THREE DECADES OF HEALTH FINANCING STUDY:

Did Malaysia Learn Anything?

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Abstract:

Health care is everyone’s right, it is the government’s responsibility to provide health care system which is equitable to the population. Malaysia’s dualism of health care system, of a heavily subsidized public sector and out-of-pocket financing of private sector, has produced a progressive system of health care. Malaysia’s health care system has provided remarkable equity and access; considering the government devotes less of its gross domestic product (GDP) to the health care than other industrialized countries. However new challenges have emerged; disease pattern and population profiles are changing, there is growth in the private health care sector, high proportion of health care expenditure comes from out-of-pocket, and increased demand for high quality and high-cost of medical technology. All these have forced the government to consider the need of restructuring the health care financing mechanism of the country. Over the last three decades the Government of Malaysia has been considering and reviewing various health’s financing mechanism aimed at reforming the country health financing mechanism in order to strengthen the national health care system. This is not only addresses the challenges and issues faced by the country health care system, but also aligns its development to the aspiration of the country in becoming a high income economy by the year 2020. There are studies recommending various health financing mechanisms such as national health insurance, medical savings account, and social health insurance. The controversial 1Care reform proposed by the Ministry of Health is the latest attempt by government to restructure Malaysia’s health care system in particular health care financing mechanism. Lack of consultation with stakeholders, commitment, support and understanding amongst politicians (government and opposition) as well as health care providers and other interested parties, lack of evidence for the proposals, lack of legal-framework to back-up the initiatives, and the lack of effort by government to educate Malaysian population on the necessity of health care financing reform in the last three decades have resulted in the initiative not being well received. The aimed of this review is to analyse experiences and lessons learned from various health care financing initiatives carried out by the Malaysian Government for the last three decades.

Key words: Health care, financing, Malaysia.
1.0 Introduction:

Health care is a sensitive and emotional issue. Finances for ill health care is the last thing one want to think about when one becomes sick. Health care is everybody’s right, and the government has the responsibility to provide health care to all the population. Becoming ill is unpredictable and everyone want health when one is ill, therefore, health care system must cover everyone within the country; citizen or non-citizen, and visitors or migrant workers (legal or illegal). Issue related with who should pay the health bills need to be resolved by the government. However, at the individual level, one wants the best of health care, but at the same time, many are taking health care risks.

The fundamental principle of equity in health financing is based on national solidarity, social responsibility and a belief that the issues of health care are a shared responsibility of all citizens (ICARE Concept Paper), that the healthy and the affluent have a duty to subsidize the cost of health care for the sick poor, and collectively share the economic burden of health care, each according to his or her ability to do so. On the other hand, sustainable and equitable health care system depends on reliable access to human, capital and consumables resources. Securing these resources requires stable financial resources. It is important for people, politicians and policy makers to understand how these financial resources are generated and managed. Developed and developing countries faces similar constant pressure on how health care system should be financed because health expenditure is increasing and government resources are scarce.

Addressing health care financing a government need to consider several key issues such as stable revenue levels of the financing mechanism, its financial sustainability, financial barriers, equity, efficiency and effectiveness of resource allocation mechanism, and people acceptability. The Government of Malaysia has, over the last three decades been assessing and reviewing various health financing initiatives aimed at restructuring the country’s health care financing mechanism in order to strengthening the national health sector. This was to address the challenges and issues faced by the country health care system, while aligning its development to the aspiration of the country to become a high income economy by 2020 (ICARE Concept Paper). Several initiatives of health care financing mechanisms such as the national health insurance, medical savings account, ear-marked tax, social health insurance and ICARE have been proposed base on the recommendations by various studies conducted by consultants. However the initiatives were strongly critiqued and not well received by the stakeholders. This paper attempts to analyse the experiences and lessons learnt from the three decades of health financing studies commissioned by the Malaysian government.

2.0 Malaysian health care system

2.1 Overview

The Malaysian healthcare system is well-recognized internationally for providing a wide range of access to curative, rehabilitative, preventive and promotive care to the population (WHO, 2012c). According to Shepard et al (2002), Malaysia in general achieves a remarkably high and equitable health status at a relatively low cost. This is an impressive accomplishment considering the Malaysian government devotes about 4.4% of its GDP (WHO, 2012a) to the health sector compare to average spent of 6 – 7% GDP (WHO, 2012b) by other countries with similar health status achievement.
Since gaining independence, the Malaysia health care system has provided a critical and invaluable service to Malaysians via an extensive network of facilities, an effective rural health system delivering primary care, well distributed secondary level hospital, highly specialized tertiary care at regional level and successful health promotion and preventive strategies (Hanafiah, 1996a). The Malaysia health care system consists of public and private sectors run parallel providing health services to the population. The public sector is government-run universal services funded through taxation, while private sector is for profit mainly providing curative and personnel health care. Public sector health care services are organized under a civil service structure under the Ministry of Health. In addition, several other government ministries and agencies are providing health-related services for specific target group of population, such as the Ministry of Higher Education runs the university teaching hospitals, the Ministry of Defence has several military hospitals and medical centres, the Department of Aboriginal (Orang Asli) Affairs provides health services to the indigenous population in collaboration with the Ministry of Health, the Department of Social Welfare provides nursing homes for the elderly and special need children, the Ministry of Home Affairs manages the drug rehabilitation centres and the Ministry of Housing and Local Government provides environmental health services and limited health services in urban areas.

The private health sector provides health care services mainly in urban areas, through physician clinics and private hospitals with a focus on curative care and personal health care. Private companies run diagnostic laboratories and some ambulance services. Non-government organizations provide some health services for particular groups. The Malaysian civil society with many non-government organizations such as the Red Crescent Society and St. John’s Ambulance provide mainly emergency ambulatory and relief services; the Lion’s Club contributes to rehabilitative services; and the Family Planning Association provides reproductive health services. Other non-government organizations cater to people with special needs, such as Down’s syndrome, cancer, autism, thalassemia and intellectual disabilities among others. Non-government organizations also provide cancer and hospice care and run community-based psychosocial and rehabilitation centres, as well as halfway homes. Traditional medicine, such as Chinese and Malay practitioners and products, is used by large sections of the population.

While the Ministry of Health plans and regulates most public sector health care services but exerts little regulatory power over the private sector. As a result of this, there is dualism of health care system running parallel with the public sector dominating provider in rural area, while private sector are mainly in urban areas serving affluent and economically developed population (Hanafiah, 1996a). The public sector provides about 82% of inpatient care and 35% of ambulatory care, and the private sector provides about 18% of inpatient care and 62% of ambulatory care (Hussein, 2009). Currently, based on their financial status or insurance package, Malaysians have the option to choose whether to go to a government-owned health care facility or a private health care facility for treatment.

As a result of this, Malaysians currently enjoy a relative high overall standard of health. This, coupled with the relatively low spending on health whilst ensuring universal access, has made the Malaysia health system well recognised internationally (Kananatu, 2002). The Malaysia health system’s remarkable achievements, especially in primary care is often referred to as a model for other developing countries. At the same time, the private sector provides an alternative choice of care to people and is responsive to market forces. The present healthcare
system is already both inequality-reducing and pro-poor (Hanafiah, 1996a), since the poorest quintile receives significantly more than 20% of the total subsidy (O’Donnell, 2007). This is achieved because it is well balanced between enabling those who can afford it to pay for high quality healthcare services, and providing a safety net for the poor in the form of the Social Security Organization (SOCSO). The success of this balance is itself explained by Malaysia’s rising national income, which means that as earnings and spending levels rise, the health needs of the higher income groups can be met and additional programmes can be targeted to the needs of the poor.

However, there are still imbalances and mismatches in terms of resources and workload in the dichotomous Malaysian care health system. In 2012, although the public sector has only about 15% of health clinics with doctors, they handled almost 80% of all outpatient visits. While there are more hospitals in the private sector, almost 75% of hospital beds remain within the public system which takes care of almost 70% of all hospital admissions (Health Facts, 2012). Yet, with these large workloads, only slightly more than half of the doctors work with the Ministry of Health and more funding goes to the private sector through out-of-pocket (OOP) financing or private health insurance. At present, 65% of the population attend public sector facilities, which are served by just 45% of all registered doctors and about 25 – 30% of specialists (Quek, 2008).

2.2 Achievements of Malaysian health care system

Marked improvement in health status of the Malaysian population over the decades is indicated by steadily decreasing specific risk group mortality rates, longer life expectancies at birth, considerable success in controlling communicable diseases, increasing efforts to address and combating new diseases, and great improvement on coverage and access of health facilities, also improvement on medical manpower to population ratio.

Table 1 shows the selected indicators of health and health service facilities. There has been marked improvement in recent years compared to that in 1970. In 1970 the number of public hospitals were 72 (MOH and Non-MOH hospitals) and clinics were 1167 (including health clinic/MCH Clinic/Community Clinic) have been increased to 146 and 2949 respectively in 2011. During the same period, private hospitals and clinics have increased from 50 private hospitals and less than 1000 private clinics in 1980 to 245 hospitals and 6589 private clinics in 2011. Under the current system more than 90 percent of population are within 5 kilometres to health facilities. At the same time an extensive system of mobile health units and subsidiary clinics further improve access to health care for those living in more remote areas.

Over the past decades Malaysia aggressive educational policies, including development of medical and health professionals in public and private institutions have contributed effectively to the development of medical and health manpower. As shown in Table 1, ratio of doctors and dentists to the population were 1:5000 and 1:40000 in 1970 improved to 1:791 and 1:6810 respectively in 2011. Growth of nursing personnel showed nearly three-fold increased from 1990 to 2011. Growth of nursing personnel showed nearly three-fold increased from 1990 to 2011. Growth of nursing personnel showed nearly three-fold increased from 1990 to 2011.

Malaysia also has shown reduced differentials in maternal and child mortality between Bumiputera and other ethnic groups and among states through more equitable social and economic development and better health services. The figure in Table 1 shows an overall improvement in mortality and morbidity and increased life expectancy. Life expectancy for
female has increased from 65.6 years in 1970 to 76.8 years in 2011, and for male from 61.6 years to 71.8 years during the same period. Infant mortality rates per 1,000 live births is comparable to developed countries, in 1970 was 40.8 per 1000 live births which has been drastically reduced over years to 6.8 per 1000 live births in 2011.

Table 1: Selected Indicators of Health Status and Health Service Facilities, 1970 -2011

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<tbody>
<tr>
<td><strong>Life expectancy at birth</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>61.6</td>
<td>66.70</td>
<td>69.00</td>
<td>70.0</td>
<td>71.7</td>
</tr>
<tr>
<td>Female</td>
<td>65.6</td>
<td>71.60</td>
<td>73.50</td>
<td>74.7</td>
<td>76.8</td>
</tr>
<tr>
<td>Infant mortality rate (per 1000)</td>
<td>40.80</td>
<td>19.70</td>
<td>13.50</td>
<td>8.1</td>
<td>6.7</td>
</tr>
<tr>
<td>Toddler mortality rate (per 1000)</td>
<td>4.20</td>
<td>1.80</td>
<td>1.30</td>
<td>0.7</td>
<td>0.4</td>
</tr>
<tr>
<td>Maternal mortality rate (per 1000)</td>
<td>1.50</td>
<td>0.60</td>
<td>0.30</td>
<td>0.2</td>
<td>0.26</td>
</tr>
<tr>
<td>Crude birth rate (per 1000)</td>
<td>32.20</td>
<td>30.90</td>
<td>27.10</td>
<td>24.5</td>
<td>17.2</td>
</tr>
<tr>
<td>Crude death rate (per 1000)</td>
<td>7.00</td>
<td>5.30</td>
<td>4.70</td>
<td>4.4</td>
<td>4.6</td>
</tr>
<tr>
<td>Doctor to population ratio</td>
<td>1:5000</td>
<td>1:3800</td>
<td>1:2700</td>
<td>1:1490</td>
<td>1:791</td>
</tr>
<tr>
<td>Dentist per population ratio</td>
<td>1:40000</td>
<td>1:20878</td>
<td>1:12500</td>
<td>1:10851</td>
<td>1:6810</td>
</tr>
<tr>
<td>Nurse to population ratio</td>
<td>-</td>
<td>-</td>
<td>1:800</td>
<td>1:747</td>
<td>1:387</td>
</tr>
<tr>
<td><strong>Public sector health facilities¹</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public hospital (MOH/Non MOH)</td>
<td>72</td>
<td>88</td>
<td>95</td>
<td>127</td>
<td>146</td>
</tr>
<tr>
<td>Number of beds</td>
<td>17063</td>
<td>33901</td>
<td>33400</td>
<td>37519</td>
<td>41716</td>
</tr>
<tr>
<td>Health clinic/MCH clinic</td>
<td>224</td>
<td>725</td>
<td>708</td>
<td>947</td>
<td>985</td>
</tr>
<tr>
<td>Klinik desa (Community clinic)</td>
<td>943</td>
<td>1509</td>
<td>1880</td>
<td>1924</td>
<td>1864</td>
</tr>
<tr>
<td>Klinik 1Malaysia²</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Private sector health facilities</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private hospital³</td>
<td>11</td>
<td>50</td>
<td>174</td>
<td>224</td>
<td>245</td>
</tr>
<tr>
<td>Number of beds</td>
<td>n.a</td>
<td>1171</td>
<td>4675</td>
<td>9547</td>
<td>13673</td>
</tr>
<tr>
<td>Number of private clinics</td>
<td>-</td>
<td>&lt;1000⁴</td>
<td>2000³</td>
<td>4500³</td>
<td>6589³</td>
</tr>
</tbody>
</table>

¹Ministry of Health facilities  
²Urban and suburban area  
³Private Healthcare Act 1998 define private hospital as any premises, other than a government hospital or institution, used or intended to be used for the reception, lodging, treatment and care of persons who require medical treatment or suffer from any disease or who require dental treatment that require hospitalisation.  
⁴Estimate by author  
Sources: Health Facts, MOH and MOH Annual Report, various year

As a result of an epidemiological transition, the causes of mortality has been shifting from communicable to non-communicable diseases. As shown in Table 2 age-standardized mortality rate indicate that this transition is more advanced than in neighbouring countries, except Singapore (WHO, 2013). Currently non-communicable diseases are dominating the top ten principal causes of death at government hospital (Health Facts, 2013) and also the alarming
increase in prevalence on non-communicable diseases such as diabetes mellitus, hypertension, obesity and stroke.

Table 2: Age-standardized mortality rates by cause, per 100 000 population, selected countries, 2008

<table>
<thead>
<tr>
<th>Causes</th>
<th>Indonesia</th>
<th>Philippine</th>
<th>Thailand</th>
<th>Singapore</th>
<th>Malaysia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communicable diseases</td>
<td>244</td>
<td>231</td>
<td>153</td>
<td>66</td>
<td>185</td>
</tr>
<tr>
<td>Non-communicable diseases</td>
<td>647</td>
<td>599</td>
<td>675</td>
<td>313</td>
<td>526</td>
</tr>
<tr>
<td>Injuries</td>
<td>70</td>
<td>55</td>
<td>106</td>
<td>21</td>
<td>51</td>
</tr>
</tbody>
</table>


As shown in Table 2, the most deaths in Malaysia are from non-communicable diseases. Diseases of the circulatory system (heart and lungs) the most common cause of death. Noncommunicable diseases dominate the top five ‘burden of disease’ categories (WHO, 2013). In Malaysia, burden of diseases study conducted in year 2000 found that total burden of diseases was amounted to 2.8 million disability adjusted life years (DALYs), with non-communicable diseases contributed 69%, communicable diseases 20% and injuries 11%, and eight leading contributors, in descending order, were road traffic injuries, cancer, septicaemia, diabetes mellitus and acute lower respiratory tract infections (WHO, 2012c).

3.0 Health care financing

3.1 Health care expenditure

Table 3 shows that Malaysia total health expenditure was at 4.4% of GDP in 2010 (WHO, 2012a), and has been on an upward trend in the last few decades. However, it is important to note that private health expenditure has been steadily increasing from 41% of total health expenditure (THE) in 2000 to nearly 45% in 2010, as compared to government spending of 59% in year 2000 decreasing to 55% in 2010. At the same period also observed that out-of-pocket (OOP) health expenditure spending increased to 76.8% of private health expenditure on health, and about 34% of total health expenditure (WHO, 2012a).

Nevertheless, Malaysia’s rapid economic growth over recent years has in fact enabled income and tax levels to keep pace with the rate of health expenditure rises, and consequently remains a relatively small share of GDP. The amount of Malaysian spending on health care is growing in real term as indicated in Table 3. Although government spending on health continues to rise but by international standards, overall health expenditure in Malaysia is much lower than in other upper middle income countries. Between 2001 to 2009 private expenditure rose from 41% to 45% from total health expenditure, in contrast to other upper middle income countries, where it decreased from 52% to 45%, and out-of-pocket health expenditure accounted for
76.8% of private health expenditure on health, it is about 34% of total health expenditure in 2009 (Chua et al, 2012). This development is unhealthy for any country, as it may cause health care inflation if not monitor properly.

**Table 3:** Trends in health expenditure in Malaysia, 2000 – 2010 (adjusted)

<table>
<thead>
<tr>
<th></th>
<th>2000</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Health Expenditure (THE) (Million RM)</td>
<td>10 745</td>
<td>18 605</td>
<td>22 470</td>
<td>24 357</td>
<td>28 107</td>
<td>32 180</td>
<td>33 657</td>
</tr>
<tr>
<td>Total Health Expenditure as % GDP</td>
<td>3.0</td>
<td>3.6</td>
<td>3.9</td>
<td>3.8</td>
<td>3.8</td>
<td>4.6</td>
<td>4.4</td>
</tr>
<tr>
<td>General government health spending % THE</td>
<td>59.0</td>
<td>52.0</td>
<td>55.9</td>
<td>54.7</td>
<td>55.2</td>
<td>55.7</td>
<td>55.5</td>
</tr>
<tr>
<td>Private expenditure on health as % THE</td>
<td>41.0</td>
<td>48.0</td>
<td>44.1</td>
<td>45.3</td>
<td>44.8</td>
<td>44.3</td>
<td>44.5</td>
</tr>
<tr>
<td>OOP as % private expenditure on health</td>
<td>72.2</td>
<td>75.5</td>
<td>76.1</td>
<td>75.8</td>
<td>76.6</td>
<td>76.8</td>
<td>76.8</td>
</tr>
<tr>
<td>OPP % of THE</td>
<td>29.6</td>
<td>36.2</td>
<td>33.6</td>
<td>34.3</td>
<td>34.3</td>
<td>34.0</td>
<td>34.2</td>
</tr>
<tr>
<td>Per capita spending in USD</td>
<td>125</td>
<td>188</td>
<td>230</td>
<td>262</td>
<td>306</td>
<td>316</td>
<td>368</td>
</tr>
</tbody>
</table>

Source: WHO (2012a), Global Health Expenditure Database.

### 3.2 Problem statements

Malaysian health care system is currently able to provide a good quality universal health care, with a fair distribution of access. The achievement of the Malaysian health care system indicated by various health indicators that is comparable with developed countries. The achievements were obtained through the present financing system, which mixes public and private sector, universal coverage is provided to Malaysian population at only 4.4% of GDP (WHO, 2012a), compared to 6 – 7% in most developed countries.

The amount Malaysian citizens spending on their health care is growing, while government spending on health continues to rise but still remains lower than other countries at similar level of development (WHO, 2012a). Between 2001 and 2009 private expenditure rose from 41% to 44% as a proportion of total health expenditure, whereas in other Upper Middle Income Countries, it decreased from 52% to 45%, and OOP health expenditure in Malaysia accounted for 76.8% of private expenditure on health and 34% of THE in 2009 (Chua et al, 2012). In term of health care expenditure, it is contends that Malaysia’s health care expenditure is currently more in line with those of lower or lower-middle income countries, making reform imperative to bring the healthcare sector in line with national target. Figure 1 below shows comparison health expenditure as percentage of GDP with selected countries.
The predominantly tax-based Malaysian health care financing is slightly progressive with a Kakwani index of 0.186. The net progressive effect of Malaysian health care financing are produced by four progressive financing sources (in the decreasing order) of direct taxes, private insurance premium, out-of-pocket financing, contributions to EPF and SOCSO, and indirect taxes produced a regressive effect (Chai Ping Yu et al, 2008).

![Figure 1: Health expenditure as percentage of GDP in selected countries, 1995 – 2010](source: WHO (2012b), World Health Statistic)

The 10th Malaysia Plan (2011-2015) clearly states that although Malaysia has been efficient in delivering improved health outcomes, as the nation develops, expenditure on healthcare may have to increase in tandem to address rising expectations and pressures on the healthcare system. The healthcare system is anticipated to face challenges and opportunities from a rapidly changing operating environment, these include; increasing expectations on quality of healthcare, increasing pressure on the public healthcare system, increasing workload in public hospitals which are already stretched to capacity, changing lifestyles and demography, advancements in medical technology and epidemiological transition from communicable to non-communicable diseases, emerging of diseases previously prevalent in animal and reemerging of diseases previously eradicated or under controlled. All these result in more pressure on government limited resources.

### 3.3 Malaysian Government initiatives

The Government of Malaysia upon reviewing the Fourth Malaysia Plan (1980-1984) is realized that although universal health care is undoubtedly humane, but at the same time it will put an enormous pressure to national resources and extremely difficult to the Government to sustain it in the long run. Several studies were then commisioned to help government to make an informed policy decision on health care financing for the country (Hanafiah, 1996b).

Early studies by consultants funded by the Asia Development Bank and coordinated by Economic Planning Unit of Prime Minister Department recommended for the establishment of National Health Insurance Scheme for Malaysian. These study include National Health Financing Study by Westinghouse in 1984-1985, the study recommended the establishment of a National Health Financing Scheme backed by National Health Security Fund to finance all
health care costs both in the public and private health sectors (Kananatu, 2002). The findings of the study was approved by the Government, and following which the Government commissioned two phases study on feasibility and acceptability on the National Health Security Fund by Birch and Davis in 1987-1989, and the National Health Plan Study 1989-1990 was conducted by British Consultant Group to study the feasible structure of the National Health Insurance proposed earlier (Hanafiah, 1996b). Due to the lacking of information dissemination, dialogue and understanding about proposed National Health Financing Scheme, the initiative was highly critiqued and opposed by stake holders. Subsequently, the implementation of National Health Financing Scheme and National Health Security Fund were deferred indefinitely (Kananatu, 2002). The need of National Health Financing Scheme was re-emphasised again by study of World Health Organization Consultant Mr. JR Herms in 1997, and the National Household Health Expenditure Study (NHHES, 1996 – 1999). The NHHES also revealed that heavy OOP expenditure by consumers which could be put to better use if health care financing scheme was in place.

Further, in 1996-1997 a study was conducted by Rashid Hussain Bhd with Professor William Hsio was commissioned for General Hospital Corporatization. This study recommended Medical Saving Account to finance health care (Kananatu, 2002), especially relating to hospitalization. Corporatization of hospital and privatization of some entities of medical services were also suggested by consultant study titled Health Care Reform Initiatives in Malaysia (Shepard et al, 2002). The basis of proposal was to increase the efficiency of services, to retain qualified and experienced manpower, to reduce MOH’s role in the provision of health services while increasing MOH’s regulatory and enforcement functions. A National Health Financing Scheme to meet health care costs was also be implemented. Subsequently, except for privatization of some non-clinical entities of medical services such as Central Medical Store, the pharmaceutical supplies, the maintenance and operation of hospital facilities, and the corporatization on National Heart Institute, the corporatization and privatization of Ministry of Health hospitals and clinical services were not taking place.

The next focus of health financing initiatives was on social health insurance. Among the studies conducted in this aspect include one by Insurgress Sdn Bhd on Malaysia Health Care Deliveries and Financing System (MEDIFIS) in 2001, and proposed health care reform under 1CARE (2009) by the Ministry of Health Malaysia. 1CARE Concept Paper was presented by Ministry of Health to Prime Minister and Economic Council in August 2009. The proposed concept of 1CARE was approved, and Ministry of Health was given two years to prepare the blueprint of 1CARE implementation. In response to these the Ministry of Health formed various Technical Working Groups (TWG) to prepare the 1CARE blueprint. Ministry of Health took positive approaches in forming various TWGs by inclusion of various stake holders including professional bodies and universities, but the methodologies are classical; workshops conducted by foreign consultants, recycling visits overseas by senior officers on fact findings mission and a few dialogues with professional bodies. There was very little effort to educate Malaysian citizens on the importance of the initiative and to gather evidence on current Malaysia health care system to support feasibility of the health care restructuring. Even though the health care system restructuring proposed under 1CARE was a comprehensive one, but lack of detail and evidence, left it open to misinterpretation, and became the centre of controversy to stake holders. The commitment of government for health care restructuring under 1CARE was obvious, due to unknown reason the presentation of the blueprint of 1CARE was deferred indefinitely.....?
3.4 Lessons learnt

In the last three decades, Malaysia has been considering and reviewing various health care financing mechanism, and spending unknown amount of tax payer money in the process; any scholar or well informed citizen of Malaysia will agreed that the Malaysia health care system need to be restructured, to ensure an integrated health care delivery system that is responsive, provides choice of quality health care, while ensuring universal coverage for the health care needs of the population that is affordable, sustainable and putting in place effective safety net measures. They also would agree that government resources for health care is scarce, and increasing of OOP health care expenditure is unavoidable under current health care financing system, which is unhealthy and may disastrous for the country health care system.

The debate on the Malaysia health care system restructuring should no longer center on who should be paying for health care. The current system already has the answer for this question. The debate should focus more on technical efficiency and allocative efficiency in managing available or future health care resources, while at the same time balancing efficiency goal and equity concerns.

There are several key issues need to be resolved by the government in this health care system restructuring. These include the need restructuring when the current health care system already internationally recognize as equitable and accessible to population, and with proven good health outcomes. The proposed of health care restructuring will be involving the integration of public-private health care sectors. The question is; What is the logic behind proposed health care restructure with integration of public-private sector?. Private health facilities (private hospital and clinic) are for profit entities, therefore should public funds be used to finance such entities? Why do we need such integration to improve quality and outcome of health care?

On equity issues following characteristics present in current health care system need to address by government; How could the government resolve existing geographical mismatch of health facility distribution? How could the government resolve mismatch in terms of quality of care between geographical areas and between sectors? How could the obvious mismatch in health manpower in term of quantity, quality, geographical and sectoral distribution to be overcome?

The above issues were debated over and over again for the last three decades by the government and the opponents of health care system restructuring. There is no simple answer. One cannot answer it without serious efforts by government to address the following issues;

First, over the last three decades the government failed to educate Malaysian citizen on the needs for health care system restructuring. Political rhetoric on health care resulting amongst politicians (either government or opposition) and also amongst government servants failed to make everyone understand the rationale behind health care restructuring. Obviously, in the last five or six initiatives for health care restructuring, critiques and oppositions not only from consumer groups and professional bodies, but also from politicians and government servants. Second, the overall proposed restructuring of health care especially on health care financing is critically hampered by a lack of detailed research and data to support it. Lack of adequate data in the public domain means that the public cannot come to a reasoned decision of whether or not to endorse the proposals, and policy-makers are themselves unable to base their proposals...
on adequate evidence. Absence of academia to provide input in an important policy issue such as national health care financing is much to be regretted. Involvement of academicians were mainly only in workshop or seminar organized by Ministry of Health. Academician can play bigger role to provide data and evidence through research such as feasibility or pilot study of the proposal. Unfortunately this did not happen in the last three decades.

Third, in the absence of legal framework for health care restructuring, all initiatives in the last three decades became just an academic exercise. There seems to be no commitment by all parties including the government to consider the proposal seriously, even if the proposal is a good one. In this context, it was important for the government to convince all Malaysian that all specific health financing authority as a result of restructuring will be incorporated into a structured body secured by statutory legislation or publicly administered as part of the health care restructuring process, and should never be privatize. Most notable in Malaysia is a heightened public suspicion surrounding the government’s motivation for the health care restructure, something which does not appear to such a crippling extent in other countries. The cause for this can be directly linked to a perception of high corruption and political cronyisms in the system; therefore Government need to be highly convincing from beginning, and that would not happen.

Fourth, the government commitment to the health care restructuring seen at face only, there are lacking in support and commitment by government to endorse the proposed restructuring of health care financing for obvious reason. Furthermore, other countries that have changed their health care financing system and those which already have a functioning health care financing model are all share some common features which are absent in Malaysia.

The debate on health care restructuring will continue and the government will no doubt be commissioning several more health financing studies to review Malaysia health care system and considering most suitable health care financing mechanism for the country. At the same time Malaysia health care system will continue to grow and health status will further to improve, at extremely high costs, while waiting for a change!

4.0 Conclusion

The broad objectives of a national health care system restructuring will include the provision of universal coverage and equitable access to both the public and private health care sectors, as well as having control of the total health care budget. For Malaysia the debate of health care system restructuring should be on technical and allocative efficiency, and how to balance its with equity concern. During the three decades of considering and reviewing various health care restructuring initiatives, Malaysia had failed to resolved some basic issues behind the rationale of the proposed restructuring. Critiques and oppositions will continue to question any attempt to change current health care system, and Malaysian need some time to understand the rationale for the change.

Declaration of competing of interests

The author declares that there is no competing of interest on publication of this article; the views and conclusion are author personnel views and are not related with any institution or organization.
References:


Health Facts, Ministry of Health Malaysia, varies year.


WHO (2012a). Global Health Expenditure Database,

WHO (2012b). World Health Statistic

WHO Health Statistic, 2013

WHO (2012c). Malaysian Health System Review