GENERAL MEDICINE

BARTS & THE LONDON SCHOOL OF MEDICINE AND DENTISTRY

Medical Elective Report

Malaysia & Singapore

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Elective Report: Malaysia - Sarawak General Hospital

Introduction

Sarawak is situated on the island of Borneo in Southeast Asia. It is the largest state in Malaysia, with a population of about 2.5 million. Its administrative capital is Kuching, which has a population of about 600,000. This is made up mainly of Chinese and Malays.

As part of my elective, I spent some time in Sarawak General Hospital (SGH), located in Kuching. With 765 inpatient beds, it is the largest hospital in Sarawak, and is the main tertiary and referral centre in East Malaysia. It offers a number of specialist services, including haemodialysis, physiotherapy and radiotherapy/oncology.

Patterns of Illness and Treatment

Malaysia is a rapidly developing country, with features of both first and third world countries. This fact is reflected in the type of illnesses commonly seen, and the major causes of mortality in this country. Generally speaking, third world countries tend to have more problems with infections, largely due to sanitation and antibiotic issues. Western countries tend to have more chronic, degenerative diseases such as cancer, heart disease, diabetes and dementia as the most prevalent problems. In Sarawak, one of the most common reasons for admission was pneumonia. Accidents and pregnancy/delivery related complications also featured highly. In the UK many of the cause of hospitalisation are due to exacerbations/complications of existing chronic diseases. However, despite this, there is still a high prevalence of some chronic degenerative diseases, such as diabetes (approx 12%) in Malaysia. Although not yet a leading cause of mortality here, it is significant enough to have gained a lot of attention and trends show it is on the increase. Whilst in SGH, a significant number of the internal medicine consultations were diabetes check-ups. We were even given a presentation on insulin effectiveness by a drug company whilst working at SGH. The management of diabetes was very similar to the UK, with the emphasis on early detection and intervention by optimising risk factors before initiating medical treatment. However, due to the sheer size of Malaysia and the distance some people must travel to see a doctor, often many patients presented with the complications of diabetes. I found many patients only came to the doctor as a last resort, when things really were getting too bad for them to handle on their own. I felt that the lack of education for patients here was a major problem, as if they came earlier when the problems they were having were less, there would be a better chance of initiating some sort of treatment to help prevent things from progressing as they so often had by the time of presentation.

Provision of Healthcare

Healthcare in Malaysia is, like the UK, mainly under the responsibility of the government. However, there is also a co-existing private healthcare system. There are four types of government hospital – district hospitals, state general hospitals, national referral centres and specialist institutions. District

hospitals have 100-200 beds, and are run by 6-10 medical officers (MO), the equivalent of UK SHOs. State general hospitals typically contain 500-1500 beds, and provide a wide range of inpatient and outpatient care. Specialist institutions provide specialist inpatient care for specific disease. There are 7 of these centres – the National Tuberculosis Centre, the Hospital for Leprosy, and 5 mental health hospitals. The National Referral Centre in Kuala Lumpur is at the top of the government hospital hierarchy, and with 2800 beds, takes referrals from al over the country to provide specialised treatments such as neurosurgery and radiotherapy. It also provides inpatient and outpatient care for the surrounding population.

Government health services are financed mainly from income taxes, but voluntary health insurance, social security and user fees also play a role. All inpatient and outpatient services are paid for by the patient, but at highly subsidised prices. There are nominal fees for outpatient services that differ according to whether it is a specialist service or not. The charge for inpatient care is capped at RM 500 per admission for 3rd Class ward.

Reflections

The main difficulty that I was anticipating whilst on elective here was the language barrier. I felt that although I would be able to observe the way healthcare is carried out, I wouldn't be able to get as much out of it as I would have liked due to this communication problem. However, when I arrived I found that all the doctors spoke good English, and so they were able to let me know what was going on. Since the vast majority of patients didn't speak English, this was extremely useful, as otherwise I would not have known much about the reasons for many of the patients' admissions.

Another aspect of healthcare in Malaysia that I found difficult to digest was the scarcity of resources. Investigations that we use routinely in the UK (such as CT scans), were often not used here except in difficult cases. I found that doctors here relied much more upon clinical examinations than various investigations. It made me realise that we take a lot for granted in the UK, both as patients and doctors, in that there is a wide variety of helpful and useful tests at our disposal to aid our diagnosis. However, on the upside, the doctors here had very good clinical skills and it was amazing how much information they could get from a simple examination. On reflection, it seemed that these tests are available here, but they are not squandered and made to be 'routine', but only used when they are really needed. All in all, it seems to me a sensible way to practice medicine.

Elective Report: Singapore - Singapore General Hospital

Introduction

Singapore is a small (700 km^2) tropical Southeast Asian country located just south of Malaysia. It is a very multicultural, with a population of 5.1 million that is made up of mainly Chinese immigrants, and significant number of Malay and Indian minorities. In addition, there are numerous ex-pats from all over the world who now reside here. Singapore citizens make up 3.2 million of the population, with the remainder being either permanent residents or foreign workers. It is the second most densely populated city in the world.

As part of my elective, I was able to spend 2 weeks in the Infectious Disease department of Singapore General Hospital (SGH). This government hospital is the oldest and largest in Singapore, catering to the healthcare needs of over 1 million people per year. SGH contains over 30 speciality services, a number of which are national referral centres. The SGH campus also houses a number of sister institutions, such as at the National Heart Centre Singapore (NHCS), the Singapore National Eye Centre (SNEC) and the National Cancer Centre Singapore (NCCS).

Pattern of Illness and Treatment

I spent my 2 weeks at SGH in the Infectious Disease department. I was expecting to see very different infections to those I had previous encountered in the UK. However, I was very surprised when I found out that the majority of the patients I saw had HIV, TB, or a combination of both. The prevalence of HIV/AIDS in Singapore is 0.1% (approx 5000 people). Prevalence in the UK is about 0.18%. The incidence of TB in Singapore is the lowest in Southeast Asia at 0.04%, but this is higher than that in the UK (0.014%). In the UK, the vast majority of TB is found in East London, likely due to the high numbers of Bangladeshi and Pakistani immigrants. Singapore also has a large Indian immigrant population, which may account for a lot of its TB.

HIV is one of the illnesses for which treatment is not subsidised by the government. Treatment is similar to that of the UK, with the principal being the use of 3 drugs from at least 2 different classes to prevent emergence of resistance. However, most cannot afford the S$500 a month it costs for antiretroviral drugs. Due to this, an underground networks of 'providers' has emergence. These people buy the HIV medications at cost in Thailand, and sell them in Singapore at more reasonable prices. Despite it being common knowledge and not technically legal, a blind eye seems to be turned to this. From what I could gather, the providers are actually very good, supplying good quality medications and counselling to those with HIV/AIDS. It is a shame that the government don't subsidise these medications – it almost seems like there is still a fair amount of stigma attached to HIV. At least there are people there that realise the problem if HIV is a global one, and are trying to provide affordable treatment to help reduce the global burden.

Provision of Healthcare

The healthcare system in Singapore is largely financed by private expenditure, in that individuals are made to take responsibility for their own healthcare. However, there are government subsidies to help with the cost of healthcare, and these are achieved through taxation. Of the total health expenditure, approximately 33% is from the government and 67% from private sources (i.e. from individuals/employers). Together, these sources of funding make up the '3M' framework (Medisave, MediShield and Medifund), which is the foundation upon which the vast majority of Singapore's healthcare system is based.

Medisave is compulsory national medical savings scheme into which a proportion of an individual's monthly wage (between 6.5 - 9%; according to age) is paid. This account can be used to pay certain hospital bills of the individual or his/her immediate family members. Only a certain amount of money (the withdrawal limit) from the Medisave account can be put towards expenses. The amount varies according to the procedures and interventions used during the hospital stay.

MediShield is a national insurance scheme against catastrophic or unusually prolonged illnesses. This scheme works by reimbursing an individual with a proportion of their expenses incurred during a hospitalisation, with the rest paid by the patient in the form of deductibles and co-insurance payments. The deductible is a fixed payment that depends upon the patients' age and the class of ward they stayed in. The co-insurance is the percentage of the bill the patient pays on the amount above the deductible. This is three-tiered and ranges from 20% to 10% (the larger the bill, the smaller the co-insurance). Generally, MediShield contribute about 80-90% of the total bill, with the patient paying 10-20%. This rate differs for higher classes of ward/private hospitals. As with any insurance, the patient is also required to pay premiums, which can be financed using funds from Medisave accounts.

DEDUCTIBLE & CO-INSURANCE*			
	Ward Class		Day Surgery
	Class C	Class B2 & Above	
Deductible Per Policy Year (aged 80 and below next birthday)	$1,000	$1,500	
Deductible Per Policy Year (aged 81 to 85 next birthday)	$2,000	$3,000	
Co-Insurance	Claimable Amount $1,001 - $3,000 : 20% $3,001 - $5,000 : 15% Above $5,000: 10%	Claimable Amount $1,501 - $3,000 : 20% $3,001 - $5,000 : 15% Above $5,000: 10%	

Summary of deductibles and co-insurance. For a hospital bill of S$8000 of a 70 year old staying in Class C ward, the patient would pay S$1000 (deductible) + 20% of the amount from S$1001 to S$3000 + 15% of the amount from S$3001 to S$5000 + 10% of the amount from

S$5001 to S$8000 = 1000 + 400 + 300 + 300 =S$2000. MediShield would pay the rest (S$6000).*For outpatient treatment, there is NO DEDUCTIBLE, and co-insurances stands at 20%.

Medifund is an endowment fund set up by the government in 1993. It acts as a safety net for those who cannot afford to pay their subsidised medical expenses, despite Medisave and MediShield coverage. The government uses interest from a capital fund (in 2009 this stood at S$ 1.7 billion) to help patients who have exhausted all other means to pay for medical treatment. It is means-tested, and based on an individual's financial circumstances at the time of application.

This is a general overview of the system, but in reality there are different criteria that must be met for before one can use Medisave accounts or make a MediShield claim etc. Also, the scheme you can use depends on the illness, length of hospitalisation and treatment received (amongst other things).

Reflections

Healthcare in Singapore is widely regarded as an excellent and efficient system, and has been commended by many other countries. What makes Singapore stand out is the fact that the general health of the population is quite good, and yet the government spends relatively little on healthcare. So on paper, the health system here works well. However, the fact that people must pay for their own health costs invariably leads to those who cannot afford the treatments. Despite having schemes such as Medifund, there are a number of people who fall through the gaps. As previously stated, there are many criteria that must be fulfilled for the various schemes to be utilised. For example, Medifund is means-tested. However, when applying for Medifund, the income of not only the patient, but also their immediate family is taken into account. So, although you may not be able to pay for treatment, it is expected that your family will, making a patients illness both an emotional and financial burden for the family. If the patient is estranged from his/her family, then they may not feel able to ask their family to pay, and what do they do then? I had heard about patients here who had not met the criteria for these schemes, and had to sell their houses to pay for treatment. Also some illness such as HIV are not covered by many health insurance providers, meaning all bills related to them must come straight out of pocket, or through Medisave (which will quickly diminish on prolonged treatment). In a country this advanced, people like this shouldn't be falling through the gaps and have to sell their livelihoods in order to fund life-saving treatments. This was probably the most difficult concept I had to grapple with whilst in Singapore. It made for a stark contrast with what I was used to back in the UK.

The UK's NHS has been long known for its debt problems and long waiting lists. The average life expectancy in the UK is lower than in Singapore, and the UK spends much, much more on healthcare. However, you do not get the case of the patient that died because he/she couldn't afford the treatment. The idea of the NHS is a good one, but its management problems and abuse of its services by those not entitled to its 'free' care has caused many problems over the years. Also the UK is much bigger and has a population over ten times the size of Singapore, which makes the delivery of healthcare more difficult.

Both of these countries have good, advanced healthcare systems, each with their own pros and cons. Experiencing healthcare in a different environment, finding out how the system works and spending time in a government hospital here has been a fantastic learning opportunity.