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Malaysia's Health System: Public or Private?

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Healthcare Resources - Funding and Spending

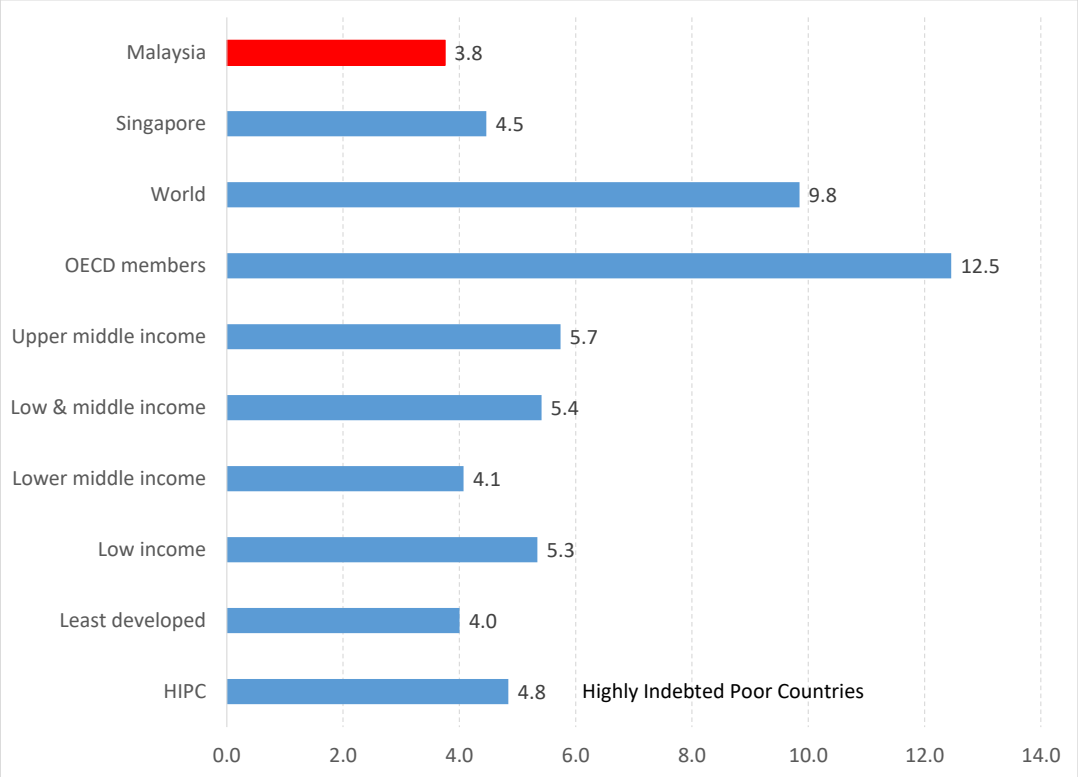
Figure 1 shows current healthcare spending data from the World Bank for 2018, the most recent full year not affected by extra spending due to Covid-19. At only 3.8% of gross domestic product (GDP) healthcare funding in Malaysia falls short by international comparisons. It is below other countries in the upper-middle income category in which Malaysia is categorised by the World Bank and it is less than one quarter of that in the high-income OECD countries. Indeed as a percentage of GDP, Malaysia's healthcare spending is even below that of low-income, less-developed and highly indebted poor countries (HIPC).

During the Covid-19 pandemic, health expenditure covering both current and investment spending in the public and private sector, has increased to 4.7% of GDP in 2020 and is expected to reach 5.0% of GDP or RM72.7 billion in 2021, according to Finance Minister Tengku Zafrul Aziz.[1] However at least part of this increase can be accounted for by extra temporary Covid-19 spending and a decline in GDP by 5.6% in 2020 which combine to raise the ratio.

Despite an emphasis in public debates on public healthcare, almost half of Malaysia's health spending comes from private sources. This further emphasises the structural funding issues since only half of the expenditure on healthcare comes from public spending. Figure 2 shows more details on some of the structural statistics for the Malaysian healthcare system before the Covid-19 pandemic.

[1] CodeBlue (2021) Malaysia's Health Spending Estimated To Hit 5% GDP In 2021, 21 September 2021

Figure 1: Current Spending on Healthcare
Percent of Gross Domestic Product 2018



Source: World Bank Expenditure on Healthcare Statistics, 2018, the comparative figures are for current spending and exclude investment spending.
https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS

Private financing accounts for 48% of healthcare funding with direct, out-of-pocket payments or pay-as-you go private payments, accounting for around 35% of spending according to Ministry of Health (MOH) data. Private insurance by contrast accounts for only 8% and other private organisations, including companies, charities and NGOs add 5%. This means that not only is a large proportion of spending from private sources but there is very little, if any, pre-planning for healthcare. Patients pay from current income or savings rather than drawing on insurance or other formal protection schemes.

Figure 2: Malaysian Healthcare Financing and Spending 2019

% Financing	Percent
Ministry of Health	45%
Private Direct Pay	35%
Private Insurance	8%
Other Public	8%
Other Private	5%
Total	100%
Total Public	52%
Total Private	48%

% Spending	Public	Private
Curative Health	68.2	67.3
Administration	10.9	4.8
Public Health	9.8	3.6
Capital Spending	5.8	2.2
Training	3.8	6.3
Out-patient	0.5	15.5
Ancillary	0.7	0.4
R&D	0.4	0.04
Long-term Care	<0.01	<0.01

Sources: Ministry of Health Malaysia (2021): Malaysia National Health Accounts 1997-2019 (Table 5.1a; Table 5.2.4a and Table 5.3.3a); Author calculations

In terms of spending, just under 70% of public and private spending is on curative treatments as opposed to preventative treatments, for example. The relatively high figure of 15.5% for outpatient services in the private sector reflects the use of general practice surgeries (sometimes called Polikliniks). Patients also often refuse or avoid admission to private hospitals which escalates costs beyond their capacity to pay. Deposits or payment in advance arrangements, often running to tens of thousands of Ringgit Malaysia, are required from patients before they are admitted to private hospitals.

Spending on long-term, rehabilitation or palliative care is negligible because either these services are not provided at all or patients in need of these forms of healthcare resort to families, charities or their own resources. Palliative and long-term care for the elderly, the disabled (Orang Kurang Upaya, OKU) or those with chronic illness is often provided on an informal basis through poorly regulated agency care assistants or even unqualified and untrained domestic maids.

In terms of infrastructure, there were around 154 public hospitals in Malaysia in 2019, with around 46,990 beds or around 305 beds per hospital. In the private sector there were 250 hospitals or medical centres, with around 17,330 beds or around 69 beds per hospital.[2]

While in major cities such as Kuala Lumpur there are very large private hospitals, across the country as a whole private medical facilities tend to be small, cottage-hospitals offering limited services with a small cohort of doctors, who are often on-call from public hospitals or other private facilities. Around 50% of the income for private healthcare facilities comes through these hospitals with around 25% of income coming from ambulance services and 13% coming from retail activities.[3]

Malaysia's Health System – Economics, Resources and Markets

This heavy reliance on private, out-of-pocket spending is problematic from an economic, social and management perspective and common outcomes include denial of access to healthcare, a focus on curative rather than preventative healthcare, under-provision of unprofitable but necessary and effective healthcare options such as physiotherapy, lower quality of treatment due to small-scale facilities in the private sector and a general lack of universal comprehensive medical offerings.

Although healthcare is popularly considered to be a public good, formally it is not a public good because it is both excludable and rival in consumption. People can and are regularly denied access to healthcare because of costs or other restrictions and the constraints on resources mean that treatments provided for one patient deny opportunities for others.

Healthcare is formally a, "merit good" or, a private product provided through public means because it is beneficial and would be under-provided by the market if the private sector was left to its own devices.
Healthcare is also subject to multiple cases where the market fails to provide adequate or equitable coverage for people who need treatment. Private insurance, which covers only 7% of healthcare costs for example, excludes people with costly long-term chronic illness or prior conditions. Properly functioning insurance markets will generally under-provide healthcare and this in itself provides a justification for greater public healthcare.

[2] Data source Statista: Hospital Beds - https://www.statista.com/statistics/794868/number-of-beds-in-public-and-private-hospitals-malaysia/ ; Hospitals - https://www.statista.com/statistics/794860/number-of-public-and-private-hospitals-malaysia/
[3] Source: Ministry of Health Malaysia (2021): Malaysia National Health Accounts 1997-2019, (TABLE 5.3.2a: Private Sector Health Expenditure to Providers of Health Care, 2019)

Other important causes of market failure in the private healthcare system include the problems of uninformed consumers. Patients are often not able to judge whether the treatment recommended is necessary, or of the right type compared to alternatives. They are also often not able to gauge whether they are being charged at the right price so they can't make a proper decision as to whether they should buy it or not.

This also leads to a form of "moral hazard," where unscrupulous private healthcare providers, which include independent medical practitioners practicing at private medical centres, can take advantage of patients. Unnecessary treatments or tests are often recommended because doctors and hospitals earn money from them and the "doctor knows best" imbalance puts vulnerable patients at a disadvantage. Obtaining a second opinion is costly and requires re-registration with another healthcare provider.

Private healthcare providers emphasise curative rather than preventative healthcare because the former pays more than the latter. They under-provide unprofitable healthcare such as physiotherapy, occupational therapy and particularly long-term residential care which accounts for less than 0.1% of private spending.[4]

Overcharging is endemic because patients often do not know the true price of treatment or whether it is necessary. While the prices of specific procedures are regulated by law, many treatments, medications or tests are not regulated.[5] Brand name medicines are overused because they have a bigger profit margin compared to generic medicines and purchases from private hospital pharmacies, especially for in-patient treatments offer patients no choice in finding cheaper alternatives.

Private hospitals deny overcharging[6] but during the Covid-19 pandemic a private hospital in Kuala Lumpur was fined RM200,000 for an offence under Section 11 of the Price Control and Anti-Profiteering Act 2011 when it charged RM11.20 for face masks which should cost only RM1.50.[7]

At the height of the Covid-19 pandemic the then Health Minister Dr Adham Baba estimated that the median cost of treatment for serious (Category 4 and Category 5) Covid-19 patients was RM870 per day, or RM18,270 for 21 days' hospitalisation. In private hospitals fees of up to RM200,000 for 15 days treatment were being charged.[8]

The annual median salary in Malaysia in 2020 was RM25,116 and the annual median household income was RM62,508. So private fees for Covid-19 treatment were 15.3 times higher than public costs, almost eight times the annual salary of half of those earning wages and 3.2 times the annual income of more than half of all Malaysian households.

Private healthcare providers were also accused of profiteering in collaboration with retailers and shopping mall owners by attempting to introduce a scheme to charge "administration fees" of up to RM150 for low-paid workers to receive free vaccines as a condition of

[4] Source: Ministry of Health Malaysia (MOH): Malaysia National Health Accounts 1997-2017
[5] The Thirteenth Schedule of the Private Healthcare Facilities and Services Act 1998 [Act 586] provides a tariff list of prices for particular procedures and treatments but does not regulate medicine prices, consumables, "hotel services", administrative charges or many other fees that accumulate during treatment episodes on private healthcare facilities.
[6] Sean Augustin (2021) We don't overcharge, says private hospital group, Free Malaysia Today, February 19, 2021 8:38 AM
[7] Bernama (2021) Private hospital fined RM200,000 for overpriced face masks, Free Malaysia Today, May 22, 2020 4:51 PM
[8] Jason Thomas (2021) Association defends charges for Covid-19 patients in private hospitals, Free Malaysia Today, July 24, 2021 12:14 AM

returning to work.[9] The alleged profiteering was denied but the scheme was blocked by the intervention of the Minister for Human Resources Datuk Seri Saravanan Murugan.[10,11]

The sources of market failure and the possibility of market exploitation, overcharging and profiteering are well understood by economists. Solutions are also well understood, especially within the social market economy framework which provides remedies based on good governance of private markets within a system of ordoliberalism.

The principle of liability within the social market ensures that there is a balance between buyers and sellers and the principle of public provision of merit goods and the principle of solidarity ensures that no-one is excluded due to market or management failures. However these principles rely on an effective, accountable and transparent system of management and governance which appears to be lacking in the Malaysian context.

Malaysia's Health System – Management and Leadership

Part of this failure arises because of the management culture within the Malaysian healthcare system which is predominantly run by clinicians, most of whom do not have management qualifications. Medical practitioners and physicians take up most of the senior manager positions in both public and private healthcare institutions and health policy bodies.

Systemic management dysfunction is common including "accidental managers," where medical specialists become managers primarily for career progression.[12] "Group think," causes resistance to innovation and growth.[13] Key functions and intuitions can be captured by special interest groups.[14]

A lack of diversity across age, gender, specialism and aptitude can lead to, "grumpy old men" syndrome that excludes important stakeholders such as women practitioners who account for around 52% of the registered medical practitioners as well as the overwhelming majority of nursing staff. Ethnic diversity is also an important consideration in multiracial Malaysia. The disparity of representation can be seen in the Malaysian Medical Council (MMC) governing body of 32 members, where 78% are men, 75% are Malay with Chinese and Indian members accounting for 12.5% each.[15] In the Malaysian Medical Association (MMA) of 32 council members for 2021/22 only one was female, 68% were Indian, 25% Chinese and two members or 6.3% were Malay.[16]

Most importantly patients, the largest and most important group of stakeholders, are often actively excluded from healthcare management and this lack of effective stakeholder

[9] Lydia Nathan (2021) Profiteering concern on vaccine fee for mall workers, The Malaysian Reserve, Wednesday, June 2nd, 2021
[10] Azreen Hani (2021) Malls association deny profiting from vaccination drive, The Malaysian Reserve, Wednesday, June 2nd, 202
[11] Jason Thomas (2021) Minister warns bosses against charging workers for vaccination, Free Malaysia Today, June 11, 2021 11:17 AM
[12] Stephen Halpern (2013), The accidental manager, British Journal of Healthcare Management Vol. 8, No. 2 - Policy Developments, Published Online: 27 Sep 2013 https://doi.org/10.12968/bjhc.2002.8.2.18912
[13] Seshia, S.S., Makhinson, M., Phillips, D.F. and Young, G.B. (2014), 'Cognitive biases plus', evidence and health care. Journal of Evaluation in Clinical Practice, 20: 734-747. https://doi.org/10.1111/jep.12280
[14] Kevin Croke, Mariana Binti Mohd Yusoff, Zalilah Abdullah, Ainul Nadziha Mohd Hanafiah, Khairiah Mokhtaruddin, Emira Soleha Ramli, Nor Filzatun Borhan, Yadira Almodovar-Diaz, Rifat Atun, Amrit Kaur Virk, The political economy of health financing reform in Malaysia, Health Policy and Planning, Volume 34, Issue 10, December 2019, Pages 732–739, https://doi.org/10.1093/heapol/czz089
[15] Malaysian Medical Council Members https://mmc.gov.my/council-members/
[16] Malaysian Medical Association Council Members https://mma.org.my/council-and-committees/

engagement has become a symptom of poor management and leadership which exacerbates the problems of market failure and leads to rigid, unresponsive management and poor resource decisions which damages patient confidence in the long-term.

Malaysia's Health System – Governance and Regulations

In principle, an effective due process system can help to regulate these problems. The primary statutory authority for healthcare in Malaysia has its basis in the Medical Act 1971 currently amended by the Medical (Amendment) Act 2012 which came into force on 1 July 2017 along with the Medical Regulations 2017.

The private sector is primarily regulated by the Private Healthcare Facilities and Services Act 1998 [Act 586] and its Regulations which are enforced in the first instance through the Private Medical Practice Control Branch (Cawangan Kawalan Amalan Perubatan Swasta (CKAPS)) in the Ministry of Health.

Multiple ancillary legislation relating to healthcare also applies along with general legislation such as the Price Control and Anti-Profiteering Act of 2011 which stipulates rules for anyone selling or providing price-controlled goods or services, in healthcare this includes face masks for example, the price of which has been set to follow a gazetted price schedule.

Within the statutory framework but outside of the courts the Malaysian Medical Council (MMC) can hear complaints of professional misconduct against individual practitioners subject to the Medical Act and Regulations, the MMC Standing Orders and various Codes of Conduct.

Despite this governance framework, many recent cases in the public domain show how dangerous the private healthcare market can be for patients. International media reported that a highly-regarded Malaysian journalist was assaulted by a doctor in a private clinic, who then reported the patient for criminal defamation when she made a complaint. The case was dropped following the intervention from the Attorney General.[17]

A Federal Court decision of September 2017 found that private hospitals are not generally liable for negligence by the medical practitioners that practice there because they are considered independent service providers rather than employees. The lawyers who won this case for the hospital celebrate the decision and the RM100,000 in legal cost awarded in their favour but for patients the effects of this decision severely limit their options for legal protection or a remedy for malpractice.[18]

The Federal Court decision denies patients any general claim against private hospitals for negligence and malpractice by the doctors recommended and credentialised by the same hospitals. Second, it encourages a moral hazard in which private hospitals can reduce the monitoring of doctors because they are protected from legal liability when the doctors misbehave. Third, for international medical tourists in particular, it signals that patients have little or no protection if anything goes wrong because the private hospitals will not accept responsibility.

[17] AGC drops plan to charge journo with defamation, MalaysiaKini, January 14, 2020 9:21 PM
[18] Raja, Daryl, Loh (2018) Federal Court: Liability of a Private Hospital, February 7 2018

The public sector is also not immune as recent cases of abuse of female doctors by male superiors[19] and the abuse of junior housemen reveals.[20] There appears to be a systemic governance problem in the medical profession which has been codified in law and has the effect of harming the customers of medical services and exacerbating market failure.

Cover-ups by the Malaysian medical fraternity have been widely reported by leading local and regional investigative journalists.[21,22] Even a former President of the Malaysian Medical Council (MMC) has publicly criticised mismanagement and conflicts of interest in the governing body of the Malaysian medical profession.[23]

Reform of Malaysia's Health System – Public and Private?

The reform of the healthcare system in Malaysia is not just a matter of increasing spending, although the low level of spending as a percentage of GDP compared to other countries is an indicator that more funding is necessary. Rather it is the structure of funding that also needs to be examined.

Malaysia finances around half of its healthcare system through direct government funding. The remainder is funded by unplanned, informal, out-of-pocket, pay-as-you go private spending in unstructured, poorly regulated private markets open to systemic market failure with little or no effective protection or remedy in the case of malpractice. It is this aspect of the Malaysian healthcare system which is the key issue that needs to be addressed.

One possible option is to convert the private out-of-pocket spending into a universal national health insurance scheme. Using pre-Covid estimates the total spending on private healthcare was RM30.6 billion in 2019 or equivalent to RM2.54 per capita per day, which would be a preliminary estimate of the per capita premium for a national healthcare insurance scheme.

Within a social market, private healthcare providers would still offer services to complement the public system but the payment would come from the government through the national healthcare insurance scheme not from the patients through out-of-pocket, direct payments.

The main advantages of turning the current private spending into a national insurance scheme are first, the coverage would be universal even if the premia for lower income groups is paid by the government, second patients do not rely on current income and savings which might be insufficient to cover immediate medical fees and third, the government becomes the purchaser of private healthcare on behalf of the patient and so can regulate over-prescription and other forms of market failure more effectively.

The general market failures within private healthcare markets provide compelling arguments for public provision as a general rule but the national healthcare insurance scheme helps to avoid crowding-out the private market, which offers choice, innovation and convenience which are valuable to patients.

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[19] Siraj Mohd Zaini (2018) 38 reports of housemen sexually abused received, says Health Ministry, New Straits Times, September 2, 2018 @ 4:24pm
[20] Malaysian Medics International (2021) 80% of housemen experience bullying, says medical body, Free Malaysia Today, January 16, 2021 2:59 PM
[21] Murray Hunter (2020) Patients betrayed: Malaysian Medical Council Protects its Own Regulatory agency goes with the malpractice flow, Asian Sentinel, February 6, 2020
[22] Mariam Mokhtar (2020) Closing ranks and cover-ups in clinical negligence, MalaysiaKini, February 14, 2020 8:11 AM
[23] Mohd Ismail Merican (2018) Malaysian Medical Council should facilitate not frustrate, The Malay Mail, Tuesday, 29 May 2018 09:10 AM MYT

Reform of management and leadership must also be a priority because systemic management dysfunction exacerbates market failures. Governance reform is also urgently needed because the current statutory, civil-law and regulatory protection of patients as customers in the market denudes them of feasible remedies at law.

This is made worse by the behavioural and governance system within the MMC, particularly the private sector members, which protects doctors at the expense of patient welfare as a matter of standard practice so that the private system is not properly regulated within a social market framework.

Given this background the need for a national discussion on the economics, management and governance in Malaysian healthcare has never been more urgent.

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