CHAPTER 1 INTRODUCTION

1.1 Healthcare in Malaysia

Most countries undergoing structural change from low to high value added activities of healthcare have been characterised by the private providers. The process of privatisation and contracting out services to the private businesses has led to an increasing shift in healthcare from being delivered as an essential public utility to a profit seeking target by private providers. Privatisation has also been used frequently by governments as a policy instrument to reduce the financial burden of the public sector.

Malaysia is one of the countries that have experienced fundamental changes in the healthcare sector since independence in 1957. The colonial healthcare system in Malaya had originally been developed primarily for the purpose of serving the needs of the civil servants and other government employees and also the plantation sector (Harper, 1999), but expanded gradually to meet the needs of the general public. In addition, healthcare facilities were concentrated in urban areas with a focus on curative healthcare during the colonial period. After the Second World War, there were greater efforts to provide services to the rural areas both as part of overall development policies and as a strategic measure to counter Communist insurgency (Chee, 1990).

The newly independent government of Malaya was committed to expanding state healthcare, especially services in rural areas has hitherto been neglected. At independence in 1957, the Federal Government assumed control of all government healthcare services, which had previously been, to a large extent, the responsibility of individual states of the Federation of Malaya (Barraclough, 1999).

Government healthcare activities encompass curative, rehabilitative, promotive and regulatory concerns. The Ministry of Health (MOH) is the major government agency responsible for the delivery of health care in the country (Chee, 1990). Both public and private sectors are important players in Malaysia's healthcare delivery system. On the one hand, the public sector is heavily subsidised and focuses on healthcare promotion, as well as, rehabilitative and curative care at the primary, secondary, and tertiary levels. On the other hand, the rapidly growing private sector offers mainly curative and rehabilitative services, and is financed strictly on a non-subsidized, fee for service basis. However, semi-government employees have continued to enjoy government-funded treatment at private clinics and hospitals when the service is not available in government hospitals.

While the government allocated funds to improve the health infrastructure by building new hospitals and clinics, the private sector has also played an increasingly important role in the growth of the sector. Indeed, private healthcare sector has become a major player in delivering healthcare services alongside the government healthcare sector.

Private practitioners have historically been important healthcare providers in urban areas in Malaysia, and all doctors had to first serve their housemanship in public hospitals before seeking to join private service. However, there has been a mushrooming of private hospitals and specialist clinics since the 1980s. Business enterprises with health functions include firms which have to provide a comprehensive scope of medical services to their workers under the existing legislation. Meanwhile, large pharmaceutical companies, and commercial insurance companies offer health insurance (Chee, 1990). There were 229 private hospitals in the country in 2011 (Matrade, 2011).

However, the unprecedented growth of the private medical sector has had wide-ranging implications for the Malaysian healthcare system. This has raised serious concerns as it is well known that leaving health care to market forces does not necessarily lead to an effective and efficient health care system (Rossenthal & Newbrander, 1996).

Privatisation in the Malaysian health sector has raised a number of issues, some of which have been discussed in public and some of which remained serene. While the government is concerned over the burgeoning cost of public expenditure going to healthcare, the public is concerned over the spiralling costs of private healthcare, and the increased movement of doctors from public to private hospitals. Civil society organisations have also expressed concerns over the rapid expansion of private healthcare as they not only charge more, but are also concentrated at higher level of urbanisation locations.

The total health expenditure of both the public and private sectors has been rising steadily in the period between 1997-2001, both in per capita terms, as well as, as a percentage of GDP (Phua, 2006). The Ministry of Health's budget has ballooned from RM 1.0 billion or 3.6% of the National Budget in 1983 to RM 8.7 billion or 6.4% of the National Budget in 2006, raising questions over its sustainability over the long term (Chua, 2007).

The growth of private hospitals has not been without problems for the government. Many highly qualified medical and nursing staff have left the public sector for higher pay and improved conditions in the private sector. In 2006, the doctor-and nurses population ratio was 1: 1,214.and 1:559 respectively. Also, the distribution of healthcare personnel was not equal amongst all states and regions. The government has

resorted to recruiting contract doctors and nurses, both foreign and local, to meet the shortage. In 2002, it was reported that 58% of the country's medical personnel were serving in the private sector (Ernst &Young, 2003).

1.2 Background of the Study

Each country in its endeavour to progress seeks to push through a massive process of development and change, and health is an important part of that process. Healthcare is often narrowly defined as medical care. The World Health Organisation defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO 1978, 2). This shows that healthcare is also used to describe a whole range of activities, which are carried out for the maintenance of good health. Indeed, health status is directly linked to income, occupation and social classes (Goldman, 2001). Health is also a concept that encompasses social and personal resources, as well as, physical capacities.

Healthcare provision differs around the world. Health provision is challenging due to the costs required as well as various social, cultural, political and economic conditions. There are number of systems seem to be emerging in the healthcare provision. Each nation's healthcare system is a reflection of its history, politics, economy and national values. They all vary to some degree but they do share common principles.

1.2.1 Healthcare System

There are four basic healthcare models in the world; Beveridge Model, National Health Insurance Model, Bismarck Model and Market-Driven Health Care Model (Chee (2008) & Roemer (1991).

1.2.1.1 Beveridge Model

Healthcare is provided and financed by the government through tax payments. Many, but not all, hospitals and clinics are owned by the government; some doctors are government employees, but there are also private doctors who collect their fees from the government. These systems tend to have low costs per capita, because the government, as the sole payer, controls what doctors can do and what they can charge. Examples of countries that apply this model are Great Britain, Ireland, the Mediterranean countries (of the EU), most of Scandinavia, New Zealand and Hong Kong, Cuba and the former Socialist Bloc countries, including Hungary (Kutzin, 2011).

1.2.1.2 National Health Insurance Model

Hospitals and doctors are privately run but the government regulates the health care market and payment of health care procedures. Hospital stay (sometimes including prescription drugs) comes from a government-run insurance program that every tax paying citizen pays into. Canada and Taiwan are the countries that use this model (Wallace, 2013).

1.2.1.3 Bismarck Model

In the Bismarck model hospitals are usually private, as well as doctors' practices. People are free to choose their general practitioners (GP), or the specialists they want to see and the hospitals where they want to be treated. Their sickness fund will simply pay the bills. There are a small number of co-payment patients who are required to pay, but

there are many exemptions. The healthcare system in Germany and Japan falls under the Bismarck model (Kutzin, 2011).

1.2.1.4 Market Driven Healthcare Model

Private insurance plays a major role in this healthcare system. Individuals need to buy insurance from the private sector in order to cover their healthcare cost. This system is famous in United States.

Most of the healthcare systems discussed above is generally used in developed countries. Developing countries, however, do not usually fall neatly into any of the four categories above. Most are characterised by large private, sometimes informal providers due to the inadequacy of state healthcare; and financing is often made out-of-pocket. Malaysia is one of the developing countries that falls under this category (Gubb and Herbert, 2009).

1.2.2 Healthcare System in Malaysia

The healthcare system in Malaysia has experienced considerable transformation since independence in 1957. Malaysian healthcare system had evolved from a simple single provider system to one of multiple providers which are categorised by public and private sector providers interacting with one another, as well as, third party financiers. Each party interacts with each other in the process to maximise their benefits.

The government has provided the major healthcare and healthcare related facilities where all are financed through central taxation. This situation started to change during

the 1980s due to growing demand for healthcare following rising incomes, urbanisation and the expansion in the middle classes (Chee & Barraclough, 2007).

Table 1.1: Summary of Healthcare System in the World

Healthcare System	Characteristics	Example of Countries
Beveridge Model	1. Healthcare is provided and financed by the government, through tax payments. 2. There are no medical bills. 3. Medical treatment is a public service. 4. Providers can be government employees. 5. Low costs and the government controls costs as the sole payer.	Great Britain, Ireland, the Mediterranean countries (of the EU), most of Scandinavia, New Zealand and Hong Kong, Cuba and the former Socialist Bloc countries (including Hungary).
National Health Insurance Model	1. Providers are private. 2. Payer is a government-run insurance program that every citizen pays into; has considerable market power to negotiate lower prices. 3. National insurance collects monthly premiums and pays medical bills. 4. Plans tend to be cheaper and much simpler administratively. 5. Can control costs by: (1) limiting the medical services they will pay for or (2) making patients wait to be treated.	Canada and Taiwan
Bismarck Model	1. Providers and payers are private 2. Private insurance plans – financed jointly by employers and employees through payroll deduction. 3. The plans cover everyone and do not make a profit. 4. Tight regulation of medical services and fees (cost control).	Germany and Japan
Market Driven Healthcare Model	1. Based on Insurance 2. Private providers 3. Individual need to purchase private healthcare insurance.	United States

In the mid 1980's, the Malaysian government initiated a program on economic liberalisation and deregulation that included a comprehensive privatisation policy, in connection with the concept of "Malaysia Incorporated". This concept sees the

Government as the provider of an enabling environment - infrastructure, deregulation, liberalisation and macroeconomic management; and the private sector as the main engine of growth (Economic Planning Unit, 1985, 1991). Gomez and Jomo (1999) and Chee (2006) argue that the government was influenced strongly by advisors from the Thatcher government of United Kingdom and the World Bank to introduce privatisation as the vehicle to reduce government expenditure.

The Mid-Term Review of the Sixth Malaysian Plan 1991-1995 stated that:

> While the government will still remain a provider of basic health services, the role of the Ministry of Health will gradually shifts towards more policymaking and regulatory aspects, as well as, setting standards to ensure quality, affordability and appropriateness of care. At the same time the Ministry of Health will ensure an equitable distribution in the provision of health services and health manpower between the public and private sectors.
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> (Source: Malaysia 1993:244)

Hence, in the following Seventh Malaysian Plan (1996-2000) it was stated that the Government "will gradually reduce its role in the provision of health services and increase its regulatory and enforcement functions" (Malaysia 1996:544).

Following strong promotion by the government towards the private healthcare particularly since the mid-1980s has resulted in the steady rise of private hospitals. A number of large Malaysian corporations and companies were set up by medical specialists, including through the involvement of foreign investors who invested in private hospitals. Most of the services in the private hospitals are paid from out-of-pocket bills. In addition, the government also launched Government Linked Companies (GLCs) that, inter alia, acquired shares or started large private hospitals. The state government of Johor, Melaka, Pahang and Terengganu and Federally controlled Khazanah Nasional and Sime Darby become owners of private hospitals.

1.2.3 Healthcare Services in Malaysia

According to Chee (1990), healthcare can be classified into two categories, which are public healthcare and personal healthcare. Public healthcare encompasses a wide range of concerns, from the provision of food and housing to specific measures for disease prevention. Many of these are actually basic needs and to a certain extent it is the responsibility of the government. The other category of healthcare is personal healthcare.

Personal healthcare can be divided into two sectors; formal health sector and informal sector. The formal sector consists of the government sector and the private sector. Healthcare in these two sectors can be divided into primary, secondary and tertiary care. Primary care is first line medical care and involves preventive healthcare as well. Secondary care is medical care given at hospitals, while tertiary care involves specialist services.

The informal sector consists of numerous traditional health systems, such as, Chinese, Ayurvedic, Malay and other traditional healers. Unlike doctors, traditional healers are not formally registered and many practice their skills on a part-time basis. The overall scope of healthcare discussed is reflected in the Table 1.2.

As the purpose of this thesis is to discuss the healthcare services issues in Malaysia involving public and private healthcare, this study will be focusing only on the formal personal healthcare sector.

Table 1.2: Scope of Healthcare

Public Healthcare	Personal Healthcare
1. Water Supply 2. Sanitation 3. Sewage disposal 4. Nutrition / Food supply 5. Housing 6. Environment, Drainage 7. Occupational health 8. Specific measures for disease prevention	1. Formal Sector i. Government ii. Private 2. Informal sector

Adopted from Chee (1990)

Public healthcare is provided by the government through national healthcare systems. Private healthcare can be provided through "for profit" hospitals and self-employed practitioners, and "not for profit" non-government providers, including faith-based organisations, example Assuntha Hospital and Adventist Hospital.

1.2.3.1 Government Healthcare Services

Government healthcare activities encompass curative, preventive, rehabilitative, promotive, and regulatory concerns. The Ministry of Health (MOH) is the major government agency that is responsible for the delivery of healthcare. MOH provides a wide range of healthcare services through a sophisticated and integrated network of programmes.

Medical care is delivered by the MOH through public hospitals. Besides being the main provider of healthcare services, public hospitals also have other roles to play. Currently public hospitals are involved in patient care, training, research and education. Malaysian public hospitals are classified based on its needs and organisational requirement. The

hospitals were classified as follows: district hospitals, district hospitals with specialist services, general hospitals and National Referral Centres/ Institutions.

i(a) District Hospitals

These are small hospitals located in the districts of a state with 24 to 150 beds. The services provided are outpatient care, inpatient and accident and emergency services. In general, these hospitals are provided with medical officers of two to four years seniority to provide basic care. Types of cases seen are simple cases in medicine, general surgery, paediatrics, obstetrics and gynaecology.

i(b) District Hospital with Specialist Services

These are hospitals located in the bigger district of state with a bed complement from 150 to 500 beds. In each state there are between from two to six hospitals depending on the size of the state. The specialist services available in these hospitals are general medicine, general surgery, paediatrics, obstetrics and gynaecology, anaesthesia, pathology and radiology. Other services based on needs are provided by visiting specialists from the general hospitals

ii. General Hospitals

Each state capital has a General Hospital. This hospital forms the final referral for all the hospitals in the state. These hospitals have a bed complement from 400 to 1000 beds. Besides providing all secondary level services, some provide tertiary level

services like neurosurgery, neurology, urology, neonatology, cardiology, cardiothoracic surgery etc.

iii. National Referral Centres / Institutions

There are several National Referral centres and institutions. The main National Referral Centre is Hospital Kuala Lumpur (HKL). Historically HKL was designated as a general hospital, however due to the central location and being in the capital of the country, it became focus of the development of hospital services. With growth of these services, several national institutions were designated for example Paediatric Institute, Maternity Hospital, Institute of Urology and Nephrology, Institute of Neurological Sciences, Institute of Orthopaedics etc. The National Heart Institute was originally part of HKL complex but it was later corporatized as a government owned entity.

iv. Non-MOH Hospitals

Non-MOH hospitals are hospitals provided by other Ministries such as the Ministry of Higher Education (University teaching hospitals), the Ministry of Defence (military hospitals) and the Ministry of National Unity and Social Development (Orang Asli hospitals). There are six non-MOH hospitals in Malaysia, having nearly 3,000 beds.

1.2.3.2 Private Healthcare Services

Privatisation can be defined as the acquisition or sale of assets by private owners from non-private control (e.g. government, communes and religious bodies) (Barraclough, 2000). It is also important to include in the definition, an increase in the private share of

particular sectors as a consequence of an increasing shift of responsibilities, functions and activities from the public to the private sector (Starr, 1988). Also, a number of services in government hospitals are delivered by private firms - e.g. the provision of drugs, linen and laundry service, cleaning, and facilities management since 1994 (Chan, 2003).

It is for these reasons assessments of ownership involving organizations and enterprises that are created and approved for operation by legal bodies for the purpose of serving all members of society are evaluated from the expenditure borne rather than on the basis of the provision of services. This is because the disadvantaged poor are both interested in free access, as well as, the quality of services they enjoy. Hence, in the developed countries, such as, the United States, United Kingdom, Canada, Netherlands and Germany, a significant amount of normal healthcare services, especially the first visit by patients, are provided by private practitioners. Government health service departments take care of the bills of citizens registered with them. Foreigners and employees access such services through insurance premiums that are subsidized or fully paid by the employers.

The private health sector consists of private hospitals, clinics, nursing homes, maternity homes, private medical practitioners, private dental practitioners, private pharmacists, private insurance companies and traditional medical practitioners. Private healthcare sector providers are predominantly urban-based. Private practitioners have been important healthcare deliverers in the urban areas. These hospitals largely operate on fee-for-service basis and mostly serve the middle and higher income groups.

In earlier years, there were few non-profit hospitals in Malaysia. These hospitals were started by community and religious organisation to complement state-run hospitals. Many of these hospitals were voluntary, however, through the years; the hospitals were purchased by business entities. This situation adds up to the growth of the private sector.

In addition, the business enterprises with health functions are also included in the private health sector. Among the enterprises are firms which have to provide a comprehensive scope of medical services to their workers under the existing legislation, large pharmaceutical companies and commercial insurance companies which offer health insurance.

1.3 Justification of the Study

High levels of private healthcare expenditures pose serious challenges to policy makers. The high private health expenditures are also a cause for concern because most of these expenditures are out-of-pocket with insurance claims only covering a small segment of the population. The provider payment systems are primarily based on fee-for-services where the professional regulation and accountability systems involved are weak and non-functional in many ways. It is not clear whether these expenditures are sustainable as it can have a number of undesirable consequences so as to make healthcare services costly, unaffordable and uncertain. Fee-for-service or out-of-pocket expenditure can lead to debt for those who cannot afford it. Majority of patients seek private treatment either by choice or because they have no choice as the treatment in public hospitals can mean being put on a long waiting list (Star, 2012). Catastrophic out-of-pocket payment can lead a household into poverty (Devaraj, 2004).

The rapid growth of private healthcare has also resulted in growing imbalance of doctors and other medical personnel from the public sector. Aggressive health tourism gives opportunities to doctors in public hospitals to work in the lucrative private medical centres. Numerous highly experienced specialist doctors have left for greener pastures in the private sector, while some have registered abroad. The loss is felt in the public sector as these specialist doctors bring with them experience and competencies accumulated over many years. Seventy five per cent of the specialists in the country are in the private sector catering to about 25 per cent of in-patients in Malaysia (Devaraj, 2004). Heavy work-load of having to serve in the government hospitals, the 75 per cent of the inpatient population, as well as, the training of housemen officers, other junior doctors and aspiring specialists is shouldered by 25 per cent of specialists in the country (Devaraj, 2004). The few specialists left in public hospitals are facing serious problems as the number of housemen per specialist ratio, which was capped at 1:4 in 1990, reached over 1:7 by 2010 (Pagalavan, 2011).

The growth of private hospitals has been concentrated in urban and industrialised areas, providing mainly curative services resulting in an uneven distribution of healthcare manpower between the higher level of urbanisation and lower level of urbanisation areas. With the private health facilities being concentrated in high income areas, the inequitable distribution of medical and health resources have aggravated further the quality of healthcare services offered to the poor rural population in Malaysia (Krishna (2003), Jeyakumar, (2009) & Rasiah et al. (2011).

Hence, there is a serious need to study the issues addressed above in order to generate an elucidating set of findings that can help check the problems currently faced by the healthcare system in Malaysia.

1.4 Objectives of the Study

The study aims to analyse the social impact of an increasing shift in the share of hospitals from public to private services since the 1990s. With a grasp of these aspects, one can understand the real issues confronting the healthcare system in Malaysia, especially the changing composition of health expenditure, movement of doctors and inequalities of health personnel between public and private sector. Taking into consideration these issues, the study assumes the following objectives:

1. To analyse changes in public-private composition of the healthcare expenditure in Malaysia.
2. To analyse changes in the public-private composition of beds, doctors and nurses in Malaysia.
3. To analyse the distribution of doctors in higher and lower level of urbanisation of the states in Malaysia.

1.5 Outline of the Study

This thesis is organised into six chapters. Chapter 1 focused on overview of the healthcare system in Malaysia, background of the study, the justification of the study, the objectives and the outline of the study. Chapter 2 reviews the main healthcare theories explaining the allocation of healthcare framed by a review of past empirical studies on the provision of healthcare. Chapters 3 discusses on the framework of the study and the methodology used. Chapter 4, 5 and 6 analyse changes in the public-private composition of healthcare expenditure, doctors and nurses and distribution of doctors in higher and lower level of urbanisation of the states in Malaysia. Finally

chapter 7 provides the summary, implications for theory and policy, and limitations of the study, as well as, directions for future research.