Health Care in Malaysia

The dynamics of provision, financing and access

Edited by
Chee Heng Leng
and Simon Barraclough

Routledge Malaysian Studies Series

Health Care in Malaysia

The health care system in Malaysia has undergone a fundamental transformation over the last two decades. For many years after Independence, Malaysia enjoyed widely available and accessible health care services. Funding was through central taxation, and hospital care almost totally provided by government. In the 1980s this began to change under the influence of growing health care demand and utilization fuelled by rising incomes, urbanization and the emergent middle classes. The hospital sector is now seeing the rapid rise of corporate, investor-owned services and specialist clinics, whilst the proposed National Health Security Fund will essentially transform Malaysian health care from a taxation-based system to a social insurance system.

This book examines this transformation in Malaysia's health care system, and explores the pressing issues it faces today. It describes the evolution of the system since Independence, from the colonial legacy of national provision bequeathed from the British to the impact of the global ideological shift against statism in the 1980s. It considers the responses of the Malaysian state and government policy, and addresses important issues such as equity of provision, women's access to health care services, HIV/AIDS health care, care for the elderly and provision for indigenous peoples. Overall, this book provides a detailed examination of the changing face of health care in Malaysia, and its impact on Malaysian citizens, users and society.

Chee Heng Leng is Senior Research Fellow in the Asia Research Institute at the National University of Singapore. Her publications include *Health and Health Care in Malaysia: Present Trends and Implications for the Future*, and she was a member of the writing team for the World Health Organization report *Genomics and World Health*. She works in the areas of health and health care, gender, women and family.

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Preface

The chapters in this volume were first presented at a workshop entitled 'Health Care in Malaysia', held at the National University of Singapore from 9–11 September 2004. We are grateful for the support we received from the Asia Research Institute (ARI), National University of Singapore, for the organization of the workshop as well as for the preparation of this volume.

We would like to thank the many individuals who contributed to the success of the workshop, in particular the chairpersons and participants, and the Events Team at ARI. Adela Baer, Angelique Chan, Chan Chee Khoon, Joel Kahn, Phua Kai Hong, Volker Schmidt, Vineeta Sinha and Wong Mee Lian very generously spent time reading the various papers and giving their comments as discussants at the workshop. We would also like to place on record our appreciation for the participation of Mary Cardosa, Chua Hong Teck, Kumar Devaraj and Ooi Giok Ling.

From the conception of the workshop to the completion of this volume, we benefited from the support and input of many individuals. The idea for a workshop on health care in Malaysia, from which an edited volume would result, came initially from Anthony Reid, Director of ARI, without whose encouragement this volume would never have been produced. We also wish to thank Gavin Jones, Research Leader of the Changing Family in Asia Research Cluster at ARI for his help at various critical junctures.

Early on, Chan Chee Khoon and Jomo Sundaram were involved in the conceptualization of this volume; they also read and commented on various chapters, with Chee Khoon contributing to an early draft of the Introduction. M.K. Rajakumar who gave a keynote address at the workshop, and who has also kindly graced us with a Foreword, provided many invaluable comments. In this regard, we also wish to thank Gerald Bloom, who also gave a keynote address at the workshop, for his critical comments and insights. Tan Boon Kean lent his editing expertise for the Introduction and the Epilogue, and provided support and encouragement during the long and arduous process of editing. Nonetheless, as editors, we bear the responsibility for the final shape and contents of this volume. And to all the contributors of the volume, *ribuan terima kasih* for collaborating with us in bringing this project to fruition.

The Editors

Foreword

M.K. Rajakumar

Health is a requirement for fitness to earn a living, to attract a mate and to raise children, indeed for life itself: it is a special good that you cannot do without. Shared health care, and education, are the principal sources of social solidarity and social cohesion between peoples sharing a land in the modern state. This is more strongly a factor in new states such as Malaysia.

Health investment also reflects the distribution of political power. Equity in access to health care is a measure of the effective functioning of democracy. Rapid economic growth in Asia has reduced poverty, but we need measures of equity that incorporate timely access to health care and education, to give direction to further economic growth.

In a complex plural society like Malaysia, continued ethnic harmony is contingent on the acceptance of a reasonable degree of economic and social inequities, and on an electoral consensus based on the assurance of progress in remedying these inequities.

It is useful to consider the development of health services in Malaysia in several phases, as determined by the governing power:

- Foreign administration
  - British colonial period, before and after the Second World War
  - Japanese military administration
  - Postwar British administration
- Independence, elected government
  - 'Malayanization'
  - Modernization
  - Privatization

British colonialism

Modern scientific medicine, so-called 'western medicine', was introduced during the colonial period. It was directed towards the health care of the British and, separately, for preserving a fit workforce in the plantations and tin mines. The principal cause of disability and death was malaria: rushed

felling of the forests for plantations created a favourable environment for the mosquito vector of the malarial parasite; and in reclaiming land for Port Swettenham, nearly half the indentured labour from India died every year so that constant replacement of imported labour was needed. On the plantations and mines, where British personnel were also exposed, anti-malarial work to keep the environment free of the mosquito vector was conducted vigorously.

As populations became concentrated into townships, prevention of epidemics of water-borne infections, typhoid and cholera necessitated investment in providing safe water. The health services moved into the hands of professionals who brought a degree of professionalism and conscientiousness to their work.

Only low status employment was given to Asian doctors, nurses and lab technologists, who were discouraged from acquiring postgraduate qualifications. In Singapore, the determination of the Chinese community was shown when it funded a medical school. Its graduates, as well as doctors qualified in India and elsewhere, were designated 'assistant medical officers' ranking below British matrons. This included a few who had acquired postgraduate qualifications on their own initiative from the United Kingdom (UK) royal colleges. (This formed the basis of a long, friendly, professional association with the royal colleges that lasted beyond British colonial rule.) Nevertheless, on returning home, they were denied specialist status, remaining 'assistants'. Asian doctors held low rank in the hierarchy but were doing major surgery and managing all illnesses. Some resigned in disgust and entered private practice, which gave general practice a wide range of skills, high status and acceptance in the community that has lasted.

Japanese military administration

The Japanese faced a hostile population. Their brutality in China had earned the hostility of the Chinese in Southeast Asia. The British, when abandoning their territories, armed the Communists, mainly Chinese, to provide a resistance. The Japanese sought to subdue the people by terror, brutality and killing, particularly targeting the Chinese.

Japanese doctors and medicines were needed for their soldiers, and the care of the population was relegated to Asian doctors. Overnight, Asian doctors found themselves running hospitals, and training their younger colleagues in managing severe illness and doing major surgery. A medical school was started in Malacca by the Japanese administration, and its students were to become the first entrants – mature, tough and experienced – to the medical school in Singapore when it reopened after the war.

A cadre of self-confident and experienced Asian doctors was in existence when the British returned to re-establish colonial administration. They would not accept reverting to being the juniors to inexperienced British doctors.

Postwar British administration

Events in Asia reflected a vastly different political climate. Malay nationalism was a powerful force and the civil servants and professionals moved to push out the British officers who remained. The reluctance to allow Asian doctors to acquire higher specialist qualifications in the UK was now remedied by sending their younger colleagues, with much experience and skills, but lacking formal qualifications, to the UK for the royal college diplomas.

'Malayanization'

With Independence in 1957, the drive to replace British staff with locals became effective. The new ministers went along with their influential professional staff. The driving force behind Malayanization were the medical alumni from Singapore. They moved systematically to replace the British doctors, although they personally liked some of them. In Kuala Lumpur, a medical school was started, which soon became a university. Demand for tertiary education – the principal channel for upward mobility, apart from politics – resulted in rapid proliferation of universities, both public and private, many of which set up medical schools.

The leaders of the health professions retained their orientation to British education, and doctors turned to the royal colleges for postgraduate training and certification. Soon local medical schools created their own postgraduate specialist programme in response to demands for Malays to be trained as medical specialists. The success of this policy can be seen in the preponderance of Malay doctors of all grades in public hospitals now. The same process took place in the civil service.

There was for the first time a preoccupation with the needs of our people. A rural health service was initiated, new specialties created, including the speciality of family medicine/general practice, and generous allocations of research funds became available. Even larger numbers of young doctors were sent abroad, still mainly to the UK, for training and certification.

Modernization

Following 'Malayanization', a high degree of professionalism emerged. Advanced training developed which was in time offered to other developing countries. The first new universities achieved high standards, and entered postgraduate training and qualifications. A self-confident generation of experts filled posts in the public services, gently replacing their local seniors who had risen by seniority out of the old colonial service.

In medicine, an emphasis on science and expertise, and keeping up to date with research became the paradigm. Research was regarded as important, and public health research, beyond malaria, received attention and funding.

New specialty institutions began to appear at the Kuala Lumpur General Hospital.

The public health services, underpaid and over-extended, remain the mainstay of health care for the majority of people. They are further strained by VIP pressure for privileged access and expensive care. Health care is virtually free to anyone willing to wait, and to overlook the shabbiness of facilities and shortage of staff. Some 80 per cent of those hospitalized are in public hospitals, and half of all outpatients attend public clinics and the outpatient departments of public hospitals. The numbers increase sharply when the economy slows.

The public sector trains all categories of medical staff, and does all research. It is the exclusive source of care for perhaps half the population and provides a safety net for those whose incomes fluctuate with the economy. It is also provider of last resort for patients who are very ill and whose savings have been exhausted, or who have been admitted as emergencies.

Our health indices are very good. For example, in 2005, life expectancy was 76 years for women, and 71 years for men, and the infant mortality rate was 5.8 per 1000 live births. Since Independence, the public health services have performed brilliantly in dealing with the principal causes of mortality and morbidity associated with a poor colonial territory. The challenge to improve further will be more difficult.

The 'developed' country pattern of disease is the price of rising living standards. The new causes of morbidity and mortality, replacing malaria, tuberculosis, infant gastroenteritis and respiratory infection, are hypertension, diabetes, ischaemic heart disease/atherosclerosis and cancer. Increasingly important are the consequences of 'lifestyles' – tobacco smoking, alcohol excess, excess fat and calorie intake, physical inactivity and obesity, and sexually transmitted infections. Infections spread by international travel are a new phenomenon, including HIV and SARS. More research will be required to design new public health approaches, and a high degree of personalized intervention will be needed to reduce morbidity and mortality from the new causes of death.

Public hospitals and ambulatory care provide open access to all Malaysians. No financial barrier exists for ambulance services, receiving emergency or normal treatment, or for admission to open wards, that is 'Third Class', where conscientious care will be given by overworked and underpaid nurses and doctors. Government servants have assured medical care, and ward accommodation allocated according to rank. There is continuity with the colonial practice of East India Company employees in 'Company' hospitals!

The public health care system is the 'safety net' for the great majority of Malaysians, and they are fiercely protective of this right to free access. It is now in a bad state, unable to deter all categories of staff from leaving for the private sector. Nevertheless, resources continue to be diverted to private contracts for building more hospitals that are beyond the available staffing capacity.

Privatization

Privatization was heralded by the 'corporatization' of profitable government departments and agencies. In reality, it was not a straightforward transfer of public assets to the successful corporate bidder in an open competition. Public assets were secretly allocated to powerful political interests.

For the first time citizen activist groups have appeared. Their hostile reaction to the possible 'corporatization' of public hospitals pressured the government to give a categorical assurance, before the general elections, that this would not happen. An unanticipated consequence was that the good idea of giving more management power to individual hospitals, instead of them being controlled by ministry officers, was scuttled. A sensible way out would be to establish statutory trusts, by Act of Parliament, mandated to manage the hospitals efficiently in the public interest.

Emerging issues

There are multiple tiers of care. The private sector looks after the better-off, and access is slowly being extended to senior public servants. Government servants are separated from the community, in the colonial tradition, by privileged access to public heath care services, and to some private hospitals. Employees of statutory authorities may also have access to private hospitals.

The urban workforce has limited access to health care as part of their employment benefits. Relatively small numbers have private insurance. The majority are outside the sphere of organized care, and they move between the public and private sectors for episodic care, depending on their income at a particular time.

The take-over of health decision-making by politicians means that projects can be awarded without assessment by the expert professionals in the Ministry of Health. This cost is hidden, noticeable post hoc in the accounts and budgets, or from reliable leaks that have become the principal source of information. There is a cost to the community.

The persistence of low relative incomes amongst the majority of the population, with increased urbanization, has generated high levels of stress among people, with predictable consequences. The Malays remain the largest number amongst the underprivileged, in spite of a half century of privileges which never reached small Malay businesses and rural Malays. This is ominous for our future.

With increased commercialization of health care, and diversion of health funds to private interests, a multi-tiered quality of care has become entrenched. The better-off in our society have sustained a parallel health system (as with education), from ambulatory care to tertiary centres, funded and managed by foreign investors under liberalized access claimed under free-trade agreements and supportive government policies. There are also World Trade Organization (WTO) concessions and an Association of Southeast

Asian Nations (ASEAN) services network agreement. Foreign investors already own most private hospitals and they are now moving into primary care through so-called 'ambulatory care' centres. (In education, too, there is a fast growing parallel system with numerous foreign investors, from kindergarten to university, offering overseas qualifications, taught by visiting teachers from overseas.) The middle and upper classes have seceded from the national stream!

The commercialization of health care, and neglect of rural health, have serious consequences for the management of diabetes, hypertension and cardiovascular disease, which require continuing care, not merely episodic care. The rural population bypasses good government rural facilities and goes to the cities for private care, believing they will get better care. The urban poor, who cannot afford the loss of income that the long wait for care at government facilities entails, either neglect their health or make visits to private doctors when they can afford it.

There is under-investment in public health facilities and failure to retain skilled staff. It is more rewarding for politicians to build costly, unnecessary hospitals with expensive equipment that carry costly maintenance contracts. Training nurses, doctors and technologists has become a subsidy to the private sector, which is growing fast and pressing for more skilled doctors and nurses.

Malaysia has targeted 2020 to be a 'developed country'. The collapse of the public sector in health (and education) gives rise to forebodings of a highly inequitable future, with health services transferred to foreign investors and their local partners.

Dr. MK Rajakumar is Past-President of the Malaysian Medical Association and was Chair of the MMA Committee that produced the landmark 1980 report 'The Future of the Health Services in Malaysia'. His previous positions include President of the Malaysian Science Association, Vice-Chair of the Malaysian Academy of Sciences and President of the World Association of Primary Health Care Physicians. He was also the last acting chair of the Labour Party of Malaya, and he is frequently consulted on health care policy in Malaysia.

Abbreviations and glossary of Malay terms

ABC	Alternative birthing centres
ADL	Activities of daily living
AIG	American International Group, Inc.
APHM	Association of Private Hospitals of Malaysia
AZT	Zidovudine
BAPPENAS	Badan Perencanaan dan Pembangunan Nasional/ National Development Planning Agency (Republic of Indonesia)
BCIC	Bumiputera Commercial and Industrial Community
BPS	Biro Pusat Statistik/Central Statistics Bureau (Republic of Indonesia)
Bumiputera	Official Malaysian category for 'indigenous', literally the word means 'sons of the soil'
CAHCP	Coalition Against Health Care Privatization
CalPERS	California Public Employees' Retirement System
CAP	Consumers' Association of Penang
CARE	Cooperative for Assistance and Relief Everywhere
CBR	Crude birth rate
CCM	Chemical Company of Malaysia
CEDAW	Convention for the Elimination of Discrimination Against Women
CHI	Citizens' Health Initiative
CHM	Citizens' Health Manifesto
CI	Composite index
CIROAP	Consumers International Regional Office for Asia and the Pacific
CNR	Crude rate of natural increase
CPM	Columbia Pacific Management
CTG	Cardiotocograph
CUSO	Canadian University Services Overseas

DAP	Democratic Action Party
DBKL	Dewan Bandaraya Kuala Lumpur/Kuala Lumpur City Hall
DOSH	Department of Occupational Safety and Health
DST	Drug substitution treatment
EPF	Employees' Provident Fund
EPI	Expanded Programme for Immunization
EPU	Economic Planning Unit
FDS	Flying Doctor Service
FELDA	Federal Land Development Authority
FFPAM	Federation of Family Planning Associations of Malaysia
FOMCA	Federation of Malaysian Consumers Associations
GATS	General Agreement on Trade in Services
GDP	Gross domestic product
GMPPK	Gabungan Membantah Penswastaan Perkhidmatan Kesihatan or CAHCP
GNI	Gross national income
GNP	Gross national product
HAART	Highly active antiretroviral therapy
HIV/AIDS	Human immunodeficiency virus/Acquired immune deficiency syndrome
HMI	Health Management International
HMO	Health maintenance organization
HTS	Healthcare Technical Services Pte. Ltd
HUKM	Hospital Universiti Kebangsaan Malaysia
HUSM	Hospital Universiti Sains Malaysia
IADL	Instrumental activities of daily living
ICPD	International Conference for Population and Development
IFIs	International financial institutions
IJN	Institut Jantung Negara/National Heart Institute
IKIM	Institut Kefahaman Islam Malaysia/Institute of Islamic Understanding
ILO	International Labour Organization
IMF	International Monetary Fund
IMR	Infant mortality rate
IRPA	Intensification of Research Priority Areas
IUD	Intra-uterine device
JHEOA	Jabatan Hal-Ehwal Orang Asli/Department of Orang Asli Affairs
JOA	Jabatan Orang Asli/Department of Aborigines
KLSE	Kuala Lumpur Stock Exchange
KPJ	Kumpulan Perubatan Johor

LGBT	Lesbian, gay, bisexual and transgender
LIAM	Life Insurers Association of Malaysia
LTC	Long-term care
MAC	Malaysian AIDS Council
MCA	Malaysian Chinese Association
MCH	Maternity and child health
MCQ	Midwife clinic cum quarters
MDA	Malaysian Dental Association
MMA	Malaysian Medical Association
MMC	Malaysian Medical Council
MMR	Maternal mortality rate
MOF Inc	Ministry of Finance Incorporated
MOH	Ministry of Health
MPAJ	Majlis Perbandaran Ampang Jaya/Municipal Council of Ampang Jaya
MPKSM	Majlis Pusat Kebajikan Semenanjung Malaysia/ Central Welfare Council of Peninsular Malaysia
MRI	Magnetic resonance imaging
MSCI	Morgan Stanley Capital International
MTUC	Malaysian Trade Union Congress
NEP	New Economic Policy
NGO	Non-governmental organization
NHFA	National Health Financing Authority
NHI	National Heart Institute
NHMS 1	National Health and Morbidity Survey (1986–87)
NHMS 2	National Health and Morbidity Survey (1996)
NPFDB	National Population and Family Development Board
NPP	New Population Policy
OECD	Organization for Economic Cooperation and Development
PAS	Parti Islam SeMalaysia
PDC	Penang Development Corporation
Pernas	Perbadanan Nasional Berhad
PIC	Preliminary Investigation Committee
PKR	Parti Keadilan Rakyat
PLI	Poverty line income
PLWHA	People living with HIV/AIDS
PMC	Penang Medical Centre
PNB	Permodalan Nasional Berhad
PPP	Purchasing power parity
PROAP	Principal Regional Office for Asia and the Pacific
PROSTAR	Program Sihat Tanpa AIDS untuk Remaja/The Healthy Programme Without AIDS for Youth

PRSPs	Poverty reduction strategy papers
PSM	Parti Sosialis Malaysia
RHS	Rural Health Service
RPS	Rancangan Perkumpulan Semula/Regroupment Scheme
SAPs	Structural adjustment programmes
SARS	Severe acute respiratory syndrome
SEAMEO-TROPMED	Southeast Asian Members on Education Organization & Regional Centre for Tropical Medicine Network
SEDC	State economic development corporation
SIHAT	Sistem Hospital Awasan Taraf
SOCSO	Social Security Organisation
STDS	Sexually transmitted diseases
Syariah	Islamic law
UEM	United Engineers Malaysia
UMNO	United Malays National Organization
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Science and Cultural Organization
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
VHP	Village health promoter
VHT	Village health teams
WB	World Bank
WHO	World Health Organization
WTO	World Trade Organization
Yayasan Pelaburan Bumiputera	Bumiputera Investment Foundation