Reformasi Pembiayaan Penjagaan Kesihatan

Health Financing Transformation

"Early wins amid fiscal realities"

KEMENTERIAN KESIHATAN MALAYSIA

Taklimat kepada Jawatankuasa Pilihan Khas Kesihatan Parlimen Kelima Belas

23 Ogos 2024

Kuala Lumpur

v2

Agenda Mesyuarat

Early wins amid fiscal realities

1. **Kata Alu-aluan Pengerusi Jawatankuasa Pilihan Khas Kesihatan Parlimen Kelima Belas**

2. **Taklimat**

3. **Perbincangan**

4. **Hal-hal lain**

Kata Alu-Aluan

1. Pengerusi Jawatankuasa Pilihan Khas Kesihatan Parlimen Kelima Belas

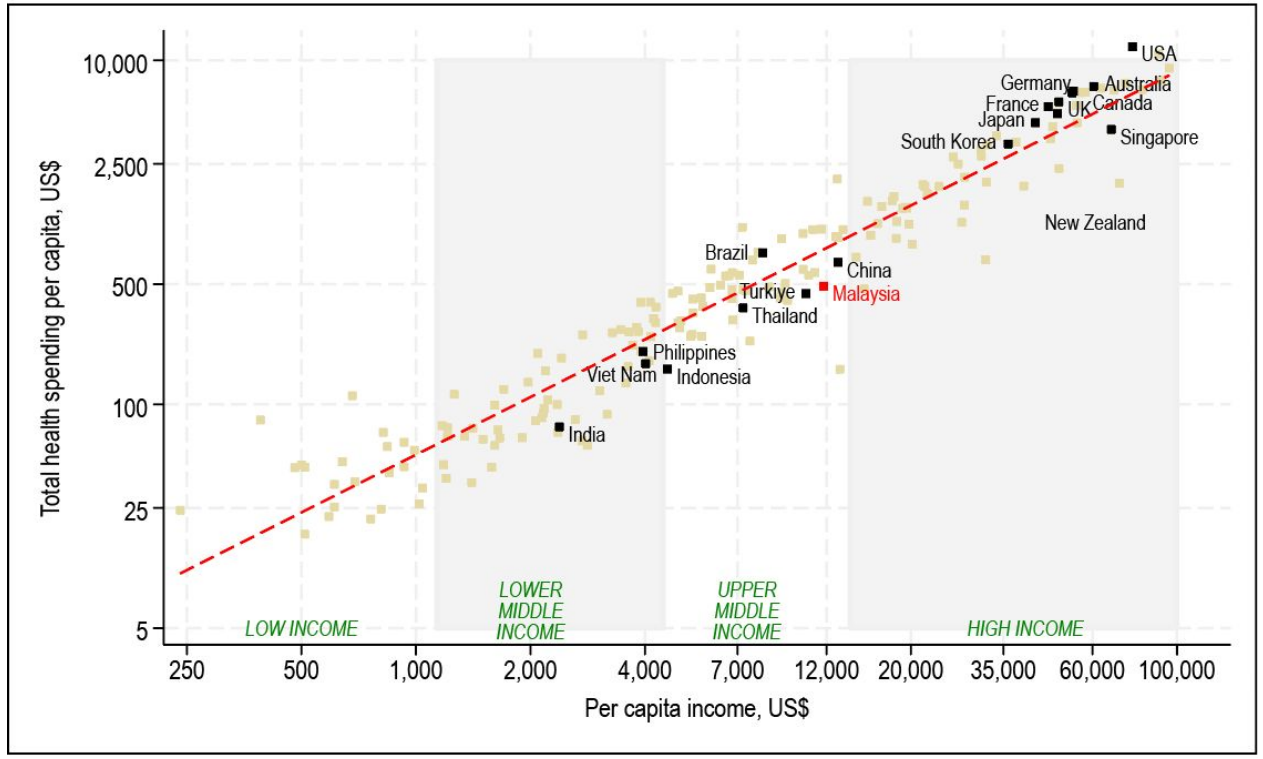
Pillar 3 of HWP

2. Health Financing Transformation

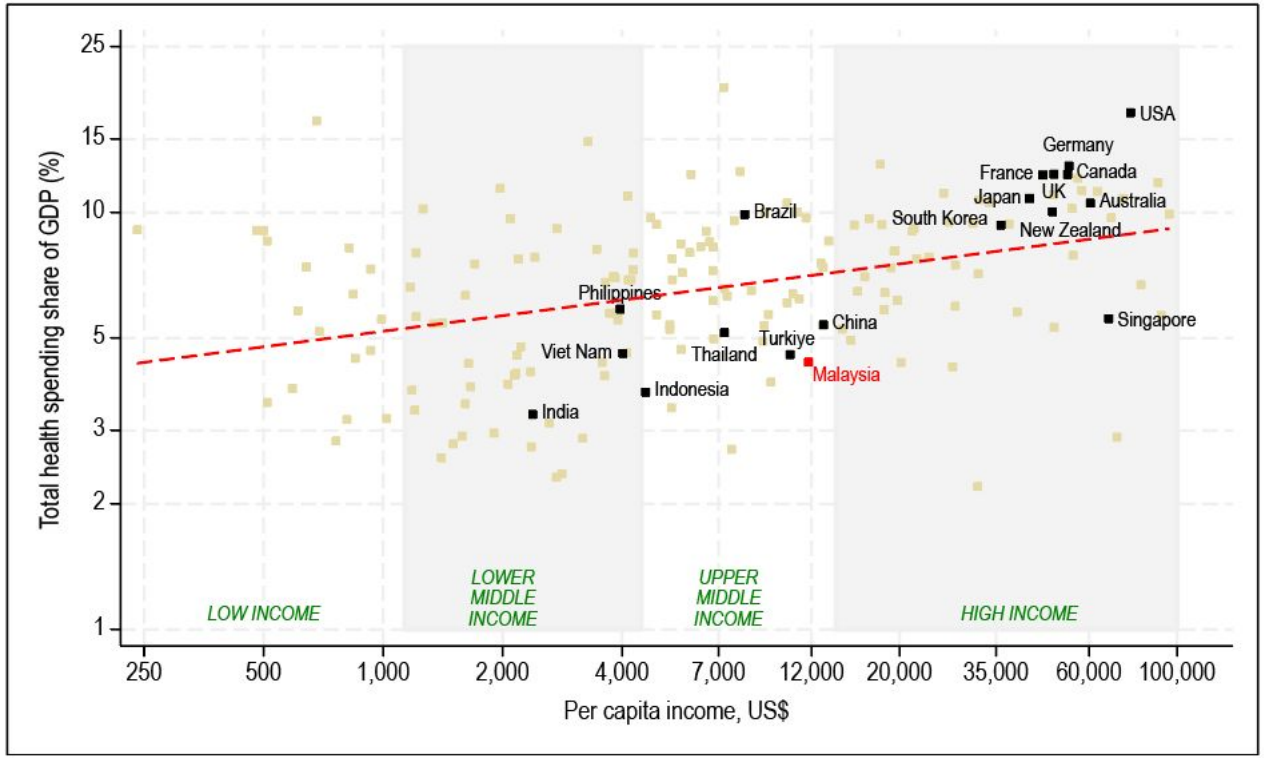
*Spend **better**, then spend **more***

The Global Perspective: *Total Health Spending Rises With Income—the First Law of Health Economics*

US$ per capita



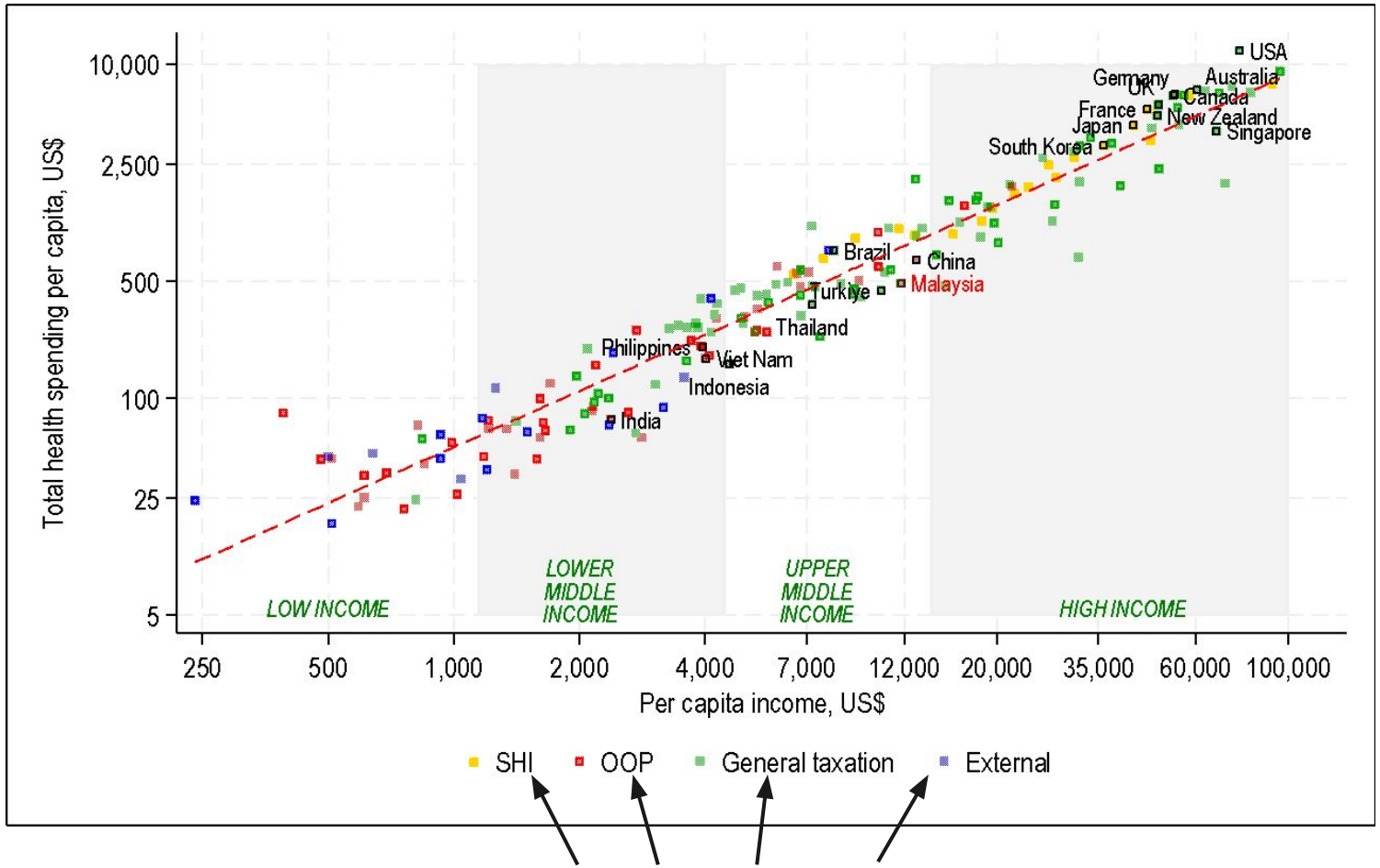
% of GDP



Malaysia is under investing in health

The Fist Law of Health Economics—Van der Gaag & Stimac (2008); Source: Ajay Tandon, World Bank Group

The Global Perspective: *The Sources of Health Spending Change With Income—the 'Health Financing Transition'*



Color coded based on largest source of health financing

The 'Health Financing Transition'—Fan & Savedoff (2014); Source: Ajay Tandon, World Bank Group

Malaysia's Health Financing Context:
Heading in the wrong direction

Sources

From 2021 to 2022

- Total Health Expenditure (THE), public and private:
  *** 4.4% of GDP (low and decreasing)**

- Public vs Private Spending
  - Public:
    *** 2.3% of GDP (decreasing); 52% of THE**
    *Note: Public sector delivers **75%** of hospital inpatient admissions*
  - Private:
    2.1% of GDP (static)

- Out of pocket (OOP) expenditure / user fees:
  *** 37% (high and increasing □ highest ever) of THE**

Composition

From 2021 to 2022

- Hospitals:
  RM 39b to RM 44b (increasing)
- Ambulatory / clinics:
  *** RM 20b to RM 17b (decreasing)**
- Preventive care expenditure:
  *** RM 10.6b to 5.2b (decreasing)**

Malaysia's current economic conditions are not conducive for expansionary health financing transformation

Macro Fiscal

(basis for +++ general government revenues)

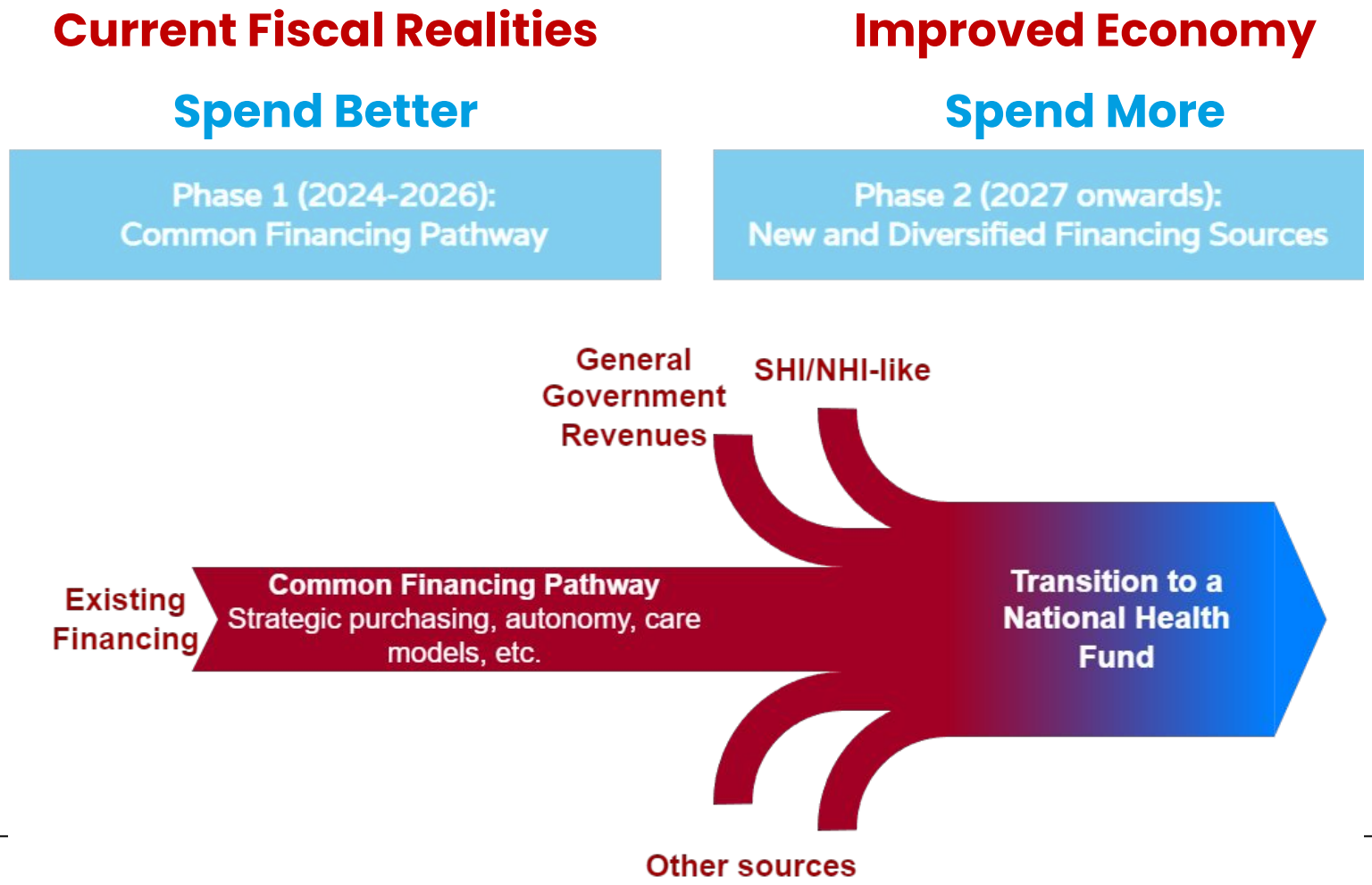
- Global, regional, and national economic growth was moderating:
  GDP growth < 4% but recently improved
- Low federal government revenues:
  16% of GDP (World Bank forecast for 2024)
- Debt service:
  16% of federal government revenues (World Bank forecast for 2024)

Labor

(basis for SHI/NHI)

- **Significant informality**: **23%**
- Rapid **ageing**
- **Salaries << Living Wage**
- **Households tight financially:** e.g., EPF withdrawals
- **Subsidy rationalization** has begun with diesel

A phased but tangible transformation cognizant of current fiscal realities, but establishes the pathway for future ambitious reforms



Phase 1: Developing a Common Financing Pathway (Now–2026)

"Spend Better"

- Current economic conditions are **not conducive** for **expansionary** health financing transformation

- BUT, **early wins:** (i) Improve the **efficiency** of spending, and (ii) develop a **Common Financing Pathway**

- **Common Financing Pathway =** the capacities / institutions needed for a *modernized health financing system*, regardless of whether it is an SHI/NHI, a modernized general gov revenue-based system, or a 'hybrid'

- Rather than wait for ideal economic conditions: Leverage **existing financing**, both public and private, **creatively** to develop this common financing pathway

The Common Financing Pathway—*3 key capacities:*

1. **National Health Fund**
   - Begin this multi-year process (legislation, etc.)
   - **≠ SHI/NHI**
2. **Strategic purchasing** (towards value-based healthcare)
3. **Public health facility operational autonomy** (gradual)
   - **Not** "financial self-reliance"

Meanwhile, on the health delivery side:

- Shift to **new models of person-centric integrated care**

Phase 2: New and diversified sources (From 2027 or sooner)

"Spend More": Prepaid and pooled financing

When/as the **economy improves** further, consider **one or more** of:

- **Expanding general government revenues,** as the anchor
  - Widest pooling, progressive, least labor market distortion
  - Expand health taxes (earmarked or not earmarked)
  - **Use health as the excuse to increase taxes or introduce new taxes (e.g. GST)**
- **Expanding and improving private health insurance (PHI)**
- **Consider an SHI/NHI-like mandatory earmarked contribution from formal payrolls**
- **Other sources:** Zakat/baitulmal, state government contributions, pension funds, etc.

Leverage the National Health Fund

- **New legislation is needed for the National Health Fund**
- **Fund holder** for a variety of public health financing sources, incl. from general government revenues and earmarked contributions (e.g., SHI/NHI).
- Purchase health services from **private and public sector**
- Complementary to and enables **public health facility operational autonomy,** benefits:
  - Better management of human resources and performance
  - Improved efficiency and health outcomes
- Transition public facilities to **demand-side financing** (pay for services or outcomes), away from input-based, line-item based financing (pay for salaries, supplies, utilities, etc.)

FAQ: Why shift from OOP / user fees to prepaid and pooled financing?

Out-of-pocket (OOP) expenditure / user fees

Not just inequitable

- A "tax" on the sick and vulnerable, foregone care (~13%)
- Financial hardship (SDG 3.8.2)

but also, inefficient

- **Curative care and hospital focused,** less on **prevention**

and inflationary

- Unable to leverage strategic purchasing—the power of **monopsony** or modernized **provider payment mechanisms** (PPMs) …
- … to address **information asymmetries** (genuine need, price, quality, etc.)

□ Even if it is the rich paying OOP, this is still sub optimal

Prepaid and Pooled Financing

Examples: General gov revenues, SHI/NHI, private health insurance, employer coverage schemes

Wider pooling and cross subsidization

- Over the life course; healthy to sick; rich to poor

Leverage strategic purchasing

- Prevention; value in healthcare; etc.

'Health financing transition'

- Legitimacy, expectations, and the increasing role of the government
- Health financing transition
- **Public tax-funded healthcare is not a 'free' subsidy … it has been prepaid and pooled**

FAQ: SHI/NHI vs General Government Revenues

Social or National Health Insurance (SHI/NHI)

(a.k.a. "Bismarckian" model)

- **What?** Mandatory wage-based **payroll** deduction **earmarked** for health. **Contribution linked to entitlement**. N.B. Modern SHIs **depend on general taxation** to subsidize the poor, informal.
- **Strengths:** An 'additional' revenue source, 'earmarked' **transparently** and accountably to health; **no longer subject** to annual government budgeting process; **explicitly defined benefits**, typically facilitates "*modernized health financing*", i.e., **purchaser-provider separation**; modern **provider payment mechanism**s, and **inclusion of private providers**
- **Weakness: Informality**, increasing labor costs/**distort labor market**, often **extensive subsidization** from general taxation
- **Examples:** Estonia, France, Germany, Japan

General Government Revenues

(a.k.a. "Beveridge" model, NHS)

- ***What?*** Mandatory, through general taxes (income, consumption, etc.). A share of these general taxes is given toward health for the entire population.
- **Strengths:** Broad revenue base, wide risk pool, coverage of informal sector. Typically, progressive (as per the general taxation system). N.B. Modern general government revenue-financed systems also can facilitate "*modernized health financing*"
- **Weakness:** Health may **not be prioritized**; health share may be unstable; dependent on revenue collection capacity of gov
- **Examples: Malaysia,** Australia, Bhutan, Canada, Cuba, Denmark, Finland, Iceland, Sweden, Norway, UK

Key points:

- **No** longer an either/or … **prepayment and pooling** is the most critical
- Many of the strengths of an SHI/NHI can be replicated with a system financed through General Government Revenues
- Ensure that **eligibility is not linked to contributions** (beware the informal sector)

Questions to ponder before considering SHI

- Economic growth, living wage salaries
- Delink coverage from contribution
- What is the added coverage for the added contribution?
- Pre-requisites: Common Financing Pathway
- General government revenues will continue to play a significant role

3. Perbincangan

4. Hal-hal lain

Terima kasih