Malaysia

Making Provider Payment Mechanisms More Strategic: Removing the Roadblocks to Implementation

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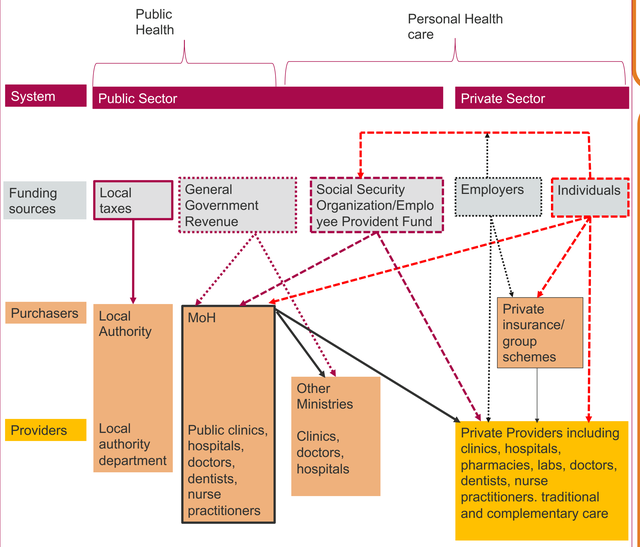
Context:

Population	31.62 M (2017 Estimate)
GDP/ Capita	$9,946 (USD, 2017)
THE/ Capita	$393 (USD, 2015) *Gov't spending comprises 51% of THE*

Organization of the Health System:



Monitoring

1. Quality of Care monitoring is not linked to provider payment
2. FPP monitoring not standardized across facilities. Monitoring is done by some facilities to avoid abuse e.g. by monitoring the proportion of public and FPP cases that any individual specialist is allowed to treat. Some have instituted additional quality checks and safeguards.

MINISTRY OF HEALTH MALAYSIA

PPM Initiatives Development

Existing & Ongoing
Line item budgets (public sector)
FFS (private sector)

- **2007** — Full paying patient program pilot
- **2013** — Capitation pilot proposal
- **2015** — Full paying patient program Phase I roll out
- **2018** — B40 program

Public sector

- Line item budgets and salaries
- All Ministry of Health (MOH) facilities are financed through general government revenue (98%) and user fees (2%).
- User fees collected go into a federal consolidated fund and are not retained at the facility.
- Challenges: Budgets based on historical allocations with rigidity in line items. Lack of financial autonomy with no incentives for efficiency.

Private sector

- Fee for service based on a fee schedule.
- Prices for drugs and diagnostics are not regulated with a fee schedule.
- Private facilities source of finance is mainly out-of-pocket payment (78%), private health insurance (16%) and to a smaller extent, employee benefits (4%) (MNHA, 2015).

Innovations

Full Paying Patient (FPP) program (2007)

- Introduced as a pilot in 2007 and later Phase 1 roll-out in 2015.
- Patients pay a non-subsidized rate based on a fee schedule allowing patients choose their own doctors and better access to treatment facilities.
- Specialists are able to keep a proportion of the fees, while the remaining goes into the consolidated fund.
- The intention was to reduce the brain drain of the MOH specialists to private sector.
- Challenges: Lack of standardization of practice and monitoring between the hospitals and governance. Only doctors benefit.

Capitation pilot (2013)

- A proposal to pilot capitation for PHC through a public-private partnership program.
- The aim was to outsource public patients to private clinics for hypertension and diabetes management, and to pay these private clinics by capitation.
- The plan did not proceed as there was no mechanism for the Government to pay prospectively.
- Bureaucratic institutional arrangements were a huge stumbling block.

Lessons Learned

✓ **Incremental changes to PPMs:** Use innovative ways to supplement the existing PPMs or make incremental changes rather than a complete overhaul of the system.

✓ **Strategic communications** is important to ensure the right message to stakeholders. The implementers must also listen and prioritize concerns to address from the different quarters.

✓ **Monitoring and evaluation** is important in determining whether the implemented PPM has served its intended purpose and if there are unintended consequences.

Challenges for UHC

- Increasing burden of non-communicable diseases:
  - 61.3% of adults have one or more chronic diseases and 44.2% are overweight.
- Health expenditure is increasing at a faster rate than GDP, raising concerns on the sustainability of the system.
- Limited resources in the public sector overstretched compared to the private sector.

Next Steps

National purchaser:

- As part of its health transformation plan, the MOH has set up a not-for-profit company that will serve the function of a strategic purchaser of any national health care plans or programs.

B40:

- This is a healthcare program for citizens earning the bottom 40% of the nation's income.
- The program promotes preventive healthcare and early treatment as well as addressing some of the common barriers to seek care among the poor, such as transportation.

Design PPM for B40:

- The main aim of the PPM design is to boost health screening uptake among this population while ensuring quality care from the provider.
- Plan to contract private and public clinics.
- Need to incentivize both private & public facilities, but the mechanism may be different between the two.

JOINT LEARNING NETWORK For Universal Health Coverage

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