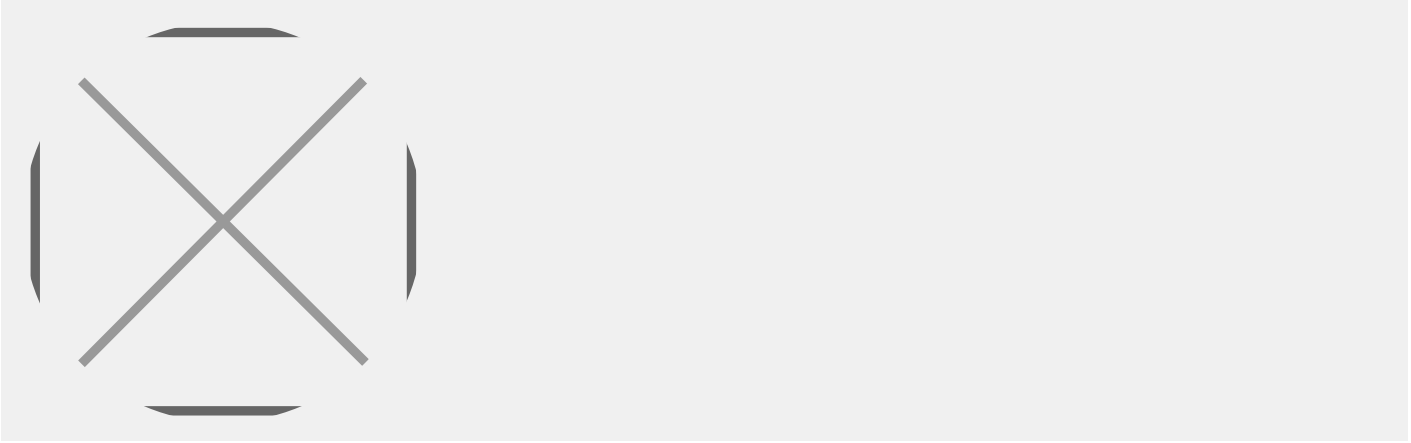
Interview with David Quek, President, Malaysian Medical Association (MMA)



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One of the key factors for the growth in the pharmaceutical market has been the increasing professionalism of healthcare in Malaysia. How does the MMA contribute to the professionalism of it s members?

It has always been the remit of the MMA to establish strong professional practice in Malaysia. Doctors in Malaysia are very stringently regulated; in fact I would say that this has always been the case. Since 2006 and the enactment of the Private Healthcare Facilities & Services Act and Regulations, the profession has increasingly been under the microscope. In my view, doctors in Malaysia are generally capable of providing a level of care on a par with middle to higher-income economies.

Where Malaysia could improve on healthcare is in the quality of drugs coming from the local generics market. Indeed, the MMA has been in discussion with Malaysian Organisation of Pharmaceutical Industries (MOPI) about the quality of generics in the country. Last year the MMA and MOPI produced a joint statement where we agreed on carrying out more thorough studies – not just complying with Good Manufacturing Practices (GMP) – to ensure that the quality of the final generics product is comparable with the quality of branded drugs. This will allow for greater confidence among Malaysian doctors and the public in using generics.

The Malaysian population itself seems to have growing confidence in locally manufactured products. What is your interpretation of how this has come about?

It is true that consumers are increasingly trusting local brands. In my opinion, this is a result partly of the fact that factories now all subscribe to GMP requirements. However, there is still much more that can be done, much further to go, and the MMA is urging the government to push for more regular bioequivalence studies and batch testing to ensure consistent and assured safety and efficacy.

Apart from regulatory paperwork and documentation, there is currently only one other requirement to get a drug registered in the country, i.e. there must be a first-time bioequivalence study and that is all. What happens afterwards depends on the GMP. The MMA would therefore like to see greater efforts at monitoring and safeguarding the production of good quality medicines within the industry.

Manufacturers naturally say that the market is over-regulated and with a number of products due to come off-patent in the next couple of years there is a potential boom in the generics market. Do you see potential log-jams in regulation and distributing licences?

Personally, I do not think there will be a problem with regulatory log-jams or licensing. It is unlikely that this would occur. The expansion of generics is very welcome, as it would lead to cheaper drugs. The MMA has always called for cheaper, good-quality generics so that doctors have greater choice of using branded drugs and cheaper generics interchangeably. It should also be mentioned that branded generics manufacturers are already present in the Malaysian market.

Ultimately, what is required from Malaysian manufacturers is to match the quality and not just the cost of branded generics i.e. produce a product, which is as bioequivalent and more cost-effective. This could lend a lot of credibility to the domestic market and potentially, the export market as well.

The National Medicine Plan aims to make pharmaceuticals more affordable and accessible to Malaysians. What is the current level of medical coverage in Malaysia?

Most Malaysians have some form of access to healthcare. It is not the normative ‘universal access to health for all’ as yet, but close. There is just a question of the quality and the waiting times for access to treatment. In reality, there is quite a lot of variation in the consistency and equitable quality of care for many Malaysians. But, healthcare in Malaysia is very affordable. If someone is seriously ill and cannot afford healthcare, they can always have access to government clinics or hospitals. In most cases, healthcare is offered at just 1 Ringgit Malaysia (MYR) for a clinic visit, and 5 MYR for a specialist visit. Thus, the public system is of course very heavily subsidised.
The majority, 62% of first time and chronic users of healthcare rely on the private sector, whereas the other 38% rely on government clinics and hospitals. Conversely, for hospitalizations the opposite is true with around 25% using private healthcare and 75% relying on the public sector. This is mainly because of cost issues.

Apart from its near universal affordability, Malaysian healthcare is noted for its good geographical coverage. Although it known that in the hinterlands and in places like Sabah and Sarawak there is still severe lack of doctors and healthcare personnel. However, in urban areas, access to medical professionals is generally good.

Addressing some of the health concerns of Malaysia, we know that diseases such as diabetes, TB and Dengue fever are all significant problems for the Malaysian population. What in your opinion are the priorities in Malaysian healthcare and which are those sectors the pharmaceutical industry needs to provide for?

There is a resurgence of infectious diseases in Malaysia and Dengue fever features as one of the most problematic diseases. This is naturally a cause of anxiety for the population representing an endemic situation where the country is unable to rid itself of the Aedes mosquito. The government is feverishly trying to implement measures to mitigate this perennial epidemic. Its latest efforts to try and repopulate some variants of genetically-modified Dengue-resistant mosquitoes to supersede the rest of the mosquito population, has met with public resistance and outcry. In this instance, greater public health measures, and more punitive preventative measures may be the best way to address the problem.

Tuberculosis is predominantly a problem with migrant workers from countries such as Indonesia, Myanmar, and Bangladesh. Unfortunately, more drug resistant strains of TB have been found to be infecting migrant workers in Malaysia. Thus, this is an imported disease problem rather than something, which is indigenous to Malaysia's epidemiology.

Clearly, the big challenge now facing Malaysia is from non-communicable diseases. With increasing development, Malaysia has perhaps imported some bad habits and lifestyle changes from the West. For example, there is a huge growing obesity problem, whilst heart disease is another significant concern. Rates of smoking continue to cause health problems and around 40% of men in Malaysia still smoke.

More worryingly still, the last (2006) national morbidity survey found that around 42% of the population has hypertension and 14.9% of the population has diabetes, which are some of the highest figures in the world. These problems are of course all related to dietary habits and the population's changing lifestyle. Among Malaysians, there is perceived to be a larger portion of the Malay population, which appears to be at heightened risks and suffering the new brunt of these chronic non-communicable diseases (NCDs).

To what extent has the pharmaceutical industry been able to cater for these needs?

There is in general, no shortage of drugs to meet the needs of the Malaysian population. A more difficult problem is one of convincing and getting patients with these usually symptom-free chronic

ailments to adhere to and stay on these medicines for long-term. The main concern then, is the affordability of these medicines.

Good, high-quality branded innovator drugs are naturally very expensive. Taking a concoction for several ailments would of course increase cost and decrease compliance. Although more and more medical care nowadays involves the use of greater number of drugs, polypharmacy remains unpopular, are feared to have more side effects, but also cost more to the patient and to the health authorities.

However, this is where use of good and affordable generics can offer greater population uptake of medicines to address chronic ailments. Regarding diabetes for example, cheap medications such as Sulfonylureas are readily used and available because most of these are off-patent and affordable. Metformin is another regularly used drug, and remains a low price drug. These two diabetic medicines form the basis of addressing the principal health concerns in diabetes, and are affordable. However, even using these 2 drugs may sometimes not be enough if compliance cannot be ensured. Hence control of diabetes, and also hypertension, remains a great challenge for Malaysians.

On the other hand, newer drugs such as Januvia and Galvus are rather expensive and therefore targeted at fewer patients.

Unfortunately, the usage of insulin is still relatively low in Malaysia partly because of the costs and cumbersome mode of administration, and negative perceptions from patients. The problem is compounded by the fact that there is a stigma attached to the use of injectable forms of drugs. In this area, I believe Malaysia can do more to find local generic variants of insulin and make it more affordable for the public. Alternative modes of administration with a better more cost-effective mechanism of reimbursement will enhance its uptake. In my view, this remains a challenge to be overcome.

Has the government done enough to promote easy access for foreign drug companies to enter the Malaysian market?

There is in general a free-market economy in Malaysia for pharmaceuticals so in that respect there is both good access and a good level of competition. Indeed, different consumer groups demand that Malaysia should now regulate the costs of new products, but the government has so far resisted price-fixing.

One problem is that there is a slightly lengthy period for registering a drug in the country. It takes roughly one to one and a half years to register a new drug in Malaysia. The medical authorities insist on proper studies being carried out on these medicines first at the country of origin and at least in one or two of the reliable high-regulatory standards major world markets, such as the UK,

Sweden, Canada, Australia and USA. Another facilitating requirement is when the EMEA or US FDA had already registered the drug.

Malaysia is behind in attracting some of the innovator companies to relocate and/or to manufacture their important drug portfolios in the country, but nevertheless most are present here, and there is a wide array of medicines available, mostly via import. There are no restraints on cost of medicines, and pharmaceutical companies are freer to decide on drug pricing than in other countries such as Canada and Australia where the governments set maximum prices for drugs to enter its national formularies.

There is a national formulary for Malaysia, the so-called ‘blue book’ of drugs available for routine use among the public sector clinics and doctors. It is naturally harder to get into this book. The drug product needs to be well-established, be cost-effective and drug companies have to persuade officials that these pharmaceuticals are worthy of entry into the drug list, though more thorough documentation and supporting research studies on their effectiveness and cost-effectiveness as well.

One of the hot topics in the industry at the moment is the relaxation of the 1956 laws on advertising. What is the position of the MMA on this form of liberalization?

Malaysians as elsewhere are now living in an era where the internet has made information much more freely accessible. Malaysians are extremely keen users of the internet, but the question is whether this tool is enough to provide people with the most relevant, accurate, reliable and safe information. The relaxation of advertising or public information regarding facilities and healthcare providers is a good thing for Malaysia. However this has to be within reason.

The MMA is still opposed to superlative advertising with phrases such as: ‘Doctor X is the best’, ‘specialist Z has performed so many 1000s of procedures’ and so on. We are also opposed to pharmaceutical direct-to-customer advertising, which is growing in many countries. However, information pertaining to the availability of services and hospitals with a truthful account of what a clinic or facility can offer should be allowed. These statements must of course be accurate, not exaggerated and should be checked or contestable for fraudulent claims.

It would be arcane to say that there should be no advertising at all. Singapore for example has opened the flood-gates to advertising in the newspapers, magazines, and the internet. The MMA is therefore in favour of more freedom of information to promote patient awareness and more informed decision making capacities. However, our regulatory authority, the Malaysian Medical Council is still relatively conservative and cautious to move forward with greater liberalization of advertising for physicians.

Whether or not this liberalization will encourage medical tourism is another matter. The government would like to see medical tourism as an important sector contributing to the Malaysian economy. However, in reality this is likely to be only a minor income generator for the country.

Do you think that Medical Tourism could lead to a brain drain from the public to the private sectors?

I think it is wrong to assume that just because of medical tourism there will be a greater exodus of healthcare workers towards the private sector. In fact, recently the Ministry of Health has improved all the perks and incentives for doctors to remain in public service to discourage such a dynamic.

Unless a doctor is exceptionally talented and enterprising, it is hard to simply venture into the private sector. In my view, there will be no major movement into the private sector purely because of medical tourism.

However, whether doctors will continue to move to private practice for other motivations is another question. There is always an overall trend to migrate toward the private sector. No matter what perks and incentives the public sector can offer, there will always be an entrepreneurial tendency for people to want to work for themselves, and away from bureaucratic or situational discords, frequently the named sources of irritation for those migrating to the private sector.

It is unfortunate that there is more expertise available in the private sector than we have remaining in the public sector. It is estimated that senior and more experienced staff in the private sector number more than 60% compared to those within the public sector. This obviously presents a dilemma, where a small number of specialists (30%) look after a much larger population (75%) of ill patients in the public hospitals. That said, there is no evidence that this discrepancy affects the overall quality of the service provided.

Do you have a last message about medical care in Malaysia?

There are plans to revamp the health structure in the country, which would take around 10 years. This 1Care health reform would drastically alter the landscape of healthcare for Malaysians and the health or medical industry. The most touted plan is to integrate the public and private sector beginning with the primary care system.

There are plans afoot that a National Health Service single-payer system will become the form of health care delivery in the future. Thus, Malaysians would possibly be experiencing some drastic changes soon, but it is too premature to project how or what would eventually be the working model.

Regarding medical tourism, I would say that the public need not fear that it will disadvantage healthcare provision for Malaysian citizens. In my view, there is unlikely to be much of a major

effect, compared with the planned health restructuring ahead. The projected 1Care health reform may actually cause more disruption and uncertainty in the near term.

However, in order to provide a system of more equitable access to healthcare for all Malaysians, we must ensure a fairer and better reimbursement mechanism (whether with or without a merger of the public and private systems), so that healthcare is offered based on need and not on affordability or financial capability of the individual.

Thus, the health authorities must address many more such intricate and challenging issues. More must be done to help attract and retain higher quality and better-trained doctors within the public sector, which is facing such a maldistribution of medical professional services, and a distortion of such a service disparity

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