Background

Malaysia is a fast developing country with an estimated population of 26.127 million people in 2005 over an area of 330,252 sq. km, giving a population density of 79 persons /sq.km. It is a relatively young country with 42.3% of its population under the age of 20 years, and only 6.6% of the population aged 60 years and above[1]. Rapid economic development over the last 2 decades have brought about urbanization and rural to urban migration. The proportion of urban population increased from about 50% in 1990 to 65.1% in 2005.

Life expectancy in 2005 was 71.8 years for males, and 76.2 for females, compared to 56 years and 58 years respectively in 1957 (when it gained Independence). Mortality rates have also improved with Infant Mortality reducing from 75.5 per 1,000 live births in 1957, to 16.4 in 1985, and 5.1 in 2005. Maternal Mortality Rate decreased from 16 per 1,000 live births in 1970 to 0.3 per 1,000 live births in 2005[1].

Healthcare System in Malaysia

Malaysia has a mixed public-private healthcare system, where the private sector is particularly strong in the urban areas. In the public sector, the Ministry of Health (MOH) is the main healthcare provider through its extensive network of primary care clinics, and hospitals – ranging from small district hospitals without specialists to large hospitals at state capitals providing specialist and subspecialty services. Besides MOH, University Hospitals under the Ministry of Higher Education are also important providers while the Ministry of Defence has two hospitals for military personnel and their families. **Table 1** shows the distribution of hospital beds in the country by sector and major providers.

Table 1 : Distribution of Hospital Beds in Malaysia, 2005

Sector	No. Beds	% of Total
Ministry of Health (122)	34761	71.7%
University Hospitals (3)	2474	5.1%
Military Hospital (2)	276	0.6%
Hospital for Aborigins (1)	166	0.3%
Private Hospitals (222)	10794	22.3%
Total :	**48471**	**100.0%**

Source : Information and Documentation Unit, Ministry of Health Malaysia

Primary care is very well developed in Malaysia as it was the focus of health development in the country after Malaya (then) gained Independence from the British in 1957. In the public sector, primary care is provided mainly by the Ministry of Health under a two tier system – rural clinics manned by one or two community nurses; and Health Clinics (or called Community Polyclinic for newer clinics) and Maternal Childhealth Clinics in bigger rural towns and in urban areas, providing a comprehensive range of services (**Table 2**).

Table 2 : Primary Care Service in Ministry of Health Malaysia - Staffing and Scope of Service

Level	Staffing	Scope of Service
Community Clinic	1-2 community nurse (2 1/2 year training programme)	▪ Maternal and childhealth ▪ Family planning ▪ Simple ailments and first aids
Maternal Childhealth Clinic	▪ Staff nurses (several) ▪ Community nurses (several)	▪ Maternal Health - antenatal, post-natal care, home visiting, domicilary service, and family planning ▪ Child health – immunization, developmental monitoring, home visiting
Community Polyclinic	▪ Family physician (in larger clinics) ▪ Medical officers (1 to several) ▪ Medical assistants (several) ▪ Staff nurses (several) ▪ Community nurses (several)	<u>Initial (traditional) services</u> ▪ Maternal and childhealth ▪ Family planning ▪ Nutrition promotion and education ▪ Medical care for acute and chronic diseases ▪ School health service ▪ Dental service <u>Expanded scope</u> ▪ Mental health ▪ Rehabilitation for children with special needs ▪ Elderly care ▪ Adolescence Health ▪ Health and Wellness ▪ Accident and Emergency service

While the public sector community or health clinics are the major primary care providers in the rural populations, private general practitioners operating as solo or group practices, are major providers in the urban areas where several clinics can be found in a housing area or commercial area.

Access to the MOH primary care service is direct, as walk-in patients, while access to specialist service in primary care centres or hospitals is through referral to ensure appropriate use of scarce resources. In the private sector, access is based on ability to pay and therefore, does not require any referral.

Malaysia's total health expenditure constituted 3.8% of its GDP in 2002 where 56% were in the public sector. The Ministry of Health (MOH) was the largest source of health expenditure within the public sector (86%) funded through general taxation. Household out-of-pocket spending accounted for the largest source in the private sector (74%)[2].

Maternal and Child Health (MCH) Service

The Ministry of Health provides a comprehensive range of maternal and child health service in its primary care facilities. However, most of those who can afford to pay, or those covered by third party payers (employer, insurance, managed care organizations) obtain maternal and child health services in the private sector as the network of private clinics is more extensive than the public sector clinics, especially in the urban areas.

In the Ministry of Health facilities, MCH services provided include the followings :

Maternal healthcare service

- Ante-natal care comprising of pregnancy monitoring and treatment of conditions arising from pregnancy; VDRL and HIV testing (voluntary); health and nutrition education; dental care during pregnancy;
- Home delivery for low risk pregnancies;
- Post-natal care which include home visit for complicated deliveries;
- Family planning.
- Nutrition promotion and education, breast feeding in particular

Expectant mothers with complications during pregnancy are referred to either the family health physician in the health clinic or relevant specialist in the hospital for further management.

Childhealth service

- G6PD screening at birth;
- Home visit for high risk babies (complications during delivery, or complicated pregnancies). However, such home visits occur mainly in the rural clinics as the huge workload in urban clinics make it difficult to carry out such visits at times.
- Immunisation which covers BCG; oral polio; triple antigen (DPT); mumps, measles and rubella (MMR), Hepatitis B and Haemophilus influenza;
- Child development monitoring, up to 4 years of age;
- Nutrition assessment and food supplement for under-weight and malnutrition children.

Paediatric and Obstetric Services

All hospitals, except special institutions, in the Ministry of Health are acute hospitals which provide basic paediatric and obstetric service. However, only about 1/3 of them have resident paediatricians and obstetricians. The services provided range from basic

secondary to tertiary subspecialty services in large state capital and national referral hospitals.

Deliveries

Most of the deliveries are conducted in hospitals or maternity homes (97% in 2004) while 3% were home deliveries. A substantial number (18.4%) were delivered in private hospitals and maternity homes[3] (**Table 3**).

Table 3 : Number of Deliveries by sector in Malaysia, 2004

Place of Delivery	Number	Percentage
Government facilities	354,856	78.5%
Private facilities	83,275	18.4%
Home delivery	13,712	3.0%
	451,843	100.0%

Source : Annual Report, 2004. Ministry of Health Malaysia

Human Resource – Health Professionals

Medical and healthcare service for children and women are provided by a number of category of healthcare professionals at various levels of care, ranging from community nurse in rural clinics to specialists in hospitals. The type of manpower and their training are as shown in **Table 4** below.

Table 4 : Health Professionals and their Training, Malaysia

Place	Category	Education/Training
Rural Clinic	Community nurse	5 years secondary school education + 2 ½ years nursing training
Community Polyclinic	Community nurse	As above
	Staff nurse	5 years secondary school education + 3 years basic nursing +/- 1 year midwivery
	Public health nurse	As above + 1 year midwivery + 1 year public health
Hospital	Staff nurse	As above
	Medical officer	5 year secondary + 2 years pre-university education + 5 years medical education
	Specialist	As above + 4 years post-graduate specialist training programme (local) or equivalent training overseas.

Specialist manpower is still very limited in the Ministry of Health hospitals where a significant number are in the private sector. In 2000, the number of doctors (specialist and non-specialist) in the private sector was 46.1% of the total registered with the Malaysian

Medical Council. The paediatrician and obstetrician manpower in the Ministry of Health hospitals are as shown below (**Table 5**).

Table 5 : Paediatrician and Obstetrician Manpower in MOH Hospitals, 2005

Specialist	Number	New Specialist Gazetted in 2004 *
Paediatrician	216	27
Obstetrician	190	29

Source : Medical Development Division, Ministry of Health Malaysia
* Annual Report, 2004. Ministry of Health Malaysia

Medical Service for Vulnerable People - Assistance in Medical Expenses for Low-Income Families

Healthcare for low-income families are well taken care of in Malaysia through very affordable healthcare; referral system and Medical Assistant Fund

Primary Care

Primary care service (public sector) in the rural areas are free, while a nominal fee of RM1.00 (US 27 cents) is charged for each visit in the urban clinics. This covers consultation, laboratory and x-ray investigations, as well as medications which could be up to 1-3 months supply for chronic diseases.

Hospital Care

For inpatient hospital care service, fees are charged by three classes. Low income families are in the third class category where the fees are very affordable. The MOH subsidises 95-98% of hospital charges for patients admitted to its hospitals. Poor patients can request for exemption of hospital charges, whether partly or fully, with supportive documents and after interview by the medical social worker or the hospital director.

The referral system and fee structure practiced by the MOH ensure all low income patients receive care that is needed irrespective of ability to pay. This include treatment in private medical centres where there is no MOH facility in the region, or for certain services that are being outsourced to overcome the shortage of its own facilities or personnel. Examples of such public/private collaboration are cardiothorasic service and cancer treatment.

Medical Assistant Fund

This is an additional safety net launched in 2003 to assist patients (Malaysian citizens only) in need of expensive healthcare services not available in government hospitals. This include the followings :

i) Full or partial payment for medical treatment cost involving facilities not available at government hospitals;
ii) Full or partial payment for the purchase of medications not supplied by government hospitals but registered with the National Pharmaceutical Bureau, and

iii) Full or partial payment for the purchase of medical equipment or equipment for rehabilitation and functional upgrading purposes not supplied by government hospitals.

Medical Service for Vulnerable People – Collaboration with Other Agencies

One Stop Crisis Centre (OSCC)

Emergency departments in hospitals receive patients who are cases of abuse and violence from time to time. These include cases of battered wives, rape and sexual assault, and child abuse. Increase awareness on human rights and of avenues to seek help coupled with increasing sensitivity of medical staff on duty has led to an increase in number of such cases seen in the hospital (**Table 6**).

One-Stop Crisis Centres (OSCC) was introduced in all hospitals in 1996. It was aimed at providing a one-stop service centre to assist and facilitate victims of abuse and violence by bringing help from all relevant departments in the hospital, as well as outside agencies, to the victim in the hospital. This spares the victim from going round to seek help from different departments/agencies, thus minimizing the trauma and stress for the victim. As an example, for a case of domestic violence or alleged rape, the hospital will call the police who would visit the victim at the OSCC to record the victim's report, while the social and welfare department officer or the legal bureau officer are contacted if needed, to offer appropriate help to the victim. In some urban centres, NGOs provide active support to the OSCC service by being "on-call" - to provide counseling, emotional support and assistance where needed.

Table 6 : Cases Seen at One-Stop Crisis Centres in Hospitals, 1998 - 2001

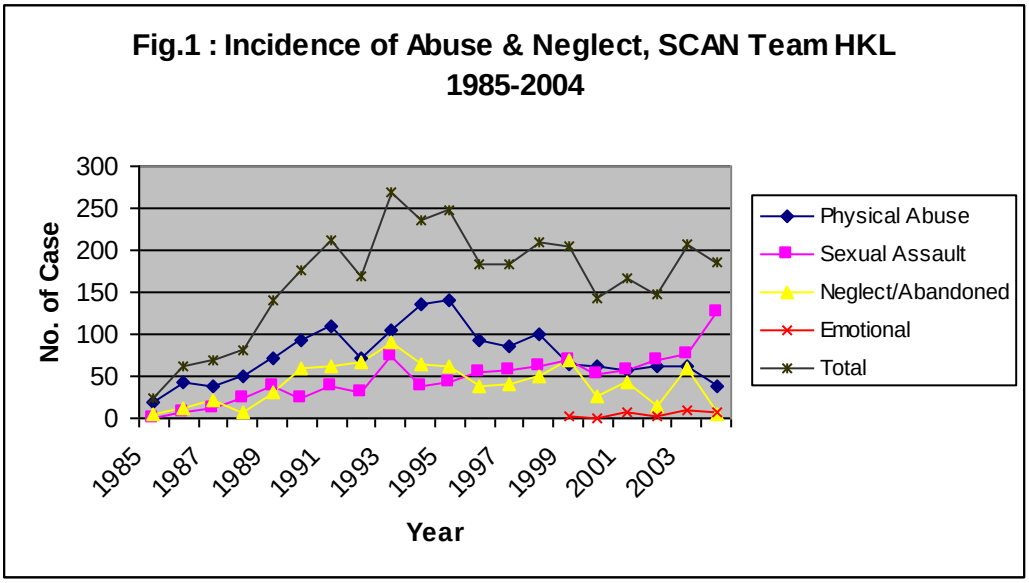
Type of violence	1998	2000	2001
Rape/Alleged Rape	654	1,047	1,131
Domestic violence	1,405	2,282	2,840
Child abuse	226	350	523
Others	NA	322	312
Total :	***1,925***	***4,001***	***4,806***

Source : Medical Development Division, Ministry of Health Malaysia

SCAN (Suspected Child Abuse and Neglect) Team

In addition, another active group called the *SCAN Team* (Suspected Child Abuse and Neglect Unit) established since 1985 at the national Paediatric Institute of Hospital Kuala Lumpur (HKL) to provide medical care, treatment and services to children who have been

physically or sexually abused. The team comprise of paediatricians, gynaecologists, child psychiatrists, medical officers, medical social worker and nurses in the hospital, as well as social workers from the Welfare Department, police, and NGOs. **Figure 1** shows the number of cases managed by the team since its inception in 1985.



Source : SCAN Team, Paediatric Institute, Hospital Kuala Lumpur

Haemodialysis Treatment

Malaysia has a unique collaboration between the government and NGOs in the provision of haemodialysis service for poor patients. Due to great pressure from unmet needs for haemodialysis treatment, the government decided in 2001 to facilitate the setting up of NGO-run haemodialysis centres and subsidise haemodialysis treatment for poor patients in these centres. The patients in the NGO centers pay about a third of the cost of the treatment, the balance being subsidized by the government or the NGO or both.

The government subsidises RM 50.00 for each dialysis treatment. The subsidies are paid through the National Kidney Foundation which serves as the coordinating body under this scheme. Although the scheme has allowed many more patients to receive haemodialysis treatment in the country, the programme is also faced with many challenges, the most critical of which is standard of care. However, with the passing of Regulations for the Private Healthcare Facilities and Services Act (1998) in April 2006, some of the quality issues would be addressed as the law is being enforced.

Training of Health Professionals – Public/Private Collaboration

Training of health professionals are undertaken by the government and also the private sector as shown in **Table 7**. Nurses training is outsourced to the private sector in a big way to overcome the acute shortage of nurses in the Ministry of Health. These private nursing colleges utilize the Ministry of Health facilities in the training of these nurses.

For the private medical schools, there are several variants to the training programme. Some are conducted fully in the country while a number conduct twinning programme with partner universities overseas. Some of the twinning programmes involve preclinical training locally and clinical training in partner universities overseas while others have reverse arrangement where pre-clinical training is conducted at its partner university and clinical training in Malaysia. All private medical colleges utilize hospitals of the Ministry of Health for its clinical teaching.

Table 7 : Training of Selected Health Professionals in Malaysia

Health Professional	Training Centre
Community nurse	▪ MOH only
Staff nurse	▪ MOH ▪ MOH/Private (17, outsourced by MOH) ▪ University hospitals' nursing colleges (3) ▪ Universities (1, degree in nursing science) ▪ Private hospitals' nursing colleges
Doctors	▪ Government medical schools (9) ▪ Private medical colleges (8)
Specialist	▪ Government medical schools (4)

Conclusion

Healthcare for the vulnerable group such as children and women are being taken care by the government through various affirmative policies and actions. However, much more can be done, considering that the private sector has a wealth of healthcare professionals but are not equally accessible to all sectors of the population. Collaboration with other related agencies like the Welfare Department and NGOs should be further explored to optimize precious resources available for the benefit of children and women in need.

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