

Review Article

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Impact of Health Financing on Healthcare Quality and Affordability in Malaysia: A Conceptual Review

Daan-Max van DongenInstitute of Education, University College London, 20 Bedford Way, London WC1H 0AL, **United Kingdom***Email for Correspondence: daan-max.dongen.21@ucl.ac.uk**ABSTRACT**

In comparison to the majority of essential health indices, the health care system in Malaysia has performed exceptionally well. Despite this, it is still behind the techniques used in many other Asian countries, despite its great potential. The primary reason for this is that patients in Malaysia are subjected to a significant amount of financial risk while seeking medical treatment. The implications of health care finance in Malaysia are investigated in this study, with a particular focus on access and equality issues. This exemplifies the urgent requirement for novel ways to the financing of medical care that are compliant with the norms that have been established. According to the findings of this study, it is recommended that efforts should be increased by employing policy changes to include money pooling and risk sharing, subsidization for the poor and the vulnerable, and mandatory enrollment. In addition, it is recommended that the efforts be increased by employing policy changes to include money pooling and risk sharing. Finally, the implication for public policy indicates that the government ought to commit to the tremendously feasible improvement of the nation's healthcare system through spending.

Keywords: Health financing, Universal health coverage, Health insurance, Out-of-pocket expenditure, Health financing mechanisms

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**INTRODUCTION**

The Malaysian government, for the public sector, and the people of Malaysia, for the private sector, have both been doing an excellent job of administering the country's health care finance, ensuring that it provides high-quality care at an affordable price. The consolidated revenue fund (CRAW), which the Ministry of Finance issues, was used by the government to provide funding for the provision of medical and public health services. The finances for CRAW originate from various taxes and revenues, as well as profits gained by government corporatized enterprises. On the other hand, the funds for private medical service providers came from out-of-pocket charges paid by customers as a whole.

For outpatient services, those who work for the government and their dependents do not have to make any payments. Still, those who work in the private sector, whether currently employed or retired, and those who are self-employed, must pay MR 1 for each visit and follow-up visit. Payment is required to receive treatment at a private clinic. The fees collected from the public sector are known as community-rated levies. Public and private hospitals are subject to the Fee Schedule and the service fee. The costs of consultation, treatment, and prescription are all billed separately. In contrast, the charges for hospital services, including nurses, classes of rooms/wards, and food, are paid to the hospital authorities.

The other funding source comes from the insurance industry, often known as third-party payers; these payers only provide reimbursement for specific ailments (Kananatu, 2002). They have been given a risk rating. Private health insurance is still in its infancy, although group insurance programs cover scheduled illnesses for specific age groups. These programs are offered through cooperative societies and employer-employee collective agreements.

In this setting, a national health care financing scheme based on community-rated premiums is needed to finance institutional, daycare/ambulatory, outpatient primary care/birthing, and hospice centers. To operate the program, the existing MOH healthcare delivery system, infrastructure, telehealth network, and development plans based on need and gradual approach must be accepted and continued. The National Registration Department (NRD) has also introduced SMART CARD/MYKAD to enable personal medical information and funding (Kananatu, 2002). In addition, everyone is used to the national health care delivery system, including referrals.

The Federal Treasury also provides public sector finance. Hospitals and outpatient/primary healthcare have appropriate annual budgets. The fee Schedule includes agreed-upon subsidies. The Public Sector's funding networks need a consolidated HEALTHCARE FUND, where the GLOBAL BUDGET, subscriptions/premiums/and payments from third-party organizations like the EPF, SOCSO, private insurance, and cooperatives will be coordinated to meet healthcare demands. In addition, self-employed people will contribute based on income. In addition, each contributor can establish a Medical Savings Account that the Authority manages (Kananatu, 2002).

UNIVERSAL HEALTH COVERAGE IN MALAYSIA

Every citizen and person legally residing in Malaysia are eligible to receive medical treatment at no cost. But on the other hand, the system is not based on any national insurance policy. Instead, the government provides substantial financial assistance to public facilities to reduce the overall cost of medical care. Both the well-established public healthcare system and the well-established private healthcare system work well together. As a result, the public healthcare system is subsidized.

The country's general taxation system financially supports the Malaysian healthcare system. Patients are required to pay nominal fees to receive medical care. A trip to the doctor for a minor condition such as the common cold or a sinus infection may cost as low as ten dollars. A consultation with a specialist typically costs around \$40, and the cost of follow-up visits is often about \$15. The cost of a private room for the night in a hospital is typically around \$50.

Patients have access to bundled medical services at some hospitals and medical institutions, which can be more cost-effective. Many of them are centered on diagnostic testing and preventative care. For instance, a comprehensive physical examination package that includes a chest x-ray, EKG, a complete set of blood tests, and a variety of other diagnostic procedures can cost approximately \$70. In addition, patients can modify their package by including additional tests, removing difficulties, or doing both. Patients adore these bundles since they are both comprehensive and economical at the same time. In the meanwhile, doctors are appreciative of the fact that patients are encouraged to seek preventative treatment.

The Malaysian government is gradually adopting measures to boost the investment it makes in its healthcare system. The allocation of 5% of the government's budget for the growth of the social sector has been moved to cover public healthcare, marking an increase of approximately 50%.

According to the findings of "the center," the following are considered to be "other health costs":

Condition / Treatment	Public Healthcare	Private Healthcare
Coronary Bypass Surgery	RM 4,000 (\$967 USD)	RM 25,000 – 80,000 (\$6,500 – \$19,345 USD)
Chemotherapy (per cycle)	RM 200 (\$48 USD)	RM 50 – 4000 (\$12 – \$967 USD)
Knee Replacement Surgery	RM 10,000 – 35,000 (\$2,420 – \$8,467 USD)	RM 25,000 – 80,000 (\$6,500 – \$19,345 USD)
One Stent Angioplasty	RM 50 – 200 (\$12 – \$48 USD)	RM 15,000 – 45,000 (\$3,628 – \$10,886 USD)
Dengue Fever	Free	RM 1,000 – 3,000 (\$242 – \$725 USD)

Source: Understanding Malaysia's Healthcare System, <https://www.internationalinsurance.com/>

Recent events have resulted in the World Health Assembly pronouncing a resolution on Universal Health Coverage (UHC) in response to the pervasive worldwide inequity that exists in terms of access to health care (Michael et al., 2019). The United Countries Health System (UCH) is predicated on two essential bedrocks: protection from financial risk and fair access to high-quality medical treatment. UHC is the focus of Target 8 of Sustainable Development Goal

3 outlined by the United Nations (SDG 3). Additionally, it is an essential factor in the accomplishment of other significant Sustainable Development Goals (SDGs), such as the elimination of extreme poverty (SDG 1), the promotion of gender equality (SDG 5), inclusive economic growth (SDG 8) and the reduction of general disparities (SDG 10). (Qin et al., 2018; Nnamuchi et al., 2019).

Establishing an appropriate health funding mechanism is a tried and tested method for accomplishing the goals of universal health coverage (UHC) (Uzochukwu, 2015). Generating, collecting, and allocating cash to provide medical treatment is referred to as "health financing" (Michael et al., 2019; Onisanwa et al., 2018). People are afforded sufficient financial protection against the potential for destitution due to their use of health services by an efficient health care funding framework (Uzochukwu, 2015). People are more likely to avoid utilizing health services, arrive late to health facilities, or use health care facilities that are not up to par when they are required to pay out of pocket (OOP). Out-of-pocket expenses create inequity because those who can pay for quality medical treatment are the only ones with access to it. In most cases, the poor and vulnerable groups most in need of the services are forced to sell their valuables, incur debts, or spend their family savings to access health care, resulting in further impoverishment for them in the household. Odunyemi (2021, Adapted from Han, 2012) presented how a family is caught up in a cycle of perpetual poverty (Figure 1).

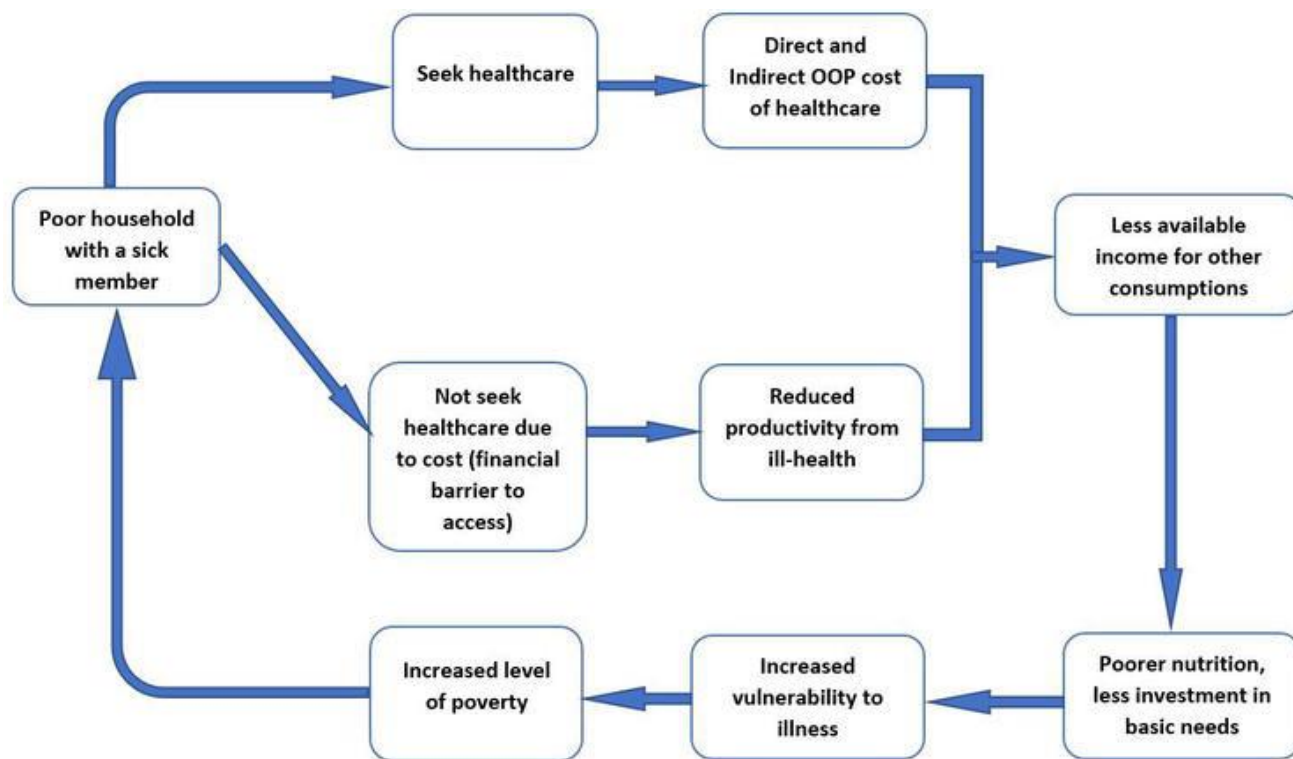


Figure 1: Cycle of impoverishment due to out-of-pocket (OOP) health spending by poor households. (Taken from Odunyemi, 2021).

MALAYSIA'S HEALTH SYSTEM FINANCING AND RELEVANT ATTEMPTS

Malaysia features a public-private health care system. The Ministry of Health provides much of the country's healthcare. Health care services are also supplied by the Ministries of Higher Education, Defense, Aboriginal (Orang Asli) Affairs, Social Welfare, Home Affairs, and Housing (Jaafar et al., 2013). One hundred forty-seven public hospitals, 209 private hospitals, 1025 public clinics, and 6675 private clinics (Health Facts 2013, 2013).

The public health care system is predominantly funded through taxes. Private health care is nonsubsidized and fee-for-service, serving those who can pay (Verma et al., 2015). Private health insurance, out-of-pocket payments, and nonprofits subsidize personal health care services (Jaafar et al., 2013). Private and employee-based health insurances exist (aka SOCSO); SOCSO and EPF cover private-sector workers (Jaafar et al., 2013).

Malaysia's government contributes heavily to health care financing through taxes. In 2003, the government subsidized 58.2% of public health sector spending, while the private sector financed 41.8%. (World Health Organization, 2006). Social security contributed 0.8% of government revenue. Out-of-pocket payments accounted for most private financing (73.8%), with private insurance accounting for 13.7%. WHO 2006 doesn't report 12.5% private funding (World Health Organization, 2000).

Malaysian health services are funded by taxes, EPF, and SOCSO (Social Security Organization). The Ministry of Finance collects direct and indirect taxes to support public services, including health care. Employees contribute to EPF. EPF's principal goal is to accumulate savings for the donor and his family's old age, although 30% of individual contributions can be withdrawn for health care reimbursement (Yu et al., 2008). The employed population earning less than RM 3,000 contributes to SOCSO, which covers work-related injuries. Individuals buy private health insurance and pay rates based on kind and degree of coverage. Out-of-pocket fees are paid at health institutions. Figure 2 shows households' financial contributions to Malaysia's healthcare system. Direct taxes, indirect taxes, EPF and SOCSO contributions, private insurance premiums, and out-of-pocket payments are routed directly or indirectly through financial intermediaries to parallel public and private health institutions.

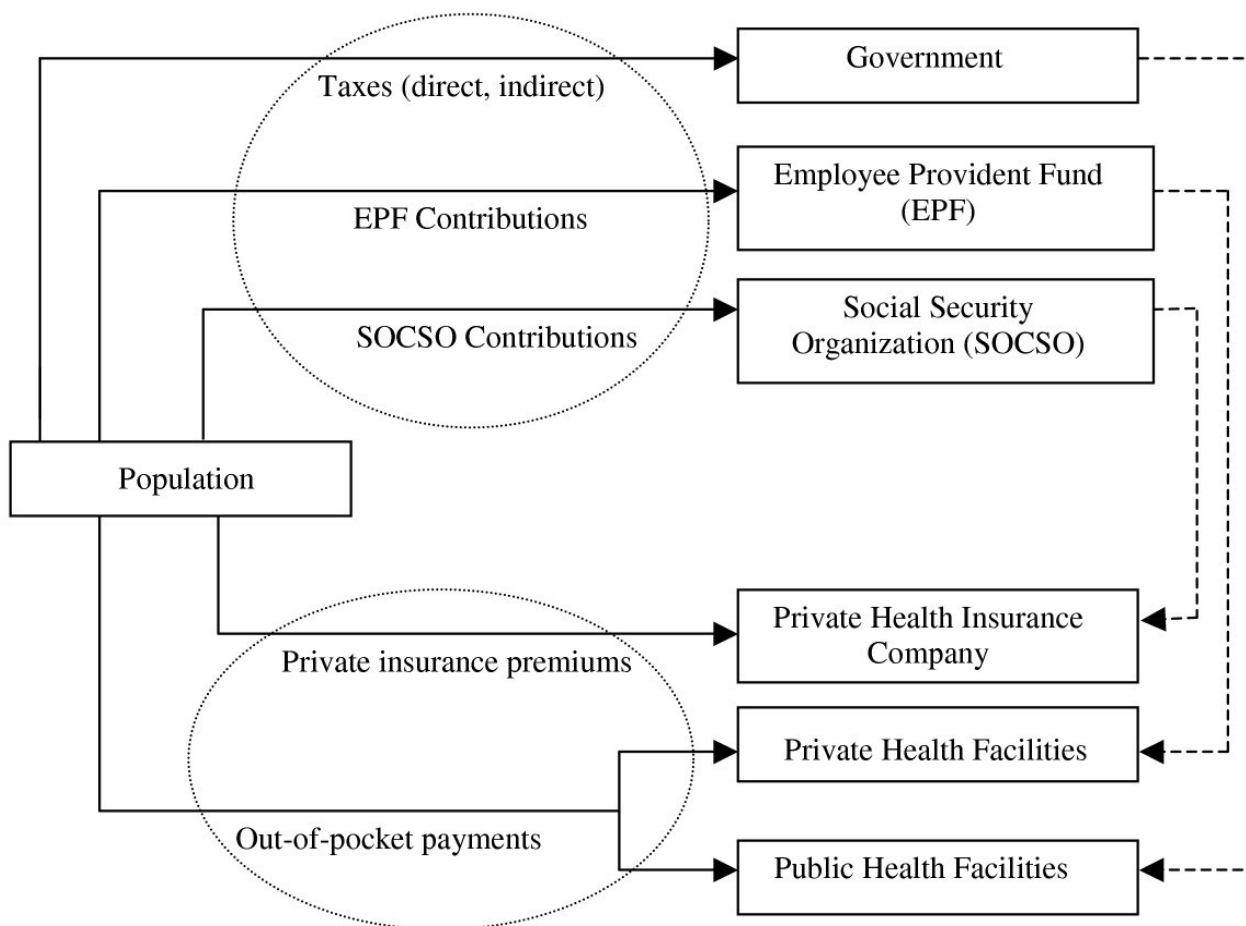


Figure 2: Households' Financial Contributions to Health Care System in Malaysia. (Taken from Yu et al., 2008).

The utilization of public health care is nearly free, with only modest charges being enforced upon specific services, whereby patients are required to pay for the service out of their funds. But on the other hand, individuals using private health services are responsible for their out-of-pocket expenditures or co-payments, even if they are covered by private health insurance. But on the other hand, the wealthy and those with the financial means to pay user fees can switch to the private sector, while those less fortunate are forced to rely on the public sector. The consensus was that personal medical care offered a higher quality experience with shorter wait times.

HEALTH CARE FINANCING MECHANISMS

Each country's difficulties are distinct; therefore, there's no silver bullet. Each country's social, economic, and political structure is unique. A health financing framework that may deliver equitable access in LMICs must be built on compulsory pre-payment, money pooling/risk-sharing, and subsidization for the poor (Averill and Marriott, 2013). Pooling and risk-sharing include distributing funds evenly between affluent and poor, employed and unemployed, healthy and sick (Ahangar, 2018). This section explores health finance methods.

Service delivery, financing, and economic policy models form health care systems. Much of the literature describes health delivery systems as national, social, or private. Each approach has general, particular, and private financing.

For example, one model cannot support a nation's health care system (Verma et al., 2015). The following models and countries have adopted them.

National health model

The Beveridge model is defined by health care coverage for all citizens by a central government. This coverage is known as the Beveridge model. It is funded by income collected through standard taxes. Health care providers are either owned by or under the supervision of central and regional governments. The provision of services and the providers' compensation are both within the control of the government (Kulesher & Forrestal, 2014). Denmark, Ireland, New Zealand, and the United Kingdom are great examples of the national health model (Graig, 1999; McPake et al., 2002).

Social insurance model

In addition, the health care coverage in this model, known as the Bismarck model, is defined by the fact that it is paid by the employer, individual, and private insurance money. Control and ownership of the factors of production can be exercised by either the government or private groups. Tax-based insurance is another name for this type of coverage. The financing comes from various employment-related taxes (Kulesher & Forrestal, 2014). As an illustration, the SOCSO and EPF in Malaysia. Countries such as Austria, Belgium, France, Germany, Luxembourg, and the Netherlands are all excellent examples of the social insurance model (Graig, 1999; McPake et al., 2002; Reid, 2010; Saltman & Figueras, 1997; Freeman, 1998).

Private insurance model

The employment-based or individual purchase of private health insurance that is financed by payments from the individual and/or the employer is the defining characteristic of this model. The provision of services and the management of funding are both owned and managed by private enterprises that operate in an open market (Kulesher & Forrestal, 2014). Switzerland and the United States of America are examples of private insurance models (Graig, 1999; McPake et al., 2002).

The national health insurance model

This model is a hybrid that combines elements of the Beveridge and Bismarck models. The payment comes from an insurance program that is run by the government and into which every citizen pays. Within the context of this model, there is no requirement for marketing, which means there is no financial basis for disputing claims. For example, Canada is home to a system known as the national health insurance (NHI) program. This model has also been adopted by some countries that have recently entered the industrial age, such as Taiwan and South Korea (Verma et al., 2015). As a result, the single-payer system has greater market power, allowing it to negotiate lower prices from businesses and other entities (Jobayer et al., 2021).

NATIONAL HEALTHCARE FINANCING SCHEME

The delivery of healthcare, the system itself, and the financing of it are all impacted by globalization, trade liberalization, and AFTA. Therefore, it is necessary to investigate the short-term repercussions while simultaneously making preparations for the long-term challenges. The growth of the private sector will have an impact on healthcare financing (Kananatu, 2002). The health insurance market and free practice outside of NHFA would be the primary focuses of this. Monitoring necessitates the utilization of standard charge structures.

Privatizing medical stores, pharmaceutical supplies, hospital engineering services, biomedical equipment servicing, laundry, and clinical waste disposal and the corporatization of UM Teaching Hospital and the IJN increased the public sector's operating budget. Uncollected public hospital bills rose. Hospital accounting staff have no motivation to collect delinquent debts. Even with a good recovery, accumulated bills will only pay 30% of operating costs. All inpatient care was heavily subsidized, and the Fee Schedule hadn't been updated. Outpatients were paid MR 1 each visit and MR 5 for follow-up specialist visits. Foreign workers admitted also defaulting on bills, either directly or through their employers. Instead of adjusting billing, collection techniques, and recovery ratio, it was time to restructure the entire system by establishing and implementing a national healthcare funding scheme under the planned National Health Financing Authority under the MOH (Kananatu, 2002).

The NHFS would assist in integrating all sources of revenue and expenditure, making it possible for customers to receive services depending on their needs and the amount of value they receive for their money. Regarding the distribution of allocations, both public and private service providers are held to the same standards regarding DRG and case mix, billing rates, prospective and retroactive budgeting, and reimbursement regulations. In addition, customers receive an approved service package at the authorized medical facility that is geographically closest to them (Kananatu, 2002). The accreditation of hospitals and clinics that have been granted NHFS

accreditation will be renewed on an annual basis, depending on the results of UR and QA procedure assessments. Because of this, need-based quality care will be guaranteed, and abuse of resources and services will be prevented (Chowdhury et al., 2021).

IMPROVING EQUITY AND POLICY IMPLICATIONS

Finance sources have varied distributional effects. Theoretically, transferring the financial burden to the rich will increase progressivity. Progressive income tax rates (lower for low-income groups, higher for high-income groups) and high sales tax rates on luxury products inflict a more significant financial burden on the rich than the poor. Rich taxes on high earners don't encourage work. On the other hand, high luxury sales tax rates might hinder market performance. Increasing direct tax progressivity or reducing indirect tax progressivity would require a tax overhaul. A progressive EPF schedule, rather than a flat rate, will improve its progressivity. Enrolling high-income groups will lower SOCSO's progressivity. Contradicts SOCSO's principle of protecting low-income employees. Measuring the progressivity of funding methods over time can help execute health finance strategies. Financing options that increase Kakwani's index by more than 0.10 (following its sensitivity within 0.10 if ATP is held constant) are regarded as substantial and should be considered for policy (Yu et al., 2008). Malaysia's progressive tax system was fair. Equitable funding aligns with a nation's egalitarian vision (Economic Planning Unit, 2001).

On the other hand, financially secure people were responsible for out-of-pocket expenses or had them covered by private insurance plans when they purchased private health services. The provision of public and private health services in tandem creates a situation in which the wealthy are allowed to voluntarily move to private health services while the poor are forced to rely on public health services. When compared to the heavily subsidized public health system, the private health care industry is considered to be a luxury good. While the population was suffering from the effects of the Asian financial crisis in 1997, private hospitals saw their patient loads decrease, while public health services saw patient loads grow by roughly 15%. (Ministry of Health Malaysia, 2000). It is anticipated that the transition of the wealthy to private health services will decrease demand in the public sector, which will lead to a reduction in the amount of government assistance provided to the rich.

In addition, the underprivileged population that is reliant on public health services can be eligible for subsidies from the government. In addition, the government actively promoted participation in the collaborative endeavor from both the public and commercial sectors, including both those sectors' employees and customers. As a result, the private sector is incentivized to deliver health services that are suited to the requirements of the public as a whole rather than focused solely on financial gain. This is in contrast to the traditional model, which incentivizes businesses to maximize profits.

CONCLUSION

Equity can be increased by altering the proportion of different types of financing provided and enhancing the progressiveness of the funding sources. In conclusion, it has been seen that the five other funding sources have resulted in the development of a progressive system that is considered equitable. For example, in Malaysia, the largely tax-financed system with the two-tiered delivery structure achieved equity in financing the nation's health care system. In light of this, however, the nation possesses the capacity to buck the trend by gleaning knowledge from other nations located all over the world that have attained UHC through the implementation of either a tax-based insurance scheme or a SHI program. As a result of the planned transformation of health care services, it is widely believed that the integration of services between the public and private sectors is essential, and it must be accomplished at a cost that the general population can manage. Moreover, because there is currently no NHI program, the question of who will be responsible for covering the cost of services has emerged as the most critical concern regarding the integration of planned benefits. Moreover, even though numerous models have been suggested, the most important thing that policymakers in Malaysia need to be mindful of is whether or not all Malaysians have equal access to holistic health services.

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