ABSTRACT
The main objective of a health care delivery system is to maintain or improve the health status of the population. A social or national health care system would also aim to guarantee access to health services for the entire population, regardless of individual ability to pay. Malaysia is one of the Asian countries that based on World Development Report in 1999 categorized as the country that has upper middle income, that is between US 3,031.00 to US 9,360.00 per capita. With health expenditure 2.4% of GDP, life expectancy at birth in Malaysia 70 years for male and 74 for female. Malaysia now is still looking for the right national health care system. So, this paper basically attempts to shortly review the idea of suitable health care financing model for Malaysia. After reviewing characteristics of current source of financing in Malaysia, the trends in health expenditure and characteristics of health care financing required by Ministry of Health, this paper closed with some of financing models (community financing model, health insurance and medical saving account) as the proposed health care financing.

Keywords: Health service, Health expenditure, Health care financing model

INTRODUCTION
The main objective of a health care delivery system is to maintain or improve the health status of the population. This is accomplished mainly by preventing disease and illness or in the case of illness, by providing curative and rehabilitative care. These objectives should be carried out as efficiently as possible, and at costs that are both bearable for the participants and financially sustainable for society.

A social or national health care system would also aim to guarantee access to health services for the entire population, regardless of individual ability to pay. Many national health care systems in Africa, Asia, Europe, Latin America and North America may be regarded as successful because of their extent of access to care, and the high quality of that care. However, there is also many schemes in the developing world do not yet provide adequate physical or financial access to quality health services for the entire population.

Health care systems today are a prominent focus for national leaders and policy makers in most countries today. This fact reflects concerns about the availability of necessary health services for the population, as well as about the efficiency and costs of current health systems in delivering those services. The degree of importance of this issue in any given country is directly related to the size of the health care system relative to the national economy.

In the past, rapid real economic growth often made it possible to increase both the level of access to and quality of care (Cichon et al., 1999). This was the case, for example, in the postwar period of most OECD countries. However, since the mid-1970s and the economic crises of 1980s and 1990s, evidence in dramatic reductions in GDP growth rates, the emphasis in many countries shifted from expanding services and improving quality to attempting simply...
to maintain the level of existing services. Thus, the sustainability and cost containment efforts of health systems have become the major challenges, and financing is a critical element in meeting these challenges.

Countries that rich usually spent more on health than poor countries. Based on patterns observed between economic development and health, shown that high income countries spent US $1,860.00 per capita per year and had 2.5 doctors per 1,000 population, also 8.3 hospital beds per 1,000 population, compare to low income countries spent only US $12.00 per capita, had just 0.1 doctor per 1,000 population and 1.4 hospital beds per 1,000 population. But, more spending on health does not necessarily improved health, as an example is USA compare to Japan. In 1990, USA spent 2,763 per capita, that is 12.7 GNP share, and had life expectancy at birth 76, compare to Japan that only spent 1,538, that is only half (6.5) of USA’s GNP share and had life expectancy at birth better than USA, that is 79.

Sometimes, countries spent more money on health care just because they have money to spend and not because they have greater medical needs. This is proved by USA high spending on health did not result in much better health indicator than Japan. And this is also shown that the more effective health financing, in this example is Japan, the more it can contribute to positive change in health care.

Malaysia is one of the Asian countries that based on World Development report in 1999 categorized as the country that has upper middle income, that is between US $3,031.00 to US $9,360.00 per capita. With health expenditure 2.4% of GDP, Malaysia had life expectancy at birth 70 years for male and 74 for female. Lately, Malaysia experienced the demographic changes that affect health provision and financing through the size and composition of population covered, and relationship between economic products and dependents. There is also a rising expectation from people who is now get a better life with higher GNP, that is increased in demand for high technology or high cost medical care. The disease pattern also changes, communicable disease overtaken by disease of affluence, standard of living improved and morbidity pattern changed. These conditions all together give impact on health care cost. Health care cost is escalating. In another side, government has to maintain the equity. The solution is that there must be contribution from individual who can afford to pay for the health services, in order to decrease the burden of escalating health care cost. So, it is appropriate to conclude that basically Malaysia needs to identify a suitable and acceptable national health care financing model.

This paper basically attempt to identify the proposed national financing health care, although not in a very detail description, or a long research, but only based on political, economical, sociological and technological short evaluation.

The arrangement of the paper are after the purpose of the paper describe in the introduction, there will be a discussion about characteristics of current source of financing in Malaysia, trends in health expenditure, characteristics of health care financing and closed with the proposed health care financing models.

DISCUSSION

Current Source of Health Care Financing in Malaysia

Basically there are seven sources of health care financing in Malaysia according to Ministry of Health of Malaysia (1996). There are:

1. General Taxation
   The tax collected mainly from public sector and from the fees collected by tax about 3 percents of Ministry of Health expenditure.

2. Population’s Out-of-Pocket Expenditure
   Based on National Health Morbidity Survey II in 1996, the population’s out of pocket expenditure is RM 3.820 billion or 1.53% of GDP.

3. Social Security Organization (SOCSO)
   This social security organization covers only private sector, with employees earning more than RM 2,000 per month.

4. Employees Provident Fund (EPF)
   The employees provident fund can be a current source of health care financing because this institution allow withdrawal of some saving for the purpose of medical expenses.
5. Private Health Insurance and MCO
There are few private health insurances in Malaysia, but basically the ministry of health considered the private health insurance and MCO is not well developed in Malaysia.

6. Medical Reimbursement Schemes (MRS)
The medical reimbursement scheme in Malaysia basically provided by larger employers such as Telekom.

7. Community Financing
The community financing basically initiated and sponsored by community, but they considered poorly organized and short-lived.

There is specific health care financing for a health care provision in Malaysia. Such as the public sector as a health care provision basically financed by general taxation (general revenue), the private sector who is the for profit organization financed by fee for services, HMO/MCO, Insurance or out of pocket employers (MRS). The ‘not for profit organization’ usually financed by fee for service, donation, insurance, MCO, government grant, or employers (MRS). The alternative medicine as a health care provision is basically financed by fee for service only. The financing of Malaysia health care provision will be shown by Figure 1.

Trends in Health Expenditure
The trend of health expenditure in Malaysia from 1990 to 1995 is shown by Table 1.

From the table we can see that the total Ministry of Health annual budget increasing from RM 1.623 billion in 1990 to RM 2.593 billion in 1995 or the increasing is about 59.77%. And from 1983 to 1996 (13 years) the total health expenditure increased by 250%.

The amount of expenditure between public and private in 1983 to 1985 according to Westinghouse NHFS are for public expenditure is 76.6%, and private is the rest, that is 23.4%. In 1993, according to World Bank, public spend is decreasing to 43.3% and private spending increasing to 56.7%. According to NHMS II in 1996, public spend is lower to 42.8% and private still increasing to 57.2%, but at year 2000 according to World Health Report public spent increasing again to 57.6% and private decreasing to 42.4% and this is make Malaysia overall performance ranked only 49 of 141 member states.

The ministry of health annual budget in 1996 was 6.17% from national Budget and 1.46% from GNP. The private sector expenditure according to National Health Morbidity Survey II (NHMS II) were 2.24% from GNP which is 57.2% of total expenditure. And the household expenditure according to NHHES 1996 is RM 2.8 billion.

The comparative health expenditures (1997) and health status of a few countries in the world, according to world health report 1999 and 2000, shown in the Table 2.

Source: Health Sector Financing Study

| Table 1. Trend of ministry of health annual budget 1990–1995 |
| --- | --- | --- | --- | --- | --- |
| Year | Development | Operating | Total | % of National Budget | % of GNP | Percapita Allocation |
| 1990 | 0.345 | 1.278 | 1.623 | 4.86 | 1.47 | 91 |
| 1991 | 0.594 | 1.446 | 2.014 | 5.31 | 1.73 | 112 |
| 1993 | 0.549 | 1.932 | 2.482 | 5.62 | 1.60 | 131 |
| 1995 | 0.427 | 2.165 | 2.593 | 5.31 | 1.35 | 129 |
Table 2. Comparative health expenditure (1997) and health status (1998)

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<tbody>
<tr>
<td>Indonesia</td>
<td>1.7</td>
<td>63 Male 67 Female</td>
<td>48</td>
<td>650</td>
</tr>
<tr>
<td>Malaysia</td>
<td>2.4</td>
<td>70 Male 74 Female</td>
<td>11</td>
<td>80</td>
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<tr>
<td>China</td>
<td>2.7</td>
<td>68 Male 72 Female</td>
<td>41.00</td>
<td>95</td>
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<tr>
<td>Korea</td>
<td>3.0</td>
<td>69 Male 75 Female</td>
<td>22</td>
<td>70</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>3.0</td>
<td>71 Male 75 Female</td>
<td>18</td>
<td>140</td>
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<tr>
<td>Papua N.G</td>
<td>3.1</td>
<td>57 Male 59 Female</td>
<td>61</td>
<td>930</td>
</tr>
<tr>
<td>Singapore</td>
<td>3.1</td>
<td>75 Male 79 Female</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Philippines</td>
<td>3.4</td>
<td>67 Male 70 Female</td>
<td>36</td>
<td>280</td>
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<tr>
<td>India</td>
<td>5.2</td>
<td>62 Male 63 Female</td>
<td>72</td>
<td>570</td>
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<tr>
<td>Thailand</td>
<td>5.7</td>
<td>66 Male 72 Female</td>
<td>29</td>
<td>200</td>
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<tr>
<td>U.K.</td>
<td>5.8</td>
<td>75 Male 80 Female</td>
<td>7</td>
<td>9</td>
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<tr>
<td>Canada</td>
<td>8.6</td>
<td>76 Male 82 Female</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Switzerland</td>
<td>10.1</td>
<td>75 Male 82 Female</td>
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<td>6</td>
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<tr>
<td>USA</td>
<td>13.7</td>
<td>73 Male 80 Female</td>
<td>7</td>
<td>12</td>
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Basically the table show that health expenditure as percentage of GDP is low, with the life expectancy quite high for female and male, the infant mortality rate is low compare to other countries, also the mother mortality rate is quite low.

Characteristics of Health Care Financing

According to Ministry of Health (2002) the characteristics of the new National Health Care Financing are:
1. Must be superior than the existing one
2. The strengths of present system must be maintained
3. Must include comprehensive coverage of services
4. The new health care financing must cover all population
5. The new health care financing can not deny emergency care
6. It must have greater equity and access
7. It must be able to manage the rate of growth of health care spending
8. It must have greater integration: between public and private, the primary, secondary, tertiary health care, and make primary health care as gate keeper
9. The new financing health care must be flexible, give a freedom of choice (between public and private)
10. Has quality and efficient
11. The most important result is can improve health status
12. The new health care financing can and will encourage innovation in health care system
13. The new health care financing is has acceptable and affordable contribution
14. It will keep the MOH expenditure at manageable level
15. It must be encourage innovation in health care system
16. It also has to be in line with Telemedicine Blueprint, goals of health system, vision for Health National Vision and Vision 2020.

Health Care Financing Model

Modeling is an involved process, and a clear definition of the nature, scope and context of financial models used in health care systems is required. The purpose of the model basically, attempt to translate complex observation into simpler images in order to better understand reality. A model is a means to describe experience reality and a basis for the prediction of future behavior. Financial model in health sector are a subgroup of the overall set financial models. They describe the expenditure and financing of the national health care delivery system, or a subsystem thereof, and permit the projection of the future financial status of the system, provided that future income and demand resemble those assumed in model. They provide a mapping of the complex interaction between financiers (contributors and
taxpayers), third-party financial intermediaries (insurance schemes or the state), providers, and beneficiaries (patients) in the health sector.

A national health care delivery system is a set of health care schemes that operates in a single country. A health care scheme is a body that organizes the delivery and financing of health care service for defined population subgroups (e.g. contributors and their dependents). Sometimes, two or more health care scheme may share a single delivery system, even though there is a line of demarcation between the schemes in term of financing (Cichon et al., 1999).

Based on the characteristics of health care financing required by Ministry of Health, this paper basically wants to review only three models that considered can be applied in Malaysia and widely used in many countries. The three models are community financing, national health insurance and medical saving account.

a. Community Financing

A specific way of organizing co-financing by household is community financing of health care. Community financing can be ‘health centre based’, implying that either the head of a health centre or a health committee are leaders in the organization of a scheme. Other organization may also be the leaders in a community financing system: village development association, cooperative, parents’ association etc. In other words, the method of community financing can sometimes build upon existing social organization.

One basic characteristic of community financing is that it always involves a certain degree of cost recovery organized at the local level. In addition, and ideally, it also requires a minimum involvement of the population in a scheme’s organization, via the election of health committees for example. Community financing may apply to rural as well as urban area. It can be arranged either by fees paid upon receiving health care or by some form of prepayment or local health insurance. It may also involve payments in kind for simple health activities, for instance, dairy product or chicken for the service of traditional birth attendants. In addition, for the construction and/or renovation of health care facilities, labor or other inputs in kind could be introduce as a means of financing them (World Health Organization, 1988).

Community financing has to involve a decentralized form of decision making. This has three distinct advantages. First, community financing may have a beneficial impact on the efficiency of health care activities. Often inefficiencies arise because of rationing of certain health inputs; either they impair the supply of health service or the quality of services suffers. If health inputs cannot be obtained from central government, it may be possible for them to be financed at the local level. For example, central government may not be able to guarantee the required supply of pharmaceuticals at the local level. Thus, if drug supplies prove to be insufficient or even non-existent, a local community financing scheme may arrange for the necessary financing. Secondly, the decentralized local administration of a scheme may affect health personnel’s incentives to collect revenues. (Twumasi and Freund, 1985). If revenues would have to be transferred to a higher bureaucratic level, there may be less incentive to enforce payments by patients (birdsall, 1983). However, with revenues being retained at the local level, health personnel may be more committed to the financing scheme, also because the expect to have a say in the allocation of revenues.

Thirdly, it is generally easier for the management of a community financing scheme, being closer to the population than in centralized scheme, to respond better to the preferences and demands of that population. This may foster the population’s compliance with costs-recovery measures. In addition, the population may have an outspoken preference for decentralized financing, if they obtain the right to control the use of a scheme’s revenues.

If adopted, the community financing approach should not, however be seen as a once and for all solution. It may be a short-run solution for administratively poor countries such as many in Sub-Saharan Africa. In the long run, a nation-wide financing scheme may well be advisable, since scattered community financing scheme may create inequalities between
communities, some may be able to finance an adequate amount of health service. While others, may be deterred from setting up a scheme owing to a lack of local administrative capacity. Also, our focus on community financing does not mean that government taxation, national health insurance or foreign aid should be neglected in the search for more health resources. Despite a number of difficulties associated with the application of the latter methods, they may become very appropriate at some point in the course of a country’s development. In some settings, some of these methods could also be used in conjunction with the community financing approach (Carrin, 1992).

**b. Health Insurance**

Health insurance is the scheme which provides coverage to individuals and family through premium paid to a carrier or agency which pool risks to protect against uncertainty. The type of health insurance including *organization of the scheme* can be divided into compulsory health insurance such as social insurance or social security, and voluntary health insurance such as private health insurance. Another type of health insurance is the kind of insurance that *manage risk* such as risk rated insurance and community rated insurance (Aljunid, 2000).

According to World Health Organization, 1988), the basic characteristic of health insurance is that expenditure for unpredictable episodes are financed in advance by regular contributions of the insured. Such a scheme has the advantage that even costly treatments can be made accessible to low-income household. Indeed, the periodic health insurance contribution may be small and therefore affordable.

The lack of government-sponsored health insurance in the rural sector of the economy does not imply that there would be no demand for insurance or no ability to contribute to insurance plans on the part of the population there. However, as yet, a centralized organization of health insurance, especially in low-income Africa, does not appear to be fully workable. Serious organizational problem have to be overcome. These include difficulties in setting up and guaranteeing the functioning of a low-cost and efficient administration. The organization of insurance may turn out be very cumbersome because problems may arise in assessing the capacity of household to pay, in determining affordable premiums and collecting them. A national health insurance programmed may also become especially costly owing to a lack of possibilities for easy communication between different bureaucratic echelons (Carrin 1992).

There are some issue in health insurance, the first issue is about premium of health insurance, the decision on premium level is depends on experience of the insured population, depend on the extends of risk sharing, subsidies given by government, and benefit package. To collect the premium is another important issue, usually employment based and there has to be a way to collect it from those in informal sector. The second issue is adverse selection. To solve this problem we have to make a compulsory scheme, exclude those with high risk or adjust premium level. The third issue is moral hazard, the moral hazard is ability of protected person to exploit benefits unduly to detriment or disadvantage of others or to the scheme as a whole, without having to bear the financial consequences of his or her behavior in part or in full. The forth issue is risk rating that usually applied on private insurance where the premium based on the actual loses experienced by the group in previous year. Young and healthy in non hazardous work has low premium but old, sick and in high risk work has high premium. This different with the community rating which is applied the same premium rate for every person in the community regardless of age, sex or health status, so every one pays the same percentage of income has premium.

The administrative cost in health insurance is high and that might be passed on to consumers. The cost including are the cost to enroll, cost to manage moral hazard or cost to pay providers.

**c. Medical Saving Account**

The medical saving account is just like a personal saving account. It is tax-free. The savings can pay for defined health care expenses and unused funds can be accumulated for future use of subscribers or family members or remain the property of
individual. This saving also can be combining with high deductible catastrophic insurance, so basically the medical saving account will provide incentives for individual to consume health care wisely.

There are three layers of medical saving account, the first is compulsory saving and family support system (MEDISAVE), the second is back up insurance for chronic conditions (MEDISHIELD) and the last one is government contribution for disadvantage groups (MEDIFUND).

The medical saving account operation is basically employment based, where employees and employers contribute to compulsory social-security fund. In the operation of medical saving account basically need maximum contribution from their member and they also have to pay to catastrophic insurance. The members will benefit from the service that covered by medical saving account and catastrophic insurance, but ambulatory care sometimes excludes and hospitalization are covered but capped. There is also out-of-pocket payment for service that excluded and deductible and co-insurance payments for catastrophic insurance. Basically the strength of MSA is encouraging members to be cost-conscious, reduce moral hazards and members can search (feel free to search) low cost providers. But, the weakness of medical saving account is that it is assume that members are rational in their choice. There is a risk selection in medical saving account in other words it is attract healthier and financially better off members and or chronic illness and those with reduce ability to purchased, they will reject medical saving account. There is also little or absence of risk pooling where the healthy get a rebate and to sick pay high premium. Further more medical saving account might discourage use of essential service such as preventive service (immunization) or delay in treatment of chronic illness, high deductible, exclusion of ambulatory care in benefits, and coverage for hospital services only.

Tax exemption of medical saving account can be seen as indirectly subsidizing the rich, because most of the member is rich. This tax exemption will be a loss of government revenue in US, the treasury could lose out $ 2 trillion in next 7 year. The medical saving account has limited application in developing countries, become and has a high degree of employment level.

Singapore introduces MSA (MEDISAVE) in 1984, MEDISHIELD (catastrophic insurance) in 1990, and MEDIFUND with means-tested safety net for poor in 1993. Medical saving account coverage of services Singapore include hospitalization capped at $ 300 per day, limited surgical operation budget, and not covered ambulatory/primary care service.

The Medishield catastrophic insurance’s annual deductible is $ 1,000 co-insurance is 20% and claim limits of S $ 20,000 per year and S $ 80,000 per lifetime and no coverage after 75 year of age. The Medifund in Singapore is for patients that unable to pay their hospital bills and the target at those with lower one third of income distribution that is less than S $ 1,400. The coverage is 80% of population in 1997, and the source of funding is 60% from private 31% from public and 9% from medical saving account.

CONCLUSION

Sometimes, countries spent more money on health care just because they have money to spend and not because they have greater medical needs. This is proved by USA high spending on health did not result in much better health indicator than Japan. This is also shown that the more effective health financing, in this example is Japan, the more it can contribute to positive change in health care. Health financing model here, is the most important aspect that a country must decide to pursue, in order to achieve the vision of health of that country.

After reviewing characteristics of current source of financing in Malaysia, the trends in health expenditure and characteristics of health care financing required by Ministry of Health, this paper proposed three health care financing models. The first model is the community financing model involves a certain degree of cost recovery organized at the local level and more decentralized. The second model is health insurance, the scheme which provides coverage to individuals and family through premium paid to a carrier or agency which pool risks to protect against uncertainty.
Finally, the third model is medical saving account which is just like a personal saving account, tax-free and the savings can pay for defined health care expenses, the unused funds can be accumulated for future use of subscribes or family members or remain the property of individual.

REFERENCE


