Health care delivery in Malaysia: changes, challenges and champions

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Abstract

Since 1957, there has been major reorganization of health care services in Malaysia. This article assesses the changes and challenges in health care delivery in Malaysia and how the management in health care processes has evolved over the years including equitable health care and health care financing. The health care service in Malaysia is changing towards wellness service as opposed to illness service. The Malaysian Ministry of Health (MOH), being the main provider of health services, may need to manage and mobilize better health care services by providing better health care financing mechanisms. It is recommended that partnerships between public and private sectors with the extension of traditional medicine complementing western medicine in medical therapy continues in the delivery of health care.

Health care system in Malaysia

Human capital and health improvement programmes are of central importance towards sustainable development and economic growth in any country.1 In Malaysia, the health care system has changed from traditional remedies to meeting the emerging needs of the population. Since the Independence of Malaysia in 1957, there has been major reorganization of health care services in the country.2 The first reorganization started at the public primary health care services and accelerated since the Alma Ata Declaration in 1978. In Malaysia, the Ministry of Health (MOH) is the main provider of health care services to the public. The organizational structure of the MOH has three levels, Federal, State and District, which are decentralized to ensure efficiency. Each hierarchical level determines the level of authority, information flow, accountability and supervision. This system encompasses all aspects of care such as preventive, promotive, curative and rehabilitative.3 The main objective is to provide a greater network of physical facilities, equity, accessibility and utilization of health care resources. At the same time, National Referral Centres were established to provide specialized care to enhance the basic care provided in health clinics.3

Over the past decade there has been an explosion of tertiary level specialized care to meet the needs of the population. Tertiary care focuses on the curative model, which is doctor and illness focused. This is expensive, fragmented and institutionally focused and inappropriate for the majority of health consumers.4 In the current era, health care is changing towards wellness services as opposed to illness services.4 This service includes a lifetime health plan that focuses on keeping the child and family well. This gives greater prominence to preventive issues and takes on healthier lifestyles by choices with risk prevention. The health care providers also need not function as controllers but act as facilitators or partners with health consumers4 (Figure 1).

Apart from the size of the hospitals, there are differences in terms of services provided. Small district hospitals provide general medical and nursing care and their manpower consist of medical officers and other personnel. Larger district hospitals and regional hospitals provide a wide range of specialist services and the public has easy access through a walk-in or referral system.3 MOH seeks to ensure the public is informed of health issues and has access to safe water, safe food and quality medicine. The Malaysian health care system focuses on Primary Health Care (PHC) that places social equity as important and allocates public funds for the poorest 20% of the population.5 In 1956, there were only 42 PHC facilities in the country.5 After independence, the health sector became an integral part of the national and development process and MOH has been able to deliver health care to communities throughout the country.4 Table 1 shows increasing health care facilities in secondary and tertiary care over the years.

The number of hospitals, community clinics and other facilities such as Special Medical Institutions (National Heart Institute, Institute of Pediatrics and Institute of Respiratory Medicine) has increased (Table 2). The total expenditure from the Health Department of Selangor in 2006, for instance, has increased to RM 881.3 million compared to RM 628.83 million in 2005 and RM 577.77 million in 2004. The increase is due to new hospitals and comprehensive health services that are provided by the government.7 The Second National Health and Morbidity Survey in 1996 reported that 88.5% of the population stays within 5 km of a health facility and 81% lived within 3 km.5 Findings also show that basic health care and facilities are accessible to about 70% of the population in Sabah and Sarawak and more than 95% of the population in Peninsular Malaysia.8 These estimates do not include other types of outreach services such as flying doctors, mobile health teams, dental clinics, travelling dispensaries and riverine services.3,4

There are other government agencies that complement the role of MOH to preserve the health of the people. For instance, the Ministry of Human Resources that enforces safety and health regulations of employees, Ministry of Education that is responsible for the operation of the teaching hospitals and training of health personnel of the country, Ministry of Defence that provides health services for its population within the territory, Ministry of Rural Development that is responsible for the health of the aborigines and Ministry of Housing and Local Government that is responsible for some of the licensing and enforcement under its purview.2,3

Studies have also shown that the Malaysian health standard is almost at par with those of developed countries.10 Data from the World Health Report in 1999 indicated that the health