Chapter: 4

Health Care Financing in Malaysia

No one fail to notice the steady stream of appeal for help in the media from pathetic patients who can not afford to pay some urgently needed medical treatment or other. A gush of generosity inevitably greets each plea. But even before the well wisher can pat themselves on the back for their public spirit, another sad story is splashed. It is the same soliciting of funds for yet another liver transplant or heart surgery or cancer cure. (New prescription needed, Malaysian Business, May 1, 2000)

But according to Malaysian governments commitment each and every citizen is guaranteed of provision of basic health care facilities irrespective of his ability to pay. That means that the government is committed to provide equal health care services to all its citizens irrespective of his social, religious, ethnic or financial standings. In accordance with the federal constitution the health matters are jointly shared between the federal and the state governments. Then why such appeals in the media for help? Where does the fault lie?

As we discussed earlier, the health care services are getting more and more expensive. The reasons are varied ranging from epidemiological to demographic, and to the technical advances. No government in the world can keep up with the pace of rapid development in the field of health care because of the limited resources.

At the same time, no one can argue that the research and development in the field of medicine (though very expensive) is for improving the quality of human life. So no government can dare deny these facilities to its citizens. So that has put many governments in a dilemma.

The question is what should they do? Answer can be many, ranging from bearing all the burden of health care provision, or leaving these services alone

and letting customers to buy these services according to financial resources available to these people. In other words letting the private sector (and the market forces) to take care of health care provision, in that case the services will be available to only those who can afford it.

But that will effect the concept (commitment) of equitable provision of health care facilities, as promised by the government of Malaysia. Another option is to continue to subsidize the health care services. But this subsidy is a never ending story and no government can afford that burden of subsidization for long.

So how does Malaysian government plan to overcome these problems? The strategy on the part of the Malaysian government was put forward in the 7th. Malaysia Plan. According to it own words it can be summarized as:

To increase the efficiency of services and to retain qualified and experienced manpower (in the public sector), the corporatization and privatization of hospitals as well as medical services will be undertaken during the plan period. The government will gradually reduce its role in the provision of the health services and increase its regulatory and enforcement functions. A health-financing scheme to meet health care cost will also be implemented. However, for low-income group, access to the health services will be assured through assistance from the government.

(Seventh Malaysia plan, EPU)

That approach, on part of the Malaysian government, in the 7th Malaysia plan appears to be a clear diversion from its earlier role as the major health care service provider in the country. It shows that the Malaysian government wants to change its role from the provider of services to the regulator or supervisor of the health care services. Letting private sector to provide the health care services. Thus in the future, the role of government will be more of setting national health priorities and determining the means by which national health objective can be achieved. The government will act as a regulator, where the regulations are aimed at influencing the private sector to respond to the need and the interests of the national health goals.

That primary role of Malaysian government as service provider is eminent not only from the earlier policy stand but also from an ever-increasing allocation of funds for the health care sector in the past.

Table 4.1 : Health care allocation for the health care sector through Ministry of Health

years	Total health expenditure
1965	142,660,938
1970	183,033,101
1975	422,025,139
1980	795,524,435
1985	1,174,786,100
1995	2,793,731,000
1997	3,786,834,900

(Source: ministry of health, Annual report, year 1965,1970, 1975, 1980, 1985, 1995, 1nd 1997)

That complete dedication on the government's part has won international recognition from World Health Organization and other health agencies for its remarkable achievement since Merdeka. Government health services in particular, financed by the taxes and other public revenues, have achieved impressive coverage for primary health care. People in the rural areas have access to an extensive network of the government health centers and kilinik desa with referral backup, while the urban resident have access to the government as well as private hospitals and clinics.

Overall more than 90 % of the population of the Malaysia lives within five (5) kilometers or one (1) hour travelling distance of a primary health care facility. This has been a major factor contributing to the Malaysian favorable health indices that are almost on par with those of richer industrialize countries. (April 22 & 23, 2000, citizen health initiative, Towards a citizens' proposal for health care

reforms, a work in progress seminar on the *Health and health care in changing environment: the Malaysian experience*)

So that look like an impressive achievement at a very low allocation of funds. It become even more significant when we compare the basic health care indicators of Malaysia with those of developed countries and other countries in the region.

Table 4.2 : Basic Health indicators of developed countries and ASEAN countries along with other countries in the Asia-Pacific region

Country	Life Expectancy	IMR	CDR	MMR
Australia	77	5.7	6.9	9
Bangladesh	58.3	77	7.9	390
Bhutan	48.0*	NA	9	NA
Brunei Darussalam	75.0*	7.9	2.9	0
Cambodia	53	115	16.6	473
Canada	77.4*	7	7.7	2
China	71	36	6.6	62
Peoples rep. of Korea	72.7	14.1	5.5	NA
France	78.6	5.9	9	12
Germany	76.8	5.3	10.8	5
India	62.9	74	9	420*
Indonesia	63.5	55	7.5	390
Italy	77.9*	7.1*	NA	4*
Japan	79	4.2	7.1	6
Laos	51	113	15.2	656
Malaysia	**72**	**10.4**	**4.6**	**20**
Myanmar	NA	49	8.6	100*
Nepal	53*	78.5	NA	539
New Zeland	76	6.7	7.8	12
Pakistan	63	86	8.7	300
Philippines	64.6*	48.9	6.3	180
Republic of Korea	71.6*	8.6	5.4	13
Russian Federation	65.9	20	14.2	49
Singapore	76	4	4.8	0
Spain	78.1	6.1	8.6	4
Sri Lanka	72.5*	17.7	5.8	40
Thailand	68.0*	15.4	5.5	11
USA	75.9*	8	8.9	8*
United Kingdom	76.9	6.2	11	7
Viet Nam	65	45.1	6.7	120

(Source: WHO report on different countries health care indicators, available on net at http://www.who.org.statistic)

* is that the record is for the previous years (1995-1996)

NA means record not available

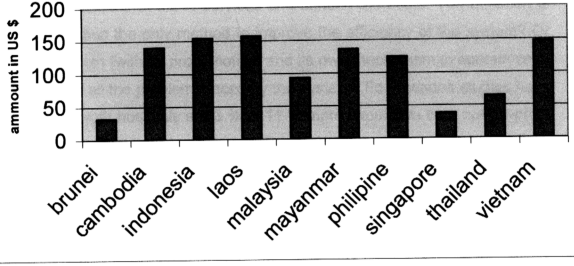
That result too is achieved with an equitable health care system with a relative low allocation (2.4 % of GDP in the year 1997) as compare to other countries.

Table 4.3 : % age of GDP spend in different countries on health care in the year 1997 (source: WHO report 2000)

Name	% age of GDP
Bangla Desh	4.9
Bhutan	7
Brunei Darussalam	5.4
Canada	8.6
Cambodia	7.2
China	2.7
Democratic Korea	3
France	9.8
Germany	10.5
India	5.2
Indonesia	1.7
Italy	9.3
Japan	7.1
Laos	3.6
Malaysia	**2.4**
Mayanmar	2.6
New Zealand	8.2
Philippine	3.4
Republic of Korea	6.7
Russia	5.4
Singapore	3.1
Sri Lanka	3
Thailand	5.7
UK	5.8
USA	13.7
Vietnam	4.8

(Source: WHO world health care indicator data available on net at)

Table 4.4 : per capitia ammount spend on the health care in ASEAN countries in the year 1997



If the statistic on the health indicator shows a favorable trend and that too at a relatively low proportion of GDP allocation (as evident from the table above), then why is this policy change? The underlying assumption can be that the populace is getting more affluent and that as disposable income goes beyond the requirement of the other consumption essentials, a market for health care services is emerging and citizens can be expected to increasingly shoulder their own health care expenditures. (Sep. 1996, Chen Chee Khoon, Privatization and the health care sector: Re-negotiating the social contract, paper presented at The Second Penang Seminar)

It is also possible that due to high growth during the last decade, with almost full employment level, and along with a favorable tax base to support the social programs, the government think that it is the high time that the public should take the responsibility of taking care of their own health. They may appear

justified as well, especially in the presence of an established primary health care network and with the commitment on the governments' part that it will assist the needy peoples in the health care provision. Especially when the governments' health care budget have doubled over a ten-year period from 1985 –1995.

The main argument that the government has put up in the seventh Malaysia plan for the privatization of the health care services is that it wants to increase the efficiency of these services and contain the costs. The question is that, is privatization the only method to improve the efficiency of the system? Or market mechanism (with its profit motive, and its own mechanism to contain cost) can take care of all the problems faced by the system? For decades studies have shown that for-profit hospitals are 3 % to 11 % more expensive than not-for-profit hospitals; no peer-reviewed study has found that for-profit hospitals are less expensive. For profit hospitals spend less on personnel, avoid providing charity care, and shorten stays. But because they spend far more on the administration and the ancillary services than not-for-profit hospitals, their total costs are higher. (Steffie Woolhander, MD, When money is the mission – The high cost of investor owned care, New England Journal of Medicine, August 5, 1999, vol.: 341, no. 6)

Before we go deep into the topic of health care financing in Malaysia, let us get ourselves familiarize with the present health care scenario in the Malaysia.

According to the last census the population is about 22.180 million people, with a growth rate of 2.3 % in 1997. 43.5 % of the Malaysian population lives in the rural areas, whereas the remaining 56.5 % of the population live in the urban centers. In 1997, 96 % of the population is under the age of 65 years. Malaysian crude death rate and birthrate in 1997 was 4.6 and 25.6 per 1000 respectively. (Evaluation of monitoring and evaluation of strategy for health for all, Ministry of Health Malaysia, May1999.)

In 1997 the total expenditure on health is 2.4 % of the GDP, that is equal to RM 3.786 billion. On average the per capita health expenditure was 85 US$. 58 % of that expenditure was spend by the government whereas remaining 42 % was spend by the private sector.

Out of the total 1997 health care expenditure (government allocation in the form of MOH budget), RM 3,236,047,600 (85.45 %) was allocated to cover the cost of running the health care services, while the remaining RM 578,538,000 (14.54 %) was used for health care development.

Public financing in Malaysia;

The government pays the 58 % of the Malaysian total health care bills. The tax-based revenue largely funds this expenditure. In Malaysia the public health care is largely free and easily assessable. The government subsidizes a comprehensive range of health services. The government funds bout 95 % of the public hospital cost, with remaining 5 % collected through the patient's charges. So that mean that the government is subsidizing 95 % in government hospitals. The fees for using the government hospitals are doubled for the non-malaysians.

Private Health care financing in Malaysia;

The private health care financing in Malaysia is mainly derived from the out-of-pocket expenditure. 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 the time that out-of-pocket expenditure is in the form of health care insurance, or private health insurance, and more than 90 % of time it is the employer who pay for these private health care insurance or managed care organizations.

Apart from the health insurance the Malaysians do have the option of drawing up to 10 % of their employment provident funds (EPF) to pay for their critical illness treatment.