**Our Progress towards “Health for All” in Malaysia**

*Health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right. The attainment of the highest possible level of health is a most important world-wide social goal. There is a need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world.*

The Declaration of Alma-Ata, September 1978.

**Health Care in Malaysia**

Malaysia has a fairly well developed health care delivery system1. There are approximately 2860 government run Health Clinics distributed throughout the nation (Health Facts 2014. MOH). 1039 are Health Clinics which have the post for a doctor, while 1821 are Community Clinics which are manned by paramedics. Over 86.2% of the population are within 5 km of a Health Clinic (Household Income and Basic Amenities Survey 2016). In addition there are 6800 private General Practitioner (GP) Clinics in small and big towns providing primary care. (Health Facts 2014)

The Ministry of Health (MOH) maintains 141 hospitals2 that provide in-patient treatment. (Health Facts 2014. MOH.) In 2017, there were a total of 2.37 million admissions to government hospitals compared to 1.05 million admissions to private hospitals (Health Facts 2018. MOH) The smaller District Hospitals do not have high tech facilities for investigation or treatment – eg no CT scanners, and most do not have the capacity to conduct operations under general anaesthesia. However the larger government hospitals are quite well equipped with diagnostic modalities and a number of specialist departments.

And then we have the private hospitals which in 2016 provided 14,620 out of the total of 60,300 hospital beds in the country3. These private hospitals are concentrated in the larger towns mainly in the West Coast of Peninsular Malaysia and they have the services of more than 70% of the specialists aged above 50 years.

Childhood immunization is nearly universal. BCG, DPT and Polio immunization was administered to between 98 – 99% of infants born in 2017 (Mins of Health. Health facts 2018)

**Current Shortcomings of Malaysia’s Health Delivery System**

Most Malaysians will agree that we have a fairly good public health care system. Any Malaysian who needs medical treatment can access care at a government clinic or hospital at very affordable rates. However there are several shortcomings as listed below –

1. **Incompetence on the part of the “gate-keepers”.**

There is a wide variation in the competency of the junior doctors manning the Health Clinics and the Out-Patient Departments of the District Hospitals. Some senior specialists in the government sector have confided that up to 30% of the junior doctors in service are dangerously incompetent! This leads to misdiagnoses and delays in diagnosis. It also contributes to the phenomenon of patients by-passing the Health Clinic and the District Hospital to go directly to the General Hospitals for assessment and treatment. Those who can afford it go directly to the private hospitals.

1. **Breakdown of the system based on Primary Health Care.**

The government hospitals still require screening by the out-patient department before patients can access specialist clinics thus keeping to the Primary Health Care approach. However this is not observed in the Private Hospitals where patients can choose which specialist to see for initial assessment of their symptoms. Most Malaysians do not have a primary care physician but “shop” around going to government OPD clinics, private GPs as well as the private specialists. Continuity of care is affected, and this inhibits interventions to promote health and prevent disease. Our system is too treatment oriented and this results in poorer outcomes for Non Communicable Diseases (NCDs)4 in addition to being less cost effective.

1. **Overcrowding of Government Clinics and Hospitals**

The General Hospitals are terribly over-crowded. Wards routinely have more than double the number of patients that they were built for; patients sometimes have to wait in the A&E Department for over a day for a bed in the ward; sometimes patients have to be discharged before they are quite ready. The overcrowding not only stresses the medical personnel and adds to the discomfort of patients but also predisposes to nosocomial (hospital acquired) infections.

1. **Shortage of Specialists in Government Sector**

There is a shortage of specialists in the government sector. In 2013, 40% of the specialists in the country aged between 50 to 60 years were in public hospitals5 but they were managing 70% of the in-patient load, as well as the training of the new generation of doctors.

The development of sub-specialty services in the government sector is continually undermined by the tendency of the trained sub-specialty doctor to migrate to the private sector within a few years of sub-specialty training.

This lack of specialists has several adverse consequences including

- delays in specialist assessment

- delays in diagnosis and misdiagnoses

- inadequate supervision of junior doctors

- treatment errors

- loss of faith in the government hospitals

1. **Long waiting times**

The waiting time to get certain investigations done eg MRI, CT scan, Stress Tests, Echo, cardiac angiograms etc can be months. This sometimes puts the patient at risk of suffering a further deterioration of their condition before they are fully investigated.

1. **A Two-Tier System of Health Care**

There is a de-facto two-tier system of health care in Malaysia. Those who can afford go directly to the private sector where they are assessed and treated quite promptly6. Those who cannot afford the charges in the private sector go to the government hospitals where sometimes, delays in investigation, diagnosis and treatment lead to poorer outcomes.

1. **Rising costs of “co-payments”.**

The newer devices and treatment modalities are not provided free by the government hospitals; they have to be bought by the patient – for example cataract lenses, plates and screws for fractures, coronary artery stents, oesophageal stents, surgical staplers for colon anastomoses etc. Some of these devices are expensive eg RM 7000 for a drug eluting stent. The number of implants and devices that now have to be paid for by the patient is large and is expanding.

1. **Catastrophic expenditure**

The families of patients with critical illnesses such as a heart attack, stroke, cancer and several others are often under severe financial stress as they struggle to obtain the best treatment for their loved ones.

**The main Causes of the Shortcomings in the Malaysian Health Care System**

**A. Insufficient Funds given the Increasing Sophistication of Modern Medicine**

Federal allocation for the Ministry of Health has gone up in tandem with the GDP from RM14.76 billion in 2010 to RM26.53 billion in 2018. (Federal Budget Estimates. MOF) This represents a 49% increase in real terms (ie after discounting for inflation7) between 2010 and 2018. However the advancements in the modalities of investigation and treatment have inflated the costs of treatment at an even faster pace. As a result the Ministry of Health has not had sufficient funds to expand its services to provide the newer modalities of treatment in a comprehensive manner despite the fact that the 9.47% of the Federal Budget was allocated to the Ministry of Health in 2018.

**B. The replacement of the Welfarist Ideology by the Neoliberal Approach**

The Malaysian Health Care system was developed in the 1950s and 1960s at a time when the governments of Britain and Malaya subscribed to the social-democratic goals of expanding the welfare net for the population. The Cold War was at its height and there was a real need to win over the “hearts and minds” of ordinary people both in Europe and in the newly independent nation of Malaya.

However the victory of Western Capitalism over USSR and the Warsaw Pact led to a realignment of priorities, and a new ideology – neoliberalism – began to gain credence from the 1980s onwards. The major tenets of neoliberalism8 include

* The market is a much better allocator of scarce resources than any bureaucracy.
* Governments should withdraw from the provision of goods and services. These should be left to the private sector as then, the competition between the different companies will result in more efficiency and in cheaper services.
* Even social goods such as education, health care, public transport etc can be provided more efficiently by the private sector.
* The government should reduce its role in the economy to that of a regulator and not a major player.
* Inequality in society is beneficial for it drives people to improve themselves so as to move up the ladder. Too much welfare provision inhibits human initiative and makes the population lazy.
* Charging people for health care is also a good thing as it will encourage them to follow a more healthy lifestyle.

**C. Privatization**

The interplay of the above 2 factors led to the policies that have greatly augmented the role of commercial interests in health care delivery in Malaysia as is set out in the table below.

|  |  |  |
| --- | --- | --- |
| **Policy** | **Benefit to the Malaysian People** | **Adverse effects** |
| Allowing for-profit private hospitals | Has reduced the emigration of Malaysian Specialists to other countries | Is a major cause of the Brain Drain that has decimated the number of specialists in government service.The involvement of GLCs in private hospitals has created a conflict of interest between the Mins of Health and the Mins of Finance. |
| Privatisation of procurement of medicines in 1993 | ? | Increase in the costs of medicines.Loss of technical expertise in assessing the efficacy of generic drugs |
| Privatisation of 5 support services in 1997 | Helped provide an “incubator” for developing Bumiputra entrepreneurs  | Increase in costs for the Ministry of HealthPushed the lowest level of staff in the Mins of Health deeper into poverty* Precarious employment
* Pertpetually at minimum wage
* No pension benefits etc
 |
| Privatisation of Hospital Construction  | ? | Increase in costsPoor quality of work. Many technical problems. Delays in completion of projects. |
| Full Paying Patients Scheme | Might have played a role in retaining some specialists in government sector | Creates conflict of interest in senior specialistsDistracts government specialists from caring for the normal non-paying patients. |

Privatization has not proven to be the panacea it was touted to be. Initially promoted as an approach to give better value for our tax dollar, privatization has not led to any appreciable savings but has exacerbated problems like the brain drain from government hospitals and worsened the plight of the bottom level of workers in the health care sector.

**D. Liberalization of the Global Economy**

The liberalization of the financial sector has made it much more difficult for government to collect taxes from the top 0.01% of society. These gentlemen are able to, with the help of their lawyers and accountants, to avoid paying taxes by employing a slew of tactics that have been made “legal” by changes in the financial regulations. These include transfer pricing so that profits made in a particular country are repatriated to a tax haven through grossly exaggerated fees, royalty payments, payments for technical services and the like.

The fear that governments that their wealthiest business people might shift their operations (or at least their headquarters) has led to a race to the bottom in corporate tax rates. Malaysia had a corporate tax rate of 40% up till 19889. It has plummeted to 24% now and the government has already indicated that it will be brought down further. (Singapore’s corporate tax rate is at 18%!)

But this is not a problem that is peculiar to Malaysia. The majority of nations are facing budgetary constraints because they too, are unable to get their super-rich to pay reasonable taxes. Consequently many countries have chalked up huge sovereign debts ranging in 2017 from 87% in the case of UK to 224% for Japan10. There is therefore a world-wide trend to keep budget deficits to below 3% of the GDP. Governments try to compensate for their inability to deal with their super-rich by instituting consumption taxes (like the GST) and/or by reducing social spending for the population.

Only recently are we hearing calls among civil society groups in the West that the loopholes that allow the super-rich to avoid paying taxes have to be closed. The issue is being framed by some as a discussion of how the wealth generated in our societies needs to be distributed. This discourse is still in its infancy in Malaysia!

**Concluding remarks**

Malaysia developed, in the first 3 decades after Independence, a fairly comprehensive public health care system that provides health care that is virtually free at the point of delivery to all Malaysian citizens. Apart from responding to the health needs of the Malaysian population, the system has played an important role in sharing the wealth of the country with the poorer sectors of the population, thus reinforcing social solidarity, building a sense of inclusivity and making our society more harmonious and stable.

However, rising costs engendered by technological advances and new modalities of treatment have put our health care system under serious financial stress. One of the responses of the BN government has been to involve the private sector in the provision of health care services. But this has had unwanted consequences such as the out-migration of government specialists and the creation of a two-tier health care system. Another response of the BN government was to look to alternative sources of funds – a National Health Fund deriving its funds from insurance premiums paid for by the public has long been on the drawing board.

Health system “experts” from agencies such as the World Bank are happy to provide advice – and they generally recommend neoliberal solutions. The recently concluded Harvard Study recommends that our government should devolve more of its health care functions to market players and concentrate mainly on regulation. None of these external “experts” advise how developing countries could strategize to retain a larger share of the wealth that we are producing, but which is expropriated by the huge MNCs that dominate the global supply chains. The current distribution of wealth is treated as a natural (God given) phenomenon by the learned men from World Bank and Harvard – something that we all have to accept and live with. Unfortunately for us, a significant portion of our current Ministers are enamoured with the learned men from Western Institutions!

It would thus be apt to conclude by quoting Dr Julian Tudor Hart’s (1927 – 2018) “Inverse Care Law”.

*The availability of good medical care tends to vary inversely with the need*

 *for it in the population served. This inverse care law operates more*

*completely where medical care is most exposed to market forces, and*

*less so when such exposure is reduced.*

 (Lancet. 1971)

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**Notes**

1. I am not detailing the improvements in Infant Mortality Rates, maternal Mortality Rates or Life Expectancy to support this assertion as one cannot conclude that the improvement in Malaysia’s health indices is due primarily to the quality of health care our citizens enjoyed. There are other factors such as improving income, better nutrition, sanitation, clean water supply and others that have played a role as well.

2. The Ministries of Education and Defence also maintain hospitals.

3. [www.statista.com/statistics/.../number-of-beds-in-public-and-private-hospitals-mal.](http://www.statista.com/statistics/.../number-of-beds-in-public-and-private-hospitals-mal.)

4. This is reflected in the not so impressive figures for life expectancy at 30 years.

5. Human Resources for Health, Country Profiles 2015 Malaysia, MOH Malaysia.

6. There is evidence that sometimes patients with third party payers tend to get over admitted, over investigated and over treated. The fee-for-service system predisposes towards this.

7. The inflation rate from 2010 -2017 was 1.7% (2010), 3.2%, 1.7%, 2.1%, 3.1%, 2.1%, 2.1% and 3.1% (2017) respectively. https://knoema.com/atlas/Malaysia/Inflation-rate

Therefore the cumulative inflation rate 2010 to 2018 was 20.76%

8. Liberalism was the ideology of the European bourgeoisie of the 19th century which had to enlist the support of the masses to fight against the privileges of the feudal lords and aristocracy that obstructed the further development of the market economy that the bourgeoisie depended on. It was overall a progressive ideology as it freed the masses from the yoke of feudalism, introduced the concepts of political democracy, universal suffrage including for women, rule of law, the universality of human right etc.

Neo-liberalism is quite different. It has roots in the critique of the totalitarian states that developed in Germany and Eastern Europe in the mid 20th century. But it was coopted by the bourgeoisie to push back against the social democratic state that sought to curb the power of the capitalist class and redistribute the wealth of the nation more equitably through taxing the rich and creating a welfare net for all.

9.

[B9 TAX RATES – COMPANIES AND UNINCORPORATED BUSINESS](http://B9 TAX RATES – COMPANIES AND UNINCORPORATED BUSINESSwww.mia.org.my/v2/downloads/resources/publications/budget/2017/B/B9.pdf)

[www.mia.org.my/v2/downloads/resources/publications/budget/2017/B/B9.pdf](http://B9 TAX RATES – COMPANIES AND UNINCORPORATED BUSINESSwww.mia.org.my/v2/downloads/resources/publications/budget/2017/B/B9.pdf)

10.. The World Factbook. US-CIA.

 Incidentally, Malaysian government debt as a percentage of GDP in 2017 was recorded in the CIA Factbook as 52.5%