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Malaysia's health care system is two-pronged, consisting of both public and private sectors. The quality of the two health care sectors is not of equal standard, however, which has led to polarization of the overall health care system. The main differences in quality are the cost of health care services, cost of prescription drugs, doctor-patient ratio, and perceived quality of care. Both prongs have strengths and weaknesses that, if unified, could form the basis for collaboration and a better health care system for all.

Introduction

The Malaysian health care system is two-pronged. There is a public sector composed of patients who receive health care through the support of government subsidies. There is also a private sector composed of patients who opt to pay out of pocket for health care. The quality of the doctors across both the public and private sectors is of a high and uniform standard, as most receive their training overseas in Europe or Australia ("6 Countries…"). However, the quality of the health care system itself is not of an equal standard. Many factors, such as the cost of health care services for patients, the cost of prescription drugs for patients, the sources of health care sector funding, the doctor-patient ratio, the doctor-patient relationship, and the perceived quality of the services, are not congruent between the public and private sectors. These discrepancies within Malaysia's two-pronged health care system reflect polarization similar to that seen in other two-pronged health care countries (Chee, "Ownership …"; "Health Care in South Africa"). However, these discrepancies are divided strengths that have the potential to form the basis for greater collaboration in the health care field overall.

History of Malaysian Health Care

In 2019, Malaysia was named the best health care system in the world based on quality, accessibility, language versatility, Joint Commission International hospital accreditation, and affordability ("6 Countries…"). The Malaysian government spends merely 4.4% of its GDP on health care, which is strikingly low compared to the United States' health care expenditure, at 21% of the GDP (Tan). However, although Malaysian health care has been on an upward trend in terms of overall population health, Malaysia is a relatively young country and has to prove it can maintain the two-pronged health care

system. The divide in strengths between the public and private health care sectors could polarize and hurt Malaysia's overall health care quality, as has been the trend with many dual-pronged health care systems. The history of Malaysian health care explains when and why this sector polarization began.

Initially, Malaysian hospitals were public and built for specific groups. Established in 1880, Taiping Hospital, the first hospital in Malaysia, was built for the tin workers of Perak and cost only 50 cents per year to visit. In Sarawak, hospitals were built for the European officers and their families and were staffed by young girls from the area functioning as nurses and midwives ("MOH History…"). In the early to mid-twentieth century, a shift began to occur. By 1957, Malaysians were predominantly served by the public sector health care, with private hospitals restricted to serving urban areas for primary care (Chee, "Ownership …").

The expansion of urban private health care began in earnest during the 1980s. A large-scale movement of native Malays into urban areas spanning the 1980s and 1990s—due to socioeconomic changes, redefined urban bounds, and increased immigration from other Asian countries—increased the patient base and thereby further encouraged the growth of the urban-bound private health care sector. This growth of private hospitals is evidenced by the increase in the percentage of total private hospital beds from 3.9% in 1980 to 23.4% in 2003 (Chee, "Ownership…"; Yaakob et al.).

The steady growth of the private sector corresponded with the growth in its control over specialist services such as radiology, MRI and CT scanning, mammography, and cardio-thoracic treatment. By 1995, approximately 60% of all specialists were practicing in private hospitals (Chee, "Ownership…"). However, the Asian financial crisis contributed to a leveling out of the annual percent increase in private hospital beds from 20% increase in 1997 to 0.4% increase in 1999. Many businesses closed or cut back entirely on health care spending for their employees. Patients who paid with out-of-pocket payments (OPPs) for private health care were the most affected. During the financial crisis, the cost of imported pharmaceuticals and medical equipment increased 10% to 50% for both domestic and imported products (Chee, "Medical Tourism…). The increased operating costs drove both the patient base and the doctors away from the private sector resulting in underutilization and decreased profits. As many private sector patients switched into the public sector, the patient burden of the public sector soared, leading to ominous futures for both sectors.

The private health care sector, with the support of the Ministry of Health (MOH), determined that the way to save Malaysian health care would be to attract a foreign patient base, as other countries have done, to fund the private sector and make it more affordable for their citizens. Both the public and the private sectors of health care worked together to increase transnational hospital care. Bringing in a foreign patient base gave the private sector the finances to continue to operate. The medical tourism market succeeded by having a low appointment waiting time, by being inherently multilingual, by acquiring Joint Commission International accreditation, and by being Muslim-friendly. The rise in foreign patient participation contributed a 10% increase in foreign patient revenue for private health expenditures by 2005 (Atun et al.; Chee, "Medical Tourism…"). As a result, the cost to participate in the private sector gradually decreased, and patients switched back to private health care. One effect, however, of the increased foreign participation in health care was the private sector's further dominance in specialist care—specifically cardiac, orthopedic, oncologic, fertility, and cosmetic procedures—to attract foreign patients ("Recent Illness/Injury…"; Chee, "Ownership…"). Thus, this crucial juncture in Malaysia's health care history was overcome thanks to the private sector's large investment into medical tourism with the support of the MOH, but this shift also furthered the polarization between the public and private sectors (Chee, "Ownership…"; Chee, "Medical Tourism…").

One recent contribution to the polarization of the public and private health care sectors is the increasing number of doctors who, having received their training overseas in Europe or Australia, chose not to return and instead practice outside of Malaysia

("6 Countries…"). Because doctors tend to migrate toward the more lucrative private health sector, irrespective of where they received their training, the 1971 Medical Act required every doctor to serve 3 consecutive years in a public hospital when they first start practicing. The compulsory service was then reduced in 2017 to only 2 years to encourage more doctors to come back to Malaysia (Cheng Yee; Merican and Bin Yon).

Malaysia has made major developments in its history of health care so far; however, it is still a young country. Having both public and private sectors makes it hard to find a healthy balance, and it remains for Malaysia to prove it can maintain its two-pronged health care system. A more in-depth review of both the public and the private sectors reveals opportunity for collaboration not only to maintain the two-pronged system but also to improve Malaysia's overall health care.

Examining the Dichotomy of Health Care

Research has identified six key differences between the two prongs of the health care system: cost of health care services for patients, cost of prescription drugs for patients, sources of health care sector funding, doctor-patient ratios, doctor-patient relationships, and perceived quality of the services. This section elaborates on these differences, which then ties into the recommendations for how to address the polarization of the health care sectors.

The Public Sector

The public health care system is a government-orchestrated health care system available to all legal residents of Malaysia. The public sector covers health promotion, disease prevention, curative care, and rehabilitative care. Hospital-based care is readily accessible in urban and suburban areas, but for rural areas it is mainly provided through clinic services. The public health care sector serves the majority (approximately 65%) of the Malaysian patient population (Quek). Its most prominent feature is its affordability.

Funding for the public sector comes from the national income tax, social security employer contributions, employee insurance obligations, private health insurance, and OPPs. The MOH subsidizes 98% to 99% of patient's medical costs, with flat rates of RM1 for a general consult and RM5 for a specialist consult. The MOH gives allowances to financially disadvantaged groups such as "preschool children; school children up to 17 years; pregnant women; civil servants and their dependents under 21 years of age; and physically, mentally and economically disadvantaged people" to make costs even more affordable (Jaafar et al.).

Additional strengths of the public health care sector include accessibility, prescription drug costs, and access to a growing budget. Accessibility is threefold as patient capacity and location of facilities as well as affordability are considered. The public sector offers more than 70% of the total hospital beds available in the country (Atun et al.). Thus, more patients can be seen at one time and can be treated in-house for longer-term care. In 2015, 68% of the population lived within 30 minutes' driving distance of an MOH clinic and 70% living within 30 minutes of a public general acute hospital (Atun et al.). Prescription drug costs in the public sector are fully covered (Babar et al.).

Health care revenue comes from multiple ministries but mainly the MOH and the Ministry of Higher Education. The budget for the MOH is proposed to the Ministry of Finance every year. By 2018, the allocation to the annual national budget for public health care was 10.4% of the annual national budget. Until 2015, the national health care expenditure was 4.6% of GDP, but since 2017 there has been a push to reach the World Health Organization's recommended 7% of GDP as the population expands, citizens age, and facilities need quality upgrades ("Country Commercial…").

The weaknesses of the public sector include overcrowding, less opportunity for ongoing doctor-patient relationships, and perceived low quality of health care. Overcrowding is a twofold issue as the incentive for doctors to work within the public sector is low, while the patient population is large because of its affordability. The result of this situation is longer wait times. The Harvard

School of Public Health "Contextual Analysis of Malaysia's Health System" revealed that "waiting times and limited hours are a source of dissatisfaction and impose high opportunity costs on patients accessing care in the public sector. These factors may discourage patients from seeking care when they do not face an acute need, a pattern which is observed in the analysis of service utilization" (Atun et al., p. 37). In public university hospitals, 49% of patients waited 4 to 5 hours to be seen in the outpatient clinic (Abdullah). However, many patients have no choice but to stay in the public health care sector because of its affordability (Pillay et al.). This puts a high demand on the medical professionals in the public sector. This is a result of the lower doctor-patient ratio in the public sector (Merican and Bin Yon). Overcrowding and increased wait-time make a dis-pleasurable experience for both doctors and patients. Contributing to this low doctor-patient ratio is the fact that health care providers in the public sector get paid the civil service rate, which is historically lower than that of the private sector. The only financial benefits for a doctor to remain in the public sector are the government servant privileges. These include free medical care for parents, spouse, or children, a pension after 30 years of public service, time-based promotions, and 25 days of leave each year. In addition, they can receive housing, public service, critical (high-risk job), and cost of living allowances (Khalid; "How Much Does…").

Another weakness in the public sector is the inability to form ongoing doctor-patient relationships. The low doctor-patient ratio forces doctors to see many patients in a day, and because of this, they spend less one-on-one time with each patient. Nursing or other staff take histories and run medical tests, and only then does the doctor come in to talk to the patients. Thus, the doctor is less likely to form a baseline of patients' presentations, which makes it more difficult to tell if something is wrong with a patient next time.

Finally, in the public sector, the perceived quality of facilities, equipment, and technology is lower. The MOH has reported that differences in perceptions of the public and private sectors stem from the disparities of service quality in aspects such as availability of private rooms, upgraded facilities, and waiting times for medical devices (Atun et al.). The 2019 Malaysian government has taken these disparities into consideration and has increased the health care budget and prioritized upgrades in these areas ("Country Commercial…").

The Private Sector

The private sector of Malaysian health care is an opt-in health care system. It complements the services provided in the public sector but concentrates heavily on specialties, with private hospitals and clinics concentrated in urban areas (Atun et al.). The private sector serves roughly 35% of the Malaysian patient population (Quek). Private sector patients pay a premium for health services, which can be financed through OPPs, private health insurance, or corporations that pay for employees (Jafaar et al.).

The strengths of the private health care sector include shorter waiting times, ability to form a stronger doctor-patient relationship, and more choice in specialties. Patients who can afford private health care redeem the benefit of spending less time waiting and more time being examined by the doctor. This is a result of the selective nature of the premium the patients pay as well as the attractive high private doctor salary.

Doctors migrate into the private sector, after their compulsory service in the public sector, for the competitive pay, the workload and environment, and the autonomy. The private sector pays specialists an average of RM15,000 to more than RM30,000 as compared to the government sector specialist wage of RM10,000 and higher ("How Much Does…"). Therefore, there are a greater number of doctors and fewer number of patients in the private sector.

In addition to shorter wait times, the higher doctor-patient ratio offers more opportunity to form a better doctor-patient relationship. In the private sector, there is a choice to visit the same doctor as compared to the public sector's randomized pairing. This practice is of significant importance as it allows a physician to be familiar with a patient's baseline presentation in order to compare

it to a new presentation. This comparison assists the doctor in diagnosing and effectively treating the patient's new condition. This relationship also allows for a patient to feel more comfortable sharing symptoms and being honest in follow-ups, which may allow doctors to catch conditions earlier in their onset (Ab Rahman et al.). In one study, the private sector caught breast cancer earlier in its development and offered more breast-conserving treatments and chemotherapy, as compared to the public sector (Kong). Therefore, the development of doctor-patient relationships benefits the patients in many aspects.

The private sector also has the largest selection of specialists and specialties. Roughly 70% of specialists practice in the private sector (Chee, "Medical Tourism…"; Quek). The private sector dominates the specialist services because the public sector lacks strength and choices in these fields. On the Martindale Center Student Associates' research trip, Kumpulan Perubatan Johor Healthcare executives stated that it was common to see people switch into the private sector because of a lack of confidence in the public sector specialties and difficulty scheduling appointments (Ahmad).

The weaknesses of the private sector include the high OPPs, high cost of prescription drugs, and a lag in technology. According to the MOH *National Health and Morbidity Survey*, there has been a steady increase in the cost of participating in private health care due to the high dependence on OPPs ("Recent Illness/ Injury…"). The private sector receives almost 66% of its funding from OPPs, 20% from private insurance, and the remainder from a mixture of the sources, such as social security and employee insurance obligations (Atun et al.). Therefore, the level of patient participation in the private health care sector is crucial to its ability to function and make a profit. Health care providers in the private sector have pricing regulations and recommendations suggested by the MOH through the Private Healthcare Facilities and Services Act of 1998, but most payments are still made on an upcharged fee-for-service payment designated by the private sector (Jafaar et al.).

There are no regulations on the pricing of medication, with the result that privatization of health services leads to increases as well as instabilities in pricing for medicines (Babar et al.; Barraclough). In particular, there has been a large discrepancy between the prices of innovator, or new to the market, medicines in the private and public sectors. This "free pricing" policy, along with the strong financial dependence on OPPs, has led to increased out-of-pocket expenditures for the private sector (Ahmad and Islahudin).

As a result of the private sector's heavy financial dependence on OPPs and private insurance, when equipment is needed or facilities need to be updated, financing comes mainly from the patient's pocket (Jafaar et al.) or from the private institutions themselves. Thus, it may take more time to accrue the necessary funds for the capital expenditures desired. As a result, there is often a lag in terms of adoption of updated technology and sometimes lower standard facilities result due to this difficulty of funding upgrade expenditures.

The Motivation and Recommendations for Public–Private Collaboration

The history of the Malaysian dual-pronged health care system has been one of gradual polarization, but going forward constructive collaboration is possible. This analysis has revealed both the public and the private health care sectors' strengths and weaknesses. The parallel existence of public and private sectors sans intersection or collaboration has created a system that fares reasonably well for the wealthier private sector but under-serves patients and is understaffed in the public sector. If Malaysia's incongruent strengths and weaknesses are not unified, the private sector will steepen in cost and flood with doctors while the public sector will become overburdened with patients. Malaysia is still a young country, and now is the time to get involved in updating and integrating both systems so as to prevent further polarization. Assuming a shared goal of improving the overall health of the nation, there is strong motivation for collaboration between the two sectors. Such collaboration can and must take place on multiple levels.

Motivated by the current polarization of the dual-pronged health care system, I propose a set of three recommendations.

First, the public sector patient burden should be addressed with the sharing of facilities, resources, and equipment between the two sectors. Second, more powerful incentives should be implemented to get more doctors to remain in the public sector. Third, there should be a reallocation of funding in the public sector specifically for the incentivization of collaboration between the two prongs. The main goal of these collaborative efforts would be to better Malaysia's overall health care system for all patients.

The first recommendation is to share the facilities, resources, and equipment in both the private and public health care sectors. Although it has been reported that earlier in Malaysia's history the private sector shared the public sector's wards (Quek), the extent to which it is actually being practiced is minimal. Increasing this practice will essentially use the strengths of each prong to address many of the weaknesses. The high wait times in the public sector, the technology lag of the private sector, the high OPPs of the private sector, and the lower perceived quality of the public sector would be addressed through a sharing of facilities, resources, and equipment. For example, the high wait times for public hospitals could potentially be alleviated by sharing high demand technologies such as MRI and CT machines in private facilities when not in use. The public sector's use of and payment for such facilities/equipment when unoccupied will help keep the OPP costs down in the private sector and thus increase the funds available to bridge the technology lag. The sharing of facilities and equipment would also even out the perceived quality of the public sector.

The second recommendation is to incentivize doctors to remain in the public sector past their compulsory service years. The high wait times of the public sector, the low doctor-patient relationship opportunity of the public sector, the low number of specialists in the public sector, and the high OPPs of the private sector would be addressed by evening out the doctor-patient ratio in the public and private sectors. As a result of having a greater number of doctors in the public sector, the time spent with each patient can be longer and continuous over visits, thus affording public sector patients the opportunity to form a relationship with their doctors. Having fewer doctors in the private sector will lighten the draw on OPPs in the private sector, while maintaining a positive yet closer doctor-patient ratio. Finally, with more doctors remaining in the public sector, more specialist doctors will be available to public sector patients. In order to incentivize the doctors, new government-funded policies could be implemented, such as time-based promotions, a new wage scale, post-basic training allowances, allowing doctors to practice in a private wing off working hours, and extended health clinic hours (Jaafar et al.). These changes, and more, should be considered as physician incentive policies to encourage more participation in the public sector.

The third recommendation is to redistribute government funds in the public sector into an account used specifically for collaborative efforts with the private sector hospitals. Specifically, from the existing tax rate, a portion should be designated for collaborative efforts as they will benefit all parties. This should incentivize collaboration. This capital would be used for many things, such as bargaining down the price of innovator drugs in the private sector and increasing access to them in the public sector. It could also be used to pay for the time used on shared equipment and facilities. This way, private patients would not be paying for the public sector's use of their facilities. Thus, the private sector will have another source of income to lessen the high dependence on OPPs. The MOH has proposed three potential sources of additional funding: growth in general revenue, more allocation of sector-specific resource taxes, and reducing subsidies given to out-of-country patients (Atun et al.). The redistribution of existing government funds combined with an effort to expand funds will help strengthen the relationship and communication between the public and private sectors to help better the practice of medicine for all patients.

Previous health minister Dato' Liow stated, "Government and private sectors should work together. Because the doctors that we train are for the nation, irrespective of [whether they work for the] government or private. Doctors are serving the people" ("Paying More

for Health care…"). He acknowledges that the common goal for the health care systems is to serve the people and, therefore, encourages collaboration between the public and private health care sectors. By uniting the strengths and weaknesses of both prongs through the recommendations provided, Malaysia can work toward the betterment of health care for all patients.

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