Executive summary

Malaysia is a federation of 13 states and 2 territories in a parliamentary democracy, with the Prime Minister the head of government and a constitutional monarch elected by the Sultans. Malaysia is a multicultural society and a secular state with Sunni Islam as the official religion. Classified by the World Bank as an upper middle-income country, its society and economy were transformed by rapid economic growth in the latter half of the 20th century. Malaysia's population (now numbering over 28 million with 70% living in urban areas) has benefited from a well-developed health care system, good access to clean water and sanitation, and strong social and economic programmes. Life expectancy at birth is 73 years. Noncommunicable diseases now account for most mortality and morbidity but communicable diseases remain a concern.

Section 2 describes the organization and governance of the health system. Health care services consist of tax-funded and government-run primary health care centres and hospitals, and fast-growing private services mainly located in physician clinics and hospitals in urban areas. Public sector health services are administered by the Ministry of Health through its central, state and district offices. The Ministry of Health regulates the private sector, pharmaceutical industry and food safety and plans and regulates its own health care services. Legislation governing health care professionals requires them to register with statutory professional bodies.

Section 3 reports on health care financing. Malaysia's public health system is financed mainly through general revenue and taxation collected by the federal government, while the private sector is funded principally through out-of-pocket payments from patients and some private health insurance. Spending on health reached 4.6% of GDP in 2009 with the majority from public spending, reaching 56% of total health expenditure (THE) in 2009. The main sources of THE in 2008 were the Ministry of Health (42%), followed by household out-of-pocket expenditure at nearly 34%. The Ministry of Health funds public facilities through line item budgets and patients pay private physicians and private hospitals on a fee-for-service basis.

Physical and human resources are described in Section 4. The number of public primary care facilities (currently 802 centres and over 2000 small community clinics) and dental clinics were expanded steadily in earlier decades, particularly to reach people in under-served rural areas. Secondary care is offered in smaller public hospitals and more complex tertiary care, in regional and national hospitals (including university teaching hospitals run by the Ministry of Higher Education). Growth has slowed in recent years, however, and public services in urban areas have not kept pace with rapid urbanization, while the population ratio of hospital beds has declined slightly. Private clinics and hospitals in urban areas have grown rapidly over the last decade. The supply of health professionals remains seriously below the required number, although the government has increased the number of training places.

Section 5 looks at provision of services. National health policies stress public health and health promotion, that is, 'a wellness' as well as a 'disease' perspective. The Ministry of Health has developed an extensive network of public primary care centres and also dental services especially for children, but these services are under strain and have staff shortages, so patients often encounter long waits. Primary care exerts only a limited gatekeeper function since people can bypass a referral from a general practitioner and for a small additional fee (if in the public sector) can go directly to specialists and hospitals. Government services increasingly serve the poor and private services the better-off people who live in urban areas. Hospital policy currently has three main thrusts: strengthening specialty care in large public hospitals; increasing the number of day surgery centres; and expanding top-end private hospital care to cater to the medical tourism market (with 35 participating hospitals in 2010). Malaysia has a large pharmaceutical manufacturing sector that exports to other countries and also supplies 30% of domestic demand.

The principal health care reforms are discussed in Section 6. The government has stepped up its surveillance and early response to infectious disease outbreaks as a result of recent pandemics such as SARS and avian flu, which had a major impact on the country's economy. The Ministry of Health has maintained its extensive vaccination programmes, has consolidated its primary health care clinics and upgraded its hospitals, and is slowly introducing information communication technology into its public facilities. The government has increased training places to counter shortages of health professionals, has strengthened food and drug safety regulation, is considering price

regulation of pharmaceuticals, and is positioning the country as a medical tourism destination.

Section 7 provides an assessment of the health system. Malaysia has a strong population health tradition and well-established and extensive health care services. Although total health expenditure at 4.6% of GDP in 2008 is in the range for middle-income countries, the government is concerned about future sustainable financing. Successive administrators have prioritized the provision of cost-effective, preventative and mainly free primary health care in public clinics. The rapid growth of private health care means that private spending has risen faster than public spending, including out-of-pocket payments by the public, with the government share (from general revenue) just above half (56%) of health expenditure in 2009.

In conclusion, Malaysia has achieved impressive health gains for its population with a low-cost health care system funded through general revenue that provides universal and comprehensive services. Like many other countries in the region, Malaysia has struggled to produce an adequate supply of health professionals, and to integrate and regulate its rapidly growing private health sector. Public services have not kept pace with population growth in urban areas and those with higher purchasing power use private rather than public doctors and hospitals, which leaves the public sector with more poorer and sicker patients.

The Malaysian Government recently revived the debate over options for a national social health insurance scheme. The financing challenge is to agree on a scheme for fair and sustainable funding and its respective contributions from general revenue and private payments. The regulatory challenge for the Malaysian Government is to strengthen its governance of both public and private health services in order to ensure high quality and safe services and fair charges. The structural challenge is to determine the balance between public and private sector delivery and to engage in a more productive partnership between public and private sectors. The administrative challenge is to consider whether the community would be better served by more decentralized and responsive services.

As Malaysia seeks to attain high income country status, and as demographic and epidemiological transitions continue and new technology expands the possibilities for intervention, the demand for

health care by the population will continue to rise. The government will need to address growing concerns about equity, efficiency and budgetary constraints and balance conflicting policy principles. Pressures are building up for health system reform in Malaysia looking towards the year 2020 and beyond.