

CHAPTER VII CONCLUSIONS

7.1 Introduction

Providing an effective healthcare system has always been one of the challenges to all the countries in the world. Healthcare issues have become serious components of development policy especially since 1980s because healthcare resources like all other economic resources are finite in the short run. While the government is determined to improve access to healthcare for the entire population of Malaysia, financial problems and manpower constraints appear to hamper the smoother implementation of a more comprehensive and cohesive system.

Healthcare issues continue to be a key policy challenge for policy makers in emerging economies. Given that it is a utility that must reach everyone, the public healthcare serves significantly a greater number of patients compared to the private healthcare sector. The private share of healthcare in Malaysia has nearly overtaken the public healthcare sector in terms of expenditure borne.

The real measure of a healthcare system is the share of patients treated and the quality of service rendered. Although the government had the noble objective of providing Malaysians better healthcare, its financially lucrative platform has attracted away most of the trained doctors to the private sector. As a consequence, the quality of diagnosis and treatment in public hospitals is viewed by many to have declined. It is because of such concerns that this study is aimed at shedding some light to the main issues facing healthcare services in Malaysia.

7.2 Main Findings

The government's effort to cap public expenditure since the 1980s has resulted inter alia, in a relative fall in public healthcare expenditure in the GDP. The government reported such a direction as a consequence of escalating financial burden from spiralling subsidies going to healthcare services. Hence, government spending had remained remarkably low compared to other middle income countries.

The private healthcare sector had taken advantage of the government's privatisation policy, including the provision of generous incentives and grants to promote medical tourism. Medical tourism was one of the instruments used by the government to protect the private healthcare providers during the Asian Financial Crisis 1997-1998 when domestic demand for private healthcare took a dive.

The Malaysian government had repeatedly stated that corporatisation and privatisation of the public healthcare was targeted as the solution for the government's financial and administrative burden. However, as shown in chapter three, in reality the reduction in the relative share of public healthcare expenditure in total healthcare expenditure raises services concerns. What is more alarming is that government subsidies were actually transferred to the private owners through concessions given to private medical drugs, equipment and service providers when the public healthcare expenditure was still large.

The rapid growth of private healthcare operators had changed the landscape of the healthcare system in Malaysia from one dominated by public sector to one in which the private sector had an increasing presence in hospitals and specialist care, as well as, financing. Contrary to government statements, public healthcare expenditure in GDP

has remained very low for Malaysia and it can be said that it is an under spending country when compared to other upper middle income countries.

Since the 1980s Malaysia's healthcare has experienced a tremendous shift in the expenditure structure with private healthcare providers growing rapidly to account for a significant share since 2005. Contrary to the claims that the privatisation policy is targeted at ameliorating the problem of burgeoning costs of the public healthcare sector, the study shows that the move was largely targeted at benefitting private owners as incentives and grants were given to preferred owners. Moreover, preferred GLCs and private owners had taken a significant share of public healthcare expenditure through concessions (Rasiah, et al., 2011).

In order to analyse the consequences of privatisation, we examined in chapter four the beds, doctors and nurses ratios between public and private hospitals. As discussed in chapter four, the evidence shows that privatisation has led to growingly shortfalls in beds, doctors (including trained doctors/specialists) and nurses in public hospitals except during the Asian financial crisis in 1997-1998. The government resolved the problem of this shortfall by promoting medical tourism which many believe was aimed at helping the private hospitals rather than the public patients.

The government's policy of increasing the number of hospitals and medical and nursing colleges has helped to lower the population-bed, population-doctor and population nurse ratios especially in 2009. However, the quality of services rendered by public hospitals will take a long time to reach acceptable standards similar to those of the experienced doctors that had moved to private sectors. Hence, it is too early to deduce if such a policy has been successful.

As argued in chapter five, privatisation had also driven greater concentration of hospitals, beds and doctors which was also a major challenge in the higher level of urbanisation states and in the health policy. The number of doctors and beds were skewed towards higher level of urbanisation states such as Selangor, Penang, Johor and Federal Territory of Kuala Lumpur compared to the lower level of urbanisation states such as Sabah, Sarawak and Pahang. The government's effort in increasing the number of medical colleges to increase the supply of doctors, nevertheless, helped to lower the population-doctor ratios. The ratio of beds to doctors and population to doctors shows a converging trend.

In terms of quality of treatment, there is little evidence to show it has improved in public hospitals. The tremendous growth of private hospitals in the urban states has continued to aggravate the skew of doctors and beds to higher level of urbanisation states. The evidence clearly shows that privatisation has driven the unequal distribution of hospitals, beds and doctors, with high concentration in the higher level of urbanisation states.

In light of the negative consequences of healthcare privatisation experienced in the country, the government should take important measures to handle the shift carefully to maintain the quality of care in public hospitals at all times.

7.3 Implications for Theory and Policy

The evidence in the thesis shows that healthcare should be treated as public utility since it is not an ordinary commodity that works efficiently in a free market. Arrow (1963) had argued that healthcare market differs from the competitive model. He explains that

healthcare does not fit the free market ideal due to the uncertainty. Baumol (1988) had argued that healthcare cost will always increase at a faster rate than the overall economy because like many services industries healthcare is labour intensive. Increase of the healthcare cost can cause a society to suffer. In a free market, poor people won't get any and the middle class people will not get very much.

The results in chapter three indicate that majority of private healthcare providers over public healthcare providers are currently widespread and the expenditures of healthcare are increasing tremendously. Leaving healthcare to the market can cause market failure and increasing of cost makes the poor patients caught in a dilemma. This result contradicts with the neo-classical economists' argument that the market will be the most efficient allocator of economic goods and services for healthcare (c.f. Buchanan, 1975). They claim that control of the economy by market forces with governments providing fellowship complementarities is the best way to ensure the most efficient service delivery and optimal responsiveness of production structures (Preker & Harding, 2000). However, social goods like healthcare have to be out of the domination of privatised goods because when healthcare is privatised it tends to create difficulty for the poor to access due to high treatment costs and the poor will not be affordable. Healthcare is demand inelastic; it is a necessity that no matter the cost, people are in need of the services. The healthcare delivery in Malaysia is highly lucrative since the rise and proliferation of private for profit healthcare providers.

Healthcare does not fit efficiently in a free market because one cannot dispense with equilibrium clearing prices as it must reach even those below such prices. Since healthcare is a public utility rather than private good, it must reach everyone. Hence, economic theory must address the need to prevent the mushrooming of a system where

there emerges a dual system in which the financially lucrative private sector attracts the best doctors and specialists and nurses, while the subsidised public sector is left with the worst doctors, specialists and nurses. According to human capital theory, workers have the highest possibility of quitting their job when they obtain a better job with a good salary and benefits.

Economic theory should accommodate the need to appropriate government support to shield patients who cannot afford private care. Given the concentration of specialists and doctors in private hospitals, and in the more urbanised states, the government should intervene to resolve such market failures. Instead of promoting health tourism and the further privatisation of healthcare, government grants should go to subsidizing the needs of the poor. Housemanships should be subsidised but should be limited to qualifying standards that are stringent. In doing so, not only will the scale synergize further healthcare delivery to the poor, it will also raise the productivity of the houseman doctors.

Despite spiralling healthcare costs, the evidence shows that Malaysia still has one of the least share of healthcare expenditure in GDP among the middle income countries. Hence, there is still considerable room for the government to avert the slide the public healthcare system is now facing by spending more on public healthcare.

7.4 Limitation of the Study

Like most studies this thesis is not devoid of limitations. Because of the nature of data compiled by government authorities, we were not able to use actual data showing the movement of doctors and nurses from public to private hospitals. Instead we used

doctors and nurses registered to account for the movement in a roundabout way. Also we did not have the household income and expenditure survey to analyse econometrically the impact of OOP on the healthcare likelihood of the poor.

7.5 Future Research

Further research should seek government support to compile the entry, exit and destination of doctors and nurses by public and private service in Malaysia, and the reasons for such a movement. Also, future research should differentiate hospitals location by rural-urban on the basis of a pre-defined radius.