers of psychiatrists in government hospitals for the year 2017, the author used two new MOH data sources, namely the National Specialist Register (NSR) and the Malaysian Medical Council (MMC) registry. These are professional registers that keep record of the number of specialist doctors and medical practitioners (including psychiatrists). The credentialing of specialists under the NSR is managed by a National Credentialing Committee composed of members from the Academy of Medicine and the MOH, whilst the MMC registry is maintained by the Malaysian Medical Council[18].

4.1.10. Numbers and distribution patterns of psychiatrists in 2017, based on NSR and MMC registry data

Figure 25: Distribution of Psychiatrists across Public & Private Healthcare Settings



Sources: Malaysian Medical Council Registry; National Specialist Register

Figure 25 above shows the distribution of psychiatrists working in public and private health care settings for the year 2017, based on data taken from the National Specialist Register (NSR) and the Malaysian Medical Council (MMC) registry[19].

A total of 223 psychiatrists were identified, working in settings that ranged from psychiatry departments in hospitals to specialist clinics/centres and universities. The top half of the chart refers to settings in the public sector, while the bottom half refers to private sector settings.

[18] For a detailed explanation of these sources and the process of data retrieval, please refer to Appendix.
[19] For a detailed explanation of these sources and the process of data retrieval, please refer to Appendix.

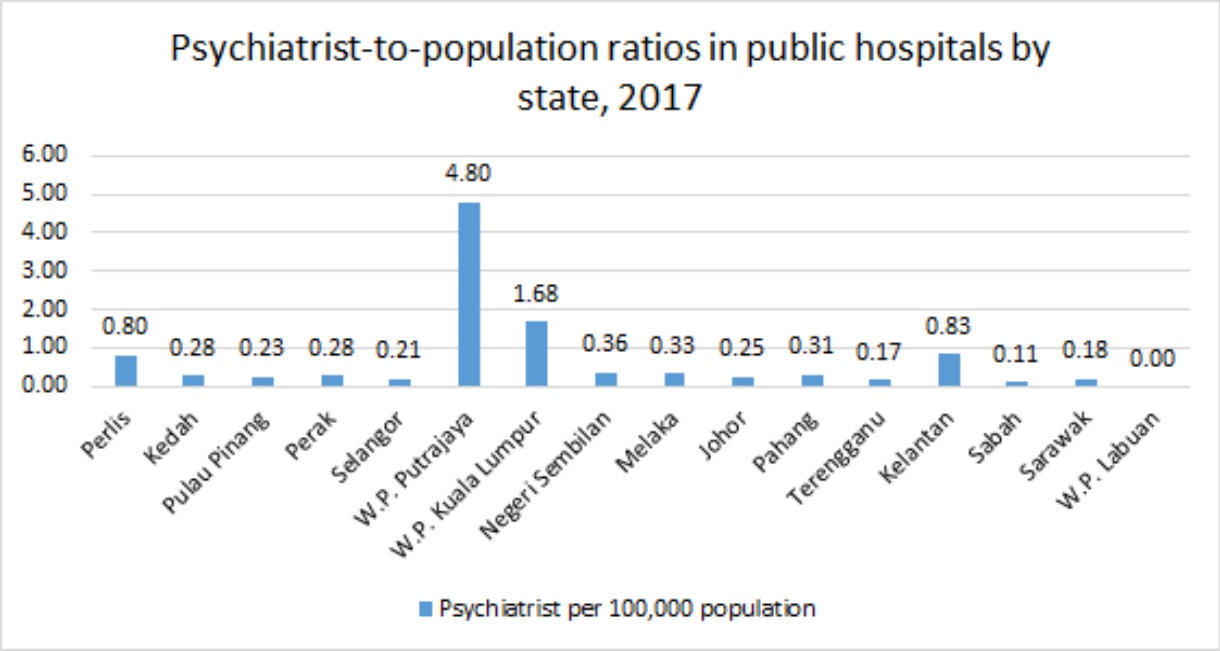
In the interest of matching the 2013 dataset which focused on psychiatrists serving in government healthcare facilities, only the numbers of psychiatrists working in the MOH hospitals and teaching hospitals were taken into account for this analysis.

The analysis excluded psychiatrists working in psychiatric institutions and army hospitals, since these specialists cater to a very specific subset of the population (the former, patients with more severe cases of psychosis who require long-term care, and the latter, military personnel and their families).

4.1.11. Psychiatrist-to-Population Ratios per State in Government Hospitals in 2017

Using data from the NSR and MMC registry, the ratio of psychiatrists working in government hospitals per 100,000 population was calculated for each state.

Figure 26: Psychiatrist-to-Population Ratios in Public Hospitals by State in 2017



Sources: National Specialist Registrar; Malaysian Medical Council Registry; Department of Statistics Malaysia; author's own calculations

Figure 26 shows the psychiatrist-to-population ratios working in government hospitals by state, for the year 2017.

In 2017, WP Putrajaya had the largest psychiatrist-to-population ratio out of all states, with 4.8 psychiatrists per 100,000 population. However, this ratio is somewhat misleading as there were only 4 psychiatrists working in WP Putrajaya in 2017, based on the list of psychiatrists that were registered under the NSR and MMC registry. However, Putrajaya had a small population of 83,300 compared to denser states like Selangor, which had a population of 6,298,400, but only 13 psychiatrists in 2017.

W.P. Kuala Lumpur and Kelantan were states with the second and third largest psychiatrist-to-population ratios, with 1.68 and 0.83 psychiatrists per 100,000 respectively. While these states recorded second and third highest psychiatrist-to-population ratios in 2017, the figures still fall below the author's calculated 'target ratio' of 3.55 psychiatrists per 100,000 population.[20]

Overall, with the exception of WP Putrajaya, psychiatrist-to-population ratios in public hospitals across the states remained at a low level. The state of Terengganu, and states in East Malaysia recorded especially worryingly low rates. Terengganu had 0.17 psychiatrists per 100,000 population, while Sabah and Sarawak each registered 0.11 and 0.18 psychiatrists per 100,000 population respectively. Meanwhile, in Labuan, there were no psychiatrists working in government hospitals, mirroring the situation in 2013.

Considering that Kuala Lumpur, Kelantan, Sabah and Sarawak were the top four states with highest prevalence of mental health problems in NHMS 2015[21], it should have been the MOH's top priority to provide a good supply of psychiatrists in these states' government hospitals to meet the potential heavy demand for their services, especially from poorer groups who are unable to afford treatment in the private sector.

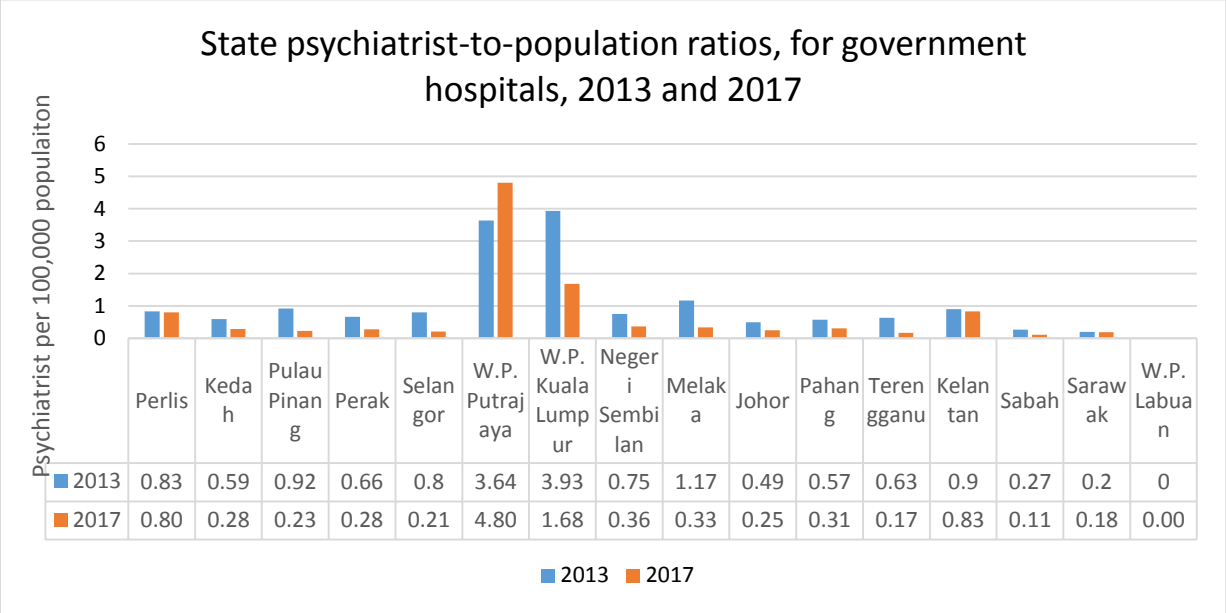
It is extremely concerning that, based on data taken from the NSR and MMC registry, these same states had apparently faced a significant undersupply of psychiatrists in government healthcare. The low supply of government psychiatrists would almost certainly have affected the quality of healthcare service and by extension, the treatment outcomes of individuals with mental health conditions seeking treatment from public healthcare facilities in Kuala Lumpur, Kelantan, Sabah and Sarawak.

4.1.12. Comparing 2013 and 2017 state psychiatrist-to-population ratios in government hospitals settings

Comparing the psychiatrist-to-population ratios in government hospitals for the years 2013 and 2017, certain key patterns over the 5-year period were observed.

[20] The figure of 3.55 was derived from the author's own calculations, based on country psychiatrist-to-population ratios taken from the 2014 WHO Mental Health Atlas report.
[21] See Figure 18 for a breakdown of prevalence of mental illness by state population in 2015.

Figure 27: State psychiatrist-to-population ratios in government hospitals for years 2013 and 2017



Sources: NHEWS report 2012-2013; National Specialist Register; Malaysian Medical Council practitioners' registry; Department of Statistics; author's own calculations.

Firstly, in the broader picture, psychiatrist-to-population ratios in all states except WP Putrajaya had shrunk from 2013 to 2017.

The extent of this 'shrinking' in ratios varied from state to state. Kuala Lumpur experienced the greatest reduction in psychiatrist-to-population ratios, going from 3.93 to 1.68 psychiatrists per 100,000 population from 2013 to 2017. This was reflected in a drop in actual numbers of these mental health providers in the state's government hospitals (from 54 in 2013 to 30 in 2017).

On the other hand, states like Johor and Pahang experienced relatively smaller reductions in psychiatrist-to-population ratios, although it should be remembered that in 2013, these same states also had much smaller numbers of psychiatrists to begin with compared to Kuala Lumpur (15 psychiatrists in Johor, 9 in Pahang).

Secondly, certain states experienced reduced psychiatrist-to-population ratios, not due to a reduction in number of psychiatrists, but rather because the population had expanded. For example, the number of psychiatrists in Perlis (2) and Kelantan (15) remained unchanged between 2013 and 2017, however population figures had increased from 241,400 to 251,000 in Perlis and 1,665,900 to 1,797,200 in Kelantan.

Finally, it is extremely concerning to note that, for the states in East Malaysia, the already low psychiatrist-to-population ratios recorded in 2013 had dipped to barely marginal levels in 2017. In Sabah, psychiatrist-to-population ratios shrunk from 0.7 to 0.11 psychiatrists per 100,000 population while in Sarawak, the

reduction was from 0.2 to 0.18 psychiatrists per 100,000. These ratios reflect a critical undersupply of psychiatric manpower available to serve the mental health needs of the population. As mentioned in previous sections, these states had recorded some of the highest prevalence rates of mental health problems in NHMS 2015.

Finally, as in 2013, no psychiatrists were available to serve the Labuan population in 2017.

Besides compromising the quality of treatment, shortages in the supply of psychiatrists in public healthcare also reduces the degree of ease for individuals to access their services, especially in rural areas. The deficiency in numbers of psychiatrists makes it challenging for certain groups such as the population living in the rural interiors of Sabah and Sarawak to get adequate and timely access to professional treatment, especially given that access is already compromised by a lack of land connectivity.

The challenge to deliver service in the rural interior areas is illustrated through a case study of Kapit, a rural district area located in the state of Sarawak, as follows:

Case Study: Kapit Administrative District

Kapit Division is located in the Central interior region of Sarawak, bordered by Miri Division to the northeast, Bintulu Division to the north and Sibu Division to the west.

The entire land area of Kapit is approximately 38,934 square kilometres and it is the largest administrative division in Sarawak, with a population size of 112, 762, as of 2010 (Department of Statistics Malaysia, 2011). In relative terms, it is about one third the size of the whole of Sarawak and is significantly larger than Pahang.

Kapit has a rugged physical terrain and is the only division in Sarawak still not linked via roads. Connectivity is largely dependent on river transportation, using longboats and express boats. A majority of towns and villages are located along the Rejang river, together with remote pockets of longhouses and settlements.

In terms of government health care, there is only one non-specialist district hospital, Hospital Kapit that provides tertiary healthcare services.

At lower levels of health care, there are health clinics located in the four district towns. For the Kapit health clinic, the staff is made up at 94 personnel, one family doctor, one medical specialist and seven MOs. There are also clinics at Song, Belanga and Sungai Asap. Aside from this, there is a Riverine Rajang Mobile Clinic that operates on board a boat to serve some 90 longhouses along the river (The Borneo Post, 2017).

Up until 2016, Hospital Kapit did not have any psychiatric services nor resident psychiatrists. Patients would have to wait for doctors to travel in from Sibu Hospital, the nearest specialist hospital. These visits would take place approximately every two weeks, with doctors travelling a 3-hour long journey by express boat. (Flying doctor services are reserved for extremely rural areas and are not available for the Kapit Hospital as it is still possible to use river transportation).

Last year, the urgent need for specialist services – including psychiatrists – to be placed at the Kapit hospital was highlighted by DAP's Katibas Paren Nyawi.

"Hospital Kapit only receives periodic visits (lawatan secara berkala) from sub-speciality officers (pegawai perubatan pakar) including those from the fields of general medicine, general surgery, ophthalmology,orthopaedics and psychiatry," he was quoted as saying (Utusan Borneo (Sarawak), 2016).

According to the same report, about 60 to 70 (unspecified) patient cases get referred to Sibu Hospital each month. However, many patients would be reluctant to make the transfer because of the long and uncomfortable journey (it is a three-hour boat journey between both hospitals) and also because they could not afford to pay.

In a phone interview with a source from Kapit Hospital, it was discovered that a specialist clinic has been set up with one resident psychiatrist as of 2017[22]. However, patients who are acutely ill or unstable and liable to harm others will still have be referred to the Sibu hospital, which probably means that there are still no inpatient wards in the hospital.

4.2. Discussion and Policy Recommendations

The alarmingly low recruitment rates of psychiatrists into public hospitals points to a clear deficit of these specialists, within treatment settings that are meant to be the most accessible for the general population.

Against the backdrop of swelling outpatient and inpatient attendance at government psychiatric clinics[23], the number of psychiatrists in public healthcare remain significantly lower than what is required for population needs. If these shortages are not addressed, patients in the public sector will be forced to bear the brunt of compromised access to mental health services and poor health outcomes.

It is important to investigate the causes of these staff shortages, in order to formulate and implement remedial strategies. The following section discusses possible reasons for the current shortages of psychiatrists in public healthcare, with emphasis on the challenges faced by medical graduates in gaining the specialist qualifications needed to practise as a psychiatrist. Several recommendations will be made as to how conditions may be improved.

[22] Phone interview with ER department, Hospital Kapit, on 26th May 2017, 5.03-5.13 p.m.
[23] Please refer to Chapter 3 for a fuller discussion of the rising demand for mental health services in Malaysia.

4.2.1. Stigma among doctors

The relatively low numbers of psychiatrists may be linked to negative attitudes towards mental illness among the medical profession, and consequently, low interest among medical graduates to pursue psychiatry as a career.

In Malaysia, literature exploring attitudes toward psychiatry as a field of specialty among medical students have come up with mostly negative findings. In 2002, for example, a study done among a sample of medical students from the Faculty of Medicine, University Malaya revealed a majority of first year students had little tolerance towards the mentally ill. Using two dependent measures (the social distance scale and dangerousness scale) to ascertain attitudes toward mental illness, the study found that a statistically significant majority of pre-clinical students harboured negative opinions about the mentally ill. One student, prior to contact with psychiatric patients, had quoted "black magic" as the cause of mental illness (Mas, 2002).

More recently, a 2015 study on recruitment measures to encourage interest in psychiatry among the student population in Penang Medical College showed a similar trend of pre-existing negative attitudes (Vasudevan. U, Jun, Panikulam, Saleem, Hassali, & Russell, 2015)[24].

In the first half of the study, a 30-item 'Attitudes to Psychiatry' questionnaire (ATP 30) had been distributed to a sample of Year 3 and Year 5 medical students. The results showed that, in terms of career preference, psychiatry was ranked sixth of seven specialties for both Year 3 and Year 5 students.

Students were then shown a film portraying the working life of a psychiatrist through a series of dramatized clinical scenarios. Although there was a generally favourable impression, among the Year 3 students, a predominant critical theme in the responses was that there was too little information about the 'negative aspects' of the profession, especially the extent to which patients could be violent. Quoting some responses:

"In reality the doctor may encounter some patients who are violent"

"It didn't really show the downside of psychiatry- how it affects the psychiatrist's life."

The findings from both these studies are important evidence of a prevailing negative attitude towards the psychiatric profession among medical students, particularly those who had not yet received any clinical experience in psychiatry. These attitudes may be have been cultivated and absorbed through being exposed to negative societal stereotypes of people with mental illness in wider society. This would then have influenced them to be ill-disposed towards the mentally ill, even before stepping into medical school and later on, as graduates entering the healthcare workforce.

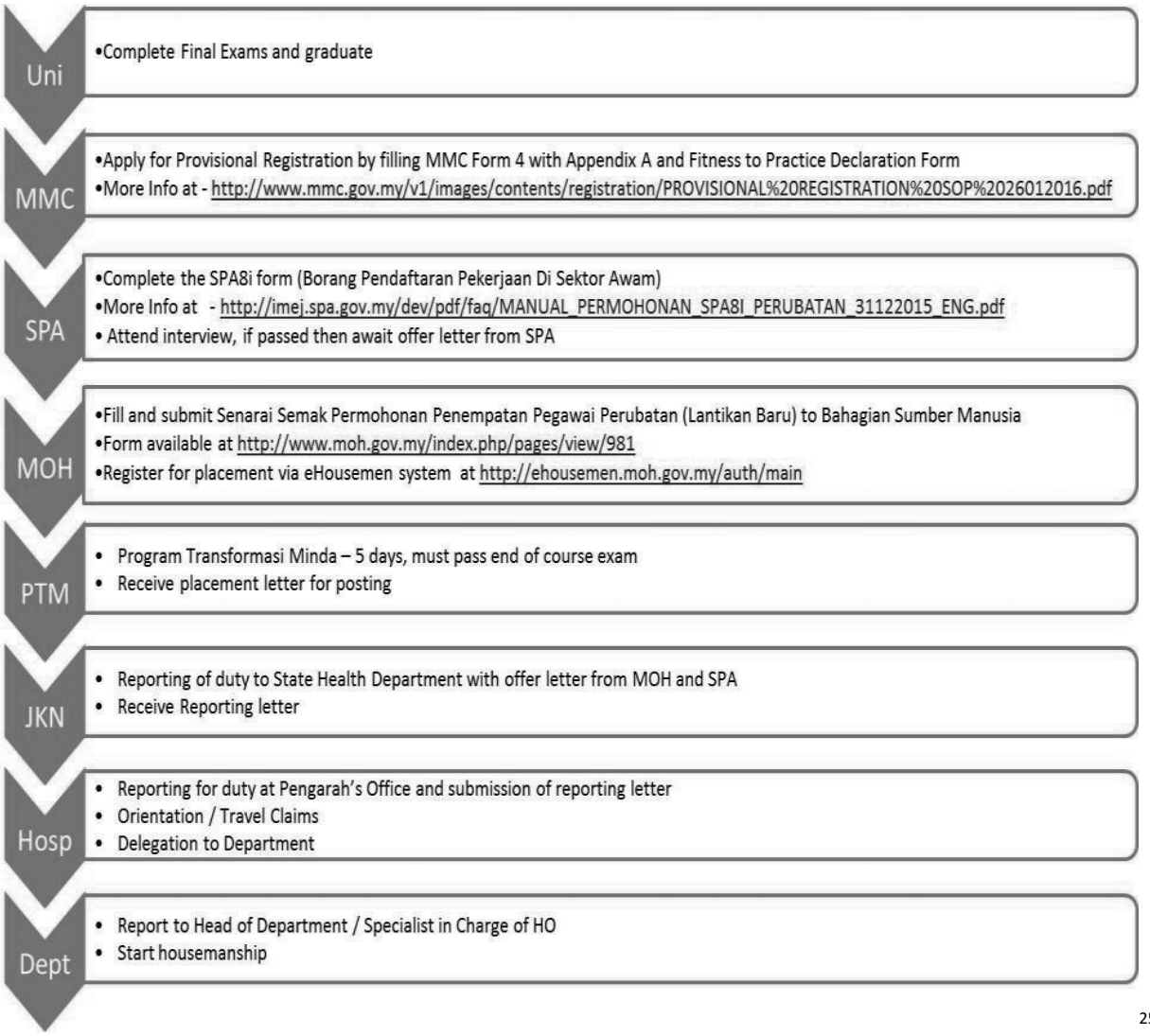
4.2.2. The Long Road to Becoming a Psychiatrist

Aside from stigmatizing attitudes, another source for the unpopularity of psychiatry among medical as a field of speciality may lie in the reality that it takes many years of education and training to enter into the profession.

In Malaysia, the medical student who aspires to become a psychiatrist must first complete five to six years of medical training in an accredited local or overseas university. After graduating with a Medical Degree, he or she would need to undergo a two-year trainee period in a government hospital (known as housemanship) in order to enter the workforce.

The journey to becoming a houseman in itself is a laborious process. The figure below shows a flowchart of steps that medical graduates must take in order to obtain a place on the programme.

Figure 28: Flow Chart Showing Medical Student Journey from Exams to Housemanship



[25]

Source: Lim Chee Han, Housemanship Programme in Malaysia: Availability of Positions and Quality of Training, 2017

After receiving the Medical Degree, a medical graduate is required to apply for provisional registration with the Malaysian Medical Council (MMC) prior to starting general clinical training. If the university is not recognized in the Second Schedule of the Medical Act 1971, the graduate will first have to sit and pass a dual-part (theory and clinical components) examination in order to 'qualify' as an applicant (Malaysian Medical Council Registry).

[25] Key : Uni = University, MMC = Malaysian Medical Council, SPA = Public Service Commission /Suruhanjaya Perkhidmatan Awam, MOH = Ministry of Health, PTM = Program Transformasi Minda, JKN = State Health Department / Jabatan Kesihatan Negeri, Hosp = Hospital, Dept = Department

If this seems somewhat tedious, the third and fourth steps tend to be the most time-consuming: waiting to be called for an interview by the Public Service Commission (PSC) and then further waiting to be allocated a position in one of 44 housemanship training hospitals under the MOH.

Last year, the MOH itself admitted that waiting periods for a housemanship placement could take anywhere between 6 to 9 months.

Once the training period is completed, the houseman formally enters the workforce as a trainee doctor (Medical Officer), and changes his status on the MMC registry to that of a "fully registered" medical practitioner.

At this juncture, he or she may finally start to consider applying for specialist training to become a psychiatrist. However, a survey of entry requirements for local postgraduate psychiatry programmes shows that a majority of postgraduate Psychiatry Departments require trainee doctors to have served a further one year in public service before applying for candidature, even after they have been fully registered with the MMC.

Table 6: Table Showing Breakdown of Postgraduate Psychiatry Courses offered in Local Universities

University	Degree Title	Course Duration	Minimum Entry Requirements	Study Fees
Universiti Sains Malaysia	Master of Medicine (Psychiatry)	4 years	i. Possession of Medical Degree, such as MBBS, MD, MBChB or equivalent qualifications approved by the University Senate ii. Full registration with the Malaysian Medical Council (MMC) iii. At least 2 years of working experience post-graduation, either in hospitals or other institutions certified and accepted by the University Senate.	RM54,400
Universiti Putra Malaysia	Master of Medicine (Psychiatry)	4 years	i. Possession of Medical Degree, such as MBBS, MD, MBChB or equivalent qualifications ii. Full registration with the Malaysian Medical Council (MMC) iii. At least 3 years working experience based in government service and at least 1 year clinical experience as a medical officer after full registration with the MMC	RM40,000

Universiti Teknologi Mara	Master of Medicine (Psychiatry)	4 years	i. Possession of recognized Medical Degree ii. Full registration with the Malaysian Medical Council (MMC) iii. At least 1 year post-registration clinical experience	RM40,000
Universiti Kebangsaan Malaysia	Master of Medicine (Psychiatry)	4 years	i. Possession of Medical Degree, such as MBBS, MD, MBChB or equivalent qualifications ii. Full registration with the Malaysian Medical Council (MMC) iii. One year of clinical experience as a medical officer.	RM40,000
University Malaya	Master of Psychological Medicine	4 years	i. Possession of Medical Degree, such as MBBS of the university or an equivalent qualification approved by University Senate ii. Qualify for registration as a medical practitioner under the Medical Act 1971 iii. At least one year of post-full registration clinical experience approved by the University Senate	RM40,000
International Islamic University Malaya	Master of Medicine (Psychiatry)	4 years	N/A	RM40,000

*These rates apply for the 2018 intake. Following a unanimous decision made during a meeting of public university Psychiatry deans in 2017, a ceiling raise was instilled for all postgraduate psychiatry course fees offered by public universities.

~ No specific details were available during the time that the author made an inquiry with IIUM's Programme Division officer, as the programme proposal was still awaiting approval from the Malaysian Quality Assurance (MQA).

Source: author's own compilation, based on data sourced from relevant academic institutions' websites and phone interviews with Postgraduate Programme Division officers.

As shown in Table 6, all current postgraduate psychiatry course providers (with the exception of the department in University Sains Malaysia (USM)) require candidates to have undergone at least one year of post-full registration clinical experience before applying to the programme.

Therefore, taking into account the compulsory four years[26]needed to complete training, the final year count for time taken by a first year medical student to become a fully qualified psychiatrist would be no less than 14 years, which is indeed a hefty time investment.

Time is precious, and so too is money, especially for the Medical Officer fresh out of housemanship training and earning a basic wage. In Malaysia, he or she would have to fork out least RM 40,000 in study fees alone to commence postgraduate psychiatry training- this, on top of other miscellaneous course payments such as application fees and living accommodation costs (if he or she is planning to stay on campus).

4.2.3. Policy Recommendations

The apparent unpopularity of psychiatry as a field of psychiatry should be addressed meaningfully, since the level of stigma and unfavourable attitudes towards psychiatry among medical students strongly contributes to a reduction in interest among students to take up psychiatry as a career. The following recommendations are proposed:

(A) Revamp undergraduate medical syllabus to include greater psychiatric education.

The Ministry of Higher Education (MOHE) should consider revising the content of the undergraduate medical course syllabus to include greater psychiatric education, in order to give medical students more exposure to discussions on mental disorders while still in medical school.

This could mean, for example, introducing a module on mental illness and psychiatry during the first two years of medical school. Exposure at the early stages might encourage more positive and empathetic attitudes towards those with emotional and mental problems, and therefore more positive attitudes towards psychiatry as a whole.

(B) Give medical students greater exposure to psychiatry in clinical settings

Students should be allowed to undergo clinical psychiatry posting in their fourth year. Fourth year medical students should be allowed to visit psychiatric departments in teaching hospitals and MOH hospitals, to expose them to patients attending the psychiatric clinic and wards. Exposure to clinical settings would give them a taste of what it is like to work as a psychiatrist in 'real life' and thus dispel some of their doubts or misgivings about the profession. It may even give them greater confidence to deal with patients with mental health problems.

[26] This is only the minimum stipulated length of a postgraduate psychiatry course. The entire duration may extend up to 7 years, if, during the course, the candidate is unable to fulfil the conditions to move on to the next phase.

(C) Make Psychiatry as a compulsory posting in the housemanship training programme and 'fast-track' deserving housemen who are keen to pursue psychiatry as a career

Change may also be implemented in the 2-year housemanship training programme. Under the current guidelines, a house officer is required to undergo six different discipline postings, each shift lasting for a total of four months. Out of these, five are compulsory major discipline postings[27] and for the sixth posting, house officers may opt for one of four alternative postings: emergency medicine, anaesthesiology, psychiatry or primary care (based in primary care clinics) (Malaysian Medical Association, 2016).

> It is recommended that Psychiatry be made a compulsory part of the housemanship training programme instead of just an alternative posting. This may be done by breaking the sixth posting into two-month shifts and allowing house officers to choose another alternative posting on top of psychiatry, which should be made a non-optional placing.

The second obstacle, namely the long road of education from medical graduate to a licensed psychiatrist, is more challenging to tackle, since good medical training is essential to produce professionals of a high quality and standard. Nevertheless, the author recommends that the MOH consider modifying the terms and conditions of the housemanship programme to encourage greater uptake of postgraduate psychiatry training without compromising the quality of training. The following recommendation to 'fast track' deserving housemen refers:

> According to standard procedures, house officers are only eligible to apply for postgraduate training once they have completed the compulsory two years of housemanship training- an achievement that earns them official confirmation into medical service and the rank of Medical Officer (Malaysian Medical Association, 2016)..

> In 2016, the Director-General of Health Malaysia, Datuk Dr Noor Hisham Abdullah had announced that the MOH was mooting a fast-track system to enable HOs with a proven track record of excellence in training, to enjoy accelerated promotion to Medical Officer in their chosen field. This proposal was in response to the challenge of medical graduates having endure a long duration of compulsory training before being free to pursue postgraduate training to become specialists.[28]
>
> The author strongly recommends that the MOH approve and implement this 'fast-track system' in order that housemen with a strong inclination to pursue psychiatry as a career may be encouraged to follow through with their goals. As a 'pilot', the MOH could shortlist a number of deserving house officers for the 'fast track' programme, and reserve a certain share of positions for those who are interested to pursue psychiatry as a career. Follow-up mechanisms should be

[27] The five compulsory core discipline postings are as follows: Internal Medicine, General Surgery, Obstetrics & Gynaecology, Paediatrics, Orthopedics.

[28] Press Statement, Director-General of Health Malaysia, "Strengthening the Housemanship Training Programme", 9 March 2016.

established to ensure that these candidates do follow through with signing up for postgraduate psychiatry training, once they have graduated from the housemanship programme.

If the above policy recommendations are properly implemented, it is the author's belief that the changes, though small, will help inculcate healthy attitudes towards psychiatry and foster greater willingness and even enthusiasm to consider psychiatry as a career option among future doctors.

4.3. Dearth of Clinical Psychologists in Public Service

4.3.1. The Role of Clinical Psychologists in Mental Healthcare

Clinical psychologists play an important role as health providers who specialize in diagnosing and treating illnesses of the mind using psychotherapeutic techniques.

Unlike psychiatrists, clinical psychologists are not medical doctors and cannot prescribe medication to treat mental illness. Nevertheless, they provide an important service to mentally ill patients by delivering evidence-based psychological interventions to assist their mental and emotional recovery. They help the patient identify the causes or triggers leading to dysfunctions in their life, be aware of the distortional thoughts, suppression and repression of emotions that create dysfunctional behaviour, and discuss intervention plans and goals to help them move forward in facing and conquering these challenges.

In that sense, clinical psychologists differ from counselling psychologists, who have a stronger focus on treating patients with fewer pathological mental problems.

4.3.2. Distribution of Clinical Psychologists

In Malaysia, there is currently no formal or legal regulation for clinical psychologists that requires them to register to practice. The lack of official regulation makes it difficult to determine the nation-wide headcount. In 2011, a report produced by Malaysian Mental Health Association for a regional conference on public health gave the number of clinical psychologists in the country in that year as 82 (Ang K. T., 2011).

Despite the lack of official sources, this study attempts to gauge the numbers and distribution patterns of clinical psychologists, by accessing the member registry of the Malaysian Society of Clinical Psychology (MSCP), the main body for the profession in the country. Although registration with the MSCP is voluntary, the number of practitioners that were registered here as of February 2017(when the register was last updated) is of sufficient volume to perform analysis

4.3.3. Methodology

Data retrieval was carried out on 7th August 2017.

The full member registry list of the Malaysian Society of Clinical Psychologists (MSCP) was downloaded from its website (Malaysian Society of Clinical Psychology). Data was extracted manually, by noting down the names of practising clinical psychologists, place(s) of practice and type(s) of practice and keying the information into an Excel spreadsheet. On the date of retrieval, a total of 98 clinical psychiatrists were registered with the MSCP. Out of the 98 names, three did not list their place of practice, while another two were working as human resource managers in corporate settings, and one member was employed as a full time private tuition teacher. These 6 names were omitted from the analysis, leaving a total of 92 names in the sample.

The members in the sample were then sorted according to workplace settings. Out of the 92 clinical psychologists whose names were registered with the MSCP, very few were based in government healthcare service. 8 clinical psychologists were working in MOH hospitals, constituting less than 10% of the entire sample. A further 3 members were based in the three teaching hospitals under the MOHE. There were no clinical psychologists serving in psychiatric hospitals.

By contrast, nearly half of the 92 members were working in private healthcare. In total, there were 45 clinical psychologists based in private settings, and of this, a majority (71%) were working in private specialist clinics. The remaining 29% were attached to private hospitals.

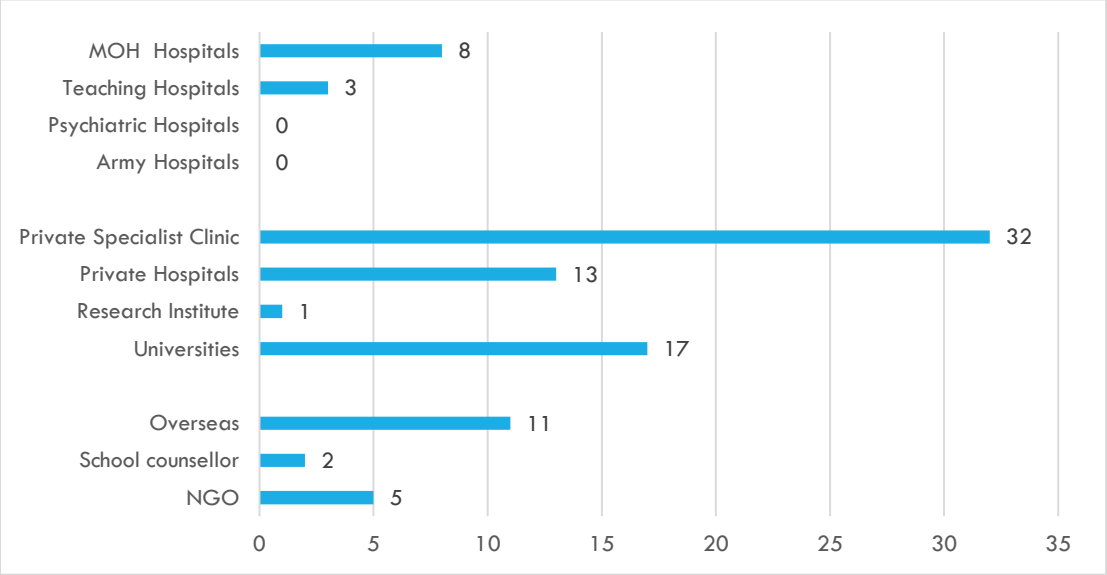
A small proportion of members were based in academic settings such as universities (17) and research institutes (1). It is interesting to note that the academic group still outnumbered the group delivering healthcare in government hospitals.

11 clinical psychologists were working overseas, based in countries such as Australia, Singapore, and China. These members were primarily working as researchers and university lecturers in their respective settings.

A final handful of members were holding non-formal healthcare occupations, either as school counsellors or in NGO-related work.

31 members (31.6%) clinical psychologists were practising in multiple locations and in a variety of workplace settings. For example, some were working in two different private clinics located in the same state, while others were dividing their time between clinics located in different states. There were also members who worked in a combination of different workplace settings (e.g. private hospitals and universities; private hospitals and private clinics; public hospitals and private clinics; and private clinics and NGOs.

Figure 29: Distribution of Clinical Psychologists across Public and Private Healthcare Settings in 2017



Source: Malaysian Society of Clinical Psychologists member list, updated 2017

4.3.4. Dearth of Clinical Psychologists in Government Hospitals

Out of the 92 MSCP-registered clinical psychologists whose names were included in the sample analysis, merely 11 were contributing their professional services in the public healthcare sector. By comparison, 45 clinical psychologists were found to be working in private healthcare settings, based in private clinics or in private hospitals.

This shortage points to a major understaffing issue of clinical psychologists in public hospitals, and a contradiction of the MOH's service development targets under the 11th Malaysia Plan framework to provide psychiatric services[29] as a resident service across the entire hospital network, including minor specialist, major specialist and state hospitals (Ministry of Health, Malaysia).

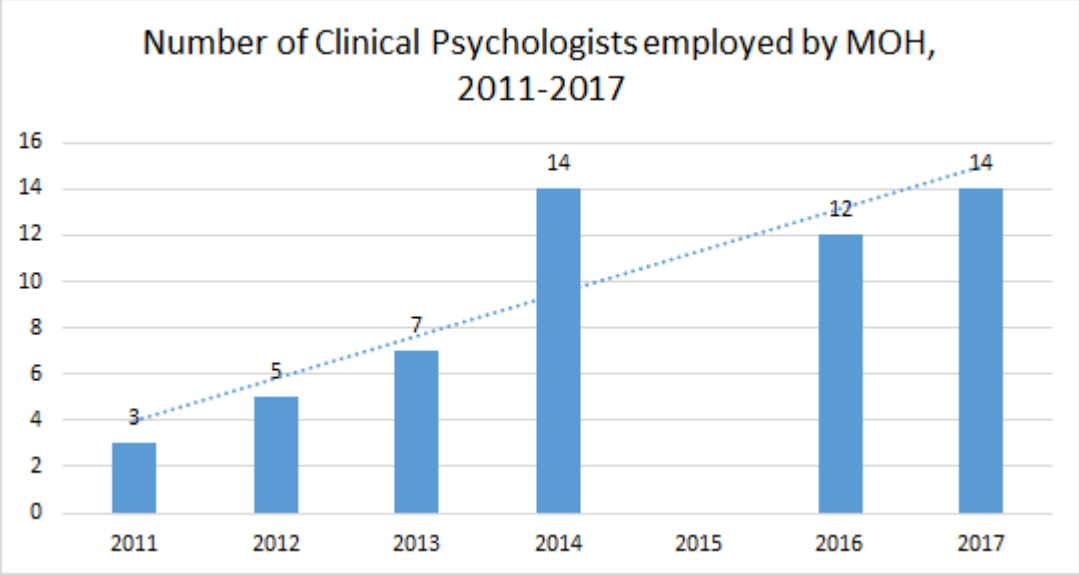
As of November 2016, 9 out of 28 minor specialist hospitals, 24 out of 27 major specialist hospitals and all 14 state hospitals were identified as having provided resident psychiatry services, according to a report produced by the Medical Development division of the MOH (Ministry of Health, Malaysia, 2016).

Yet on the 31st of January 2017, the Health Minister Datuk Seri Dr S. Subramaniam, responding to a question raised in the Dewan Rakyat on the numbers of clinical psychologists serving in Malaysia, stated that only 15 clinical psychologist positions were available in MOH facilities, and out of this, 14 had been filled.

[29] According to the Psychiatric and Mental Health Operational Policy, hospitals with resident psychiatric services should include 'psychosocial interventions' as a health service. These services are primarily performed by clinical psychologists.

The distribution pattern of these clinical psychologists was not revealed by the Health Minister, but what is clear is that the supply is not enough to meet the targets of the MOH to provide residential service in the 69 hospitals. In fact, their numbers are barely enough to cover the 14 state hospitals. There is a shocking undersupply of clinical psychologists in the government hospitals, but even more worryingly, this shortage has been a chronic problem for many years. In 2011, for example, there were just 3 clinical psychologists serving in government hospitals across the entire country. While the numbers have risen since then, the rate of increase has been extremely marginal, going from 3 to 14 over the span of six years.

Figure 30: Number of Clinical Psychologists employed by MOH from 2011 to 2017

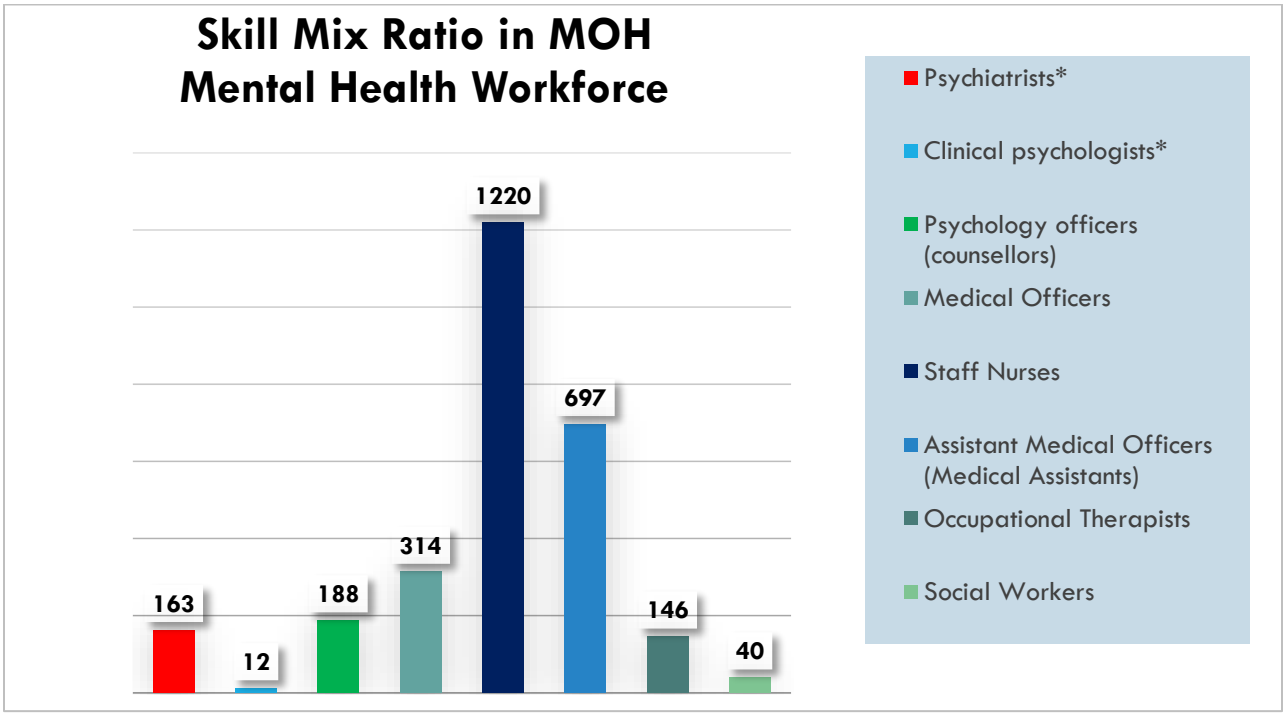


Sources: Ang, "Current Perspective in Mental Health", 3rd Asia Pacific Conference on Public Health, 14 Nov 2011; Ministry of Health Malaysia Country Profiles 2015 Malaysia Report; ASEAN Mental Health Systems report 2016; Parliamentary reply by Datuk Seri Dr S Subramaniam to YB Dr Ong Kian Ming (Question No. 416), 2017

4.3.5 Imbalance in Skill Mix

Compared to other categories of mental health providers, the number of clinical psychologists employed by the MOH has historically been extremely low.

Figure 31: Skills Mix in the MOH's Mental Health Workforce in 2016



Source: ASEAN Mental Health Systems Report, 2016

**The figure given for psychiatrists contradicts the figure given in the Speciality & Subspeciality Framework of MOH Hospitals under the 11th Malaysia Plan (2016-2020) report, which states the number of MOH-employed psychiatrists for the year 2016 as 190. The reason for this contradiction is as of now unclear to the author.*

In 2016, clinical psychologists made up the lowest proportion of all categories of government-based mental health providers, making up 0.04% of the entire workforce, or 12 of out of 2780 workers.

Furthermore, compared to other groups of mental health providers, clinical psychologists were found to be at abnormally low levels. In 2016, only 12 clinical psychologists were working in government healthcare facilities, compared to 163 psychiatrists, 188 counsellors and 146 occupational therapists. The approximate ratio of clinical psychologists to psychiatrists was 1:14.

Figure 32: Ratio of Clinical Psychologists to Psychiatrists employed by the MOH in 2011, 2013, 2016 & 2017

Sources: Human Resources for Health, 2015; Ministry of Health Malaysia; Parliamentary reply by Datuk Seri Dr S Subramaniam to YB Dr Ong Kian Ming (Question No. 416), 2017; National Healthcare Establishment and Worforce Statistics, 2009, 2012-2013; Malaysian Medical Council Registry; National Specialist Registrar; author's own calculations

Further comparing the ratio of psychiatrists to clinical psychologists employed by the MOH over the years, it is clear that there have been extremely anomalous disparities between the ratios of the two groups of mental health providers. To give an example, in 2011, there were as many as 62 psychiatrists to every 1 clinical psychologist working in the government hospitals.

These disparities in ratios have barely reduced over the years. Most recently, in 2017, MOH-employed psychiatrists still outnumbered clinical psychologists by a ratio of 10:1.

Compared to other mental health professionals, the ratio of clinical psychologists has remained heavily imbalanced over the years, and their absolute numbers in critically low supply. This dearth is a serious issue, as it hampers the provision of holistic care for people with mental disorders, especially poorer groups for whom public hospitals are the main point of access to care services.

4.4. Discussion and Policy Recommendations

4.4.1. Shortage of Clinical Psychologists in Government Hospitals Contradicts Recommended Standards

By and large, the recognition of services provided by clinical psychologists has not been well acknowledged by the MOH, even though on paper, they are duly recognized as an important group of mental health providers. As the official Psychiatric and Mental Health Services Operational Policy states:

"The need for clinical psychology services is on the rise in both private and public settings as people's awareness on mental health issues and the importance of psychological well-being increases every day. Clinical psychologists aspire to reduce psychological distress, as well as to enhance and promote psychological well-being. Working in a health and social care settings as a part of a multi-disciplinary team enables them to empower positive changes on their patients (Ministry of Health, Malaysia, 2011)".

The Operational Policy provides guidelines pertaining to different components of clinical psychology services, including the organization of human resources within the department. According to the recommendations:

"the unit shall be headed by a senior clinical psychologist… (who) forms a team of dedicated staff comprising clinical psychologists, trainees, general psychology officers and assistant psychologists that work closely with psychiatrists, medical officers, occupational therapists, social workers and nurses."

In reality, it is impossible that such a diverse team could be established in any government hospital, given the incredibly limited number of clinical psychologists in government service. As mentioned by the Health Minister, there are only 14 clinical psychologists currently serving in MOH healthcare facilities, yet there are already 45 MOH hospitals offering psychiatric services throughout the country!

4.4.2. Limited Vacancy Positions for Clinical Psychologists in Government Service

A potential key factor driving the critical lack of clinical psychologists in government service may be that the MOH creates very limited positions for these mental health professionals. In 2017, the Health Minister stated in a Parliamentary reply that as of 31st January 2017, there were 15 positions for Clinical Psychologists available in government healthcare facilities and of these, 14 positions had been filled.

Is there any way to verify the theory of limited supply of clinical psychologist vacancies in government hospitals? Although the MOH could not be contacted for an official statement, several red flags do suggest that there is at the very least an undervaluation of their roles.

Back in 2008, in an article published in the Malaysian Journal of Medical Science, former Vice President of the Malaysian Society of Clinical Psychology (MSCP), Dr Rahmatullah Khan, addressed the issue of the dearth of clinical psychologists in public service and the reasons underlying this critical lack.

Two main reasons were put forth in that article. Firstly, it was argued that the roles of clinical psychologists were quite often confused with that of counselling psychologists, as to a certain extent, both groups use similar techniques in treating mentally ill patients. Quoting the article:

"Clinical Psychologists use counselling techniques in their therapy and sometimes, because of that, their roles are quite often confused with counselling psychologists, who assist people with their daily problems that are not very serious in nature. In Malaysia, this confusion has also created some problems in government hospitals, where instead of creating positions for Clinical Psychologists, positions of Counsellors were increased."

Recent data strongly supports this statement made by the former MSCP Vice-President. In 2016, only 12 clinical psychologists were working in government healthcare facilities, compared to 163 psychiatrists, 188 counsellors and 146 occupational therapists).

4.4.3. The Process of Recruitment into MOH Services

In Malaysia, the Public Services Commission of Malaysia (PSC) acts as the official appointing authority for civil servants into federal public services, including paramedical trainees for the MOH[30]. Under Article 144(1) of the Federal Constitution, the PSC is mandated "to appoint, confirm, confer into permanent or pension status, promote, transfer and to exercise disciplinary control over personnel in for services covered by its jurisdiction."

The PSC maintains a fully computerized recruitment system called the Continuous Recruitment System (eMSM). Malaysians looking to enrol into public service must apply for vacant posts by completing the job registration form which is available on the PSC portal.

According to the PSC job registration guidelines, applications may be made any time and each application remains valid for one year. Applicants are also advised against waiting for published advertisements to be made before applying, as "the main purpose for media advertisement is to highlight any job vacancy" (Public Services Commission of Malaysia).

The process of shortlisting and appointment of candidates begins with the MOH supplying the PSC with information regarding available vacancies and criteria requirements for each post. The PSC will then scrutinize all candidates registered in its system prior to the date of vacancy submission and shortlist candidates based on the MOH's requirements. Successful applicants will then be contacted to attend an interview with a board consisting of PSC personnel and representative from the MOH.

[30] Allocations of successful trainees to nominated training centres are managed by the MOH themselves.

The guidelines further stipulate that, when the total number of vacancy is relatively small compared of the number of applicants, the shortlisting process shall be based on CGPA or the field of specialization depending on Ministry requirements (Public Services Commission of Malaysia).

4.4.4. The 'Three-in-One' Recruitment Conundrum

Out of the 15 vacancies for clinical psychologists that were opened up by the MOH early this year, 14 positions were filled, implying that there was a high demand for these positions among applicants.

Clinical psychology is a highly specialized field. Typically, those looking to enter into professional practice must pursue rigorous formal clinical training and supervision involving psychological knowledge and practice. Qualified clinical psychologists typically hold a Masters or PhD in Clinical Psychology. To a large extent, their training is comparable to the specialist training of a medical doctor who embarks on a postgraduate degree after completing his basic medical studies.

Given the high degree of training and standards of qualified clinical psychologists, it would not be unreasonable to expect that the MOH would create a separate vacancy rank for them, to distinguish them from other applicants who are either medical trainees or 'junior doctors' with basic degree qualifications.

At the very least, there should be a separate set of recruitment criteria requirements for clinical psychologists, that are distinct from the recruitment criteria of counsellors and psychologists who have not undergone formal clinical training.

However, based on the information on offered positions under the PSC portal's job listings, it appears that there are no specific vacancy posts designated for clinical psychologists. The closest vacancy position for clinical psychologists appears to be that of a 'Psychology Officer' (Pegawai Psikologi Gred S41).

The MOH's qualification criteria requirements for Psychology Officers are extremely sweeping and encompass the following:

a) Bachelors' degree in the fields of psychology, clinical psychology or counselling from a local institution or 'on par' qualifications that are recognized by the government.
b) Bachelors' degree in the field of behavioural sciences together with a diploma in counselling psychology from a local institution or 'on par' qualifications that are recognized by the government.
c) Master's degree in the fields of psychology, clinical psychology or counselling from a local institution or 'on par' qualifications that are recognized by the government.
d) Postdoctoral (PhD) degree in the fields of psychology, clinical psychology or counselling from a local institution or 'on par' qualifications that are recognized by the government.

The job description of a Psychology Officer is given as follows: an officer is responsible for planning, executing and coordinating all activities related to the field of psychology/clinical psychology/ counselling

to clients ("bertanggungjawab merancang, melaksana dan menyelaras aktiviti-aktiviti berkaitan bidang psikologi/ psikologi klinikal/kaunseling kepada klien").

The Psychology Officer may also be recruited into various Ministries/Agencies (pelbagai Kementerian/ Jabatan) and not just hospital-based settings.

Several observations may be drawn from the qualification requirements and job description for the post of Psychology Officer.

Firstly, the post is open to mental health providers from various backgrounds, including clinical psychologists, psychologists and counsellors, and applicants need not have a specific level of qualification in order to be eligible. Bachelors, Masters and even PhD degree-holders are all eligible to apply for the same post.

Secondly, candidates who are successfully appointed to become Psychology Officers may not necessarily end up serving in a hospital, but in settings that are non-related to healthcare, depending on where the MOH chooses to post them.

Several problems arise from these conditions of appointment. Firstly (and particularly since the PSC does not provide information on the exact number of available vacancies), the clinical psychologist thinking of enrolling might be led to believe that he or she is disadvantaged in terms of hiring opportunities, given the 'three-rolled-into-one' recruitment that appears to force competition for positions with other professionals, namely psychologists and counsellors.

Secondly, clinical psychologists are not totally guaranteed of a job that enables them to put their clinical training to use. From the somewhat sweeping job description, not only they may be required to perform other tasks related to the field, they might even be posted to government ministries or agencies that have nothing to do with healthcare.

4.4.5. Perspectives of Clinical Psychologists on Hiring Opportunities in Public Healthcare

These issues regarding the recruitment process are a turn off for clinical psychologists to apply, especially since they have already invested time and money into gaining formal clinical training experience and qualifications.

Interviews conducted with two practising clinical psychologists in the private sector, both of whom were at different career stages, revealed their concerns for choosing not to enter into public service.

The first interviewee, Justine, was working as a full time clinical psychologist in a local private psychological centre. Her career was just beginning, having recently graduated from a local Masters of Clinical Psychology degree programme in early January of this year[31].

As a new practitioner, Justine shared that the biggest concerns for her and her fellow graduating batch mates, were career opportunities and pay.

"The general feeling among my course mates was that, after graduating, we needed to find jobs with pay that could justify that investment we put into our master's programmes," she explained.

After graduating, Justine had considered looking for a job based in a government hospital. However, her initial impression was that there were limited hiring opportunities in public service.

"From my understanding, a lot of (public) hospitals are not hiring clinical psychologists. Especially those in smaller towns. As far as I know, none of the public hospitals in Ipoh (her hometown) are hiring clinical psychologists. If I wanted to practise there, I would have to open my own practice," she shared.

While she believed that hiring opportunities are slightly better in the urban areas, her overall impression was that of a shortage of hiring opportunities in government service.

"In Selangor, there are public hospitals and the teaching hospitals like Hospital UKM and the UMMC that offer psychological services. But when it comes to hiring opportunities, it really depends on the hospital. Some hospitals hire clinical psychologists on a consultation basis, whereas other hire (them) full time," she observed.

Besides this, Justine was also noted that clinical psychologists were often required to take on heavy supervision duties for trainees apart from performing their duties.

As part of her clinical training, Justine had spent six to seven months based in the psychiatry units of Selayang Hospital and Kajang Hospital. While there, she noticed that there was often a shortage of practising clinical psychologists available to supervise students.

"There were issues where hospitals did not have enough clinical psychologists available to oversee students to clock the required supervision hours. Each trainee must have a supervisor to oversee him or her, but one supervisor usually couldn't take on more than three trainees at one shot. It was also a matter of whether they (clinical psychologists) wanted to supervise," she shared.

Even after making these observations, Justine had still entertaining thoughts of entering into public service. However, it was after scanning through the terms and conditions listed on PSC's job application form that she was convinced against applying.

[31] A telephone interview was conducted on 17 August 2017. For reasons of privacy, the interviewee did not wish to disclose her last name.

In particular, the failure of the PSC to clearly disclose hiring opportunities for clinical psychologists, was a turn off.

"As I recall, the only position listed on the PSC webpage which applies to a clinical psychologist is 'pegawai psikologi' (psychology officer). It was not very clear what we were signing up for," she explained.

Besides this, Justine was also discouraged that, instead creating a separate recruitment pathway for clinical psychologists, the MOH had chosen to combine recruitment of clinical psychologists, psychologists and counsellors into a single post.

To her, this seemed to suggest that there were limited job vacancies for clinical psychologists, though she did not know if the former was actually true.

"I think the problems are, on one hand, that there aren't enough positions, and secondly they're (the government) not really trying to find us. They don't actively recruit and they don't make the positions that are available known. Not many of my classmates knew about the PSC's recruitment process," she explained.

Significantly, she felt that there was an apparent undervaluing of her skillsets, due to the apparent 'blending' of roles between clinical psychologists and other mental health providers in the MOH recruitment process.

"While there is quite a fair bit of overlap between the work of clinical psychologists and counsellors and psychiatrists, (but) the fact is that psychiatrists don't do therapy. Perhaps some who are very motivated do, but in terms of practice, most of them function as doctors. In an ideal world, they would refer patients to psychologists, who perform assessments and come up with a diagnosis. Psychiatrists are not trained to write psychological reports, nor are they equipped with tools that we can use to tap into psychological symptoms. As psychologists, we are trained to use physical, observational, cognitive tests which we then use to write a comprehensive report."

The deterrents to applying for a job in public service for young clinical psychologists were also echoed by more senior and experienced practitioners, especially regarding lack of appreciation.

In a second interview, Dr. Joel, a clinical psychologist and director of a private psychological centre in Petaling Jaya, stressed underappreciation for the services of clinical psychologists in the public hospitals as a major demotivating factor for the profession as a whole.[32]

"Most government hospitals do not recognize clinical psychologists. In the eyes of the government, we are not needed because there are already psychiatrists and counsellors to do our work," he said.

[32] Telephone interview was conducted on 22nd March 2017. For reasons for privacy, the interviewee did not wish to disclose his last name.

4.4.6. Policy Recommendations

The issues driving the shortage of clinical psychologists in public service appear to be primarily related to the views held by practitioners that firstly, there are not enough positions for clinical psychologists in government hospitals, and secondly, that their services are undervalued by the MOH.

In particular, the apparent 'blending' of roles between clinical psychologists, psychologists and counsellors in the recruitment process sends a strong message to clinical psychologists that the MOH regards these other groups capable of delivering the same services, when in fact, they play a more nuanced and wide-ranging role, as pointed out by Dr Rahmatullah Khan had pointed out in his article.

"Unlike counselling, the field of clinical psychology (has) branched into sub-specializations, (with over) 200 kinds of therapeutic techniques," he wrote.

Moreover, although each performs psychological treatment a certain extent, trained clinical psychologists have specific set of skills such as interpreting psychological test and treating patients using evidence-backed psychotherapy techniques which are unique from the roles of the other two mental health providers. This, according to Dr Rahmatullah Khan, leads to them contributing clinical expertise to other sub-specialties of medicine.

"Clinical psychologists… are not only called upon to treat psychological disorders but are also required to investigate, screen and advise or give recommendations for the treatment of clients referred to them by physicians, surgeons, medical practitioners, social workers, nurses, lawyers etc. In some teaching hospitals, clinical psychologists served in (a wide range of departments including) psychiatry, paediatrics, surgery, medicine, community medicine, obstetrics and gynaecology."

For the degree and level of training experience that they have gone through, it is not unreasonable to expect that the MOH's apparent undervaluing of their skillsets- as perceived through the 'combined recruitment' and sweeping job description terms- would be a turn off for any clinical psychologist. Whether or not these allegations are true, it remains these perceptions have influenced several against applying to serve in government hospitals.

In order to address the undersupply of clinical psychologists meaningfully and encourage a shift in perception of public service, the following policy recommendations are proposed:

(A) Create separate recruitment posts for Clinical Psychologists

The MOH should restructure its hiring system and create separate recruitment pathways for clinical psychologists, instead of 'lumping' their recruitment together with other health providers. This entails working together with the PSD to create separate and distinct job positions/ranks specifically for clinical psychologists.

The current combined recruitment of clinical psychologists, psychologists and counsellors into the single post of 'psychology officer' is a misguided allocation. It is very likely that the absorption rate of clinical psychologists into government service will remain low if they believe that they have to keep competing for positions with psychologists and counsellors. Moreover, as Justine's case has shown, candidates may even be discouraged to apply to work with the MOH if they are unable discern a clear career development pathway in public service.

(B) Set up separate Clinical Psychology departments in all government hospitals

Secondly, the MOH should consider setting up a separate department of clinical psychology in all government hospitals with resident psychiatric services. Currently, clinical psychologists working in public hospitals are most based in outpatient clinics within the psychiatry unit.

While this arrangement is indeed recommended by the Psychiatric and Mental Health Operational Policy, it reflects a perception that that the clinical psychologist's role is only relevant within the domain of psychiatry, when in fact their skills in mental health and psychological therapies extend to many other areas of healthcare.

Aside from working with psychiatric patients, clinical psychologists are often called upon to investigate and screen patients referred by other departments, ranging from paediatrics, surgery, community medicine, obstetrics and gynaecology, who may show symptoms of mental health disturbances as a side-effect of their physical illness.

As the services of clinical psychologists regularly intersect with other medical services, it would make sense to establish a separate department for them and create more vacancy positions for these mental health providers to work in government hospitals.

(C) Create more public-private partnerships to share human resources

Psychotherapy is a crucial form of mental health care, and statistics show that there is a great need for more clinical psychologists to treat the population in need.

Malaysia currently faces a severe skills shortage in clinical psychologists based in public service. Even as measures to address these are carried out, it is clear that there will still be a recruiting lag before the services of more clinical psychologists are made accessible to a majority of the population.

As an interim measure, and to help assuage the shortage, the MOH should consider forming partnerships with private healthcare providers to outsource services of private clinical psychologists, either on a temporary or permanent basis.

Priorities should be given to hospitals located in rural areas which have populations that are more prone to developing mental health issues, as well as certain states which have been identified as having high risk populations, like Sabah, Sarawak and Kelantan.

Though it will require detailed discussion collaboration and buy-in from both the public and private sector to set terms and conditions, the idea of public-private partnerships is not entirely unusual. In fact, suggestions for such actions have already been put forth in the "Specialty and subspecialty framework for the MOH Hospitals under the 11th Malaysia Plan" framework report, drafted by the Medical Development division of the MOH.

In that report, the MOH outlined several guiding principles to improve medical services performance delivery, of which included the following:

"Where there is no specialist/subspecialist to provide a critically needed service, services may be procured from the private sector, universities, medical colleges or the non-MOH sector on a contract (outsourced) sessional or honorarium basis. The Medical Advisory Committee of the relevant hospital will identify the need for such procurement and make recommendations to the respective State Health Department or the MOH for approval (Ministry of Health, Malaysia, 2016)."

The MOH should seriously consider applying the principle of sharing human resources between the public-private sectors to clinical psychologists, as this would help increase the availability of their services to a wider majority of the population.

4.5 Developing Clinical Psychology Manpower in Malaysia

Aside from introducing more avenues for clinical psychologists to serve in public hospitals, the development of their services must come hand-in-hand with ensuring that there is a good pool of available talent to meet these service needs.

Unlike psychiatrists who exist in larger numbers (though still insufficient to wholly meet population needs), the number of practising clinical psychologists in Malaysia has remained at dismally low levels. In 2011, there were 82 practitioners. Six years later, the numbers of clinical psychologists based in Malaysia were at 92, based on the MSCP members' registry- an extremely minimal increase.

It is clear that Malaysia is suffering an overall shortage of these mental health provider. To address this shortage, there is a need to scrutinize the formal training programmes for clinical psychologists provided in local universities and assess whether these are of sufficient quantity and quality to train more batches of qualified professionals to serve in the mental health workforce.

4.5.1. Clinical Psychology Training Programmes

Formal clinical psychology training typically takes the form of a postgraduate Masters or doctoral programme involving supervised clinical placements and coursework.

Clinical psychologists are allied health professionals who have a Bachelor's degree in psychology and at least a Master's degree in Clinical Psychology[33]. Unlike the medicine, where graduates must pass through a two-year period of housemanship training before enrolling in postgraduate studies, a psychology graduate may apply to a clinical training programme immediately after completing the basic degree.

Until today, there is only one local university that provides postgraduate clinical training for psychology, namely Universiti Kebangsaan Malaysia (UKM), which offers a two-year full time 'Masters of Clinical Psychology' programme. Quoting the programme prospectus:

"The programme consists of structured coursework, research and clinical practical training. Core subjects include child and adolescent clinical psychology, adult clinical psychology, psychological testing and assessment, psychotherapy approaches, cognitive-behavioural assessment and therapy, and research methods and statistics. Students will undergo clinical placement and training at the UKM Health Psychology Clinics as well as several government hospitals, university hospitals and mental health institutions nationwide. Throughout the clinical practicum students are trained to conduct clinical assessment, diagnosis and perform individual and group psychotherapy with children, adolescents, adults and older adults. Students are also required to carry out a research project in clinical psychology such as psychological disorders related to issues, psychogeriatric, psychosexuality, substance misuse and abuse, quality of life, psychological medicine and psychological rehabilitation under close supervision of faculty members" (University Kebangsaan Malaysia).

Apart from UKM, none of the other public universities appear to have followed suit in setting up postgraduate programmes in clinical psychology. While a handful do offer postgraduate programs related to psychology, these programs are largely cross-disciplinary in nature (such as educational psychology or philosophy in psychology) instead of a focussed clinical psychology approach.

Table 7: Breakdown of Postgraduate Psychiatry Courses Offered in Local Universities

University	Degree Title	Course Duration	Available Places	Entry Requirements	Total Study Fees*
Universiti Kebangsaan Malaysia	Master of Clinical Psychology	2 years	10 per intake	Good pass in SPM and credit in Malay Language. A Bachelor's Degree in Psychology with minimum 3.00 CGPA, or its equivalent.	RM10,040

[33] In overseas countries, most hiring positions for clinical psychologists call for practitioners to have doctorate on top of their masters and basic degree qualifications.

HELP University	Master of Clinical Psychology	2 years	12-15 per intake	Bachelor's degree in Psychology, with at least a Second Class Honours (Upper division), and minimum 3.00 CGPA, or its equivalent.	RM 57, 000
Cyberjaya University College of Medical Sciences	Master of Clinical Psychology	2 years	20 per intake	Bachelor's Degree in Psychology with a minimum 2.75 CGPA / Bachelor's degree in other fields with minimum 2.75 CGPA. This degree should have a minimum 30 or 45-credit Psychology module or equivalent, and applicant must have obtained a 2.75 CGPA in said module. For the 30-credit module, applicant should have a minimum score of 550 in the Psychology subject of the Graduate Record Examination (GRE).	RM32,650
Sunway University Malaysia (in partnership with University of East Anglia)	Doctoral Programme in Clinical Psychology (ClinPsyD)	2+1 model˜	N/A	Equivalent of at least a 2:1 honours degree in Psychology; at least one year's relevant experience at the time of application; English language proficiency of IELTS level 7. Applicant must undergo an academic and clinical Interview with a panel of UEA Academic staff and Clinical Psychologists from the region.	RM 295,946 + additional fees for third year+

Sources: author's own compilation, based on data sourced from MQA website, phone interviews with Programme Division officers and website information from various universities: https://help.edu.my/department-of-psychology/master-of-clinical-psychology/ ; http://www.ukm.my/fsk/future-students/postgraduate/programmes-offered/master-of-clinical-psychology/; http://cybermed.edu.my/master-of-clinical-psychology/;
https://www.uea.ac.uk/documents/246046/12984259/International+Student+Brochure+2016-17.pdf

* Fees quoted are not inclusive of other miscellaneous charges incurred such as administrative fees and (where applicable) accommodation and lodging costs + this rate was calculated based on the stipulated fee of £26,950 for the 2017/18 academic year provided in the UEA's Doctoral of clinical psychology programme leaflet. According to the same document, tuition fees are subject to an annual increase. However, a reduced rate of tuition fees will be charged in the third year if candidates perform their final placements in their home country

4.5.2. Clinical Psychology Training is Dominated by Private Higher Education Providers

A survey of postgraduate clinical psychology programmes available in Malaysia shows that clinical psychology training is largely dominated by the private higher education sector. HELP University is the leading provider, being the first private university in Malaysia to offer psychology as a degree course and subsequently, a broad range of psychology-related programmes.

Besides HELP, the two other private universities that provide postgraduate clinical training in psychology are Cyberjaya University College of Medical Sciences and Sunway University Malaysia, which offers a three-year "2+1" doctoral programme in partnership with the University of East Anglia in the UK.[34]

4.5.3. High Costs and Stiff Competition to Enter into Clinical Training Programmes

Compared to UKM's postgraduate clinical psychology course, the tuition fees for these private courses are extremely steep. Sunway University's doctoral programme is currently the most highly priced. Candidates have to fork out approximately RM 300,000[35] for the first two years of training in the United Kingdom, on top of additional tuition fees incurred for their final year training in Malaysia.

While the Master's in clinical psychology courses offered at HELP and Cyberjaya University are much cheaper in comparison, these rates are still by no means affordable for the average Malaysian student. For example, Cyberjaya's tuition fees, while cheapest out of all three private courses, still triple the fees of UKM's Masters of Clinical Psychology course. To give another illustration, clinical psychology candidates in the private universities pay at least RM32,650 for a two-year course, compared to postgraduate psychiatry trainees, who pay RM 40,000 for a four year training programme in the local universities.

These are significant costs for aspiring clinical psychology students, and probably affect the demographic of students applying for courses. Those coming from wealthier backgrounds may have greater accessibility, but for the students of lower socio-economic standing, affordability is likely to be a major concern.

[34] The Sunway-UAE doctoral programme in Clinical Psychology is structured such that candidates are clinically trained in the UK for the first two years, before returning in their final year to complete training in Malaysia.

[35] This figure was derived by taking the fees for the 2017/2018 academic year i.e. GBP 26,950, multiplying by two and converting to Malaysian ringgit based on a GBP-MYR exchange rate of 5.49.

Another barrier is the difficulty in gaining a place. Based on the survey of courses, each programme takes in a very limited number of candidates, ranging from 10 to 20 students per intake. This may be due to a shortage of clinical training sites and available clinicians to supervise trainees, especially since government hospitals already suffer from an extreme shortage of clinical psychologists.

An interview with a graduate from HELP's clinical psychology Masters programme corroborated this. As part of her training, the interviewee had spent six to seven months based in the psychiatry units of Selayang Hospital and Kajang Hospital, two MOH hospitals based in Selangor.

While working in these public hospitals, one issue she had observed was the shortage of practising clinical psychologists available to supervise students.

"There were issues where hospitals did not have enough clinical psychologists available to oversee students to clock the required supervision hours. Each trainee must have a supervisor to oversee him or her, but one supervisor usually couldn't take on more than three trainees at one shot. It was also a matter of whether they (clinical psychologists) wanted to supervise," she shared[36].

4.5.4. Policy Recommendations

Formal training programmes are an important part of manpower planning and development. With regards to clinical psychologists, the availability and quality of these training programmes will have a direct influence on the potential of creating more qualified and trained professionals to contribute to the manpower required locally.

The following recommendations are suggested in order to create greater access and equity to postgraduate clinical training programmes in Malaysia:

(A) Increase the number of postgraduate clinical psychology training programmes, especially in the public universities

To date, the spectrum of formal clinical psychology training available in Malaysia consists of three Master's programs offered by UKM, HELP University and Cyberjaya University, and one doctoral level program offered by Sunway University Malaysia.

We seem to be doing slightly better than Singapore in terms of numbers[37], but overall, the number of local training programs for clinical psychologists is still rather low. Especially considering the demand for

[36] A telephone interview was conducted on 17 August 2017. For reasons of privacy, the interviewee did not wish to disclose her last name.

[37] At the time of writing, there were only two local universities in Singapore, namely the National University of Singapore (NUS) and James Cook University (JCU), offering postgraduate programs in clinical psychology. NUS offers two separate master's programs while JCU offers one program.

their services, it is important to introduce more training and professional development opportunities for clinical psychologists in local universities.

This includes measures such as increasing and improving on existing master's programs and implementing more doctoral level programs to facilitate a good supply of trained professionals. In particular, the MOH should work together with the Ministry of Higher Education (MOHE) to develop and implement more training programmes in public universities to cater for aspiring clinical psychology students who may not be able to afford the costly fees in the private sector.

(B) Make scholarships available for students who are keen to pursue clinical psychology training

To the author's best knowledge, all local clinical psychology training programs are currently self-funded, with study fees ranging from RM10,040 (in the public sector) to above RM 300,000 (for a doctoral program in the private sector).

These are significant costs for students, and potentially affects the demographic of those who are financially able to enrol in these programs.

To provide for more equitable enrolment and selection of clinical psychology trainees, the MOHE should consider opening up postgraduate scholarships for psychology graduates with good CGPA scores to further their studies in the clinical field. This will ensure that access is not restricted to only those individuals with affluence.

Scholarships are not only useful tools to improve access for students- they also guarantee the availability of local supply, since recipients are usually required to serve a bond with their sponsoring organization for stipulated period. Scholarships thus increase the likelihood of clinical psychologists remaining in Malaysia and contributing their service to meet local requirements.

The burden of providing sponsorship funding need not rest on the shoulders of the MOHE alone, but could also come from a variety of sources. In Singapore, a number of scholarships are provided by various sponsoring entities. Aside from the Ministry of Education, these include the MOH Holdings (MOHH), Institute of Mental Health (IMH), Singapore Prison Service universities and even several hospitals. Malaysia could explore a similar model of 'distributed' funding.

(C) Address clinical supervision needs of trainees

Much like the housemanship training that a medical graduate receives, clinical supervision is a key element in the training and promotion of the professional development of clinical psychologists. It involves the trainee meeting with a senior mentor professional to discuss coursework and other professional issues, to learn from the mentor's experience, and develop skills to enable trainees to address the challenging clinical, ethnical and professional issues that may be encountered in future practice.

Malaysia currently mirrors the example of other clinical psychology programmes offered in developed nations such as Australia and the UK, in recognizing clinical supervision as an essential part of the training process. However, we seem to be suffering from limited number of senior and highly trained clinical psychologists based in the hospitals to provide mentorship and clinical supervision to trainees. Among other reasons, this is largely due to the issue of staff shortages discussed in previous sections.

This merely reinforces the fact that the problems surrounding the clinical psychologist workforce do not exist in isolation, but are in fact interlinked. To address these problems effectively requires the government to take a committed stance towards supporting the development of the profession of clinical psychology as an overall capacity-building measure. In particular, there needs to be emphasis on providing greater funding to the development and training of the profession, be it in terms of developing more postgraduate programs in universities, or creating avenues to increase hiring opportunities in the public hospitals.

PART THREE: DISCRIMINATION AGAINST THE MENTALLY ILL

5.0. Cultural Barriers - The Challenge of Stigmatization of Mental Illnesses and Discrimination against the Mentally Ill

5.1. Defining stigma

Stigma is defined as a label of mark of disgrace that sets a person apart from others. A stigmatized person is no longer seen as an individual but part of a stereotyped group. Negative attitudes and beliefs towards this group create prejudice which in turn leads to negative actions and discrimination.

This report defines the stigmatization of mental illness as the formation of negative beliefs and assumptions towards a person suffering from mental health problems. Over time, stigma gives rise to actions of prejudice and discrimination, ranging from extremes such as chaining and abuse in certain countries, to systemic denial of opportunities, personal hostility, name-calling or social shaming.

Stigma has become a marker for adverse experiences for the mentally ill in Malaysia. Compared to the barriers related to workforce shortages and treatment costs, stigma towards mental illness is perhaps the most difficult barrier to overcome, since it involves engrained beliefs and assumptions.

This chapter will explore how the stigma against mental illness in various settings creates major structural roadblocks for affected individuals to seek care and access to professional treatment.

Firstly, it will discuss stigma in the workplace, using case examples of employer-related discrimination against workers who either have a pre-existing mental health condition or develop a mental illness as a result of work related stress and pressures.

From workplace settings, it will turn to the insurance sector and discuss the lack of health insurance coverage for mental illness in Malaysia. It will argue that the failure of private health insurance providers to offer cover for mental health treatment acts as a barrier to accessing mental healthcare, particularly in the private healthcare sector where treatment costs are high.

Finally, the chapter will discuss the existence of negative perceptions of mentally ill within Malaysian society. It will explore how embedded cultural narratives have given rise to notions of mental illness as a personal weakness or character flaw associated with social disgrace, and how these negative perceptions discourage the mentally ill from seeking help.

The final part of the chapter will recommend ways to model positive outcomes for the mentally ill that they may enjoy equal access to opportunities and better community integration, and thus, a better quality of life. Tackling stigma requires greater education and public awareness on mental health issues, yet public education should not just revolve around aetiology of mental illness, it should also introduce ways that the community may meaningfully support those affected by mental illness to manage and overcome the challenges that arise.

5.2. Employment Discrimination

The ability to participate in gainful work is an important determinant of mental health for any individual, as it provides a platform for independence, dignity and interaction with wider civil society and the economy. Yet for the mentally ill, such opportunities are often curtailed due to discrimination arising from a lack of sympathy and understanding from employers.

Case examples that have been evident in Malaysia concerning employer-related discrimination are as follows:

(i) Discrimination or non-hiring of someone with a pre-existing mental health condition that is declared.
(ii) Firing or 'cold-storaging' someone with a mental illness after a person is hired.
(iii) Employers who neglect the medical needs of an employee who develops a mental illness as a result of work related stress and pressures

5.2.1. Discrimination or Non-Hiring of Someone with a Pre-Existing Mental Health Condition that is Declared

Compared to non-affected job candidates, it is harder for job candidates with a pre-existing mental illness to get hired if they disclose their condition to a potential employer during the job interview.

In 2015, a qualitative study on stigma and discrimination of mental illness revealed that a majority of mental health patients faced higher levels of discrimination from employers when it came to hiring practices.

The study, which interviewed various mental health professionals for their opinions on discrimination based on patients' sharing of experiences, found that over half of doctors interviewed discovered that their patients had faced active stigma and discrimination from their employers when it came to hiring practices.

One psychiatrist shared the following:

"Employers think you are a risk. It's a challenge for my patients to disclose his or her condition especially during [job] interviews. There's one case where my patient told the potential employer about his condition at the final stage of the interview and they withdrew his offer."

Evidence of hiring discrimination against the mentally ill is also found in government reports. For example, the MOH Strategic Plan for Health Care 2016-2010 found that, in 2015, 90 per cent of patients with a mental health condition failed to find employment, even after undergoing the government's Individual

Placement & Support-Supported Employment (IPS-SE) scheme at local community mental health centres (MENTARI). Moreover, these figures were projected to improve only marginally (up less than half of total mental health patients) by the end of 2017 (Ministry of Health, Malaysia, 2016).

5.2.2. Firing or 'Cold-Storaging' Someone with a Mental Illness After a Person Is Hired.

Even if they succeed in finding work, employees who have a mental illness may not necessarily be guaranteed job security. Through interviews with mental health providers, the 2015 study found that doctors had patients who disclosed that they had lost their jobs after taking a leave of absence to attend treatment for their illness, regardless of the fact that their condition had not previously affected their work performance.

"One patient told me that he took sick leave because he was depressed. Then, when he came back, he was told that he (had been) fired." – Government psychiatrist 2.

When it comes to seeking treatment, mental illness is often not given the same understanding that is accorded to physical illness. It is still difficult for employers to accept that mental illness is no different from a cough and cold, except in the site of the disease and the manifestations.

Because of this stigma, many employees tend not to disclose their conditions to employers, fearing that this may taint their employment prospects. One patient's account of keeping silent about his struggles with an anxiety disorder to his superior and work colleagues illustrates this:

"I know my superior and colleagues are not happy with me and think that I am weird. I am not able to go for meetings too. The idea of sitting in a big room with all my colleagues just scares me. I always think of what would happen if I have a panic attack in the middle of a meeting. People will not understand and they will laugh at me. I have been skipping meetings for the past two months... I think I am going to be fired very soon" (Malaysian Mental Health Association, 2016).

5.2.3. Neglecting the Needs of an Employee Who Develops a Mental Illness as a Result of Work-Related Stress and Pressures

Apart from employees with pre-existing mental illnesses, a sub-set of workers may also develop mental health conditions such as depression and anxiety due to work-related pressures.

This phenomenon is not uncommon in today's fast-paced and competitive work environment, where the pressures and demands placed on workers to meet target outcomes can take a heavy toll on personal mental health. Being overworked and stressed, in addition to leading unhealthy lifestyles, can all result in

a high potential to develop a mental illness, as evidenced by a recent workplace-based survey of employee health and well-being patterns carried out by insurance giant AIA Vitality.

The study revealed that in Malaysia, out of 5,369 employees from 47 organizations, over half were at risk of mental health issues, with some 53% reporting at least one dimension of work-related stress and a further 12% experiencing high levels of anxiety or depression[38].

Despite the high risk prevalence, occupational mental health is still an area that has not received much attention or support from employers as compared to physical health. Despite legal provisions requiring employers to protect the rights of workers with disabilities, (including those with an experience of mental illness)[39], it is rare in Malaysia to find employers that would accommodate workers with medical needs arising out of mental illness. The example given by the psychiatrist in the 2015 study illustrates how one patient who took leave for his depression was summarily dismissed by his employer without any reason given.

While this represents the extreme end of such cases, it is nevertheless true that Malaysia's workplace policies still provide insufficient accommodation for employees who may need to take time off for counselling or medical appointments related to mental health issues.

A recent report on depression by the Star cited a case of a woman who went through a bout of depression and was forced to miss work on a number of occasions due to the side-effects of taking medication.

During the course of her treatment, the woman reported experiencing a severe lack of sympathy and understanding from her employer. Quoting the article:

"They (her employers) couldn't or failed to understand what I was going through, and my absenteeism from work was chalked down to a negative attitude and indiscipline. As a result, I received poor appraisals and was overlooked for promotion. In fact, even my psychiatrist didn't want to put down 'depression' in my medical report because of the stigma attached and also the concern for my future employment" (Martin, 2017).

[38] The title of the survey quoted is "Malaysia's Healthiest Workplace by AIA Vitality Survev 2017" which studied employee lifestyle and wellbeing trends across four countries. Besides Malaysia, Singapore, Hong Kong and Australia were also included in the analysis. A total of 214 organizations and 10,001 employees were studied. More information can be found at http://www.freemalaysiatoday.com/category/nation/2017/11/18/poor-health-among-msians-due-to-work-stress-says-survey/.

[39] Under Section 29 of the Persons with Disabilities Act, employers are required to protect the rights of persons with disabilities at the workplace. Under clause (2), these rights include the rights to just and favourable conditions of work, including equal opportunities, and to safe and healthy working conditions.

5.3. Exclusion of Mental Health Coverage in Health Insurance Schemes

As discussed in the previous chapter, though government mental health services are affordable, quality treatment is often hard to come by due to workforce shortages and drug supply issues.

On the other hand, professional therapy in the private sector, while generally of good standard, is very costly. In terms of access to services, a majority of people with mental illnesses would be disadvantaged in the financial negotiation for private medical services. Individuals living with more several mental disorders are not in a position to contribute their labour to the workforce, and the rest (for various reasons, although commonly due to stigma) may find it difficult to hold down stable employment and would thus require some form of financial assistance to seek treatment.

5.3.1 Medical and Health Insurance

Especially for those who cannot afford substantial out-of-pocket expenditures, purchasing a medical and health insurance (MHI) policy could be one way to circumvent expensive treatment in the private sector.

MHI policies are generally designed to cover the cost of private medical treatment, such as the cost of hospitalization and healthcare services, if an individual is diagnosed with a covered illness or has had an accident (Persatuan Insurans Am Malaysia).

These policies are issued to individuals by licensed insurance companies, in exchange for premiums, which are usually paid by the policy holder on a monthly or annual basis. Once payment begins, the insurer is required to provide coverage for any claims made by the policy holder against the policy, provided that the illness falls within the scope of coverage.

5.3.2. Exclusions in MHI policies

As with other types of insurance, MHI policies also contain certain exclusion clauses which outline specific conditions and health care expenses not covered by the plan. Exclusions carve away coverage for risks that insurers are unwilling to cover.

Table 32 below shows a list of common MHI policy exclusions in Malaysia:

Table 8: Common exclusions for medical policies in Malaysia

Exclusion Clause	Criteria
Pre-existing conditions	Most insurance companies require individuals to disclose all relevant facts related to their medical condition before they purchase an insurance product. If there are any conditions or illnesses experienced by the individual prior to applying for the policy, the insurer will decide whether or not to provide cover. However, in a majority of cases, these conditions would not be granted cover by the insurance company.
Specified illnesses	Certain disabilities and their related complications will not be covered for, if these illnesses have been treated or have occurred during the first 4 months of the policy.
Qualifying/waiting period	Individuals will not be eligible for any claims arising from any medical or physical conditions within the first 30 days of the cover (except for accidental injuries) and critical illness policies may carry longer waiting periods.
Overseas treatment	This is often excluded, apart from emergency conditions. The amount claimable may also be reduced to a level consistent with customary charges in Malaysia
Pregnancy/Child birth and related conditions	Nil
Congenital anomalies/ Hereditary conditions	Conditions which a child is born with (whether known or unknown to the policy owner)
Plastic/Cosmetic surgery and non-accidental dental treatment	Nil
Treatment of sexually transmitted diseases e.g. HIV or any **psychiatric conditions**	Nil
Accidental injuries due to hazardous sports/activities	Nil

Source: Persatuan Insurans Am Malaysia, Life Insurance Association of Malaysia

Based on Table 8, the clauses related to pre-existing conditions and treatment of psychiatric conditions may limit policy holders with mental health conditions from benefitting from MHI policies.

Firstly, given that a wide variety of health issues could be considered pre-existing, taking medication to treat a mental health condition or attending formal psychotherapy sessions would likely be considered grounds for exclusion.

The exclusion related to psychiatric conditions presents an even more obvious restriction for people with mental disorders. Although the term 'psychiatric conditions' is broad and could be interpreted in many degrees, we shall see that, in almost all categories of a typical MHI policy, coverage is denied for all mental health conditions.

5.3.3. Categories of MHI policies and their exclusion of mental health benefits

Out of the major types of MHI policies (commonly called 'covers') offered in Malaysia, two particular types may be linked to providing benefits for people with mental health conditions. These are hospitalization and surgical cover and critical insurance cover.

Table 9: Description of hospitalization and surgical covers and critical illness cover in Malaysia.

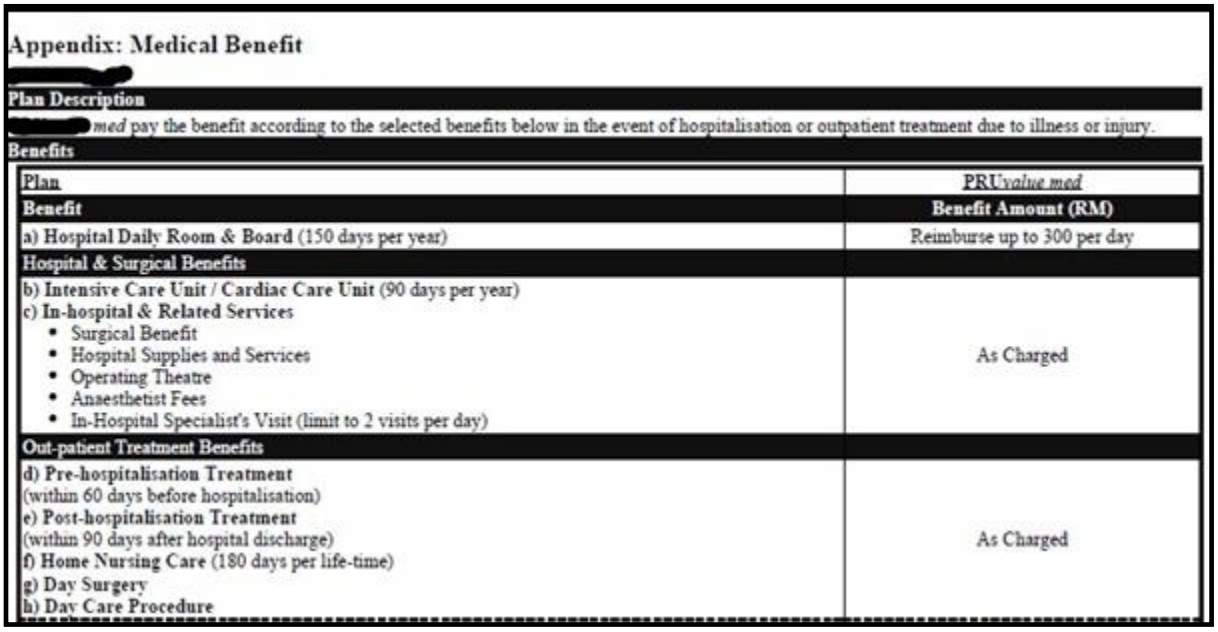
Cover	Description
Hospitalization and surgical insurance	Reimbursement of actual medical expenses incurred in the event of hospital treatment/surgery for covered conditions. This amount is subject to the annual or lifetime limit fixed by the product plan.
Critical illness insurance	Provides a specified lump sum benefit upon the diagnosis of certain critical conditions and illnesses stated in the policy

Source: Persatuan Insurans Am Malaysia, List of FAQ's on Medical and Health Insurance (MHI)

In each of these categories, the provision of coverage for mental health conditions is little to none.

Hospital and surgical insurance

Figure 33: Screenshot of a sample insurance policy product disclosure sheet generated in 2016, showing description of hospitalization and surgical cover



Appendix: Medical Benefit

[redacted]

Plan Description

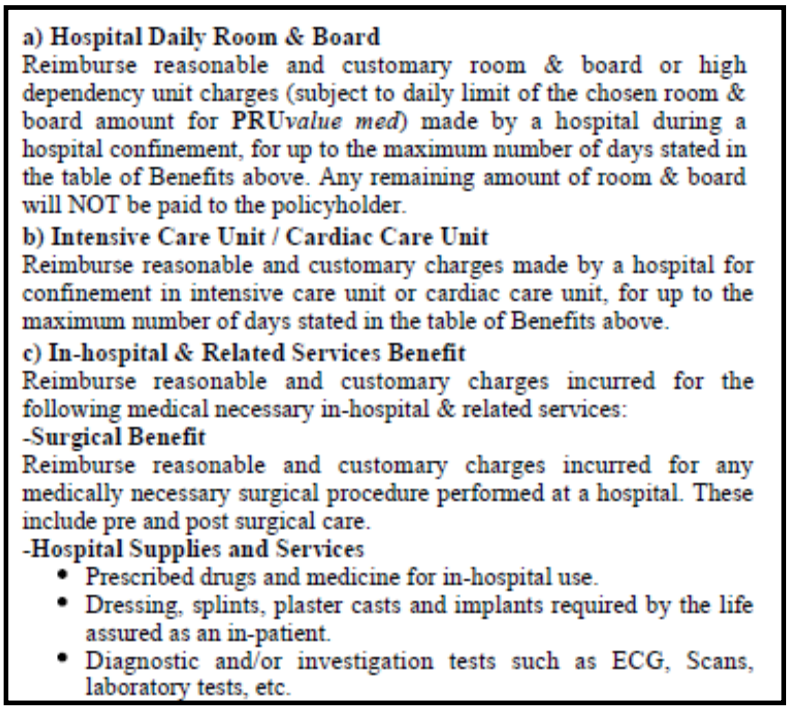
[redacted] *med* pay the benefit according to the selected benefits below in the event of hospitalisation or outpatient treatment due to illness or injury.

Benefits

Plan	PRU*value med*
Benefit	**Benefit Amount (RM)**
a) **Hospital Daily Room & Board** (150 days per year)	Reimburse up to 300 per day
Hospital & Surgical Benefits	
b) **Intensive Care Unit / Cardiac Care Unit** (90 days per year) c) **In-hospital & Related Services** • Surgical Benefit • Hospital Supplies and Services • Operating Theatre • Anaesthetist Fees • In-Hospital Specialist's Visit (limit to 2 visits per day)	As Charged
Out-patient Treatment Benefits	
d) **Pre-hospitalisation Treatment** (within 60 days before hospitalisation) e) **Post-hospitalisation Treatment** (within 90 days after hospital discharge) f) **Home Nursing Care** (180 days per life-time) g) **Day Surgery** h) **Day Care Procedure**	As Charged

Source: Insurance company licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia (BNM)

Figure 34: Screenshot of specific benefits related to hospitalization and surgical cover



a) Hospital Daily Room & Board

Reimburse reasonable and customary room & board or high dependency unit charges (subject to daily limit of the chosen room & board amount for **PRU***value med*) made by a hospital during a hospital confinement, for up to the maximum number of days stated in the table of Benefits above. Any remaining amount of room & board will NOT be paid to the policyholder.

b) Intensive Care Unit / Cardiac Care Unit

Reimburse reasonable and customary charges made by a hospital for confinement in intensive care unit or cardiac care unit, for up to the maximum number of days stated in the table of Benefits above.

c) In-hospital & Related Services Benefit

Reimburse reasonable and customary charges incurred for the following medical necessary in-hospital & related services:

-Surgical Benefit

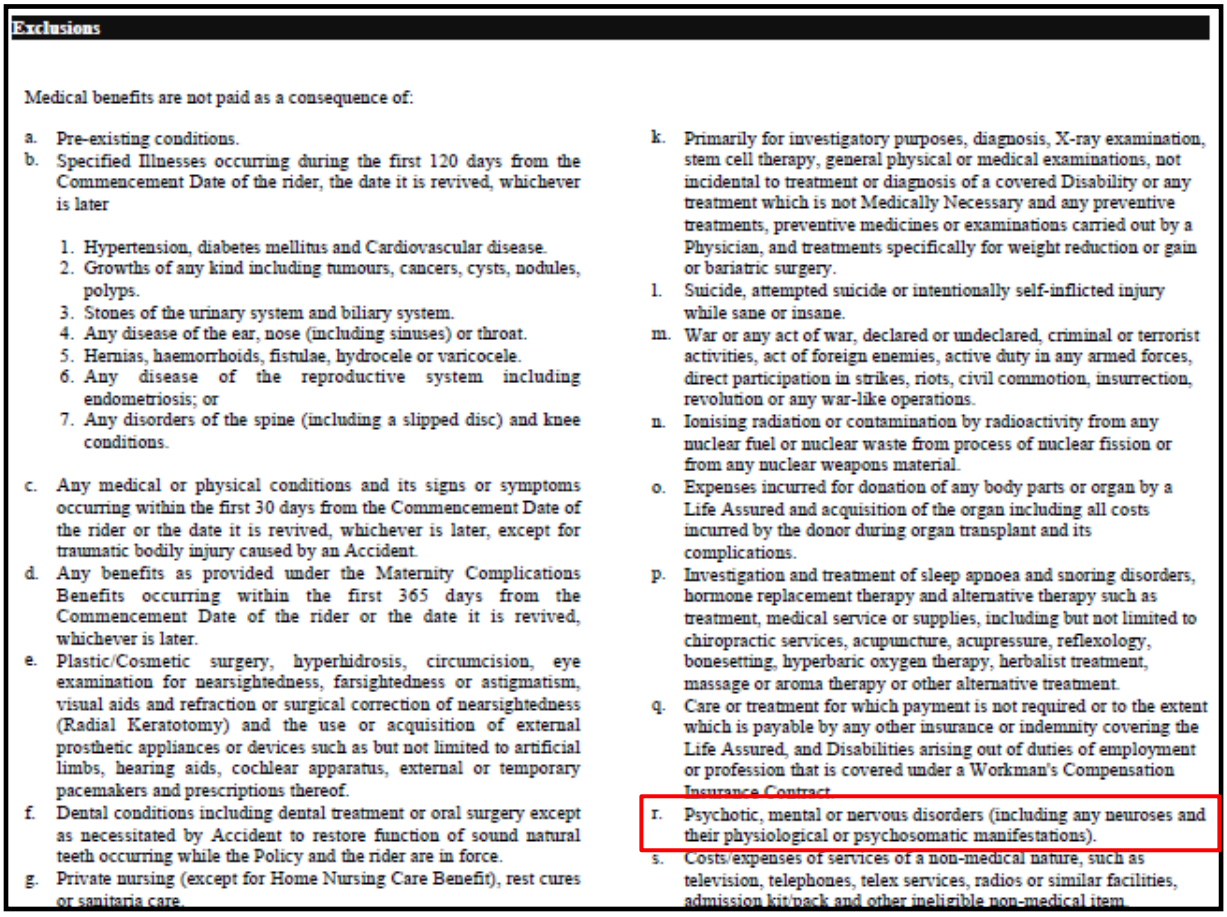
Reimburse reasonable and customary charges incurred for any medically necessary surgical procedure performed at a hospital. These include pre and post surgical care.

-Hospital Supplies and Services

- Prescribed drugs and medicine for in-hospital use.
- Dressing, splints, plaster casts and implants required by the life assured as an in-patient.
- Diagnostic and/or investigation tests such as ECG, Scans, laboratory tests, etc.

Source: Insurance company licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia (BNM)

Figure 35: List of conditions and illnesses excluded under the hospitalization and surgical cover



Exclusions

Medical benefits are not paid as a consequence of:

a. Pre-existing conditions.
b. Specified Illnesses occurring during the first 120 days from the Commencement Date of the rider, the date it is revived, whichever is later

   1. Hypertension, diabetes mellitus and Cardiovascular disease.
   2. Growths of any kind including tumours, cancers, cysts, nodules, polyps.
   3. Stones of the urinary system and biliary system.
   4. Any disease of the ear, nose (including sinuses) or throat.
   5. Hernias, haemorrhoids, fistulae, hydrocele or varicocele.
   6. Any disease of the reproductive system including endometriosis; or
   7. Any disorders of the spine (including a slipped disc) and knee conditions.

c. Any medical or physical conditions and its signs or symptoms occurring within the first 30 days from the Commencement Date of the rider or the date it is revived, whichever is later, except for traumatic bodily injury caused by an Accident.
d. Any benefits as provided under the Maternity Complications Benefits occurring within the first 365 days from the Commencement Date of the rider or the date it is revived, whichever is later.
e. Plastic/Cosmetic surgery, hyperhidrosis, circumcision, eye examination for nearsightedness, farsightedness or astigmatism, visual aids and refraction or surgical correction of nearsightedness (Radial Keratotomy) and the use or acquisition of external prosthetic appliances or devices such as but not limited to artificial limbs, hearing aids, cochlear apparatus, external or temporary pacemakers and prescriptions thereof.
f. Dental conditions including dental treatment or oral surgery except as necessitated by Accident to restore function of sound natural teeth occurring while the Policy and the rider are in force.
g. Private nursing (except for Home Nursing Care Benefit), rest cures or sanitaria care.
k. Primarily for investigatory purposes, diagnosis, X-ray examination, stem cell therapy, general physical or medical examinations, not incidental to treatment or diagnosis of a covered Disability or any treatment which is not Medically Necessary and any preventive treatments, preventive medicines or examinations carried out by a Physician, and treatments specifically for weight reduction or gain or bariatric surgery.
l. Suicide, attempted suicide or intentionally self-inflicted injury while sane or insane.
m. War or any act of war, declared or undeclared, criminal or terrorist activities, act of foreign enemies, active duty in any armed forces, direct participation in strikes, riots, civil commotion, insurrection, revolution or any war-like operations.
n. Ionising radiation or contamination by radioactivity from any nuclear fuel or nuclear waste from process of nuclear fission or from any nuclear weapons material.
o. Expenses incurred for donation of any body parts or organ by a Life Assured and acquisition of the organ including all costs incurred by the donor during organ transplant and its complications.
p. Investigation and treatment of sleep apnoea and snoring disorders, hormone replacement therapy and alternative therapy such as treatment, medical service or supplies, including but not limited to chiropractic services, acupuncture, acupressure, reflexology, bonesetting, hyperbaric oxygen therapy, herbalist treatment, massage or aroma therapy or other alternative treatment.
q. Care or treatment for which payment is not required or to the extent which is payable by any other insurance or indemnity covering the Life Assured, and Disabilities arising out of duties of employment or profession that is covered under a Workman's Compensation Insurance Contract.
r. Psychotic, mental or nervous disorders (including any neuroses and their physiological or psychosomatic manifestations).
s. Costs/expenses of services of a non-medical nature, such as television, telephones, telex services, radios or similar facilities, admission kit/pack and other ineligible non-medical item.

Source: Insurance company licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia (BNM)

Figure 34, 35 and 36 above showcase a standard hospitalization and surgical cover issued by an insurance company in Malaysia, together with specific terms and conditions and the attendant list of exclusions related to the cover.

Under the hospitalization cover provided by this particular insurance company, policy owners may be reimbursed for daily hospital room and board charges (subject to a certain price cap) made by a hospital for up to a maximum number of days. Besides that, reasonable and customary charges for in-hospital prescribed drugs and medicine and diagnostic tests such as ECG, scans, laboratory tests are also reimbursed.

However, as shown in Figure 36, these benefits do not cover claims arising from mental health conditions. As stipulated in clause r., 'psychotic, mental or nervous disorders (including any neuroses and their physiological or psychosomatic manifestations' are excluded from coverage.

While different insurance underwriters may differ in their particular choice of words, the essence of the disclaimer remains: that hospitalization for mental health conditions will not be considered eligible for claims.

In 2017, the estimated number of inpatients admitted to government hospitals alone for psychiatric conditions was 19,400 individuals, according to Ministry of Health statistics (Ministry of Health, Malaysia). This is not an insignificant figure. Furthermore, the number of inpatients admitted to government hospitals have increased over the years, going from 17,738 inpatients in 2013 to 19,400 in 2017[40].

These patterns strongly suggest that there is a demand for psychiatric conditions to be included under hospitalization cover. Those who would benefit in particular are individuals who suffer from more severe forms of mental illness such as schizophrenia, or others whose conditions have reached such a chronic and debilitating level that continuous supervised care of professionals is necessary to ensure safety.

It is also significant to note that, under hospitalization cover, no benefits are offered for utilizing outpatient specialist services based in hospitals, such as those of psychiatrists and psychologists.

Based on Ministry of Health statistics, the burden on psychiatric outpatient services at government healthcare facilities heavily outweighs inpatient services. For example, in 2015, 34,699 new outpatient cases and 553,257 follow-up cases were seen in government healthcare facilities. In 2017, these figures were estimated to have increased to 36,800 and 586,900 new and follow-up cases respectively.

Compared to inpatient treatment, the demand for outpatient services is visibly much higher among the population. This is not surprising, given that a majority of mental health conditions are usually treatable on an outpatient basis. The unfortunate reality in Malaysia is that, when it comes to seeking treatment for mental illness, be it on an inpatient or outpatient basis, the need for insurance coverage is unmet.

Critical Illness cover

When it comes to critical illness cover, the exclusion of mental illness is more clear-cut and standardized.

In Malaysia, all insurance companies follow a standard set of definitions for critical illnesses for underwriting critical illness cover, as determined by Life Insurance Association Malaysia (LIAM) and Bank Negara Malaysia (BNM), the main regulatory body for the insurance industry.

In total, out of 36 officially listed critical illnesses, two conditions relate to mental illness, namely Alzheimer's disease (or Severe Dementia) and Parkinson's disease. The definitions of these conditions are given below:

[40] See Chapter 2 "Evaluating Demand for Mental Health Services" for further discussion on inpatient and outpatient trends seen at government healthcare facilities.

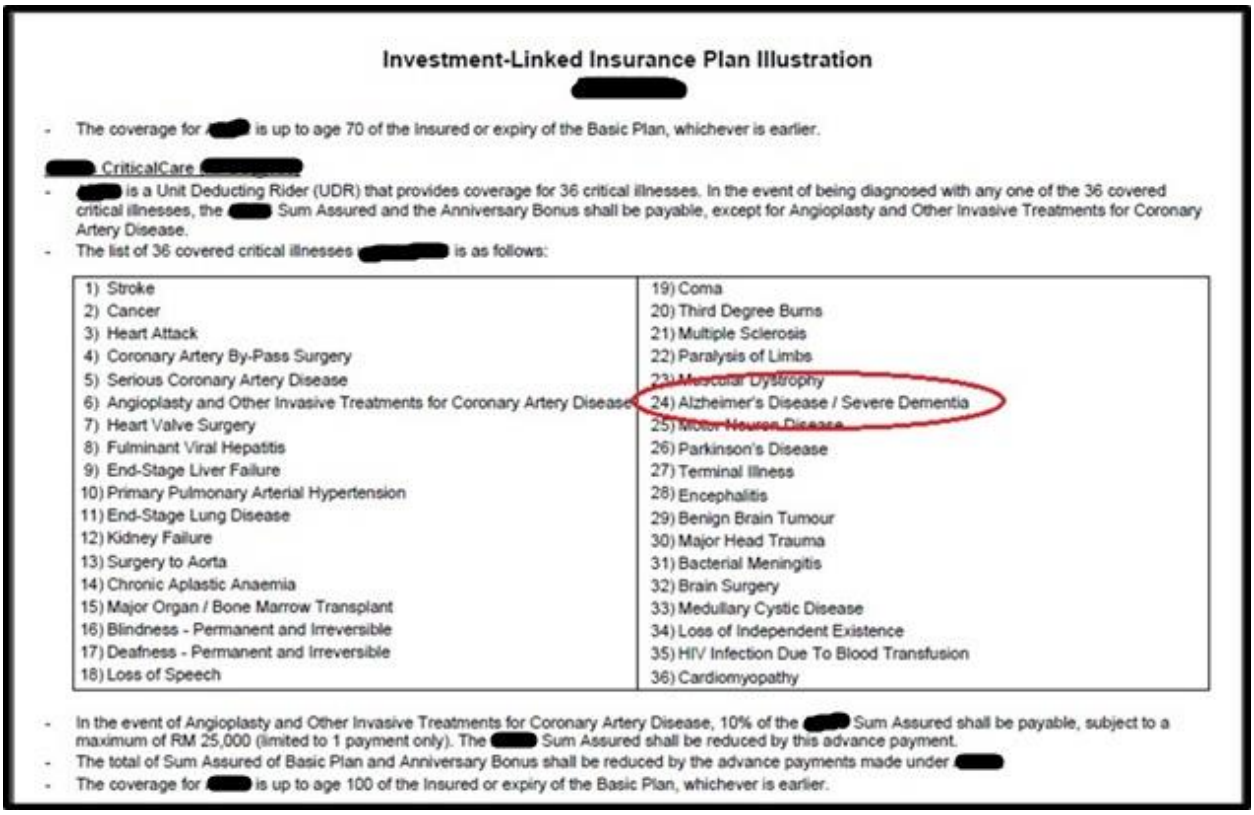
Table 10: Insurance industry-wide standard definitions of Alzheimer ’s disease and Parkinson’s Disease

Critical Illness	Description
Alzheimer's Disease/ Severe Dementia	Deterioration or loss of intellectual capacity confirmed by a clinical evaluation and imaging tests arising from Alzheimer’s Disease or Severe Dementia as a result of irreversible organic brain disorders. The covered event must result in significant reduction in mental and social functioning requiring continuous supervision of the Covered Person. The diagnosis must be clinically confirmed by a neurologist. From the definition, the following are not covered: (a) Non organic brain disorders such as neurosis (b) Psychiatric illnesses (c) Drug or alcohol related brain damage
Parkinson’s Disease – resulting in permanent inability to perform Activities of Daily Living	A definite diagnosis of Parkinson’s disease by a neurologist where all the following conditions are met: (a) cannot be controlled with medication; (b) shows signs of progressive impairment; and (c) confirmation of the permanent inability of the Covered Person to perform without assistance of three (3) or more of the Activities of Daily Living. Only idiopathic Parkinson’s Disease is covered. Drug-induced or toxic causes of Parkinsonism are not covered.

Source: http://mypf.my/2016/04/01/ci-definition-standardization/

While Alzheimer’s disease and Parkinson’s disease are rightfully included in the list of critical illnesses, other mental disorders that can cause extremely disabling conditions, such as schizophrenia and bipolar disorder, are not included in this list.

Figure 36: Screenshot of a sample insurance policy product disclosure sheet generated in 2016, showing description of critical illness cover



Investment-Linked Insurance Plan Illustration

[redacted]

- The coverage for [redacted] is up to age 70 of the Insured or expiry of the Basic Plan, whichever is earlier.

[redacted] CriticalCare [redacted]

- [redacted] is a Unit Deducting Rider (UDR) that provides coverage for 36 critical illnesses. In the event of being diagnosed with any one of the 36 covered critical illnesses, the [redacted] Sum Assured and the Anniversary Bonus shall be payable, except for Angioplasty and Other Invasive Treatments for Coronary Artery Disease.
- The list of 36 covered critical illnesses [redacted] is as follows:

1) Stroke	19) Coma
2) Cancer	20) Third Degree Burns
3) Heart Attack	21) Multiple Sclerosis
4) Coronary Artery By-Pass Surgery	22) Paralysis of Limbs
5) Serious Coronary Artery Disease	23) Muscular Dystrophy
6) Angioplasty and Other Invasive Treatments for Coronary Artery Disease	24) Alzheimer's Disease / Severe Dementia
7) Heart Valve Surgery	25) Motor Neuron Disease
8) Fulminant Viral Hepatitis	26) Parkinson's Disease
9) End-Stage Liver Failure	27) Terminal Illness
10) Primary Pulmonary Arterial Hypertension	28) Encephalitis
11) End-Stage Lung Disease	29) Benign Brain Tumour
12) Kidney Failure	30) Major Head Trauma
13) Surgery to Aorta	31) Bacterial Meningitis
14) Chronic Aplastic Anaemia	32) Brain Surgery
15) Major Organ / Bone Marrow Transplant	33) Medullary Cystic Disease
16) Blindness - Permanent and Irreversible	34) Loss of Independent Existence
17) Deafness - Permanent and Irreversible	35) HIV Infection Due To Blood Transfusion
18) Loss of Speech	36) Cardiomyopathy

- In the event of Angioplasty and Other Invasive Treatments for Coronary Artery Disease, 10% of the [redacted] Sum Assured shall be payable, subject to a maximum of RM 25,000 (limited to 1 payment only). The [redacted] Sum Assured shall be reduced by this advance payment.
- The total of Sum Assured of Basic Plan and Anniversary Bonus shall be reduced by the advance payments made under [redacted]
- The coverage for [redacted] is up to age 100 of the Insured or expiry of the Basic Plan, whichever is earlier.

Source: Insurance company licensed under the Financial Services Act 2013 and regulated by Bank Negara Malaysia (BNM).

Figure 36 above shows a critical illness cover offered by a local insurance company in 2017, as illustrated in its product disclosure sheet. With the exception of Alzheimer's disease and Parkinson's disease, no other severe mental illnesses are covered.

One possible reason for the non-inclusion of other severe mental illnesses from critical illness cover is that, while standard definitions for the *types* of critical illnesses have been outlined, to the author's best knowledge, no standard definition or concept exists as to what conditions would constitute being 'critical'. Neither the Insurance Act 1996, nor its accompanying regulations, provide a definition of 'critical illness' per se. By comparison, the Disabilities Act 2008 clearly spells out the definition of "persons with disabilities", making it easier for insurers to conceptualize and underwrite disability-related policies.

5.3.4. Employer-Sponsored Health Insurance

Besides personal insurance, employees who work for companies usually have the option of claiming for medical treatment via employer-sponsored health insurance, otherwise known as "employee health benefits".

Larger multinational companies particular tend to provide medical benefits for their staff, through purchase of a group insurance policy plan from an insurance company. The insurance company assumes the risk, controls the plan's administration, establishes reserve capital levels and manages the major decisions concerning health care coverage provided to employees and dependents.

By and large, employer-provided group health insurance policies offer a range of medical benefits covering the costs of hospitalization and outpatient treatment. However, as these schemes are largely purchased from private insurance companies, (the same entities who supply personal insurance plans to individual policyholders) it is very likely that the same degree of restriction on insuring for mental illness applies as with the individual policy plans (see above).

While it lies beyond the scope of the present study to conduct extensive research into the range of personal and group insurance policies offered by various providers, testimonial evidence published in the news seems to suggest that there is still a gap in mental health coverage.

For many years, government officials, mental health advocates and even medical practitioners have come out publicly to voice their criticism over the lack of insurance coverage for the mentally ill.

In 2011, the year that the federal government set up the Mental Health Promotion Advisory Council, Tan Sri Lee Lam Thye, a founding member and prominent mental health advocate, had called on insurance companies to provide insurance coverage for the mentally ill (Daily Express, 2011).

Since that year, Lee has repeatedly made calls for companies to provide mental health insurance coverage for workers. Three years later, in 2014, he again raised the issue of non-coverage and lack of workers' mental healthcare benefits in a media statement: "there should be more benefits for the mentally ill such as insurance coverage which is now denied to them" (Lee, 2014).

In October 2017, Lee took to the public again, this time to highlight the failure of employers to utilize their Safety and Health committees[41] as forums to raise issues on workers' mental health. Speaking to reporters at the launch of the World Mental Health Day, he criticized these committees for mainly focussing on safety aspects of the workplace such as physical hazards and risks, instead of promoting mental health issues. In his words:

[41] Under the Occupational Safety and Health Act 1994, every workplace with over 40 workers is required to have a safety and health committee.

"What is usually discussed in the committee is related to, for instance… problems like no protective equipment for employees. It is more focussed on the physical and safety aspect. There is nothing on mental health."

Early this year, in a letter to the star, a medical practitioner from Malacca made reference to the lack of insurance coverage for mental health conditions in a letter to the Star:

"Many employers provide insurance coverage for their employees, but sadly, insurance policies, be they personal or group, do not cover mental health issues. Most organizations generally perceive mental health illnesses as character flaws or inability to cope. When it comes to mental health ailments, employers tend to be reactive rather than proactive. It is only when an employee commits suicide then there will be soul searching" (Chuah, 2017).

That these messages have been repeated over the years, seems to indicate that they have fallen on deaf ears.

5.4. Cultural Misconceptions about Mental Illness

Culture refers to a group's shared set of beliefs, norms and values. In any given society, cultural beliefs tend to shape the understanding and conceptualization of mental illness, which in turn influences attitudes and the degree of acceptance towards the mentally ill.

In Malaysia, attitudes towards mental illness ranges from belief in the biomedical to the supernatural among the various multi-ethnic communities. Many studies have reported how patterns of understanding and responses towards mental illness tend to differ substantially from group to group.

Among all ethnic groups, culture plays a strong role in influencing perceptions. Certain groups retain many traditional supernatural beliefs, including the belief that illness is caused by spirit attacks and black magic.

On top of culture, religion adds another layer of complexity in the way that these groups understand and perceive mental illness. In Malaysia, each of the three major ethnic groups tends to adhere to different religions. Malays predominantly follow the teachings of Islam. The majority of the Chinese ethnic group claim affiliation with Christianity and Buddhism, while a sizeable number of Indians are Hindus (Chong, Mohamad, & Er, 2013). These different religions each have their own framing and interpretation of mental illness.

Due to resource constraints, the author was not able to carry out an extensive field study among the various ethnic groups to investigate the extent of influence of culture and religion upon attitudes and perceptions. In the absence of such primary research, a literature review of recent academic and medical studies looking at the perceptions of mental illness among the three major ethnic communities (Malay, Chinese, Indian) was carried out.

The review yielded the following observations on certain religious and cultural norms practised by groups, which then had a bearing upon the way mental illness was understood and perceived:

5.4.1. Malay traditional and Islamic perspective

- According to Malay traditional customs, psychiatric illness is usually referred to as *sakit mental* or *gila* (crazy or madness). These terms carry a highly negative connotation, and seeking help from a mental health provider would have a similar effect.
- Malay traditional customs recognise and understand different types of clinical mental illnesses based on unique beliefs and culture. For example, a woman suffering from post-partum depression, who displays symptoms of hallucination, insomnia, stress and depression, might be labelled as suffering from a condition called 'gila meroyan' or being possessed by mysterious elements. To give another example, a recently divorced man who displays symptoms of depression or emotional disturbance associated with grief mood disorder might be classified as suffering from the 'gila talak' syndrome, meaning someone who has divorced his spouse but still yearns for her. Lastly, someone who behaves in a way that is perceived to be abnormal and appears to have extra ability, strength and power would be regarded as 'dirasuk' or possessed by supernatural elements such as ghosts/spirits/jinn.
- Stigma tends to be reduced when the individual afflicted with a mental health condition has demonstrably experienced some form of emotional stress or when there is a known organic etiology, such as epilepsy. However, when there is no known biological cause, the root of the illness is often believed to lie with supernatural elements.
- Besides cultural beliefs, the attitudes of Malay Muslims are also shaped by Islamic religious teachings. A majority of Malay Muslims tend to attribute the cause of mental illness to fate and religion. This in turn shapes treatment-seeking behaviour, whereby treatment by folk healers (bomoh) or religious-spiritual healers is favoured over modern psychiatric care. By adopting spiritual healing methods, the individual is seen as going through a 'normal' emotional disturbance and would not be as heavily stigmatized as if they had a 'labelled' diagnosis from a medical professional. Help from the medical profession tends to be the last resort[42].

5.4.2. Chinese perspective

- While the belief in modern medicine and biomedical causes of illness is fairly prevalent within the ethnic Chinese, the more traditionally inclined and rural communities still tend to attribute mental illness as a mixture of organic (yin-yang) imbalances and spiritual possession.

[42] Razak, A. A. (2017). Cultural Construction of Psychiatric Illness in Malaysia. *The Malaysian Journal of Medical Sciences : MJMS*, *24*(2), 1–5.

- In Chinese traditional culture, family is regarded as an important cohesive unit in society. Members of this group who subscribe to these traditional beliefs are accustomed to placing their family's honour, continuation, prosperity and stability as a major priority. Certain Chinese families may feel ashamed to disclose a family member or relative's mental illness to others, for fear of bringing disgrace upon the family, let alone seek professional intervention (Mohamad, Subhi, Zakaria, & Aun, 2014).

5.4.3. Indian/Hindu perspective

- Few studies have been done into the Indian community perspective of mental illness in Malaysia. One review of mental health concepts in Malaysia suggested that the understanding of mental health among Indians was strongly influenced by Hindu beliefs, where mental illness is deemed to be the result of imbalance between the four elements of "Dharma", "Kama", "Artha" and "Moksha".
- The same review also suggested that cultural understandings of mental illness within the Indian community was framed by the principles of Ayurveda, a system of philosophical knowledge about the human health and life derived from the Hindu classical Vedic texts. The Ayurvedic approach rests on the premise that life is a combination of body (sharira), mind (sattva) and soul (atma), and mental illness is seen to be caused by the prevalence of passion (rajas) and darkness (tomas) which cause an imbalance in the constitution of the person, causing perversion of the mind, intellect, consciousness, knowledge, manners and behaviour.
- Religious beliefs also permeate strongly into treatment seeking avenues for mental illness. A 2014 study on attitudes and perceptions among caregivers for the mentally ill noted how one Indian Hindu caregiver had brought her relative to seek spiritual healing in India, as she believed 'the healing process would be more effective' in such an environment (Mohamad, Subhi, Zakaria, & Aun, 2014).

While there is much variation in these cultural and religious narratives, a common denominating factor is the linking of mental illness to weakness in an individual's personal character. Overall, there is a prevailing sense that the person with a mental illness has, in one way or another, brought the condition upon him or herself due to moral deficit or a lack of religious piety.

The labelling and representation of mental illness as a shameful social failing (or at the extreme end, a religious or spiritual curse) leads to highly damaging outcomes for the person suffering from a mental illness.

On one level, negative public beliefs lead to discriminating attitudes, and a tendency to label mentally ill persons as those who carry with them a mark of disgrace or discredit. Not only is this 'shame' associated with personal failure fundamentally inaccurate, it also has an extremely damaging effect on how the mentally ill are treated in social systems. The extent may range from systemic ill treatment (as with workplace and insurance discrimination) to social exclusion, name-calling and ostracizing among the wider community.

Secondly, negative attitudes and actions have a damaging effect on how the mentally ill regard themselves personally and undermine their chances of recovery.

Studies have shown that across much people suffering from depression and anxiety (so-called more 'socially acceptable' mental health conditions) have difficulty disclosing their struggles to others and reaching out for help. A study done on the Malaysian population found that, out of the sampled individuals, 62.3% did not want to let other people know that they suffered from mental illness. More disturbingly, over three quarters (76.5%) professed that they did not believe anyone could suffer from mental health problems (Yeap & Low, 2009).

The prevalence of negative stereotypes associated with mental illness is a strong demotivating factor for the affected to seek out professional treatment. Many people suffering from a mental illness may want to be formally diagnosed, either because of the effect it can have on employment prospects or in purchasing health insurance, or simply because they fear being labelled as 'crazy'.

**In general, culture-bound supernatural beliefs about health and mental illness tend to be stronger among rural communities. On the other hand, recent studies have shown that the more urbanized populations in cities appear to have a more Westernized understanding of mental illness and mental health literacy, perhaps due to greater exposure and education.*

Nevertheless, this should be tempered by the reality that negative attitudes still exist. As evidenced by occupational discrimination, a certain level of prejudice and discrimination towards mentally ill patients remain commonplace.

5.5. Discussion and Policy Recommendations

5.5.1. Addressing employment discrimination

Discrimination in the workplace towards people with mental health disabilities is a common problem in many countries worldwide. Interestingly, studies on employers' perspectives and attitudes towards hiring and retention of workers have shown that although some cultural differences exist (Kaye, Jans, & Jones, 2011; Tsang, et al., 2007), employers in many countries commonly express a range of concerns about hiring and retaining employees with mental health problems.

Among the concerns reported, several common themes emerge: among them include the belief that people with mental health problems have limited productivity and job performance, especially in tasks concerning cognitive skills; that they are unreliable and might pose threats to the safety of other employees, customers or themselves; or that they might behave in a strange and unpredictable manner (Brouwers, Mathijjssen, Van Bortel, & et al., 2016).

While these may be valid concerns, such denial of equal opportunities is indeed short-sighted.

These negative attitudes are rooted in the stigma that is associated with mental health problems and a lack of mental health literacy. What makes is especially harmful is the vicious cycle it creates for the mentally ill.

On one hand, job seekers facing continuous rejection by employers may over time suffer from diminished self-esteem and give up trying to pursue a meaningful career. On the other, employees who develop mental health disorders at the workplace will shy away from disclosure for fear of damaging their careers. Yet concealment puts employers in a difficult situation; without disclosure from employees who are struggling, the lack of awareness of their mental health needs will only perpetuate.

5.5.2. Policy Recommendations

Public policy approaches to remedy employer discrimination, and facilitate hiring and retention of workers with mental health needs, could be carried out in several ways.

Firstly, the government might take the 'mandate' approach, by introducing company quotas for hiring people with mental health conditions. In South Korea and Japan, for example, the employment quota system mandates the employment of people with disabilities, including mental disabilities, according to established numerical standards. In both systems, companies with over 60 employees are required to abide by the employment quotas[43]. Other countries such as France, Italy, Austria, Poland and Korea have also adopted similar measures.

The second approach is based on 'equality of opportunity', where governments adopt greater equality legislation for workers with disabilities based on anti-discrimination laws. Aside from equal hiring opportunities, employers are usually required to make reasonable accommodation for workers with disabilities, such as restructuring jobs and adjusting work schedules to best suit work capacities, modifying the physical environment of the workplace or even providing part-time work options, thus putting disabled workers' wellbeing on an equal basis with persons without disabilities.

In Malaysia, the Persons with Disabilities Act (Act 685) does provide a degree of protection for the mentally ill , but its coverage is limited to individuals "who have long term physical, mental, intellectual or sensory impairment which...may hinder their full and effective participation in society"(Persons with Disabilities Act 2008 (Act 685)). The Act therefore has limited effect on workers who may have less severe forms of psychiatric illness, such as depression or anxiety.

[43] It should be noted that even in these systems, protection for the mentally disabled is somewhat limited. For example, South Korea has not included dementia in its disability categories yet, while Japan had only included mental disability into its quota scheme in 2005.

In and of itself, however, these protection measures will not solve the fundamental problem of stigma surrounding mental health workplace discrimination.

Employers must realize that, with the exception of psychotic disorders (conditions that cause abnormal thinking and hallucinations) and a handful of mental disorders, most mental health conditions are not severely disabling, if treated and addressed at the early onset stages. Many mental health conditions can be managed with medication and proper therapy, and, with the right support, people living with mental illnesses are still able to maintain productive and meaningful lives.

Ultimately, education is the key to overcoming stigma and building better and healthier environments for workers with mental health conditions. Instead of pushing them out of the workplace, there should be a fostering of greater dialogue between employers and employees with mental health needs, in order that the former might see the latter as a resource rather than as a burden.

From this standpoint, interventions that focus on enhancing mental health awareness and reducing stigma and discrimination in the workplace are highly recommended. Such programmes should involve employers and employees coming together to openly discuss mental health. Importantly, there should be formal safeguard mechanisms for job seekers to be upfront in interviews about their mental health condition, and for employees to disclose their mental health problems to their employers, without having to fear damage to career opportunities.

5.5.3. The Barriers of Private Health Insurance

In Malaysia, private health insurance policies are either bought by the individual policyholder or by an employer on behalf of the individual.

In general, insurance policies, or premiums (the amount of money paid to purchase an insurance policy) are priced based on individual, community or group-rated risk (Mossialos & Thompson, 2004).

People with mental health disorders face serious equity barriers when it comes to purchasing insurance policies, even from the very start of the process. A majority of private insurers will refuse cover to individuals who have pre-existing mental health problems or high probabilities of mental illness. Similarly, individuals with a family history of mental health problems or with a proven genetic pre-disposition may either be denied cover or find enrolment into policies prohibitively expensive[44].

[44] This discrimination applies to most pre-existing medical conditions, and not just mental health-related issues. In community- and group-rated premiums, where the information used to calculate risk is pooled together with other individuals, those with mental disorders may stand a better chance of accessing insurance. But even so, this only for a selective group who are in the workforce. The mentally ill who are unemployed are excluded.

Even if they are granted access to insurance, people who develop mental disorders would rarely benefit from their insurance policies, as many private insurers would exclude coverage for mental health treatment from medical insurance policies (Datta, 2017).

A cross-country study on mental health financing mechanisms, including that of private health insurance, has identified that the main factor driving this reluctance to insure is due to the chronic nature and high cost of mental health treatment and interventions, especially in the private sector (Dixon, McDaid, Knapp, & Curran, 2006).

On a basic level, insurance companies calculate risk by creating algorithms based on key indicator data about policyholders (factors like gender and age) and measuring this against detailed economic data sets (such as economic forecasts, wage and industry trends, and market stability assessments) to weigh the probability that policyholders may file a claim against the policy.

Ultimately, the insurance industry is a risk-pooling business, hence insurance underwriters must balance the insurance company's profitability with the policyholder's potential need to use the policy. Insurance companies rely on data to predict risks and evaluate potential exposure to claims that could result in expensive pay outs to the company.

Certain chronic diseases and medical conditions such as cancer are strongly associated with high treatment costs. If there is a statistical likelihood that policyholders will develop these conditions and claim for treatment (hence incurring greater pay outs), the premium rate for the insurance product will likely be increased.

Countries which have private insurance coverage for mental health treatment tend to have a strong national research depository or clearing house for local mental health data. In the United States, for example, the Centers for Disease Control and Prevention (CDC), one of the major operating components of the Department of Health and Human Services, collects a large volume of information on mental health and mental illness surveillance data both at federal and state level. These statistics are captured through various established mechanisms such as the Behavioural Risk Factor Surveillance System[45] (BRFSS), the National Health and Nutrition Examination Survey (NHANES)[46].

Unlike the United States, however, Malaysia still lacks a comprehensive body of knowledge concerning mental health issues in the country. While the government does collect information on various aspects of mental health in the public sector, including prevalence data and service uptake rates, the amount and type of information may not be adequate to generate statistically robust datasets. To the author's best knowledge, no efforts have been made to generate such models. Research on the economic cost burden of certain major mental diseases, such as schizophrenia, does exist but these tend to be incidental studies rather than long-term surveys.

[45] The BRFSS is an annual state-based telephone survey of the U.S. Civilian, non-institutionalized adult population. The survey consists of four validated health-related questions which assess the respondent's quality of life, with emphasis on mental health.
[46] The NHANES is a program of studies designed to assess the health and nutritional status of adults and children in the United States. Established in 1960, it is a household-based survey that collects data on the amount, distribution and effects of illness and disability in the United States. It combines interviews and physical examinations, and is targeted at participants age 12 and older.

Perhaps the greatest challenge in sketching an accurate picture of mental illness burden lies in the largely dispersed nature of data. A bulk of public health data on mental health is not compiled into a single "storehouse" where it may be easily accessed by interested research parties. On top of this, there is hardly any published data concerning mental health treatment in the private sector since this is (for the most part) strictly classified under the authority of private healthcare providers.

The deficiencies of data on mental health explain why private insurance underwriters are so guarded against introducing policies for mental health coverage. Without solid evidence-backed data on mental health conditions in our country, it is hard for them to act as they would not be able to perform calculations of mental health risk, let alone gauge potential premium rates for mental health treatment.

5.5.4. Policy Recommendations

(A) Address the data caveat by creating a national research depository for mental health data

From a risk standpoint, the private health insurance industry is unlikely to promote or offer mental health coverage unless solid statistical data is made available for them to calculate risk. There is therefore an urgent need for the government to invest in setting up a national research depository or 'clearing house' for local research on mental health in the country.

Currently, the government collects various sources of useful information on mental health, including national prevalence data and suicide registry data and mental health services at primary care level. In academia, much research related to mental health has also been carried out, including studies on the burden of specific mental health diseases and vulnerable groups as well as public perceptions of mental illness and help-seeking behaviour among the mentally ill. Finally, certain mental health NGOS like the Malaysian Mental Health Association (MMHA) are useful sources of information on community based services such as mental health rehabilitation programmes.

These various data could be compiled and stored in a single location for ease of access to interested third parties, such as insurance underwriters. More importantly, researchers and public health analysts who are invested in effecting changes for better mental health service in the country could also benefit from such resources to come up with policies for best practices.

(B) Social health insurance as an alternative financing option

Besides private health insurance, an alternative financing option for mental health could lie in the form of publicly funded mental health care services, such as a tax-funded social health insurance scheme that is based on mandatory wage-related contributions shared between the employer and employee.

Social health insurance is the dominant model of financing in a number of Asia countries such as Japan, Taiwan and Korea, where contributions are independent of risk and access is granted to all regardless of their health status or risk. In this sense, individuals who either have pre-existing mental health conditions

or have a high risk of developing a mental health disorder would not be discriminated against as they might be by private insurers offering risk-rated premiums. In Malaysia, there are two major form of social health insurance for workers. The first is SOCSO, a tax-funded social security organization managed by the Human Resources Ministry. Besides that, the government has plans in the pipeline to introduce another form of social health insurance called the Voluntary Health Insurance Scheme (VHIS). A discussion of these alternative health financing models, and the ways in which they may benefit workers with mental health conditions, follows:

I. SOCSO

In Malaysia, the government provides a form of social health insurance to the Malaysian workforce[47] through the Social Security Organization (SOCSO)[48], a tax-funded social security organization managed by the Ministry of Human Resources. Under the Employees' Social Security Act 1969, employers in Malaysia are required to register with SOCSO and make monthly contributions on behalf of their employees. The sum of these contributions are either shared by the employer and the employee at fixed ratios, or paid wholly by the employer.[49]. Malaysians who contribute to SOCSO are entitled to claim for financial assistance, medical treatment and injury benefits if they encounter injuries and health problems arising from work[50].

While SOCSO's original focus was to assist workers with physical injuries or medical claims, in 2006, the Human Resources Ministry revised its disability assessment guidelines (The Star, 2006) to compensate workers for mental and psychological disorders caused by traumatic incidents or stress-related ailments at the workplace[51].

Under the guidelines, workers suffering from moderate to severe mental and behavioural impairments related to on-site accidents would be recommended for compensation by government doctors trained to assess workers with such conditions[52].

[47] Workforce, in this context, includes employers, permanent/full-time employees and temporary/part-time employees.

[48] SOCSO (Social Security Organization) also known as PERKESO (Pertubuhan Keselamatan Sosial) was established in 1971 under the Ministry of Human Resources. Among its functions are to provide cash payment and benefits to registered workers and/or their dependents in the event of tragedies such as emergencies, injuries or even death.

[49] The Third and Fourth Schedules of the Employees' Social Security Act set out finite contribution rates for employers and employees, according to 34 wage categories, with the highest wage category being RM 2,900 and exceeding. These rates are calculated with reference to monthly wages (wages payable to an employee in respect of all wage periods ending in the month). Since the Act's latest amendment in 2006, more wage categories have been created; these are available on SOCSO's official website at https://www.perkeso.gov.my/index.php/en/social-security-protection/employer-employee-eligibility/rate-of-contributions

[50] For a detailed breakdown of SOCSO's coverage, please refer to Appendix.

[51] Examples of trauma could include various acts of violence, sexual harassment, serious job accidents or sudden death of an employee

[52] The Impairment and Disability Assessment of Traumatic Injuries, Occupational Diseases and Invalidity guidelines. The latest edition of these guidelines was released in 2014, as a follow up to the earlier two editions. According to the then Human Resource Minister, Datuk Seri Richard Riot Jaem, the guidelines are based on the latest disability assessment concepts or models.

The inclusion of coverage for mental and psychological disorders under SOCSO is undoubtedly a progressive measure taken by the government, and one which greatly increases equity of access to healthcare and livelihood support for workers with mental illnesses.

For example, SOCSO's Employment Injury Scheme provides access to free medical treatment at approved panel clinics and government hospitals, benefiting workers with minor psychological disorders who may need to seek outpatient treatment. Furthermore, if treatment is sought outside these facilities, workers may submit reimbursement claims through their employers.

SOCSO also provides benefits for workers who are rendered unemployable as a result of severe and chronic mental illness. Under the Employment Injury Scheme, those who suffer from permanent disablement may enjoy free access to vocational or physical rehabilitation services provided by SOCSO. Meanwhile, a separate Invalidity Pension Protection scheme entitles workers who are deemed permanent morbidity to receive a monthly pension rate from the date that notice is given of invalidity, for as long as he or she remains invalid or until death[53].

Together, the various schemes under SOCSO offer a great deal of protection for workers with mental health conditions. However, the stigma surrounding reporting mental health issues remains a key barrier. In the case of employment injuries and occupational diseases, employers are required to report to SOCSO on behalf of the injured worker. For invalidity and permanent disablement claims, applicants must make a written application at the SOCSO office in order for their case to be reviewed by the medical board. Unless the stigma surrounding mental illness is meaningfully addressed, it is unlikely that many workers will be brave enough to come forward to claim benefits for seeking treatment, let alone disclose to their employers that they are suffering from mental health issues (stigma and negative perceptions are discussed in greater detail below).

II. The Voluntary Health Insurance Scheme

In May, the Health Minister Datuk Seri Dr S. Subramaniam announced plans to launch another form of social insurance known as the "Voluntary Health Insurance Scheme" as part of efforts to control the high cost of private medical treatment (The Malay Mail Online, 2017). The Health Minister did not provide further details of costing, coverage and products offered at that point in time.

In theory, funding mental health treatment through the Voluntary Health Insurance Scheme could benefit people with mental health treatment needs, by providing them with the resources needed to access effective treatment. The poor, informal workers and the rural population are groups who would stand to gain the most from such a scheme.

[53] For a detailed breakdown of SOCSO's coverage, please refer to Appendix.

However, equity of service would also depend on the quality of the government's resource allocation mechanisms. To the best of the author's knowledge, Malaysia still lacks robust monitoring and epidemiological tracking data on population psychiatric needs. Hence, resource allocation may tend to fall back on broad historical expenditure patterns. By this token, the mentally ill may find that the allocations may be just enough to pay for treatment in the public sector, but would not be sufficient to finance private sector services, where in terms of waiting times, the quality of treatment may be of a better standard. Therefore, the MOH must commit to firstly gathering more data on psychiatric needs and secondly, creating a resource allocation formula weighted by estimates of psychiatric needs so that revenue can be distributed in accordance with identified needs.

(C) Addressing negative attitudes and social exclusion of the mentally ill

Tackling and reducing discrimination associated with mental health issues is undoubtedly a challenging issue, given that certain entrenched cultural norms in our society heavily impede the acceptance of those living with mental illness.

Moreover, the damaging effects of stigma are not just confined to a single environment, but spill over into various areas of the affected person's life, be it work, equity of access to healthcare service or standing in social order within the wider community. Yet for these very reasons, it is perhaps the most fundamental and important barrier to break.

Ultimately, the improvement of social conditions for the mentally ill rests on cultural acceptance. People living with mental illness will never truly find a place in communities that reject them or treat them with grudging acceptance.

A coordinated national approach to anti-stigma and anti-discrimination programmes is highly recommended. The MOH must start the ball rolling by firstly establishing a "Mental Health Promotion Agency" to provide funding and oversight. This agency must work in tandem with NGOs based in various states to develop suitable programmes and deliver national coordination and communication efforts. Examples of programmes could include nationwide advertising campaigns to raise awareness of common mental illnesses, to emphasize the possibility of recovery, and most importantly, to point people towards avenues where they may seek help for their needs.

At the moment, several mental health NGOs exist in the country, notably the Malaysian Mental Health Association (MMHA) which was established in 1967, the Perak Society for Promotion of Mental Health Association, the Alzheimer's Disease Foundation Malaysia (ADFM) as well as various other state mental health associations and family support groups. These independent organizations would be much more effective in their community outreach and advocacy efforts if they were to band together under one umbrella organization, while maintaining strong communication links with the proposed government mental health agency.

At the same time, the anti-stigma movement needs effective advocates to be at the forefront of leadership and project delivery and surely none better to do this than individuals with experience of mental illness.

In the developed countries, a host of prominent personalities including Prince Harry of Wales, actress Catherine Zeta-Jones, author J.K. Rowling and many more have come forward to speak openly and honestly about their struggles. While their courage should not be discounted, combatting stereotypes and modelling positive outcomes for the mentally ill need not be confined to actors and celebrities alone. If more 'down-to-earth' people were to talk about their lived experiences of mental illness, the effect would be one of normalizing discourse on mental illness, as the message sent will be one of not being ashamed to share openly about their struggles. The affected have an important role to play as stakeholders in the decision making process, shaping everything from individual access to treatment to overarching mental health policy.

At the same time, anti-stigma efforts need to be culturally appropriate. For this, community and faith-based groups must step into the breach to conduct local efforts. Leaders of these groups are at an advantage, since they are able to understand issues relevant to their particular communities, and hence work on improving knowledge and attitudes towards mental illness within these contexts.

Starting a coordinated anti-stigma movement is just one part of the process; sustaining it will be the further challenge, since it will likely take time for such a project to bear fruit. To take a real life example, New Zealand's 'Like Minds, Like Mind" anti-stigma and anti-discrimination programme took decades from its foundation in 1997 to achieve relative success in integrating people with mental illness into the community (The Economist Intelligence Unit).

Yet there is proof that long term, consistent efforts can overcome entrenched barriers. New Zealand has come far in this transformation process through years of dedicated effort in working through the necessary practical and systemic challenges. If our MOH and mental health NGOs can rise to the challenge, our country will surely see similar success and transformation in overcoming cultural limitations and mind sets towards mental illness.

PART FOUR: ESTIMATING DEPRESSION TREATMENT COSTS IN THE PUBLIC AND PRIVATE SECTORS

6.0 Calculating the Costs of Mental Healthcare in the Private and Public Sectors

The aim of this chapter is to estimate the costs associated with seeking treatment for clinical depression in Malaysia. A comparison of costs will be made for the public and private healthcare sectors, in order to assess if there is a significant difference.

The first part of this chapter will define the study design and methodology. Since the existing research literature on the topic is rather thin, the author attempted to design an original study framework, including modelling a 'typical' treatment pathway for depression based on evidence-backed research from the clinical practice guidelines. The scope of cost components and various terminologies will also be explained.

The next part of the chapter deals with the actual calculation of costs, drawing on various types of information, including medical fee schedules, clinical practice guidelines and consumer price guides. An attempt was made to present the information in a methodological fashion, yet one that is easily understood.

The final part of the chapter will suggest potential policy changes to improve access to treatment.

Being cognizant of the medical costs for patients can be useful information for policymakers who are working to improve access to treatment for the mentally ill. It is also useful for the lay person who wishes to understand the personal economic consequences associated with mental illness.

6.1. Study Design and Methodology

6.1.1. The MOH Clinical Practice Guidelines as a Roadmap

In most cases of mental illness, the nature of development and experiences are so varied that there is no such thing as a 'standard' treatment[54]. Each patient will present a unique clinical picture, and it is left to the discretion of the doctor to diagnose and design a treatment plan that caters to the patient's needs.

Despite these complexities, there are certain diagnostic tools, such as clinical practice guidelines (CPGs) that may be used as a roadmap for researchers to model typical treatment pathways. While they are certainly not substitutes for the advice of a knowledgeable and experienced health care provider, CPGs

[54] In mental health clinical practice, there is a theory called the "biopsychosocial" approach, which most mental health professionals adhere to. This theory asserts that mental illness is not mono-causal, but develops from a full range of psychological, biological and sociocultural influences. For instance, a person suffering from depression might have become that way due to the stress of a pre-existing medical condition, a social condition (such as losing a loved one), or a psychological condition (such as an overly self-critical nature).

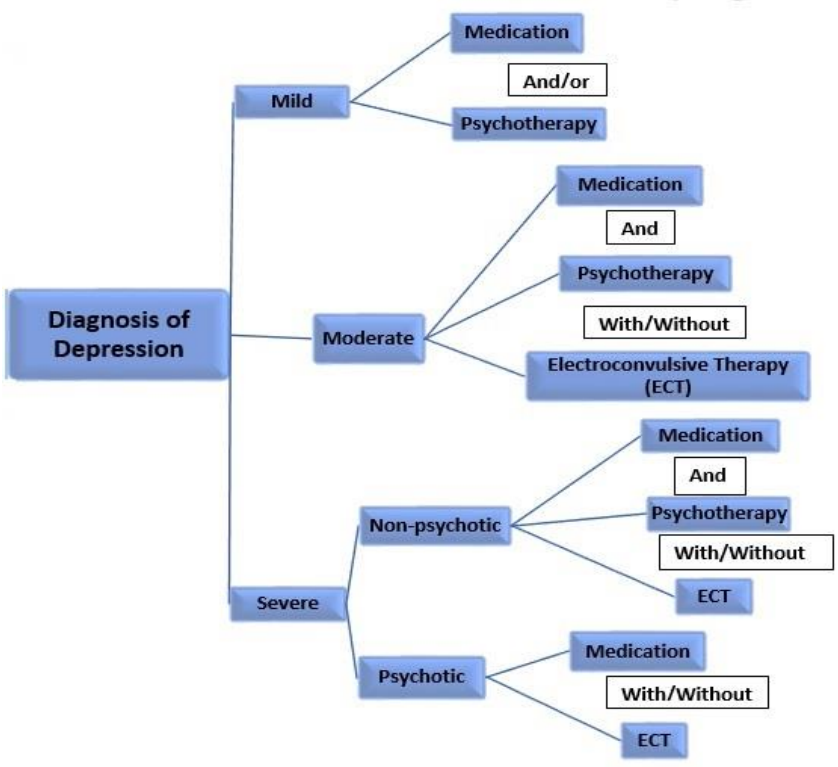
are nevertheless useful as they contain evidence-backed recommendations on diagnosis and courses of intervention for patients with specific clinical conditions.

To date, the MOH has published six such CPGs related to the treatment and management of psychiatric disorders including depression, attention deficit hyperactive disorder, schizophrenia, dementia, bipolar disorder and autism spectrum disorder. These documents are available for download on the official ministry website (Ministry of Health, Malaysia).

For the purposes of this study, depression was selected as the mental illness of choice to estimate treatment costs since, together with anxiety disorders, it is a mental disorder that has become increasingly prevalent within the Malaysian society in recent years.

Attempts to model a 'typical' treatment pathway will be guided by information contained in the MOH's Clinical Practice Guidelines for Management of Major Depressive Disorder (hereafter called the 'Clinical Practice Guidelines').

Figure 37: Algorithm for treatment of mild, moderate and severe cases of depression.



Source: adapted from the MOH Clinical Practice Guidelines for Management of Major Depressive Disorder (MOH/P/PAK/124.07 (GU))

Figure 38 outlines the treatment intervention pathways for various forms of depression, as outlined in the Clinical Practice Guidelines.

Barring cases of severe psychotic depression, the recommended medical interventions for most forms of depression consist of two treatment prongs, namely pharmacotherapy (i.e. medication) and psychotherapy. Indeed, many studies have shown that in a majority of patient populations, the combination of medication and psychotherapy generally provides the quickest and most sustained improvement in depressive symptoms and increased quality of life (Medscape, 2017).

Note: Electroconvulsive therapy (ECT) was also listed as "an effective for of somatic treatment for major depressive disorder". Though it is not often used as a form of treatment of depression, the Clinical Practice Guidelines nevertheless recommend ECT as an effective treatment strategy for reducing depressive symptoms "if there is a life-threatening condition such as refusal to eat or high suicide risk." Elsewhere, it may also be considered "for the acute treatment of moderate or severe depression for short-term therapeutic benefits" (Ministry of Health, Malaysia, Malaysian Psychiatric Association, Academy of Medicine of Malaysia, 2007). Besides these two components, regular consultation sessions with psychiatrists, who act as the patient's clinical case managers, may also be factored in as an additional cost.

6.2. Defining Cost Components and Various Terminologies

6.2.1. Identifying cost components of treatment

Mental health treatment may be divided into three main cost components: direct medical costs, direct non-medical costs and indirect non-medical costs.

- Direct medical costs refer to the actual costs of utilizing psychiatric services. These include consultation fee charges for psychological treatment and psychotherapy, and the cost of purchasing medication.
- Non-direct medical costs refer to "hidden costs", such as the cost of transportation to obtain medical services, or the charges borne by the patient's family for hired nurses and nursing home stay.
- Indirect non-medical costs may be measured through the individual's productivity losses for absenteeism (leave from work) and presentism (reduction of work performance).

This chapter will focus on calculating the direct medical costs of mental health treatment in public and private health care, since data availability makes this the most measurable component. Nevertheless, the reader should be aware that non-direct medical costs and indirect medical costs also translate to a significant cost burden on the patient.

6.3. Psychiatric Consultation Fees

Under the NSR, psychiatry is registered and classified as a medical specialty, together with sub-specialities such as child and adolescent psychiatry and forensic psychiatry (National Specialist Register).

In government hospitals, access to specialist psychiatric services is controlled through a national referral system, whereby patients are referred to see a psychiatrist by the primary healthcare general practitioner (Ministry of Health, Malaysia) (GP).

Patients who attend a government psychiatrist outpatient clinic with a referral letter will usually obtain an appointment to see a psychiatrist within 2 weeks. Patients need only pay a nominal fee to see a psychiatrist. According to the MOH official fee guide to treatment charges (Ministry of Health, Malaysia), for the first visit, patients either pay nothing (if their referral is from a government medical officer) or are charged RM 30 (if their referral comes from a private practitioner). Each follow-up consultation is then charged RM 5, regardless of referral source.

In the private sector, patients need not present a referral letter to seek an appointment with a psychiatrist. However, private psychiatrist fee charges tend to be very costly compared to charges in government outpatient clinics, despite regulation efforts by the MOH. In 2013, the Private Healthcare Facilities and Services (Private Hospitals and other Private Healthcare Facilities) Regulations 2006 incorporated a professional fee schedule into its Thirteenth Schedule. This document spells out the maximum allowable specialist fee charges by the private medical profession. As specialists, psychiatrists are governed by these charges.

Table 11: Fee Schedule showing maximum chargeable fees for private medical specialist consultations and procedures

Specialist Consultation Fee	**Fee (RM)**
(a) First visit/ initial consultation	80-235
Consultation only	
Consultation with examination	
Consultation with examination and treatment plan	
(b) Follow-up visit/ Follow-up consultation	40-105
Consultation only	

Consultation with examination	
Consultation with examination and treatment plan	
Consultation after stipulated clinic hours	*Up to 50% above usual rate*
House call or home visit	*Up to 100% above the usual rate*

Source: Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) (Amendment) Order 2013 [Regulation 433], p. 94

During the first visit to a psychiatrist, the patient's health history and details concerning symptoms, physical tests, blood tests will be jotted down. If necessary, psychological tests to assess the patient's mental state will also be performed. Once a diagnosis is made, a treatment plan will be drawn up and discussed together with patients.

6.4. Psychotherapy Fees

As a medical doctor, a psychiatrist's main tasks are to manage clinical cases and prescribe medication. Depending on their training, some psychiatrists are also capable of treating patients using psychological methods. However, in most cases, such work is usually left to a clinical psychologist, who is trained to work using several models of psychological therapy[55] (Royal College of Psychiatrists).

In government hospitals, psychotherapy services are mainly delivered by clinical psychologists based in outpatient clinics in the Psychiatry department.

The clinical charges for psychotherapy services are mostly standard across government hospitals. According to MOH official guidelines, patients pay RM 30 for initial consultation and RM 5 for each follow-up visit. A referral letter must be submitted in advance in order to get an appointment date (usually between 5-10 working days).

In the private sector, psychotherapy tends to be much more costly. The Private Healthcare Facilities and Services (Private Hospitals and other Private Healthcare Facilities) Regulations 2006 contains a list of charges that specifically apply to psychotherapy services.

[55] Examples include Cognitive Behavioural Therapy, psychodynamic/systemic models and others)

Table 12: Fee Schedule showing maximum chargeable fees for various kinds of psychotherapy sessions in the private sector

Psychiatry (Psychotherapy) Procedure Fee	Fee (RM)
Individual psychotherapy – not less than 45 minutes per session including behaviour therapy and hypnotherapy	250
Group psychotherapy per person – one hour per group of not less than three patients and not more than eight patients	65
Marital therapy per couple – not less than 45 minutes per session for a couple together	250
Family therapy per family – not less than 45 minutes per session and not less than three members	250
Child psychotherapy – not less than 30 minutes per session including relevant family interviews	250
Each electroconvulsive therapy (ECT)	315

Source: Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) (Amendment) Order 2013 [Regulation 433], p. 130

Data on consultation charges and psychotherapy fees in the public and private sector are summarized in the table below:

Table 13: Breakdown of Psychiatric Consultation Fees and Psychotherapy Fees in the Public and Private Sector

		Public	Private
Psychiatric Consultation Fees	First visit	Free (Referral from government medical officer). RM 30 (Referral from private practitioner).	RM 80-RM 235
	Follow-up visit	RM5	RM 40-RM 105
Psychotherapy Fees		Free services provided by hospital's Psychology and Counselling Unit	RM 65-RM 250

Source: MOH official fee guide to treatment charges, the Private Healthcare Facilities and Services (Private Hospitals and other Private Healthcare Facilities) Regulations 2006 Medical Fee Schedule, author's own calculations.

It should be noted that even with these regulations governing private medical professional fee charges, it is common practice for many private specialists to charge for their services at a higher rate than the stipulated maximum charges. To give an example, the Malaysian Society of Clinical Psychology (MSCP)'s general professional fee structure guidelines recommend charges within a range of RM 150-RM450 per hour (Malaysian Society of Clinical Psychologists)!

6.5. Medication Costs

In the public health system, medication is theoretically free for patients, or available at very low costs, as the government subsidises access to many pharmaceutical drugs[56].

The cost of medication in the private sector is much higher compared to public healthcare and varies depending on the type of illness and duration of treatment. The MOH does not regulate drug prices, nor does it publish an official pharmaceutical price list. The closest official pharmaceutical price list it has is the Recommended Retail Price for the National Essential Medicines List (RPP NEML), published in 2011.

6.5.1. The Recommended Retail Price for National Essential Medicines List (RRP NEML) 2011

The RPP NEDL was developed "as a tool or reference for price negotiation (for medicines) in the public and private sector procurement process"[57]. It lists 288 types of medicines, of which 60.01% had Recommended Retail Prices. These prices reported were in reported in minimum, median and maximum prices.

Altogether, 14 medicines used to treat mental illness were listed on the RPP NEDL 2011, comprising drugs used in psychotic disorders, mood disorders and generalized anxiety and sleep disorders. Six of these items did not have RRP Unit Prices. The total list is displayed in the table below.

[56] In the Malaysian public health system, patients who are prescribed medical drugs at public healthcare facilities may obtain their medication at no charge, or at very low costs, as the government subsidises many pharmaceutical drugs. The Ministry of Health's Medicines Formulary contains a list of over 1,600 drugs which are provided for free at MOH facilities. The list includes types of psychiatric medications such as chlorpromazine, haloperidol, fluphenazine (anti-psychotics); fluvoxamine, sertraline, escitalopram (anti-depressants); lithium, carbamazepine, lamotrigine (mood stabilizers).

[57] Recommended Retail Price (RRP) for NEDL 2011, p. vi.

Table 14: Summary of Psychotherapeutic Medications

	Strength	Unit	RRP Unit Price (RM)		
			Min	Med	Max
Medicines Used in Psychotic Disorders					
Chlorpromazine HCl 100mg Tablet	100mg		0.18	0.18	0.18
Chlorpromazine HCl 25mg Tablet	25mg	Cap/Tab	0.24	0.24	0.24
Fluphenazine Decanote 25mg/ml Injection	25mg/ml	Each	2.2	2.2	2.2
Haloperidol 1.5 mg Tablet	1.5mg		-	-	-
Haloperidol 5mg/ml Injection	5 mg/ml		-	-	-
Sulpiride 200 mg Tablet	200 mg	Cap/Tab	2.23	4.03	4.03
Medicines Used in Mood Disorders					
Amitryptiline Hcl 25mg Tablet	25 mg	Cap/Tab	-	-	-
Carbamazepine 200mg Tablet	200mg	Cap/Tab	-	-	-
Fluvoxamine 50mg Tablet	50mg	Cap/Tab	3.15	3.15	3.15
Sertraline Hcl 50mg Tablet	50mg	Cap/Tab	0.5	1.2	5.72
Sodium Valproate 200mg Tablet	200mg	Cap/Tab	0.77	0.83	0.83
Medicines Used in Generalized Anxiety and Sleep Disorders					
Clonazepam 0.5mg Tablet	0.5mg	Cap/Tab	-	-	-
Diazepam 10mg/2ml Injection	5mg/ml	Each	-	-	-
	5mg/ml (2ml)	Each	5	5	5
Diazepam 5mg Tablet		Cap/Tab	0.21	0.21	0.21

Source: Recommended Retail Price for National Essential Medicines List (RRP NEML) 2011

It may not be useful to refer to the RPP NEML as a definitive source of information on the purchasing prices of drugs. Firstly, the list has not been updated since 2011, making it somewhat dated. Between then and now, various market pressures and inflation forces would almost certainly mean these recommended prices are non-operational.

More importantly, as stated in the document, the RPP NEML serves only as a "reference for price negotiation". It is not a regulatory instrument. In reality, pharmaceutical companies are highly likely to raise drug prices in order to drive their revenue.

6.5.2. The MOH Consumer Price Guide (CPG)

In 2015, the government Pharmaceutical Services Division, a department under the MOH, drew up a Consumer Price Guide (CPG) to serve "as a guide on the availability of medicines and their prices for consumers when making choices" (Ministry of Health, 2015).

The latest update made to the CPG was in December 2015, making it a more recent source of information on drug prices than the RPG NEDL. Again, while it is not a regulatory instrument, the CPG is more useful than the RPG NEDL useful as a benchmark to estimate drug prices and calculate the baseline cost of psychiatric medication, since its pricing information is more updated than the RPG NEML.[58] Hence, the CPG was chosen as a reference source for drug prices.

The following steps were carried out to collect data on the cost of antidepressant drugs, based on the prices listed in the CPG:

1. Appendix 3 of the MOH Clinical Practical Guidelines for Managing Depression (Ministry of Health, Malaysia) was consulted. The Appendix contains a comprehensive list of antidepressants used in the treatment and management of depression illness, together with information on recommended 'starting dose' and 'usual dose' quantities to be administered to patients. In total, there were 17 types of antidepressants listed, categorized into six major groups.
2. Names of all 17 antidepressants were keyed into the online database of the MOH Consumer Price Guide index (CPG). Out of 17 types, the search returned a total of 10 antidepressants. Some antidepressants, like sertraline and fluoxetine, had many branded product variants, while others, like citalopram, had just one variant.
3. Information on the unit cost prices for each of the 10 types of antidepressants was extracted from the CPG and matched to corresponding information on starting dosages and usual dose range quantities of each drug.
4. The information was then organized and compiled into a table. Where dosage quantities were given in a range, the mid-point (average) was calculated, so as to enable the exact calculation of costs.

Table 15: List of Antidepressant Medications, Starting Dose and Usual Dose Quantities

Drug class	Generic Name	Product Name	CPG/Unit (RM)	Starting Dose (mg/day)	Average Starting Dose (mg/day)	Usual Dose range (mg/day)	Average Usual Dose (mg/day)
SSRI	Fluoxetine HCl 20 mg Capsule	Fluovex Capsule 20mg	2.3	20	-	20	-

[58] As the CPG guidelines were published in 2007, there were some concerns that the information contained in that document relating to drugs and medication may be outdated. However, after performing a cross-check against the list of medications contained in Appendix 4 of the 2011 Psychiatric and Mental Health Services Operational Policy, it was found that the types of drugs recommended as well as recommended dosage quantities were still relevant and applicable.

	Fluoxetine HCl 20 mg Capsule	Salipax Capsule	3.24	20	-	20	-
	Fluoxetine HCl 20 mg Tablet	Anzack Tablets 20mg	2.02	20	-	20	-
	Fluoxetine HCl 20 mg Capsule	Prozac 20mg Capsule	5.59	20	-	20	-
SSRI	Fluvoxamine 50 mg Tablet	Apo-Fluvoxamine 50mg Tablets	1.28	50-100	75	100-200	150
SSRI	Sertraline HCl 50 mg Capsule	Apo-Sertraline 50 mg Capsules	1.27	50	-	50-200	125
	Sertraline HCl 50 mg Tablet	Aurasert 50mg Tablets	0.5	50	-	50-200	125
	Sertraline HCl 50 mg Tablet	Sertraline Tablet 50mg	1	50	-	50-200	125
SSRI	Escitalopram 10 mg Tablet	Espran 10mg Tablets	2.5	10	-	10-20	15
	Escitalopram 10 mg Tablet	Deprilept Tablets 10 mg	2.46	10	-	10-21	15
	Escitalopram 20 mg Tablet	Deprilept Tablets 20 mg	4.09	10	-	10-22	15
SSRI	Citalopram Hbr 20mg Tablet	Apo-Citalopram Tablets 20mg	2.89	20	-	20-40	30
SSRI	Paroxetine HCl 20 mg Tablet	Apo-Paroxetine 20 mg Tablets	3.64	20	-	20-40	30
Tricyclic	Dothiepin Hcl 25 mg Tablet	Depropin Tablet 25mg	0.55	50-75	62.5	75-225	150
Tricyclic	Amitriptylline HCl 25 mg Tablet	Apo-Amitriptyline 25mg Tablet	0.27	25-75	50	75-200	137.5
	Amitriptyline HCl 10 mg Tablet	Apo-Amitriptyline 10mg Tablet	0.19	25-75	50	75-200	137.5

Tricyclic	Clomipramine HCl 25 mg Tablet	Anafranil 25mg Tablet	2.65	10-75	42.5	75-150	112.5
	Clomipramine HCl 10 mg Tablet	Apo-Clomipramine 10mg Tablet	0.44	11-75	42.5	75-150	112.5
	Clomipramine HCl 25 mg Tablet	Apo-Clomipramine 25mg Tablet	0.81	12-75	42.5	75-150	112.5
SNRI	Duloxetine Hcl 30mg Capsule	Cymbalta Capsule 30mg	5.68	40-60	50	60	60

Source: MOH Pharmaceutical Services Division Consumer Price Guide (CPG) 2015.

6.6. Modelling a Typical Treatment Pathway for Depression Based on Clinical Practice Guidelines

In one year, the number of visits to specialists, as well as the type and dosage amounts of antidepressant medication prescribed will vary from patient to patient. Like most mental illnesses, the initial onset of depression is deeply influenced by a patient's unique biological, psychological and social blueprint. As the illness progresses, no one's experience will be the same.

Likewise, treatment plans for depression will be different for each patient, tailored according to their needs- for example, specialists may prescribe more psychotherapy for some, while other patients may find that medications are more beneficial. In most cases, specialists will try to find an effective balance between therapy and medications to help with the remission of symptoms.

For the purposes of calculation, the author chose to model a 'typical' treatment intervention programme based on recommendations provided in the MOH Clinical Practice Guidelines.

6.6.1. Psychiatric Consultations

For psychiatric consultations, the Clinical Practice Guidelines indicate that patients should be seen again by their prescribing clinician within 2 weeks of the first visit, and subsequently on an appropriate and regular basis. For the first 3 months, follow-up consultations should be timed every 2-4 weeks and at longer intervals, if the patient is responding well to treatment. Furthermore, the frequency of patient

follow-up and monitoring will necessarily consider "the severity of illness, social support and co-morbid conditions".[59]

It was assumed that the patient made an initial visit to the psychiatrist in week 0. The patient then made one more follow-up visit in the same month, spaced two weeks apart from the first visit. The 2-week visit interval was repeated for the second and third months. After that, the patient visited the psychiatrist every four weeks, or once a month, for the remaining nine months. In total, there were 15 visits made for the entire year.

6.6.2. Psychotherapy Sessions

With regards to psychotherapy, the Guidelines recommend Cognitive Behavioural Therapy (CBT) as the intervention of choice. In cases of moderate and severe cases of depression, the duration of psychological interventions "should be in the range of 16 to 20 sessions over 6 to 9 months". However, the Guidelines do not specify exactly how often these sessions should take place.

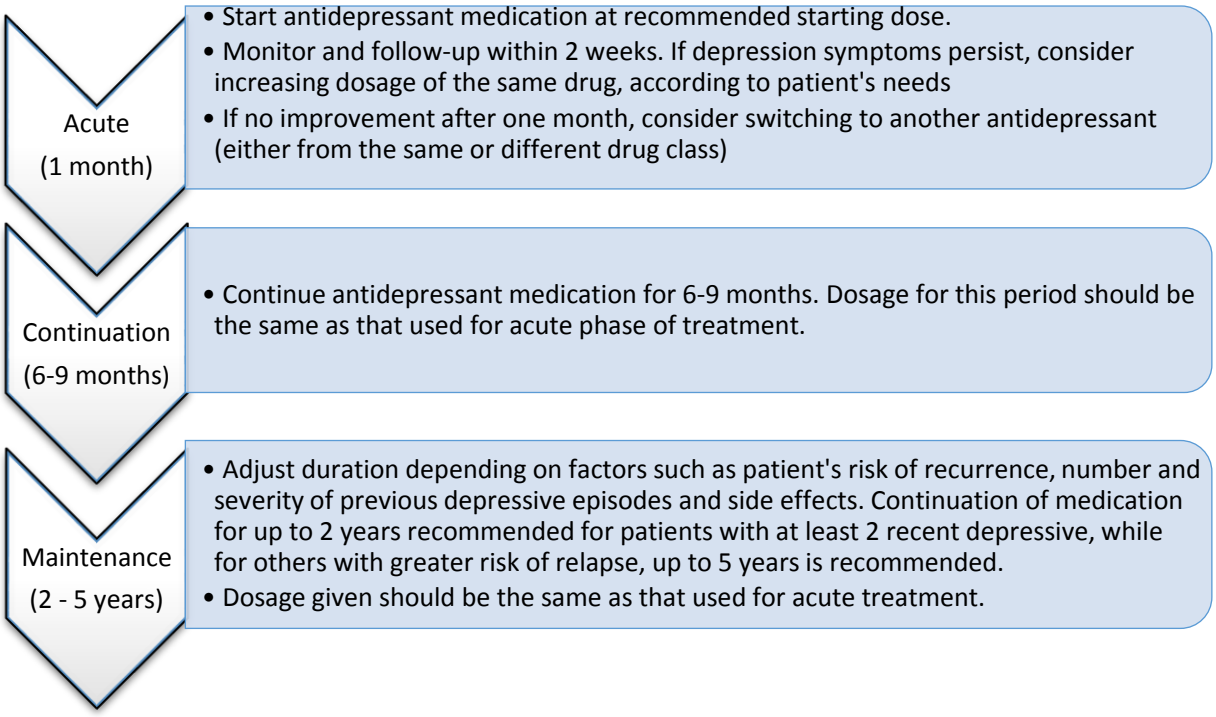
In this study, it was assumed that the patient attended the maximum recommended number of 20 sessions, taking place over the span of 9 months.

6.6.3. Antidepressant Medication

According to the MOH Clinical Practice Guidelines, antidepressant medication is typically recommended for patients with moderate to severe depression as an initial treatment choice. In some cases, patients with mild depression may also be treated with antidepressants, if other means of managing the illness do not prove effective (Ministry of Health, Malaysia).

[59] The CPG's recommendations are based on the UK National Institute for Clinical Excellence (NICE) Clinical Practice Guidelines for managing Depression.

Figure 38: Summary of Flow of Pharmacotherapy Intervention Steps for the Acute, Continuation and Maintenance Phases of Treatment



Source: the MOH Clinical Practice Guidelines for Managing Depression.

According to the Guidelines, once an antidepressant medication has been initiated, it is usually continued until the patient terminates treatment. However, the initial dosage amounts given to a patient may change at different stages of treatment, depending on the patient's age, treatment setting, patient response to the drug and any side effects.

Such adjustments will affect the total cost of medication. For this study, two hypothetical pathways charting the yearly medication costs for depression patients were drawn up, based on evidence-backed recommendations from the MOH Clinical Practice Guidelines for Managing Depression:

Pathway A: Patient responds well to the antidepressant medication that was given as a first-line measure, and continues taking the same antidepressant, at the same dosage level, throughout the entire year.

Pathway B: Patient does not respond satisfactorily to the initial prescribed antidepressant dose after two weeks, and is put on an increased dose of the same medication for another 2 weeks. After a month, the patient starts responding well to the increased dosage. He or she then continues being treated at this dosage level throughout the rest of treatment.

6.7. Formula for calculating annual direct costs for depression treatment

The annual direct costs for depression treatment in the public and private sectors was calculated using the following formula:

Annual Direct Costs for Depression Treatment
= Total Psychiatric Consultation Fees + Total Psychotherapy Fees + Total Medication Costs

6.8. Annual Direct Costs for Treating Depression in the Public Sector

The total annual cost of psychiatric and psychotherapy visits in the public sector was calculated based on consultation fee charges listed in the MOH official fee guide. The summary of costs is displayed in the table below:

Table 16: Per-patient Annual Costs of Psychiatric Consultations and Psychotherapy Treatment in Government Mental Health Services

		Number of sessions per year	Cost Per Session (RM)	Annual Cost (RM)	
Psychiatric Consultations	Initial Consultation	1	0	70	100*
			30*		
	Follow-up Session	14	5		
Psychotherapy Sessions	Initial Consultation	1	30	125	
	Follow-up Session	19	5		

Source: MOH official guide to fee charges, author's own calculations.

**These fees apply to patients who have been referred to government mental health services by a private practitioner. According to the MOH guide, such patients are charged higher rates for the initial consultation.*

In government hospitals, medicines stocked by in-house pharmacy departments are either provided to patients entirely free or sold at cheap prices (relative to external market prices). In this study, it was assumed that patients seeking treatment through mental health services at government hospitals did not have to pay for their medication.

Based on the figures above, the total annual direct cost of seeking treatment for depression in the public sector was calculated as follows:

Patients referred to government mental health services by a public medical practitioner

= Total Psychiatric Consultation Fees + Total Psychotherapy Fees + Total Medication Costs
=RM 70 + RM 125 + 0
=RM 195

Patients referred to government mental health services by a private medical practitioner

= Total Psychiatric Consultation Fees + Total Psychotherapy Fees + Total Medication Costs
=RM 100 + RM 125+ 0
=RM 225

6.9. Annual Direct Costs for Treating Depression in the Private Sector

The total annual cost of attending psychiatric consultations and psychotherapy sessions in private mental health services was calculated based on the medical specialist fee charges listed in the Private Healthcare Facilities and Services (Private Hospitals and other Private Healthcare Facilities) Regulations 2006.

Table 17: Per-patient Annual Costs of Psychiatric Consultations and Psychotherapy Treatment in Private Mental Health Services

		Number of visits per year	Fee Per Session (RM)	Annual Cost (RM)
Psychiatric Consultations	Initial Consultation	1	157.5	1172.5
	Follow-up Session	14	72.5	
Psychotherapy Sessions*		20	157.5	3150

Source: author's own calculations. Source: Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) (Amendment) Order 2013 [Regulation 433], author's own calculations.

**Unlike government mental health services, where patients are charged different rates for initial consultation and follow-up visits, the charge rates for psychotherapy in the private sector are usually standard across all sessions. Hence there was no need to divide the visits into "initial consultations and follow-up sessions"*

Based on the figures above, total annual costs of psychiatric consultations and psychotherapy sessions in the private sector was calculated as follows:

=RM 1172.5 (total psychiatric consultations) + RM 3150 (total psychotherapy sessions)
= RM 4322.5

Next, to calculate medication costs, information on drug prices, starting dosage and usual dose range quantities listed in the CPG was applied to the 'modelled' treatment pathways charted out in Pathway A and Pathway B.

Table 18: Total Annual Medication Costs for Depression, According to Type of Antidepressant and Modelled Treatment Intervention Pathway

Generic Name	Product Name	Pathway A annual medication cost (RM)	Pathway B annual medication cost (RM)
Fluoxetine HCl 20 mg Capsule	Fluovex Capsule 20mg	772.8	-
Fluoxetine HCl 20 mg Capsule	Salipax Capsule	1088.6	-
Fluoxetine HCl 20 mg Tablet	Anzack Tablets 20mg	678.7	-
Fluoxetine HCl 20 mg Capsule	Prozac 20mg Capsule	1878.2	-
Fluvoxamine 50 mg Tablet	Apo-Fluvoxamine 50mg Tablets	645.1	1263.4
Sertraline HCl 50 mg Capsule	Apo-Sertraline 50 mg Capsules	426.7	1040.1
Sertraline HCl 50 mg Tablet	Aurasert 50mg Tablets	168.0	409.5
Sertraline HCl 50 mg Tablet	Sertraline Tablet 50mg	336.0	819.0
Escitalopram 10 mg Tablet	Espran 10mg Tablets	840.0	1242.5
Escitalopram 10 mg Tablet	Deprilept Tablets 10 mg	826.6	1222.6
Escitalopram 20 mg Tablet	Deprilept Tablets 20 mg	1374.2	2032.7
Citalopram Hbr 20mg Tablet	Apo-Citalopram Tablets 20mg	971.0	1436.3
Paroxetine HCl 20 mg Tablet	Apo-Paroxetine 20 mg Tablets	1223.0	1809.1
Dothiepin Hcl 25 mg Tablet	Depropin Tablet 25mg	462.0	1081.9

Amitriptylline HCl 25 mg Tablet	Apo-Amitriptyline 25mg Tablet	181.4	485.7
Amitriptyline HCl 10 mg Tablet	Apo-Amitriptyline 10mg Tablet	319.2	854.5
Clomipramine HCl 25 mg Tablet	Anafranil 25mg Tablet	1513.7	3911.5
Clomipramine HCl 10 mg Tablet	Apo-Clomipramine 10mg Tablet	628.3	1689.5
Clomipramine HCl 25 mg Tablet	Apo-Clomipramine 25mg Tablet	462.7	1273.7
Duloxetine Hcl 30mg Capsule	Cymbalta Capsule 30mg	3180.8	3823.9

Source: MOH Consumer Price Guide Index, MOH Clinical Practice Guidelines, author's own calculations

** For Pathway B, which includes increased drug dosage as part of the intervention steps, it was not possible to calculate the costs of medication treatment using fluoxetine, since the starting dose and usual dose amounts for this particular anti-depressant are the same. (20 mg/day)*

The total annual direct cost of psychiatric consultations and psychotherapy sessions were then added on to the annual medication costs for each antidepressant, using the formula below, which was also applied to calculate the total direct treatment costs in the public sector:

Annual Direct Costs for Treating Depression in the Private Sector
= Total Psychiatric Consultation Fees + Total Psychotherapy Fees + Total Medication Costs

Total cost of depression treatment using monotherapy for each of the 10 types of antidepressants are summarized in the table below[60]:

Table 19: Total Annual Cost of Depression Treatment Using Monotherapy in the Private Sector, According to Type of Antidepressant and Modelled Treatment Intervention Pathway

Generic Name	Product Name	Pathway A yearly treatment cost (RM)	Pathway B yearly treatment cost (RM)
Fluoxetine HCl 20 mg Capsule	Fluovex Capsule 20mg	5095.3	-
Fluoxetine HCl 20 mg Capsule	Salipax Capsule	5411.14	-
Fluoxetine HCl 20 mg Tablet	Anzack Tablets 20mg	5001.22	-

[60] It was assumed that the patient was treated using one type of antidepressant (monotherapy) for the entire duration of the year. According to the Clinical Practice Guidelines, switching antidepressants should only be considered if the patient does not respond well to the first choice of medication after a month of treatment.

Fluoxetine HCl 20 mg Capsule	Prozac 20mg Capsule	6200.74	-
Fluvoxamine 50 mg Tablet	Apo-Fluvoxamine 50mg Tablets	4967.62	5585.86
Sertraline HCl 50 mg Capsule	Apo-Sertraline 50 mg Capsules	4749.22	5362.63
Sertraline HCl 50 mg Tablet	Aurasert 50mg Tablets	4490.5	4732
Sertraline HCl 50 mg Tablet	Sertraline Tablet 50mg	4658.5	5141.5
Escitalopram 10 mg Tablet	Espran 10mg Tablets	5162.5	5565
Escitalopram 10 mg Tablet	Deprilept Tablets 10 mg	5149.06	5545.12
Escitalopram 20 mg Tablet	Deprilept Tablets 20 mg	5696.74	6355.23
Citalopram Hbr 20mg Tablet	Apo-Citalopram Tablets 20mg	5293.54	5758.83
Paroxetine HCl 20 mg Tablet	Apo-Paroxetine 20 mg Tablets	5545.54	6131.58
Dothiepin Hcl 25 mg Tablet	Depropin Tablet 25mg	4784.5	5404.35
Amitriptylline HCl 25 mg Tablet	Apo-Amitriptyline 25mg Tablet	4503.94	4808.23
Amitriptyline HCl 10 mg Tablet	Apo-Amitriptyline 10mg Tablet	4641.7	5177.025
Clomipramine HCl 25 mg Tablet	Anafranil 25mg Tablet	5836.18	8234.04
Clomipramine HCl 10 mg Tablet	Apo-Clomipramine 10mg Tablet	4950.82	6011.96
Clomipramine HCl 25 mg Tablet	Apo-Clomipramine 25mg Tablet	4785.172	5596.22
Duloxetine Hcl 30mg Capsule	Cymbalta Capsule 30mg	7503.3	8146.45

Source: MOH Consumer Price Guide Index, MOH Clinical Practice Guidelines, author's own calculations.

According to the MOH Clinical Practice Guidelines, once a treating doctor decides to start a patient on a course of medication, it is usually recommended that monotherapy (treatment using the same type of antidepressant) be administered and that the same dosage level maintained for at least a month. However, if there is insufficient response or depression symptoms persist during this period, the doctor may choose to optimize by increasing the dose of medication or switching to another antidepressant.

In Pathway A[61], patients who were prescribed sertraline (a type of Selective Serotonin Reuptake Inhibitor or SSRI) at the start of treatment and continued being treated at the same dosage level throughout the year (Pathway A) paid the least amount for a year's course of treatment, including costs incurred for psychiatric consultations and psychotherapy sessions. The total annual cost of depression treatment amounted to RM 4490.50.

On the other hand, patients who took duloxetine (a type of serotonin-norepinephrine reuptake inhibitor, or SNRI) paid the highest amount for a year's treatment. Here, the total annual costs of depression treatment amounted to RM 7503.3.

In Pathway B, where the patient does not respond satisfactorily to the initial dose and is put on an increased dose of the same antidepressant, higher treatment costs were incurred. For patients on sertraline, the annual direct treatment cost amounted to RM 4,732, while patients on duxoletine monotherapy had to pay RM 8146.45 for treatment.

These are no small sums, yet it is important to bear in mind that the calculations above are a mere baseline of what mentally ill patients in the private sector might expect to pay for medication and, by extension, their treatment costs.

Several assumptions were built into the calculation model, including the assumption that patients were treated using just one type of antidepressant (monotherapy) instead of a combination of drugs. In reality, if patients do not respond well to drugs during the acute phase of treatment, the psychiatrist may choose to introduce another antidepressant to treat the depression, or put the patient on combination therapy (combining two or more types of antidepressants). Such adjustments would necessarily affect the total cost of medication, and consequently, the overall treatment costs.

Secondly, although every effort was made to make an accurate estimation of drug costs, there were limitations to using the Consumer Price Guide (CPG) to determine the unit cost price of antidepressants. As the CPG is primarily a reference guide for consumers to purchase medicines, the drug prices given may differ widely from actual market retail prices, where market forces and additional GST tax costs come into play.

These extra costs were not factored into the present study's calculations. Moreover, given that the government does not regulate medicine prices, it is likely that the CPG's list of recommended prices does not reflect the actual prices of antidepressants sold in the free market.

Therefore, the reader should take these calculations to represent only the minimum costs of seeking treatment in the private sector. In reality, the actual cost borne by patients could amount to much higher figures.

[61] Patient responds well to the type and dosage level of antidepressant medication given as a first-line measure, and maintains this level of dosage throughout the entire year.

6.10. Discussion and Policy Recommendations

The financial cost of seeking mental health treatment by patients is something that has not been looked at too closely in the literature of mental illness studies in Malaysia.

Most official government reports tend to deal with aspects of delivery of mental health services.

Few studies have been done on the costs, and even those that do tend to deal with the economic burden associated with a particular mental disorder that is borne by government or society, rather than the financial costs to the patient.

Notwithstanding, patient treatment costs is an important area to address, as part of the wider framework of evaluating access to mental health services. Apart from stigma, costly treatment is a major barrier preventing people with mental illnesses from getting professional help, especially those individuals belonging to the lower socio-economic groups.

In Malaysia, a majority of poorer groups seek healthcare services from government facilities. The NHMS 2015 population survey found that 60.1% of respondents had utilized outpatient facilities at government hospitals.

Out of these, states with larger rural populations, such as Kelantan (84.0%), Perak (72.4%), Kedah (71.0%), Sabah & Labuan (68.6%) and Sarawak (61.4%) had recorded higher utilization rates of outpatient facilities versus states such as Kuala Lumpur, (42.5%) and Selangor (40.1%) and Pulau Pinang (59.2%). Overall, populations in the rural areas had sought healthcare through government facilities significantly more compared to the urban areas, with a 73.6% versus 54.6% rate (Ministry of Health, Malaysia, 2015).

By group household income, the highest utilization of government health services came from households earning under RM1000 (84.8%) and RM 1000-1,999 (73.6%). Similarly, by household income quintiles, 84.6% of the Q1 group (the poorest 20%) and 73.7% of Q2 utilized government outpatient healthcare, and by socioeconomic quintiles, groups that recorded the highest utilization rates were Q1 (70.2%) and Q2 (73.1) (Ministry of Health, Malaysia, 2015).

By ethnicity, communities with the highest utilization of government outpatient healthcare facilities were also those that had a strong association with lower socio-economic status. Out of all the ethnic groups, the highest utilization of government outpatient care was recorded by Bumiputera Sabah (79.9%), followed by Orang Asli (77.3%) and Bumiputera Sarawak (68.4%) and Other groups (63.2%) (Ministry of Health, Malaysia, 2015).

A key factor driving the preference for government healthcare services by the poorer groups is the high degree of affordability versus private healthcare, where treatment is far more costly. This contrast applies to all types of treatment services, including mental health services, as illustrated by the stark contrast in depression treatment costs between the public and private healthcare sectors.

Table 20: Range of Annual Treatment Costs for Depression in the Public and Private Healthcare Sectors

Treatment setting	Annual treatment cost range (RM)
Public Sector	195-225
Private Sector	4491-8147

Source: Author's own calculations

From the calculated estimates, the maximum amount payable for a year's worth of depression treatment in government facilities falls under RM300. These rates would not be unaffordable even for groups coming from the lowest socioeconomic quintiles. By comparison, the medical bill for private mental healthcare cost thousands of ringgit per year. While these charges may be considered affordable to the middle class and high income groups, the poorer groups would certainly find it challenging to pay for these expenses.

The affordability of treatment in the public sector has a positive impact on accessibility of mental healthcare, especially for poorer groups and those living in the rural areas that tend to be more vulnerable to developing mental health problems.

However, government healthcare has also been associated with low quality of service. In the NHMS 2015, it was found that a large percentage of the population perceived aspects of the healthcare delivery system to be poor. In particular, waiting times to see a doctor, availability of specialist and the amount of time spent with the treating doctor were rated as "poor" and "very poor" (Ministry of Health, Malaysia, 2015)

Official data taken from the MOH Clinical Performance Surveillance Unit appears to suggest that performance standards for psychiatry clinical services in government hospitals have dropped over the years. In 2014, the Unit's as[62] National Clinical Services Performance Index revealed that, from 2009 to 2013, the average performance index for psychiatry program had dropped from 1.40 to 1.10 (Ministry of Health, Malaysia, 2013).

From a service standard perspective, these problems may be traced back to supply and distribution issues related to the government's mental health workforce, which have been discussed at length in Chapter 4[63]. Aside from that, overcrowding, low hygiene standards and scarcity of certain essential medicines are some concerns that are commonly raised by those who visit government hospitals for treatment (Free Malaysia Today, 2014).

These shortcomings highlight a problem in equity of access to quality mental health services for the poorer groups. While they may be able to pay for treatment at government hospitals without suffering too much

[62] The Clinical Performance Surveillance Unit, previously known as the Quality Assurance Unit, is a unit under the Medical Care Quality Section of the Medical Development Division in the MOH. It is entrusted to conduct clinical performance surveillance of government medical services, including specialist services, and generate indices to measure performance and delivery standards.
[63] Aside from workforce issues, there are other wider concerns that affect quality of mental health services, such as the standards of available facilities and delivery of care. These concerns, while duly important, lie beyond the scope of the present study to address.

financial strain, the quality of service and care in these facilities may be less than ideal compared to the private healthcare sector, where issues of understaffing and uncomfortable or unhygienic clinical environments are rare. Here, however, prices for services tend to be prohibitively expensive. This is not entirely unexpected given that all of private healthcare is for profit.

As discussed in Chapter 5.2, private insurance in Malaysia currently does not cover for mental health treatment. Realistically speaking, therefore, only the wealthy who can afford to pay out-of-pocket can have access to private healthcare. Meanwhile, financial constraints mean that access to these private mental health services are largely denied to poorer groups.

Strategies to break down these barriers and improve equity of access to quality mental health services for the poorer groups are two-fold.

Firstly, the government must strive to raise the standards of clinical psychiatry services in government hospitals by addressing workforce shortages and other salient issues. Doing so will require greater resources to be allocated towards the health budget and prudent planning measures on the part of the MOH.

Secondly, insurance coverage for mental health treatment should be made available, so that the poor may have the option of accessing private healthcare if they wish. Since most poor groups cannot afford to purchase private insurance, coverage for these groups could be introduced in the form of an alternative health financing scheme such as social insurance, where access to resources is granted to either the entire or a majority of the population[64].

[64] For a discussion of the viability of social insurance as an alternative health financing model in Malaysia, please refer to Chapter 5.4.

Conclusion

In Malaysia, the medical professional ethics code known as the Patient's Charter upholds the standards of healthcare which the government and healthcare providers should strive to achieve[65].

The Charter also enshrines patients' rights to equitable healthcare, among which include:

- A right to access to competent health care and treatment regardless of age, sex, ethnic origin, religion, political affiliation, economic status or social class.
- A right to accessible health care services, available on the basis of clinical need regardless of the ability to pay. (The Charter also declares that it is the responsibility of the Government to ensure that every person has access to essential health services) (Malaysian Medical Association).

At the same time, patients' rights to enjoy good health in wider society is given as follows:

- A right to an environment that is conducive to good health. This includes and extends to a healthy and safe work environment, a healthy and safe home environment and a healthy and safe environment at the place where he or she gets his medical care and treatment (Malaysian Medical Association).

Together, these points capture the state of best conditions for people living with mental health conditions to recover. It is one which pairs access to quality healthcare in clinical settings with adequate support to 'recover' and lead a meaningful life (as defined by them) in the community.

At the moment there is still a significant gap between the ideal and reality. In treatment settings, Malaysia's mental health care system still faces a number of structural issues. While mental health services are fairly advanced and have even expanded to community-based care, these services are still significantly under-staffed. In terms of having enough psychiatrists to cater to the population's mental health needs, Malaysia still has not achieved adequate provider-to-population ratios. Many states remain underserved and the East Malaysian states fare especially poorly. Looking beyond to the allied professions, the current numbers of clinical psychologists are even worse.

These shortages hurt access, by limiting the capacity of the mental health workforce to deliver quality care to the mentally ill. Yet beyond the healthcare system, there are other issues at play. Getting treated for mental illness is nominally free in government healthcare, but costs are prohibitively high in the private sector. Health insurance plays a big role in reducing the barrier to seeking private specialist treatment but to this day, health insurers in Malaysia do not offer coverage for mental health, even though the rise in numbers seeking treatment from government psychiatric clinics is clear evidence that such policies would be in demand.

[65] The Charter was drawn up and signed in 1995 between the Malaysian Medical Association (MMA) and three other healthcare statutory bodies, namely the Federation of Malaysian Consumers Association (FOMCA), The Malaysian Dental Association (MDA) and the Malaysian Pharmaceutical Association (MPA).

Finally, stigma against those living with mental illness is a critical issue. All too often, there is an underlying societal belief that mental illness stems from moral deficiency or is a sign of weakness and failure to cope with normal life stressors.

These ongoing negative perceptions perpetuate stigma-induced actions that ultimately restrict individuals with mental health conditions from leading a meaningful and productive life among the community. A clear example lies in discriminatory workplace practices. Many employers assume that mentally ill employees are unfit to work, whether or not their condition significantly affects that ability. Few companies make adequate provisions for mental health support and assistance available to employees, even though quality of life at the workplace is a key determinant in mental health.

Stigma also leads to self-blame, shame and an unwillingness to seek treatment on the part of the afflicted. While wrestling with their illness, they must also face ill treatment from others- some are judged even by their peers and family members, the very people who should be their pillars of support. In the long run, this leads to shame, self-blame and an unwillingness to seek help for their conditions.

Improving access to mental healthcare will require efforts to bridge these barriers, be it in workforce gaps, financial costs or stigma. While detailed recommendations have been provided in previous chapters, a few key observations may be made here:

1. **Understand the nature of the challenge**: Data collected on mental illness in Malaysia is fairly wide, ranging from periodic mental health prevalence surveys (within the National Health and Morbidity Surveys) and records of psychiatric outpatient and inpatient figures. Besides the Health Ministry, private researchers in academia have also contributed to the literature on mental health, including studying public perceptions and attitudes towards the mentally ill. However, important deficiencies remain. For example, very little has been done to study the factors that influence vulnerabilities and risks of developing a mental illness. Neither is there comprehensive data on mental health service outcomes, to know the difference that treatment is making. In the context of national efforts to develop and implement mental health policy, it is vital to have a strong evidence base that covers such information. Equally, the furnishing of evidence-backed data would enable insurance industry to perform risk calculations and come up with policies that include coverage for mental health treatment, thus addressing the barrier of non-coverage in health insurance. The government should make it a goal to set up a specific mental health research arm within the Ministry of Health, or an official research depository, with the aim of collecting information on these metrics.

2. **Build greater capacity in the health system and wider society**: Currently, the numbers of psychiatrists and clinical psychologists working in the government's mental health workforce are thinly stretched. Low supply of these providers make it difficult to make mental health care services equitably available in all government hospitals. Without sufficient numbers, most clinicians are concentrated in larger urban areas, while the rural areas are heavily underserved.

The government must endeavour to build up key human resources in mental healthcare. Dedicated funding needs to be implemented, with more going towards building up the mental health workforce capacity. This will no doubt take time. In the interim, the Ministry of Health could develop and integrate a range of resources to work within non-clinical settings. Training primary health workers, NGOs and non-experts to detect symptoms of mental health problems and provide basic counselling services could provide effective in building a wide range of stakeholders with the knowledge needed to provide effective community-based care.

3. **Increase cultural acceptance:** As important as it is to address structural barriers, meaningful improvement cannot happen if stigma and discrimination remain entrenched in society. There is a pressing need to challenge and correct the various misconceptions that stigmatize mental health conditions and ostracize those living with mental illnesses. For this, support from a range of stakeholders, from government to civil society leaders and even those from the mentally ill community is needed. Examples of efforts include hosting public engagements and workshops that feature the voices and experience of people who have lived through mental illnesses, for their voices hold great power. Intervention campaigns aimed at improving public attitudes, combatting stereotypes, raising awareness of discrimination and modelling positive behaviour are encouraged, though care must be taken to ensure that these programmes are sensitive to cultural and ethnic values and beliefs.

Easy solutions do not exist. At government level, the funding allocated for change, how well it is sustained and the manner in which it is spent, will largely determine success in resolving workforce shortage issues, and other issues which impact the delivery of quality of care. But the government need not work in isolation. Coordination with key stakeholder groups, such as the insurance industry, NGOs and think tanks, can help tremendously to increase mental health research and care delivery, while also tackling the barriers in access to affordable care and cultural stigma.

At the end of the day, only long term and consistent efforts can overcome entrenched barriers. More policymakers, leaders and members of the society must come forward, with vision and spirit to pave the path for improving treatment outcomes for those living with mental illness and increasing their acceptance in the wider community. It is the author's hope and belief that Malaysia is slowly but surely building up momentum in the right direction.

Appendix

SOCSO coverage and benefits

1) Employment Injury Insurance Scheme (EIIS)

Under the Employment Injury Insurance Scheme (EIIS), employees are allowed to claim for benefits for various work-related injuries such as:

a. Industrial accidents
b. Commuting accidents
    i. on a route between the place of residence or stay and the place of work
    ii. on a journey made for any reason directly connected to employment
    iii. on a journey between the workplace and the place where a meal is taken during any authorized recess
c. Accidents during an emergency at the employer's premises while in the course of assisting, rescuing or protecting other people from disaster or danger during an emergency.
d. Occupational diseases as described in the Fifth Schedule of Employees' Social Security Act 1969. There are 26 listed types of occupational diseases and a majority are related to diseases caused by excessive use or exposure to harmful substances and irritants; exposure to harmful levels of heat or sound pressure, or injuries involving strenuous and prolonged manual labour[66].

Although none of these conditions make direct reference to mental disorders, in 2006, the Human Resources Ministry revised of the disability assessment guidelines to cover workers who inadvertently develop mental health conditions due to trauma at the workplace (for example, a construction worker who sustains severe head injuries as a result of an on-site accident) would be eligible to claim for EIIS benefits. These benefits are fairly wide-ranging and include:

e. Medical benefits- employees may receive free medical treatment, including specialist services if so required, at approved SOCSO panel clinics or government clinics/ hospitals until they are fully recovered. If treatment is sought outside these facilities, employers may also submit claims for reimbursement.
f. Temporary Disablement benefits- these are benefits paid to employees who have been certified by a medical doctor to be unfit for work, for the period of certified medical leave, for not less than 4 days including the day of the accident. Benefits are paid on a daily rate of 80% of the employee's average assumed daily wage, subject to a minimum of RM 30 or a maximum of RM 105.33 daily.

[66] For a full list of descriptions of claimable occupational diseases or injuries, refer to Fifth Schedule of the Employees' Social Security Act 1969.

g. Permanent Disablement benefits- subject to confirmation from the Medical Board that permanent disability has been incurred as a result of sustained injuries, the employee will be entitled to permanent disablement benefits. These benefits are set at a daily rate of 90% of the employee's average assumed daily wage, subject to a range of RM 30.00 per day or a maximum of RM 118.50 daily. Claims must be made within 12 months from the last date of the temporary disablement.
h. Constant-attendance allowance- this is a fixed allowance of RM 500 monthly, paid to an employee suffering from total permanent disablement and who is so severely incapacitated as to require the personal attendance of another person.
i. Facilities for Physical/ Vocational Rehabilitation- If the employee needs vocational or physical rehabilitation, based on stipulated rates, terms and conditions, SOCSO will bear expenses incurred for various physical and vocational rehabilitation services. These include physiotherapy, occupational therapy, reconstructive surgery, supply of prosthetics, orthotics and other appliances, and apparatus such as wheelchair, crutches, hearing aids and others. Workers who cannot find jobs due to their disablement can also apply to undergo free training in courses such as electrical, sewing, radio/TV repair, typing and other activities.

Other benefits under the EIIS include dependants' benefit, education benefit and funeral benefit (Ministry of Human Resources, Malaysia).

2) Invalidity Pension Protection scheme (IPPS)

While the EIIS covers mostly work-related claims, non-work-related claims can also be made under a second scheme known as the Invalidity Pension Protection scheme (IPPS).

As its name suggests, this scheme insures against conditions of invalidity and provides 24-hour coverage against "permanent morbid conditions that render the individual incapable of engaging in any substantial gainful activity" (Ministry of Human Resources, Malaysia).

Specific details of qualifying conditions for invalidity benefits are laid out in Section 16(2) of the Employees' Social Security Act. Firstly, a morbid condition shall be deemed permanent if it is either incurable or unlikely to be cured. Secondly, the condition must incapacitate the worker such that he or she is no longer able to earn one-third of the normal pay that he or she would otherwise have received by performing the required work duties as a mentally and physically sound employee.

Like the EIIS, employees may claim for various benefits under the IPPS, such as:

a. Invalidity Pension- this is a pension payable as long as the employee is invalid or until death occurs. The pension rate ranges from 50%-65% of the average assumed monthly wage, subject to a minimum pension of RM 475 per month[67].
b. Invalidity Grant- this is payable to employees who have been certified invalid but failed to qualify for Invalidity Pension. The grant is given as a one-time lump sum payment, and the amount is equivalent to the sum of contributions paid with interest.

Other benefits under the IPPS are similar to those of the EIIS, and include constant-attendance allowance; survivors' pension (payable to dependents after the IPPS-insured claimant has passed away); funeral benefits; facilities for Physical/ Vocational Rehabilitation and Dialysis and education benefits

Under SOCSO's regulations, both the EIIS and IPPS are available to employees below the age of 55 years, and contributions are shared by the employer and the employee according to fixed ratios. However, for workers who have reached the age of 60, or are at least 55 years of age and are entering an industry covered by the Act for the first time, only EIIS coverage applies and contributions are wholly borne by the employer.

[67] In order to qualify for the Invalidity Pension, the employee must have made at least 24 months' worth of contributions within a period of 40 consecutive months (full conditions) or not less than 2/3rd of the complete months (at least 24 months' worth of contributions) between the date of first contribution and the date of notice (reduced conditions).

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