The Malaysian health system that developed since the independence from the British in 1957 is heavily influenced by the UK health system. The system is centrally administered with the Ministry of Health playing a major role to administer, fund and manage the services at national, state and even district levels. For the past five decades, the Government of Malaysia has made very minimum progress to transform the system to one that is more competitive and responsive to current health care need of the population. There are at least three main policy issues that are important if one attempts to examine the present health system scenario in Malaysia:

Centralisation of Health Policy Development

One of the major challenges in facing the Malaysian health system currently is in the development of sustainable policy to address changing health care needs of the population. The government of Malaysia has been investing quite well to provide an extensive health infrastructure throughout the country. Currently, at the primary health care level, the basic curative and preventive services are provided through 2,856 government health centres and community clinics and more than 6,000 private clinics. The in-patient curative care is provided by 147 public hospitals which covers 75% of the total beds in the country. All of these services and facilities are being centrally monitored. The state and district authorities have no role in influencing all aspects of services provided by these facilities. All policies pertaining to health matters are developed by the central level Ministry of Health (MOH). Even in the three states of the country governed by opposition parties, the state government has a very limited role on health policies and decisions. At the central level, there are also very minimum consultations with other ministries and other stakeholders in health services in development of such policies. As such, whenever new policies were developed and implemented, many times these policies failed to address important issues that might affect the provision of quality and efficient services at the ground level. Often the policies were not able to reflect the demand and need of the local population. Furthermore, it is not the norm for MOH to consult with health experts in other sectors such as in the universities and private sector before developing any important policies in health. Health information systems in the country are also highly centralised. Data collated at the district and state level are normally sent to MOH headquarters for processing and storing. The procedures of sharing centrally analysed data with other researchers outside MOH are unclear and bureaucratic. Use of these data for effective decision-making is quite limited in Malaysia. Most of the policy decisions are more likely to be influenced by political agendas than professional advice from researchers and experts.

Health Financing

Overall expenditure on health in Malaysia is still quite low compared to many developed nations in the world. The latest estimate is at 4.4% of GDP; 53% of which is public contribution and the remaining 47% are private expenditure, mainly through out-of-pocket spending. The public health services are mainly funded through the taxation system.

MOH received only 7.7% of the government-operating budget, which no way nears the government expenditure on education (23.5%) and defense (12.1%). The high out-of-pocket expenditure is one of the reasons why the government is trying to establish the national health financing system based on social health insurance. For the past three decades the efforts to set up the social health insurance programme were not successful.

Among the reasons for such failure is the lack of technical capacity within MOH to develop the system, inadequate consultations with major stakeholders in the country, intense lobbying by private insurers and lack of political will to transform the current health financing system. Health financing experts from within the counties but outside MOH were not being effectively utilised by the government to develop the system. Instead, MOH brings in the so-called “experts” from international donors with very little exposure on the national health system to support them. Many times the models proposed by these international consultants failed to be supported by major stakeholders in the country.

Public and Private Health Care Interface

Private health care providers play significant complementary roles in providing high quality services appealing to consumers. Currently, there are 209 private hospitals providing 25% of the in-patient services in the country. There are 6,675 private medical clinics in the country; most of them are providing primary care services. There are 11,240 or 29%

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of the medical doctors working in the private sector. Despite the significant private sector infrastructure and workforce, there is a strict division between public and private sectors in the country. The interface between the two sectors is minimal; public doctors are not allowed to work in or own private health facilities. Although this division is to certainly extend some good outcomes in preventing abuses of public health care facilities and prevent these facilities from becoming the channelling centre, the health workforce in government services loses highly talented and skilled human resources to private health services within the country. It was estimated that nearly 70% of medical specialists are now in the private health sector even though only 30% of complicated cases requiring specialists’ care are being managed in this sector. Over the past five years the government tried to address these issues by allowing limited private practice in public facilities by setting up private wings in government hospitals. A number of government teaching hospitals have taken this step but the outcome was not encouraging. Monitoring mechanisms to ensure that doctors in public hospitals do not neglect publicly funded patients by giving priority to privately funded patients were not adequately put in place. Furthermore, there is very limited information available on the outcome of this programme in preventing specialists and doctors from leaving the public sector.

The three issues highlighted here are very important aspects of the Malaysian health system that need to be addressed by policy makers. Failure to do so may put the current system at risk and may not be able for the country to achieve universal coverage, which is one of the goals set by many developing countries in this millennium.

References:

Reviewer

Kenneth KC Lee, BSc (Pharm), MPhil, PhD, Professor of Pharmacy and Head of Pharmacy Programme, School of Medicine and Health Sciences, Monash University, Kuala Lumpur, Malaysia

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