Universal Health Coverage Assessment

Malaysia

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Global Network for Health Equity (GNHE)

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Universal Health Coverage Assessment: Malaysia

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Introduction

This document provides a preliminary assessment of the Malaysian health system relative to the goal of universal health coverage, with a particular focus on the financing system and related aspects of provision.

In the 2010 World Health Report, universal health coverage is defined as providing everyone in a country with financial protection from the costs of using health care and ensuring access to the health services they need (World Health Organisation 2010). These services should be of sufficient quality to be effective.

This document presents data that provide insights into the extent of financial protection and access to needed health services in Malaysia.

Key health care expenditure indicators

This section examines overall levels of health expenditure in Malaysia and identifies the main sources of health financing (Table 1). In relation to the country’s economic development, Malaysia’s investment in health is quite modest, although the share has been increasing over the years. In 2012, total health expenditure accounted for 4.0% of the country’s Gross Domestic Product (GDP), an amount that was substantially lower than the average of 6.1% for other upper-middle-income countries and more than half the global average of 9.2%.

Public allocations to fund the health sector were only around 6% of total government expenditure. This was half the average of 12% for other upper-middle-income countries. It was also well below the 15% target set by the

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Table 1: National Health Accounts indicators of health care expenditure and sources of finance in Malaysia (2012)

<table>
<thead>
<tr>
<th>Indicators of the level of health care expenditure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total expenditure on health as % of GDP</td>
<td>4.0%</td>
</tr>
<tr>
<td>2. General government expenditure on health as % of GDP</td>
<td>2.2%</td>
</tr>
<tr>
<td>3. General government expenditure on health as % of total government expenditure</td>
<td>5.8%</td>
</tr>
<tr>
<td>4a. Per capita government expenditure on health at average exchange rate (US$)</td>
<td>230</td>
</tr>
<tr>
<td>4b. Per capita government expenditure on health (PPP $)</td>
<td>380</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicators of the source of funds for health care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5. General government expenditure on health as % of total expenditure on health*</td>
<td>55.0%</td>
</tr>
<tr>
<td>6. Private expenditure on health as % of total expenditure on health</td>
<td>45.0%</td>
</tr>
<tr>
<td>7. External resources for health as % of total expenditure on health</td>
<td>0%</td>
</tr>
<tr>
<td>8. Out-of-pocket expenditure on health as % of total expenditure on health</td>
<td>34.9%</td>
</tr>
<tr>
<td>9. Out-of-pocket expenditure on health as % of GDP</td>
<td>2.7%</td>
</tr>
<tr>
<td>10. Private prepaid plans on health as % of total expenditure on health</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

* This includes tax-funded health spending and Social Security funds

Source: Data drawn from World Health Organisation’s Global Health Expenditure Database (http://apps.who.int/nha/database/Key_Indicators/Index/en)

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3 The data quoted in this section all derive from the latest (2012) data in the World Health Organisation’s Global Health Expenditure Database (http://apps.who.int/nha/database/Home/). Comparisons with other countries are based on figures expressed in terms of purchasing power parity. The country’s income category is determined from the World Bank’s classification for the same year (http://data.worldbank.org/about/country-and-lending-groups).
Organisation for African Unity’s 2001 Abuja Declaration (which, coincidentally, was the same as the global average for 2012). This raises the question of whether government is sufficiently committed to funding the health sector.

In fact, government health expenditure (including Social Security)\(^3\) translated into only 2.2% of GDP. This amount was much lower than the upper-middle-income country average for that year of 3.4%, and is low for what is essentially the mandatory pre-paid component of a health financing system. The global average, for example, was 5.3% in 2012.

Yet the Malaysian government’s expenditure on health was around $380 (in terms of purchasing power parity) in 2012. This was roughly equivalent to the upper-middle-income average of $371, although substantially less than the global average of $652.

Like other upper-middle-income countries, Malaysia does not receive any donor funding.

As would have been expected from relatively low levels of government expenditure in relation to GDP, out-of-pocket payments played a significant role in Malaysia (at about 35% of total financing in 2012). This was high in global terms (where the average was 21%). It was also well above the 20% limit suggested by the 2010 World Health Report to ensure that financial catastrophe and impoverishment as a result of accessing health care become negligible (World Health Organisation 2010).

Malaysia does not have any sort of mandatory, payroll-based scheme, such as social or national health insurance, apart from two very small Social Security schemes.

Private health insurance in Malaysia accounted for almost 8% of total health sector financing in 2012. This was close to the upper-middle-income country average of 7.2%. All in all, private expenditure – which includes out-of-pocket payments and voluntary prepaid plans – accounted for just under half of health financing in Malaysia.

**Structure of the health system according to health financing functions**

Figure 1 provides a summary of the structure of the Malaysian health system, depicted according to the health care financing functions of revenue collection, pooling and purchasing, as well as health service provision. Each block represents the percentage share of overall health care expenditure accounted for by each category of revenue source, pooling organisation, purchasing organisation and health care provider.\(^4\)

**Revenue collection**

Federal government revenues, made up of both tax and non-tax sources, were the largest single health financing source in the country. As Table 1 shows, 55% of total health financing in Malaysia came from this source in 2012. Direct taxes made up the largest component of government revenues and contributed 28 per cent of the total health expenditure in 2004 (as shown in Table 4).

The private sector in Malaysia has expanded rapidly over the last few decades. This was partly due to efforts by the government to increase private participation in the country’s economy by privatising certain public services, starting from the 1980s.

Within the ambit of the public health sector, privatisation activities only affected drug procurement and distribution services, hospital laundry services, disposal of clinical wastes, cleaning services, biomedical equipment maintenance services, and general facility engineering maintenance services, which were transferred to private companies in stages from 1995. Also, the 1997 Asian financial crisis saw health tourism being promoted as a means of survival for existing private hospitals and later as a means of bringing in foreign revenue to the country (Chee and Barraclough 2007).

One of the consequences of this private sector expansion was a change in the health financing mix in the country. Although taxation remains the pre-dominant financing source, private sources of financing have become increasingly more prominent in recent years. In particular, private household out-of-pocket payments for health care currently make up a significant share of total health financing in the country, whereas in 1997 they accounted for only just over 10% (see Figure 2).

Fees in the private sector are much higher than in the public sector, where minimal fees are charged. The government maintains a legislated fee schedule that covers care provided in all Ministry of Health facilities: these fees have hardly changed since they were first set in 1982. The fee

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\(^3\) Different countries use the terms “national health insurance,” “social health insurance” and “social security” differently to describe different types of mandatory health insurance. In each country assessment in this series, the term applied is the one commonly in use in the country in question. Malaysia has almost no mandatory health insurance: it is limited to two very small Social Security schemes.

\(^4\) The data quoted in this section are slightly different from the previous section because they are based on more detailed disaggregation by the authors of Ministry of Health (2011).
for an outpatient consultation is currently equivalent to about US$0.23. This fee covers not only the consultation itself but also basic laboratory tests and medications for two weeks.

In addition, many who do use public services do not pay at all. In 1996, it was reported that 93% of people who used services provided by public clinics made no payments at all (Institute for Public Health 1997). It is estimated that revenue collected from patients only contributes about 3% to 5% of the Ministry of Health’s annual budget (Rohaizat 2004).

There are two small Social Security funds in Malaysia, the Employees Provident Fund and the Social Security Organisation. In 2009, these two funds contributed less than 0.5% of the country’s total health expenditures.

Private health care services are financed from a variety of sources. The health care for employees may be paid for in full, or partially, by their employers as part of their employment benefit packages. However, direct household out-of-pocket payments is the predominant source of private funding for health care in the country.

### Pooling

The Ministry of Health receives an annual allocation from the federal government to fund its services. This allocation is generally based on historical spending as well as planned new programmes. The Ministry can make additional requests to fund budgetary shortfalls: this is usually done in the second half of each year. These funds have been used to keep user fees low for most services provided in public health facilities.

The allocation process from the Ministry of Health to lower levels of the health system is not entirely transparent. It tends to be partially needs-based and partially based on historical spending patterns.

Private health insurance schemes provide some limited pooling although the risk pools are relatively small. Even that component of government financing that flows through other government agencies is somewhat fragmented. These include health care services provided by the Ministry of Defence to military personnel and their dependants. The Ministry of Higher Education also funds and manages a total of three teaching hospitals affiliated to the medical faculties of the three main public universities in the country. Several local authorities and town councils, which are under the purview of the Ministry of Local Government and Housing, also provide some health care services, mainly relating to sanitation, food quality control and vector control services in the larger towns.

As Figure 1 shows, a significant proportion of the total financing system is not pooled because of the high level of direct out-of-pocket payments.

### Purchasing

The Malaysian public health system has traditionally been one where health care services are delivered through publicly owned facilities, hospitals and clinics. These facilities essentially receive line item budgets based on historical spending. Health care staff working in these facilities are salaried civil servants.

The public health system currently provides a comprehensive package of services, from preventive and promotive care through to tertiary care.

The Social Security funds purchase services from public and private providers (The Employees Provident Fund mainly from private providers and The Social Security Organisation from public providers). This is done on a fee-for-service basis.

Direct purchasing of especially private services through out-of-pocket payments plays a significant role in Malaysia. This form of purchasing is not very efficient given the incentives for cost escalation under a fee-for-service system.

### Provision

Since independence from colonial rule in 1957, the path taken by the government has been to gradually expand access to care by investing in health infrastructure and human resources, especially in the rural areas. This, combined with generous government subsidies financed through general taxation, was intended to ensure that health care remained accessible and affordable to the public (Rohaizat 2004).

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5 Using an exchange rate of 4.2 Malaysian Ringgits to US$1.
6 The Employees Provident Fund receives pre-determined monthly contributions from both the employee and the employer. The scheme covers all private sector employees and non-pensionable public sector employees. It allows for withdrawals to pay for health care for a specified list of serious medical conditions suffered by members and their dependants.
7 The Social Security Organisation provides benefits through two social insurance schemes sustained through contributions from both employees and employers. These schemes cover private sector employees who earn a monthly wage of US$720 or less. The scheme provides payments for medical treatment, rehabilitation and medical aids, mainly in cases of accidents related to work or when employees develop occupation-related diseases.
Services are provided from an extensive network of health facilities of differing levels of sophistication from small rural health clinics manned by auxiliary health personnel to large tertiary care hospitals located in urban areas. It has been claimed that Malaysia has achieved universal health coverage mainly because of the existence of this network of public health care providers, which all citizens are entitled to access, albeit upon payment of minimal user fees.

Private health care providers did not play a major role in the country’s early years. Private care was then mainly restricted to primary care delivered in single-doctor clinics. Rising demands from an increasingly affluent and discerning society incentivised the development of a dynamic private health sector which does not only include the hospitals and clinics of old but also a myriad of other more recent providers offering a diverse range of health care services.

Private health sector development has been most significant in the hospital sector. By 2013, private hospitals contributed 24% of all hospital beds and 31% of all admissions in Malaysia (Ministry of Health 2014).

The growing private hospital presence in the country has had ripple effects on the performance of the public health sector. One of the most debated is that of the public-to-private migration of health care professionals, especially experienced doctors who can obtain much higher financial rewards in private practice compared to working in the public sector (Chan 2007, Rasiah et al. 2011). This has raised concerns that the quality of care in public facilities may be compromised and that, since private care is characterised by high fees and limited geographical distribution, equity in the distribution of health care may be similarly compromised.

**Financial protection and equity in financing**

A key objective of universal health coverage is to provide financial protection for everyone in the country. Insights into the existing extent of financial protection are provided through indicators such as the extent of catastrophic payments and the level of impoverishment due to paying for health services. This section analyses these indicators for Malaysia and then moves on to assess the overall equity of the health financing system.

**Catastrophic payment indicators**

Using the 40% threshold of non-food household expenditure for assessing catastrophic payments, Table 2 shows that only a quarter of a per cent of the population incurred catastrophic spending in Malaysia in 2004 as a result of accessing health care. However, it is agreed in the international literature that this percentage is difficult to interpret as it can understate the actual problem. This is because it may not capture the reality that there are people who do not utilize health services when needed because they are unable to afford out-of-pocket payments at all (Wagstaff and van Doorslaer 2003).

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**Figure 1: A function summary chart for Malaysia (2009)**

<table>
<thead>
<tr>
<th>Revenue collection</th>
<th>General taxation</th>
<th>Other</th>
<th>Private insurance</th>
<th>Out-of-pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pooling</td>
<td>Ministry of Health</td>
<td>Other government agencies</td>
<td>Private insurance</td>
<td>No pooling</td>
</tr>
<tr>
<td>Purchasing</td>
<td>Ministry of Health</td>
<td>Other public providers</td>
<td>Private providers</td>
<td>Individual purchasing</td>
</tr>
</tbody>
</table>

Note: ‘Others’ in the revenue collection row refers to payments made by companies for their employees (these companies are self-insured), as well as the small contributions from the Employees Provident Fund and the Social Security Organisation.
Source: Created by the author using Ministry of Health (2011)
Figure 2: Private sources of financing in Malaysia (1997-2009)

Source: Created by the author from Ministry of Health (2011)

Table 2: Catastrophic payment indicators for Malaysia (2004)*

<table>
<thead>
<tr>
<th>Threshold</th>
<th>10%</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catastrophic payment headcount index</td>
<td>1.44%</td>
<td>0.25%</td>
</tr>
<tr>
<td>(the percentage of households whose out-of-pocket payments for health care as a percentage of household consumption expenditure exceeded the threshold)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weighted headcount index**</td>
<td>1.04%</td>
<td>0.23%</td>
</tr>
<tr>
<td>Catastrophic payment gap index</td>
<td>0.13%</td>
<td>0.05%</td>
</tr>
<tr>
<td>(the average amount by which out-of-pocket health care payments as a percentage of household consumption expenditure exceed the threshold)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weighted catastrophic gap index**</td>
<td>0.08%</td>
<td>0.07%</td>
</tr>
</tbody>
</table>

Notes:
* Financial catastrophe is defined as household out-of-pocket spending on health care in excess of the threshold of 10% of total household consumption or 40% of non-food household consumption.
** The weighted headcount and gap indicate whether it is the rich or poor households who mostly bear the burden of catastrophic payments. If the weighted index exceeds the un-weighted index, the burden of catastrophic payments falls more on poorer households.
Source: Calculations by the author using data from a nationally representative household expenditure survey conducted in 2004/05 by the Department of Statistics, Malaysia (unpublished).
However, as Table 2 shows, catastrophic payments in Malaysia affected wealthier households more, as revealed by a lower proportion for the weighted headcount compared to the un-weighted headcount. This is because poorer households mainly use public services which are minimally priced and wealthier households are responsible for most of the out-of-pocket payments paid for more expensive private care.

Thus, despite out-of-pocket payments making up a third of total health expenditure in the country, the average health payment share of household consumption was small. Overall, this share was only 1.1% in 2004, and showed an increasing gradient from the poorest household quintile to the richest quintile (see Figure 3). These out-of-pocket payments were also found to be concentrated among richer households, which contributed to progressive payment distributions, as discussed later. Regardless of the level of household ability-to-pay, most of the out-of-pocket health payments were made to purchase private health care.

It should be remembered, however, that all these findings are based on data that are a decade old.

**Impoverishment indicators**

While the extent of catastrophic payments indicates the relative impact of out-of-pocket payments on household welfare, the absolute impact is shown by the impoverishment effect. In Malaysia, only around 1% of the population lived below the World Bank $1.25 per day poverty line in 2004 (see Table 3). Only 7% lived below the $2.00 per day poverty line. Only an extra 0.1% and 0.2% respectively dropped into poverty as a result of paying out-of-pocket when accessing health services.

The normalised poverty gap (also shown in Table 3) measures the percentage of the poverty line necessary to raise an individual who is below the poverty line to that line. The difference between the prepayment and the post-payment poverty gaps was very low at around 0.0% and 0.1% respectively. This means that the intensity of poverty caused by health payments was very low as, on average, those who were impoverished did not experience a large drop in their levels of consumption below the poverty line.

These proportions might be very low due to the fact that the methodology only captures those who access health care services, excluding those already very poor individuals who cannot afford to pay for health care. Poor Malaysians can technically fall back onto the public health system as fees are low and waived if they are unable to pay. However, the non-medical costs of accessing care can be high (such as for transport). Geographic access to care can also be an issue in certain parts of the country. Further, poor non-citizens cannot access public care if they are unable to pay.

**Figure 3: Out-of-pocket payments for health as a share of household consumption in Malaysia (2004)**

![Figure 3: Out-of-pocket payments for health as a share of household consumption in Malaysia (2004)](source: Calculations by the author using data from a nationally representative household expenditure survey conducted in 2004/05 by the Department of Statistics, Malaysia (unpublished).)

Source: Calculations by the author using data from a nationally representative household expenditure survey conducted in 2004/05 by the Department of Statistics, Malaysia (unpublished).
On humanitarian grounds life-saving care is provided to these people for free, but there is a large section of illegal migrants in the country who are generally poor and try not to access public care for fear of deportation and other legal measures. Needless to say, the poor cannot access private care due to the inability to pay.

### Equity in financing

Equity in financing is strongly related to financial protection (as described by the indicators above) but is a distinct issue and health system goal. It is generally accepted that financing of health care should be according to the ability to pay.

A ‘progressive’ health financing mechanism is one in which the amount richer households pay for health care represents a larger proportion of their income. Progressivity is measured by the Kakwani index: a positive value for the index means that the mechanism is progressive; a negative value means that poorer households pay a larger proportion of their income and that the financing mechanism is therefore regressive. Table 4 provides an overview of the distribution of the burden of financing the Malaysian health system across different socio-economic groups (i.e. the financing incidence) as well as the Kakwani index for each financing mechanism, in 2004.

Table 4 shows that, overall, Malaysia had a progressive health financing system in 2004 as the Kakwani Index was 0.2.

The only component of direct taxes that could be assessed was personal income tax. The personal income tax distribution was found to be the most progressive health financing source in Malaysia. However, personal income taxes contributed a relatively small share (5%) to total health financing, compared to other direct taxes, such as company and petroleum income tax.

Indirect taxes made a smaller contribution towards the financing of health care compared to direct taxes. Of the many components of indirect taxes, only sales taxes could be assessed directly. The distribution of sales taxes was found to be proportional in 2004. This is unusual, as taxes based on consumption tend to be regressive or less progressive than direct taxes. The reverse situation in Malaysia may be attributed to the tax structure, which includes features that are protective of the poor, such as the sales tax exemption on many basic food items such as rice. The lack of such exemptions for some non-tax revenues - such as payments for licenses, services, fines and other penalties - was probably why these were regressive.

The Social Security funds had a progressive distribution but did not play a major role in financing health care. The two private sources of health financing - private health insurance and out-of-pocket payments - were also progressive as they are largely financed by wealthier sections of the population. The progressive nature of out-of-pocket payments is unlike the situation in most other countries, and an important reason why catastrophic expenditures and impoverishment as a result of seeking health care is limited in Malaysia. Because out-of-pocket payments made up a third of health financing, the progressivity of this source of financing greatly influenced the distribution of the entire financing system in Malaysia.

### Table 3: Impoverishment indicators for Malaysia using a range of poverty lines (2004)

<table>
<thead>
<tr>
<th>World Bank poverty lines</th>
<th>$1.08 (1993 prices)*</th>
<th>$2.15 (1993 prices)*</th>
<th>$1.25 (2005 prices)*</th>
<th>$2.00 (2005 prices)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-payment poverty headcount</td>
<td>1.3%</td>
<td>13.5%</td>
<td>1.1%</td>
<td>6.9%</td>
</tr>
<tr>
<td>Post-payment poverty headcount</td>
<td>1.3%</td>
<td>13.8%</td>
<td>1.2%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Percentage point change in poverty headcount (pre- to post-payment)</td>
<td>0.1%</td>
<td>0.3%</td>
<td>0.1%</td>
<td>0.2%</td>
</tr>
<tr>
<td>Pre-payment normalised poverty gap</td>
<td>0.2%</td>
<td>3.3%</td>
<td>0.2%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Post-payment normalised poverty gap</td>
<td>0.2%</td>
<td>3.4%</td>
<td>0.2%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Percentage point change in poverty gap (pre- to post-payment)</td>
<td>0.0%</td>
<td>0.1%</td>
<td>0.0%</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

*These prices are in terms of purchasing power parity

Source: Calculations by the author using data from a nationally representative household expenditure survey conducted in 2004/05 by the Department of Statistics, Malaysia [unpublished].
### Table 4: Incidence of different domestic financing mechanisms in Malaysia (2004)

<table>
<thead>
<tr>
<th>Financing mechanism</th>
<th>Percentage share</th>
<th>Kakwani index</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Direct taxes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal income tax</td>
<td>5%</td>
<td>0.51</td>
</tr>
<tr>
<td>Unallocated direct tax*</td>
<td>23%</td>
<td></td>
</tr>
<tr>
<td>Total direct taxes</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td><strong>Indirect taxes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sales tax</td>
<td>4%</td>
<td>0.01</td>
</tr>
<tr>
<td>Unallocated indirect tax**</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Total indirect taxes</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td><strong>Non-tax revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allocated***</td>
<td>5%</td>
<td>-0.08</td>
</tr>
<tr>
<td>Unallocated****</td>
<td>8%</td>
<td></td>
</tr>
<tr>
<td>Total non-tax revenue</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Other revenues (unallocated)</td>
<td>0.3%</td>
<td></td>
</tr>
<tr>
<td>Mandatory health insurance contributions (Social Security organisations (allocated))</td>
<td>0.8%</td>
<td>0.13</td>
</tr>
<tr>
<td><strong>Total public financing sources</strong></td>
<td>56%</td>
<td></td>
</tr>
<tr>
<td>Commercial voluntary health insurance (allocated)</td>
<td>6%</td>
<td>0.25</td>
</tr>
<tr>
<td>Out-of-pocket payments (allocated)</td>
<td>34%</td>
<td>0.13</td>
</tr>
<tr>
<td>Other private sources (unallocated)</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td><strong>Total private financing sources</strong></td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL FINANCING SOURCES</strong></td>
<td>100%</td>
<td>0.20#</td>
</tr>
</tbody>
</table>

Notes:
- = data not available
*These include company income tax, petroleum income tax and other unspecified direct taxes.
**These include service tax, excise duties, import and export duties and other unspecified indirect taxes.
***These include household payments for licenses and permits, service fees, fines and penalties.
****These include ‘interests and returns from investments’ and other non-tax revenues.
#The Kakwani Index for total health financing was computed under the assumption that unallocated direct taxes were distributed as personal income tax, unallocated indirect taxes were distributed as sales tax, unallocated non-tax revenues were distributed as allocated non-tax revenues, and that all other unallocated sources were then distributed according to the weighted average of allocated sources other than non-tax revenues.

Source: Computation by author based on a nationally representative household expenditure survey conducted in 2004/05 by the Department of Statistics, Malaysia (unpublished).

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### Equitable use of health services and access to needed care

This section considers how benefits from using different types of health services are distributed across socio-economic groups. Universal health coverage requires that all people receive the health care that they need. It is estimated that, in 2011, there were 4.4 outpatient clinic visits per person and 86 hospital admission per 1,000 persons in Malaysia (Institute for Public Health 2012). The distribution of these services was equal across all households, regardless of socio-economic status, while poorer households used more public services than richer ones.

It is generally agreed that individuals’ use of health services should be in line with their need for care. Unfortunately there are no data for Malaysia that compare need to utilisation, but poorer segments of a population generally have greater health needs. In an equitable system, therefore, one would have expected utilisation for those of a lower socio-economic status to have been higher.

### Conclusion

The claim that Malaysia has achieved universal health coverage appears to be supported by the findings from this brief assessment of the country’s health system. Financing of health care has a progressive distribution and average household out-of-pocket payments are relatively small, especially for poorer households. Overall, the population enjoys high levels of financial
risk protection and the use of public health care services is equitably distributed.

In Malaysia, the fact that the poor are spared a high burden of out-of-pocket payments can be partially attributed to the extensive network of public health facilities: this provides a wide range of very cheap health care services to those in need. Direct household out-of-pocket health payments in Malaysia are in fact almost exclusively for the purchase of private care. Out-of-pocket payment distributions favouring richer households indicate that, in general, private care is mainly purchased and consumed by the rich, a finding which should not be surprising since these households are more likely to be able to afford such care.

Increasing public demand for better quality care, as well as changing demographics and disease burdens, are putting the Malaysian public health system under tremendous strain. Major health reforms are being discussed within government although very few details have been released to the public. It is likely that a future system would involve social health insurance, a single purchaser and both public and private provision.
References


Universal Health Coverage Assessment: Malaysia
Acknowledgments

This country assessment is part of a series produced by GNHE (the Global Network for Health Equity) to profile universal health coverage and challenges to its attainment in countries around the world. The cover photograph for this assessment was accessed from Wikimedia at https://commons.wikimedia.org/wiki/File:Pensiangan_Sabah_Klinik-Kesihatan-04.jpg. It was taken by CEphoto (Uwe Aranas) under the Creative Commons license CC-BY-SA-3.0. The photo is titled ‘Pensiangan, Sabah, Malaysia: Hospital (Klinik Kesihatan Pensiangan).


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More about GNHE …

GNHE is a partnership formed by three regional health equity networks – SHIELD (Strategies for Health Insurance for Equity in Less Developed Countries Network in Africa), EQUITAP (Equity in Asia-Pacific Health Systems Network in the Asia-Pacific, and LANET (Latin American Research Network on Financial Protection in the Americas). The three networks encompass more than 100 researchers working in at least 35 research institutions across the globe.

GNHE is coordinated by three institutions collaborating in this project, namely: the Mexican Health Foundation (FUNSALUD); the Health Economics Unit of the University of Cape Town in South Africa; and the Institute for Health Policy based in Sri Lanka.

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