Chapter: 7

Managed Care – Malaysian Perspective

Managed care can be defined as

"A health plan that attempt to control the cost and quality of the health care by co-ordinating the medical and the other related services"

Managed care organization acts as a middleman used by the employers to contain the health care cost of their employees. They basically consist of hospitals, doctors and clinics and other medical providers joined in a network to control the cost.

At the simplest level the MCOs only take over the administrative work now carried out by the company's human resource department each time an employee seek medical treatment. They determine the entitlement, make payments to the clinics, and issues the guarantee letters when referral treatment is needed. (Your money or Your life, Malaysian Business, May 1, 2000)

Managed care organizations differ from the indemnity insurers that did not manage the delivery of medical services – they simply paid for them. Whereas MCOs today, plays a role in determining what services will be covered and, most important, how much provider be compensated for these services.

Broadly managed care organization can be divided into two major types, based on the two models developed and practised in two different part of the world. These are:

- **European Model:** more socialized and egalitarian in nature, and regard the provision of health care service as a social service that should be available to all. It follows the European definition of managed care that says it is a process to maximize the health gain of a

community within the limited resources and fixed budget. As it uses the fixed budget so there is a greater emphasis to bring down the cost and the patients do not have too many choices, and have to content with whatever available to them.

- In Malaysia the ministry of health appear to follow the same ideology, and trying to make available an equitable health care to all the population. Ministry is providing an appropriate range and level of services, and monitoring it to meet the national target of health.
- **American Model:** more commercialized and based on the fee-market system. It is built around specific measures taken by the provider system, health care plan or the insurance plan to provide services to a given population within a specified budget. So the patients have all the choices till his medical cover last and no choice after his funds exhausted. Here in Malaysia the managed care organizations are modeled against these American models. For a detailed discussion of USA health care system please see appendix 1 : G.

So the difference between the two types of MCOs (non-profit and for-profit) is in purpose, values, attitudes, and behaviors of the organizations concerned. The philosophy of the non-profit MCO is one that makes a profit so that it can provide a service whilst that of a for-profit MCO is one that provide a service so that it can makes a profit. Both makes profit, but why they do so and what they do with a profit marks the difference.

The managed care is here with two aim, that is to control cost and maintain the quality. But how do it intend to do it? It intend to do it by using tools such as:

- Information technology
- Better management, by employing case managers and financial controllers
- By maximizing the quality of patient outcomes while ensuring that only the appropriate levels of service are used

- Uniform fee schedule
- Integrated medical benefits
- Better recovery of account receivable
- Referral system

But why do we in Malaysia needs a managed care organization? According to our vital health statistic we are doing reasonably good, that signify the quality and equity in the existing system. We are spending only 2.4 % of GDP on our health sector, so even the cost is not that much, so the argument of cost containment can also be excluded. So why?

To me the reasons can be;

- Fluctuating health care costs, that makes budgeting difficult for big organizations
- Inefficiencies in the private health care sector; for e.g.
  - Poor utilization of resources
  - High concentration of urban facilities
  - Poor hospital bed occupancies
  - Financial inefficiencies; for e.g. poor account receivables
- Increase affluence in the community
- Growing awareness about the health care and health care needs
- Growing market willing to pay for these needs

The managed care was introduced in Malaysia about 5 years ago in the year 1995. The government does not regulate the managed care organizations but they operate under the general guidelines issued by the ministry of health. The legislation to regulate the managed care organizations, though passed in the form of The new Private Health Care Facilities and Services Bill by the Parliament, and has already received the Royal consent, and is waiting to gazetted before it can be implemented.

Around 8 million (35 %) of Malaysian population is covered by the employer sponsored health care plan. Most of this health care cover is for out

patient care with only 10 % of the employer insuring their workers for inpatients care. Most of that coverage is through some form of managed care organizations.

In Malaysia there are forty-five (45) MCOs established so far, almost all of the members of these MCOs are employees of the big corporation interested in containing costs. Though there are 45 MCOs, but one (universal Etna life Assurance) far exceeds (ten times) the total paid up capital of the other five. Most are agents of the insurance companies, and offer different benefit schemes. At present, most of the managed care organizations in Malaysia plan to implement fee for services, none of them offer integrated medical benefits. All of these MCOs are investor owned and profit-motivated.

As more MCOs comes into the market they are forced to lower the premium to remain competitive. They often do so not by lowering their profit margin but by curtailing services offered, so that has effected the quality of care. That means that in long term managed care does not save money. Patient denied of services can get sicker and sicker, and thus cost more to treat. Therefore if they place more emphasis on the cost containment it may effect the quality, and then the MCO has actually gone against their professed aim. That means, that the health of their patient is not well protected and they have not effectively controlled the cost of treatment.

Disadvantages of the MCOs in Malaysia includes:

- Differing benefits
- Absence of uniform fee schedule
- Exclusion clause for the old age and patients with the chronic illness
- Provide limited choice of the care providers
- No specialist or hospital care included
- Patients confidentiality at risk
- The agreement between the companies and the MCOs is not transparent.
- Charges the administration fees

Advantages of MCOs:

- Guaranteed availability of health care services
- Encourages the patient to seek early treatment
- Serious conditions can be diagnosed early
- Save costs

But despite all these disadvantage and criticism, we can say for sure that these MCOs are here to stay. So we should rather concentrate on improving and regularizing their services.

The success for the MCOs will depend on number of factors that includes

- Good partnership between the MCOs and the providers
- Ability of the MCOs to develop innovative products
- Working relationship with the health insurers
- Expanding their scope into public health care facilities

For a more detailed of the concern of various parties about MCOs please see appendix 2

Now if we analyze this managed care organization as the model for health care financing in Malaysia, we can appreciate that it do have many potential draw back that restrict it from being an ideal solution.

As for equity, the MCOs are for-profit organizations, so they do not offer universal memberships. Their membership is conditional, risk-rated with exclusion clauses for high-risk individuals. So that mean that it do not even satisfy the first and the foremost condition of Ministry of Health, that is the system should be equitable.

Mostly the members of the MCOs are the employees of the big national and multi national companies that are mainly concentrated in the urban areas, and are very concerned about the fluctuation in the cost of health care as this will effect their planning and budgeting. So the MCOs do not have much of a

presence in the rural areas, and more so these organization do not cover the public health care so are of little significance to a common person.

On these grounds the managed care solution can not provide a universal and equitable coverage to the entire population. So if the system is not equitable it can be very appropriate for improving the general health status of the nation.

Though it restrict the supply by offering the standard packages of services, but it do not have the standard for those who require more than the standard services / treatments. Another way of restricting the cost is by fixing the capitation cost. Capitation cost is the fixed cost paid to the providers for each patient per year (or any other specified duration) irrespective of the number of patient's visits. In that way it provides the incentive to the provider to treat the patient effectively, and promptly, so that patient does not repeat the visit. But at the same time, in chronic cases it may restrict the treatment choice, and interfere with the clinical decisions.

On the other hand it can also increase the demand as the payments are not made directly by the patients, so the patients do not have any restriction (price do not matter to the patients) to visit the doctor and avail the health care services.

As far as the cost is concerned it its essence it is supposed to stabilize the costs, but in reality the contrary may happen. If the patients are not paying on their own it creates an increase in demand that will push the prizes up. At the same time, as the patients are not paying their and then, the health care providers can overutilize these services, as the patients do not mind expensive medication, excessive tests and longer stay at hospitals. That will contribute to the escalation of prizes.