CHAPTER IV PUBLIC AND PRIVATE HEALTHCARE EXPENDITURE: ABSOLUTE AND RELATIVE CHANGES

4.1 Introduction

Worldwide, healthcare cost is escalating and the two main reasons are, one, technology is driving relentless medical advances, and two, rising expectations of better informed patients. Both private and public health expenditures are rising faster than any other sectors. Since healthcare is essential, and most economies are unable to sustain the rapid growth in expenditures, a public debate rages regarding the provision of public and private healthcare services.

Malaysia is one of the developing countries that has experienced extensive changes in the healthcare system, particularly in the balance between private and public sectors in healthcare provision and financing. The Malaysian healthcare system has transformed into a resilient two-tiered parallel system, with a sizable and booming private sector. The share of public healthcare in total healthcare expenditure has shown a falling trend since the 1980s.

Most international organisation accounts herald Malaysia as having a successful healthcare system (WHO, 2000). The growth of private healthcare has been viewed by some to complement the public healthcare system financed by the government. Growth in private healthcare is considered to relieve some of the pressure of demand for health services, allowing the government to concentrate more on the needs of the poor. However, according to Quek (2011), poor patients have resorted to mass media appealing for financial assistance to help defray medical costs, especially for some costly or tertiary specialists care. Thus this has driven some stopgap measures such as

setting up Medical Assistance Fund (MAF) of RM25 billion by the Ministry of health. Yet, this fund can only be utilised at public or quasi-governmental healthcare facilities, and appeals have to be vetted strictly to ensure need and priority which had drawn sharp critism of being too bureaucratic and slow, even unfair.

Some poor patients have been asked to go to the private wings or centres for quicker access for some surgeries or procedures, which caused complaints of unfair rationing, pressure and preferential treatment. There is always the fear and perception that poor subsidised patients would be short charged and asked to wait longer, even be pressured to move toward the full paying side for quicker queue jumping accelerate care. It is claimed that waiting time for the needy and poor have become 'inordinately long' at the institute and could go up to two years, while those who can afford it could pay to get their treatment overnight.

This situation will lead to the inequitable financing and impoverishment due to catastrophic health expenditure. In addition, medical tourism is also another factor that contributes to the tremendous increase in healthcare expenditure. Medical tourism as another engine of growth for the economy is overstated. Medical tourism only contributes to a small percentage of the country's overall GDP. The rapid increase in incentives and the opening up of new private hospitals suggests the need for revisiting this public-private debate.

This chapter attempts to examine whether Government expenditure in total healthcare expenditure of Malaysia is increasing or declining. In so doing, it analyses the public and private share of health expenditure over the period 1980 to 2006 and changes in the relative share against the upper middle income countries in the world over the period

1995-2009. The next section reviews critically the public funding on healthcare and followed by public and private health expenditure in Malaysia (1980 to 2006), while section 4.4 report the share of public health expenditure in GDP in Malaysia against the upper middle income countries over the period 1995-2009. The chapter finishes with a summary in section 4.5.

4.2 Public Funding on Healthcare

The financing of healthcare is a basic issue that every country must address. In principle, a country's healthcare can be financed either entirely publicly, or entirely privately. However, most of the countries practise a mix of public and private financing where it generally creates the best possibilities for the efficient provision of accessible and good-quality health care.

In terms of public and private share in health expenditure, it is more difficult to generalize. Currently, private sector financing plays a major role in funding healthcare in most of the countries. Private financing refers to funds paid directly to healthcare providers from private sources, including direct household expenditures such as out-of-pocket payments, expenditures through private insurance plans, employers' direct payments for health services, and charitable contributions.

Similarly in Malaysia, in line with the new direction in economic policy, and fuelled by rising incomes and urbanisation, from the mid -1980s onward, the healthcare system has profound changes. It is stated in the 7th Malaysian Plan that the government will gradually reduce its role in the provision of health services and increase its regulatory and enforcement functions. Since 1980s to 2000, the number of private medical

facilities in Malaysia grew tremendously. Moreover, within that two decades, the number of private hospitals increased by four times. This indicates that the healthcare expenditure in Malaysia is increasingly driven by increased privatisation within the healthcare service provision.

4.2.1 Government Budget Allocation for Health Sector

It is important to get an overall idea of how significant the health sector has been in the context of the national economy and the government development plans. A quick and effective way of doing this is to examine the proportion of government allocation that has been directed into health.

Budgetary allocation plays an important role in development process of any country. The budget is a crucial indicator of implementation of policies and it should give a good overview about the policy priorities of a particular sector. In this regard, the objective of this budget analysis is to analyse the coherence between the health sector priorities and government funding.

Malaysian health services are ultimately funded through the general population by tax payments, and contributions to EPF (Employee Provident Fund) and SOCSO (Social Security Organization). The Ministry of Finance (MOF) collects general taxes (as direct and indirect taxes) to finance the public services including health care.

Table 4.1 shows the Government budget allocation from 1980 to 2009. The cost seems to be rising in terms of continuous increase in overall budget of the MOH. Figures for per cent increase over the years for the overall budget are also examined. The data

shows that there is a significant increase in the overall budget over the years. It is noticed that there are remarkable increase of healthcare budget in certain years, for example in 1990 and 2004 the increase are 21% per cent compared to the year before. There are certain years like 1983, 1987, 1993, 1994, 1999 and 2005, where the budget shows a negative increase compared to the year before. The most obvious year of negative increase on the overall budget can be observed in the year 2005.

During Asian Financial Crisis in 1997 and 1998, it is noted that the percentage of annual budget of healthcare decreases extremely. The increase of budget from 1996 to 1997 was only 7 per cent compared to the increase between 1995 to 1996 which was 19 per cent, a difference of 12 per cent. In 1999, there was no increase of budget compared to the year 1998. However, in term of MOH budget as percentage of national budget it remained relatively constant, especially 1990 onwards. This denotes that even though the MOH budget keeps rising over time, the national budget has also been rising and the government is continuously allocating a relatively constant share of the national healthcare budget, around 5-6 per cent except for the year 2007 and 2008 around 7 per cent.

Officials from the Malaysia's Ministry of Health say that healthcare budget is spiralling out of control. This statement can be argued when the share of national healthcare budget is relatively constant. The increase in healthcare costs is not a real problem for the government since the government is allocating a constant share of national budget to the MOH. Moreover, the annual changes of consumer price index for medical care and health expenses have not been particularly high except early 1980s, 1991, 1992, 1994, 1998 and 2008. Thus, the main reason of the budget increment in the healthcare sector is not solely because of the rising of healthcare costs as claimed by some parties.

Table 4.1: Ministry of Health Allocated Budget and Healthcare Inflation, Malaysia, 1980-2009.

Year	MOH Budget (Nominal (RM))	MOH Budget ((RM) in constant 2000 prices)	% Increase Over Previous Years	% of National Budget	Healthcare Cost Inflation
1980	895,579,857	1,655,979,958	-	5.27	-
1981	1,011,686,375	1,851,041,540	12	4.38	10.0
1982	1,075,043,070	1,918,450,792	4	3.35	5.5
1983	1,034,468,227	1,754,967,244	-9	3.58	4.0
1984	1,126,810,440	1,811,178,021	3	4.07	3.4
1985	1,256,333,300	2,050,315,730	13	4.30	0.6
1986	1,273,622,440	2,275,031,298	11	4.13	0.4
1987	1,174,786,100	1,988,508,629	-13	4.29	0.8
1988	1,264,729,700	2,065,971,590	4	4.50	2.5
1989	1,470,384,550	2,299,298,418	11	5.00	3.0
1990	1,840,321,780	2,772,251,172	21	5.51	3.1
1991	2,178,672,370	3,168,388,748	14	5.66	4.4
1992	2,487,821,000	3,532,665,535	11	5.47	4.6
1993	2,513,981,010	3,432,949,962	-3	5.69	3.5
1994	2,462,149,700	3,234,805,682	-6	5.22	3.9
1995	2,793,731,000	3,541,754,007	9	5.73	3.3
1996	3,434,778,000	4,199,860,914	19	6.17	3.3
1997	3,786,834,900	4,474,537,932	7	6.31	2.8
1998	4,237,960,000	4,615,338,531	3	6.61	5.2
1999	4,237,960,000	4,613,236,259	0	6.61	2.9
2000	4,931,315,300	4,931,315,300	7	6.32	1.5
2001	5,765,553,410	5,858,223,113	19	6.33	1.4
2002	6,299,073,770	6,206,135,996	6	6.27	1.8
2003	7,556,006,400	7,206,776,863	16	6.88	1.1
2004	9,668,810,000	8,699,171,425	21	8.00	1.5
2005	8,499,030,000	7,024,192,023	-19	6.69	2.9
2006	9,502,700,000	7,553,107,293	8	6.33	3.6
2007	11,200,560,000	8,488,258,039	12	7.02	2.0
2008	13,101,865,000	8,994,629,382	6	7.29	5.4
2009	14,429,766,040	10,537,689,785	17	6.60	0.6

Source: Ministry of Health (Annual Report, Health Facts), Department of Statistics.
*Constant value deflated using GDP deflator, World Bank (2012)

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the government since the government is allocating a constant share of national budget to the MOH. Moreover, the annual changes of consumer price index for medical care and health expenses have not been particularly high except early 1980s, 1991, 1992, 1994, 1998 and 2008. Thus, the main reason of the budget increment in the healthcare sector is not solely because of the rising of healthcare costs as claimed by some parties.

4.3 Healthcare Expenditure

The past three decades have generated a rash of healthcare issues into the spotlight, especially those related to the total healthcare expenditure. Total healthcare expenditure rose markedly in recent decades, largely due to an aging population and technological advancements in private healthcare sector (Clements, et al., 2011). Rising healthcare expenditure is becoming important health issue, which poses social, political and ethical problems for the health industry.

4.3.1 Public Healthcare Expenditure

The rapid increase in public healthcare expenditure can be observed before 1980s, after the introduction of National Economic Policy (NEP) in 1970s. According to Rasiah, et al. (2011), the initial National Economic Policy period of 1971-1981 was characterised by extensive public expenditure targeted at expanding the provision of healthcare to rural areas and poor states. The government played a major role in the provision and financing of healthcare up until the 1980s. This welfarists role of the government benefited the poor Malays particularly those living in the rural areas. However, the government's healthcare spending started to fall from 1982 onwards as the private sector was promoted strongly from the early 1980s.

The public healthcare expenditure was RM1.4 billion in 1980, increasing to 10.7 billion or a jump of 631 per cent in 2009. Based on the data from Table 4.2, the higher percentage increase over previous years can be seen in the years 1996 (20.9%), 2003 (30.5%) and 2009 (20.1%). For the year 2003, the public health expenditure has been increased to 8.6 billion representing a jump of 220 per cent as compared to 1990. The operating expenditure was really high in 2003 due to the government policy in increasing the salary of doctors. Rising healthcare cost is unavoidable. Although the data indicates that the healthcare cost is rising over the years, but the share of public healthcare expenditure to GDP remain constant, except for the year of 2003 and 2009.

From 1980 to 2009, as evident from the Figure 4.1, government expenditure on health as a percentage of GDP has been relatively flat around 1.6 per cent, before it showed a sharp rise in 2003 (2.15 per cent) and dropped in 2004. It began to rise again, moderately, in 2005 and stood around 2.16 per cent in 2009. The share of public healthcare expenditure to GDP in Malaysia is still lower than the 5 per cent of GDP recommended by the World Health Organisation for middle income countries and lower than the OECD average of 9.7 per cent.

Table 4.2: Total Public Healthcare Expenditure, Malaysia, 1980-2009

Year	Public Health Expenditure Nominal (RM)	Public Health Expenditure ((RM) in constant 2000 prices)	% Increase Over Previous Years
1980	795,329,995	1,470,612,053	-
1981	946,765,751	1,732,258,907	17.8
1982	1,038,295,550	1,852,873,597	7.0
1983	978,550,839	1,660,103,833	-10.4
1984	1,035,529,731	1,664,458,034	0.3
1985	1,101,838,891	1,798,183,341	8.0
1986	1,197,008,375	2,138,178,028	18.9
1987	1,171,146,143	1,982,347,434	-7.3
1988	1,182,433,590	1,931,538,576	-2.6
1989	1,441,517,682	2,254,158,156	16.7
1990	1,775,618,426	2,674,782,376	18.7
1991	2,031,816,764	2,954,820,312	10.5
1992	2,381,804,811	3,382,124,263	14.5
1993	2,398,137,919	3,274,761,203	-3.2
1994	2,497,837,264	3,281,692,488	0.2
1995	2,745,368,991	3,480,443,044	6.1
1996	3,442,049,346	4,208,751,923	20.9
1997	3,703,205,169	4,375,720,737	4.0
1998	4,030,100,200	4,388,969,394	0.3
1999	4,446,258,089	4,839,979,384	10.3
2000	5,402,992,423	5,402,992,423	11.6
2001	6,241,263,967	6,341,579,763	17.4
2002	6,665,257,030	6,566,916,516	3.6
2003	8,986,128,716	8,570,800,644	30.5
2004	9,373,510,000	8,433,485,645	-1.6
2005	8,696,930,000	7,187,750,406	-14.8
2006	9,902,210,000	7,870,653,032	9.5
2007	11,242,840,000	8,520,299,611	8.3
2008	13,036,250,052	8,949,583,723	5.0
2009	14,712,834,927	10,744,407,767	20.1

Source: Ministry of Health (Annual Report various years)
*Constant value deflated using GDP deflator, World Bank (2012)

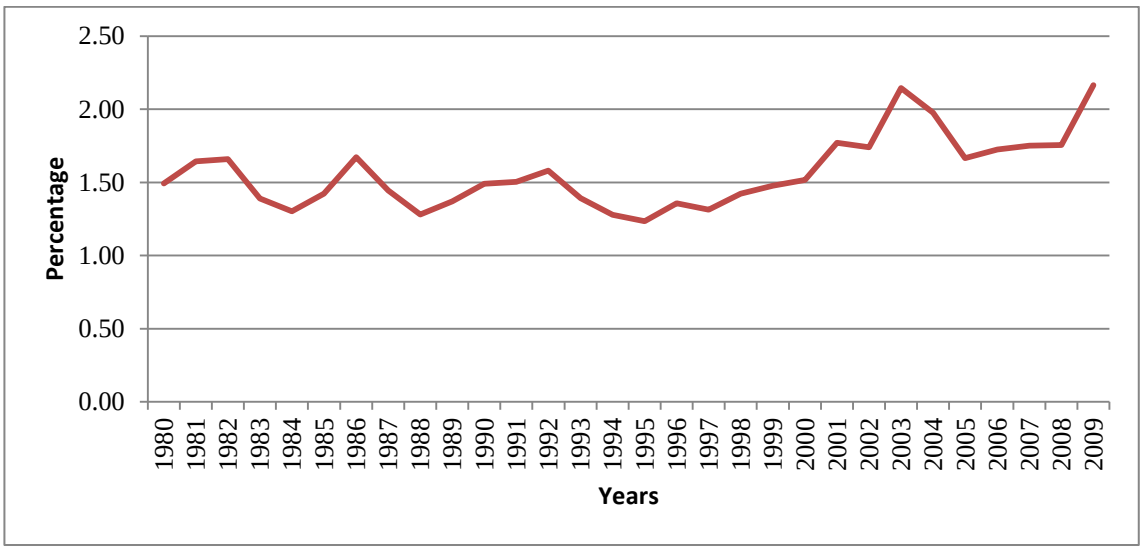

Figure 4.1: Share of Public Healthcare Expenditure Percentage of GDP, Malaysia, 1995-2009

(Sources: Ministry of Health, various years)

There is a considerable variation in financing the healthcare across the states in Malaysia. Wide variation in overall public health expenditure between states can be observed in Table 4.3. The highest public healthcare expenditure in 1997 was noted in Kuala Lumpur (RM856 million) followed by Perak (RM442 million) and Sarawak (RM436 million). In term of the public health expenditure trend among the states, almost all the states shows increasing trend over the years, except for the year of 1998, due to economic crisis in 1997.

In 1998, it is observed that the lower level of urbanisation states such as Kedah and Kelantan, the public health expenditure decreased around 15 per cent compared to the previous year, meanwhile higher level of urbanisation states such as Kuala Lumpur, Selangor and Labuan shows an increasing trend; 10 per cent, 5 per cent and 4 per cent respectively.

The tremendous increase of public healthcare expenditure from 1997 to 2009 can be seen in the state of Selangor when the percentage of increase shot up to 388 per cent

followed by Labuan 198 per cent and Penang 188 per cent. Kuala Lumpur had a significant growth of public healthcare expenditure annually while Kelantan faced the slow growth annually except for the year 2001 and 2006.

The data (see Table 4.3) reflects that public healthcare expenditure are high in higher level of urbanisation states such as Selangor, Penang, Johor and Kuala Lumpur compared to the lower level of urbanisation states such as Kedah, Kelantan, Terengganu and Pahang. Generally, the public healthcare expenditure is increasing in all the states in Malaysia over the years. Public healthcare is heavily subsidised by the government and increasing cost of healthcare will make the service difficult to sustain in the long run.

Currently, it is claimed that the private sector plays a major role in funding healthcare and private healthcare is the main reason for the increase of healthcare cost. The next section will discuss further on the private healthcare expenditure.

Table 4.3: Total Public Healthcare Expenditure By State, Malaysia, (Constant Value) 1997-2009

Year/ States	1997		1998		1999		2000		2001		2002		2003	
	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years
Johor	392.61	-	367.52	-6.39	412.89	12.34	442.21	7.10	511.06	15.57	514.61	0.69	626.10	21.66
Kedah	280.70	-	237.55	-15.37	273.54	15.15	265.23	-3.04	316.44	19.31	336.38	6.30	371.70	10.50
Kelantan	266.94	-	226.24	-15.25	253.65	12.11	268.17	5.73	341.23	27.24	333.75	-2.19	377.57	13.13
Kuala Lumpur	856.70	-	942.79	10.05	994.27	5.46	972.33	-2.21	1101.32	13.27	1133.18	2.89	1196.29	5.57
Melaka	117.75	-	119.90	1.83	137.88	14.99	145.21	5.32	159.14	9.59	170.02	6.84	191.16	12.43
Negeri Sembilan	187.16	-	179.18	-4.26	205.26	14.55	205.54	0.14	242.44	17.95	252.62	4.20	289.57	14.63
Pahang	211.48	-	205.71	-2.73	235.07	14.27	245.68	4.52	289.06	17.65	286.33	-0.94	347.33	21.30
Perak	441.88	-	426.13	-3.57	468.95	10.05	475.44	1.38	526.79	10.80	542.20	2.93	658.27	21.41
Perlis	52.48	-	48.31	-7.95	51.27	6.13	52.15	1.72	66.75	28.00	65.13	-2.43	80.57	23.71
Penang	255.54	-	235.07	-8.01	258.50	9.97	271.74	5.12	324.64	19.47	327.87	0.99	414.97	26.57
Selangor	278.62	-	293.55	5.36	380.82	29.73	396.24	4.05	488.44	23.27	523.02	7.08	603.61	15.41
Terengganu	161.95	-	163.48	0.94	170.61	4.36	177.71	4.16	207.17	16.58	212.94	2.79	253.33	18.97
Putrajaya	0.13	-	0.12	-5.44	0.13	2.53	10.59	8170.66	20.85	96.94	79.05	279.20	81.14	2.64
Labuan	11.76	-	12.25	4.15	12.66	3.39	13.08	3.32	15.18	16.04	16.81	10.71	19.40	15.42
Sabah	395.72	-	366.21	-7.46	410.85	12.19	402.74	-1.98	471.79	17.15	493.88	4.68	579.87	17.41
Sarawak	436.19	-	428.89	-1.67	504.87	17.72	514.15	1.84	557.65	8.46	581.22	4.23	667.38	14.82

‘Table 4.3 Continued’

Year/ States	2004		2005		2006		2007		2008		2009	
	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years
Johor	582.32	-6.99	568.40	-2.39	806.27	41.85	815.59	1.16	793.04	-2.76	912.00	15.00
Kedah	384.57	3.46	370.80	-3.58	470.62	26.92	514.43	9.31	515.11	0.13	583.10	13.20
Kelantan	382.66	1.35	390.43	2.03	477.61	22.33	430.24	-9.92	437.19	1.62	512.42	17.21
Kuala Lumpur	1290.98	7.92	1203.83	-6.75	1319.37	9.60	1345.62	1.99	1434.87	6.63	1611.89	12.34
Melaka	190.89	-0.14	186.23	-2.44	228.90	22.91	262.86	14.83	257.67	-1.97	295.58	14.71
Negeri Sembilan	274.64	-5.15	295.08	7.44	349.60	18.47	361.24	3.33	363.44	0.61	412.87	13.60
Pahang	340.19	-2.05	318.09	-6.50	400.51	25.91	444.21	10.91	460.53	3.67	523.81	13.74
Perak	645.27	-1.97	645.36	0.01	755.02	16.99	790.55	4.71	786.92	-0.46	864.74	9.89
Perlis	85.74	6.42	80.37	-6.26	106.50	32.50	103.23	-3.06	109.84	6.40	126.81	15.45
Penang	415.56	0.14	380.54	-8.43	468.85	23.21	549.56	17.21	532.26	-3.15	736.92	38.45
Selangor	635.45	5.28	630.33	-0.81	962.79	52.74	1095.65	13.80	1148.64	4.84	1359.76	18.38
Terengganu	249.17	-1.64	243.44	-2.30	321.91	32.24	322.31	0.12	332.33	3.11	372.62	12.12
Putrajaya	79.39	-2.15	98.36	23.90	112.97	14.86	112.31	-0.59	122.90	9.43	155.09	26.19
Labuan	20.98	8.12	18.04	-13.98	26.36	46.10	27.73	5.20	27.18	-1.97	35.10	29.11
Sabah	603.31	4.04	562.83	-6.71	691.70	22.90	771.87	11.59	775.91	0.52	911.11	17.42
Sarawak	651.38	-2.40	622.75	-4.40	741.48	19.07	782.51	5.53	779.75	-0.35	878.63	12.68

Source: Malaysia National Health Accounts (*Constant value deflated using GDP deflator, World Bank (2012))

4.3.2 Private Healthcare Expenditure

Corporate private sector, viewed healthcare as a developing industry since 1980s and as a result more private hospitals were built and owned by businesses. These hospitals were set up solely for profit and the trend was followed by other corporate entities. Large Malaysian conglomerates, corporations and companies were formed by medical specialists, including those involving foreign investors who have invested in private hospitals with government encouragement. The tremendous increase of private hospitals can be observed after the Asian Financial Crisis and when the health tourism was introduced by the government.

The unprecedented growth of private healthcare since the 1980s had wide-ranging implications for the Malaysian healthcare system. Leaving healthcare to market forces does not necessarily lead to an effective and efficient healthcare system. The private sector development in Malaysia did not happen solely in response to the opportunity provided by the increase in consumer demand for health.

The private healthcare expenditure increased tremendously over the years since the privatisation policy was introduced in Malaysia. Figure 4.2 shows the private healthcare expenditure using real value calculated using GDP deflator from the year 1997 to 2009.

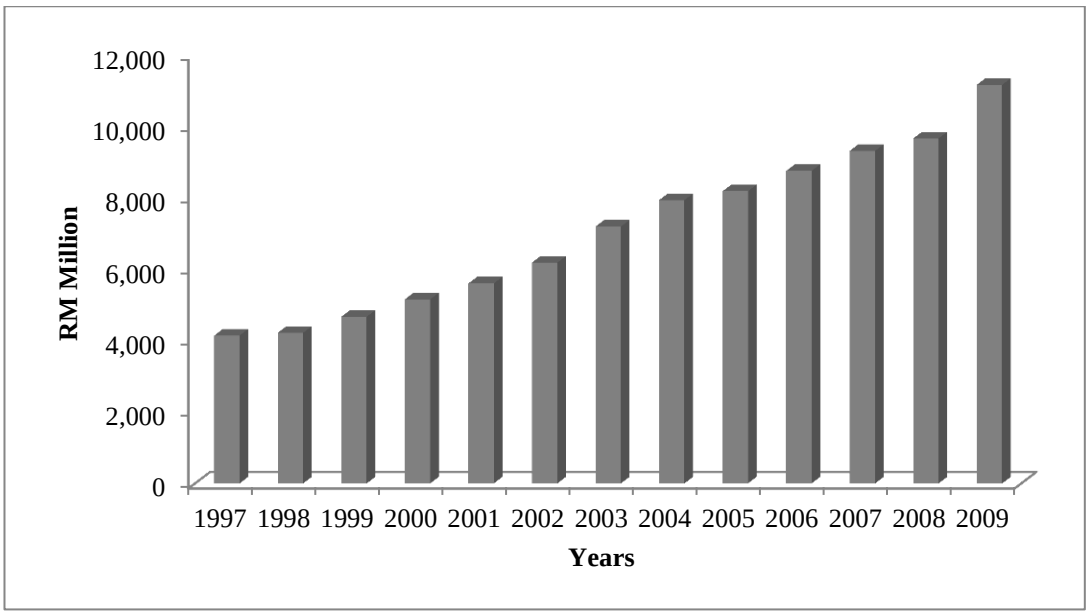

Figure 4.2: Private Healthcare Expenditure (Constant Value), Malaysia, 1997-2009.
(Sources: Ministry of Health, various years)
*Constant value deflated using GDP deflator, World Bank (2012).

In the year 1997, the private healthcare expenditure was RM4,140 million and it reached RM11,167 million in the year 2009. The private healthcare expenditure started to increase tremendously starting from the year 1999, an increase of 10.7 per cent from the previous year. The expenditure rose by 170% from 1997 to 2009. The most dramatic increase took place in the years 2002 to 2003 (16.3 %). During the period of 1997-2009, the share of private expenditure in overall healthcare expenditure rose to 44%.

In 1997, the expenditure was quite low compared to other years due to the Asian Financial Crisis. The Asian financial crisis of 1997 caused businesses in private hospitals to fall by 18 - 20%, and 3 - 4 year delay in the development of new private hospitals. Ringgit depreciation led to cost increase in imported drugs and technology. Private hospitals had to bear additional 20-120% drug costs and a 30% rise in surgical costs (Gross, 1999, Barraclough, 1999).

As domestic demand contracted following the 1997-98 financial crisis, the government promoted medical tourism to assist the private healthcare providers to attract demand from abroad. The emphasis on medical tourism as another engine of growth helped expand markets for private providers at the end of 1990s. Medical tourism has been earmarked as a key revenue generator since 2000. The collaboration between state and capital to promote medical tourism is reflected in the agreement between the Ministry of Health and the Association of Private Hospitals Malaysia (APHM).

Nevertheless, the Malaysian Government has targeted more private sector initiatives to promote Malaysia as a healthcare hub for both traditional and modern medical treatment (Malaysia, 2006, Rasiah, et al. 2011). The development helped boost the growth of private healthcare expenditure since 1997 (see Figure 4.2). The increase in health tourism benefitting the private sector is often exaggerated as it only represents a small percentage of the nation's GDP (see Figure 4.3). The private healthcare expenditure as percentage of GDP is only around one to two per cent from the year 1997 to 2009.

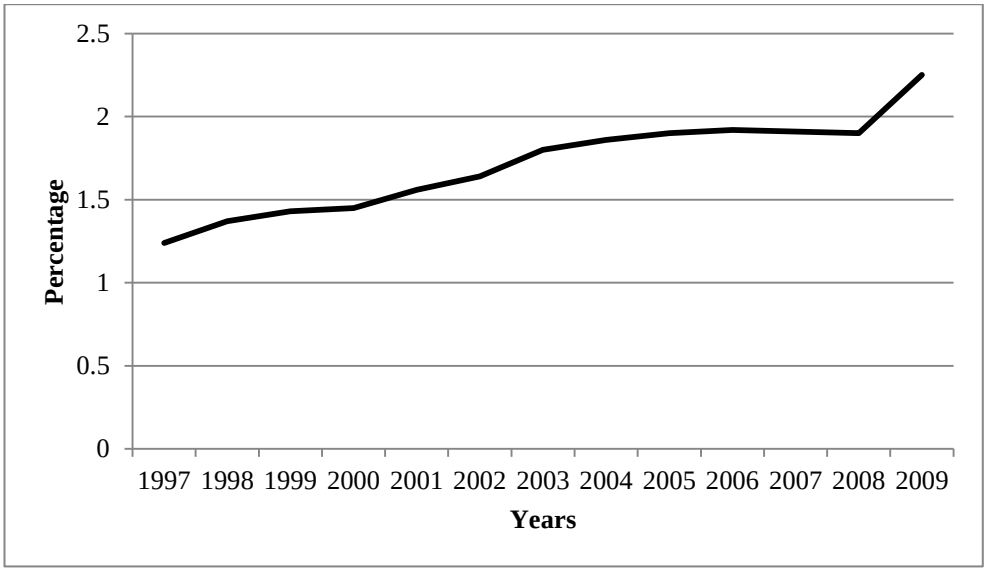

Figure 4.3: Private Healthcare Expenditure as Percentage of GDP, Malaysia, 1997-2009.
(Sources: Malaysia National Health Accounts).

The geographical location and diversity of some states in Malaysia also contributed to the growth of private healthcare expenditure. It is noticed that private healthcare expenditure are extremely high in higher level of urbanisation states such as Selangor, Kuala Lumpur and Penang compared to the lower level of urbanisation states; Terengganu, Kedah, Kelantan, Perlis, Pahang, Sabah and Sarawak (see Table 4.4). There is inadequate integration between the public and private health sectors. The private health sector concentrates mainly in urban areas, leading to inequitable distribution of health services and resources.

Based on the data in Table 4.4, in 1997 Selangor recorded the highest private health expenditure (874 million) followed by Kuala Lumpur (754 million). Meanwhile Terengganu (69 million), Kelantan (101 million) and Kedah (180 million) falls under the category of lowest, besides Putrajaya (4.8 million), Perlis (19.3 million) and Labuan (36 million) which are considered as small territories and state with lower population. The difference in private healthcare expenditure between Selangor and Terengganu in 1997 was almost 85 per cent.

However, in 1998 the private healthcare expenditure in all the states showed a decreasing trend and the higher percentage of drop compared to previous year is observed in lower level of urbanisation states like Kedah , Pahang and Sarawak, around five per cent compared to higher level of urbanisation states which is only around one to two per cent. The decrease was a consequence of the financial crisis 1997 when some of the private hospitals collapse. The promotion of medical tourism by the government and the incentives given to the private hospitals had boosted the private healthcare expenditure after the year of 2000.

In 2009, the private healthcare expenditure in Selangor, Kuala Lumpur and Penang shot up to RM1944 million, RM1372 million and RM1121 million respectively. Penang showed the largest increase compared to the three states from the period of 1997 to 2009 (146 per cent). Kedah, Kelantan and Terengganu recorded RM344 million, RM260 million and RM124 million respectively.

The difference in terms of public health expenditure between higher and lower level of urbanisation states was greater in 2009 compared to 1997 for Selangor and Terengganu state (88 per cent). The data revealed that the private healthcare expenditure is very huge in higher level of urbanisation states compared to the lower level of urbanisation states. The proliferations of private hospitals are dominant in urban areas and it caters for the upper middle class patients.

With increasing affluence in urban areas, the demand for private hospitals increases tremendously. Healthcare provision is a primary welfare function of the state, state involvement in private healthcare can be seen as a conflict of interests. However, since the Malaysian government is a major investor in private hospitals, it is therefore not surprising for state agencies to support the growth of private healthcare and the development of the health tourism.

Table 4.4: Total Private Healthcare Expenditure By State, Malaysia, (Real Value) 1997-2009

Year/ States	1997		1998		1999		2000		2001		2002		2003	
	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years
Johor	414.40	-	396.10	-4.42	430.71	8.74	479.66	11.36	496.00	3.41	556.68	12.23	559.44	0.50
Kedah	180.12	-	170.36	-5.42	201.25	18.13	224.98	11.79	235.03	4.47	259.40	10.37	285.15	9.93
Kelantan	101.81	-	99.12	-2.64	113.67	14.68	175.19	54.12	184.28	5.19	198.21	7.56	213.99	7.96
Kuala Lumpur	754.19	-	740.22	-1.85	812.01	9.70	854.68	5.25	884.37	3.47	982.28	11.07	929.78	-5.34
Melaka	189.49	-	184.96	-2.39	197.02	6.52	218.43	10.87	227.76	4.27	211.21	-7.27	528.39	150.17
Negeri Sembilan	123.45	-	119.56	-3.15	127.47	6.62	139.93	9.78	144.88	3.54	162.10	11.88	161.06	-0.64
Pahang	124.57	-	118.26	-5.07	134.24	13.51	148.25	10.44	151.92	2.48	177.20	16.64	164.28	-7.29
Perak	325.05	-	308.24	-5.17	311.47	1.05	353.67	13.55	359.06	1.52	397.94	10.83	435.80	9.51
Perlis	19.26	-	18.14	-5.82	22.85	25.98	23.87	4.47	25.27	5.84	27.52	8.91	31.63	14.95
Penang	455.97	-	446.69	-2.04	493.46	10.47	552.44	11.95	577.28	4.50	622.50	7.83	686.01	10.20
Selangor	874.22	-	866.19	-0.92	911.71	5.26	1042.62	14.36	1088.43	4.39	1108.85	1.88	1464.58	32.08
Terengganu	68.69	-	66.23	-3.59	84.65	27.83	77.08	-8.95	78.93	2.41	87.27	10.56	98.07	12.38
Putrajaya	4.79	-	4.37	-8.82	3.69	-15.66	5.32	44.34	5.46	2.61	5.54	1.46	5.94	7.21
Labuan	35.97	-	34.47	-4.16	45.12	30.89	43.91	-2.67	44.66	1.71	17.06	-61.79	17.43	2.12
Sabah	231.19	-	225.62	-2.41	206.22	-8.60	213.22	3.39	225.42	5.72	246.15	9.19	261.98	6.43
Sarawak	244.28	-	231.83	-5.10	261.60	12.84	270.14	3.26	278.08	2.94	309.20	11.19	298.53	-3.45

'Table 4.4 Continued'

Year/ States	2004		2005		2006		2007		2008		2009	
	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years	RM Million	%Increase Over Previous Years
Johor	614.36	9.82	692.36	12.70	700.85	1.23	741.88	5.85	733.15	-1.18	713.02	-2.75
Kedah	308.10	8.05	315.81	2.50	336.66	6.60	352.15	4.60	350.73	-0.40	343.74	-1.99
Kelantan	227.54	6.33	241.29	6.04	246.57	2.19	256.11	3.87	260.55	1.73	260.20	-0.13
Kuala Lumpur	1118.48	20.29	1281.20	14.55	1400.96	9.35	1487.21	6.16	1359.46	-8.59	1372.23	0.94
Melaka	415.37	-21.39	266.17	-35.92	293.79	10.37	316.68	7.79	309.56	-2.25	352.32	13.81
Negeri Sembilan	180.45	12.04	198.31	9.90	204.22	2.98	214.23	4.90	217.33	1.45	227.92	4.87
Pahang	200.32	21.94	200.63	0.16	244.22	21.72	258.94	6.03	261.67	1.05	277.52	6.06
Perak	507.65	16.49	514.57	1.36	547.11	6.32	576.08	5.29	571.78	-0.75	656.17	14.76
Perlis	34.34	8.58	28.90	-15.84	37.94	31.26	40.03	5.51	41.16	2.83	50.64	23.04
Penang	776.03	13.12	847.21	9.17	886.81	4.67	924.56	4.26	932.14	0.82	1121.05	20.27
Selangor	1563.02	6.72	1607.82	2.87	1768.56	10.00	1908.85	7.93	1864.40	-2.33	1944.33	4.29
Terengganu	104.71	6.77	94.60	-9.65	111.32	17.67	116.97	5.08	120.26	2.81	124.16	3.24
Putrajaya	7.11	19.75	9.24	29.87	7.96	-13.84	8.93	12.26	8.91	-0.22	8.64	-3.06
Labuan	49.13	181.93	80.62	64.08	81.18	0.70	82.34	1.43	85.60	3.96	80.83	-5.57
Sabah	278.36	6.25	332.52	19.46	310.51	-6.62	360.51	16.10	342.26	-5.06	326.03	-4.74
Sarawak	345.36	15.69	345.49	0.04	426.64	23.49	487.52	14.27	423.40	-13.15	409.64	-3.25

Source: Malaysia National Health Accounts

*Constant value deflated using GDP deflator, World Bank (2012)

The growth of private healthcare has not been without problems for the government as there have been a frequent complaints that the private hospitals are charging excessively high fees. In addition, Malaysia's charitable hospitals are reducing their philanthropic mission since they have to compete in a commercial market, which leaves little margin for cross-subsidizing the poor by charging higher fees for those who are better off (Barraclough, 1999). The growth of the private sector has obviously fuelled the private share of the healthcare expenditure. Especially the large corporations have been aggressively pushing profit margins higher and higher. Evidence shows that the private healthcare sector is expanding at the expense of a rather than as a complement to the public healthcare sector.

It was claimed that the healthcare cost is increasing greatly because of the government policy encouraging privatisation of healthcare. The Malaysian government through its economic policies encouraged the growth of private enterprises and corporations in all sectors of the economy including health. The initiation of the Privatisation Master Plan (PMP) in 1991 after it was drafted in 1988 formally included healthcare for private ownership. The Mid-Term Review of the sixth Malaysian Plan published in 1993 indicated that:

While the government will remain a provider of basic health services, the role of the Ministry of Health will gradually shift towards more policy-making 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. (Malaysia, 1993: 244).

The formalisation of privatisation has sped up the proliferation of private hospitals from the 1990s (Rasiah, et al. 2011). The entry of different national and transnational capital

into the private healthcare system has further developed the service capacities of private healthcare. They have greatly influenced the direction and expansion of these private services, while at the same time inflating the cost of private healthcare services by offering more sophisticated facilities and newer technology-driven expert care.

The government spent RM300 million in 1995 to procure drugs in public hospitals and currently the government spends RM800 million annually on drugs to subsidize almost 97 per cent of healthcare cost (Babar, 2006) but still faces challenges of access. The government drug procurement and distribution centre was privatised in 1994 to reduce the administrative and financial burden of the government as well as to improve the efficiency of the health sector. However, the pharmaceutical market, the free market strategy alone may not be able to control the prices as reflected in the case of Malaysia. In Malaysia, drug prices have reportedly escalated faster than the drug prices in the developed nation. According to Babar et al. (2007), a WHO expert commented that community drug prices are tantalizingly high in international terms. This indicates that that are some other factors, not only the free or deregulated prices which influence the pricing.

In the same year of privatisation of drug procurement and distribution centre, a 15 year contract for five support services (cleansing, linen and laundry, clinical waste management, biomedical engineering maintenance and facility engineering maintenance) for all hospitals under the Ministry of Health was awarded to three private companies. According to Chan (2003) privatisation of hospital support services in Malaysia in 1996 has tripled the costs with no commensurate expansion of services or improvement in quality.

This contract was expected to generate an annual revenue of RM600 million (Chee, 2008). As a consequence Pantai Holdings has become one of the largest conglomerates in the country in 1990s, which not only owns seven premier hospitals in Malaysia but also holds three lucrative government contracts through its subsidiary companies. Khazanah Nasional has significant ownership in India's Apollo Hospital chain and also acquired majority control of the International Medical University (Rasiah, et al. 2011).
In addition, Sistem Hospital Awsan Taraf (a private consultancy consortium comprising Kejuruteraan Kota Aman, Paramount Merge and QSTD-SIHAT) was appointed to support Ministry of Health engineers charged with the task of supervising the performance of the three concession holders. Another monitoring function privatised by the government was concerned with the medical inspection of foreign workers, which the government seeks to screen for diseases (Barraclough, 2000).

National Household Health Expenditure Survey 1996 showed that the charges per day in private hospitals were 30 times higher than that in public hospitals (Mohd. Ismail, et al. 2003). However, in 1997 Asian financial crisis bankrupted private companies those were not able to service their foreign currency debts. Large companies under the control of rentier elites were also on the same boat as other small companies. For example, UEM, the parent company of Remedi Pharmaceuticals (renamed Pharmaniaga) has since been taken over by Khazanah Nasional Holdings, the government's investment agency (Chee, 2008).

Backed by strong government support and growing local and international demand, private healthcare has firmly established itself as a pillar in the strategic plans of the Malaysian government. In the efforts to stimulate development of the private healthcare system in Malaysia and to reduce dependence on public hospitals, the government has

offered incentives and grants to further enhance private healthcare services in the country (Rasiah et al., 2009).

The tax incentives offered include tax exemption on any capital expenditure involving the cost of building new hospitals or acquiring any building for hospital premises. In terms of human development, private healthcare providers are eligible for tax exemptions on expenditure incurred in the training of medical personnel (Malaysian Health, 2009).

The largest private healthcare provider in Malaysia is KPJ Healthcare (KPJ, 2010). KPJ Healthcare is the healthcare division of Johor Corporation. Listed on the Malaysian Stock Exchange, KPJ has a network of 19 hospitals in Malaysia and 6 overseas, and a nursing college. Meanwhile, the Pantai Group of Hospitals, fully supported by its shareholders Khazanah Nasional, the investment arm of the Government of Malaysia, and Parkway Holdings, is another large healthcare group in Malaysia.

Sime Darby, one of Malaysia's oldest and largest conglomerates with a global presence in more than 20 countries, is also active in healthcare provision through the Sime Darby Healthcare Group. In addition the flagship hospital, Sime Darby Medical Centre Subang Jaya, the group's portfolio features the Sime Darby Specialist Centre Megah and a nursing college. With another hospital in construction and ambitious international expansion plans, healthcare remains of strategic relevance for Sime Darby.

PETRONAS, Malaysia's national petroleum company is the healthcare industry's newest corporate player. After a landmark investment of USD 150 million, the purpose built Prince Court Medical Centre in the heart of Kuala Lumpur, is poised to set new

standards in healthcare at regional level (Malaysian Health, 2009). Interestingly, all the above major private healthcare providers are actually controlled by the government.

The assertively expanding private sector in healthcare is not supported by a well-placed health financing system, which partly explains the ballooning of out-of pocket payments to finance the use of private medical care. Malaysian private household out-of pocket (OOP) spending forms the largest component of private healthcare expenditure. The OOP spending can result in catastrophic financial burden on households leading to poverty, and if large enough, eventually lead to a poor economic status of a nation. There is ample evidence that payments for healthcare though out-of-pocket can easily become catastrophic part of health expenditure especially when the public healthcare system is weak or unattractive, and poor people have to make use of private services.

Household OOP expenditure remains the largest single source of funding throughout the period of 1997 to 2009 (see Figure 4.4). Household OOP contributes between 32 to36 per cent of the total healthcare expenditure, or average of 76 per cent of private sector expenditure. This figure shows that the main revenue for private healthcare expenditure is through the out-of-pocket and over 70 % of private payments in Malaysia are paid out of pocket, which is nearly double the percentage reported in high income countries.

The second National Health and Morbidity Survey Report (Public Health, 1999) stated that the country representative population survey found 64 per cent financed their healthcare from out-of-pocket. The data clearly indicated that the households, through direct out-of pocket expenditures at the point of service consumption, make a significant contribution to the private healthcare expenditure in Malaysia. Higher out-of-pocket payment will increase healthcare cost. Higher cost in private healthcare will give impact

to the patients who cannot afford it and this situation may cause inequitable financing and can lead to impoverishment due to catastrophic health expenditure.

In addition, there is growing revenue from foreign patients that also benefitting Malaysian private hospitals. Eight private hospitals reported an increase of 197% in revenue from foreign patients between 1998 and 2001. From 2000 to 2001, ten private hospitals reported an increase in the number of foreign patients: the total rising from 56,133 in 2000 to 75, 210 in 2001 (an increase of 34 %) (Chee & Barraclough, 2007:29).

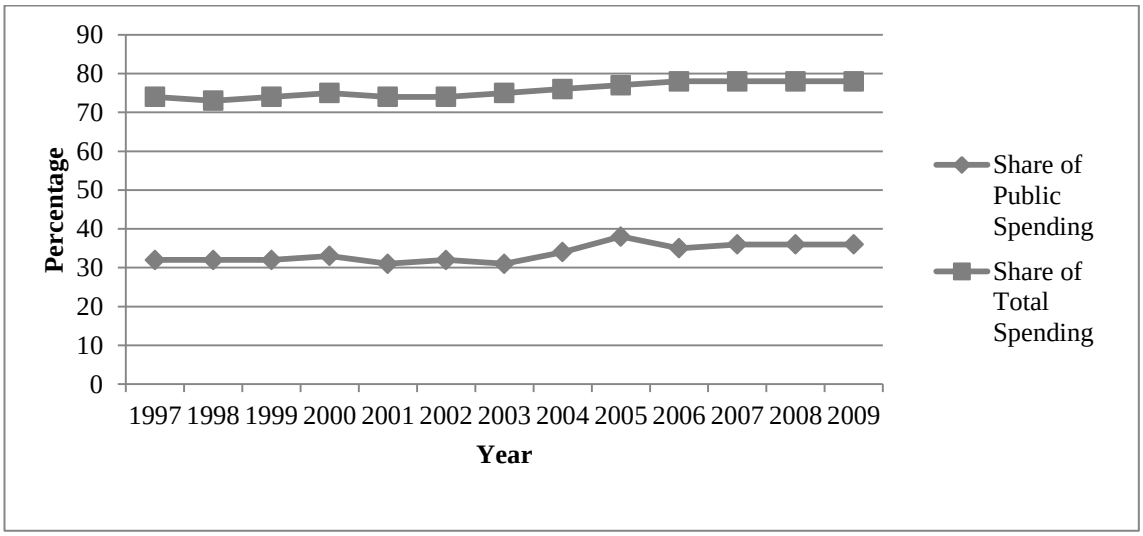

Figure 4.4: OOP Share of Total and Private Sector Expenditure as Per Cent GDP, Malaysia, 1997-2009.
(Sources: Malaysia National Health Accounts).

Figure 4.5 shows the out-of pocket expenditure and out-of-pocket as per cent of GDP for Malaysia from 1997 to 2009. The OOP expenditure from 1997 to 2009 has increased from RM3, 044 to 8,753 which is an increase from 0.91% GDP to 1.76% GDP. The OOP percentage of GDP shows the highest percentage in the year of 2003 and it decline sharply in the year 2004. However, it starts to increase again after 2004. Clearly, the high pace of expenditure shows a rapid shift towards private healthcare.

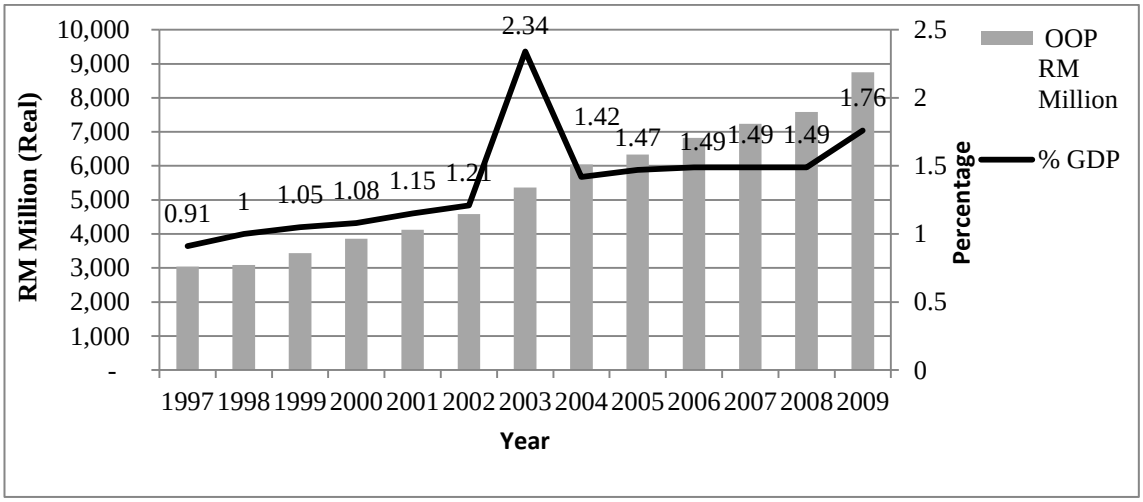

Figure 4.5: OOP Expenditure (Constant Value) and OOP as Per cent GDP, Malaysia, 1997-2009.

(Sources: Malaysia National Health Accounts).

*Constant value deflated using GDP deflator, World Bank (2012)

The tremendous increase of out-of-pocket expenditure can be observed in the year 2000, 2002, 2003 and 2004 when it is compared with the percentage increase of previous years; 12 per cent, 11 per cent, 17 per cent and 12 per cent respectively. Government policy introducing health tourism after the Asian Financial Crisis has increased the out-of-pocket expenditure hugely in 2000 compared to the year 1998 and 1999. Out-of-pocket expenditure percentage of GDP also increases greatly after the year of 2000.

The government subsidies for private sector growth via tax incentives to build hospitals has encouraged more private hospitals in Malaysia and this leads to the tremendous increase in the out-of-pocket expenditure after the year of 2000. Introduction of health tourism and different charges for foreign and local patients will drive up the cost of services for local consumers over time. This will give impact to the poor patients. Even though they can get services from the public hospitals with the low payment up-to-RM1, the waiting time and sometimes when the appointment in public hospitals drags

to a year, it drives the poor households to seek treatment in private hospitals. Some are in debt since they have to pay higher fees in private hospitals.

According to Ramesh (2007) 93% of users of government health clinics and 66% of users of public hospitals paid nothing for the service. For hospitalisation, 91% of users of public facilities paid less than RM100 and another 5% paid RM101-200. In contrast, in private hospitals only 14% paid less than RM100, while 53% paid over RM1, 000 (Ramesh, 2007:76).

Accordingly per capita of OOP expenditure and per capita of total healthcare expenditure are also showing an increasing pattern (see Figure 4.6). Total healthcare per capita expenditure increased four fold and OOP per capita expenditure increased around 102 per cent from the year 1997 to 2009. It is noticed that OOP per capita increased 12 per cent in the year of 2001 compared to the previous year and it increased 19 per cent in the year of 2003 compared to year 2002. The pattern of OOP per capita disproportionately high and it is very clearly shown in the Figure 4.6. This is the main reason for many people in Malaysia complaining about high healthcare cost, although it is relatively true only in the private sector when compared with that in the hugely subsidised public sector.

The category of OOP that raises the most concern is the amount spent in the private hospitals for specialist inpatient and outpatient care compared to the public hospitals (see Figure 4.7). Out-of-pocket expenditure for private hospitals was RM1, 119 million in the year of 1997 and increased up to RM3, 417 million in the year of 2009. The increase was up to 205 per cent within 13 years compared to the public hospitals where the increase was only about 38 per cent. The largest increase of private hospital out-of-

pocket expenditure can be observed in the year of 2003, around 22 per cent increase compared to the previous year.

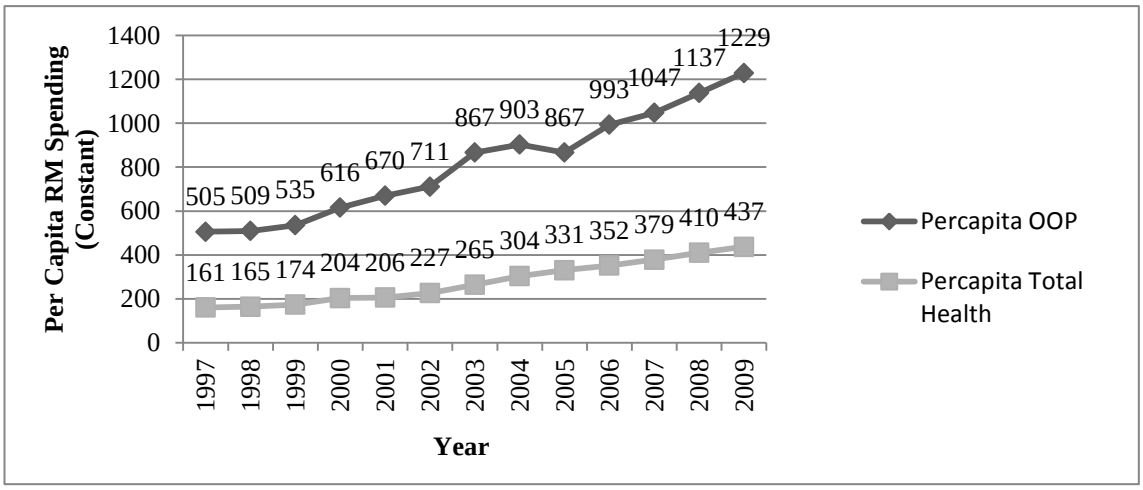

Figure 4.6: Per Capita Total Health and Per Capita OOP Expenditure (Constant Value), 1997-2009, Malaysia.

(Sources: Malaysia National Health Accounts).

*Constant value deflated using GDP deflator, World Bank (2012)

The private hospitals generally are visited by the richer class who can afford it. However, an inadequacy in public hospitals such as the lack of treatment facilities and doctors, overcrowding and long waiting lists (Rasiah, Wan Yusof & Nwagbara, 2010) forces the poor to seek treatment in private hospitals (www.freemalaysiatoday.com). Under the stress and anxiety of disease some people have no choice but to pay the fees requested by private health providers even when the cost is more than what they can afford. Thus future welfare is put at risk by incurring debts, selling off productive assets, or sacrificing investment in future productivity.

The threat that out-of-pocket (OOP) payments pose to household living standards is an important issue in most of the developing countries. The extent to which such concern is justified depends upon the unpredictability of OOP payments, and the distribution of the

income. Figure 4.8 shows the out-of-pocket expenditure based on household income from the National Health and Morbidity III Survey (2006).

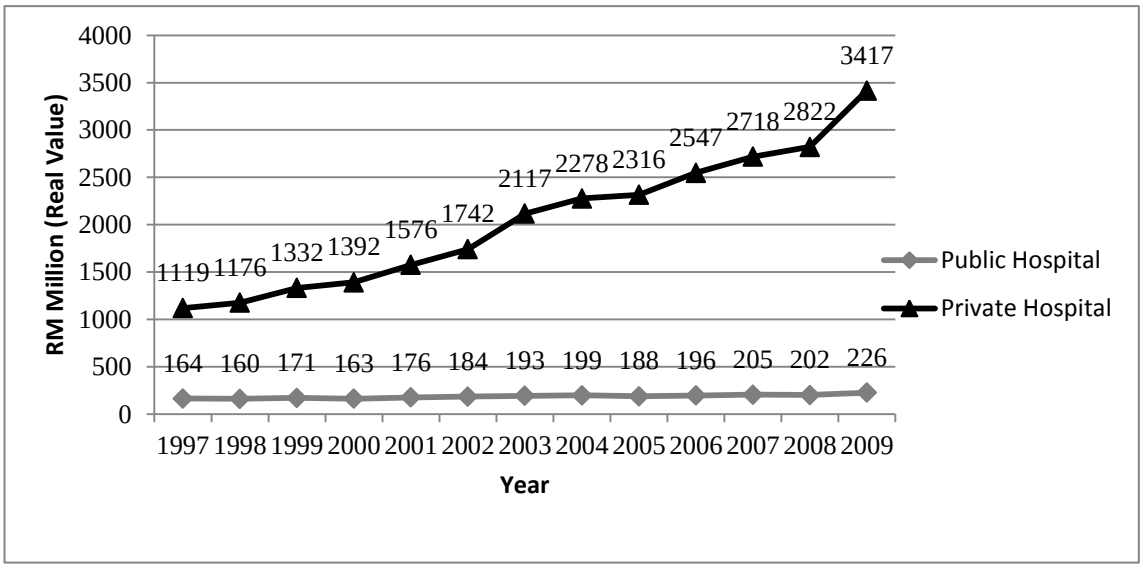

Figure 4.7: OOP Expenditure at Public and Private Hospitals (Real Value), 1997-2009, Malaysia.

(Sources: Malaysia National Health Accounts).

*Constant value deflated using GDP deflator, World Bank (2012)

The result shows that as the household income increases the mean household OOP health expenditure also increases. For household income more than RM3000, their mean household OOP health expenditure is more than RM1,000. In the First (1986) and Second (1996) National Health and Morbidity Survey, the result for OOP health expenditure for household based on income category shows the similar trend with the Third National Health and Morbidity Survey. Lower household income group has higher propositions of free care in public hospitals and they only pay around RM1for per outpatient visit. The average amount paid per day for those who are admitted in the public hospital was less than RM100 and for private hospitals was more than RM1, 000.

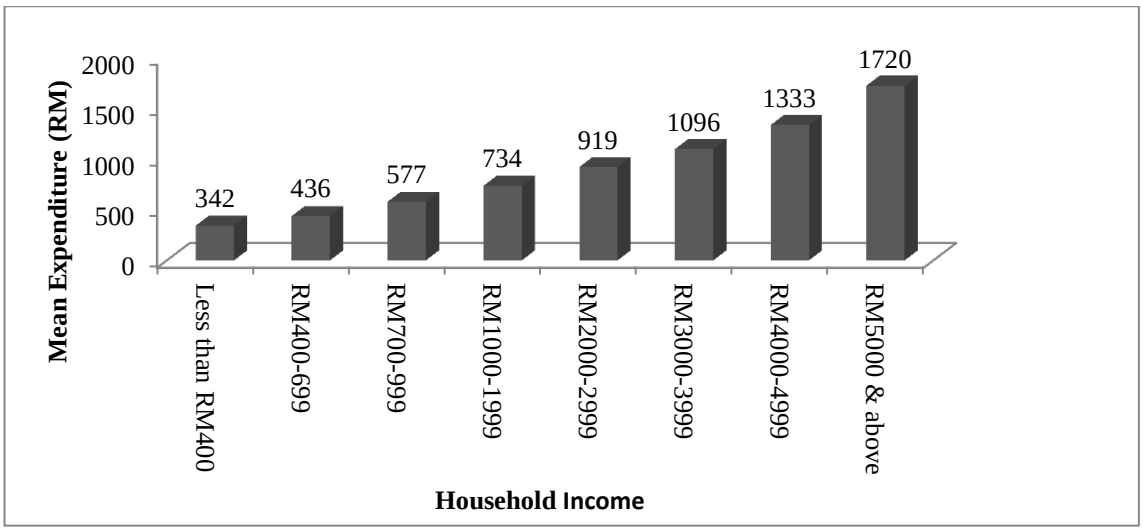

Figure 4.8: Mean Household OOP Health Expenditure by Household Income Category, 2006, Malaysia.
(Sources: The Third National Health and Morbidity Survey).

The government claims that only those who have higher income are going to the private hospitals and the poor are going to the public hospitals where the public healthcare has been continuously subsidized by the government, hence the lower income groups are not burdened by the high healthcare cost. However treatment and medical prescriptions in government hospitals increasingly require payments through insurance or private treatment schemes (Rasiah Nik Rosnah & Makmor, 2011). Although subsidies were stated for Malaysians who could not afford private insurance or whose employers are unable to cover the costs, preferential treatment given to private payees often left disadvantaged Malaysians waiting in long queues. This situation will jeopardise the health of poorer patients.

Having said that, the waiting time in public hospitals are very long and some of the patients can only get an appointment with the doctor after almost a year, driving the poor patient, especially those who are having serious illness to seek doctors in private hospitals. According to Sau Seng Lum, a leading non-profit health system in Malaysia, the number of individuals suffering from kidney, stroke and diabetes illness is

increasing every year in Malaysia and these individuals are affected with these diseases at a much younger age. An average of 3000 new kidney failure patients every year but only 10% of the non-government servants are able to seek treatment at government hospitals, whilst the majority of patients have to seek treatment at private hospitals (www.sausenglum.com.my).

Another issue that arise is the shrinking of middle income household (Yap, 2011). This issue is seldom discussed latently in healthcare. Average household income of between RM1500 to RM5000 are called as middle income groups in Malaysia and the increase of OOP among this group will also give a negative impact towards the society and economy in the long term. Higher expenses on healthcare expenditure will cause the middle income household face financial burden. The middle income household will shrink if the inflation of healthcare cost increases tremendously over the years.

4.3.3 Public VS Private Health Expenditure

The trend in Malaysian private hospitals has changed over time. Malaysia has a significant number of private hospitals, with an estimated 220 private hospitals established in 2011. These private hospitals were mainly operated by major groups. The government's share of overall healthcare financing has, since 1982, began to fall as state development corporations and other government-linked conglomerates started acquiring private hospitals in the country.

Based from the Figure 4.9, the private share in the total healthcare expenditure is increasing greatly over the years. The average contribution of public healthcare expenditure was 56 per cent in 1997 and it declined to 54 per cent in 2009. Meanwhile

private healthcare expenditure contribution was 43 per cent in 1997 and it increased to 45 per cent in 2009. In the year 2005, the shares of public and private healthcare expenditure were almost equal due to the slight drop in the public spending over total health expenditure. However, generally the public healthcare sector is still the largest source of healthcare expenditure in Malaysia.

The expansion of the private hospital sector has very much been the results of government's privatisation policy, which refrained from placing any restrictions on private sector growth. As the transnational market in the healthcare grows, the private share of healthcare resources, and their ability to influence and shape the system increases, particularly if the country moves in the direction of allowing the market to control the healthcare sector. The increase in private out-of-pocket spending constitutes the bulk of the high healthcare expenditure contributed by private providers meanwhile the public healthcare sector is still heavily subsidised by the government.

Over the span of 30 years, the healthcare system in Malaysia has been transformed from one dominated by the public sector in both the provision and the financing, to one in which the private sector has an increasing presence in hospital and specialist care, as well as, in financing.

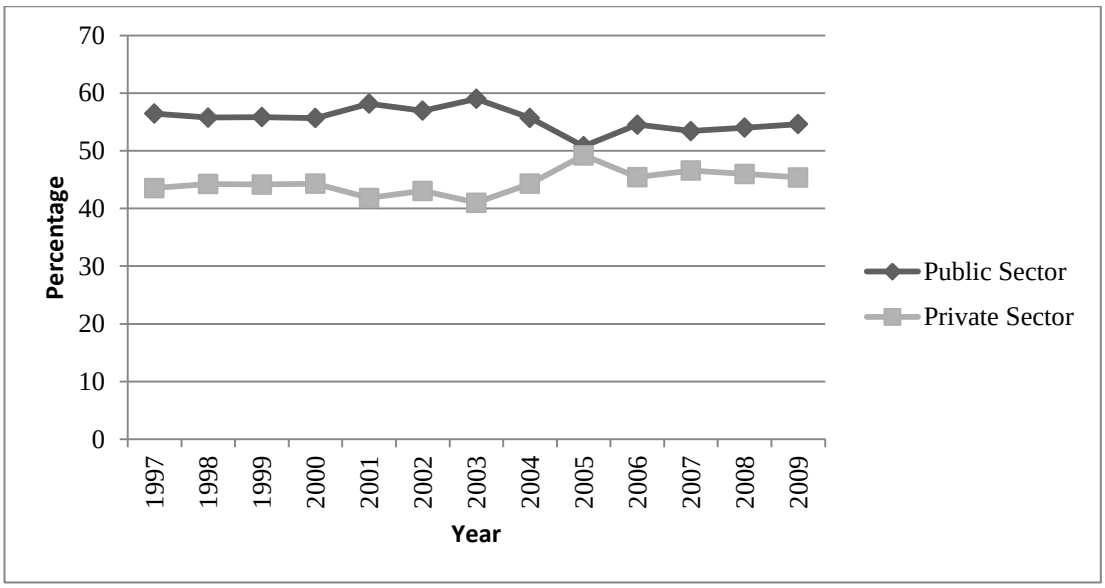

Figure 4.9: Health Expenditure by Source of Financing, Malaysia 1997-2009. (Sources: Ministry of Health, various years).

4.4 Malaysia's Public Healthcare Expenditure Among Upper Middle Income Countries

International comparisons have underpinned a huge area of research into the relationship between health expenditure and GDP. GDP explains most of the variance in health expenditure between countries (Hopkins, 2010). The public sector is the dominant financier of health in most of the middle income countries, but in the last two decades the share of private finance in total healthcare expenditure has increased in most of these countries. Private finance now accounts for at least a quarter of all healthcare expenditure in many of these countries.

Against the backdrop of concerns with cost containment, there has been a trend for the share of government expenditure to fall in recent years. Table 4.5 provides information on the public healthcare expenditure as a percentage of GDP in upper middle income countries. The comparison is made against the countries at similar levels of development.

Public health expenditure as a percentage of GDP has increased in most of the upper middle income countries. However, the average increase from 1995 to 2009 was quite low. Table 4.5 also indicates a wide variation in the public health care spending by various countries from 1.7% of GDP in Gabon to 4.9% in Poland, and 8.8% in Palau in the year of 2009.

It is noticed that the countries that showed an increasing trend, the Gross National Income (GNI) per capita was around USD3,500 to USD4,700, while the countries that showed a downward trend, the GNI per capita was around USD7,000 to USD8,500, except for Uruguay (USD4,000). The evidence shows that an upper income country enjoying higher per capita incomes has lower public healthcare expenditures as a share of GDP, while countries with lower per capita income have higher public healthcare expenditure in GDP.

Botswana has experienced rapid growth in public healthcare expenditure as a percentage of GDP over the last 15 years from 2.19% in 1995 to 8.20% in 2009. Botswana, as a middle income country, having been one of the fastest growing economies in Africa during the last decade (Dowrick & DeLong, 2001), due to the introduction of extensive HIV prevention programmes.

Botswana's HIV infection rate is the second highest in the world, with 248 cases per 1,000 adults, compared with a global average of 8/1000 cases and an African average of 47/1000. This figure appears to have stabilised from the mid-2000s as sex education and prevention measures have begun to take effect (World Bank, 2012).

Turkey ranks second after Botswana with a similar percentage in the share of public health expenditure in GDP in 1995. However, over the years, the percentage share has increased considerably. According to Sulku and Caner (2011), after 1998, some major events and policy changes have affected the income health expenditure relationship in Turkey.

In 2003, the government launched the Health Transformation Program, impacting the public health expenditure in Turkey (World Bank, 2008). Most of the upper middle income countries' governments spend less than 5% of GDP on public healthcare when the internationally recommended norm is around 5 to 6% of GDP (see Table 4.5). There are only seven countries among the upper middle income that achieved more than 5% in 2009, namely, Argentina (6.3%), Costa Rica (7.1%), Panama (5.9%), Slovak Republic (5.7%), Estonia (5.3%), Hungary (5.1%), Croatia (6.6%) and Palau (8.8%).

Compared to the other upper middle income countries, Malaysia showed a modest increase in the share of public healthcare expenditure in GDP until 2002, reaching its peak of 2.6% in 2003. Malaysia only spent around 2.2% of its GDP on healthcare. Clearly, it appears that the concerns over escalating health care costs are to a large extent unfounded.

Despite the relatively low healthcare expenditure share in GDP borne by the government, the infant mortality rate for Malaysia in 2001 was only 5.4% compared to other countries that have similar public health spending such as Gabon 50% followed by Venezuela 16 %, Libya and Mauritius 13%. Indeed, Malaysia did better than the United States and the Organisation for Economic Corporation and Development where their infant mortality rate in 2010 were 6.5% and 7.8% respectively (see World Bank, 2011).

Based on the discussions above, it may seem that Malaysia is trying to reduce the public healthcare expenditure primarily to promote the private sector rather to simply contain escalating costs to the government. The evidence also shows that Malaysia's privatisation policy is transforming public money to private owner. Most of the upper middle income countries with the same range of income per capita as Malaysia showed a higher share of public spending on GDP.

Table 4.5: Public Healthcare Expenditure in GDP, Upper Middle Income Countries, 1995-2009 (%).

Country	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Gabon	1.13	1.19	1.01	1.42	1.07	1.05	1.20	1.16	1.46	1.37	1.10	1.19	1.26	1.15	1.70
Malaysia	1.43	1.58	1.47	1.65	1.70	1.67	1.95	1.93	2.62	2.24	1.85	1.92	2.00	1.90	2.15
Libya	1.73	1.60	1.46	2.06	1.82	1.88	2.56	3.14	2.33	1.97	1.56	1.44	1.84	2.13	2.57
Turkey	1.76	2.01	2.24	2.59	2.91	3.11	3.51	3.79	3.84	3.83	3.70	3.97	4.10	4.44	5.07
Venezuela	1.80	1.48	1.39	1.47	2.09	2.36	2.42	2.22	2.23	2.31	2.35	2.39	2.70	2.43	2.41
Mauritius	1.98	1.91	1.91	1.95	1.88	1.97	2.00	2.19	2.18	2.35	2.16	1.87	2.04	1.92	2.10
Mexico	2.17	1.94	2.15	2.25	2.4	2.36	2.44	2.46	2.55	2.70	2.64	2.57	2.65	2.76	3.12
Botswana	2.19	2.23	2.50	2.24	2.22	2.95	3.73	4.31	4.08	6.38	5.69	4.91	6.01	5.93	8.20
Trinidad& Tobago	2.23	1.98	1.93	1.45	1.89	1.67	1.96	2.43	2.42	2.37	2.99	2.67	2.45	2.28	2.72
Chile	2.57	2.74	2.79	3.08	3.28	3.45	3.61	3.67	2.89	2.82	2.77	2.79	2.98	3.30	3.83
Belize	2.63	2.05	2.26	2.50	2.32	2.16	2.12	2.09	2.13	1.89	2.11	2.24	3.13	3.13	3.59
South Africa	2.94	2.86	3.20	3.38	3.56	3.43	3.47	3.37	3.50	3.26	3.38	3.41	3.45	3.27	3.78
Grenada	3.01	3.02	3.16	3.15	3.71	4.17	5.56	4.36	3.76	3.44	3.65	3.96	3.59	3.27	3.78
Lebanon	3.02	3.17	3.46	3.15	3.12	3.25	3.56	3.31	3.34	3.57	3.67	3.96	3.88	4.10	4.00

‘Table 4.5 continued

Country	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
St. Lucia	3.04	3.54	3.01	3.09	3.09	3.17	3.49	3.44	3.21	3.27	3.16	3.54	3.44	4.13	5.36
St.Kittts and Nevis	3.21	3.17	2.96	3.03	3.04	3.30	3.25	3.69	3.68	3.52	3.38	3.57	3.54	3.38	3.57
Equatorial Guinea	3.31	2.32	1.89	2.57	1.27	0.95	1.22	2.94	1.60	1.22	1.00	1.20	1.33	1.50	3.41
Antigua and Barbuda	3.60	3.49	3.32	3.29	3.24	3.29	3.75	3.76	3.29	2.96	3.07	3.61	3.24	3.20	3.79
St. Vincent and The Grenadines	3.78	3.76	3.91	3.38	3.46	3.59	3.63	4.03	3.99	3.75	3.66	3.79	3.27	3.24	3.20
Latvia	3.83	3.52	3.47	3.73	3.75	3.24	3.12	3.25	3.24	3.65	3.44	3.80	3.62	3.94	3.94
Russian Federation	3.94	3.95	5.00	4.29	3.57	3.23	3.31	3.51	3.28	3.07	3.21	3.34	3.45	3.10	3.51
Lithuania	3.99	3.93	4.16	4.62	4.65	4.53	4.57	4.82	4.95	3.68	3.79	3.96	4.15	4.51	4.51
Poland	3.99	4.31	4.03	3.86	4.08	3.87	4.21	4.51	4.14	4.01	4.02	4.05	4.25	4.73	4.86
Dominica	4.16	4.22	4.37	4.16	4.15	4.10	4.17	4.36	4.23	3.91	3.74	3.90	3.83	3.76	4.08
Seychelles	4.42	4.67	5.04	4.40	4.45	3.98	3.95	3.82	4.28	4.73	3.89	3.77	3.20	3.12	3.10
Argentina	4.97	4.63	4.55	4.62	5.15	4.96	5.10	4.45	4.34	4.35	4.58	4.71	5.01	5.28	6.33

‘Table 4.5 continued’

Country	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Costa Rica	4.98	5.07	4.64	4.76	4.72	5.01	5.37	5.71	5.72	5.59	5.31	5.38	5.64	6.30	7.06
Panama	5.25	4.63	4.88	4.73	4.54	5.28	5.18	5.54	5.05	5.69	5.21	4.72	4.32	5.01	5.91
Slovak Republic	5.37	5.71	5.30	5.18	5.16	5.58	5.87	6.14	5.63	5.32	5.08	4.91	5.10	5.37	5.72
Estonia	5.67	5.81	5.52	4.80	4.75	4.10	3.82	3.74	3.85	3.90	3.85	3.68	3.97	4.75	5.28
Hungary	6.13	5.69	5.47	5.28	5.21	4.97	4.93	5.30	5.82	5.54	5.80	5.65	5.05	4.98	5.08
Uruguay	6.85	5.72	3.52	3.73	6.35	6.14	6.04	5.84	4.92	4.18	4.14	4.35	4.25	4.91	4.70
Croatia	6.94	7.31	5.80	6.74	6.41	6.73	6.07	5.03	5.37	5.43	6.06	6.15	6.64	6.64	6.64
Palau	9.56	10.7	9.72	7.80	8.40	8.50	8.34	8.42	8.64	9.38	8.35	8.46	8.46	8.46	8.83

(Sources: World Bank, 2009)

4.5 Summary

The modest share of public health expenditure in GDP reflects that the government has been quite restrained in its spending on this essential social service, a fact which is marked by the repeated claims of onerous financial burden and unsustainable subsidies. Rather than over spending, the evidence shows otherwise as it has remained remarkably low compared to most other upper middle income countries.

The rapidly growing private sector has benefited from the government's privatisation policy, which has included the provision of incentives and grants to promote medical tourism. In fact, what emerged as a channel to shield private healthcare providers during the Asian Financial crisis of 1997-1998 when domestic demand crashed, medical tourism has been promoted aggressively since 2000.

The Malaysian government continues to proclaim corporatisation and privatisation of the public sector as the panacea for these interlinked crises, and repeatedly asserts that the financial and administrative burden on government is excessive (Chan, 2007). In truth, public sector expenditure in healthcare is very modest. While the public healthcare expenditure is still large, a significant provision of government subsidy was actually transferred to private owners through concessions given to private medical drugs, equipment and service providers.

The swift growth of private health sector has transformed the healthcare system in Malaysia from one dominated by the public sector in both provision and financing, to one in which the private sector has an increasing presence in hospital and specialist care, as well as financing. When compared to other upper middle income countries, Malaysia is considered an under spending country as its public healthcare expenditure in GDP is very low. Yet, taking into account Malaysia's major health indicators such as infant mortality rate and life expectancy at birth, the country has done really well.

In short, it is clear that Malaysia's healthcare sector had faced a significant shift in the expenditure structure since in the 1980s with private providers growing rapidly to account for worst of the expenditure since 2005. The government through its privatisation policy has been the main architect of this transition. Contrary to claims that spiralling healthcare costs has been the cause of this policy-driven structural shift, the evidence shows that the move is largely targeted at benefitting private owners as incentives and grants have also been provided to preferred owners. Also a significant share of public healthcare expenditure has actually been appropriated by preferred private owners through concessions.