

**REVIEW OF MALAYSIAN TENTH HEALTH PLAN 2011-2015**

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**ABSTRACT**

Malaysia is an energetic nation has appreciated monetary development on political soundness since his freedom. Malaysians are extra sound, have a more drawn out future and beneficial. The level of general health accomplished means that the achievement of the nation. Great health permits the nation to appreciate profitable and significant lifespan. Great health adds to the thriving and general social solidness.

Tenth Malaysia Plan 2011-2015 has point by point on the health arrangement for country. There are 4 Technical Working Group was built up to deliver issues identified with health administrations conveyance, administration, and finance, health mindfulness and solid way of life and strengthening of individual and group to oversee own health.

**INTRODUCTION**

The Ministry of Health, under the Malaysian government, is in charge of healthcare in Malaysia. The healthcare system in Malaysia is divided into two sectors, namely, the government healthcare system and the private healthcare system. Healthcare in Malaysia is included in the 12 National Key Economic Areas (NKEA) under the tenth Malaysia plan of 2011–2015. Contributions and investments from the healthcare industry are expected to contribute to the income of the nation come 2020 (MGCC, “Market Watch 2011”, Shazali et al., 2013). The Malaysian government has also become tenacious in providing efficient healthcare system. The increase in the number of medical schools serve as proof that Malaysia is vigilant in providing quality health care not only to its citizens but also to the expatriates, tourists, migrants, and visitors.

Malaysia, similar to other Asian countries, allocates a considerable amount of budget to the health sector. Malaysia is fortunate to have wide-range of healthcare services. The Malaysian government is tenacious in providing access to high-quality health care by means of a network of nationwide clinics and hospitals. However, certain problems related to the environment and climatic change need to be addressed as well (Allianz Worldwide 2013, Qureshi, et al., 2014). The problems raised in the 10MP are somewhat like those problems that were raised in the 9th Malaysia Plan (9MP); issues include problem in globalization and rising tendency of private healthcare expenditure. Such pose

a great challenge and difficulty on how to maintain the power of the present healthcare of the country (Ministry of Health 2011).

Malaysia, at present, is still recuperating from its past economic crisis wherein it was trapped in the label of a middle income country for a considerable length of time. The Malaysian government has set in the 10MP the objective of becoming a high-income nation come 2020. In order to reach this goal, Malaysia needs to make a growth rate 5.5% per year in the economy. The Malaysian government had allocated RM180 billions of development expenditure ceiling for all the government sectors; RM 15 billion has been set apart of Private Funding Initiative Facilitation Fund. The private Funding Initiative expected RM 50 billion through private investment.

### **THE TENTH MALAYSIA HEALTH PLAN (2010 - 2015) '1CARE FOR 1MALAYSIA'**

After the independence, the country had witnessed big developments in the delivery of its healthcare. Malaysia has a complete range of healthcare facilities which is provided by a two types of health delivery system that includes the stakeholders from both the public and private sectors. The government though ruins as the main policymaking and controlling authority despite of dual system in the healthcare provision. The commitment of the government to worldwide access of reasonable and high quality healthcare is plain in the abundant public health services that cover health advancement, illness preclusion, remedial, and rehabilitative care. These go beyond the allopathic and Traditional and Complementary Medicine (TCM) practices across the primary, secondary, and tertiary levels of care.

The Economic Planning Unit (EPU) recognized five National Mission Thrusts for the country to realize its objectives in the economic development and comprehend Vision 2020. Fourth National Mission Thrust states the development of standard and the ability to sustain a quality kind of life. The meetings made by the Mission Cluster Group for Key Result Area 2, which covers assurance of access to excellence healthcare and promotion of healthy life, have attempted to reach an agreement to address the gaps and to discuss the key result areas and outcomes and to come up with strategies in order to create a plan to reach the objective of ensuring provision for growth the accessibility to quality health care, public recreational and sports facilities, and to support active healthy lifestyle. Included also are the means in order to overcome hindrances.

The contributions of the health sector are mainly from the availability of services that could contribute to the improvement of health outcomes and eventually a healthier status of the citizens of the nations. The 10MP emphasizes the excellence of healthcare and having a healthy public. The strategy includes the objectives of establishing a comprehensive healthcare system and public recreational and sports infrastructures that could support an active lifestyle. The Ministry of Health (MOH), being the chief activity of health, has been tasked to provide an efficient and effective healthcare system. As such, the MOH developed a conceptual framework in order to redesign the health system in Malaysia.

## HEALTH STATUS OF MALAYSIANS

### Demographic Information

Malaysia has total 330,803 square Kilometer area. The population is 86 persons in one SKM in 2010 as compared with 2000 it was 71. Total population was recorded in 2010 was 28.3 million which shows that the growth rate of 2% in 2000-2010 period.

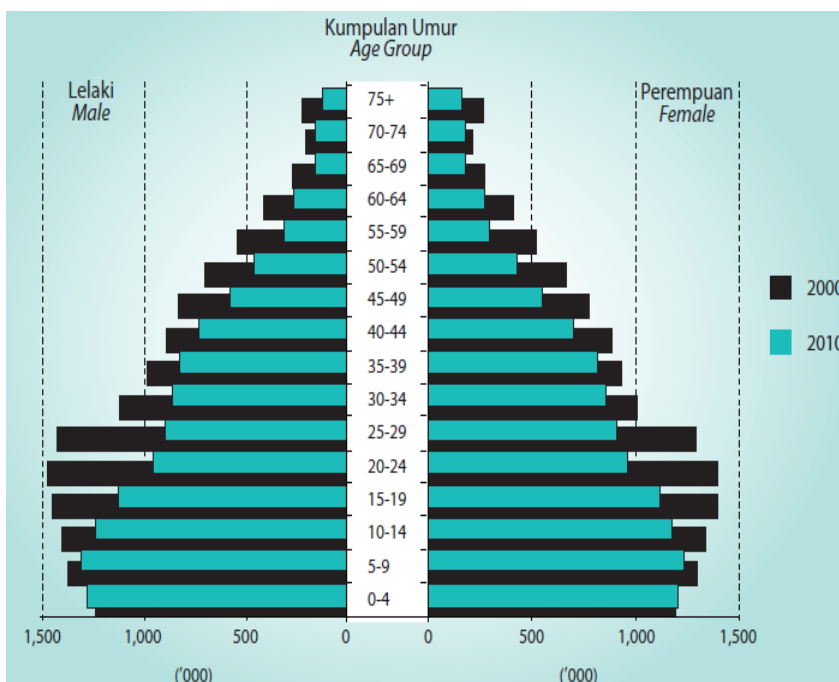
The 6,891 peoples per SKM are recorded in Kuala Lumpur, Penang has 1,490 and Putrajaya 1,478 in the year 2010. On the other hand, the state of Sabah, Sarawak and Phang had population less the 100 per SKM (Ministry of Health 2011).

### Rural-Urban Population

In Malaysia urban population in 2000 was 62.0% and in 2010 increased and recorded 71%. With the comparison of Kula Lumpur and Putra Jaya, the Putra Jaya with 100% level in Urbanization the Selangor and Pulau Pinang with 91.4% and 90.8%. The lower level, were at Kelantan was 42.4%, Pahang 50.5% and Perlis 51.4% (Ministry of Health 2011).

### Age Distribution and Dependency Ratio

The population in Malaysia is comparatively young, in 2010 where below 15 years was 27.6% decreased as compared with 33.3% in 2000. The population of age 15-65 years increased 67.3% from 62.8%. The senior citizens 65 years and above was increased by 5.1% from 3.9% in year 2000. As for the middle age population had increased from 23.6% in 2000 to 26.2% in 2010 (Ministry of Health 2011).

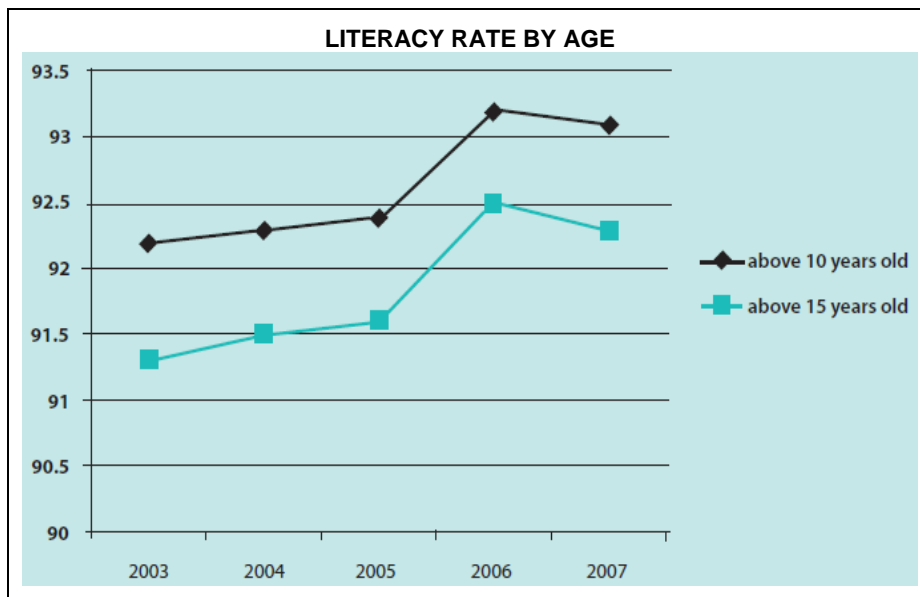


Source: Department of Statistics, 2011.

**Figure 1: The Population Pyramid for 2010**

## SOCIO-ECONOMIC STATUS

The Figure 2 shows the literacy rate among 10 years and above have 92.2% in 2003 and 93.2% in 2006 which was increased, in the year 2007 dropped to 93.1%. Similar trends were seen in 15 years and above age group.



Source: Health Informatics Centre

Figure 2: Literacy Rate by Age form 2003-2007

In 2009 the labour force was 66.9% (12142000) of the total population. From them 52.6% was working on service sector, followed by in manufacturing 28.4%, 12% in agriculture, in construction was 6.6% and 0.4% in mining. The unemployment in 2009 was 4.5% as compared to 2001 was 3.6%.

The GNP (Gross National Product) for 2007 was RM 607,212 million, in 2008 per capita income was RM 22,345 (US\$ 6,726). The purchasing power in 2007 was US\$ 13,289 per capita incomes (WHO Country Health Profile).

## ISSUES & CHALLENGES IN THE TENTH MALAYSIA PLAN

A lot issues has arisen and has posed as a threat to the performance and sustainability of the health system in Malaysia; this includes the increase of health expenditures. In addition to this, the distinct features of the health system that gives universal coverage by means of network providers and payers have created a public-private dichotomy. At present, the expectations and demand for healthcare are increasing along with the increase in public scrutiny.

The health system has a certain degree of control on the supply of health services but limited on the demand for healthcare services. Ramifications include unequal access to health services, inappropriate interventions and treatments either demanded by patients or stated by providers, differences in the quality and standards of care and costs. Such concerns cannot always be put under control and monitoring.

The government of Malaysia has identified the concerns and has undertaken the needed solutions in order to resolve the issue. However, interrelated concerns need to be recognized and addressed as well. The shortcomings include insufficient information on service-mix, costs, and evidence from the private sector in the diagnosis of the problems. Certain resolutions have been unable to achieve the desired and sustainable effect because they have failed to recognize the main causes; moreover, political considerations have made the efforts to resolve the issues more complicated.

### **CONCLUSION**

The Malaysian government needs to find another source of finance for the system, cost efficiency, or even for both. As has been practiced, the country has relied on the subsidies of the government, out-of-pocket payments, payments of employers and insurance premiums in order to finance healthcare. To a certain degree, the burden of the mentioned financing schemes will become a strain on the economy of the nation.

The government of Malaysia needs to improve its policies and regulatory roles on the entire public and private system in order to have an upper hand control on issues related to the allocation of medical resources, establishment of clear objectives for providers, and mechanisms in order for the government to demand from them a more coordinated means of the delivery of service, jurisdiction on the development of clinics and hospitals, purchase of high-priced medical equipment so that the usage of such equipment can be maximized. The payments of providers need to limit the total amount paid because most systems rely on what diagnosis-related groups (DRGs) do in order to cover outpatients. Moreover, hospitals and doctors still benefit financially by keeping patients in beds or by giving unnecessary and low-quality kind of service.

The present economic situation of Malaysia does not provide positive choices. The country may have to acknowledge the possibility of increasing the healthcare funds in order to address the increase in healthcare expenditures and ensure sustainability. Cutting fees do not do much in order to decrease the demand for healthcare. In addition, prices can be limited only up to a certain degree before products could become unavailable, and as consequence, the lowering of the quality of healthcare. Furthermore, a country that cuts fees across the board, considered as a fast political approach, unsuccessfully accounts for the relative value of services given.

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