Challenges and Proposals to the Malaysian Healthcare System

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Abstract

The healthcare sector in Malaysia is facing many changes and influences that pose new challenges to the government and private healthcare organizations. Malaysia is a dynamic, rapidly progressing, multicultural country and constantly undergoing evolution from every aspect of its development, specifically the healthcare industry. Like many countries in the world, Malaysia is also facing healthcare issues and challenges. These challenges from pre-independence era have morphed into global issues which are more complicated as the country moves into the millennial age. Inevitably, the healthcare system will collapse in the future unless the government proactively tackles the challenges now. A healthcare system has been defined by WHO as all the activities whose primary purpose is to promote, restore or maintain health. This article has identified the major issues plaguing the healthcare system in Malaysia under the various headings: governance, economic and social challenges. The authors have also put forward various proposals to the meet the challenges.

Keywords: healthcare, healthcare system, issues and challenges, governance, proposals.

1. Introduction

The healthcare sector is facing many changes and influences that pose new challenges to the government and private healthcare organizations. Malaysia is a dynamic, rapidly progressing, multicultural country and constantly undergoing evolution from every aspect of its development, specifically the healthcare industry. Like many countries in the world, Malaysia is also facing healthcare issues and challenges. These challenges from pre-independence era have morphed into global issues which are more complicated as the country moves into the millennial age. Inevitably, the healthcare system will collapse in the future unless the government proactively tackles the challenges now. A healthcare system has been defined by WHO as all the activities whose primary purpose is to promote, restore or maintain health[1]. This article has identified the major issues plaguing the healthcare system in Malaysia under the various headings: governance, economic and social

[1] World Health Organisation, 'The world health report 2000 - Health systems: improving performance' (2000).

challenges. The authors have also put forward various proposals to the meet the challenges. This study is a library-based research which involved primary and secondary sources.

1.1 Pre-independence Healthcare in Malaysia

In 1910, general hospitals offering western medicine were available at each state in Malaya[2], existing hand in hand with traditional healing methods practiced by communities residing in Malaysia, namely Chinese medicine, indigenous beliefs as well as practices originating from Islam and Hindu Religion. Allopathic healthcare service was provided by the civil service and the focus at that time was to keep the British personnel and workforces in the plantations and mines, healthy from diseases namely malaria.[3] The challenges evolved into a fight against the epidemics of water-borne infections such as typhoid and cholera when the populations expanded into townships.

After the Japanese invasion, the colonial government provided midwifery clinics and first-aid facilities to the Chinese settlements, established to vanquish the Malaysian Communist's Party which were contesting for ruling power in Malaya. It was during this era that missionary hospitals such as Assunta Hospital in Petaling Jaya and Fatimah Hospital in Ipoh were set up, mainly to address the healthcare needs of these communities.[4] The healthcare services planning soon encompassed the rural areas which were populated heavily by the Malays.

1.2 Post-independence Healthcare in Malaysia

Being a colonial country, it is expected that Malaysia inherits a healthcare system similar to Britain. Strongly founded on socialist belief by the Health Minister, Aneurin 'Nye' Bevan, National Health Service Act was passed in Britain in 1946 and subsequently enforced on 5th July 1948[5]. The UK National Health Service was established and is held in high esteem throughout the world until today, as a comprehensive and holistic system, accessible to every citizen in the country.

Following the liberal welfarist ideology in post Second World War, the public hospital system, initially intended for the expatriate and local government officials, were accessible to the general population after Malaya was granted independence in 1957. The cost was

[2] Chee Leng Chee and Simon Barraclough, 'The Transformation of Health Care in Malaysia' in Chee Heng Leng and Simon Barraclough (eds), *Healthcare in Malaysia: The dynamics of provision, financing and access* (Routledge 2009).
[3] MK Rajakumar, 'Foreword' in Chee Leng Chee and Simon Barraclough (eds), *Healthcare in Malaysia: The dynamics of provision, financing and access* (Routledge 2009).
[4] Chee and Barraclough (n 1).
[5] Tommy Thomas, 'A Constitutional Right to Healthcare'', *Abuse of Power: Selected Works on the Law and the Constitution* (Strategic Information and Research Development Centre 2016).

heavily subsidized despite stratification of the wards according to the rank of government officers. The predominance of public hospitals persisted until 1970s, whereby corporate, for-profit hospitals were non-existent, save a few nursing homes and small maternity homes established by entrepreneurs.

In contrast to the hospitals, clinics which provided primary health care services (medical and dental) were made up by mainly by the private sectors, concentrated heavily in the cities and towns. These clinics operated on for-profit basis and relied on out-of-pocket payment by patients who can afford the service, hence services were aimed at the city-dwellers with higher income. This trend still persists till this day and in fact, has influenced the establishment of other types of private healthcare facilities and services, whereby the urban areas are very much coveted whilst the rural populations are left to the cared by the government. In 1967, as many as 1046 medical practitioners, 59% from a total of 1759 registered medical practitioners, were believed to be in private practice. [6]

Through national economic plans and expanded under New Economic Policy in 1970s, government set up a network of health clinics, to serve the rural population, where there was one health centre for every 21,697 population while the ratio for midwifery clinic was 1:5,147).[7] The success of this programme to address the challenges at that time was reflected by the drop in Maternal Mortality Rate (MMR) from 500 per 100 000 live births in 1950, to under 30 per 100 000 live birth in 2008.[8] Similarly, the infant, toddler and under 5 mortality rate were reduced from 75.5 per 1000 live births in 1957 to 5.5 per 1000 live births in 2008.[9] Communicable diseases which were viewed as a threat to the community were successfully reduced with the last polio outbreak occurring in 1977 and Malaysia was certified polio-free country in 2000[10]. Although diphtheria and whooping cough (tetanus) incidences has been low, dengue and tuberculosis persist to be endemic until today.

2. Healthcare Challenges in Malaysia

Malaysia faces a different facet of healthcare challenges with greater complexity presently compared to the issues in the 1970's and 1980's. Not limited to healthcare professionals, there are now more players and interested parties involved in the industry, as the stakes are higher due to liberalization policy and globalization. The major issues plaguing healthcare industry discussed in this paper are divided into governance, economic and social challenges. In this section, references are also made to other countries relevant to the discussion.

[6] Safurah Jaafar and others, *Malaysia Health System Review*, vol 3 (Judith Healy ed, World Health Organization (WHO) 2012).
[7] Chee and Barraclough (n 1).
[8] Jaafar and others (n 5).
[9] ibid.
[10] ibid.

2.1 Governance

2.1.1 Unclear stand on the role of the state

The policy that the Government held throughout 1970's and 1980's was that Malaysia is a welfare country. The taxes collected were used appropriately to strengthen the education system by building schools and universities, and likewise in the healthcare aspect, multiple hospitals and clinics were set up, specifically in the rural area. This approach was contingent in ensuring that healthcare was accessible and equitable for most of the citizen in the country. The role that the state has upheld is that the government is the service provider, and this is reflected in the steady rate of GDP expenditure of 5.6 – 6.6 percent in the period of 1971-1981.[11]

However, under the 7th Malaysia Plan (1996-2000), due to pressure from international and regional financial institutions such as the International Monetary Fund, the World Bank, and the Asian Development Bank, the Mahathir administration introduced the concept of privatization. 'Malaysia Incorporated' was envisioned whereby the private sector is the main engine of a country's growth while the government ensures the enabling environment in the form of infrastructure, deregulation and liberalization.[12] Privatization Masterplan (PMP) , launched in 1991 officially included healthcare for private ownership when it recognized twelve private hospitals amongst 149 agencies to be privatized. The 6th Malaysia Plan also claimed that the government is committed to shift its role towards more policy-making, regulatory aspect as well as setting standards to ensure quality, affordability and appropriateness of care.

As such, there was a change in the policy which affected the nation in all aspects of governance, especially power, water and healthcare. With respect to healthcare, non-medical services segment of the medical functions was privatized in 1994, starting with MOH's pharmaceutical store in 1994, hospital support services in 1996 and followed by medical examination of foreign workers in 1997 to FOMEMA.[13] Subsequently, Remedi Pharmaceuticals, subsidiary of United Engineers Malaysia (UEM) were awarded a renewable fifteen-year concession to become supplier for government's medical store, inclusive of manufacturing, purchasing , storage and distribution activities.[14]

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[11] Rajah Rasiah, Nik Rosnah Wan Abdullah and Makmor Tumin, 'Markets and Healthcare Services in Malaysia: Critical Issues' (2011) 3 Institutions and Economies (formerly known as International Journal of Institutions and Economies) 477 <http://ideas.repec.org/a/umk/journl/v3y2011i3p467-486.html> accessed 20 June 2019.

[12] Chee and Barraclough (n 1).

[13] Lee Poh Onn, 'What Lies Ahead for Malaysian Healthcare ?' (2015) 4 ISEAS Economics Working Paper <https://www.iseas.edu.sg/images/pdf/ISEAS_Economics_Working_Paper_2015-04-01.pdf> accessed 16 April 2019.

[14] ibid.

The privatization of hospitals stemmed from the belief that better management and institutional flexibility will drive the hospitals to be more efficient and effective.[15] It is also intended to serve those who can afford it, while relieving the public hospitals to cater for those who cannot use the public hospitals. Although PMP was launched in 1991, state development corporations and other government-linked conglomerates had started acquiring private hospitals from the year 1982.[16]

Consequently, the share of private ownership in overall healthcare expenditure had risen from 5.8 percent in 1981, reaching 7.6 percent in 1982 and later achieved 30.6 percent in 2004[17]. The government started to diversify its role into becoming investors when Kumpulan Perubatan Johor (KPJ) which was established in 1991, expanded its role and become one of the major private hospital owners in Malaysia. Malaysian government's investment arm Khazanah Nasional, owns a substantial portion of private hospitals when its subsidiary, IHH Healthcare acquires Parkway Pantai Ltd and Gleneagles chain hospitals, making it 14 private hospitals in Malaysia in total with 2,182 operational beds.[18]

As a state, the government cannot run from its role as regulator. Albeit drafted rather late as the private hospitals have mushroomed all over the country, the objective of Private Healthcare Facilities and Services Act 1998 (PHFSA) is to ensure that minimum standards are complied to ensure patient safety and quality of care rendered to Malaysian citizens.[19] The Act is also intended to improve accessibility to healthcare and rationalize medical charges to a reasonable rate. [20] Furthermore, the act replaced the Private Hospital Act 1971, which were deemed inadequate as it did not cover other type of healthcare facilities and had no enforcement power even to inspect the premises.[21]

PHFSA is touted as far-reaching and governs almost all aspect of a private hospital's operation, from the pre-establishment state up until mortality assessment investigation. It also allows the enforcement officers to enter a premise should he believe that, amongst others, the investigation would be adversely affected or evidence tampered or destroyed, if he delays the raid due to the delay in obtaining the warrant. The private healthcare facilities could also be closed down by the Ministry, due to reasons such as posing grave danger to

[15] Rasiah, Abdullah and Tumin (n 10).
[16] ibid.
[17] ibid.
[18] 'Our Hospitals' <https://www.ihhhealthcare.com/hospital-overview.html> accessed 16 April 2019.
[19] Afidah Ali, 'Legal Requirement For Medical Practitioners', *Persidangan Pakar Program Perubatan 2015* (2015) <http://medicalprac.moh.gov.my/v2/uploads/Laws & Medical Practitioners.pdf> accessed 16 April 2019.
[20] Nik Rosnah, Wan Abdullah and Lee Kwee-heng, 'Impact of Private Healthcare Facilities and Services Act 1998 [Act 586] and Regulations 2006 on the Medical Practice in Corporate Private Hospitals in Malaysia' (2006) 2 International Journal of Sustainable Development 91.
[21] Private Hospital Act 1971.

the public, through legal-administrative procedures such as revocation of licence and enforcement action by the Ministry. [22]

Therefore, the government now plays a tripartite role; investor, regulator and service provider. The mixture of roles leads the government to be ambivalent in its policy making and decision making. The role of service provider has long been the governments' most effective tool to ensure election victory as the majority of the public depends heavily on public healthcare facilities. [23] On the other hand, the government is also the major shareholders in the companies owning most of private hospitals in the country, bringing in up to RM509 million in every quarter yearly.[24] Should any of these hospitals contravene any of the provision of law, the government must be decisive and impartial in legal action against all parties involved.

The Ministry's conflict is most apparent in the case of closure of a private hospital, Mawar Medical Centre in Negeri Sembilan in 2019. The hospital had received a substantial amount of fundings in capital grants and leased government land at a hugely discounted rate for the past 20 years. In November 2018, all but one specialist had mass-resigned from the centre. Effectively, the hospital has failed to comply with the Private Healthcare Facilities and Services Regulations 2006 (Private Hospitals and Other Healthcare Facilities) and following show cause letter[25] from the Director General of Health, the centre's licence was revoked. The patients were relocated to public hospitals as well as other private haemodialysis centres to ensure continuity of care. The government did not take over the hospital as it would be "selfish" since the government is also a service provider. The MOH is placed in a difficult position as it has to be mindful of its responsibility to uphold the law for the sake patient safety and to also consider public perception towards Minister and the Ministry.

2.1.2 Deteriorating quality of healthcare professionals

Malaysia has long suffered from the shortage of healthcare professionals, until recently. Previously, the shortage of doctors was rather critical, whereby the doctor: population ratio was 1:1,105 in 2008. The target is to reach 1:400 in the year 2020. The ratio for other

[22] Private Healthcare Facilities and Services Act 1998.

[23] David Quek, 'The Malaysian Health Care System: A Review', *Intensive Workshop on Health Systems in Transition* (2009) <https://www.researchgate.net/publication/237409933_The_Malaysian_Health_Care_System_A_Review> accessed 20 June 2019.

[24] 'IHH Healthcare Q4 2018 Profit Quadrupled to RM509.4 Million; Recommends Dividend of 3 Sen per Share for FY2018' (2019) <https://ihh.irplc.com/medianews.htm?filepath=IHH/IHH Q4 2018 Press Release 27 2 2019_final.pdf> accessed 16 April 2019.

[25] Private Healthcare Facilities and Services Act 1998, s 43.

categories such as dentists and nurses were worse with the ratio being 1:7618 and 1:512 respectively.[26]

To increase the availability of healthcare professionals to the public, Malaysia has embarked on many programmes since 8th Malaysian Plan, whereby one of them being outsourcing of training. In 2011, it was found that the government has licenced more than 34 medical schools, offering more than 50 medical programmes to resolve the issue of insufficient doctors as speedily as possible. This is in addition to increased number of oversea medical institutions recognized from 239 in 1989, reaching up to 338 institutions in 2016.[27] The outcome was that Malaysia is faced with influx of new medical graduates yearly, more than the post of housemen training that the public hospitals could offer, resulting in long wait to be posted, between 6 months to one year. Hence, the MOH had to impose certain measures: revising the method of appointment, from permanent to contract appointment and introducing a moratorium on medical programmes with the cooperation of the Education Ministry up to April 30, 2021 with the aim of imposing quota on medical graduates by universities in the country. Training slots for houseman has also been increased from 10,835 to 11,706 by adding more training hospitals to become 47 hospitals in total.[28]

The more important issue however is the subpar quality of these mass-produced doctors, caused by decreased working hours, insufficient specialists to train and poor attitudes amongst most of the junior doctors. This is supported by data which shows that, less than 60% of houseman finished their training in the stipulated period, as well the number of housemen dropping out had tripled, from 368 in 2008 becoming 1441 in 2014. It was also found, that from those who had to extend their housemanship, 55% were due to incompetence and 45% had disciplinary issues.[29]

Likewise, the issue of quality of the workforce is not only limited to doctors but nurses as well. A private hospital reportedly claimed that as many as 79 out of 80 graduate nurses were unemployable and this is due to the quality of training received at the private institutions which were questionable[30]. This would later spiral to result in smaller number of

[26] Safurah Jaafar and others, *Malaysian Health System Review* (Judith Healy ed, World Health Organization (WHO) 2012).
[27] Lim Chee Han, 'Housemanship Programme in Malaysia: Availability of Positions and Quality of Training' (*Penang Institute KL*, 2017) <https://penanginstitute.org/wp-content/uploads/jml/files/press-releases/2017/Housemanship-in-Malaysia-Press-Conference-21-July-Final.pdf> accessed 17 April 2019.
[28] Bernama, 'Government to Resolve Issue of Housemen Placement' *The New Straits Times* (9 June 2018) <https://www.nst.com.my/news/nation/2018/06/378286/government-resolve-issue-housemen-placement> accessed 16 April 2019.
[29] Chee Han (n 30).
[30] Malaysia Productivity Corporation (MPC), 'Reducing Unnecessary Regulatory Burdens on Business: Medical Professional' (2016) <https://www.healthpoint.co.nz/register/> 79.

staffs qualified with post basic training, which were highly critical in technically demanding discipline such as peri-operative and haemodialysis specialty.

2.1.3 Weak support for regulatory mechanism

It is claimed that the private healthcare sectors in Malaysia is heavily regulated, with more than 50 legislations pertaining to medical and healthcare in the country[31]. Other than Medical Practice Division, MOH, other regulatory bodies are namely the professional bodies (boards and councils), authorities which regulates the healthcare facilities (Fire Department and local authorities) and equipment (medical devices and radiation containing equipment), as well as the enforcement agencies which enforce the statutes which governs the medical practices (for example Medicine Advertisement Board which issues advertisement approvals)[32].

Since healthcare affects all the citizens of Malaysia directly (which impacts the future of the country), it is only befitting that proper legal framework exists to protect patient's safety and quality of healthcare. Regulation is intended to enforce "responsible" conduct on business enterprises and in many countries, the presence of regulations is an indicator of proper monitoring and quality of services offered.[33] The government recognized the importance of regulatory and enforcement and has repeatedly reiterated its intention to strengthen the regulatory framework from 7th Malaysian Plan up till 11th Malaysian Plan.

On the other hand, the government is seen to be hesitant in upholding or carrying out strategic planning with regards to strengthening the regulatory mechanism in the healthcare industry. An example of that is the Pathology Laboratory Act 2007 [Act 674] which was drafted more than 10 years ago but yet to be enforced.[34] [35] One wonders whether the situation was partly affected by well-connected big laboratories' reluctance to be regulated. The drafting of several important bills (namely Organ and Tissue Transplantation Bill and Assisted Reproductive Technology Bill) were delayed as the existing resources have to be diverted to complete the drafting process of Private Aged Healthcare Facilities and Services Act 2018 {Act 802] and its Regulations.

The manpower planning seemed to be non-existent as there is no plan to increase the government's enforcement officers, whereby less than 200 officers from Private Medical

[31] Ali (n 19).
[32] ibid.
[33] Lydia Nahan, 'Medical Tourism Expected to Reach RM2.8b in Revenue by 2020' *The Malaysian Reserve* (2018) <https://themalaysianreserve.com/2018/09/04/medical-tourism-expected-to-reach-rm2-8b-in-revenue-by-2020/> accessed 20 June 2019.
[34] Pathology Laboratory Act 2007.
[35] 'Implement Pathology Lab Act, Says MMA' (*The Star Online*) <https://www.thestar.com.my/news/nation/2017/06/15/implement-pathology-lab-act-says-mma/> accessed 16 April 2019.

Practice Control Section are expected to enforce Act 586, covering more than 10,000 licensed and registered healthcare facilities of varying stage of legal compliance all over Malaysia.[36] This is excluding estimated 1000 old folks/nursing home which comes under Act 802 and 500 private laboratories under Act 674.[37] This is an unreasonable and daunting task for any authority, especially with limited equipment and no additional incentives whatsoever. The situation is no different with other enforcement agency under MOH such as Medical Device Authority, Traditional and Complementary Medicine Division and Inspectorate Unit.

2.2 Economic Challenge - Lack of health financing system

The public sector in Malaysia has always been traditionally the provider of healthcare services for 65% of its citizen. Yet, Malaysia's health expenditure as a per cent of GDP (4.4% in 2018) is relatively low by the world average and lower still when compared to the high-income countries such as Australia which spends 9.4% of the GDP for health expenditure, Japan 10.2%, South Korea 7.2%, and Singapore 4.9% respectively. Increased expenditure would translate to more public healthcare facilities built, better system delivery and overall wellbeing of the people in general.[38] The government currently subsidises 98% of public hospital services amounting to RM12.8 billion/year while the patients only pay 2% of the cost.[39]

However, there seem to a policy shift when corporatisation is introduced in the healthcare system. This shift is dictated by the market forces and the argument that the current healthcare system is unsustainable in the long run. The introduction of the concept of public hospital autonomy and full paying patient in the 10th Malaysia Plan signifies the slow entrance of privatisation into some of the services provided by the public sector.[40] The public is being cultured into thinking that if you want the service fast, you have to pay for it yourself.

Undeniably, privatisation of healthcare helps in offloading the workload of the understaffed and poorly maintained government healthcare facilities, by catering to the health needs of those who can afford such services. Private healthcare facilities, not bogged down by administrative bureaucracy, offers high tech equipment not available in government

[36] 'Bilangan KPJKS Berlesen Dan Berdaftar Bawah Akta 586' (2019) <http://medicalprac.moh.gov.my/v2/modules/mastop_publish/?tac=Bilangan KPJKS Berdaftar Berlesen> accessed 18 April 2019.
[37] Department of Standards Malaysia, 'Status Report On The Number Of Malaysian Laboratories Accredited By Standards Malaysia' (2019) <http://www.jsm.gov.my/statistics2#.XLjgHS-B3ow> accessed 17 April 2019.
[38] Loh Foon Fong, 'WHO Lauds More Healthcare Spending' *The Star Online* (24 May 2018) Nation <https://www.thestar.com.my/news/nation/2018/05/24/who-lauds-more-healthcare-spending-ministers-measures-important-as-malaysians-are-living-longer-says/> accessed 17 April 2019.
[39] Quek (n 23).
[40] ibid.

hospitals, faster service and convenience to the patients. In addition, private hospitals also increase the country's revenue by attracting medical tourists, as evidenced by Malaysian Healthcare Travel Council (MHTC) report of RM1.3 billion revenue in 2017 and more than one million health travellers' volume in 2017.[41]

In spite of that, due to the absence of national health financing system, the premium healthcare services and facilities remain out of reach for the average Malaysians. Most of the payment for services in private hospitals are from out-of-pocket payment which is unsustainable for long term. Burdened with monthly transportation, education, and property costs, most Malaysians consider insurance as a luxury, resulting in Malaysian health insurance rate of only 30%. Furthermore, global increase in healthcare costs (encompassing cost of medicine, professional fees and devices) will drive more and more Malaysians to public facilities in the future, resulting in underutilization of facilities in the private healthcare sector.[42]

2.3 Social Challenges

2.3.1 *Change in disease burden*

Disease pattern in Malaysia is undergoing transitional phase whereby major problems from acute infectious disease has changed into chronic lifestyle related disorders, such has cardiovascular diseases, diabetes mellitus, cancers and age-related disorders. In 2008, motor vehicle accidents, cardiovascular disease and cancers are major causes of admissions to public hospitals ranking 3rd, 5th and 10th respectively.[43] On the other hand, the prevalence of certain infectious diseases has been rising steadily, for instance in 2013, 43,346 dengue fever cases were reported, which is a 98% increase from 21,900 cases in 2012.[44]

The presence of immigrants and refugees have contributed to the changing demographic of disease burden. Tuberculosis notification was found to have increased from 78 per 100,000 population in 2012 to 81 cases per 100,000 in 2013.[45] In addition to that, the maternal mortality ratio has worsened from 23.8 in 2015 to 29.1 in 2016, due to increase in cases of obstetric embolism, postpartum haemorrhage and other associated medical disorders. [46]

2.3.2 Increased expectation and awareness

[41] Nahan (n 36).
[42] Mark Rao, 'Malaysia's Top-Rated Private Healthcare Not Accessible to General Public' (*The Malaysian Reserve*, 2019) <https://themalaysianreserve.com/2019/02/12/malaysias-top-rated-private-healthcare-not-accessible-to-general-public/> accessed 16 April 2019 and Quek (n 23).
[43] Ministry of Health, 'Country Health Plan: 10th Malaysia Plan 2011-2015' (2013).
[44] Unit Perancang Ekonomi, 'Kertas Strategi 5: Mencapai Akses Sejagat Kepada Penjagaan Kesihatan Berkualiti' (2015).
[45] ibid.
[46] Ministry of Economic Affairs, 'Mid-Term Review of Eleventh Malaysia Plan 2016-2020 : New Priorities and Emphases' (2018).

With the advancement of technology, Malaysians are exposed to more information and social media than the previous generation. In response, the expectation and awareness of Malaysians regarding healthcare services received have increased exponentially. A study done by Galen Centre for Health & Social Policy, a public policy research and advocacy organization, recently have identified that most citizens' wish list are shorter waiting time and caring doctors, in addition to cheaper medicine, tests and health insurance[47]. Thus, the healthcare system must be empowered and trained on how to handle public's expectation.

Online selling of healthcare products and consultation are preferred by patients who values convenience, cheaper price and privacy. Patients can also book any doctor they want through their mobile phone, and even get healthcare professionals to see them at home at premium fee. Currently, there is no specific law regulating the delivery of healthcare services or products via online, and MOH is looking into regulatory mechanism to regulate this industry to curb fake products and fraud transaction before this practice becomes uncontrollable.[48]

2.3.3 Emerging health technologies

The advent of new technologies to solve medical illness and condition have open up a new horizon. Proliferating rapidly amongst others is the aesthetic industry. Currently, the government attempts to regulate the industry by ensuring that only registered medical practitioners with Letter of Credentialing and Privileging (LCP) are allowed to practice aesthetic in private clinics, which are registered with Ministry of Health (MOH). Nonetheless, there are a lot of beauty spas manned by personnel with doubtful qualification and experience which are beyond the jurisdiction of MOH.

Looking closer, there are healthcare facilities which conduct operations done by fly-by-night surgeons, as well as unethical practice of operating patients without appropriate post-operative care.[49] Australia medical experts have condemned this practice and issued warnings to its citizens when Mr Leigh Aiple, an Australian was found dead after undergoing bariatric surgery in Malaysia.[50] This incident had somewhat tarnish the image of Malaysia and raised the question of the number of times such incidence went unreported in Malaysia.

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[47] Codeblue, 'What Matters To Malaysians In Health Care' (*Codeblue.galencentre.org*, 2019).
[48] Affairs (n 51).
[49] 'MMC: We Can Act against Fly-by-Night Doctors' *The Star* (26 May 2007) <https://www.thestar.com.my/news/nation/2007/05/26/mmc-we-can-act-against-flybynight-doctors/> accessed 16 April 2019.
[50] FMT Reporters, 'Australian Experts Warn of Risks of Getting Plastic Surgery in Malaysia' (*FMT News*, 2017) <https://www.freemalaysiatoday.com/category/nation/2017/12/19/australian-experts-warn-of-risks-of-getting-plastic-surgery-in-malaysia/> accessed 15 April 2019.

Fertility treatment is another field where exciting new methods are being developed for affluent, childless couples. Although MHTC is aiming for Malaysia to be a fertility hub by 2020, caution is imperative as many of the procedures are still untested and controversial. [51] Another highly coveted experimental treatment is stem cell therapy which is believed to be the "magic" pill to solve all medical illness, yet there is only a handful of haematological cancers recognized to be treated with stem cell therapy[52]. Areas such as genetic modulation is fast becoming a favourite as well due to the potential of benefits that can be reaped from the technology.

At the moment, the Ministry's capacity and capability planning to equip the regulators or technical experts with the latest knowledge regarding these new health technologies is perceived to be insufficient. To be able to use the technologies, the government must have technical experts to advise the management properly on the next course of action.

2.3.4 Foreign equity and professionals

Malaysia has pledged commitments to comply with the General Agreement in Trade in Services (GATS) whereby countries signatory to this agreement agrees to cross border supply of services, consumption of services abroad, foreign direct investment and movement of health professionals between borders. Under GATS, there is a limit on the degree to which foreign operators can operate in the market, thus offering some protection towards local healthcare industry. At the same time, 1995 ASEAN Framework on Agreement in Trade in Services aims to promote free flow of goods, services, investments, capital and skilled labour to create an ASEAN Economic Community (AEC) by 2020.[53]

However, starting 2015, the government has introduced the concept of autonomous liberalization whereby new private healthcare facilities such as private hospitals and private medical/dental specialist clinics are allowed to have 100% foreign equities. There is some restriction towards other facilities such as for ambulatory care centres and haemodialysis centres, it is limited to 49% as well as having a joint venture with local company.[54]

This has effectively open up the floodgate to entry of foreign investors, who will bring in foreign professionals into Malaysia as well. Indirectly, this would increase flow of money out of the country, particularly the haemodialysis sector which is heavily subsidized by

[51] Nahan (n 36).
[52] 'Arahan Ketua Pengarah Kesihatan Bil. 1/2016 Mengikut Peruntukan Akta Kemudahan Dan Perkhidmatan Jagaan Kesihatan Swasta 1998 [Akta 586]: Rawatan Terapi Sel' (2016).
[53] Nicola S Pocock and Kai Hong Phua, 'Medical Tourism and Policy Implications for Health Systems: A Conceptual Framework from a Comparative Study of Thailand, Singapore and Malaysia' (2011) 7 Globalization and Health 12 <http://www.globalizationandhealth.com/content/7/1/12> accessed 20 June 2019.
[54] 'Dasar Penyertaan Ekuiti Asing Dalam Kemudahan Kesihatan Jagaan Swasta' (2015).

government, state zakat authorities, SOCSO and NGOs. By monopolization, this policy could be killing the local healthcare industry which is not backed by multinational giant pharma and equipment companies.

3. Proposals to Meet Healthcare Challenges

Looking at the current scenario, Malaysia requires a multiprong approach to tackle these issues without jeopardizing either the economic status of the country or the wellbeing of its citizens. The strategies that the government could consider are - establishing a single payor mechanism; strengthening the regulatory and enforcement arm; reducing political interference in healthcare policies and regular engagements with the stakeholders.

3.1 Establish a single payor mechanism

It is fairly obvious that the government will not go back to being the welfarist state such as Norway, Sweden or Denmark where the tax collection is appropriated to cover the healthcare costs of all its citizen in all private healthcare facilities. Too deeply trapped in the web of capitalism, the only way to ensure equity and accessibility is maintained is by establishing a single payor mechanism[55].

The national health financing must fulfil several criteria to ensure that it is not misused and achieve its intended goal namely ; be based on cost and risk sharing, made compulsory for everyone who can afford and integrates primary, secondary and tertiary levels as well as within the public sector and between the public and private sectors. [56] No doubt the current government has started to introduce two health financing schemes, MySalam and Skim Peduli Kesihatan untuk Kumpulan B40 (PeKaB40) but the schemes are far from what has been envisioned before.

MySalam is plagued by political issues regarding the foreign equity of Great Eastern Takaful Berhad, an insurance company which is owned by Singapore. There are various questions that were raised by the public, for example, the exclusion clause will exclude majority of Malaysians from benefitting it, the inclusion criteria were too narrow and the sustainability of the scheme after 5 years.[57] PeKaB40 was queried on why it had to be run by a corporation (costing the government another RM2 billion) when it can use government's

[55] A single payor mechanism is where one entity not only collects healthcare fees and premiums, but is also the payer for all healthcare costs.

[56] MI Merican, Y Rohaizat and S Haniza, 'Developing the Malaysian Health System to Meet the Challenges of the Future.' (2004) 59 The Medical journal of Malaysia 84 <http://www.ncbi.nlm.nih.gov/pubmed/15535341>.

[57] Dr Michael Jeyakumar, 'Will MySalam Help, Harm Or Make No Difference?' (*Codeblue.galencentre.org*, 2019) <https://codeblue.galencentre.org/2019/03/05/will-mysalam-help-harm-or-make-no-difference/> accessed 20 June 2019.

machinery and network.[58] It was also reportedly being shunned by most general practitioners as the payment offered was lower than what was prescribed under Seventh Schedule, Private Healthcare Facilities and Services (Private Medical Clinics or Private Dental Clinics) Regulations 2006[59].

In other words, the government may choose between compulsory health financing or tax-based system, both will ensure equity and access through single payor, multiple-provider system. Both systems have their own pros and cons and the government have to weigh them carefully to ensure that the coverage is comprehensive, and the system is sustainable in the long term. To address the concern of the public, some had even proposed that the government withhold the implementation of MySalam until all factors have been discussed thoroughly with all the relevant stakeholders.[60]

When the single payor mechanism is in place, the government can utilize all the general practitioners'(GP) clinics to play a bigger role in enhancing awareness, carrying out promotional activities and following up on patients with non-communicable disease within their vicinity effectively. This has been suggested by Dr Steven Chow, the President of Private Medical Practitioners Associations of Malaysia, for the past few years. Increased involvement of GPs with the community will hopefully address the issue of changing disease burden as well as manage the public's expectation towards healthcare delivery.[61] The impact of this win-win collaboration will greatly reduce the workload in government's clinic, decrease waiting time for the patients, provide personalised and focused treatment for the patients and strengthen the concept of private-public partnership, which has long been one of MOH's strategic plan.

3.2 Strengthening the regulatory and enforcement arm

The complaints regarding uncoordinated enforcement activities of the MOH are not unheard of and thus, the Ministry has embarked on efforts to integrate the enforcement agencies into one Programme/ Authority[62]. However, this task proved to be easier said than done since the acts, power under the law, qualifications of enforcement officers and training required are very diverse. The merging of the enforcement entities requires critical analysis from multiple governance and technical aspects lest poor implementation of this

[58] Mohamed Rafick Khan Abdul Rahman, 'Putting Political Mileage Ahead of Public Healthcare' (*Malaysiakini*, 2019) 1 <https://www.malaysiakini.com/letters/462637> accessed 16 April 2019.
[59] Private Healthcare Facilities and Services (Private Medical Clinics or Private Dental Clinics) Regulations 2006.
[60] Jeyakumar (n 61).
[61] Dr Steven Chow, 'Utilise Our GPs To Ease Patients' Waiting Time and Cost' (*Codeblue.galencentre.org*, 2019) <https://codeblue.galencentre.org/2019/03/07/utilise-our-gps-to-ease-patients-waiting-time-and-cost/> accessed 12 April 2019.
[62] Ekonomi (n 49).

initiative could result in negative outcome to the government, in particular legal implications as well as public safety.

Whether the integration of enforcement agencies takes place or not, it is high time that the government reviews all the laws pertaining to medical practice and healthcare in Malaysia. Some of it are already outdated, such as Nursing Act 1950[63] and the professional acts need to be standardized so that the implementation would be smooth. It is proposed that the government set up a professional body to oversee the registration and accreditation of all professional bodies such as Australian Health Practitioner Regulation Agency (AHPRA).[64] This way, not only all the boards and councils are standardized but it would also control the quality of education of healthcare professionals.

The government must also allocate a dedicated unit equipped with the skills and knowledge needed to review the regulations regularly. Although some amendments of the PHFSA are already on its way and currently undergoing public engagement phase, this exercise has to scheduled properly and the stakeholders involved need to be committed as well. Training and adequate human resources issues need to be tackled so that the implementation will be as per intended.

A proactive approach is essential so that new technologies can be regulated (if needed) before it inflicts too much damage to the society. Technical experts need to be trained, exposed and retained, as well as educating the public adequately on the risks taken by using any device/technology before the device/technology is sufficiently studied.

3.3 Reduce political interference in healthcare policy

Increased involvement of the state in the shares of private healthcare facilities makes quality monitoring or compliance assessment to legal requirements difficult to be carried out properly. Pressure from influential people may skew the officers' efforts into approving applications without comprehensive scrutiny and should there be any legal implications later, the officers will be held accountable. Overall, this promotes a culture of corruption, disintegrate the integrity of the processing officers and the officers trapped in a lose-lose situation which will affect their mental health and performance.

Even during the operation of healthcare facilities, since the government is the biggest stakeholders in private hospitals, investors will attempt to maximise earnings and profits from its investment. Hence, the attempt to control the fee and price of consumables will be

[63] Nursing Act 1950.

[64] 'Australian Health Practitioner Regulation Agency' (*Legal Services Commission Australia*, 2019) <https://lawhandbook.sa.gov.au/ch09s05s01.php> accessed 10 April 2019.

futile and left to the market forces to decide[65]. Reduced politician's interference will also lead to impartial policy making and fair distribution of financial subsidies such as capital grants or funds in the healthcare industry. The legislative and executive arm must be separated again to maintain the check and balance, as intended by the Federal Constitution.

3.4 Transparency and increased engagement with the public and stakeholders

The mistake commonly made by the government is inadequate engagement with all the stakeholders and lack of transparency, resulting in unenforceable act or unactionable policy. An obvious example is Mental Health Act 2001[66] and Mental Health Regulations 2010[67], whereby none of the existing private psychiatric nursing home can be licenced as they cannot comply with the requirement set by the Act.[68] Similarly, Telemedicine Act 1997[69] was not enforceable and said to be repealed soon, because it was not comprehensive enough to cater to issues that could arise, for example how confidentiality and liability issues should be handled if a wrong diagnosis is made over a phone consultation.

A statute should be the last method of regulating any type of industry as compared to self-regulatory or usage of soft law. Statute is the least cost-effective method to monitor standards and ensure that they are adhered to. Soft law also facilitates compromise, and thus encourages cooperation between parties with different interests and values, different time horizons and discount rates, and different degrees of power. [70] Adequate awareness and public readiness is imperative before any law is enforced to ensure smooth implementation by the regulators.

4. Conclusion

The healthcare challenges in Malaysia are varied and extremely dynamic, influenced by multiple factors both from within and out of the country. During the pre-independence and independence period, healthcare was focused on the well-being of the British officers, plantation and mine workers, as well as eradicating communicable diseases, respectively. However, 1990's ushered in privatization plans of healthcare industry and the Government was supposed to change its role from service provider into policy makers and regulators. The major issues pertaining to healthcare in Malaysia can be divided into three; governance, economic and social challenges.

[65] Chow (n 66).
[66] Mental Health Act 2001.
[67] Mental Health Regulations 2010.
[68] 'Bilangan KPJKS Berlesen Dan Berdaftar Bawah Akta 586' (n 40).
[69] Telemedicine Act 1997.
[70] Kenneth Abbott and Duncan Snidal, 'Hard and Soft Law in International Governance' (2000) 54 International Organization 421.

The root cause of current issues faced was indecisiveness of the government on which of the tripartite role (investors, regulators or service providers) that the government would like to play in near future. The other issues which reflect poor governance are the deteriorating quality of healthcare professionals and weak support for regulatory framework. The economic challenge was the absence of national health financing system, which is critical for ensuring universal health access, while the social challenges posed are the changing disease burden, increased public's expectation and emerging health technologies.

To handle these issues efficiently, it is proposed that a single payor mechanism is established, strengthening of regulatory and enforcements and increased engagements and transparency with the stakeholders before any policy or law is enacted. Implementation of these strategies hopefully could contribute to consolidate the current universal access to quality and safe healthcare, which will result in improved well-being of Malaysian citizens as a whole.

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