Short Communication

Health care financing in Malaysia: A way forward

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ABSTRACT

Malaysia has a two-tier health care system consisting of the public and private sectors. The Ministry of Health is the main provider of health care services in the country. The private health care sector provides services on a nonsubsidized, fee-for-service basis, and mainly serves for those who can afford to pay. For financing health care two types of health insurances are available currently: Private and employee based (aka SOCSO). SOCSO and Employee Provident Fund provide some coverage to private-sector employees. There are several challenges in pure Bismarckian model (private insurance etc.) like smaller portion of total population will be "economically active," international competition to attract firms, and maintain/increase employment will put downward pressure on labor taxes. How to sustain universal coverage in this context? In a population setting where unemployment is high informal sector, payroll taxes will not be a major source of funds. However, it is possible to create a universal health financing system by transforming the role of budget funding from directly subsidizing provision to subsidizing the purchase of services on behalf of the entire population. The integration of services between the public and private sector is very much needed, at a cost the people can afford. At present, there is no national health insurance scheme in place. Although there are many models proposed, the main question that the policymakers need to be aware of is that of the equity of access to holistic health services for all Malaysians.

Key words: Health care, health care financing, Malaysia

ORGANIZATION OF MALAYSIAN HEALTH CARE SYSTEM

Malaysia is a tropical country situated in Southeast Asia, bordering Thailand to the north, to west is the Strait of Malacca, to east is the South China Sea, and the Island of Singapore to the south. The northern one-third of the Island of Borneo is also part of the country as East Malaysia, bordering Indonesia to the south, the South China Sea to the north, and to east is the Sulu Sea and Celebes Sea. Malaysia consists of 13 states and a federal territory covering an area of 330,252 km^2. The population of Malaysia in 2013 was estimated to be 29.2 million. The population is relatively young with 26% between the age of 0 and 14 years, 65.5% between 15 and 59 years and only 8.5% more than the age of 60 years.[1]

At present, Malaysia has a two-tier health care system consisting of the public and private sectors. The Ministry of Health is the main provider of health care services in the country.[2] Health care services are also provided by other ministries in the country that includes Ministry of Higher Education, Ministry of Defense, Department of Aboriginal (Orang Asli) Affairs, Department of Social Welfare, Ministry of Home Affairs and Ministry of Housing.[3] Currently, there are 147 public hospitals, 209 private hospitals, 1025 public clinics, and 6675 private clinics.[4]

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HEALTH CARE FINANCING IN MALAYSIA

The public health care system largely funded by the government and financed mainly from public tax revenue.[2] The private health care sector provides services on a nonsubsidized, fee-for-service basis, and mainly serves for those who can afford to pay. Health care services by private sectors are funded mainly by private health insurance, consumers' out-of-pocket payment, and nonprofit institution.[3]

The two types of health insurances are available currently: Private and employee based (aka SOCSO). SOCSO and Employee Provident Fund (EPF) provide some coverage to private-sector employees.[3]

HEALTH CARE FINANCING MODELS

Health care systems are comprised of service delivery, financing, and economic policy models. Much of the literature depicts health delivery systems in terms of a national health system, social insurance, or private insurance model. Each model has various forms of financing such as general taxation, specific taxation, and private financing. A nation's health care system cannot be adequately supported with just one model.[5] The following types of models and country(s) adopted it in their health system.

National health model

Furthermore, known as the Beveridge model is characterized by health care coverage for all citizens by a central government. It is financed by general tax revenues. Central and regional governments either own or control health care providers. A government controls service distribution and provider payments.[5] Examples of the national health model include Denmark, Ireland, New Zealand, and the UK.[6,7]

Social insurance model

Furthermore, known as the Bismarck model is characterized by health care coverage that is funded by employer, individual, and private insurance funds. Government or private entities control and own factors of production. It is also referred to as tax-based insurance. The funding is derived from employment taxes.[5] E.g., SOCSO and EPF in Malaysia. Examples of the social insurance model include Austria, Belgium, France, Germany, Luxemburg, and the Netherlands.[6-10]

Private insurance model

This model is characterized by employment-based or individual purchase of private health insurance financed by individual and/or employer contributions. Private entities operating in an open market own and manage service delivery and financing.[5] Examples of the private insurance model include Switzerland and the USA.[6,7]

The national health insurance model

This model is an amalgamation of both Beveridge and Bismarck. Payment comes from a government run insurance program that every citizen pays into. There is no requirement marketing in this model so there is no financial ground to deny claims. The single payer system has more market power to negotiate for lower prices from pharmaceutical companies and others.

The national health insurance (NHI) system is found in Canada. Some newly industrialized countries such as Taiwan and South Korea have also adopted this model.[11]

BEVERIDGE VERSUS BISMARCK

As mentioned in Table 1, service entitlement basis in Bismarck is based on the contribution person make toward the services required. Noncontributors cannot avail the service, whereas Beveridge model offers services only to the resident or citizen of the country. The funding base for Bismarck is the wages earned by the contributor's; on the other hand, Beveridge uses all the public revenues like taxes from different sources. The insurer for the services in case of Bismarck is occupational and in Beveridge it's provided by the state. Benefit package is explicit that is, stated clearly and in detail, leaving no room for confusion or doubt in Beveridge model and implicit that is, implied though not plainly expressed in Bismarck model. The management is independent in Bismarck model but it is with the government in case of Beveridge model. Providers of services in Bismarck are privately contracted and in Beveridge are salaried and publicly contracted.

Table 1: Differentiating features between Bismarck and Beveridge model

Feature	Financing models	
	Bismarck	Beveridge
Entitlement basis	Contribution	Citizenship/residence
Funding base	Wages	All public revenues
Insurer	Occupational	State
Benefit package	Explicit	Implicit
Management	Independent	Government
Providers	Privately contracted	Salaried and publicly contracted

CHALLENGES IN HEALTH CARE FINANCING IN MALAYSIA

Of pocket payment for health care service is a major financial barrier to health care. High out of pocket payment for health care means that health care is like a market commodity. Those who are better-off can afford higher out of pocket payments for health care, use more medical care, or use private-sector providers, whereas the poor cannot afford to pay and even give up treatment. There is a huge increase health care cost in Malaysia every year.

TOWARD THE BEV-MARCK OR BIS-ERIDGE MODEL

Irrespective of the source of funds, we observe variations and innovations across models in the organization of pooling, mechanisms for purchasing of services, and ways that the entitlements and obligations of the population. Labeling a system as Beveridge or Bismarck is not especially useful.

Need for health care during the crisis increases, but public revenues decline. If public spending on health falls, the burden shifted to patients, who may either forego needed care or run a greater risk of incurring potentially catastrophic spending. Major cuts in public expenditure may result in disruption of continuity of care and deterioration of the quality of care.

Improving efficiency (more health for the money) is essential to lessen severity of the tradeoffs by eliminate inappropriate and ineffective services, improve rational drug use (including volume control), allocate more funds to primary care and outpatient care at the expense of hospitals, invest in infrastructure that is cost-effective to run, cut the volume of least cost-effective services, reduce unproductive administrative costs.

Main health financing tool for this is strategic purchasing (pay for performance): Allocations of resources need to be linked with providers to measures of their performance and health needs of the population being served. Changing the incentive environment through tailored use of markets and planning. Strategic purchasing irrespective of the label attached to the system.

TOWARD BEV-MARCK OR BIS-ERIDGE MODEL: IMPLICATIONS OF CONVERGENCE

Current scenarios of health care financing reform are portraying the choice between general taxation (aka Beveridge model) and social health insurance (aka Bismarck model). A single system for the entire population is needed. Key features include the role and gradual development of the compulsory health insurance fund as a single purchaser of health care services for the entire population using output-based payment methods. Complete restructuring of pooling arrangements from the former decentralized budgetary structure to a single national pool and establishment of an explicit benefit package. Central to the process was transformation of the role of general budget revenues, the main source of public funding for health from directly subsidizing the supply of services to subsidizing the purchase of services on behalf of the entire population by redirecting them into the health insurance fund. Through their approach to health financing policy, and pooling in particular funds, can be used in an explicitly complementary manner to enable the creation of a unified, universal system.

After analyzing the costs of insurers, employers, doctors, hospitals, nursing homes, and home-care agencies in USA it was found that administration consumes 31.0% of total health spending[12] and universal coverage system and a single payer in USA as in Canada can save administrative costs (10% of total health spending) that would be enough to cover the expense of universal coverage.[13]

A major portion of the health budget is consumed by utility costs reflects a health financing system characterized by incentives designed to meet the "needs" of the physical infrastructure, rather than the needs of the population. E.g., "more beds that a hospital have, the more staff positions it is allowed to have and the greater budget it receives."

Single-payer NHI can recapture the wasted money. The potential savings on paperwork can save a huge amount per year. Mandatory NHI fund will be an effective reform. An important step for the transition to a universal system is the establishment of a single hospital information system for all patients regardless of their insurance status. Insurance package for the insured population will simply top up the existing budget flows to the public health care system.

In a population setting where much of the population is not employed in the formal sector, payroll taxes will not be a major source of funds. However, it is possible to create a universal health financing system

by transforming the role of budget funding from directly subsidizing provision to subsidizing the purchase of services on behalf of the entire population.

It is not necessary to choose between Beveridge and Bismarck; well-defined policy can enable their complementary co-existence in a unified universal health system as "Single-payer NHI."

CONCLUSION

With the transformation of health care services being planned, it is perceived that the integration of services between the public and private sector is very much needed, at a cost the people can afford. The major question that arises with the planned integration of services relates to the issue of who will bear the cost of services because, at present, there is no NHI scheme in place. Although there are many models proposed, the main question that the policymakers need to be aware of is that of the equity of access to holistic health services for all Malaysians.

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