

# **MALAYSIAN HEALTHCARE**

## **Where are We Heading?**

**A critical look at the proposed  
National Health Financial Scheme**

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# Malaysian Healthcare – Where are we heading

*Ministry of Health's Vision for Health in which " Malaysia is to be a nation of healthy individuals, families, and communities, through a health system that is equitable, affordable efficient, technologically appropriate, environmentally adaptable and consumer-friendly, with emphasis on quality, innovation health promotion and respect for human dignity, and which promotes individual responsibility and community participation towards an enhanced quality of life".*

## 1. Introduction

Since Merdeka almost about 50 years ago, Malaysian healthcare system as a whole has performed fairly well. The government recognizing the importance of health as a basic right has been the major player in the health care system. Government public health services which are financed mainly by taxes have provided excellent cover for primary healthcare, with extensive network of rural health centres and clinics, supplemented by urban government hospitals and specialist referral clinics based in these hospitals.

Private health sector meanwhile is playing an increasingly important role. Before 1980, private hospitals were few and consisted mainly of hospitals which were community-or- philanthropic-supported. Private practice then were primarily by way of individual general practice and a limited number of specialists in these not-for profit institutions.<sup>1</sup> But over the years, especially since the 80s, profit-orientated private hospitals have mushroomed , especially in the urban areas. Private health care business is now dominated by investor-owned healthcare businesses; some of them are even listed on the stock exchange. <sup>2</sup>

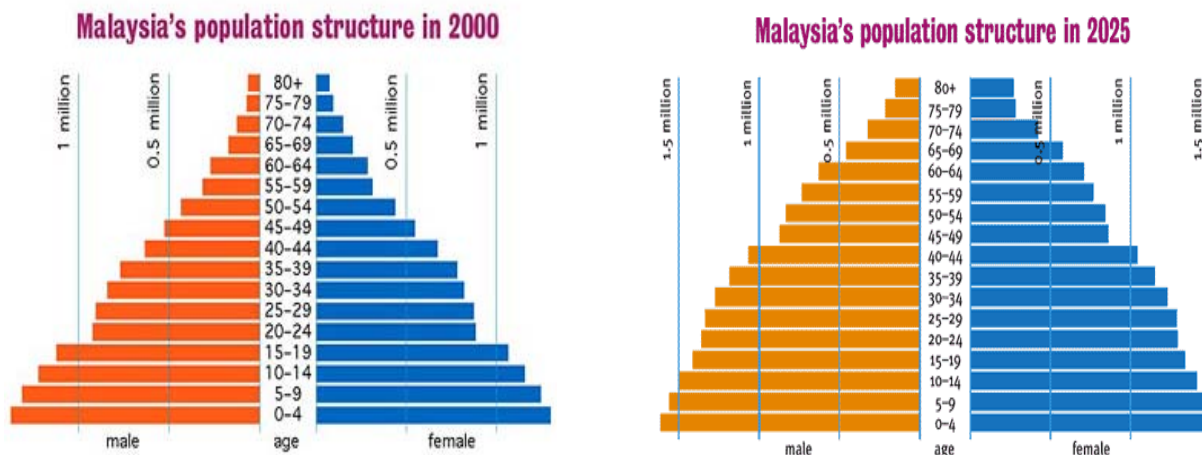
In the 1980s, government contributed about 76% of the total health care expenditure. By 2000, the private health sector share of the health care expenditure is estimated to be about 40%. <sup>3</sup> The rapid growth of private health sector is a direct

result of government's policy of letting private sector play a greater role in areas such as health and education since the early eighties.

This rapid growth of private hospitals and clinics has resulted in a "brain drain" of doctors and other medical personnel from the public sector. About two third of surgeons and physicians now work in private sectors, with the remaining one-third in government hospitals . This is despite the fact that government hospitals have  $\frac{3}{4}$  (about 34000 beds) of total hospital beds whereas private hospitals have only 9100 beds .<sup>4</sup>

The consequence is a very overworked public health sector and a perceived decline in the quality of healthcare in the public sector. The fact is, despite the heavy workload, Malaysian public health sector is still functioning well and this statement will be backed with figures and statistics in the later part of this report.

Besides the heavy workload, there are many other challenges facing the public healthcare sector. As with many other countries, the proportion of older people is set to increase over the next few decades (figure 1). This couples with rising cost of medication and equipment, rising demand of quality healthcare and sophisticated equipment and changing patterns of diseases will inevitably lead to a higher healthcare cost in future.



**Fig. 1 Malaysian Population breakdown by age groups in 2000 & 2025 (projected)**

In view of this expected increase in healthcare cost, the government has, since the early eighties, been studying the feasibility of privatizing certain aspects of health services. Under the Sixth Malaysian Plan period, a number of public health facilities and related services were corporatised and privatized. The National Heart Institute (IJN) was corporatised in 1992. The general medical store was privatized in 1993. Hospital supportive services such as laundry and cleaning, equipment maintenance, waste disposal and facility maintenance services in all hospitals were privatized on a regional basis in 1995. <sup>5</sup>

At the same time, the government has been considering introducing a national health financial insurance in place of tax revenue as the main financing of its national healthcare system.

The aim of this report is to consider whether such a scheme is necessary and feasible and whether the introduction of such scheme will bring any adverse effects to the people.

## **2. Proposed National Health Financial Scheme**

As part of the privatization policy started in the early 1980s, the government has in 1983 commissioned a study on health service planning with a grant from the Asian Development Bank. The report was completed in 1985, but was not released for public consideration. It was learnt that the report made a few recommendations, among them were the creation of a National Health Security Fund., selective privatization of certain medical services and development of health management organization (HMOs) .<sup>1</sup>

In the Seventh Malaysia Plan (1996-2000), it was stated that “the *Government will gradually reduce its role in the provision of health services and increase its regulatory and enforcement functions. A health financial scheme to meet health care costs will also be implemented. However, for the low income group, access to health services will be assured through assistance from the government*” .<sup>6</sup>

The government has undertaken several feasibility studies on the establishment of a National Health Financial Scheme. The latest was by a consultant from Australia which was asked to study the details of financial mechanism of the proposed National Health Financing Scheme (NHFS).<sup>24</sup>

Very little is known about the proposed scheme. So far little consultation was done with the interest groups such as general public, civil rights groups, consumer groups and medical associations. This perceived lack of transparency has created a lot of unhappiness and uncertainties among interested groups.

According to the certain sources, the Ministry of Health’s proposal on NHFS has the following components .<sup>7</sup> These are:

### **i. The National Health Fund**

There will be an establishment of a new fund known as The National Health Fund. It will pay for the treatment of all the conditions/illnesses that are specified in the “Essential Health Benefit Package”.

Payments will be made to both the MOH hospitals and clinics as well as to the private hospitals and GP clinics.

But few things are known as the mechanism of how this fund is to be set up and who will contribute to this fund.

#### **ii. Mandatory Monthly Contributions.**

It is possible that one source for this fund will be a mandatory monthly contribution not unlike EPF contributions by both employers, employees and self-employed. The government will also make payment to this fund for government servants, pensioners the poor as well as the handicapped

#### **iii. Essential Health Benefit Packages**

The fund will make payments for treatment under the essential Health Benefits Package. The package has not yet been made known

#### **iv. Restructured MOH Hospitals and Clinics**

With the establishment of a National Health Financial scheme, the government would restructure government hospitals and clinics. The ultimate plan may be to corporatise these hospitals. An example of this is the National Heart Institute (IJN) which was privatized in 1992.

#### **v. The Private Sector**

The NHFS will also pay for visits to general practitioners. There are two models of making payments: on a fee-for-service basis or on a capitation basis.

The National Health Fund will also cover either fully or a portion of the costs for the treatment of conditions listed under the “Essential Packages” even in private hospitals.

#### **vi. Private Insurance for Extra Coverage**

Richer families have the option of purchasing additional private insurance packages to top up for the payment of conditions for which the National Health Fund will pay only a portion of the costs that private hospitals charge.

The private insurance packages will also cover conditions not specified in the Essential package underwritten by the National Health Financial Scheme.

#### **vii. The National Health Financing Authority**

A new body will be set up to oversee the overall administration and evaluation of the new health care system. How this would be constituted and run has not been made known.

The setting up of this National Health Financial Scheme will have a very great impact on the lives of everyone. It will undoubtedly shift the burden of healthcare from the government to the ordinary citizens initially. Whether it will be cost effective in the long run, to the government as well as to the people, remains to be seen and will need to be studied very carefully.

Before establishing the proposed National Health Financial Scheme, we need to ask:

- a. What is the present status of the Malaysian Healthcare? **Is a change necessary?**
- b. What are the points to consider in proposing a national health scheme?

### 3. Present Status of Malaysian Healthcare

#### A. National & Government Expenditure on Healthcare

Let us examine how much we spend as a nation on our healthcare and how much is the proportion of government spending on this. According to the WHO country report 2006 on Malaysia, our country spent less than 4% of our GDP on healthcare, with about 3.8% and 3.7 respectively of our GDP in 2003 and 2004.<sup>12</sup> The government share is about 58.2 % & 58.3% of total health expenditure with the private sector spending 41.8% and 41.7% respectively in 2003 and 2004. (Table 1) Government spending on Healthcare in fact is only around 2.21% and 2.15% of GDP in the respective years (last row, Table 1).

	2000	2001	2002	2003	2004
<b>Expenditure ratios</b>					
Total expenditure on health (THE) % GDP	3.3	3.7	3.7	3.8	3.7
General government expenditure on health (GGHE) % THE	52.4	55.8	55.4	58.2	58.3
Private expenditure on health (PvtHE) % THE	47.6	44.2	44.6	41.8	41.7
GGHE % General government expenditure	6.5	6.4	6.6	6.9	7.3
Government expenditure as a % of GDP	1.73	2.06	2.04	2.21	2.15

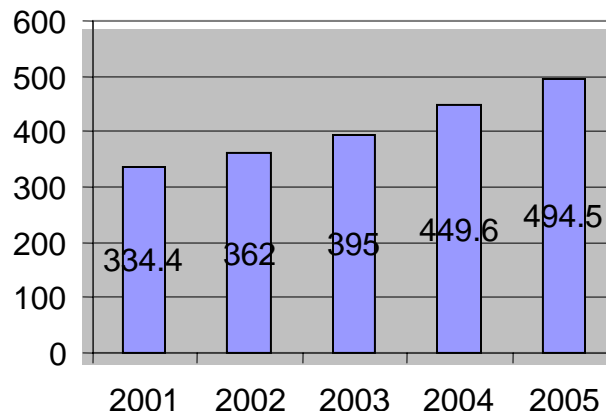
**Table 1. National Expenditure ratio on Health for Malaysia**

In absolute term, Malaysia's total expenditure on healthcare is RM15.09 billion and RM16.687 Billion in 2003 and 2004 and government expenditure is RM 8.79 billion and RM 9.735 billion (Table 2) .<sup>8-11</sup>

	2000	2001	2002	2003	2004
Total expenditure on health (THE) (RM bn)	11 331	12 287	13 340	15 099	16 687
General government expenditure on health (GGHE) (RM bn)	5 936	6 860	7 392	8 793	9 735

**Table 2. Total expenditure on Healthcare in Ringgits (billion)**

Just for information, Malaysia's GDP over the past few years are depicted in the fig. 2 and table 3.<sup>13</sup>



**Fig 2. Malaysian GDP at market prices (RM bn)**

	2001	2002	2003	2004	2005
GDP at market prices (RM bn)	334.4	362	395	449.6	494.5
GDP at market prices (US\$ bn)	88	95.3	104	118.3	130.6

**Table 3. Malaysian GDP at Market prices (RM and US\$ bn)**

Table 4 below shows the per capital spending on healthcare.

	2000	2001	2002	2003	2004
THE per capita at exchange rate (US\$)	130	138	146	163	176
GGHE per capita at exchange rate (US\$)	68	77	81	95	103

**Table 4. Per capital spending on Healthcare**

In 2003 & 2004, per capital spending on health care is only US\$163 and US\$176 respectively, out of which the government spent US\$96.00 and US\$103 per capita respectively.<sup>11</sup>

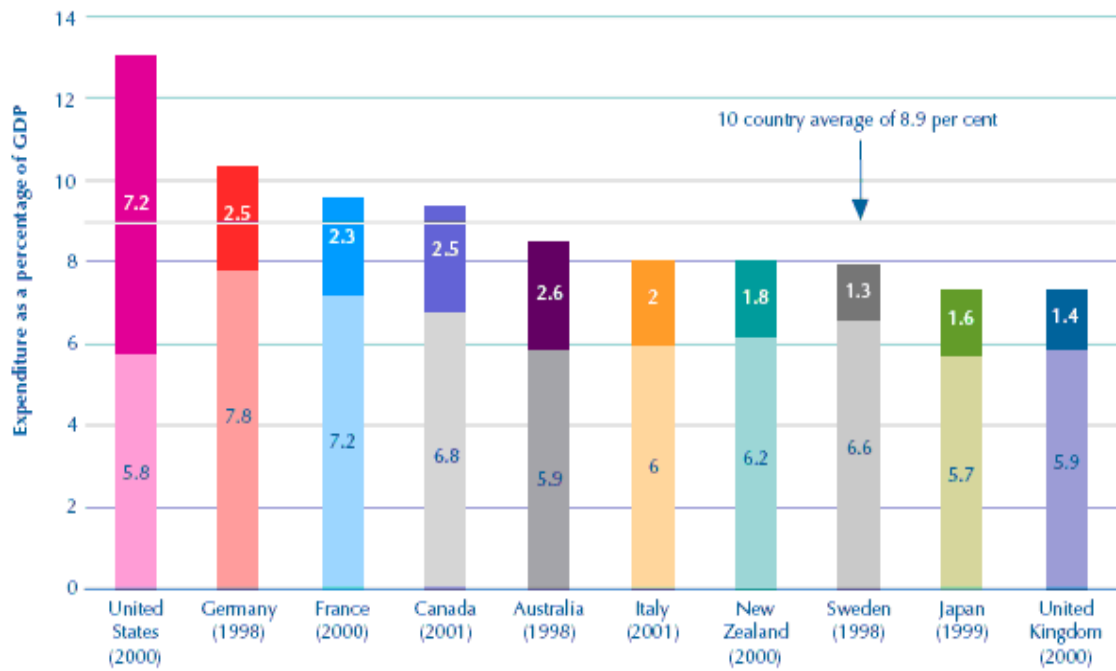
How does this level of spending compare with other countries?

## **B. Comparing Malaysian healthcare expenditure with other countries**

WHO recommends that a country spends a minimum of 5-6% of GDP on healthcare. In fact, in 1997, the total healthcare expenditure of the world is 7.9% of world GDP.<sup>14</sup>

Comparatively, Malaysia spends only about 3.7%, which is considered low comparing with other countries. A look at the following charts will show that we are spending much less than many countries.

Fig. 3 shows how much 10 of the OECD (Organization of Economic Cooperation and Development) countries spend on healthcare as a % of their GDP (with breakdown into government and private spending). The 10 countries spent an average of 8.9% of GDP on healthcare.



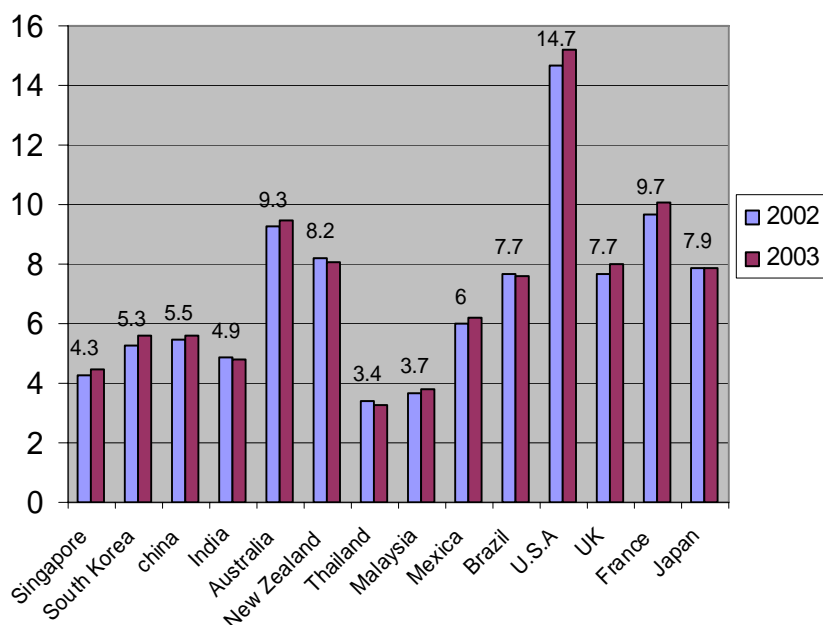
The darker tinted bars represent private expenditure. The lighter tinted bars represent public expenditure.

Source: National Audit Office, UK.<sup>15</sup>

**Fig. 3 National Expenditure on Health as a % of GDP (10 OECD countries)<sup>15</sup>**

Fig. 4 shows Total Health expenditure (THE) as a % of GDP ratio of Malaysia in 2002 and 2003 compared with 13 other countries.

Even countries with comparables GDPs in international dollars such as Mexico and Brazil spent much more on health care than Malaysia. Developing countries with lower GDPs such as China and India also spent higher proportion of their GDPs on the health of their citizens.<sup>8-11</sup>



**Fig. 4. National expenditure as a % of GDP (Malaysia against 13 others)**

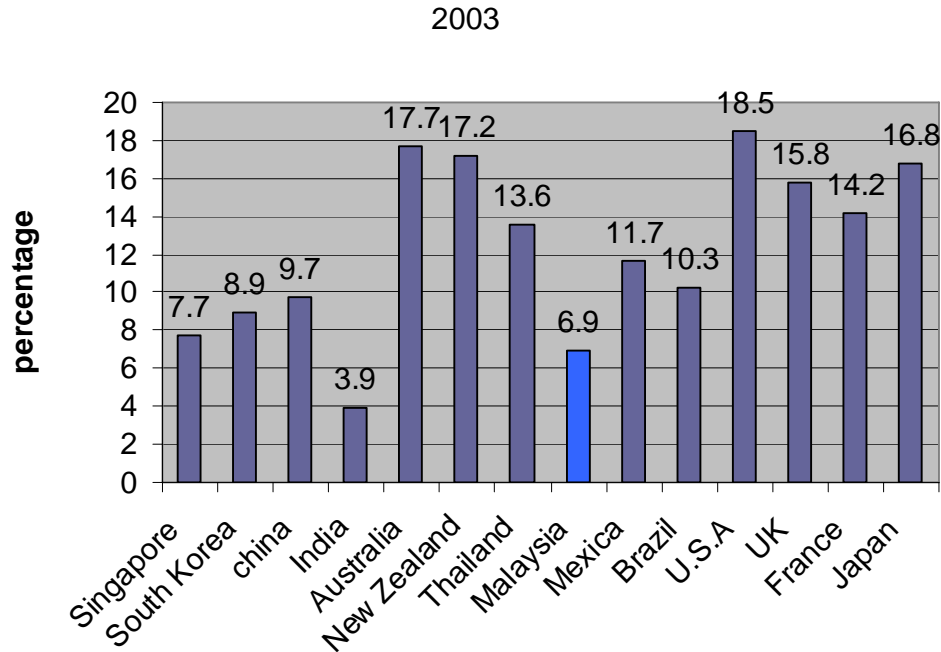
As for per capita spending (table 5), we are spending US\$146 & US\$163 per capita in 2002 and 2003 respectively which is only a small fraction of what the OECD countries spent. In fact government spending per capita amounts only to US\$81 and US\$95 for the respective years.<sup>8-11</sup>

Per capita spending on health (2002 & 2003)	US dollars		International dollars	
	2002	2003	2002	2003
Singapore	894	964	1101	1156
South Korea	607	705	975	1074
china	54	61	247	278
India	23	27	75	82
Australia	1961	2519	2693	2874
New Zealand	1255	1618	1844	1893
Thailand	68	78	242	260
Malaysia	146	163	342	374
Mexico	381	372	559	582
Brazil	199	212	592	597
USA	5324	5711	5324	5711
UK	2031	2428	2231	2389

France	2339	2981	2762	2902
Japan	2450	2662	2139	2244

**Table 5. Per capital spending of Healthcare in US dollars and International dollars.**

Fig 5 compares the general government expenditure of health as a percentage of total government expenditure of Malaysia against the 13 countries in 2003. Again, we are spending much less proportion of our budget on healthcare when compared to not only the OECD countries but also countries even in the same economic class.<sup>11</sup>



**Fig. 5. General government expenditure on Health as % of total government expenditure in 2003**

But despite this low spending, our healthcare is among the best in the developing world. This statement will be substantiated in the next segment.

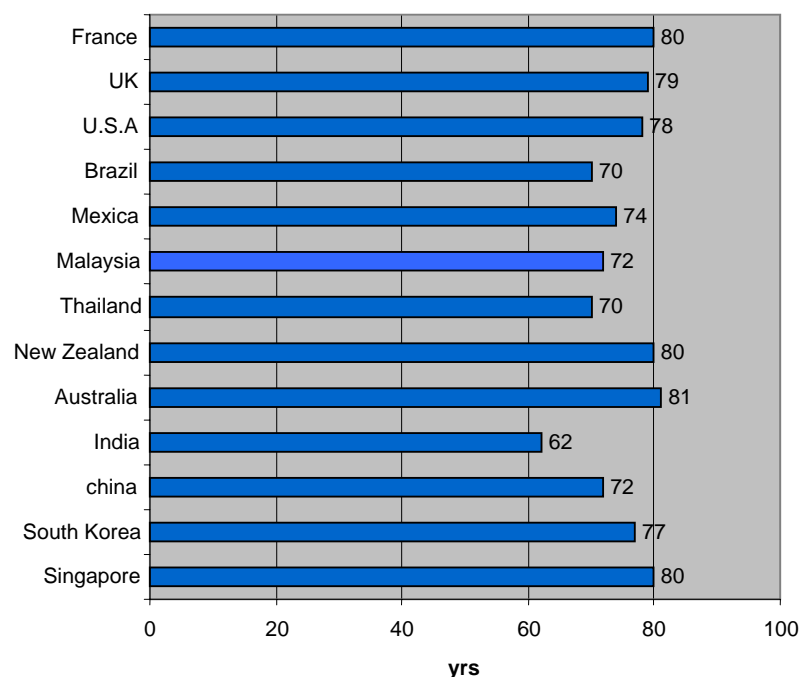
### **C. How does our Healthcare fare comparing with other countries?**

Despite the low level of healthcare spending, our health indicators are comparable even to the developed countries. This is mainly due to the fact that we have in place a very good system of public hospitals, with many mainly well equipped general hospitals serving as referral centres to a wide network of smaller but equally effective district hospitals spreading all over the countries, supplemented by a even wider network of rural clinics and health centres. These public hospitals are heavily subsidized by the government.

There are also numerous private hospitals serving the people in the urban and suburban areas although these centres operate on as a fee-for service basis, whereas the government centres charge only a nominal amount. The people have the choice of paying a hefty sum to go to private centres or pay next to nothing to utilize the government centres.

A measure of the performance of our health care system is by the use of health indicators such as Infant Mortality Rate(per 1000 live births), Life expectancy at birth and under 5 years mortality rate(per 1000 live births) .

Fig, 6 shows that the Life expectancy at birth (for both sexes) in 2004 of Malaysia is comparable with the most developed nations. In fact, life expectancy for both males and females has been rising from 68.8 yrs for males and 73.5 for females in 1999 to 71 yrs for males and 76 for females in 2004. <sup>2</sup>



**Fig. 6 Life expectancy at birth (both sexes) compared -2004**

	Infant Mortality Rate (per 1000 live birth)		Under 5 mortality Rate (per 1000 live birth)	
	1970	2002	1970	2002
Malaysia	46	8	63	8
Thailand	74	24	102	28
U.S.A.	20	7	26	8
U. K.	18	5	23	7
Japan	14	3	21	5
Australia	17	6	20	6
India	127	67	202	93
China	85	31	120	39

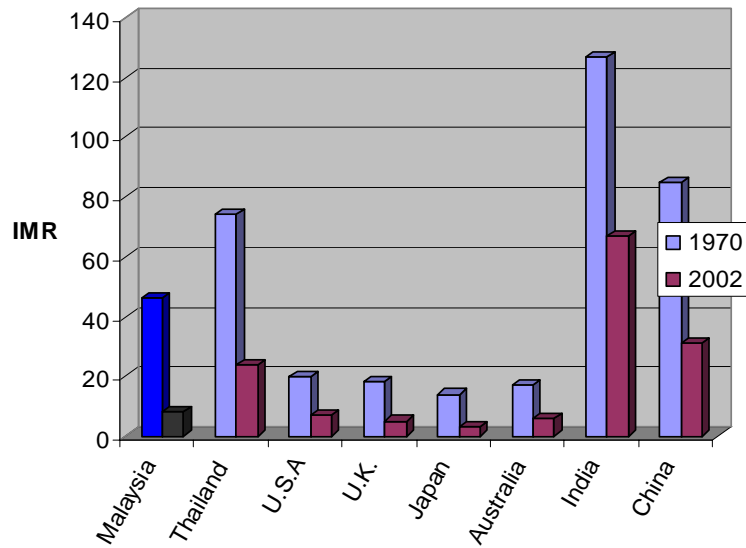
**Table 6. Comparison of mortality indicators of selected nations. (source: UNDP 2004) <sup>21</sup>**

Infant mortality rate (IMR) of Malaysia has improved tremendously since the 1970s. It has been falling from 10.4 per 1000 in 1995 to 5.8 in 2003. <sup>2</sup>

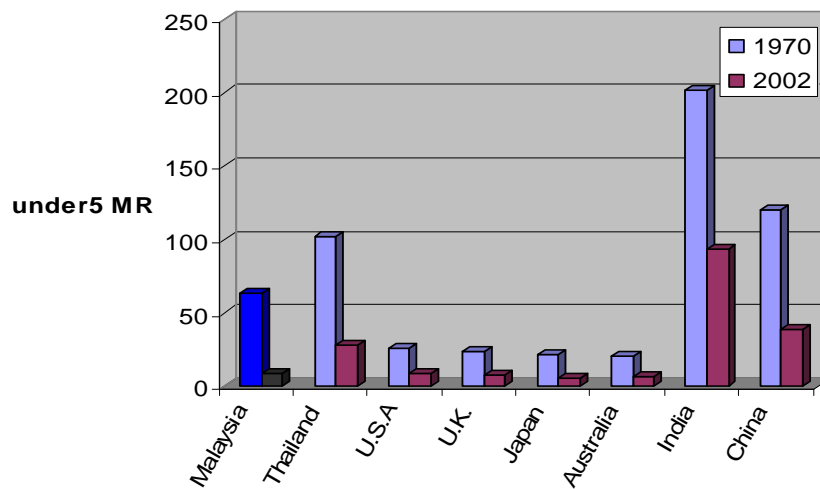
Table 6 shows that IMR of Malaysia is now comparable to developed countries such as USA, Australia, and U.K.

Fig. 7 shows graphically that our Infant Mortality Rate has come down many folds since 1970 and by year 2002, our IMR is comparable to the most developed nations such as USA, Australia and United Kingdom which spent many more times than us on the health of their citizens.

Fig. 8 shows Malaysia's Under- 5 years Mortality rate has similarly reached very impressive level comparable to the most advanced nations.



**Fig.7 Infant Mortality Rates (per 1000 live birth) of Malaysia and other countries in 1970 and 2002**



**Fig.8 Under-5 Mortality rates(per 1000 live birth) of Malaysia and other countries in 1970 and 2002 .**

All these data show that we are among the best in the world in the provision of healthcare to our citizens.

This means that our present system is effective in delivering good healthcare to the people of Malaysia.

As such, do we need a new system?

#### **4. Important considerations in the planning of a new Healthcare system**

Any change in our healthcare system is going to have a big impact on the lives of our people. Health is a basic right. It is something that affects us directly. Without a healthy body, most of us will not be able to function as we are now. Thus, any change needs to be thought over thoroughly. We wish to raise the following points in planning for a change in our healthcare system.

**A.** From what we have shown in section 3 above, we can draw 2 conclusions.

- i. Our present healthcare system is good. Any good system should not be changed for the sake of changing.

Despite the low spending on healthcare with the government spending only 2.1% of GDP (6.9% of total budget) and national spending only 3.7% of GDP (2004), we still manage to provide very good healthcare to our people.

Our present system is **really value for money**.

- ii. The present system can be improved upon if our spending on healthcare can be raised. This point will be discussed further in section 5.

**B.** Any change in healthcare system needs to be discussed openly with “interest groups” since it is going to affect everyone.

The government must do away with the perceived secrecy involved in formulation of this scheme. It should be done in an open, transparent and consultative manners and feedback must be obtained from medical associations,

civil rights groups, consumer associations, and workers' union and political parties. At present, a lot of unhappiness was due to the perceived lack of information that is given to the public.

- C. The government has given assurance that the proposed National Health Financial Scheme (NHFS) and the overseeing body National Health Financing Authority will not be privatized but instead be run by the Ministry of Health. But the government has not given any assurance that government hospitals will not be corporatised or privatized after the NHFS is set up.

An earlier example of corporatisation of government hospitals is Institute Jantung Negara (IJN). The government, since the privatization of IJN, does not contribute funds directly to the national heart institute. However, the government expenditure on cardiac services has instead increased from just subsidizing the poor and paying for the civil servants seeking treatment there.<sup>16</sup>

If the proposed privatization of government hospitals takes place after the setting up of the NHFS, the expenses of these hospitals are foreseen to increase tremendously and hence NHFS payout to these hospitals will be much more than what the government is spending on healthcare presently.

For the past decade, government expenses on healthcare has increased (though by world standard it is still low) partly because of the increased expenditure on the privatized services of certain sectors of the public healthcare.

For example, in 1993, the procurement of medicine for government hospitals and clinic (medical store) was privatized and the cost of medicine doubled the following year. In 1996, following the privatization of five more areas including laundry, cleaning, equipment maintenance, waste disposal and facilities

maintenance, the costs for these services skyrocketed from Rm140million to RM450 million the following year.<sup>4</sup>

Hence, the privatization of government hospitals, after the proposed NHFS is set up, will definitely lead to skyrocketing of national healthcare expenditure.

In other words, it is still privatization but in another form. Whoever will be funding the NHFS will have a heavy burden to shoulder.

**D. The big question next is: Who will be funding for the proposed NHFS?**

What is known is that the government will pay for the 1.1 million civil servants, 200,000 disabled, 430,000 pensioners and the poor.

It is highly probable that every employer, employee and the self employed will be asked to contribute to this fund. This will then be like a form of compulsory health insurance for individuals and a form of additional tax on the part of the employer. The quantum is not known, but if the implementation of NHFS brings about a tremendous increase in healthcare costs, everyone in this category will have to pay more.

Looking at examples of national health insurance schemes elsewhere in the world, it will definitely be much more than what most of us are paying now. For the employers, it will add cost to doing business. Since healthcare is an essential item, the cost of living will go up. For employees and the self employed, it will be an extra financial burden. The people that will be affected will be the urban poor and the middle lower income group. To these groups, any extra financial burden will be hard for them to shoulder.

An example of a National Health Insurance scheme being implemented is Taiwan.

Taiwan started a compulsory universal national health insurance scheme (NHI) for its citizens in 1995. Taiwan's NHI is a government-run, single-payer national health insurance scheme financed through a mix of premiums and taxes, which compensates a mixed public and private delivery system predominantly on a fee-for-service basis.<sup>17</sup>

Contribution to this scheme is made mandatory, with the share of contribution as listed below:<sup>17</sup>

- i. Public employees pay 30 % and government pay 70% of the premium
- ii. For private employees, the insured pay 30%, employers pay 60% and government subsidizes 10%
- iii. For low income groups , the government pay all.

The Taiwan government has hoped that with this scheme, it would help to contain healthcare cost. But immediately after the implementation of the scheme, costs spiraled upwards (table.7).<sup>18</sup> Escalation of medical costs ultimately forced an increase in annual contribution of every group including the government in 2002 when the NHI scheme faced the prospect of bankruptcy.<sup>17</sup>

	1994	NHI in 1995	% increase
<b>Cost in US\$ per visit</b>			
clinic	9.6	11.7	21.9
District hospital	18.7	25	33.7
Regional hospital	31.3	39.8	27.1
medical center	41.5	48.6	17.1
<b>Cost US\$ per inpatient day</b>			
District hospital	55.2	73.4	33
Regional Hospital	107.2	131	22.2
Medical center	153.3	181.8	18.6

**Table 7. Health cost increase in Taiwan in 1994 and 1995 after implementation of National Health Insurance.**

Further more, the quality of health care delivered took a tumble immediately after the implementation of NHI in Taiwan. This is because physicians started to see a lot more patients per day so they had less time to devote to each patient. <sup>17</sup>

The story of Taiwan should serve as a lesson for those countries, including Malaysia, contemplating the implementation of a national health insurance scheme.

- E.** The proposed NHFS will make payment for all conditions /illnesses that are specified in the “Essential Health Package”. What is specified in this package is not known. Whether chronic diseases such as renal failure or acute cases like heart attack would be in the package is not known. Whether preventive aspects like immunization or antenatal care will be covered is also not known.
- F.** If certain illnesses are left out, who is going to pay for the illnesses? The rich perhaps can resort to buying private insurance but the poor and the not-so-poor will be hard pressed to come up with money for these types of illnesses if they have the misfortune of contracting them.

If certain illnesses are left out of the essential packages, people may have to resort to private insurance to cover these illnesses. This may lead to a situation where an average person may end up paying for both the NHFS as well as the private medical insurance cover. For those who cannot afford private insurance but does not qualify to be the hard core poor, who is going to foot for them?

A system with 2-tier quality may result.

- G.** Another question to be considered is that for a similar procedure, private and government hospitals charges differently. Under NHFS, will the fund be paying

the differential rate or will it pay the private hospital the same rate that the government hospital is charging?

If the fund makes full payment to whatever rate the private hospital is charging, then all patients covered under the scheme will probably be going to the private hospitals. This will create a huge demand for private healthcare, leading to proliferation of private centres and an aggravation of the “brain drain” of experienced personnel from public hospitals.

If the fund pays a standard rate to both private and public hospital for a similar procedure, will those patients utilizing private hospitals be asked to top up the difference? If so, this will again encourage the growth of private insurance and again, as discussed in section 4F, a 2-tier quality health system will likely emerge. This is against the Ministry of Health ‘s Vision for Health under which healthcare is supposed to be equitable for all.

- H.** What is known is that the National Health Fund under the NHFS would make payment to Ministry of Health hospitals as well as private hospitals for illnesses under the package. As mentioned above, once the MOH hospitals are restructured and corporatised, the expenditures of these hospitals will definitely increase as in the example of IJN leading to an increase in the health costs. These health costs will be paid through the funds and if increases are faster than the growth of the fund, it is likely that every contributor will have to increase their monthly contribution.

This is the case in Taiwan, where in 2002, all contributors were asked to increase their quantum of contribution when the National Health Insurance scheme faces the prospect of bankruptcy as a result of the unexpected increase in healthcare cost.<sup>17</sup>

- I.** The fund will most probably make payment for visits to the general practitioners. There are 2 models of making payment: on a fee-for service basis or on a capitation basis.

At the present moment, when a patient visits a GP and pays out of his own pockets, there is always an element of goodwill between the patient and the doctor and very often the doctor will charge less because of the goodwill factor. However, if the payment is involving third party (from the fund), the doctor will probably be charging according to the scheduled fees and any visits would be deemed a strictly business transaction.

Both fee-for-service and capitation fees will be subjected to a lot of abuses.

On a fee-for-service basis, doctors will encourage more visits from patients and there would be the risks of over investigations and over treatment. Clinics will be crowded and there will be less quality time for each patient as the doctor sees more patients and becomes overworked. Quality of care will deteriorate as in the example of Taiwan. Skyrocketing costs will result. Preventive aspects of health may be neglected.

On a capitation basis, in which a fixed amount is paid per year to the doctor per patient, there would probably be under-treatment, under investigation, and quality of care will again deteriorate as there is no incentive to work harder.

- J.** Professor Dr S Sothi Rachagan, a professor of Law from the University of Malaya, in a paper presented to National Conference on Managed Care in 1996, argued that:

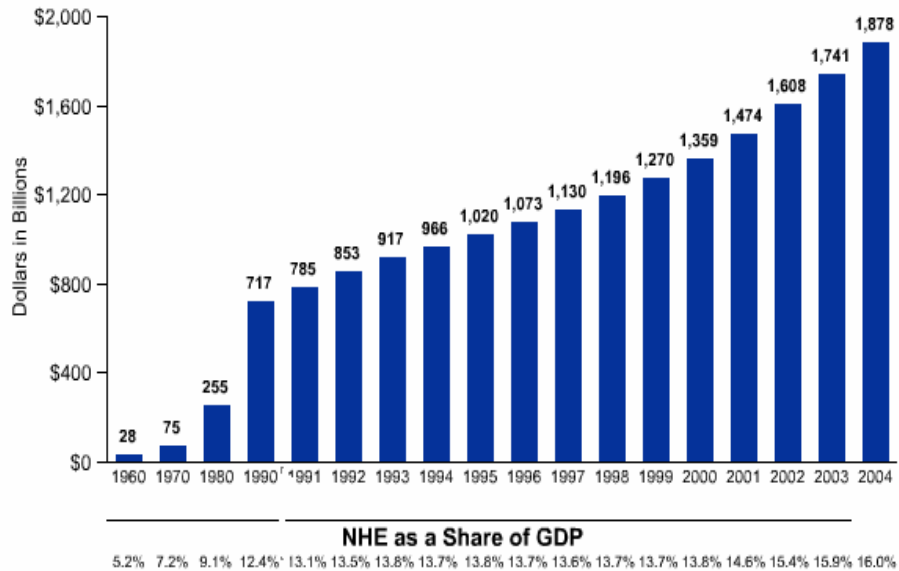
*“The provision of subsidized health care by the public sector by way of budget allocation has had the significant effect of containing private sector prices. It is not only possible, but very likely probable, that a departure from this practice, including the establishment of a special fund for national health financing, will ‘free’ the private sector to set its own price and , hence, increase the total national expenditure”.*<sup>1</sup>

This is the experience of many countries. Where compulsory and private health insurance is predominant, healthcare costs have spiraled upwards because the system encourages the insured and the provider to use the healthcare services liberally and without restraint. The practice of defensive medicine in private hospitals, motivated by a desire to avoid medical negligence litigation, will add further to an uncontrolled rise in health care costs.<sup>16</sup>

We just need to look at the example in USA, where healthcare cost is the most expensive in the world.

The United States' healthcare system is predominately privately funded, with 55 per cent of the revenue from private sources. Individuals can purchase private health insurance or it can be funded by voluntary premium contributions shared by employers and employees on a negotiable basis. It covers 58 per cent of the population.

Public funds (payroll taxes, federal revenues and premiums) fund Medicare, a social insurance programme for the elderly, the disabled, and end stage renal patients. It covers 13 per cent of the population. Medicaid, a joint federal-state health insurance programme covers certain groups of the poor. It covers 17 per cent of the population.



(Source: Centers for Medicare and Medicaid Services,)

**Fig. 9 National Health Expenditure – USA from 1960 to 2004 (US\$)** <sup>19</sup>

In 1980, National Health Expenditure (NHE) of USA was about US\$ 255 billion. By 1992 it has doubled. By 2002 it has increased four folds to US \$1.6 trillion representing 14.9% of GDP. By 2004, at US\$ 1.9 trillion, NHE is almost 7 times the 1980 value and represents a whopping 16% of GDP.(Fig.9). Even so, about 50 million American are without insurance cover. <sup>20</sup>

Per capita spending of USA on healthcare is US\$5711 in 2003, more than 15 times of Malaysia’s per capita spending on Healthcare at US\$374. Yet, our health indicators are comparable.

This should serve as a reminder to all of us especially our healthcare planners that health planning must be done carefully and conscientiously if we want to avoid a scenario like the above happening to our healthcare system.

## 5. Recommendations

### A. Upgrade and improve the present system

The government contention that a NHFS should be set up is that health cost is going up and the government may not be able to cope with it. But looking at the figures above, our spending on health is low and there is a lot of leeway for the government to spend more. Any foreseeable increase in healthcare cost due to aging population and changing pattern of diseases can easily be off set by a slight increase in government spending on health.

Further more, the adoption a untested new scheme may initially lower the government spending but in the long run, the costs may spiral out of control and lead to an eventual escalation of government expenditure on healthcare. We need to look far ahead and not be shorted-sighted on this aspect.

Since our present system is good value for money, it should not be abandon at this moment to be replaced by a new scheme which is totally not tested and which will very likely result in an increase in healthcare cost.

Thus we **recommend an upgrading of the present system** with increased spending on the part of the government to strengthen the public healthcare services and improve the efficiency and image of the public hospitals.

At the present moment, one third of all physician and surgeons work in government hospitals, looking after  $\frac{3}{4}$  of all admissions. These government doctors are doing many times the work of private physicians and surgeons and yet their remuneration is only a fraction of what the private doctors are earning.

Government hospitals, despite the long queues and waiting time, and no frill clinics and wards, are the only avenues for the poor to seek treatment. At the same time, it also acts as a safety net for richer groups of people during times of economic downturn.

As shown earlier, National spending on healthcare in 2004 is only 3.7% or RM 16.68 billion with the government spending about 2.1% GDP and RM9.73billion. Our GDP at market prices in 2005 is RM 494 billion.

An additional 1 % of GDP spending on healthcare by the government (to raise government spending it to about 3.1% of GDP and total national healthcare expenditure to 4.7%) will give an additional RM 4.96 billion to the public health sector. This 1% increase spending in GDP will be equivalent to a 51% increase over the total government expenditure on health which was RM 9.7 billion in 2004. (Table 8a and Table 8b). Even with these 1% increase in health expenditure, our spending on healthcare is still below world average and WHO recommendations of 5-6%..

Total expenditure on health (THE) % GDP, 2004	3.7%
Government expenditure as a % of GDP, 2004	2.15%
Total expenditure on health (THE) (RM), 2004	16.6billion
General government expenditure on health (GGHE) (RM), 2004	9.7 billion
GDP 2005 at market prices (RM)	494.5billion

**Table 8a Expenditure Ratio before 1% hypothetical increase**

1% extra spending of GDP on healthcare	4.95billion
Govt expenditure as a % of GDP after 1% increase	3.15%
Total expenditure on health % GDP after 1% increase	4.7%
World average expenditure as a% of GDP	7.9%

**Table 8 b. Expenditure ratio after 1% hypothetical increase**

Part of the addition RM 4.96 billion should be use to improve the service conditions of our health personnel including doctors, nurses and paramedics. It can also be used to recruit more doctors especially those currently working overseas (and are very experienced) to alleviate shortages in government hospitals,

If working conditions can be improved, less healthcare workers will leave for private sector. With better staffing, the public sector can provide better care and services. This, along with improvement in hardware such as building more new government centres and renovating and upgrading the existing centres, will undoubtedly improve personnel morale and efficiency in providing quality healthcare to the people. Ultimately, the aim should be to upgrade the healthcare standard to a comparative level as that in the private sectors.

### **B. No privatization**

Government hospitals should not be corporatised or privatised as the experience has shown that cost will go up many folds after corporatisation or privatization.

This increase in cost ultimately comes from the pocket of the consumers. As with all increase in cost, the lower middle group and the poor will be the most affected.

### **C. Strengthen primary care system**

Primary care services must be strengthened. A good primary care system with easy accessibility will be the most effective way to contain escalation of health cost. Public primary healthcare centres must be properly organized and staffed with experienced

personnel. This, complemented with a good network of public hospitals serving as secondary support base, will be an effective way of delivering quality healthcare especially to the poorer section of the population.

#### **D. Universal preventive care.**

Preventive care such as immunization, antenatal and perinatal healthcare must be made universal. At present the system is already running well but more should be done in the eradication of diseases such as dengue and cardio vascular diseases through more effective public health education and promotion of a healthier lifestyle.

---The End---

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*\* All charts and tables , except fig. 2 & fig.9, are drawn by the author with the data from the references listed under the reference section.*

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## **Appendix: Summary of Healthcare System in Other Countries** <sup>15</sup>

### **1. Australia**

Public finances are raised from a general and compulsory health tax levy on income, through Medicare, the public health insurance system. Medicare reimburses 75 per cent of the scheduled fee for private in-patient services and 85 per cent of ambulatory services, including GP consultations.

Out of pocket payments (16 per cent of total health expenditure), are for pharmaceuticals not covered under the Pharmaceutical Benefits Scheme, patient contributions for pharmaceuticals, dental treatment, the gap between the Medicare benefit and the schedule fee charged by physicians, and payments for other services such as physiotherapy and ambulance services, not covered by Medicare.

Private insurance accounts for about 8 per cent of health care expenditure and about 45 per cent of the population have private insurance (mostly supplementary). Mainly not-for-profit mutual insurers cover the gap between Medicare benefits and schedule fees for in-patient services. Doctors may bill above the scheduled fee. Private insurers also offer private hospital treatment, choice of specialists and avoidance of queues for elective surgery.

### **2. Canada**

National health insurance plans (Medicare) are funded by general and dedicated taxation and cover all medically necessary physician and hospital services.

The majority of the population has supplementary private insurance coverage through group plans, to include dental care, prescription drugs, rehabilitation services, private care nursing and private rooms in hospitals.

### **3. United Kingdom**

The United Kingdom's healthcare system is predominately public sector with the majority of the funds coming from general taxation and some from national insurance contributions. About 11.5 per cent of the population have supplementary private medical insurance, usually for reasons of faster access.

National Health Service care is free at the point of delivery, but charges are levied on prescription drugs, ophthalmic services and dental services. There are exemptions, for example, for children, elderly, and the unemployed and 85 per cent of prescriptions are exempt from the charge.

### **4. New Zealand**

Public hospital out-patient and in-patient services are free, but most people meet some costs of primary health care (although some groups are exempt or have health concession cards) and make a payment for pharmaceuticals. Income-related patient contributions are required for GP services and non-hospital drugs.

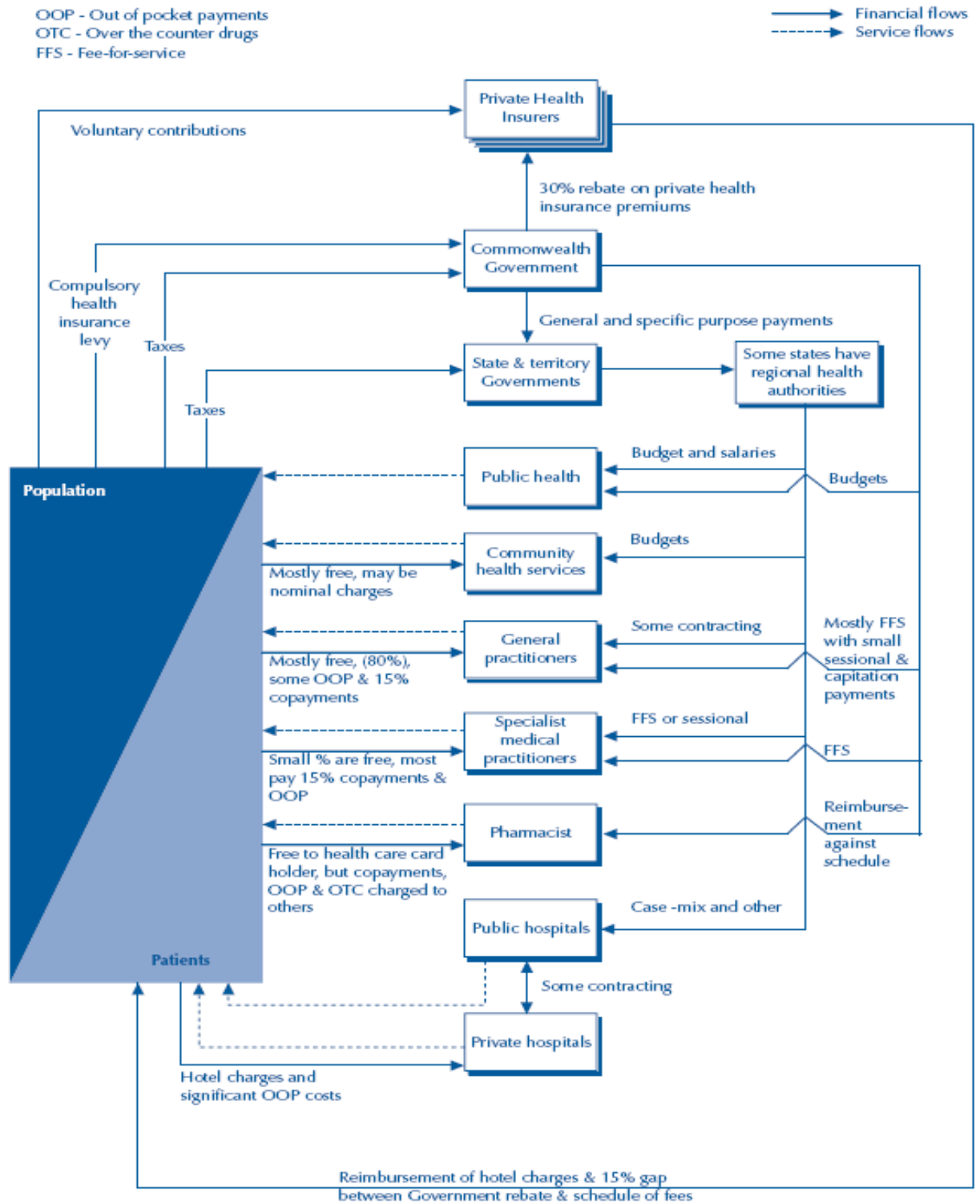
Private insurance is mainly not-for-profit covering private medical care and complementary, used to cover cost-sharing requirements, elective surgery in private hospitals and specialist out-patient consultations. It does not offer comprehensive health cover. It covers about a third of the population.

### **5. United States of American**

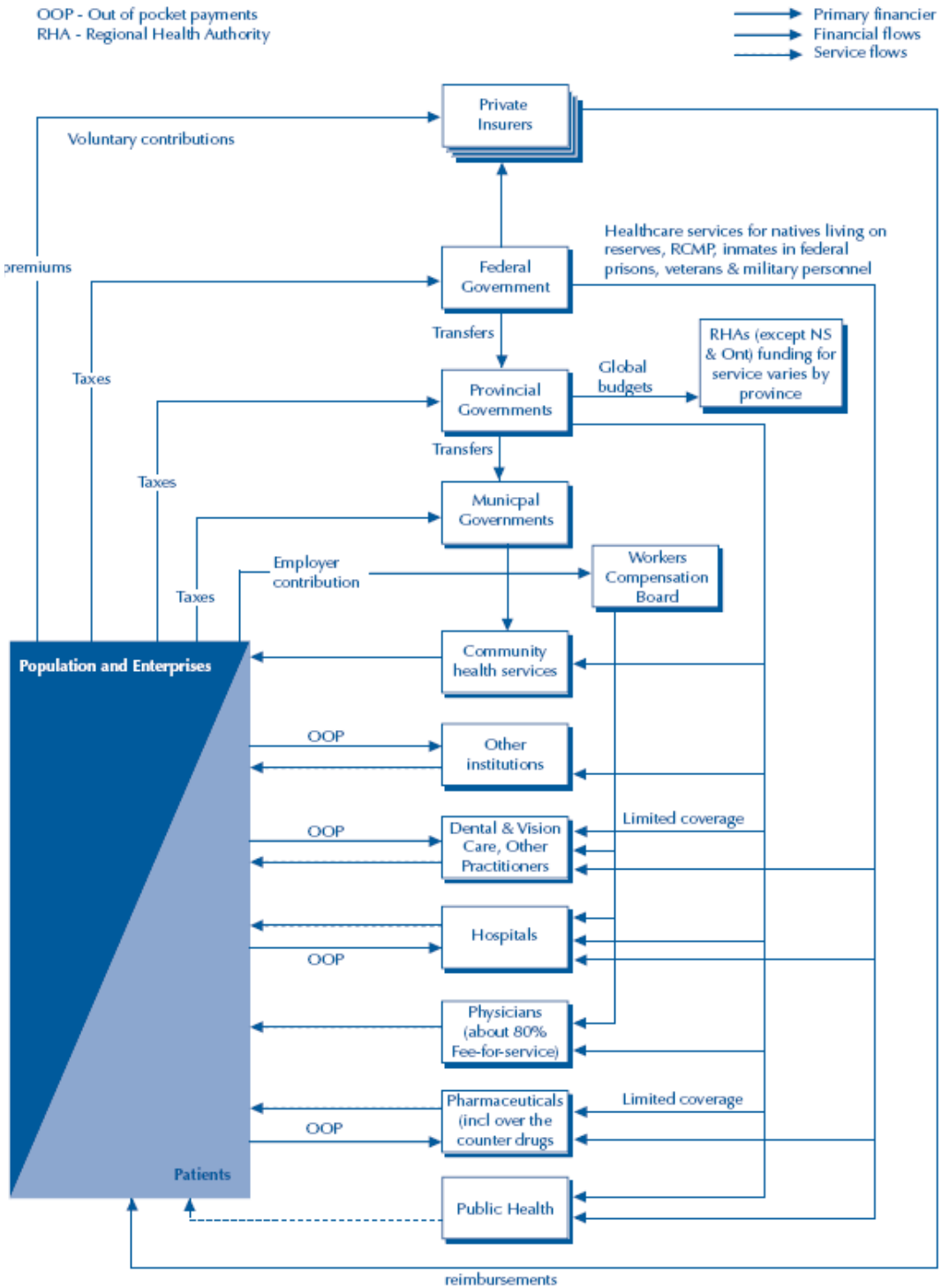
The United States' healthcare system is predominately privately funded, with 55 per cent of the revenue from private sources. Individuals can purchase private health insurance or it can be funded by voluntary premium contributions shared by employers and employees on a negotiable basis. It covers 58 per cent of the population.

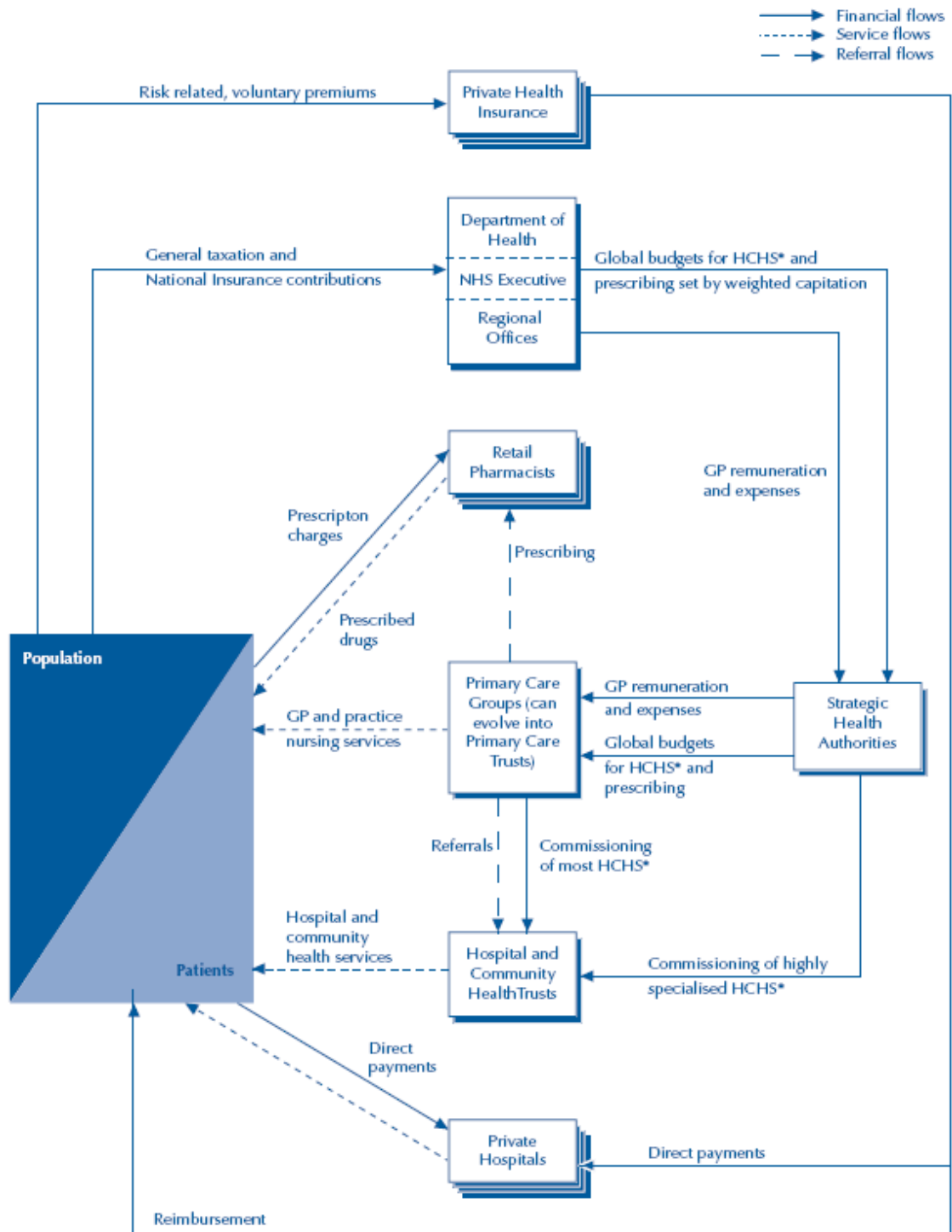
Public funds (payroll taxes, federal revenues and premiums) fund Medicare, a social insurance programme for the elderly, the disabled, and end stage renal patients. It covers 13 per cent of the population and accounts for 20 per cent of total health expenditure. Medicaid, a joint federal-state health insurance programme covers certain groups of the poor. It covers 17 per cent of the population and accounts for 20 per cent of total health expenditure.

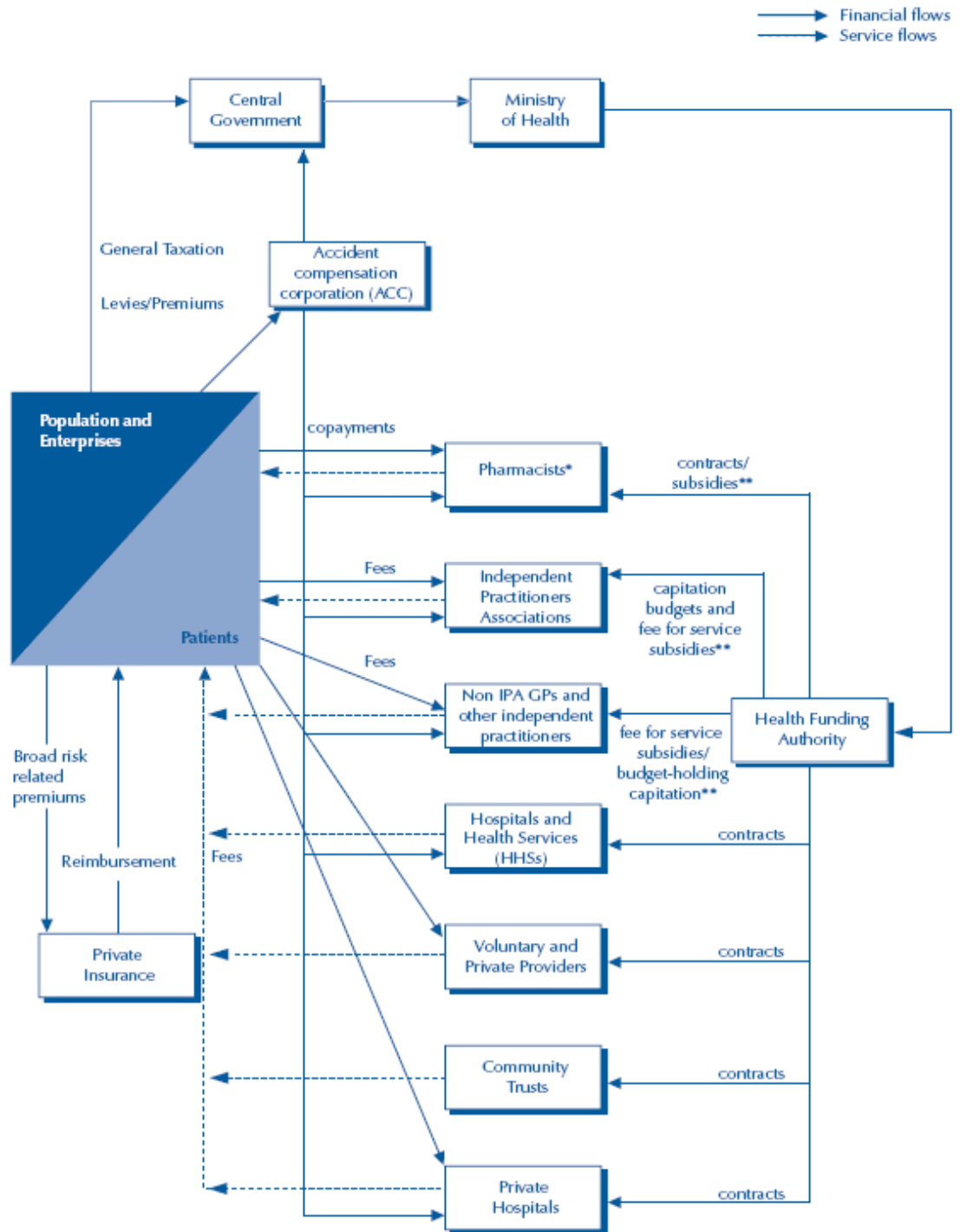
Financing of healthcare in Australia, 1999



Financing of healthcare in Canada, 2000







\* and other providers such as laboratories and radiology clinics  
 \*\* relating to contracts with the Health Funding Authority

