MALAYSIAN SOCIETY AND HEALTH: ISSUES AND CHALLENGES IN THE 21ST CENTURY

Introduction

Health is complete physical, mental, social well-being and not only the absence of illness of an individual.
WHO/Allopathic Practitioner

Health is not simply a physical or a mental state. Health is a state of balance in the body, the family, the village, the country, and the world.
Sri Lankan Ayurvedic Practitioner

In a new era, Malaysia may be well on the road towards achieving developed nation status. To some extent and in comparison to neighbouring countries, Malaysian society today enjoy relatively high standards of living, above-average health status, political and economic stability. Yet, we must not become complacent. With the dawning of the new millennium, there are also numerous challenges to our society, not least of which is ensuring the availability of sustained quality health care and services. The recent economic and financial climate pose serious challenges to the Malaysian health care system and our above-average health status. There is also the need to continually improve the management of our health care system to cope with changing demography, rapid social change due to modernisation/urbanisation, newly emerging as well as re-emerging diseases previously well-controlled.

Health status

Access

Malaysians today enjoy greater accessibility to health services as indicated by the proportion of doctors per 10,000 population that had trebled from 2.6 in 1980 to 6.8 in 2000. Eighty-eight percent of the urban poor and 77% of the rural population are within 9 km of either a Government or private clinic. It is important to point out that these milestones towards achieving good health status had been gained with relatively low health expenditure. The 1996 National Household Health Expenditure Survey (NHHES) found that although private healthcare costs were higher, private facilities were the most frequently utilized sources of care for acute conditions. However, for inpatient care, the low-income group tended to utilize services provided by the public or government health sector (Eighth Malaysia Plan 2001-2005).

Mortality

It is an undeniable fact that Malaysians enjoy a relatively good health status as reflected in our selected health indicators (see Table 1). Increasing life expectancy and the sustained decline in infant (IMR) and maternal mortality rates (MMR) are significant indicators of the above average health status of Malaysian society. Male life expectancy has been increasing from 66.7 years in 1980 to 70.2 years in 2000, while Malaysian women today are expected to live up to 75 years. As shown in Table 1, the sharp decline in the Malaysian infant mortality from 19.7 per 1000 livebirths in 1980 to 9.5 per 1000 livebirths in 2000 is an impressive achievement, comparing to that for middle-income and high-income countries. However, IMR rates for Sabah and Sarawak are not comparable to that in the Peninsula because of under-reporting, lower level of development, and higher proportion of births delivered by untrained birth attendants (WY Low *et al*, 1996).

Over these last 20 years, maternal deaths had not only been significantly reduced, from a MMR of 0.6 per 1000

Table 1. Selected Indicators of Health Status

Health Status Indicator	1980	1985	1990	1995	1997	2000[P]
Life Expectancy: Male	66.7	67.9	69.0	69.3	69.6	70.2
Female	71.6	73.0	73.5	74.0	74.5	75.0
Crude birth rate (per 1,000)	30.9	31.7	28.4	28.0	25.5	24.5
Crude death rate (per 1,000)	5.3	5.0	4.7	4.4	4.6	4.4
Doctors per 10,000 population	2.6	3.2	3.8	4.5	6.6	6.8
Dentist per 10,000 population	0.5	0.7	0.7	0.9	0.9	0.8

Source: Sixth Malaysian Plan; Vital Statistics Malaysia 1997; Social Statistics Bulletin Malaysia 2000.

Note: P – preliminary figures

livebirths to 0.2 per 1000 livebirths, but the latter has been sustained since 1995. Once again, we need to take note of the regional and social class differences. For instance, while the rate of decline seems more rapid for Peninsular Malaysia, it has appeared to have stabilized in the eighties period due to the lag in development in Sabah (0.4 per 1000 livebirths in 1998). In Sabah, the implications of migrants from poorer neighbouring countries have to be considered, that is, their lower socio-economic status impacting upon infant and maternal mortality (MOH, May 2000).

Morbidity

As has been mentioned earlier, Malaysian society experience both infectious and chronic diseases due to the health or epidemiologic transition that we find ourselves in today.

Communicable/Infectious Diseases

Malaysia has been successful in controlling communicable diseases through child immunization programmes, provision of safe water supply, proper sanitation and waste disposal, and food quality control. For example, the immunization program in 1999 achieved 100% coverage for BCG, 94.1% for the triple antigen vaccine (diptheria, pertussis and tetanus), 86.2% for measles, and 93.4% for poliomyelitis. Indeed, Malaysia was declared a polio-free area in October 2000. The incidence rate for malaria declined from 286.1 per 100,000 population in 1995 to 60.8 in 1999 (Eighth Malaysia Plan 2001-2005). Outbreaks of dengue haemorhagic fever occur periodically, more so in urban areas. A seasonal variation in dengue outbreaks has been identified, with increased rates during the dry season (May to September) (Sekhar & Ong 1992/93). Malaysian society was recently shaken by the emergence of the Nipah Virus outbreak. Learning from this experience, efforts to establish the Infectious Disease Centre were started in 1999; and rapid response and greater collaboration efforts were established through the inter-ministerial committee and networking with international bodies, such as, WHO and the CDC in Atlanta (Eighth Malaysia Plan 2001-2005). Full coverage of piped water supply was achieved for urban areas and 84% for rural areas in 2000. These efforts contributed to a reduction in the incidence of water-borne disease from 3,500 in 1995 to 2,100 in 2000. The rural sanitation program covered 99% or 1.7 million households in the same year (Eighth Malaysia Plan 2001-2005).

Malaysian society ought to wake up to the HIV/AIDS epidemic in our midst impacting on everyone – men, women, adults and adolescents, and not confined only to intravenous drug users. The data point to a dramatically increasing trend since the first cases were identified in 1986. The HIV/AIDS incidence rate increased steadily over the ten years, from 0.01 per 100,000 population in 1987 to 2.43 per 100,000 population in 1997. Whilst the mortality rate of AIDS followed a similar increasing trend from 0.02 per 100,000 population in 1988 to 1.88 per 100,000 in 1997 (Abu Bakar Suleiman & M Jegathesan, undated). From 3 HIV cases in 1986, the number escalated to 4692 cases in 1999, with a cumulative total amounting to 33,233. The cumulative total for AIDS cases was 3,554 in 1999. Ninety-four percent of these were men and six percent were women. The upward trend for women is noticeable since 1995 and this is worrisome. Forty-two percent of the HIV+ cases were below 29 years of age and 30 per cent of AIDS cases were found within this cohort. Although a relatively small proportion (4 per cent) of known AIDS cases were adolescents (13-19 years), 22 percent of them were between 20-29 years. This latter group may have first contracted HIV during their teens, given the possibly lengthy period between viral infection and appearance of disease symptoms. Indeed, data showed that the Heterosexual category had the second highest proportion of HIV+ and AIDS cases, following after the intravenous drug user category (Malaysian AIDS Council, 2000).

Table 2. Principal causes of hospitalisation in government hospitals, Malaysia, 1998

Principal causes	Number of discharges
Total	1,552,845
Normal delivery	305,380
Complications of pregnancy	186,994
Injury and poisoning	162,170
Diseases of the circulatory system	103,512
Certain conditions originating in the perinatal period	83,022
Diseases of the respiratory system	101,123
Diseases of the digestive system	72,006
Signs, symptoms and ill-defined conditions	63,120
Infectious and parasitic diseases	116,703
Diseases of the urinary system	68,590
Diseases of the blood and blood forming organ	10,749
Others	279,476

Source: Social Statistics Bulletin 2000

In terms of programs, the Ministry of Health Malaysia began monitoring and surveillance since 1985 of the numbers afflicted by instituting mandatory reporting under the Prevention and Control of Infectious Diseases Act (1988). In 1995, a Malaysian AIDS Charter was launched by the Minister of Health, a document formulated by nearly 80 government and NGO agen-

Table 3. Deaths by medically certified and inspected cause, Malaysia, 1994-1998

Cause of death	Year				
	1994	1995	1996	1997	1998
Total deaths	38,223	41,395	41,694	44,154	43,514
Pneumonia	1,245	1,492	1,433	1,670	1,865
Tuberculosis	525	524	573	569	573
Septicaemia	1,980	2,399	2,641	2,741	2,923
Malignant neoplasm of tranchea, bronchus and lung	832	884	821	909	941
Malignant neoplasm of female breast	260	320	297	339	339
Malignant neoplasm of cervix uteri	165	142	146	129	177
Diabetes mellitus	720	734	677	807	729
Hypertensive disease	275	285	362	530	450
Acute myocardial infarction	3,166	3,383	3,306	3,426	3,328
Other ischaemic heart disease	899	931	932	1,039	1,062
Cerebrovascular disease	3,136	3,349	3,271	3,355	3,367
Atherosclerosis	5	5	2	1	1
Other diseases of circulatory system	3,274	3,664	3,621	3,830	3,902
Motor vehicle traffic accidents	2,039	2,289	2,693	2,985	2,577
Suicide and self-inflicted injury	36	52	92	177	200
Homicide and injury purposely inflicted by other persons	47	44	74	117	141
Other violence	2,303	2,534	2,429	2,300	2,115

cies involved in AIDS-related activities, in consultation with people with HIV/AIDS, representatives from various groups, including religious leaders and sex workers. This Charter explicitly states the rights and responsibilities of individuals, organisations and government bodies pertaining to AIDS, and addresses significant issues such as testing, confidentiality and access to information and education (WY Low *et al*, 1996).

Among the principal causes of hospitalisation at government hospitals in 1998 in Malaysia, excluding normal birth deliveries and pregnancy complications, injury and poisoning and infectious and parasitic diseases were prominent causes (Vital Statistics Malaysia 2000).

Data on deaths by medically certified and inspected cause in Table 3 show that septicaemia, pneumonia and tuberculosis were the most common fatal infections in 1998, accounting for 6.7%, 4.3% and 1.3% of total deaths (35,612), respectively. Moreover, there was an increasing trend for all three diseases for the period 1994 to 1998 (Vital Statistics Malaysia 2000).

Chronic Diseases

Chronic diseases have become more prominent in this country with time. Part of the increase in chronic ailments is due to improved longevity among Malaysians as mentioned earlier. At the same time, economic progress and increased affluence have been accompanied by changes in lifestyle, including diet, which have also contributed to this change in disease pattern.

The Second National Health Morbidity Survey showed increasing incidences of non-communicable or chronic diseases amongst the Malaysian population, such as, hypertension, diabetes, and obesity as well as mental disorders (Eighth Malaysia Plan 2001-2005). A review of hospital deaths also revealed the relative importance of adult non-infectious diseases related to lifestyle, occupation and environmental risks such as cardiovascular diseases, cancers, injuries, and accidents. While deaths due to communicable/infectious diseases and fevers have seen marked reductions in all age-specific groups, deaths from accidents, cardiovascular related diseases, and cancers have increased in almost all age-specific groups between 1982 – 1996 (Abu Bakar Suleiman & M Jegathesan, undated, pp 409-410).

Table 3 shows the increasing prominence of non-communicable illnesses, such as heart disease and cerebrovascular disease, compared to infectious diseases such as pneumonia over the period 1994 - 1998. The most common certified cause of death continues to be cardiovascular, particularly acute myocardial infarction, and cerebrovascular disease. As a group (hypertensive disease, myocardial infarction, ischaemic heart disease, cerebrovascular disease, artherosclerosis and other diseases of the circulatory system), these conditions constitute about 27% of total deaths in 1998 (Social Statistics Bulletin 2000).

Malignant neoplasms have increased as a contributor to total deaths in this country, particularly malignant

neoplasms of trachea, brochus and lung (see Table 3). In 1999, the annual prevalence of cancer in Malaysia was estimated to be 230 per 100,000, and the annual incidence was estimated to be 30,000. The incidence of cancer is expected to rise with an increasingly ageing population. A regional cancer registry has shown that the ten leading cancers among men were lung, nasopharynx, stomach, urinary bladder, rectum, non-Hodgkin's lymphoma, larynx, liver, colon, and the oesophagus. While the ten leading cancers among women were cervix, breast, ovary, lung, nasopharynx, oesophagus, thyroid, colon, rectum, non-Hodgkin's lymphoma (Social Statistics Bulletin 2000; Ministry of Health, 1999, pp 219-220). It is important to note here that cancer of the lung is the most common killer amongst malignancies.

Mental Health

Until very recently, relatively little attention has been paid to mental health issues in this country despite the growing manifestations. Hence, it is timely to take note of this problem here. Mental health problems tend to bear the stigma of shame and embarrassment for family members, and hence, are kept concealed. Skilled manpower resources, such as psychiatrists, psychologists, counsellors and behavioural scientists, capable of dealing with mental health issues are very much lacking in this country in this stage of its development. It is alleged that traditions, religious beliefs, and social behaviours have important influences on suicide in every country, as illustrated in the consistently low rates in Islamic countries and rising trends in societies experiencing rapid social change (Ministry of Health, 1999).

As an indicator of mental health, the number of deaths due to suicides and self-inflicted injuries had increased from 36 or 0.1% in 1994 to 200 or 0.4% in 1998 (see Table 3). While data collected from the Ministry of Health hospitals from all states showed that there were 2,931 suicide cases in 1996 and 2,738 cases in 1997. In Malaysia, the suicide rate is 3 per 100,000 population which is relatively low as compared to a rate of 20% in France (1990). The suicide rate prevalent in a society is said to be one of the important indicators of its socioeconomic structure and status and is determined by various psychological, socio-economic and cultural factors. There seemed to be a gender difference in suicide rate, as shown in data on suicide and parasuicide from public hospitals in the country whereby the rate among women was higher than that among men for the years 1995, 1996 and 1997 at 59.9%, 63.3%, and 60.8% respectively (Ministry of Health, 1999). Data on attempted suicides admitted to a major public hospital in the capital city showed that the majority were women of lower income, low education, Indian ethnicity, and younger age (<39 years) (Mohd Hussain *et al* 1992/1993). There were twice as many women as men among the cases. Depression caused by maladjustment to psychosocial stressors, particularly financial problems and interpersonal conflicts with spouses, friends and family members, was the main predisposing factor involved in the suicide attempt.

Health Issues and Challenges

Despite the tremendous health gains and above-average health status that Malaysians now enjoy as described above, we are compelled to take stock of the emerging health issues as well as to handle serious challenges to our health in the 21st century. These include changing trends in diseases due to demographic and health transitions, environmental health, migration influxes and health, effects of gloablisation on health, mental health and wellness as well as fundamental access and equality in health care.

Demographic and Health Transitions – Impact on Morbidity Patterns

The changes in the Malaysian demographic profile that will warrant attention from the health sector are our gradually ageing population, urbanization/modernization, the nuclear family structure, and a population that is increasingly health conscious (Abu Bakar Suleiman & M Jegathesan, undated). In the foregoing discussion on diseases, some of the recorded changes in the pattern of morbidity have been due to changes in the age composition of the population. At the same time, modernisation has also influenced society's values and behaviour with an impact on both communicable and non-communicable diseases. For example, demographic changes have led to an increase in the number of adolescents and young adults being exposed to the related rise in the risk and prevalence of sexually transmitted diseases. Moreover, changing attitudes towards sexuality might also influence sexual behaviour and the transmission of disease. Thus, how sex education can impact positively on sexual behaviour in the future and how to prevent or diminish the incidence of disease will be one of the future challenges. Although generally Malaysia has been successful in controlling communicable diseases, some of these, such as, HIV/AIDS , dengue, and tuberculosis will continue to be a challenge together with non-communicable diseases such as cardiovascular-related diseases, cancers, and accidents. Thus, we would need to be vigilant in sustaining the health successes and gains and not be lulled into complacency.

Environmental degradation and Health

The Ministry of Health has identified environmental factors to be the major contributors to the health problems of Malaysian society in the future. Environmental degradation is becoming a great concern for the coun-

try because it will undermine the sustainability of social and economic development and health. The three areas pertinent to environmental consideration and public health are water pollution, air pollution, and the management of solid waste. The MOH alleged that the observed rise in cardiovascular diseases, cancer, and accidents should not attributed entirely to individual lifestyle changes or viral infections. Instead, environmental and occupational hazards such as industrial conditions, crowded roads and pollution are major causes of injuries, respiratory disease, linked cardiovascular disease, and cancer. The impact is more marked in males in the 30-63 years age group, particularly in relation to accidents, cancers, and heart attack rates. It is important to note the MOH views seriously the effects of urbanisation on the environment and health. The urban areas, with the "built environment", are now faced with a host of new problems arising out of atmospheric and water pollution, accidents, urban housing, town planning as they relate to mental, social, and physical health (Abu Bakar Suleiman & M Jegathesan, undated; WY Low *et al*, 1996).

Migration and Health

Here, we are concerned with the issue of foreign migrant workers in particular. As Malaysia's relative favourable socioeconomic conditions have drawn a large pool of foreign workers, it has also created a whole set of health and social issues and problems, especially in the introduction and transmission of diseases and different value systems that need to be addressed. In 1994, foreign workers represented 35.4% (118 cases) of the total reported cases of leprosy nationwide. With regards to tuberculosis, they constituted 10.5% (1,230 cases) of the total, and they made up 12.6% (7,421 cases) of new cases of malaria. Foreign workers constitute a large proportion of the urban poor living in unhealthy and crowded squatter/slum conditions, leading to problems of violence and disease infection (Abu Bakar Suleiman & M Jegathesan, undated).

Globalisation

With the fervour about globalisation raging around us, it is also increasingly acknowledged as a force that is changing our lives, including our health, far beyond financial markets and international trade. Changes in trade and markets, the movement of people, goods and services including trade in legal and illegal substances, contaminated foodstuffs, inappropriate medical technology and in military arms are being facilitated by the globalisation process. It is, thus, a concern that continuing globalisation reduces the control that governments have over a growing number of health determinants that derive from the international transfer of health risks (Abu Bakar Suleiman & M Jegathesan, undated).

Mental Health & Wellness

As it has been mentioned earlier that mental disorders are one of the chronic diseases that have been on the rise. However, the issues of early recognition and detection in the form of depression and anxiety illnesses are being taken seriously only recently. Another issue is the failure to link the relationship between mental health and physical illness, and hence the inadequate as well as ineffective treatment being given to mental health patients. For instance, while millions of dollars are spent on reduction of cigarette smoking, there are few attempts to relate smoking behaviour to mental health factors in the smoker. Similarly, in health promotion efforts to reduce obesity so as to decrease incidence of non-insulin dependent diabetes and cardiovascular diseases, mental factors are seldom, if ever, taken into account in looking into the causes of diet, eating habits and obesity (Deva MP, 1999, p 58).

Although as has been discussed earlier that the suicide rate in Malaysia is relatively low compared to other countries, it is doubtful that this low trend will continue as our society is now going through rapid and unprecedented social changes mentioned previously. It is pertinent to stress, here, that studies have indicated that approximately 80% of parasuicide cases have no underlying psychiatric disorders, thus emphasising the need for increasing awareness of general public and health care practitioners on the association between risks of suicide and mental health (Malaysia's Health, 1999). Thus, for the immediate and now, specific services to promote mental health and to help people cope with such traumatic social and structural changes are greatly needed. Whilst, for the long run, preventive approaches such as Wellness programs are also equally important. The fundamental concept of wellness or healthy lifestyle dates back to the concepts of "holistic health". Wellness refers to a lifestyle that one chooses and designs to maximise one's potential for well-being through a balanced life that gives a sense of purpose, inner peace, and satisfaction. Wellness involves eight dimensions, each an important facet of life: the social, physical, spiritual, emotional, nutritional, intellectual, occupational and the environment. It is also a framework that can be used in many ways to help in organising, understanding, and balancing human growth and development towards a more proactive, responsible, and healthier existence. The Eighth Malaysia Plan has specifically stated that the expansion of the wellness program will be one of the strategies for the country's health sector development (Eighth Malaysia Plan 2001-2005).

Equity Health Care

The Ministry of Health has acknowledged that although progress in the health status of the general Malaysian society is evident, the number of people living in pov-

erty and poor conditions of nutrition and health is significant. Indeed, it has been alleged that the issue of equity in health care will be the most challenging of all. Equity in health care refers to equal access to available care for equal needs, equal utilisation for equal need and equal quality of care for all. Closely associated with equity health care is the appropriateness of care, availability of affordable care and quality of care. The MOH has stressed that any future health system should ensure the delivery of dependable and high quality care which is based on need and not on the ability to pay (Abu Bakar Suleiman & M Jegathesan, undated). Fundamental and complex issues of health costing and health financing, thus, arise and many are still in the process of being debated: health reform, privatisation, national health insurance, public-private mix and so forth. In essence, the debate has revolved around whether health financing is a social responsibility or it is a private matter to be left to market forces. It has been argued that usually the pursuit of free price setting and consumer choice (market forces) is in conflict with concerns for equity, efficiency and budgetary constrains (Abu Bakar Suleiman & M Jegathesan, undated).

Future Prospect

In view of the above health issues and challenges facing Malaysian society today, pressure is building for health care reform and transformational changes are taking place. It has been alleged that this can only occur if the MOH is successful in its mission of building partnerships in health and the creation of health as an asset. It is hoped that Malaysia will continue its emphasis in upholding and conforming to the principles of Primary Health Care. At the same time, both the Vision for Health and the Health for All strategy should remain on Malaysia's health agenda in the new millennium. As pressures on resources increase, health care decisions have to be made explicitly and publicly, warranting a basic scientific approach to health care management (Abu Bakar Suleiman & M Jegathesan, undated).

Thus, the strategies for health sector development during the Eighth Malaysia Plan period will include the following:

- Improving accessibility to affordable and quality healthcare
- Expanding the wellness programme
- Promoting coordination and collaboration between public and private sector providers of health care
- Increasing the supply of various categories of health manpower
- Strengthening the telehealth system to promote Malaysia as a regional center for health services
- Enhancing research capacity and capability of the health sector
- Developing and instituting a healthcare financing scheme, and
- Strengthening the regulatory and enforcement functions to administer the health sector, including traditional practitioners and medical products

Concluding Remarks

Being pro-active, resilient, and innovative, Malaysian society would forge ahead towards our Vision for Health in this new era. That is, to be a nation of healthy individuals, families, and communities, through a health system that is equitable, affordable, efficient, technologically appropriate, and environmentally adaptable, with emphasis on quality, innovation, health promotion and respect for human dignity, and which promotes individual responsibility and community participation towards an enhanced quality of life.

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