

Asia Research Institute

Working Paper Series

No. 18

Current Health Care Financing Issues in Malaysia

Chee Heng Leng

Asia Research Institute
National University of Singapore
arichl@nus.edu.sg

February 2004



The **ARI Working Paper Series** is published electronically by the Asia Research Institute of the National University of Singapore.

© Copyright is held by the author or authors of each Working Paper.

ARI Working Papers cannot be republished, reprinted, or reproduced in any format without the permission of the paper's author or authors.

Note: The views expressed in each paper are those of the author or authors of the paper. They do not necessarily represent or reflect the views of the Asia Research Institute, its Editorial Committee or of the National University of Singapore.

Citations of this electronic publication should be made in the following manner: Author, "Title," ARI Working Paper, No. #, Date, www.nus.ari.edu.sg/pub/wps.htm. For instance, Smith, John, "Ethnic Relations in Singapore," ARI Working Paper, No. 1, June 2003, www.ari.nus.edu.sg/pub/wps.htm.

Asia Research Institute Editorial Committee

Anthony Reid, Chair

Cherian George

Geoff Wade

Jamie S. Davidson

Jennifer Lindsay

Mark Frost

Tan Ying Ying

Asia Research Institute

National University of Singapore

Shaw Foundation Building, Block AS7, Level 4

5 Arts Link, Singapore 117570

Tel: (65) 6874 3810

Fax: (65) 6779 1428

Website: www.ari.nus.edu.sg

Email: arisec@nus.edu.sg

The Asia Research Institute (ARI) was established as a university-level institute in July 2001 as one of the strategic initiatives of the National University of Singapore (NUS). The mission of the Institute is to provide a world-class focus and resource for research on the Asian region, located at one of its communications hubs. ARI engages the social sciences broadly defined, and especially interdisciplinary frontiers between and beyond disciplines. Through frequent provision of short-term research appointments it seeks to be a place of encounters between the region and the world. Within NUS it works particularly with the Faculty of Arts and Social Sciences, Business, Law and Design, to support conferences, lectures, and graduate study at the highest level.

Current Health Care Financing Issues in Malaysia¹

Chee Heng Leng

Introduction

Through the decades since Independence (1957), the health status of Malaysians has shown a consistent trend of improvement; reflected by a steady decrease in mortality rate indicators. Not all of this improvement may be attributed to the health care system, as health outcomes are the product of a complex interplay of many factors ranging from income levels, education, and fertility, to sanitation, environment, and access to safe water. The health care system has an important role, nonetheless, and primary and preventive health care, arguably, a pivotal one.

The Malaysian health care system has expanded and evolved as the nation has developed. In 1957, the doctor: population ratio was 1:7352 (for Malaya); by 1981, it had been halved to 1:3661 (for Malaysia), and in 2000, it was 1:1490. By far the most laudable achievement must be the rural health service, which started essentially from scratch in the early 1950s. In 1960, the ratio of main health centre to rural population was 1:638,000, health sub-centre to rural population 1:319,000, and midwife clinic to rural population 1:121,000. By 1984, when all health sub-centres were upgraded to health centres and midwife clinics to general clinics, the ratio of the health centre to rural population had dropped to 1:26,608, and for the general clinic, or *klinik desa*, it had dropped to 1:5,431.²

Nevertheless, even as mortality rates dropped and health facilities grew, new challenges arose to increase pressure on the health services. From 1960 to 2000, the population grew three-fold (8.3 million in 1960, 23.3 million in 2000), with an increasing proportion of urban population, older people, and migrants. These pressures were exacerbated by a trend toward heart disease and other chronic illnesses. Societal changes such as an increase in household incomes, improvements in technology, and rising expectations, were also important contributors to increasing the demand on health services.

Demand for health services is reflected in utilisation rates. The utilisation rates of Ministry of Health (MOH) outpatient services have remained fairly constant over the last 30 years (1,260 outpatients per 1,000 population in 1970, 1,186 in 2000). Hospitalisation rates, on the other hand, have increased steadily since the 1970s (56.6 per 1,000 population in 1970, 69.3 in 2000), reflecting a gradual outstripping of population growth.

Private general practitioners are a large segment of outpatient service providers who would have met much of the increase in demand for outpatient care. In addition, a rapid increase has been seen in the utilisation rates of private hospitals, both for inpatient as well as outpatient care. Whereas in 1985, there were 62

¹ An earlier version of this paper was presented under the title of 'Building on the strengths of the present system to plan for the future health care system' at the seminar on *Planning the Health System for the Future*, International Medical University, Kuala Lumpur, 8 March 2003.

² Improvement in geographical access is documented in the *National Health and Morbidity Survey II* (NHMS II) (Public Health Institute, NHMS II, volume 3, 1999) where it is reported for Peninsular Malaysia, that in 1986 (NHMS I), 74% of those surveyed lived within 3 km of a health facility and 89% within 5 km, whereas by 1996 (NHMS II), the corresponding figures had risen to 86% and 93%.

outpatients per 1,000 population at private hospitals, and 9.8 admissions per 1,000, in 1997, the corresponding figures were 179 outpatients and 20.8 admissions per 1,000.

Indeed, the last 20 years has seen a phenomenal rise of more than 300% in the number of private hospitals and institutions (from 50 in 1980 to 224 in 2000). This rise is also shown by another indicator, the percentage of private hospital beds, which increased from 4.7% in 1980 to 25.1% in 1998, before dropping to 21.9% in 2000.³

This private sector expansion did not happen solely in response to the opportunity provided by the increase in consumer demand for health care. Governmental policy played a crucial role. Government not only did not act to regulate private sector growth in health care provision, but through its economic policies, encouraged the growth of private enterprises and corporations in all sectors of the economy, including the health care sector.

Despite this growth, the public sector remains, at this point, the dominant provider of health care, in particular, hospital care. Although only slightly more than half (54%) of all doctors are in the public sector, they treat three and a half times as many inpatients compared to the private sector, and public beds constitute more than three quarters of all hospital beds. Public facilities also treat six to seven times as many outpatients as private hospitals, although this discounts the large numbers that are seen by the general practitioners.

More recent figures from a nation-wide survey found that, in terms of episodes of acute conditions, 42% utilised private facilities as opposed to 20% who utilised public facilities,⁴ while the second national health and morbidity survey (NHMS II, 1996) reports that 54.2% of recent illness or injury was seen in private clinics, 38.7% in government facilities, and only 2.3% in private hospitals.⁵ For hospital care, however, 80% utilised public facilities compared to 20% who used private health care (NHHES, 1996), a finding supported by the NHMS II (1996) findings where 78.4% of those hospitalised used MOH hospitals compared to 17.9% who used private hospitals.

Overall, therefore, a large proportion of the population still relies on public health care. It was therefore of great concern when the government announced that it would be retreating from its role as provider of health care, in line with its privatisation and corporatisation policy (Seventh Malaysia Plan, 1996-2000). Furthermore, the Eighth Malaysia Plan (2001-2005) reiterated that a health care financing mechanism, first mooted in the mid 1980s, will finally be put in place. Although there have been rapid changes in health care in the past two decades, a change in health care financing heralds a fundamental shift, raising questions pertaining to the impact on accessibility, equity, and universal coverage.

Health Care Financing

The problems in Malaysian health care are many. For the users of public health services, queues are long, and in recent years, patients have had to pay for their own

³ Figures are from Ministry of Health *Annual Reports*.

⁴ The remainder were 18% self medication, 16% pharmacy or shop, 4% traditional (Department of Social and Preventive Medicine, Faculty of Medicine, University of Malaya, *National Household Health Expenditure Survey* (NHHES), 1996).

⁵ The remaining 4.8% was by alternative practitioners and others. It should be noted that measurement was different in the two surveys. The NHMS II figures are percentages of those who sought care for illness or injury within last two weeks only, i.e. excluding those who self-medicated.

surgical implants and essential medicines, due to hospital budgetary constraints. Even as the low income contend with these difficulties, those who can, struggle to afford the more expensive private facilities. Although only 20% of hospital users utilise facilities in the private sector, they account for 86% of the total household expenditure for hospitalisation, paying on average, RM1,955 for each episode of care compared to RM81 in the public sector.⁶

The perceived need to bypass government health services has led to public appeals by individuals for donations to fund various types of surgical procedures and treatment. In 2002, a flurry of such appeals culminated in the saga of a well-known television announcer receiving large amounts of public donations to go to Australia for a medical procedure, the necessity and cost of which was subsequently questioned.⁷ Following the public uproar, the government set up the National Health Welfare Fund to receive public donations on behalf of needy patients, who now have to go through an application and vetting process by the MOH.⁸ Although this fund plays an important role in rationalising and safeguarding the use of public donations for poor patients, it also represents the institutionalising of health care as charity.

Appealing for public donations, by its very nature, can only be the recourse of a minority. For the majority, a perception that government health services are no longer viable combined with a felt need to utilise the more expensive private health services on the one hand, and rising charges in the private sector on the other, have given rise to a trend toward purchasing private health insurance.⁹

A health system that is dominated by private health insurance will be detrimental to objectives of social solidarity and universal coverage. Private health insurance is voluntary, with the possibility of individuals opting out. Premiums are risk-rated by age and health record, and those who really need health care could be excluded. Spiralling costs, attributed to 'moral hazard', 'supplier-induced demand', and overheads, is a dominant problem. In the United States (US), where health care financing is primarily through private insurance, health spending spiralled to a record high of 14.1% of GDP in 2001, while 41 million citizens (14.5% of the population), including 10 million children, remained uninsured even though the government contributes 40% of total health care spending through its Medicare and Medicaid programmes for the aged, disabled, and poor.¹⁰

In Malaysia, the universally available public health care system is funded from central taxation, while private health care utilisation has primarily been funded directly from out-of-pocket payments of individuals or employers. Nevertheless,

⁶ The median amount spent per episode of care in the private sector was RM900, compared to RM15 in the public sector (*National Household Health Expenditure Survey* (NHHES), 1996).

⁷ The amount of public donation received in this case was probably unduly influenced by the individual's celebrity status, and her receiving a visit at her sick bed by the Prime Minister.

⁸ In early 2003, the Director-General of Health announced that the fund held a total of RM5.5 million, and since its inception in September 2002, had received 102 applications, among whom 63 had been approved. The majority of those approved (55 out of 63) could be, and were, treated at public hospitals. *The Sun*, 27 February 2003.

⁹ The *National Health and Morbidity Survey II* found that private health insurance was used as a source of financing by 0.1% of users (NHMS II, vol. 3, 1999).

¹⁰ Robert Pear, 'Panel, citing health care crisis, presses Bush to act'. *The New York Times*, 20 November 2002; and Robert Pear, 'Spending on health care increased sharply in 2001'. *The New York Times*, 8 January 2003. The second article also reported that from 1992 to 2000, US health care spending was between 13.1% to 13.4% of GDP, which was higher than Switzerland (10.7%), Germany (10.6%), France (9.5%), and Canada (9.1%) for 2000. Estimate of uninsured children from Children's Defence Fund, *Child Health Fact Sheet*, 17 January 1997, Washington DC: Children's Defence Fund.

private health insurance has recently made inroads as a mode of financing health care. Its role was boosted by the Employees' Provident Fund (EPF) when it gave the option to its five million active members to use their savings for a risk-rated health insurance scheme (*The Star*, 18 January 2000).¹¹ In the context of a fast growing health insurance market, the national health financing scheme that has been proposed could be considered overdue.

A National Health Financing Scheme

Through the years, the more highly remunerative private sector has been drawing medical and allied health personnel out of government services. As more and more leave, those who are left behind face ever increasing workloads. Deteriorating service conditions encourage more to leave, leading to a downward spiral. An appropriate policy response would be to increase government health spending in order to increase remuneration for skilled personnel and improve service conditions so as to stem the flood of departures.

In the last five years, government allocation for health has remained fairly constant at about 2.5-2.6% of GNP.¹² Official calculations based on the NHMS II data state that the MOH 1996 annual budget was 1.02% of GDP or 1.07% of GNP, while community out-of-pocket spending was 1.28% of GDP or 1.35% of GNP (NHMS II, vol 3, 1999).¹³ The same report states that, including estimates of health expenditure by other governmental and non-governmental bodies, employers and insurance would bring total health expenditure beyond 3%. This level is still below the four to six percent recommended by the WHO.

Continuing the government's dominant role in financing and providing viable health care services on the one hand, while regulating the growth of the private sector on the other, could have ensured and extended the ideals of universal coverage, accessibility and equity in health care. Nevertheless, the government has stated that an alternative source of financing other than central treasury funds will be set up, and that this would be the foremost priority in the Eighth Malaysia Plan (2001-2005) period.

First announced in the Mid-term Review of the Fourth Malaysia Plan (1981-1985), these plans have been 20 years in the making, reflecting perhaps the monumental task that it is. In March 2001, the MOH announced that it has forwarded a proposal on the setting up of the National Health Financing Authority (NHFA), the body that will manage the National Health Financing Scheme (NHFS), to the Economic Planning Unit (EPU) of the Prime Minister's Department, and that it was likely for it to be set up within the year.¹⁴

¹¹ The EPF allows a member to use up to 10% of contributions for medical purposes, functioning as a medical savings account. The scheme offered would appear attractive to those under 35 years old, for whom the annual premium of an assured sum of RM10,000 to cover 13 critical illnesses would only be RM30; but for those who are in the 65-70 year age group, the corresponding premium is RM1,883. The difference is greater for higher coverage: RM20,034 for 65-70 year olds to cover 36 critical illnesses for an assured sum of RM100,000, compared to RM347 for under 35 year olds.

¹² Ministry of Health, *Annual Report 2000*. The MOH budget constitutes the dominant portion of governmental expenditure on health care.

¹³ It is argued that community health expenditure has risen by 40% over the last decade or so, and is now larger than the annual budget of the MOH, and that even without a formal change in the financing structure, the MOH may no longer be the largest funder or provider (NHMS II, vol 3, 1999). Based on utilisation figures presented earlier in this paper, however, the MOH is still the largest provider of hospital care. In rural areas, it may even be the sole provider of outpatient care.

¹⁴ *The Sun*, 4th March 2001, page 1. Since then, there has been no report on the decision taken by EPU, nor of the progress in the setting up of the NHFA.

The necessity for establishing a national health fund may be questioned, particularly from the point of view of the public, for whom contributions may be considered an additional tax. Other problems will also arise. A national health fund, assuming that it would be a social insurance scheme, would first of all incur large additional costs in administration. In announcing the NHFA proposal, the MOH reassured the public that 'There is a need to establish a scheme that is fully owned by government and functions as a non-profit entity'.¹⁵ It is envisaged that this fund will be the second largest in the country, after the Employees Provident Fund (EPF). Inevitably, then, questions of transparency, accountability and governance spring to the fore. Private management of such a large public fund will surely give rise to countless problems in regulation. Who would monitor the management, to whom would they be answerable, and how would public accountability be achieved?

Financing health care by central taxation allows the government direct control in planning, and costs may be controlled by global budgeting. Financial equity, in this case, is determined by the tax structure, and is equitable and progressive to the extent that taxation is so. In a social insurance scheme, governmental control will depend on the extent to which the financing body is independent of government. The health fund will be an additional source of funds for the public health sector, provided that there are no cut-backs in current central treasury allocations. Financial equity will depend on whether premiums are progressively structured, and coverage will be universal to the extent that participation is compulsory. There will be cost-containment problems.

Accessibility and equity in the distribution of health care will to a large extent be determined by the coverage of services. Will the scheme cover all immunisations and maternal care? Will co-payments be needed for medical consultations, treatment of acute conditions, surgery, drugs, etc? How much will the co-payments be, and how will they be set? If coverage is insufficient, and co-payments are too high, users who find that they cannot afford out-of-pocket payments will eventually have to resort to private health insurance.

The MOH has proposed that the scheme will emphasise comprehensive coverage, equity, accessibility, as well as efficiency, acceptability, and affordability.¹⁶ It has also been stressed that participation in the national scheme will be compulsory for all who can afford it, and that government will cover the poor, the underprivileged and their dependents. It remains to be seen, however, to what extent the new financing scheme that emerges will be as envisioned by the MOH.

Provision of Health Care

The government's intention to withdraw from the provision of health care is tied to its privatisation and corporatisation policy. The plan to corporatise government hospitals was abandoned, some analysts say, in response to public and political pressure, just before the general elections of 1999. The buzz word 'corporatise' has since been replaced by the term 'restructure', perhaps for the same reason. Nevertheless,

¹⁵ Datuk Dr Mohd Ismail Merican, Deputy Director-General (Research and Technical Support), MOH, in a letter to *The Sun*, 14 March 2001.

¹⁶ Datuk Dr Mohd Ismail Merican, Deputy Director-General (Research and Technical Support), MOH, in a letter to *The Sun*, 14 March 2001.

corporatisation is still very much on the agenda,¹⁷ although what exactly it involves is still not clear. Questions arise with respect to ownership, accountability, public interest, and whether corporatisation is an intermediate step to privatisation.

In the current mixed public-private system, government health services play an essential role in providing a floor price with which price levels of private services will be compared. If a private health service is priced too high, consumers have the choice of reverting to the nominally priced government health service. Even if a compulsory health insurance scheme is put into place, utilising private health care might entail an out-of-pocket co-payment. The existence of an alternative which does not require co-payment would then serve as a floor price to keep co-payments down.

The argument for corporatising government hospitals revolves primarily around the need to bypass governmental salary structures in order to increase remuneration for medical personnel, with the objective of retaining them within the public health service. Presumably then, the public nature of the health service should not be transformed as a result of the restructuring.

Corporatisation will have an impact on accessibility and equity. If public hospitals can no longer rely on central treasury allocations, unprofitable facilities may have to be closed, thereby affecting geographical accessibility, unless profits generated at other facilities are centralised and ploughed back into non-profit making facilities for the sake of maintaining accessibility and equity. The fundamental question therefore is whether the restructured hospitals will be run on a for-profit or not-for-profit basis.

It should be clarified how the public nature of health services will be preserved while government withdraws from a provider role. This will have an important bearing on the objectives of accessibility and equity in the health care system as a whole.

Regulation and Cost Containment

It is generally accepted that health care, if left to the exigencies of supply and demand, does not result in cost efficiencies. The nature of health care is such that the market is bound to fail, not least because the user depends on the provider for information, to the extent that the provider often determines the type and level of health care utilised. In the private sector, the rationing of health care is based on the ability to pay, unlike in the public sector, where there is an established practice of decision-making based on clinical, epidemiological and ethical criteria.

There is no referral system in the private health care system in Malaysia. This has led to the inefficient utilisation of specialists, with private sector specialists managing a majority of cases that do not require their expertise.¹⁸ The unregulated

¹⁷ Thus, in Dr. Mohd Ismail's Merican's letter to *The Sun* (14 March 2001), he stated, 'The government is also responsible for the provision and financing of *public health* services, such as disease control, environmental health and the like. The future role of the government will be mainly regulatory, policy formulation, monitoring and evaluation of health services.' (Emphasis mine).

¹⁸ It has been shown that only about 25% of patients managed by private sector specialists were cases that required the expertise of a specialist, compared to 70% in the public sector (Abu Bakar Suleiman, Wong Swee Lan, A Jai Mohan, et al., 1993, *Utilisation of Specialist Medical Manpower: Report of a Collaborative Study by the Ministry of Health and the Academy of Medicine*, Kuala Lumpur: Ministry of Health).

acquisition of expensive medical technology by competitive players in the private sector has also led to an inefficient use of societal resources.¹⁹

Private wings established in public health facilities, where public medical personnel may see private patients, have given rise to problems. The media has reported on consultants abusing such arrangements, focusing on private patients to the detriment of public patients, and inducing insured patients to switch from the public to the private ward.²⁰ Such media reports need to be substantiated, but the fact remains that in the absence of regulatory structures and monitoring mechanisms, the system is open to abuse.

The Private Health Care Facilities and Services Act (1998) is an important step toward improved regulation of the private sector. In the event that a national health insurance scheme comes into being, the need for cost-containment will require increasingly more regulation and monitoring. If acceptability and affordability are to be achieved, the public interest should be strongly represented in regulatory bodies as well as processes that determine user charges and prices. There should be a strong framework and an effective process for consumer complaints, and for users to seek redress in cases of contention.

Privatisation

The Malaysian government's privatisation policy has brought about a vast expansion of the market for health care products and services.²¹ In the two cases where public services were privatised, costs to the public sector have increased manifold. In 1996, five hospital support services which together accounted for 14% of the MOH budget were privatised to three corporations -- Faber Mediserve Sdn Bhd, Radicare (M) Sdn Bhd, and Tongkah Medivest Sdn Bhd -- after which MOH hospital expenditures on support services went up by 3.2 times.²² Subsequently, the government contracted a private company to oversee and monitor these companies, incurring additional costs.

Two years earlier, in 1994, the Government Medical Stores had been privatised to Remedi Pharmaceuticals (M) Sdn Bhd, a subsidiary of the Renong group of companies, in a fifteen year concession to procure, store and distribute pharmaceuticals and medical supplies to government health care facilities, an activity that had accounted for 8% of the MOH budget. A 1997 study found that prices increased by 3.3 times after privatisation.²³

¹⁹ An example of this is the proliferation of MRI (magnetic resonance imaging) scanners. At the end of the 1990s, the president of the Association of Private Hospitals Malaysia (APHM) appealed for regulatory measures to limit the acquisition of expensive technology by private hospitals. Cited in Chan Chee Khoo, *The political economy of health care reforms in Malaysia*, paper presented at the *International Conference on Restructuring of Health Services*, Maastricht, Netherlands, 5-7 July 2001.

²⁰ Michelle Lee, 'Private wing in medical centre milks the rich, neglects the poor', *Malaysiakini*, 22 March 2002.

²¹ This is discussed in Chan Chee Khoo, 'The political economy of health care reforms in Malaysia', paper presented at the *International Conference on Restructuring of Health Services*, Maastricht, Netherlands, 5-7 July 2001.

²² Chan Chee Khoo, Noorul Ainur Mohd Nur and Dzulkifli Abdul Razak, 'A sunrise industry: the emergence of investor-led, corporate health care', paper presented at the *National Seminar on Health and Health Care in Changing Environments: the Malaysian Experience*, 22-23 April 2000, Kuala Lumpur.

²³ Mohd Izham Mohd Ibrahim, Zubaidah Che Embee and Dzulkifli Abdul Razak, 'Drug distribution systems in Malaysia: the privatisation of the General Medical Store', paper presented at the *National Conference on Privatisation and Health Care Financing in Malaysia*, 5-6 April 1997, Penang.

The government has increased spending in the health sector in absolute terms, but this increase is being channelled into privatised services.²⁴ The Citizens' Health Initiative, an informal grouping of individuals and non-governmental organisations has called for a moratorium on the privatisation of government health services pending a thorough review and assessment of the cost-effectiveness of previous privatisation exercises and impact on quality.²⁵ If public hospitals are corporatised, and governmental allocations are removed, it would be important for hospital budgets that services are contracted on a cost-effective basis while maintaining quality.

Conclusion

The World Health Organisation (WHO) lists government's roles in health care as service provision, resource generation, financing, and stewardship, or responsible management, and emphasises that ultimate responsibility for the performance of the health care system lies with the government.²⁶ A government is most effective in its roles if it is able to maintain a high level of credibility. Credibility is best achieved through being transparent and accountable to the public.

In this regard, one needs to take issue with the way in which the process of decision-making in the twenty years of deliberations for the national health financing scheme has been shrouded in secrecy. Not one of the numerous studies commissioned through the years was publicly released; even at this stage, the details of the national health financing scheme have not been released for public scrutiny and debate. In planning for the challenges of the future, the government cannot afford to neglect the role that the public and civil society can play. It is only by engaging the public in its planning that the government can truly work in the interests of the people.

²⁴ In the Seventh Malaysia Plan period, increased financial allocation was also channelled to building hospitals and clinics.

²⁵ *Citizens' Health Manifesto*, 8 July 1998, <http://prn.usm.my/chi.html>

²⁶ World Health Report 2000, *Health Systems: Improving Performance*, Geneva: WHO 2000.