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As a young surgeon at the General Hospital Kuala Lumpur in the 1970s, I remember pleading with Tan Sri Majid Ismail, then Director-General of the Ministry of Health, for funding of my research project. A distinguished clinician turned policy maker, Tan Sri Majid was professionally interested in my proposal. Nonetheless he politely declined it, but not before offering me a comforting explanation. Between funding me and building a *Klinik Desa* (rural clinic) in Ulu Kelantan, the choice was clear, he gently told me. Besides, he assured me, I would have minimal difficulty securing funding elsewhere while those poor Kelantanese had no choice. Tan Sri Majid said something else that reverberates in me today. "Healthcare is a bottomless pit," he advised me, "but the resources to meet those literally endless worthy needs are limited, so society must set its priorities and draw the line somewhere." The job of government is to ensure a minimal acceptable level of care for all, he added, and beyond that it is for individuals to set their own limits with their own resources. Malaysia does this with its dual public and private healthcare systems. Tan Sri Majid was adamant in maintaining this clear separation lest there would be confusion in the respective missions and objectives.

America today is in the midst of a wrenching debate on healthcare reform, specifically its massive price tag and the provision for a "public option," a government-run insurance company (1). Similar debates occur elsewhere, Malaysia included. These deliberations would be elevated greatly if we were to heed Tan Sri Majid's observation on resources being necessarily limited and the necessity to set priorities. It is understandable for America, the richest country, to have difficulty acknowledging the first, and as for the second, the setting of priorities is too often confused with rationing, a highly emotive issue.

This need for setting priorities is never more urgent today. In the past, the best that physicians could do was to bring our patients back to their pre-morbid state. Today the goals go far beyond, from enhancing lives (cosmetic surgery) to eliminating genetic diseases through genetic engineering.



Consider the wonders of modern drugs. In the past they were for curative purposes in a limited setting, as with antibiotics for infections. Today the biggest expenses are for drugs in maintaining chronic conditions (anti-inflammatory medications), enhancing life (Viagra and oral contraceptives), and reducing risk of diseases (the statins) (1). Similarly with public health; in the past interventions were limited to specific communicable diseases as with childhood immunizations. Today we have the various screening tests for cancers.

Regular exercise, good diet, and smoking cessation too are also health enhancing and good preventive measures. Issues would arise however, if we insist that health insurers pay for our lean cuisine and health club membership. Where to draw the line, in public health as well as clinical setting, is the great challenge. Also often forgotten is that there is minimal correlation between outcomes and expenditures in healthcare. America spends twice as much as Britain (relative to the economy), yet it would be hard to argue that Americans are as healthy as the Brits, let alone twice that (2).

While the bulk of the healthcare dollar is expended on hospitals, pharmaceuticals, and physicians, nonetheless the costs are primarily physician-driven (3). Many are thus misled into believing that focusing on physicians specifically is the key to improving citizens' health and or controlling costs. In truth, much of our present good health is due more to civil engineering marvels like central sewer and water treatment plants, as well as modern refrigeration. Malaria,

still a scourge in the Third World, was eliminated in California's Sacramento Delta through the building of levees and consequent drainage of the swamps, not advances in parasitological research.

This observation is worth emphasizing. With rapid urbanization, the inadequacy of these basic infrastructures has turned Third World cities into public health time bombs (4). Stroll through an exclusive neighbourhood of Kuala Lumpur and you will see garbage strewn all over, stagnant drains spewing unbearable stench, and septic tanks leaking their waste. Aesthetics aside, those are real health hazards. These infrastructures are prerequisites for our good health, yet perversely they are not considered as healthcare expenses. Malaysia spent hundreds of millions on the aborted new bridge to replace the existing causeway in Johor Bahru, yet it does not have a water treatment plant. The returns on investment for a new water treatment facility would be much more in terms of health and thus productivity of citizens.

In between necessary infrastructure spending and providing basic medical care, there is a legitimate need for publicly-funded medical research even, if not especially, for a developing country like Malaysia. I did research in transplant immunology before returning home but felt minimal inclination to continue it in Malaysia even though the country then had an active kidney transplant program under the capable leadership of Drs. Hussein Awang and Bakar Sulaiman. For one, I did not think that we could compete intellectually and resource-wise with programs in the West. For another, I was more attracted to the neglected but more relevant area of immunology of parasitic infections. You can be assured that there is minimal interest in the West to undertake such research, hence the need for countries like Malaysia to undertake them. Besides, they are best done locally as we have the most at stake.

Incidentally, Dr. Hussein's brother Yahya, once my medical officer in Johor Bahru, would later perform the first heart transplant in the region. I am grateful to the wisdom Tan Sri Majid imparted on me. All of us involved in healthcare, from the policymakers to administrators and practitioners to researchers ought to participate in the exercise of acknowledging our limitations and setting our priorities.

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